SMALL EMPLOYER HEALTH INSURANCE

A Report to the
Joint Standing Committee on
Banking and Insurance
of the
116th Maine Legislature

Prepared by the
Bureau of Insurance
January, 1993

PREFACE

Maine Public Law 1991, Chapter 861, "An Act to Provide More Affordable Health Insurance for Small Businesses and Community Rating of Health Insurance Providers," contained in Section 5 a requirement that the Bureau of Insurance report on five issues on or before January 1, 1993. The following five sections of this report address those five issues:

Section 1. "STANDARD AND BASIC HEALTH INSURANCE PLANS THAT INCLUDE HEALTH INSURANCE MANDATES"

Section 2. "GUARANTEED ISSUANCE AND RENEWABILITY OF HEALTH INSURANCE AND THEIR APPLICABILITY WITH AND WITHOUT STANDARDIZED PLANS"

Section 3. "DATA COLLECTION REGARDING HEALTH INSURANCE COVERAGE AND EMPLOYER PRACTICES FOR EMPLOYERS OF FEWER THAN 25 EMPLOYEES AND THE SELF-EMPLOYED."

Section 4. "WELLNESS PROGRAMS DESIGNED FOR INTRODUCTION AT PLACES OF EMPLOYMENT, THEIR USAGE AND EFFECT, ANY USE BEING MADE OF THEM IN RATING BY CARRIERS AND A DEFINITION FOR THEM FOR STATUTORY ENACTMENT"

Section 5. "ALTERNATIVE MODELS FOR RISK SHARING IN THE ISSUANCE OF SMALL GROUP HEALTH PLANS"

A copy of the law is appended to this report.

TABLE OF CONTENTS

Section 1.

"STANDARD AND BASIC HEALTH INSURANCE PLANS THAT INCLUDE HEALTH INSURANCE MANDATES"

A. INTRODUCTION

Title 24-A MRSA §2808-B, subsection 8, which was enacted by Maine Public Law 1991, Chapter 861, "An Act to Provide More Affordable Health Insurance for Small Businesses and Community Rating of Health Insurance Providers," requires that any insurer or HMO offering health insurance to small employers must offer two standardized plans to be defined by rule by the Superintendent of Insurance. One plan, called the "standard" plan, is to be similar to plans typically sold to small employers. The other, the "basic" plan, is to emphasize preventive care and is to contain lesser benefits to the extent necessary to reduce the anticipated cost by 20%. Both plans are to meet the statutory requirements concerning mandated benefits.

Minimum standards for two of the mandated benefits, mental health and substance abuse, are established by rule. Revisions to these rules were proposed by the Bureau on October 1, 1992. Public hearings were held on October 29 and written comments were accepted through November 9. The Bureau is currently considering those comments and has not adopted a revised version to date. The illustrative standardized plans included in this report may need to be revised if they fail to meet these new minimum standards.

Most of the material in this section was provided by Janet M. Carstens, FSA, and Ted A. Lyle, FSA, of Tillinghast, who were retained by the Bureau to assist in this project. The illustrative standardized plans were developed by them, under direction of the Bureau's Life and Health Actuary, Richard H. Diamond, FSA, MAAA. These plans are currently under review by the Superintendent and other Bureau staff, and may be amended before being included in a proposed rule. Further amendment may occur through the rulemaking process.

In developing the illustrative standardized plans, standardized small group health insurance plans adopted by several other states were analyzed. These states included Florida, Iowa, Massachusetts, Minnesota, New Mexico, North Carolina, Oregon, Vermont and Wyoming. Detailed summaries of these benefit plans are included as an appendix to this section.

B. STANDARD PLANS

A "standard" benefit plan was developed which is similar to standard plans adopted by other states, but includes coverage of Maine-mandated benefits. The standard benefit plans for indemnity carriers and health maintenance organizations (HMOs) are illustrated on Exhibits A and B, respectively. In developing the HMO standard benefit plan, benefits were determined which were believed to be comparable to the standard indemnity plan from the policyholder's perspective, as opposed to constructing an HMO standard plan which was equivalent in price to the standard indemnity plan. The benefits provided under the proposed indemnity and HMO standard plans are considered representative of benefits commonly offered by small employers and somewhat richer than the standard plans developed by other states. The proposed standards represent comprehensive and meaningful benefit plans.

The standard indemnity plan has a variable deductible. That is, a choice of deductibles can be offered, with the employer choosing the one he or she considers most appropriate. The plan also includes 20% coinsurance to a maximum coinsurance limit of $1,000 for an individual ($2,000 for a family), and a $25 emergency room copayment.

The standard HMO plan includes a $250 inpatient hospital copayment per admission, a $100 outpatient surgery copayment, a $50 emergency room copayment, a $5 copayment on physician services, a $10 copayment on outpatient mental health and substance abuse services, and other miscellaneous copayments.

Subject to the deductible, coinsurance and copayment amounts, the standard plans provide coverage of the following benefits:

- Average semi-private room and board,
- Intensive care up to 3.0 x average semi-private,
- Other hospital charges --- inpatient or outpatient,
- Usual and customary surgical and physicians' charges,
- Diagnostic x-ray and laboratory services (DX&L),
- Ambulatory surgical center,
- Drugs requiring a physician's prescription,
- Private duty nurse,
- Ambulance and equipment,
- Home health care by an accredited agency under a written plan by a physician, and

- State-mandated benefits.

The standard plans also provide coverage of certain preventive services at 100% (i.e., no deductible, coinsurance or copayments are applicable to these benefits). Although the law only specifies that preventive services should be emphasized in the "basic" plan, it seems equally desirable to include these benefits in the standard plan. Furthermore, it would be difficult to achieve the required 20% cost differential if preventive care benefits were only included in the "basic plan". They are emphasized more in the basic plan, in that they represent a larger portion of the total benefit package. A listing of the specific preventive services covered is provided in the "Basic Plans" section of this report.

The benefit plan limitations and exclusions are:

- 12 month preexisting condition exclusion for groups without prior coverage or late entrants to a group,
- Lifetime limit of $25,000 for substance abuse charges,
- Lifetime limit of $25,000 for mental health charges,
- No coverage for cosmetic surgery, reversal of a sterilization, implantation of an ovum, or experimental treatment,
- No coverage for work-related injuries or illness,
- Coordination with other carriers on the usual priority bases, and
- Extension of benefits after termination of individual coverage, or employers' termination, or group termination is in effect while totally disabled, but not to exceed 90 days.

C. BASIC PLANS

The "basic" benefit plans for indemnity carriers and HMOs are illustrated on Exhibits A and B, respectively. The plans have an actuarial value approximately equivalent to 80% of the actuarial value of the standard benefit plans. The plans have been developed to emphasize preventive care by covering the following preventive benefits at 100% (i.e., no deductible, coinsurance or copayments are applicable to preventive benefits):

- Neonatal Care
  - one prenatal office visit per month during the first two trimesters of pregnancy
  - two office visits per month during the seventh and eighth months of pregnancy
  - one office visit per week during the ninth month and until term
- Newborn Care
  - inpatient hospital nursery
  - in-hospital pediatrician
- Well Baby Care
  - inpatient hospital and in-hospital pediatrician
  - 6 office visits in the first year
  - vaccines and immunizations
- Well Child Care
  - child health services
  - 2 visits per year for ages 1 and 2; annual visits for ages 3 and over (maximum pediatrician charge of $50, and maximum DX&L charge of $50)
  - vaccines and immunizations
- Well Adult Care
  - annual physical examination (maximum physician charge of $100, and maximum DX&L charge of $100)
  - mammography screening (maximum charge including tests of $200)

To derive an actuarial value of benefits equivalent to 80% of the actuarial value of benefits of the standard plans, cost sharing amounts for the basic indemnity and basic HMO plans were increased. In addition, as illustrated on Exhibits A and B, coverage for certain benefits was eliminated or made more restrictive.

The savings were achieved without relying on a higher deductible. Like the standard indemnity plan, the basic indemnity plan has a variable deductible. The differential in actuarial value of the basic plan with a given deductible is approximately 80% of the standard plan with the same deductible. The basic plan includes 40% coinsurance to a $1,000 coinsurance limit for single coverage ($2,000 for family coverage). While 40% may seem high, the $1,000 limit (the same limit as on the standard plan) should mitigate the impact on insureds.

The basic HMO plan includes a $250 per day inpatient hospital copayment (with no cap on the number of days the copayment is applicable), a $250 outpatient surgery copayment, a $150 emergency room copayment, a $20 copayment on physician services, a $20 copayment on outpatient mental health and substance abuse services, and other miscellaneous copayments. Here again, the copayments may seem high, but there is an out-of-pocket limit of twice the annual premium. If this level is reached, no further copayments will be applied. In addition, in order to derive an actuarial value of approximately 80% for the basic HMO plan relative to the standard plan, the benefits offered under the standard plan were slightly increased from those which would commonly be offered to small employer groups. Specifically, the $5 office visit copayment and $3/6 drug copayment amounts are less than might typically be expected in a standard plan.

Subject to the deductible, coinsurance and copayment amounts, the basic plans provide coverage of the following benefits:

- Average semi-private room and board,
- Intensive care up to 3.0 x average semi-private,
- Other hospital charges --- inpatient or outpatient,
- Usual and customary surgical and physician charges,
- DX&L, up to a $2,000 calendar year maximum,
- Ambulatory surgical center,
- Private duty nurse,
- Ambulance and equipment,
- Home health care by an accredited agency under a written plan by a physician, and
- State-mandated benefits.

Mandated benefit coverage under the basic plan is more restrictive than under the standard plan. For example, adjustive and manipulative services under the basic plan have been limited to a maximum of 6 visits versus 12 visits under the standard plan. Mental health and substance abuse benefits have also been limited. However, all plans must meet statutory and regulatory requirements.

The benefit plan limitations and exclusions are:

- 12 month preexisting condition exclusion for groups without prior coverage or late entrants to a group.
- Lifetime limit of $10,000 for substance abuse charges.
- Lifetime limit of $10,000 for mental health charges.
- No coverage for cosmetic surgery, reversal of a sterilization, implantation of an ovum, or experimental treatment.
- No coverage for work-related injuries or illness.
- Coordination with other carriers on the usual priority bases.
- Extension of benefits after termination of individual coverage, or employers' termination, or group termination is in effect while totally disabled, but not to exceed 90 days.

Exhibit C illustrates the estimated actuarial value of the standard and basic benefit plans for the indemnity plans. For illustrative purposes, the benefit value relationships between the basic indemnity and standard indemnity have been shown for deductibles of $250, $500, and $1,500. The average ratio for these three deductible plans is approximately 80%.

Exhibit D compares the standard and basic plans for HMO's. The actuarial value of the proposed basic HMO plan is approximately 80% of the actuarial value of the proposed standard HMO plan. The net medical expense for both the standard and basic HMO plans is higher than the net medical expense for the corresponding indemnity plans, reflecting the general comprehensiveness of HMO coverage even with substantial copayments.

EXHIBIT A

ILLUSTRATIVE BENEFIT PLANS: INDEMNITY PLANS

Limits	Standard Plan	Basic Plan
Deductible	Variable	Variable
Maximum Coinsurance Limit	$1,000/$2,000	$1,000/$2,000
Calendar Year/Lifetime Maximum	$1,000,000 Lifetime	$500,000 Lifetime
Primary Services		
Inpatient Hospital Services	80/20	60/40; 90 Day Calendar Year Limit
Outpatient Hospital Services	80/20	60/40
Diagnostic X-Ray and Lab	80/20	60/40; $2,000 Calendar Year Limit
Maternity Services	80/20	60/40
Physician Services	80/20	60/40
Emergency Services	80/20	60/40
(In Emergency Room, Not Admitted)	$25.00 Copayment	$50.00 Copayment
Ancillary Services		
Ambulance	80/20	60/40
Durable Medical Equipment	80/20	60/40
Skilled Nursing - (100 Day Maximum)	80/20	Not Covered
Home Health Care	80/20	60/40
Prescription Drugs	80/20	Not Covered
Adjustive & Manipulative Services	12 Visits; 80/20	6 Visits; 60/40

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Mental Health		
Lifetime Limit	$25,000	$10,000
Inpatient	80/20; 30 Days Per Calendar Year	60/40; 20 Days Per Calendar Year 40 Days Per Lifetime
Outpatient	50/50; $1,500 Per Calendar Year	50/50; $1,000 Per Calendar Year
Substance Abuse		
Lifetime Limit	$25,000	$10,000
Inpatient	80/20; 30 Days Per Calendar Year; 60 Days Per Lifetime	60/40; 20 Days Per Calendar Year 40 Days Per Lifetime
Outpatient	80/20; $1,500 Per Calendar Year	50/50; $1,000 Per Calendar Year
Infertility & Sterilization Services	Not Covered	Not Covered
Preventive Care		
Pre- & Postnatal	No Deductible or Coinsurance	No Deductible or Coinsurance
Well-Baby/Child Care	No Deductible or Coinsurance	No Deductible or Coinsurance
Well Adult	No Deductible or Coinsurance	No Deductible or Coinsurance
Mammography Screening	No Deductible or Coinsurance	No Deductible or Coinsurance

EXHIBIT B

ILLUSTRATIVE BENEFIT PLANS: HMO PLANS

Limits	Standard Plan	Basic Plan
Deductible	None	None
Maximum Coinsurance Limit	200% Total Annual Premium	200% Total Annual Premium
Calendar Year/Lifetime Maximum	None	None
Primary Services		
Inpatient Hospital Services	$250 Per Admission	$250.00/Day; 90 Day Calendar Year Limit
Outpatient Hospital Services	$100.00/Outpatient Surgery	$250.00/Outpatient Surgery
Diagnostic X-Ray and Lab		$2,000 Calendar Year Limit
Maternity Services	Same As Any Other	Same As Any Other
Physician Services	$5.00 Copayment	$20.00 Copayment
Emergency Services	Same As Any Other	Same As Any Other
(In Emergency Room, Not Admitted)	$50.00 Copayment	$150.00 Copayment
Ancillary Services		
Ambulance	$25.00 Copayment	$25.00 Copayment
Durable Medical Equipment	No Charge	No Charge
Skilled Nursing - (100 Day Maximum)	$25.00 Per Day	Not Covered
Home Health Care	$10.00 Copayment	$20.00 Copayment
Prescription Drugs	$3.00 Generics/$6.00 Brand	Not Covered
Adjustive & Manipulative Services	12 Visits; $5.00 Copayment	6 Visits; $20.00 Copayment

continued...

EXHIBIT B (cont.)

Mental Health		
Lifetime Limit	$25,000	$10,000
Inpatient	Same As Any Other; 30 Days Per Calendar Year	Same As Any Other; 20 Days Per Calendar Year; 40 Days Per Lifetime
Outpatient	$10.00 Copayment; $1,500 Per Calendar Year	$20.00 Copayment; $1,000 Per Calendar Year
Substance Abuse		
Lifetime Limit	$25,000	$10,000
Inpatient	Same As Any Other; 30 Days Per Calendar Year; 60 Days Per Lifetime	Same As Any Other; 20 Days Per Calendar Year; 40 Days Per Lifetime
Outpatient	$10.00 Copayment; $1,500 Per Calendar Year	$20.00 Copayment; $1,000 Per Calendar Year
Infertility & Sterilization Services	Not Covered	Not Covered
Preventive Care		
Pre- & Postnatal	No Copayments	No Copayments
Well-Baby/Child Care	No Copayments	No Copayments
Well Adult	No Copayments	No Copayments
Mammography Screening	No Copayments	No Copayments

EXHIBIT C

ESTIMATED VALUE OF INDEMNITY PLANS

STANDARD INDEMNITY		Deductible		
		$250	$500	$1,500
Value of 100% Plan[1] - Dollar Value[2]		$161.56	$161.56	$161.56
- Factor		100.00%	100.00%	100.00%
Deductible, 80% Coinsurance, $1,000 Coinsurance Max	x	76.50%	67.90%	48.80%
Add Preventive Care	x	105.20%	105.20%	105.20%
Subtract Emergency Room Copay - $25	x	99.80%	99.80%	99.80%
	=	80.32%	71.29%	51.23%
Dollar Value of Standard Plan[2]		$129.76	$115.18	$82.77
BASIC INDEMNITY				
Value of 100% Plan[1]		100.00%	100.00%	100.00%
Deductible, 60% Coinsurance, $1,000 Coinsurance Max	x	68.40%	61.50%	45.50%
$500,000 Lifetime Maximum	x	99.60%	99.60%	99.60%
90 Day Inpatient Hospital Limit	x	99.10%	99.10%	99.10%
$2,000 Diagnostic X-Ray and Lab Limit	x	99.80%	99.80%	99.80%
Subtract Emergency Room Copay - $50	x	99.50%	99.50%	99.50%
Limit Adjustive and Manipulative Services to 6 Visits	x	99.70%	99.70%	99.70%
Eliminate SNF	x	99.90%	99.90%	99.90%
Eliminate Outpatient Prescription Drugs	x	91.10%	91.10%	91.10%
Limit Inpatient Mental Health to 20 Days	x	99.80%	99.80%	99.80%
Limit Inpatient Substance Abuse to 20 Days	x	99.80%	99.80%	99.80%

EXHIBIT C (cont.)

Limit Outpatient Mental Health to $1,000	x	99.70%	99.70%	99.70%
Limit Outpatient Substance Abuse to $1,000	x	99.80%	99.80%	99.80%
Add Preventive Care	x	105.20%	105.20%	105.20%
	=	63.42%	57.02%	42.19%
Dollar Value of Basic Plan[2]		$102.46	$92.12	$68.16
Benefit Plan Relationship (Basic Plan/Standard Plan)		79.0%	80.0%	82.4%

(1) Includes Outpatient Prescription Drugs, Chiropractic Services and Preventive Care.

(2) Estimated monthly cost for an individual, year beginning 7/1/93; Net Medical Expense Only, Does Not Include Retention (Administrative Expenses)

EXHIBIT D

ESTIMATED VALUE OF HMO PLANS

STANDARD HMO

Value of 100% HMO Plan[1] - Dollar Value[2]		$149.19
- Factor		100.00%
Hospital Inpatient Copayment - $250 Per Admission	x	98.70%
Outpatient Surgery Copayment - $100	x	99.70%
Office Visit Copayment - $5	x	98.80%
Emergency Room Copayment - $50	x	99.50%
Ambulance Copayment - $25	x	99.95%
SNF Copayment - $25/Day	x	99.99%
Home Health Care Copayment - $10	x	99.98%
Outpatient Prescription Drug Copayment - $3/$6	x	98.50%
Adjustive and Manipulative Services Copayment - $5	x	99.80%
Outpatient Mental Health Copayment - $10	x	99.80%
Outpatient Substance Abuse Copayment - $10	x	100.00%
	=	94.80%

Dollar Value of Standard Plan[2]	$141.43

BASIC HMO

Value of 100% Plan[1]		100.00%
Hospital Inpatient Copayment - $250/Day, No Day Cap	x	93.90%
90 Day Inpatient Hospital Limit	x	99.10%
Outpatient Surgery Copayment - $250	x	99.20%
Office Visit Copayment - $20	x	95.30%
$2,000 Diagnostic X-Ray and Lab Limit	x	99.80%
Emergency Room Copayment - $150	x	98.50%
Ambulance Copayment - $25	x	99.95%
Eliminate SNF	x	99.90%
Home Health Care Copayment - $20	x	99.96%
Eliminate Outpatient Prescription Drugs	x	91.10%
Limit Adjustive and Manipulative Services to 10 Visits	x	99.70%
Adjustive and Manipulative Services Copayment - $20	x	99.30%
Limit Inpatient Mental Health to 20 Days	x	99.80%
Limit Inpatient Substance Abuse to 20 Days	x	99.80%
Limit Outpatient Mental Health to $1,000	x	99.70%

EXHIBIT D (cont.)

Outpatient Mental Health Copayment - $20	x	99.50%
Limit Outpatient Substance Abuse to $1,000	x	99.80%
Outpatient Substance Abuse Copayment - $20	x	99.90%
	=	76.70%
Benefit Plan Relationship (Basic Plan/Standard Plan)		80.9%
Dollar Value of Basic Plan[2]		$114.43

(1) Includes Outpatient Prescription Drugs, Chiropractic Services and Preventive Care.

(2) Estimated monthly cost for an individual, year beginning 7/1/93; Net Medical Expense Only, Does Not Include Retention (Administrative Expenses)

APPENDIX

Standardized Plans Adopted by Other States

FLORIDA
SMALL GROUP INDEMNITY DESIGN
STANDARD PLAN

Physician Services	
Primary Care Physician Office Visits	80/20 Coinsurance
Specialist Consultation, Diagnosis & Treatment	
Other Outpatient Nonsurgical Physician Care	
Periodic Physical Exams (1/CY)	
Surgical Care in Physician's Office	
*Carriers may limit non-surgical back treatments to ten visits	
Hospital Services	
Emergency Care through Primary Care Physicians Office	80/20 Coinsurance
Emergency Care Services through ER	
Hospital ER visit (waived if admitted or if other safe and adequate care is not available)	$25 copay per visit
Ancillary Services	
Home Health Care	80/20 Coinsurance
Ambulance	80/20 Coinsurance
Skilled Nursing Facility (Max 100 days/lifetime)	80/20 Coinsurance
Durable Medical Equipment	80/20 Coinsurance
Mental & Nervous Disorders	
Inpatient	80/20 Coinsurance $5,000 Annual Max
Outpatient	80/20 Coinsurance Maximum charge of $50 20 Visits/CY $20,000 Lifetime Max
Alcoholism & Chemical Dependency	
Inpatient Detoxification	Not Covered
Outpatient Visits	Not Covered
Maternity Services	80/20 Coinsurance Same as any illness

FLORIDA
SMALL GROUP INDEMNITY DESIGN
STANDARD PLAN (Cont.)

Infertility & Sterilization Services	Not Covered
Prescription Drugs	80/20 Coinsurance
Maximum Coinsurance Out-of-Pocket Limit	$2,000 per person with a 2 person limit
Annual Deductible	$500 per person
Maximum Annual Limit	3 person limit
Annual Calendar Year Maximum Benefit	N/A
Lifetime Policy Maximum	$1,000,000

FLORIDA
SMALL GROUP INDEMNITY DESIGN
BASIC PLAN

Physician Services	
Primary Care Physician Office Visits Specialist Consultation, Diagnosis & Treatment Other Outpatient Nonsurgical Physician Care Periodic Physical Exams (1/CY) Surgical Care in Physician's Office *Carriers may limit non-surgical back treatments to ten visits	60/40 Coinsurance However, first $150 in physician office services (including lab tests) will be paid without coinsurance or deductible application.
Hospital Services	
Emergency Care through Primary Care Physicians Office	60/40 Coinsurance
Emergency Care Services through ER Hospital ER visit (waived if admitted or if other safe and adequate care is not available)	$25 copay per visit
Ancillary Services	
Home Health Care	Not Covered
Ambulance	60/40 Coinsurance
Skilled Nursing Facility (Max 100 days/lifetime)	Not Covered
Durable Medical Equipment	60/40 Coinsurance - (These services may be included in case management.)
Mental & Nervous Disorders	
Inpatient	60/40 Coinsurance $500 Annual Max
Outpatient	60/40 Coinsurance Maximum charge of $50 5 Visits/CY
Alcoholism & Chemical Dependency	
Inpatient Detoxification	Not Covered
Outpatient Visits	Not Covered

FLORIDA
SMALL GROUP INDEMNITY DESIGN
BASIC PLAN (Cont.)

Maternity Services	60/40 Coinsurance Same as any illness
Infertility & Sterilization Services	Not Covered
Prescription Drugs	Not Covered
Maximum Coinsurance Out-of-Pocket Limit	$4,800 per person with a 2 person limit
Annual Deductible	$250 per person
Maximum Annual Limit	3 person limit
Annual Calendar Year Maximum Benefit	$50,000
Lifetime Policy Maximum	N/A

FLORIDA
SMALL GROUP HMO PLAN DESIGNS
STANDARD PLAN

Physician Services	
Primary Care Physician Office Visits	$10 copay per visit
Specialist Consultation, Diagnosis & Treatment	$10 copay per visit
Other Outpatient Nonsurgical Physician Care	$10 copay per visit
Periodic Physical Exams (1/CY)	No charge
Surgical Care in Physician's Office	$25 copay per procedure
*Carriers may limit non-surgical back treatments to ten visits	
Hospital Services	
Inpatient care at participating hospital including all general services and semi-private room	$100 per day, days 1-5 Balance paid at 100%
Outpatient Surgical Care	$50 copay per procedure
Outpatient Non-Surgical Care (including X-Ray and Lab)	Covered in full
Preadmission Testing	Covered in full
Emergency Services	
Emergency Care through Primary Care Physicians Office	$10 copay
Emergency care through Emergency Room	
- In service area Hospital ER visit (waived if admitted)	$25 copay per visit
- Out of service area Hospital ER visit	$50 copay per visit
Ancillary Services	
Home Health Care	$10 copay per visit
Ambulance	$25 copay
Skilled Nursing Facility (Maximum 100 days/lifetime)	$20 copay per day
Durable Medical Equipment	No charge
Mental & Nervous Disorders	
Inpatient	$100 per day 10 days per CY
Outpatient	$10 copay per visit 20 visits per CY

FLORIDA
SMALL GROUP HMO PLAN DESIGNS
STANDARD PLAN (Cont.)

Alcoholism & Chemical Dependency	
Inpatient Detoxification	Not Covered
Outpatient Visits	Not Covered
Maternity Services	Same as any illness
Infertility & Sterilization Services	Not Covered
Prescription Drugs	$7 copay for generic drugs $14 copay for name brand
Maximum Copay Out-of-Pocket Limit	200% of total annual premium

FLORIDA
SMALL GROUP HMO PLAN DESIGNS
BASIC PLAN

Physician Services	
Primary Care Physician Office Visits	$10 copay per visit
Specialist Consultation, Diagnosis & Treatment	$20 copay per visit
Other Outpatient Nonsurgical Physician Care	$20 copay per visit
Periodic Physical Exams (1/CY)	No charge
Surgical Care in Physician's Office	$50 copay per procedure
*Carriers may limit non-surgical back treatments to ten visits	
Hospital Services	
Inpatient care at participating hospital including all general services and semi-private room	$250 per day, days 1-5 Balance paid at 100%
Outpatient Surgical Care	$100 copay per procedure
Outpatient Non-Surgical Care (including X-Ray and Lab)	Covered in full
Preadmission Testing	Covered in full
Emergency Services	
Emergency Care through Primary Care Physicians Office	$10 copay
Emergency care through Emergency Room	
- In service area Hospital ER visit (waived if admitted)	$50 copay per visit
- Out of service area Hospital ER visit	$100 copay per visit
Ancillary Services	
Home Health Care	Not covered
Ambulance	$25 copay
Skilled Nursing Facility (Maximum 100 days/lifetime)	Not covered
Durable Medical Equipment	No charge
Mental & Nervous Disorders	
Inpatient	$250 per day 3 days per CY
Outpatient	$20 copay per visit 5 visits per CY

FLORIDA
SMALL GROUP HMO PLAN DESIGNS
BASIC PLAN (Cont.)

Alcoholism & Chemical Dependency	
Inpatient Detoxification	Not Covered
Outpatient Visits	Not Covered
Maternity Services	Same as any illness
Infertility & Sterilization Services	Not Covered
Prescription Drugs	Not Covered
Maximum Copay Out-of-Pocket Limit	200% of the total annual premium

IOWA INSURANCE LAWS
BASIC BENEFIT COVERAGE POLICY

An insurer may issue a basic benefit coverage policy if the following criteria are met:

1. The individual, spouse, family or group obtaining coverage under the policy or subscription contract has been without hospital and medical insurance coverage, a health services plan, or employer-sponsored health care coverage for all of the twelve-month period immediately preceding the effective date of the basic hospital and medical coverage policy or subscription contract, provided that for groups in existence for less than twelve months, the group has been without hospital and medical insurance coverage, a health services plan, or employer-sponsored health care coverage since inception of the group.

2. The insurer may include any or all of the following managed care provisions, subject to the approval of the commissioner, to control costs:

   a. A procedure for preauthorization by the insurer, or its designees.

   b. An exclusion for services that are not medically necessary or are not covered preventive health services.

   c. First-dollar coverage for preventive and emergency care.

   d. Except as otherwise provided, copayments for all other physician visits.

   e. Exclusions or limitations upon benefits or direct pay requirements otherwise mandated.

   f. Deductibles or copayments which vary based upon the service provided.

3. The insurer may include any or all of the following managed care provisions to control costs:

   a. A preferred panel or providers who have entered into written agreements with the insurer to provide services at specified levels of reimbursement. Any such written agreement between a provider and an insurer shall contain a provision under which the parties agree that the insured individual or covered member will have no obligation to make payment for any medical service rendered by the provider that is determined to be medically necessary.

   b. Provisions requiring a second surgical opinion.

   c. A procedure for utilization review by the insurer or its designees.

This section does not prohibit an insurer from including in its policy or subscription contract additional managed care and cost control provisions which, subject to the approval of the commissioner, have the potential to control costs in a manner which does not result in inequitable treatment of insureds or subscribers.

4. The policy or subscription contract shall provide basic levels of primary, preventive, and hospital care for covered individuals, including, but not limited to, all of the following:

   a. A minimum of thirty days of inpatient hospitalization coverage per policy year.

   b. Prenatal care, including a minimum of one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy, and one office visit per week during the ninth month and until term. Coverage for each such visit shall include necessary and appropriate screening, including history, physical examination, and such laboratory and diagnostic procedures as may be deemed appropriate by the physician based upon recognized medical criteria for the risk group of which the patient is a member.

   c. Obstetrical care, including physician's services, delivery room, and other medically necessary hospital services.

   d. For covered individuals, a basic level of primary and preventive care, including but not limited to, two physician office visits per calendar year.

   e. Such other coverages as the commissioner may determine are cost-effective.

5. The commissioner may also authorize the issuance of a basic benefit coverage family plan for spouses and dependents of employees, even if the employer currently provides individual health benefits exclusively for employees. The commissioner may also authorize the issuance of a basic benefit coverage plan for part-time employees or full-time, part-year employees, even if the employer currently offers health benefits for full-time employees.

MASSACHUSETTS
DIVISION OF INSURANCE LIMITS (DOI)
ON MEMBER OUT-OF-POCKET PAYMENTS

SERVICE, BY TYPE OF PAYMENT	DOI LIMIT*
COPAYMENTS	
Required Services**	
1. Physician (or other provider such as nurse-practitioner) office visits and other required outpatient services such as mental health and alcoholism; physical, occupational, and speech therapy; medically necessary ambulance, home care, etc.	$25 per unit of service (office visit, home visit, ambulance trip, etc.)
2. Emergency room visits	$50 per visit
3. Inpatient physician and hospital services	$500 per admit***
4. Day surgery physician and facility services	$500 per admit
Non-required Services	DOI Prior approval
DEDUCTIBLES	
Required Services	None allowed
Non-Required Services	DOI Prior approval
BENEFIT CEILINGS**	
Required Services	None allowed
Non-Required Services	DOI Prior approval
TOTAL ANNUAL OUT-OF-POCKET MEMBER PAYMENTS	
Required Services	$2,000 per year per member, may not exceed $4,000 per family
Non-Required Services	No DOI limit

MASSACHUSETTS
DIVISION OF INSURANCE LIMITS (DOI)
ON MEMBER OUT-OF-POCKET PAYMENTS (Cont.)

* In addition to these limits, any copayments applied to mandated benefits may not exceed those for other benefits.

** Required services are contained in attached table.

*** Copayments for multiple admissions for inpatient care (or day surgery followed by inpatient care) for the same or a related illness, when the admissions are separated by 30 or fewer consecutive days out of the hospital, may not exceed a total of $500.

**** Benefit ceilings are limits on the amount the HMO will pay for a given service per year or per lifetime. A member is responsible for the cost of the service above the ceiling. Benefit ceilings are not allowable for "required services". Note, however, that if a minimum level of coverage for a given service is set forth by law, only that minimum level is "required"; ceilings at or above that level are allowable. For example, if the law requires $500 per year of mental health or alcoholism coverage, a ceiling at or above $500 is allowable.

REQUIRED SERVICES FOR MASSACHUSETTS HMO'S

Reasonably comprehensive physician services, including but not limited to:

1. Routine office visits;

2. Preventive services, including, but not limited to, immunizations, periodic adult health exams, well child care including vision and auditory screening, voluntary family planning, infertility services, nutrition counseling, and health education;

3. Maternity services, including, but not limited to, hospitalization, prenatal and postnatal care, newborn care during the child's initial confinement, and termination of pregnancy necessary to save the life of the mother, and including single conversion option to family coverage without waiting period and/or single maternity benefits;

4. Pediatric services, including, but not limited to, coverage from birth for reasonably comprehensive physician, inpatient, outpatient, and emergency services relating to children;

5. Inpatient and outpatient medical, surgical, anesthesia, consultation and specialist services supervised by physicians licensed to practice in Massachusetts.

Reasonably comprehensive inpatient and outpatient services, including but not limited to unlimited days of hospitalization in a 12-month period and a minimum of one hundred days in a twelve-month period or 365 lifetime days of non-custodial care in a skilled nursing facility. Services shall include but not limited to room and board, inpatient drugs and medication, laboratory, anesthesia, x-ray, blood ancillary costs, maternity, pediatric, and preventive services.

Reasonably comprehensive emergency health services, including in-area and out-of-area physician and hospital services rendered in the case of a medical emergency, provided that such services could not have been rendered by the health maintenance organization without jeopardizing the member's health.

MINNESOTA HEALTH RIGHT LEGISLATION

SUBDIVISION I

Each health carrier in the small employer market must make available to any small employer both of the small employer plans described in subdivisions 2 and 3 below. Under subdivisions 2 and 3, coinsurance and deductibles do not apply to child health supervision services and prenatal services. The maximum out-of-pocket costs for covered services must be $3,000 per individual and $6,000 per family per year. The maximum lifetime benefit must be $500,000.

SUBDIVISION II

The benefits of the deductible type small employer plan offered by a health carrier must be equal to 80 percent of the eligible charges for health care services, supplies, or other articles covered under the small employer plan, in excess of an annual deductible which must be $500 per individual and $1,000 per family.

SUBDIVISION III

The benefits of the copayment type small employer plan offered by a health carrier must be equal to 80 percent of the eligible charges for health care services, supplies, or other articles covered under the small employer plan, in excess of the following copayments:

$15 per outpatient visit, other than to a hospital outpatient department or emergency room, urgent care center, or similar facility;

$15 per day for the services of a home health agency or private duty registered nurse;

$50 per outpatient visit to a hospital outpatient department or emergency room, urgent care center, or similar facility;

$300 per inpatient admission to a hospital

SUBDIVISION IV

The medical services and supplies listed in this subdivision are the benefits that must be covered by the small employer plans described in subdivision 2 and 3:

Inpatient and outpatient hospital services, excluding services provided for the diagnosis, care, or treatment of chemical dependency or a mental illness or condition;

Physician and nurse practitioner services for the diagnosis or treatment of illnesses, injuries, or conditions;

Diagnostic x-rays and laboratory tests;

Ground transportation provided by a licenses ambulance service to the nearest facility qualified to treat the condition, or as otherwise required by the carrier;

Services of a home health agency if the services qualify as reimbursable services under Medicare and are directed by a physician or qualify as reimbursable under the health carrier's most commonly sold health plan for insured group coverage;

Services of a private duty registered nurse if medically necessary, as determined by the health carrier;

The rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;

Child health supervision services up to age 18;

Maternity and prenatal care services;

Inpatient hospital and outpatient services for the diagnosis and treatment of certain mental illnesses or conditions;

Ten hours per year of outpatient mental health diagnosis or treatment;

60 hours per year of outpatient treatment of chemical dependency;

50 percent of eligible charges for prescription drugs, up to a separate annual maximum out-of-pocket expense of $1,000 per individual for prescription drugs, and 100 percent of eligible charges thereafter.

NEW MEXICO
MINIMUM HEALTHCARE PROTECTION ACT

Section 3. Policy or Plan - Definition - Criteria

A. For purposes of the Minimum Healthcare Protection Act, "policy or plan" means a healthcare benefit policy or healthcare benefit plan that the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan chooses to offer to individuals, families or groups of fewer than twenty members formed for purposes other than obtaining insurance coverage and that meets the requirements of Subsection B of this section. For purposes of the Minimum Healthcare Protection Act "policy or plan" shall not mean a healthcare policy or healthcare benefit plan that an insurer, health maintenance organization, fraternal benefit society or nonprofit healthcare plan chooses to offer outside the authority of the Minimum Healthcare Protection Act.

B. A policy or plan shall meet the following criteria:

1. The individual, family or group obtaining coverage under the policy or plan has been without healthcare insurance, a health services plan or employer sponsored healthcare coverage for the six-month period immediately preceding the effective date of their coverage under a policy or plan except that for groups in existence for less than six months, the group has been without healthcare coverage since the formation of the group.

2. The policy or plan included the following managed care provisions to control costs:

   a. An exclusion for services that are not medically necessary or are not covered preventive health services.

   b. A procedure for preauthorization of elective hospital admissions by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan.

3. Subject to a maximum limit on the cost of healthcare services covered in any calendar year of not less than fifty thousand dollars ($50,000), the policy or plan provides the following minimum healthcare services to covered individuals:

   a. Inpatient hospitalization coverage or home care coverage in lieu of hospitalization or a combination of both, not to exceed twenty-five days of coverage inclusive of any deductibles, copayments, or coinsurance, provided that a period of inpatient hospitalization coverage shall precede any home care coverage.

   b. Prenatal care, including a minimum of one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy and one office visit per week during the ninth month and until term, provided that coverage for each office visit shall also include prenatal counseling and education, and unnecessary and appropriate screening, including history, physical examination and the laboratory and diagnostic procedure demand

appropriate by the physician based upon recognized medical criteria for the risk group of which the patient is a member.

c. Obstetrical care, including physicians' and certified nurse midwives' services, delivery room and other medically necessary services directly associated with delivery.

d. Well-baby and well-child care, including periodic evaluation of a child's physical and emotional status, a history, a complete physical examination, a developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards, provided that such evaluation and care shall be covered when performed at approximately the age intervals of birth, two weeks, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four years, five years and six years.

e. Coverage for low-dose screening mammograms for determining the presence of breast cancer, provided that the mammogram coverage shall include one baseline mammogram for persons age thirty-five through thirty-nine years, one biennial mammogram for persons age forty through forty-nine years and one annual mammogram for persons age fifty years and over, and further provided that the mammogram coverage shall only be subject to deductibles and coinsurance requirements consistent with those imposed on other benefits under the same policy or plan.

f. A basic level of primary and preventive care including, but not limited to, no less than seven physician, nurse practitioner, nurse midwife or physician assistant office visits per calendar year, including any ancillary diagnostic or laboratory tests related to the office visit.

C. A policy or plan may include the following managed care and cost control features to control costs:

1. A panel or providers who have entered into written agreements with the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan to provide covered healthcare services at specified levels of reimbursement, provided that any such written agreement shall contain a provision relieving the individual, family or group covered by the policy or plan from any obligation to pay for any healthcare services performed by the provider that is determined by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan not to be medically necessary.

2. A requirement for obtaining a second opinion before elective surgery is performed.

3. A procedure for utilization review by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan.

4. A maximum limit on the cost of healthcare services covered in any calendar year of not less that fifty thousand dollars ($50,000).

NORTH CAROLINA
SUMMARY OF STANDARD PLAN

Lifetime Maximum Benefit	$1,000,000
Lifetime Benefit limit - Mental/Nervous disorders	$10,000
Lifetime Benefit limit - Alcohol/Drug addiction	$10,000
Lifetime Benefit limit - Outpatient private duty nursing ($2,500 per CY)	$10,000
Deductible	$500 Max of 3 per family
Emergency room deductible (waived if admitted)	$50
Out-of-Pocket Limit (after deductible)	$2,000 $4,000 max per family
Daily Room and Board	Semi-private based upon the largest class of semi-private rooms of hospital
Intensive Care Room and Board limit	3 times semi-private
Daily Extended Care	Half of Semi-private rate of hospital where confined prior
Prenatal doctor's charges for first pre-natal visit if within three months after pregnancy begins	100% no deductible
Hospital Services	
Inpatient and outpatient	80%
Emergency Care	80%
Surgical Services	
Surgeon, assistant surgeon, anesthesia	80%
Medical Care	
Inpatient services	80%
Outpatient diagnostic services	80%

NORTH CAROLINA
SUMMARY OF STANDARD PLAN (Cont.)

LIMITATIONS

Maternity
Groups > = 10 -- same as any illness
Groups < 10 -- $2,500 maximum per normal delivery

Psychiatric Care	
Outpatient	25 visits per year $60 max charge per visit 50% coinsurance
Physical Therapy	$40 per visit 20 visits per year 50% coinsurance
Out-Patient Chiropractic	$40 per visit 35 visits per year 50% coinsurance

NORTH CAROLINA
SUMMARY OF BASIC PLAN

Deductible (applies to all services except wellness benefits)	$250
Emergency Room Deductible (waived when admitted)	$50 per visit
Family Deductible Limit	3 family members
Out-of-Pocket Limit (Does not include amounts paid for outpatient psychiatric)	$2,400 per insured per year (plus $250 deductible)
Annual Maximum	$25,000 per insured
Hospital Services	
Inpatient and outpatient	60%
Emergency Care	60%
Surgical Services	
Surgeon, assistant surgeon, anesthesia	60%
Medical Care	
Inpatient services	60%
Outpatient diagnostic services	60%
Outpatient therapy services	$40 max charge per visit 20 visits per year
Maternity	60%
Groups > = 10 -- same as any illness	
Groups < 10 -- $2,500 maximum per normal delivery	
Psychiatric Care	
Outpatient	5 visits per year $40 max charge per visit
Combined inpatient/outpatient max	$1,000 max charge per year
Organ Transplant Services	60%
Cornea / Heart	
Combined hear and lung / Kidney	
Liver / Lung, single and bilateral	
Ambulance Services	60%
Prescription Drugs	60%

NORTH CAROLINA
SUMMARY OF BASIC PLAN (Cont.)

Medical Supplies		60%
Prosthetic Appliances		60%
Wellness Benefits		$100 max per year per insured
Well Baby Care and Immunizations		100% of providers reasonable charge
Routine Physical Examination		100% of providers reasonable charge
Benefits are limited to:		
General health checkups	X-rays	
Blood pressure checks	Urine tests	
Tuberculosis tests	Routine diagnostic tests	
Colon exams	Prostate exams	
Rectal exams		
Pap Smears		1 per year per insured
Mammography		1 per year, varies by age

NORTH CAROLINA
STANDARD HMO PLANS

Physician Services	
Office visits	$10 copay per visit
Inpatient visits	Covered in full
Outpatient surgery	Covered in full
Hospital Services	
Inpatient	Covered in full
Emergency Room (waived if admitted)	$25 copay per visit
Skilled Nursing Facility	Covered in full 100 days per year
Physical, Occupational, and Speech Therapy	$10 copay per visit
X-ray, Lab Tests (including pap and mammogram)	Covered in full
Eye Exam	Vision screening covered in full up to age 17
Ambulance-Emergency	Covered in full
Preventive Services (including routine physicals, and well baby care)	$10 copay per visit
Immunizations	Covered in full
Pre-Natal & Post-Natal Outpatient Visits	Covered in full
Hospice Care	Covered in full
Home Health Care (including physician house calls)	$10 copay per visit
Alcoholism/Substance Abuse	
Inpatient Detoxification	Covered in full
Outpatient	Not covered
Mental Health	
Inpatient	Covered in full 30 days per year
Outpatient	$50 copay per visit 20 visits per year
Outpatient Prescription Drug	50% copay/30 day supply
Durable Medical Equipment	50% copay per item
Prostheses	Covered in full

NORTH CAROLINA
BASIC HMO PLANS

Physician Services	
Office visits	$15 copay per visit
Inpatient visits	Covered in full
Outpatient surgery	Covered in full
Hospital Services	
Inpatient	$500 copay or $100/day up to 5 days, less than 50% of charges provided
Emergency Room (waived if admitted)	$50 copay per visit
Skilled Nursing Facility	$500 per admission, not not to exceed 50% of total charges, then covered in up to 100 days per year
Physical, Occupational, and Speech Therapy	$15 copay per visit
X-ray, Lab Tests (including pap and mammogram)	Covered in full
Eye Exam	Vision screening covered in full up to age 17
Ambulance-Emergency	$50 copay per use
Preventive Services (including routine physicals, and well baby care)	$15 copay per visit
Immunizations	Covered in full
Pre-Natal & Post-Natal Outpatient Visits	Covered in full
Hospice Care	Covered in full
Home Health Care (including physician house calls)	$15 copay per visit
Alcoholism/Substance Abuse	
Inpatient Detoxification	Covered in full
Outpatient	Not covered

NORTH CAROLINA
BASIC HMO PLANS (Cont.)

Mental Health	
Inpatient	5 days covered in full then 50% for 25 days per year
Outpatient	$50 copay per visit 20 visits per year
Outpatient Prescription Drug	Not covered
Durable Medical Equipment	50% copay per item
Prostheses	Covered in full

OREGON BASIC HEALTH CARE PLAN
INSURANCE PRODUCT

The Committee recommends that the following cost sharing standards apply to all basic health care plans offered and issued by carriers other than health maintenance organizations:

1. For all preventive services a $15 copayment for each visit.

2. For all other covered services (except outpatient prescription drugs) a 50% coinsurance.

3. A stop-loss limit of $7,500 per benefit year based on eligible charges. For coverages other than Employee Only, the stop-loss limit shall be two (2) times the annual dollar amount for Employee Only coverage.

4. For outpatient (take-home) prescription drugs, an eligible health plan member shall pay, per prescription, the greater of: (1) a copayment of $15, or (2) 50% of the eligible charges. The outpatient drug benefit is not subject to the stop-loss limit noted in 3 above. The carrier may limit coverage to a 30-day supply per prescription/refill.

5. Maximum lifetime coverage of $1,000,000.

OREGON BASIC HEALTH CARE PLAN
HMO

The Committee recommends that the following cost sharing standards apply to all basic health care plans offered and issued by health maintenance organizations:

1. Copayment charges may not exceed 50% of the total cost (or actuarial equivalent) of providing any single service.

2. Copayment charges in the aggregate may not exceed 20% of the total cost (or actuarial equivalent) of providing all basic health services.

3. The maximum out-of-pocket expense for copayments may not exceed $3,000 per member. This approximates 200% of the annual premium cost; another copayment maximum under Federal qualification. The maximum out-of-pocket for copayments under family coverage may not exceed three (3) times the maximum out-of-pocket expense for copayments for Employee Only coverage.

4. For outpatient (take-home) prescription drugs, an eligible health plan member shall pay, per prescription, the greater of: (1) a copayment of $15, or (2) 50% of the eligible charges. The outpatient drug benefit is not subject to the maximum out-of-pocket limit noted in 3 above. The carrier may limit coverage to a 30-day supply per prescription/refill.

VERMONT

COMMON BENEFIT INSURANCE PLAN PROPOSAL

Annual Deductible	
Individual	$ 150
Two-Person	$ 300
Family	$ 450
Out-of-Pocket Limit	
Individual	$ 500
Two-Person	$1,000
Family	$1,500
Lifetime Maximum (Exc. Transplants)	$1,000,000
Transplant Aggregate	$1,000,000/Lifetime
Mental Health Inpatient	45 days/year
Mental Health Outpatient	40 visits/year
Preventive Care	$ 200/year

VERMONT

INSUREDS PORTION OF COVERED CHARGES FOR COVERED SERVICES

	COINSURANCE
Ambulance	20%
*Cardiac Rehabilitation	20%
*Dental	20%
*Diagnostic	20%
*General Hospital	20%
*Home Care	20%
*Hospice Care	20%
*Maternity	20%
Pre-Natal Care	0%
*Medical Equipment/Supplies	20%
*Medical Care	20%
*Mental Health	
Inpatient	20%
Outpatient (40 visits)	20%
*Physical Rehab Facility	20%
Prescription Drugs	0% (See Below)
Preventive Care	0% up to $200, then 20% thereafter
*Skilled Nursing Facility	20%
*Substance Abuse Rehab Facility	20%
*Surgical	20%
*Therapy	20%
*Transplants	20%

CO-PAYMENTS APPLY TO THE FOLLOWING BENEFITS:

PRESCRIPTION DRUGS - $5 FOR GENERIC BRAND AND $10 FOR NAME BRAND

DEDUCTIBLES APPLY TO ALL SERVICES EXCEPT:

PREVENTIVE CARE
PRE-NATAL CARE

* YOU MUST RECEIVE ADMISSION REVIEW OR PRIOR APPROVAL FROM US FOR SPECIFIC SERVICES AS DEFINED IN YOUR POLICY OR LISTED ON THIS OUTLINE OF COVERAGE.

WYOMING STANDARD PLAN
DRAFT

Lifetime Maximum	$1,000,000
Deductible (without carryover) (3 times/family)	500

80 percent coinsurance next $5,000
R&C used by carrier for other groups within the class

Hospital Benefit -- Based upon semi-private room -- hospitals with only private, benefit based upon 90 percent of lowest rate.

Special Care Units -- Benefit based upon charges up to the hospital's actual daily room and board charge.

Out-of-pocket Maximum (Deductible +)	$ 1,000

Maternity:

Groups < 15 employees -- $2,500 maximum per delivery
Groups > = 15 employees -- as any illness

Adult screening (without any deductible applied, benefit at 100 percent)	100/year

Well-Infant Care to age six (6) -- without any deductible applied, benefit at 80 percent

Exclusions/limitations (Other than exclusions and limitations specified, no other limitations will be permitted.)

	Service	Maximum Benefit
A:	Spinal manipulation	$ 250/year
B:	Nervous/Mental	7,500/year
	Drug/Alcohol	7,500/lifetime
C:	Physical Therapy	500/year
D:	Rehabilitation	25,000/lifetime

See attached for other exclusions/limitations.
CARRIERS TO INCLUDE OWN COST CONTAINMENT/MANAGED CARE

WYOMING BASIC PLAN
DRAFT

Lifetime Maximum	$250,000
Deductible (without carryover) (3 times/family)	500

50 percent coinsurance next $10,000 -- i.e., individual out-of-pocket maximum at $5,000 plus deductible ($15,000/family plus deductible)

Benefits based upon reasonable and customary at percentile used by company with other plans for that market.

Hospital Benefit -- Based upon semi-private room -- hospitals with only private, benefit based upon 90 percent of lowest rate.

Special Care Units -- Benefit based upon charges up to the hospital's actual daily room and board charge.

Maternity:

Groups < 15 employees -- $2,500 maximum per delivery
Groups > = 15 employees -- as any illness

Well-Infant Care to age two (2) including immunizations -- without any deductible applied and benefit at 50 percent.

Exclusions/limitations (Other than exclusions and limitations specified, no other limitations will be permitted.)

	Service	Maximum Benefit
A:	Spinal manipulation	$ 250/year
B:	Nervous/Mental	2,500/year
	Drug/Alcohol	2,500/lifetime
C:	Physical Therapy	500/year
D:	Rehabilitation	25,000/lifetime

See attached for other exclusions/limitations.
CARRIERS TO INCLUDE OWN COST CONTAINMENT/MANAGED CARE

Section 2.

"GUARANTEED ISSUANCE AND RENEWABILITY OF HEALTH INSURANCE AND THEIR APPLICABILITY WITH AND WITHOUT STANDARDIZED PLANS"

Title 24-A MRSA §2808-B, subsection 4, which was enacted by Maine Public Law 1991, Chapter 861, "An Act to Provide More Affordable Health Insurance for Small Businesses and Community Rating of Health Insurance Providers," requires that all small group health plans be available on a guaranteed basis and that renewal be guaranteed in except under a few specified circumstances.

Several other states have adopted a model small group health insurance reform bill which requires guaranteed issue only for two standardized plans. Other plans can be offered subject to underwriting bases on health status or claims experience under a prior carrier. Under this approach, it is to be expected that the standardized plans would be subject to adverse selection and higher rates, since those who qualify could get a more favorable rate with an underwritten plan. Such an approach would not be consistent with Maine's law, which is intended to eliminate rating differences based on health status or experience.

Section 3.

"DATA COLLECTION REGARDING HEALTH INSURANCE COVERAGE AND EMPLOYER PRACTICES FOR EMPLOYERS OF FEWER THAN 25 EMPLOYEES AND THE SELF-EMPLOYED."

A. METHODS

A survey was mailed to a 500 employers, randomly selected from all Maine employers with 25 or fewer employees. This sample was obtained from the Maine Department of Labor, Division of Economic Analysis and Research.

The survey was mailed in April of 1992, with a cover letter from the Superintendent of Insurance, and a follow-up mailing was done approximately two weeks later. A copy of the survey and cover letters can be found in the Appendix to this section.

The survey instrument consisted of a two-page questionnaire plus a census sheet for reporting the number of full-time, permanent employees and dependents, the numbers insured, and their age and gender. One of the primary purposes for this information is to provide a base for determining the effects of community rating and guaranteed availability. The intent is to conduct a follow-up survey after the law is in effect and to compare the results to the results of the initial survey.

The questionnaire sought information on the type of insurance, if any, the carrier, frequency of changing carriers, deductible levels and recent increases in deductibles, and employee premium contributions and recent increases in these.

Of the 500 surveys sent out, 368 were returned. 48 were eliminated due to duplication or insufficient information. This resulted in a usable response rate of 64%.

Responses were analyzed in four categories based on number of employees. Responses to some questions were also analyzed separately for Blue Cross and other carriers and the results of this analysis are reported here to the extent significant differences were found.

Many responses were incomplete. For each table in this report, those which did not include the relevant information had to be excluded. Therefore, some items such as total number of employers and total number of employees vary from table to table. For example, several employers did not provide age and gender information. Therefore the total number of employees on Tables 3 and 4 is less than that shown on Table 2.

An age/gender analysis was performed based on the information on the census sheets. Two methods of grouping employees were considered for this purpose. The first method grouped them based on whether or not their employer offered health insurance. The second method grouped them based on whether or not they were insured through the employer. The difference between the two methods is how they classify those who are not insured through their employers, but whose

employers do offer insurance. Overall results were analyzed using both methods. The following table shows that the results did not differ significantly. Therefore all further analysis was performed using the first method only.

Average Age

	Average Age of Insured Employees	Average Age of All Employees
Employer Offers Blue Cross	39.1	38.5
Employer Offers Other Insurer	36.1	35.7
All Employers	37.2	36.6

A similar survey was sent to 100 self-employed individuals in September. Again, a follow-up was mailed about two weeks later. This sample was obtained from the Small Business Development Center. 37 surveys were returned, of which 34 were usable. This sample was too small to draw any meaningful conclusions.

B. RESULTS

1. Extent of Coverage

Of 320 small employers providing usable responses to the survey, 187 (or 58%) offer health insurance to their employees. The percentage varies with the size of the employer, from 44% for those with fewer than five employees to 87% for those with 15 to 25 employees.

Table 1: Employers Offering Health Insurance

	Total	<5 Employees	5-9 Employees	10-14 Employees	≥15 Employees
Total Employers	320	144	90	47	39
Number Offering Insurance	187	63	57	33	34
Percent Offering Insurance	58.44%	43.75%	63.33%	70.21%	87.18%

The 133 employers not offering health insurance have a total of 643 employees. The 187 who do offer insurance have a total of 1,624 employees, of which 1,112, or 68%, are insured. (It should be noted that the remaining 32% are not necessarily uninsured; they may have other coverage, such as through a spouse's employer.) These employees have 1,714 dependents, of which 1,211, or 71%, are insured through the group. (See Table 2.)

30 employers reported having offered health insurance in the past, but no longer offer it. 70% indicated that the primary reason was related to cost.

2. Age and Gender

Table 3 shows the age distribution for insured and uninsured groups. Table 4 shows the distribution by gender. Insured groups were split between those covered by Blue Cross and those covered by other carriers to determine the extent to which community rating has attracted older groups to Blue Cross. Each category was further split between employers with fewer than 20 employees and those with 20 or more, since Blue Cross only used pure community rating for the smaller groups. (They have since introduced age and gender adjustments for these groups as well.)

The average age for all employees was 36.6. For employees of employers offering health insurance, the average age was 36.8, overall, 38.5 for those insured with Blue Cross, and 35.7 for those insured with commercial insurers. For those not offering health insurance, the average age was 34.7.

Table 2: Extent of Coverage

	<5 Employees	5-9 Employees	10-14 Employees	≥15 Employees	Total
Insured Employees in Insured Groups	139 (41%)	274 (44%)	230 (41%)	469 (63%)	1,112 (49%)
Uninsured* Employees in Insured Groups	24 (7%)	131 (21%)	168 (31%)	189 (25%)	512 (23%)
Total Employees in Insured Groups	163 (48%)	405 (65%)	398 (72%)	658 (88%)	1,624 (72%)
Employees in Uninsured Groups	177 (52%)	219 (35%)	158 (28)%	89 (12%)	643 (28%)
Total Employees	340 (100%)	624 (100%)	556 (100%)	747 (100%)	2,267 (100%)
Insured Dependents in Insured Groups	149 (51%)	264 (46%)	259 (48%)	539 (25%)	1,211 (56%)
Uninsured* Dependents in Insured Groups	27 (9%)	129 (22%)	144 (27%)	203 (9%)	503 (23%)
Total Dependents in Insured Groups	176 (60%)	393 (68%)	403 (75%)	742 (34%)	1,714 (79%)
Dependents in Uninsured Groups	115 (40%)	181 (32%)	131 (25%)	17 (1%)	444 (21%)
Total Dependents	291 (100%)	574 (100%)	534 (100%)	759 (100%)	2,158 (100%)

* "Uninsured" here means not insured through the group; other coverage may be in effect.

Table 3: Age Distribution

AGE GROUP SIZE	<30	30-39	40-49	50-59	60+	AVERAGE AGE
BLUE CROSS						
Groups <20	103 (25%)	124 (30%)	109 (26%)	47 (11%)	25 (6%)	38.7
Groups 20+	21 (24%)	30 (34%)	22 (25%)	11 (12%)	4 (5%)	38.2
Total	124 (25%)	154 (31%)	131 (26%)	58 (12%)	29 (6%)	38.5
ALL OTHER						
Groups <20	253 (33%)	286 (37%)	165 (21%)	49 (6%)	22 (3%)	35.4
Groups 20+	33 (32%)	21 (20%)	23 (22%)	21 (20%)	5 (5%)	39.3
Total	286 (33%)	307 (35%)	188 (21%)	70 (8%)	27 (3%)	35.7
TOTAL INSURED GROUPS						
Groups <20	356 (30%)	410 (35%)	274 (23%)	96 (8%)	47 (4%)	36.6
Groups 20+	54 (28%)	51 (27%)	45 (24%)	32 (17%)	9 (5%)	38.8
Total	410 (30%)	461 (34%)	319 (23%)	128 (9%)	56 (4%)	36.8
UNINSURED						
Groups <20	144 (30%)	154 (32%)	110 (23%)	50 (10%)	18 (4%)	36.4
Groups 20+	13 (65%)	2 (10%)	4 (20%)	1 (5%)	0 (0%)	27.7
Total	157 (32%)	156 (32%)	114 (23%)	50 (10%)	18 (4%)	34.7
GRAND TOTAL						
Total	567 (30%)	617 (33%)	433 (23%)	178 (10%)	74 (4%)	36.6

The average age of those covered by commercial insurers differed by only a year from the average age of those in uninsured groups. Interestingly, the average age for groups insured by Blue Cross was only about three years older than that for commercial insurers, indicating that while community rating has attracted somewhat older groups to Blue Cross, the impact has not been great. It may be that age has been overshadowed by other factors, such as health status, in causing rate differences between commercial insurers and Blue Cross.

For whatever reason, it appears that age has not been a major factor in determining which groups are insured, or with what carrier they are insured. The extent of any change in this situation after implementation of the new law will provide some indication of the extent to which the new rating restrictions drive out younger employees and/or bring in older employees.

Table 4: Gender Distribution

GROUP SIZE	Female		Male	
BLUE CROSS				
Groups <20	161	(40%)	246	(60%)
Groups 20+	23	(26%)	65	(74%)
Total	184	(37%)	311	(63%)
ALL OTHER				
Groups <20	282	(36%)	495	(64%)
Groups 20+	29	(28%)	74	(72%)
Total	311	(35%)	569	(65%)
TOTAL INSURED GROUPS				
Groups <20	443	(37%)	741	(63%)
Groups 20+	52	(27%)	139	(73%)
Total	495	(36%)	880	(64%)
UNINSURED				
Groups <20	228	(48%)	248	(52%)
Groups 20+	15	(75%)	5	(25%)
Total	243	(49%)	253	(51%)
GRAND TOTAL				
Groups <20	671	(40%)	989	(60%)
Groups 20+	67	(32%)	144	(68%)
Total	738	(39%)	1,133	(61%)

39% of the employees overall were females. Those groups not offering insurance were 49% female while those offering insurance were 36% female. Those offering insurance through Blue Cross were 37% female and those with other carriers were 35% female.

Gender does not appear to have been a large factor in choice of carrier. There does, however, appear to be a significant relationship between the gender distribution of a group and the likelihood that the employer offers health insurance. It could not be determined whether this is a causal relationship or whether both factors are correlated to some third factor, such as type of business or availability of coverage through the employee's spouse.

One possible factor which was explored was employer size. Table 5 shows this analysis. While smaller employers do have a greater percentage of female employees, and are less likely to be insured, this does not account for all of the variation noted above. There is only a very slight difference between the gender distributions of insured and uninsured groups for the smallest insurers, but this difference increases significantly with employer size. It reaches striking proportions for the largest small employers. However, it should be noted that these results are based on only three uninsured employers in the ≥ 15 employee category.

Table 5: Gender Distribution by Employer Size

GROUP SIZE	<5 Employees	5-9 Employees	10-14 Employees	≥15 Employees	Total
INSURED GROUPS					
FEMALES	66	147	121	164	498
MALES	87	205	184	397	873
% FEMALE	43%	42%	40%	29%	36%
UNINSURED GROUPS					
FEMALES	64	71	68	32	235
MALES	82	87	59	19	247
% FEMALE	44%	45%	54%	63%*	49%
TOTAL					
FEMALES	130	218	189	196	733
MALES	169	292	243	416	1,120
% FEMALE	43%	43%	44%	32%	40%

* This cell based on only three employers with a total of 51 employees.

3. Carriers and Market Shares

Blue Cross and Blue Shield of Maine is the dominant carrier, covering 39% of the small employers who identified their carrier. The remaining 108 employers were divided among 39 carriers, with the largest, USLife, having only a 7% market share.

About a third report being covered through an association, the largest being Maine Merchants Association (insured through Blue Cross) with 8% of the sample. (See Table 6.)

Table 6: Insurers and Associations

CARRIERS		Associations	
Blue Cross/Blue Shield	69	ME Merchants	14
USLife	13	Chamber of Commerce	6
New York Life	12	ME Dental	5
Prudential	10	ME State Grocers	5
Durham/United Plans	9	N.E. Businessmen's	5
Golden Rule	7	ME Bar	3
Time	7	ME Auto Dealers	2
Aetna	5	Nat'l Assn. of Self-Employed	2
Fidelity Security	5	Other	20
Travelers	4	Total	62
American Chambers	3		
Protective Life	3		
Healthsource (HMO)	2		
John Alden Life	2		
Lincoln National	2		
Principal Mutual	2		
All Others	24		
Total	177		

59% of the insured employers have been with their current carrier for three years or less. Only 23% had been with their current carrier for more than five years. Of the 101 (54%) responding to a question concerning prior coverage, 65% were with that carrier for three years or less, and only 16% for more than five years. This indicates a fairly high degree of movement from carrier to carrier. This is particularly true for larger employers. Only 15% of employers with 10 to 25 employees have been with their current carrier for more than five years, compared to 30% for those with fewer than five employees. (See Tables 7 and 8.)

Table 7: Number of Years With Current Carrier

Years with Current Carrier	All Responses	<5 Employees	5-9 Employees	10-14 Employees	≥15 Employees
<2	52 (29%)	14 (25%)	18 (32%)	9 (27%)	12 (35%)
2	25 (14%)	7 (12%)	11 (19%)	5 (15%)	2 (6%)
3	30 (17%)	11 (19%)	4 (7%)	5 (15%)	10 (29%)
4	12 (7%)	4 (7%)	2 (4%)	4 (12%)	2 (6%)
5	20 (11%)	4 (7%)	7 (12%)	6 (18%)	2 (6%)
6-10	32 (18%)	12 (21%)	14 (25%)	3 (9%)	3 (9%)
11+	10 (6%)	5 (9%)	1 (2%)	1 (3%)	3 (9%)
Average	3.98	4.49	3.7	3.85	3.71

Table 8: Number of Years With Prior Carrier

Years with Prior Carrier	All Responses	<5 Employees	5-9 Employees	10-14 Employees	≥15 Employees
<2	21 (21%)	3 (9%)	6 (23%)	6 (33%)	6 (25%)
2	29 (29%)	9 (21%)	7 (27%)	5 (28%)	8 (33%)
3	16 (16%)	3 (9%)	3 (12%)	5 (28%)	5 (21%)
4	12 (12%)	6 (18%)	3 (12%)	2 (11%)	1 (4%)
5	7 (7%)	4 (12%)	2 (8%)	0 (0%)	1 (4%)
6-10	14 (14%)	7 (21%)	5 (19%)	0 (0%)	2 (8%)
11+	2 (2%)	1 (3%)	0 (0%)	0 (0%)	1 (4%)
Average	3.14	4.1	2.77	2.16	2.85

4. Deductibles and Employee Premium Contributions

Deductibles ranged from a low of $100 to a high of $3,000, with an average of $317. Deductibles tend to be higher for smaller employers ($377 average for those with fewer than five employees) and lower for larger employers ($273 average for those with 15 to 25 employees). (See Table 9.)

Table 9: Deductibles

Deductible	All Responses	<5 Employees	5-9 Employees	10-14 Employees	≥15 Employees
<$100	0	0	0	0	0
$100	24	4	9	5	6
$150 - $200	55	17	15	10	13
$201 - $300	50	15	15	10	9
$301 - $400	0	0	0	0	0
$401 - $500	20	9	8	2	1
$501 - $749	0	0	0	0	0
$750	2	1	0	0	1
$1,000	6	3	1	0	2
$1,001 -$1,999	0	0	0	0	0
$2,000	1	0	1	0	0
$2,400	1	0	0	1	0
$3,000	1	1	0	0	0
Average: BC/BS	308	250	370	219	305
Other	322	426	272	335	229
ALL	**$317**	**$377**	**$302**	**$302**	**$273**

90% of the employers in our sample pay at least some portion of the premium for their employees. 55% pay the entire premium. 30% also pay the entire premium for dependents. Smaller employers are more generous in this regard. Of those with fewer than ten employees, 63% pay the entire premium for employees and 41% pay the entire premium for dependents. The corresponding percentages for employers of 10 to 25 are 39% and 13%. (See Table 10.)

Table 11 shows the responses to two questions concerning cost shifting to employees over the last three years. One question concerned increases in deductible and the other concerned increases in employee premium contribution. Those who did not respond to either question are excluded from the following analysis. However, for those who answered one but not the other, it was assumed that they did not understand the question to which they did not respond. It was further assumed that

had they increased the variable in question, they would have understood the question. Therefore, the answer to the question not answered was assumed to be "no". The adjusted results are shown in table 12.

Table 10: Employee Premium Contributions

Percentage of **Employee** Premium Paid by Employee	Total	<5 Employees	5-9 Employees	10-14 Employees	≥15 Employees
0	100	40	34	11	15
1-20	16	4	5	1	6
21-40	13	3	3	3	4
41-60	28	6	7	9	6
61-80	5	2	1	2	0
81-99	3	0	2	1	0
100%	18	5	5	5	3

Percentage of **Dependent** Premium Paid by Employee	Total	<5 Employees	5-9 Employees	10-14 Employees	≥15 Employees
0	48	21	19	4	4
1-20	15	2	5	1	7
21-40	23	13	2	5	3
41-60	19	2	5	7	5
61-80	8	5	2	1	0
81-99	3	1	2	1	0
100%	41	0	18	10	13

As shown in Table 12, 38% of employers reported having increased deductibles within the past three years. 19% reported having increased employee premium contributions within this period. These percentages include an overlap of 9% who increased both deductibles and premium contributions. This means 48% have passed some portion of their cost increases on to employees, while 52% have not.

Table 11: Cost Shifting to Employees (Unadjusted)

Increased Deductible	Increased Employee Contribution	Number of Employers	Percent
Yes	--	5	3%
Yes	Yes	16	9%
Yes	No	49	27%
No	--	4	2%
No	Yes	12	7%
No	No	53	29%
--	Yes	6	3%
--	No	37	20%

Table 12: Cost Shifting to Employees (Adjusted)

Increased Deductible	Increased Employee Contribution	Number of Employers	Percent
Yes	Yes	16	9%
Yes	No	54	30%
No	No	94	52%
No	Yes	18	10%

Appendix to Section 3

Survey Instrument

Following are the cover letters and questionnaire which were sent to 500 small employers.

John R. McKernan, Jr.
Governor

Richard E. Johnson
Acting Superintendent

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE
(207) 582-8707
Telecopier (207) 582-8716

April 22, 1992

Dear Small Employer:

As you may know, the Maine Legislature has enacted legislation which will have a major impact on health insurance for small businesses. In order to assess the impact of these changes and to determine what further changes may be appropriate, it is crucial that we establish a base of information concerning the current status of the small employer health insurance market.

The enclosed survey is being sent to only a small, randomly selected sample of Maine's small businesses. In order to obtain meaningful results, it is important that we get a high rate of response. Better information will result in better public policy. Therefore I request that you take a few minutes to complete this survey.

We are interested in your response whether or not you currently have a health insurance plan. Please answer the questions as completely as possible and return the completed questionnaire in the enclosed postage-paid envelope to:

David Stetson
Bureau of Insurance
State House Station 34
Augusta, ME 04333

If you are interested in receiving a summary of the results of this survey, you may so indicate on the questionnaire. The summary will not identify individual employers. All responses will be held in strict confidence and will be used for statistical purposes only.

If you have any questions, please call David Stetson or Rick Diamond at 624-8435.

Thank you for your cooperation.

Sincerely,

Richard E. Johnson
Acting Superintendent

John R. McKernan, Jr.
Governor

Richard E. Johnson
Acting Superintendent

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE
(207) 582-8707
Telecopier (207) 582-8716

May 13, 1992

Re: MAINE SMALL EMPLOYER HEALTH INSURANCE SURVEY

Dear Small Employer:

About two weeks ago, we sent you a questionnaire about health insurance. If you have already completed and returned the questionnaire, please accept this letter as a "thank you" note. If you haven't done so, we would appreciate it if you would complete the survey, today if possible. It will only take a few minutes of your time.

Your response is very important, because the appropriateness of any actions that the State of Maine takes depends on having accurate information. Since the survey was sent to only a small, randomly selected sample of Maine's small businesses, your response will represent hundreds of firms.

We have enclosed a duplicate questionnaire in case the original was misplaced. Please return the completed questionnaire in the enclosed postage-paid envelope to:

David Stetson
Bureau of Insurance
State House Station 34
Augusta, ME 04333

If you have any questions, please call David Stetson or Rick Diamond at **624-8435**.

Thank you for your cooperation.

Sincerely,

Richard E. Johnson
Acting Superintendent

MAINE SMALL EMPLOYER HEALTH INSURANCE SURVEY

1. YOUR NAME:_____ POSITION:_____

   BUSINESS NAME:_____

   ADDRESS:_____

   PHONE NUMBER:_____

2. How many employees does your company have (including the employer if actively involved):

   _____

PLEASE COMPLETE THE ATTACHED CENSUS SHEET FOR FULL-TIME, YEAR-ROUND EMPLOYEES.

3. A. Does your company offer a health insurance plan?

   ☐ YES Go to Question 4. ☐ NO Go on to Question 3 B.

3. B. Has your company ever offered a health insurance plan ?

   ☐ YES ☐ NO

   C. If yes, when did you terminate the plan ?_____

   D. Why ?

   _____

   _____

IF YOUR COMPANY DOES NOT OFFER HEALTH INSURANCE, STOP HERE,COMPLETE THE CENSUS SHEET, AND RETURN BOTH FORMS IN THE ENCLOSED ENVELOPE. THANK YOU

4. Which Company provides your company's health insurance?

   ☐ Blue Cross/Blue Shield of Maine ☐ Travelers

   ☐ Prudential ☐ State Mutual

   ☐ Aetna ☐ New York Life

   ☐ Other _____

5. Is your coverage provided through an association?

   ☐ Yes ☐ No

   If yes, which one? _____

6. A. How long have you been with your present carrier? _____years

B. How long were you with your previous carrier ? _____years

7. A. What type of coverage do you offer ?

☐ Comprehensive (deductible and copayment on all or most services)

a. What is the deductible $_____

b. Have you increased the deductible within the last three years?

☐ Yes ☐ No

☐ First-dollar coverage (such as traditional Blue Cross/Blue Shield Plan)

B. If first dollar coverage, do you also have Supplemental Major Medical, and if so, from which company?

☐ Blue Alliance (BAMICO)

☐ Other _____

☐ None

8. A. What percentage of the premium is contributed by the employee? (Check one box on each line.)

	None	1-20%	21-40%	41-60%	61-80%	81-99%	100%
Employee Coverage							
Dependent Coverage							

B. Have these percentages increased within the last three years?

☐ Yes ☐ No

Please make any additional comments here and on back.

☐ Check here if you would like a copy of the final report.

Thank you for your cooperation. Please return the completed questionnaire and census sheet in the enclosed postage paid envelope to:

David Stetson
Bureau of Insurance
State House Station 34
Augusta, Maine 04333

CENSUS SHEET

Please provide the following information concerning each of your full-time, year-round employees (including the owner if actively involved).

Employee	Age	Sex	Insured?	Number of Dependents	Number of Dependents Insured
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					

Section 4.

"WELLNESS PROGRAMS DESIGNED FOR INTRODUCTION AT PLACES OF EMPLOYMENT, THEIR USAGE AND EFFECT, ANY USE BEING MADE OF THEM IN RATING BY CARRIERS AND A DEFINITION FOR THEM FOR STATUTORY ENACTMENT"

Title 24-A MRSA §2808-B, subsection 2, paragraph C, which was enacted by Maine Public Law 1991, Chapter 861, "An Act to Provide More Affordable Health Insurance for Small Businesses and Community Rating of Health Insurance Providers," permits insurance carriers to vary premium rates based on "participation in wellness programs", but does not define such programs. This section of the report includes information on wellness programs, including the types of programs currently in place, the effectiveness of these programs, their impact on rates currently charged by carriers and their potential effect on rates under the new law. The purpose is to assist in the definition of wellness programs which will qualify for rate reductions pursuant to the law. Most of the material in this section was provided by Janet M. Carstens, FSA, and Ted A. Lyle, FSA, of Tillinghast, who were retained by the Bureau to assist in this project.

Information regarding the general nature of wellness programs is addressed first. Exhibit A at the end of this section describes several specific types of wellness programs that have been used in practice. Exhibits B and C provide some additional overview information regarding the usage and effectiveness of these types of programs.

General Considerations

In general, wellness programs are designed to encourage employees to live healthy lifestyles, either by providing access to programs or by using rewards and/or penalties based on lifestyle patterns.

The effect of specific programs is often difficult to measure. This is partially due to the lack of credible data. It is also partially due to the difficulty of isolating the effect of secular trends through time. That is, it is difficult to separate behavioral patterns resulting from the imposition of wellness programs from those which would otherwise occur due to societal changes in general.

Imposition of wellness programs often has a direct effect on areas other than medical costs. For example, they may result in reduced frequency or length of absenteeism. They may also result in increased employee productivity or morale. The effects on absenteeism, productivity, and morale are often more easily measured than the effect of wellness programs on medical costs. In fact, some programs may actually increase medical costs, while at the same time increasing expected life expectancy.

Small Employers

Several other considerations arise when dealing with the small employer market. These considerations have both positive and negative effects on the potential results of wellness programs.

Since small employers typically have high turnover rates, and since the potential benefit of most wellness programs is long-term in nature, the results of offering such programs today are less likely to be reflected in the future medical costs of the small employer. This makes it less viable to use these programs as rating variables for the small employer market.

On the other hand, small employers have several attributes which could result in more favorable results than would generally be seen with large employers. These attributes are essentially workplace cultural issues, and include a higher level of interdependency between employees, a more commonly held work culture and an increased level of workplace efficiency. In addition, top management may be more approachable, and there may be more of a family orientation.

Impact on Rates

These programs have generally been offered by large employers with self-funded medical expense plans. In general, no explicit cost reductions have been observed as a result of implementing a wellness program. To the extent that savings have been realized, they have been reflected in the actual experience costs related to the employer's medical expense program. To the extent that cost savings are long-term in nature, the impact of such programs would affect the evolving experience of the employer.

Since experience rating is not permitted for small groups, any rate reductions would have to be explicit. Due to the long-term nature of any potential savings, and the high turnover rate of employees within small employer groups, it would appear difficult to develop any recommended rate reductions.

Potential Impact Under the New Law

Some programs, such as fitness programs, may appear to result in lower costs for employees that use such programs. It is not clear, however, if the lower costs are due to the existence of the fitness program or to the fact that the employees who opt to participate in these programs tend to be in a better state of health to begin with. To the extent it is the latter, using participation in such programs as a rating variable may be equivalent to rating based on health status. That is, the rating variable could potentially reflect not only the expected reduction in costs resulting from participation in such programs, but also the expected relative cost level among the employee group likely to participate.

By imposing rate differentials based on the use of fitness facilities, an insurer may be able to attract a more healthy population, thereby lowering its overall claim cost level. This could potentially give

carriers who offer discounts, based on an individual's fitness profile, a better risk spread, and could lead to a competitive advantage for these carriers. Any rate differentials would likely be somewhat artificial, reflecting not only the cost savings resulting from the imposition of fitness programs, but also reflecting the impact of the selection process that will occur, since employers with a large percentage of employees eligible for such discounts will be attracted to carriers who use these discounts.

Statutory Definition

A simple definition of "wellness program" would be "any program designed to encourage employees to live healthy lifestyles, either by providing access to programs or by using rewards and/or penalties based on lifestyle patterns". However, based on the considerations noted above, it may be unlikely that an insurer would choose to offer a discount for wellness programs except as a surrogate for health status or age. Therefore, it might be desirable to restrict the definition to avoid this possibility. This could be done either by excluding those types of programs, such as fitness programs, which could be considered to be surrogates, or by specifying the types of programs which would qualify. On the other hand, if the intent is to encourage wellness programs, the less restrictive definition might be preferable.

EXHIBIT A

TYPES OF PROGRAMS

Blood Pressure Screening

Blood pressure screening is defined as a regular, preventive screening designed to allow employees to track their blood pressure level and their trend in blood pressure readings over time. The program is designed to detect problems early, and to allow an employee to see the results of a changed lifestyle on blood pressure. The program also serves to educate employees on the importance of blood pressure as a measure of health status.

Cooking Classes

Cooking classes are used as a means to educate employees on the importance of a healthy diet (i.e., low fat, low cholesterol). The classes provide employees with examples of healthy meals, information regarding healthier substitutes in food preparation and preparation techniques themselves.

Diabetes Screening

Diabetes screening is preventive screening designed to test employees for diabetes as well as the risk of acquiring diabetes. The program is designed to detect problems early and to educate employees on the disease. The education aspect includes an analysis of the importance of diet on the onset of diabetes and the role of genetics.

Educational and Community Based Programs

These are defined as programs which provide employees with easy access to educational programs. Access may be through the workplace or in conjunction with other local sponsors, such as local libraries. The programs take the form of brown bag lunches or videotapes that can be checked out. The programs are designed to cover a variety of topics of interest to various demographic subgroups (i.e., the general effect of exercise and diet on health, the importance of prenatal health care, or child care referral networks).

Employee Assistance Programs

Employee Assistance Programs (EAPs) provide confidential assessment and referral. They help employees and their families to solve personal problems that may affect their health, family life or job performance. They encourage employees to seek assistance early for a variety of problems.

The early diagnosis aspect of EAPs may initially result in increased medical expense costs through increased usage of mental, nervous and substance abuse benefits. It is hoped that these plans will lower costs in the long run. For small employers, especially those with high turnover rates, the early diagnosis aspect may eliminate the attractiveness of these types of programs.

Employee Newsletters

These are newsletters or other information distributed directly to employees, either at work or at home. The newsletters may provide information directly, or could provide notice of other health/lifestyle-related opportunities and materials.

Family Planning

These are educational programs providing employees with information related to birth control, prenatal care, and parenting, as well as where to turn for additional information.

Fitness Programs

A fitness program is generally defined as one which leads to an increased level of cardiovascular fitness.

Fitness programs may be either on site or off site. On-site programs generally include the construction of the employee fitness center. Less intensive on-site options include the use of employer facilities for company-sponsored aerobics classes. For on-site programs, the reward is usually considered to be the offering of the program or facility itself. Some employers, however, have provided financial rewards for attending the fitness center up to a specified number of times (i.e., 3) per week.

Off-site programs include provision of membership to fitness centers, the partial payment of membership and dues to fitness centers, or the sponsoring of specified off-site programs for employees (such as aerobic classes). These programs may include financial rewards for attaining specified goals. The financial rewards are generally incidental in scope.

Of employers with fitness programs, approximately 20% rate them as being very effective. One study indicates that medical costs for program participants are one-half those of nonparticipants. This study, however, did not account for the relative health status or age of those who initially chose to participate in the program, relative to those who did not.

Absenteeism rates often decline significantly with these types of programs. Some studies indicate improved productivity levels.

High Serum Cholesterol Screening

These programs relate to regular, preventive screenings designed to allow employees to track the level and trend in their cholesterol readings over time. As with other screening programs, the program is designed to detect problems early, and to allow employees to see the results of a change in lifestyle on cholesterol levels. It also serves to educate employees on the importance of cholesterol level as a measure of health.

Lifestyle Incentives

This includes programs providing employees with financial or other incentives to adopt healthier lifestyles. Incentives are often provided for evidence of exercising, smoking cessation or for use of health screenings.

Mammography Screening

Mammography screening is the regular screening for breast cancer. The recommended frequency varies by age. The availability of the screening process as well as the process itself will also educate employees on the danger of breast cancer and the advantages of early detection. The program will also provide referrals to specialists for those in immediate need of care.

While coverage of mammography screening is mandated in all health insurance policies in Maine, a workplace-based program should increase utilization.

Nutrition Counseling

Nutrition counseling is defined as a source which employees can use to get nutritional advice. The counseling covers all aspects of diet and its importance on health. The counseling could take the form of brown bag lunches, materials that could be checked out such as videotapes, or access to a professional counselor to answer specific questions.

Seat Belt Usage

This covers programs providing employees with information regarding the importance of seat belt usage.

Smoking Cessation

This includes programs which provide employees with education on the danger associated with smoking, as well as tools to help quit, and advice on how to stop smoking.

Special Family Health Fairs

These are used as a means to provide information to employees and their families regarding what they can do as a family to promote more healthy lifestyles. The topics covered include many of the educational and screening issues covered elsewhere in this section.

Stress Management

These include programs which educate employees on the issue of stress, both at work and at home. It can include information regarding identification of the cause of stress, as well as information on how to deal with stress.

Weight Loss and Control Programs

These are programs which educate employees on the dangers associated with being overweight. It could include information regarding the level of an individual's body fat, as well as with information for effectively reducing and maintaining one's weight. The programs should also cover the topics of proper diet and the danger of anorexia and bulimia.

EXHIBIT B

LIMITED SAMPLE OF THE EFFECTIVENESS OF VARIOUS PROGRAMS

- MESA LIMITED PARTNERSHIP

Program Includes:

- Health education.
- On-site fitness center.
- Financial award for attending the fitness center three times per week.

Results:

- Employee earnings increased.
- Company saved $300,000 per year in medical costs.
- Absenteeism dropped from 3.3 days to 1 day per employee per year.
- Participants' annual medical costs were one-half of the nonparticipants.

- BAKER HUGHES

Program Includes:

- $10 surcharge on contribution rate if employee is a tobacco user.
- $50 payment to employee if he gets cholesterol, blood pressure and height/weight checked.
- $100 pre-tax contribution to employee's health account if he passes three out of the four tests above.

Results:

- Tobacco surcharge more than paid for the wellness awards.
- Employer saved from 9% to 12% of the total premium over three years.

- ADOLPH COORS

Program Includes:

- On-site fitness center.

Results:

- Estimated saved $1.9 million in decreased medical costs.
- Increased productivity.

- CONTROL DATA

Program Includes:

- Weight control program.
- Smoking cessation program.
- Exercise program.
- Blood pressure screening.
- Seat belt use.
- Cholesterol screening.

Results:

1981-1984 Averages	Smoke	Exercise	Weight	BP	Seat Belt	Chol.
Cost Per Employee Before Programs	$1,040	$1,040	$1,050	$1,150	$1,100	$980
Cost Per Employee After Programs	$ 830	$ 800	$ 820	$ 850	$ 820	$810

- SUNBEAM

Program Includes:

- Prenatal program (educational classes, nutrition counseling, etc.). Mandatory participation.

Results:

- Saved 10% to 17% on maternity costs over three years.
- Reduced the rate of premature babies.

EXHIBIT C

LIMITED SAMPLE OF THE USE OF VARIOUS PROGRAMS

GROUP HEALTH ASSOCIATION OF AMERICA
SURVEY OF HMOS WHICH ARE THREE YEARS OR OLDER

Type of Benefit	Percent Covering
Well Baby Visits	100.0%
Pap Smears	100.0%
Mammography Screening	100.0%
Influenza Shots	97.9%
Child Immunizations	99.5%
Adult Immunizations	97.3%
Routine Physicals	99.5%
School/Work Physicals	35.5%
Nutrition Counseling	85.0%
Health Education Classes	75.0%

BUSINESS AND HEALTH
PERCENTAGE INDICATING WELLNESS PROGRAM IS "VERY EFFECTIVE"

Type of Program	Percent Indicating "Very Effective"
Mammography Screening	52.0%
Dollar Incentives to Meet Health Criteria	48.0%
On-Site Health Screening	45.0%
Dollar Penalties For Not Meeting Health Criteria	38.0%
Employee Assistance Programs (EAPs)	36.0%
Health Risk Assessments	31.0%
Wellness Programs For Dependents	25.0%
On-Site Fitness Center or Gymnasium	22.0%
Out-of-House Fitness Program	17.0%
Smoking Cessation	17.0%
Weight Loss and Control	16.0%
Stress Reduction and Management	11.0%

417 Survey Respondents Primarily Comprised of CEO/COO/President/Medical Directors

Section 5.

"ALTERNATIVE MODELS FOR RISK SHARING IN THE ISSUANCE OF SMALL GROUP HEALTH PLANS"

A. INTRODUCTION

The provision of Public Law 861 which requires the Bureau of Insurance to report on risk-sharing models specifies the following:

> In developing alternative models, the Bureau of Insurance shall consult with insurers, nonprofit hospital and medical service organizations, representatives of businesses and consumer groups and other interested parties. The alternative models must include provisions allowing carriers to determine whether they will or will not participate in the risk-sharing mechanism and must be based on the principle that the carriers that participate in the risk-sharing mechanism bear the costs for the obligations of the risk-sharing mechanism.

Timothy M. Harrington, QHA, MAAA, of William M. Mercer, Incorporated, was retained by the Bureau to assist in this project. Mr. Harrington prepared an initial report, with input from Bureau staff, which was circulated to interested parties. Mr. Harrington and Richard H. Diamond, FSA, MAAA, of the Bureau staff met with the following interested parties to receive their input on the report and on risk-sharing mechanisms generally:

William A.J. Bremer, MAAA, Blue Cross and Blue Shield of Maine
David R. Clough, National Federation of Independent Business
Joseph R. Mackey, Health Insurance Association of America (HIAA)
Representative Charlene Rydell
Christopher St. John, Pine Tree Legal Assistance, Incorporated

In addition, John Dwyer of Travelers Insurance Company provided comments by telephone. Also, Mr. Bremer subsequently provided written comments.

The following individuals requested and received copies of the initial report but did not comment:

Joseph Ditre, Consumers for Affordable Health Care
Charles T. Doe, FSA, Aetna Life and Casualty

Mr. Ditre did not receive the report or notice of the meeting until shortly before the meeting because they were sent to an outdated address. He was given an opportunity to provide comments subsequently. The Bureau apologizes to Mr. Ditre for any inconvenience.

The report was revised based on the comments received, and was augmented to include the views expressed by interested parties. The resulting draft was circulated to interested parties and further amended based on telephoned comments from Representative Rydell and Mr. Harrington.

B. GENERAL DESCRIPTION OF RISK SHARING

Many states have developed or are in the process of developing various models of small group health insurance reform. The models are viewed as a logical first step in solving some of the major problems of access to health insurance. For reasons discussed below, the concept of risk sharing among small group health insurance carriers is common to those models that require small group health insurance carriers to provide coverage to any small group that requests it. The approaches to risk sharing vary, and will be discussed in this report.

Perhaps the best way to describe the risk-sharing concept is to give a hypothetical example of why risk sharing is needed, how it works, and what its impact is.

Consider the simple example in which there are four small group carriers in a state. Each of the carriers has 25% of the small group market. There are 100 small groups in the state that have been unable to obtain small group coverage because of serious health problems. On January 1 of next year, the provisions of small group health reform become effective. These 100 small groups can now approach any carrier and demand to be covered.

When January 1 arrives, there is a chance that the 100 small groups approach the four small group carriers proportionally - 25 groups to each of the four carriers. If this were the case, the burden would be spread evenly, more or less.

However, because the number of small groups entering the market is expected to be small relative to existing business, it is more likely that there will be an uneven spread. The worst case scenario would be that all 100 went to only one of the carriers.

With the more than likely chance of an uneven spread, a carrier with a higher proportion of poor risk groups in relation to that carrier's share of the small group market would be threatened financially. The limitations on premium rate variation mean that the carrier won't be able to charge the new high risk groups a premium commensurate with their expected claims. Therefore, the difference would have to come from another source.

One source might be additional premiums from that carrier's existing small group business. However that would put the carrier at a competitive disadvantage, because it would have to raise its rates to all of its small group business.

Another source might be the new small group business of all small group carriers combined. This is advantageous because of its wider scope and because it puts no particular carrier at a competitive disadvantage. This is the basic concept that underlies each of the models that will be discussed in this report.

C. DESCRIPTION OF SPECIFIC TYPES OF RISK SHARING

There are several types of specific risk-sharing models that are in place or are being contemplated. Some are inconsistent with Maine law. For instance, the National Association of Insurance Commissioners (NAIC) Allocation Model assigns high-risk groups to insurers after the group has been rejected in the voluntary market. Such rejection would not be permissible under Public Law 861. Also models which require all carriers to participate or which require public funds are specifically precluded by the law. Eliminating or modifying these models leaves the following options:

- NAIC prospective model (modified),
- Retrospective stop-loss model,
- New York model (modified),
- Vermont model, and
- No risk sharing.

Following is a description of each model, a discussion of its advantages and disadvantages, and the views of it expressed by interested parties.

1. The NAIC Prospective Model

While this model provides for the use of public funds in some instances, it could easily be modified to eliminate this provision, as has been done in other states.

Under this model, carriers must make an initial choice whether or not they wish to be a part of the risk-sharing pool. The initial decision is binding for three years.

The pool is operated by a board of directors representing small groups and small group carriers appointed by the Commissioner. The board is responsible for the day to day management of the pool. Their first task is to submit a plan of operation to the Commissioner for approval. It must contain plans for accounting of assets, selecting an administering carrier, establishing procedures for risk sharing in accordance with specified guidelines in the law, and establishing procedures for assessing carriers. It is granted the powers and authority generally granted to an insurance company or HMO.

A carrier must decide within 60 days of enrolling a new small group or a new member in an existing small group whether to assign the entire small group or specific members of the small group to the shared risk pool. The decision is usually based upon the results of some very careful underwriting screening of the group.

The carrier must pay a premium to the pool, and, in return for the premium, the pool assumes the responsibility for claims in excess of $5,000 per person per year for a "standard" level of benefits. The carrier retains 10% of the liability for the next $50,000, and the pool is responsible for the remainder. The premium would be designed to reflect the expected excess claims cost of these high

risk groups and individuals.

This model provides reinsurance protection only for newly written small groups. It does not cover existing small groups, although it could be modified to do so, as was done in Connecticut.

At the end of the fiscal year, the pool administrators compare the premiums and investment income that were earned during the year to the estimated incurred claims and administrative expense. If the income exceeds the expense, the gain can be left in the pool as a reserve for future contingencies. If the expense exceeds income, assessments are made on the participating carriers. If the assessments exceed 5% of small group premium, the model allows for state money to fill the gap. If this model were to be adopted in Maine, it could be adjusted to eliminate the possibility of state money.

Initially, the premiums would be set at 1.5 times the premium for a standard group, where an entire group is assigned to the pool, and 5.0 times the premium for a standard member, where just a member is being assigned.

The board of directors would adjust the premiums and benefit levels annually, or as necessary, to assure the fiscal soundness of the pool.

This model is called prospective because groups and individuals are assigned to the risk-sharing pool before claims occur.

It has the advantage of allowing for a transfer to the pool of a large portion of the risk for those groups or individuals which the insurer deems to be high risks. However, it does have some drawbacks. The concept of assigning groups or members of groups to the pool prospectively (within 60 days of enrolling the group or the member) means that carriers would have to put a lot of reliance on expert health underwriting techniques to screen all groups applying for coverage, so that the carrier could make the right determination about who to assign to the pool. Generally, that expertise is not resident in community based plans that have a history of accepting all small groups. Therefore, the carriers with the best underwriters would fare the best in terms of risk sharing.

For this reason, Blue Cross and Blue Shield of Maine is opposed to this model. Representative Rydell opposes it for similar reasons; she feels that a model which encourages medical underwriting is inconsistent with the intent of Maine's law. Mr. St. John opposes such a model being developed with public resources, but does not necessarily oppose it if developed by the carriers themselves. This approach is discussed below under the Vermont Model.

Carriers with the best underwriters would only assign those groups or individuals whose claims would exceed the pool premiums. Therefore the premiums would likely be deficient, creating the need for assessments on members.

Another disadvantage of this model is that it is complex and expensive to operate.

Connecticut, Florida, North Carolina, Delaware, Iowa, and Minnesota have adopted or are in the

process of adopting versions of this model.

The HIAA favors this model. However, Mr. Dwyer of Travelers Insurance Company stated that this model does not make sense in conjunction with community rating. This is somewhat surprising in that Travelers is the administering insurer for the pool in Connecticut and elsewhere.

A copy of the language from the NAIC Model Act describing this form of risk sharing is presented in Appendix A at the end of this section.

2. The Retrospective Stop-Loss Model

This model was designed as a result of the desires of some states for an effective but more simplified approach to risk sharing among small group carriers.

Since the purpose of risk sharing is to protect any one carrier from the financial consequences of enrolling more than its fair share of new poor risk small groups, the retrospective stop-loss model attempts to spread the catastrophic portion of large claims over all small group carriers in the pool, and then to all new small groups enrolled by those carriers.

The appointment of the board of directors and the administration of the pool would be set up just as in the previous model. However, the operation of the risk sharing would be somewhat different.

In lieu of high-risk groups and individuals being assigned to the risk pool through medical underwriting, the retrospective stop-loss model simply provides that for new small groups enrolled by a participating small group carrier after the effective date of the pool, or new employees in existing small groups, the pool will assume the liability for claims in excess of $20,000* per person per year. The participating carrier need only supply the pool administration with proof of such a claim. In addition, the participating carrier would be made responsible for 5% of the next $50,000, to assure that managed care and utilization review controls are still carried out by the carrier.

Premiums would be determined on an actuarially self-sustaining basis, and charged as a community rate to all small group carriers for all new small group business enrolled after the effective date.

For example, for the first year of pool operation, the premiums may be:

Single	Family
$20.00/month	$45.00/month

Each new small group subscriber enrolled by a participating small group carrier would generate premium at the above rates. In return, the risk-sharing pool would assume liability for all claims in excess of $20,000 per person per year, subject to the 5% corridor mentioned earlier.

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* *Note: The $20,000 attachment point may be adjusted as the need varies.*

At the close of the year, the pool administrator would determine gains or losses. In the case of a loss, an assessment would be made to each participating carrier in the form of an additional community rate increment. No provisions for state money are made. The pool must be managed closely and have strong actuarial input.

Each year the pool premiums and the stop-loss attachment point would be adjusted as necessary to keep pace with inflation and the expected cost of claims.

This is an effective way to spread the excess portion of catastrophic claims over all participating small group carriers and their new small group insureds. It is also a very simple mechanism. Prospective underwriting screening is not needed. No provisions for a subsidy from the state are made. The participating carrier need only provide proof of a large claim to the pool administration, and the pool pays the excess amount.

The disadvantage of the method is that its effectiveness is limited, since the carrier would be responsible for the first $20,000 of each claim. Also, the method is untested in any state, although the concept of stop-loss insurance is well accepted.

Virginia and South Dakota are considering this simplified risk-sharing model.

Appendix B at the end of this section provides a copy of the proposed language.

3. The New York Model

The State of New York enacted a law requiring guaranteed issuance, guaranteed renewability, and community rating for small groups and individuals. This was at least partially in response to financial problems experienced by Empire Blue Cross and Blue Shield. Previously, Blue Cross Plans in New York were required to community rate, while commercial carriers were not.

Pursuant to the new law, New York's Superintendent of Insurance has proposed a regulation establishing two pooling mechanisms. The proposal would require all carriers to participate. However, it could be modified to include an opt-out provision.

This model provides for two basic risk-sharing elements: demographics and excess claims.

The demographic risk sharing is designed to equalize any variations in the demographic distribution of each of the carriers in relation to the average demographic distribution of all of the carriers combined. A table of age/gender risk factors forms the basis for calculating a demographic risk factor for each carrier and for all carriers combined.

Carriers with risk factors higher than the average risk factor would collect money from the pool. The money collected is used to subsidize the carrier's rate to assure that the carrier is competitive despite the unfavorable demographics in its risk pool.

Carriers with risk factors lower than the average would pay money to the pool. Their premium rates would have to be raised to the appropriate level to collect the money due.

If this concept works properly, the community rate charged by each of the insurers should reflect approximately the same age and gender distribution. Carriers such as Empire Blue Cross and Blue Shield who have always community rated and, as a result, have a higher average age would receive money from the demographic risk pool, allowing that carrier to lower its rates to the average demographic distribution of all the carriers.

The excess claim risk sharing is the second element. It is a simple retrospective stop-loss arrangement, similar to the one described above. It pays 50% of the excess over $25,000 per person per year up to $50,000, and 80% of the excess over $50,000 per person per year. This pool should also help carriers such as Empire Blue Cross and Blue Shield, which have always accepted poor risks and therefore have higher community rates, to be more competitive.

Both of the risk-sharing elements apply to all small group business written by the carrier rather than just the new small group business written after the effective date.

The pool would be overseen by the Superintendent of Insurance, who would choose a firm or firms to administer the program. The Superintendent is allowed to make equitable assessments on carriers to insure the financial integrity of the pool.

This model has the potential advantage of levelling the playing field for all of the carriers in terms of the demographic characteristics of their existing business. It also adds the protection of a simple retrospective stop-loss protection. There are no requirements for sophisticated underwriting for the pool to operate properly.

The data in Section 3 of this report indicate that employees in small groups covered by Blue Cross and Blue Shield of Maine may not be significantly older on average than those covered by other insurers. This may mean that Blue Cross' poor experience is primarily due to unhealthy risks resulting from lack of medical underwriting rather than to older insureds attracted by community rating. Therefore, the demographic pooling may not be greatly advantageous to Blue Cross. However, the stop-loss pool available for existing business would be beneficial.

This model has the same disadvantages noted above for the retrospective stop-loss model: its effectiveness is limited, since the carrier would be responsible for a large portion of each claim, and the method is as yet untested. Also, the age/gender factors proposed for the demographic risk sharing may not be a perfect indicator of expected claims.

Another potential disadvantage is that if the model were modified to include an opt-out provision, there would be an incentive for carriers with below average age/gender factors, or healthier than average insureds, to opt out. However, in so doing they would also give up the protection of the stop-loss pool.

Copies of the New York proposal were not available prior to the meeting of interested parties, but

were distributed at the meeting. No comments specifically relating to this model were subsequently received. It would seem that the party with the most to gain from this model, as in New York, would be Blue Cross, since it insures a higher-risk population than other carriers. However, Blue Cross and Blue Shield of Maine advocates no risk sharing at all, as noted below.

Appendix C at the end of this section contains the proposed New York regulation.

4. The Vermont Model

In the State of Vermont, a strict small group reform law became effective in July, 1992. It requires that small group carriers accept any small group that applies for coverage, but it does not require a formal risk-sharing pool. Instead, it contains the following provision:

> Registered small group carriers, except nonprofit medical and hospital service organizations and nonprofit health maintenance organizations, shall form a reinsurance pool for the purpose of reinsuring small group risks. This pool shall not become operative until the commissioner has approved a plan of operation. The commissioner shall not approve any plan which he or she determines may be inconsistent with any other provision of this section. The participants in the plan of operation of the pool shall guarantee, without limitation, the solvency of the pool, and such guarantee shall constitute a permanent financial obligation of each participant, on a pro rata basis.

To date, no pool has been formed in Vermont, although the law has been in effect since July 1, 1992.

Mr. St. John favors the Vermont approach. Representative Rydell favors it if any risk-sharing mechanism is to be adopted at all. She feels that it would be inappropriate for the Bureau of Insurance to be involved in designing the pool, but rather the insurance industry should develop a proposal and submit it to the Bureau for approval. Mr. St. John expresses concern that for the state to play a role in creating the pool would set the stage for a public bail-out should it fail.

However, the HIAA has expressed concerns that insurers acting together to form a pool could run afoul of anti-trust laws. Representative Rydell responds that if this is a problem, the Legislature can address it by amending the anti-trust laws.

5. No Risk Sharing

The ultimate in simplicity would be to provide no risk-sharing mechanism at all. The disadvantage is that some carriers would be likely to receive more than their share of high-risk groups. This would create two problems. First, if the excess claims had not been anticipated in pricing, rates would be inadequate, causing a loss to the carrier and potentially threatening its solvency. Second, if the carrier subsequently raised rates, it would not be competitive in trying to attract new business.

Many carriers have indicated that they would not be willing to remain in the market in the absence of a risk-sharing mechanism. However, recent experience in Vermont casts some doubt on this. As noted above, in Vermont, carriers are accepting high-risk small groups without the protection of a formal risk-sharing pool. Some thought that carriers would leave Vermont if they had to guarantee acceptance without risk sharing. Some carriers did leave but they had little market penetration. Other carriers came into the state to do business for the first time. The net effect was positive.

The question left unanswered is why small group carriers were willing to guarantee acceptance of any small group effective July 1, 1992, without the protection of a risk-sharing pool to assure a proportional distribution of the poor risk groups and individuals that would enroll. Yes, some carriers left Vermont, but others came in.

Is this an indication that risk sharing is not as important to carriers as was once thought? Perhaps, not. Vermont had community based carriers that always accepted any small group seeking coverage. Therefore, chances were small that many poor risk groups were waiting to seek coverage on July 1, 1992.

Vermont would also provide an experimental test ground for carriers. Because it is a small state, not much money could be lost by any one carrier, and valuable experience could be gained in dealing with small group health reform.

To some extent, circumstances in Maine are similar to Vermont. All small groups have always had access to coverage through Blue Cross, although at a rate considered by some to be unaffordable. However, Maine is a somewhat larger market than Vermont, having about double the population. Also, to the extent that carriers regard Vermont as a test ground, they may not want another test ground.

Blue Cross and Blue Shield of Maine favors the "no risk sharing" approach. Representative Rydell and Mr. Dwyer of Travelers Insurance Company also favor this approach, at least until definable problems arise.

D. EXPECTED UTILIZATION AND COST OF RISK SHARING

Strictly speaking, the only additional cost associated with these risk-sharing models is the cost of the administration associated with them. The claims that become the liability of the pool would have been the liability of the small group carrier had there been no risk-sharing pool.

The board of directors would incur only travel and meeting expenses. No salaries would be involved.

The carrier designated to operate the pool would be expected to incur expenses for legal, actuarial, underwriting, accounting, claims review, and other typical insurance related services. Administrative costs would vary depending on the number of small groups that seek coverage as a result of the guaranteed acceptance provision, how small groups were defined in terms of size, the number of high risk individuals associated with these small groups, the size of the catastrophic claims associated with these individuals, and the risk-sharing model chosen.

The provision of small group health reform that does produce additional claims costs is the guaranteed acceptance provision. Small groups that were unable to obtain coverage because of their health status would now seek out that coverage. Their poorer than average claims experience would be added to the average claims experience and raise that average. Therefore, premiums would increase somewhat on an overall basis.

In states where all of the carriers have carefully underwritten small groups and excluded some because of health status, it has been estimated that overall small group claims costs could increase 8% to 12% as a result of these groups reentering the market, and other good experience groups leaving the market for self-insurance.

In states where community based carriers have historically accepted all small groups, the impact would be much less, perhaps in the range of 2% to 4%.

Essentially, the NAIC prospective model risk-sharing pool assumes liability for claims in excess of $5,000 per person per year for those in the pool. In 1992 claim dollars, one might expect that approximately 50% of all small group claim dollars would be those in excess of $5,000 per person per year. Approximately 10% of small group members would be expected to incur these types of claims. Since small group carriers could choose who they assign to the pool, those with excellent underwriting staffs would only assign those groups and individuals whose claims experience is expected to be higher than the premium charged by the pool. As a result, the chances are quite good that the premiums would be deficient and assessments would be required.

The retrospective stop-loss model assumes pooling of all claims in excess of $20,000* per person per year. Only 1% of claimants incur these claims, and the excess would approximate 10% to 15% of total claim dollars. The chances of any assessment are a lot smaller for this model. No choices are being made as to what groups or individual are assigned to the pool. The stop-loss protection

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* *Or any other chosen attachment point.*

extends to all small group members enrolled after the effective date. Assessments would only happen if the actuarially based rates were deficient.

The New York model provides 50% coverage between $25,000 and $50,000 and 80% coverage above $50,000. While the coverage and the associated utilization would be less than the retrospective stop-loss model, the demographic risk sharing in the New York model fills the gap. Less stop-loss protection is needed if carriers are equalized for demographics. Since the New York model applies to existing and new business, the risk-sharing administration would have more volume to deal with than a model that deals with new business only.

E. SUMMARY

There are different risk-sharing models in effect or being contemplated. They all are designed to protect any one carrier from the financial consequences of having to accept more than that carrier's fair share of poor risk groups taking advantage of the guaranteed acceptance provision of health reform.

The NAIC prospective model is the most complicated, in that it requires rigorous underwriting of new small groups to determine whether or not they should be assigned to the risk-sharing pool. It is also the model that is most likely to require carrier assessments, because participating carriers are likely to assign only those groups or individuals to the pool whose claims are likely to exceed the pool premium. It is viewed as complex and expensive to operate. However, it is also the model which permits the most complete pooling of high-risk groups. The HIAA favors this model.

The retrospective stop-loss model is effective, simple, and much less prone to the need for assessments because of its basic design. However, it is as yet untested, and it requires the carrier to assume liability for the first $20,000 of each large claim.

The New York model repeats the simplicity of a retrospective stop-loss model at higher limits with the addition of the demographic pool for equalizing demographic differences among carriers. It is a powerful model to support the strong New York community rating model and it applies to existing as well as new business. However, it still leaves a significant portion of the risk involved with high-risk groups with the carrier insuring the group.

The Vermont model leaves it to the insurers to determine what type of pool, if any, is to be formed. This minimizes state involvement, but may raise anti-trust questions. Representative Rydell and Mr. St. John favor this approach.

Lastly, there is the option of providing no risk sharing at all. This is the simplest approach, but does not alleviate the risk that an insurer may acquire more than its share of high-risk groups. Blue Cross and Travelers Insurance Company both favor this approach.

While no one expressed support for the retrospective stop-loss model, or the somewhat similar New York model, these models also avoid the aspects of the other models which elicited the most strenuous objections. They do provide at least some degree of risk sharing without raising anti-trust questions. They do not depend on medical underwriting. Therefore these models may present potential for a compromise.

Appendix A to Section 5

NAIC Prospective Model

The following is excerpted from a National Association of Insurance Commissioners Model Act:

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

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 binding 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 would 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 (5) 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(3), the board shall be expanded to include two (2) 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(3)(d)(ii)]. 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(3).

(3) The initial board members shall be appointed as follows: two (2) of the members to serve a term of two (2) years; three (3) of the members to serve a term of four (4) years; and three (3) of the members to serve a term of six (6) years. Subsequent board members shall serve for a term of three (3) 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 to provide 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 written approval 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, adopt and promulgate a temporary plan of operation. The commissioner shall amend or rescind any plan 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 are 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 of 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 fiscal 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;

(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 commencement of coverage with the small employer. A newly eligible employee or dependent of the 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 ten percent (10%) of the next $50,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carriers' 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 with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

[(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 is 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 $5,000 of covered benefits. States that adopt an initial retention level of less than $5,000 under Paragraph (4) should include the above language.

(7) A reinsuring carrier shall apply all managed care and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

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 (adjusted to reflect retention levels required under this Act).

(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 to 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.

(4) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

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 the 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 percent of an amount which is based on the proportion of (i) 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 (ii) 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 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 total premium and to the previous year's premium 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 earned by a reinsuring carrier that are less than an amount determined by the board to justify the cost of assessment 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 ninety (90) days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file a report with the commissioner within ninety (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 calendar 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 (2) consecutive calendar years exceed the amount specified in Subparagraph (c), the program shall be eligible to receive additional financing as provided in Item (ii).

(ii) The additional funding provided for in Item (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 be equal to the amount by which total assessments in the preceding two (2) calendar years exceed five percent (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 (2) previous calendar years pursuant to this subparagraph, the amount of additional financing shall be subtracted from the amount of total assessments for the purpose 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 (2) 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 the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals

or groups with the program until such time as it pays the 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.

Appendix B to Section 5

Retrospective Stop-Loss Model

SMALL EMPLOYER CARRIER REINSURANCE PROGRAM

A. All small employer carriers may participate in the reinsurance program.

B. There is hereby created a nonprofit entity to be known as the 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 (8) members appointed by the superintendent plus the superintendent or his or her designated representative, who shall serve as an ex officio member of the board.

(2) In selecting the members of the board, the superintendent shall include representatives of small employers and small employer carriers and such other individuals determined to be qualified by the superintendent. At least five (5) 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 superintendent.

(3) The initial board members shall be appointed as follows: two (2) of the members to serve a term of two (2) years; three (3) of the members to serve a term of four (4) years; and three (3) of the members to serve a term of six (6) years. Subsequent board members shall serve for a term of three (3) 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 superintendent. A board member may be removed by the superintendent for cause.

D. Within sixty (60) days of the effective date of this Act, each small employer carrier shall make a filing with the superintendent 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 superintendent a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the program. The superintendent may, after notice and hearing, approve the plan of operation if the superintendent determines it to be suitable to assure the fair, reasonable and equitable administration of the program, and to provide 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 written approval by the superintendent.

F. If the board fails to submit a suitable plan of operation within 180 days after its appointment, the superintendent shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The superintendent shall amend or rescind any plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the superintendent.

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 superintendent;

(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 are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the superintendent, to enter into contracts with similar programs of 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 or portions thereof 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 participating small employer carriers in accordance with the provisions of Subsection K, 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 fiscal 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;

(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 small employer 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 small groups first written on or after the effective date of the small employer carrier reinsurance program.

(3) A small employer carrier may reinsure new employees of an existing small employer subsequent to the effective date of the small employer carrier reinsurance program.

(4) (a) The program shall not reimburse a small employer 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 $20,000 in a calendar year for benefits covered by the program. In addition, the small employer carrier shall be responsible for ten percent (10%) of the next $50,000 of benefit payments

during a calendar year and the program shall reinsure the remainder. A small employer carriers' liability under this subparagraph shall not exceed a maximum limit of $23,000 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 superintendent approves a lower adjustment factor.

(5) A small employer carrier may terminate reinsurance with the program after three years of initial participation. The superintendent may require the carrier to maintain reinsurance if the carrier's financial condition would be threatened without reinsurance.

(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 is 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.

(7) A small employer carrier shall apply all managed care and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

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 small employer carriers pursuant to this section. In determining the method, the board shall assure that all participating small group carriers pay premiums that are community based. This can be accomplished by determining that all participating small group carriers pay exactly the same percentage of their new small group premium written on and after the effective date of the Reinsurance Program. It can also be accomplished by determining that all participating small employer carriers pay the same rate per contract month for newly enrolled groups.

(2) Due consideration will be given to the provisions of Section K(5) in determining premiums for federally-qualified health maintenance

organizations.

(3) The board will require an actuarial report certifying the adequacy of the proposed rates prior to their implementation.

(4) The board may propose changes to the methodology in this section which shall be subject to the approval of the superintendent.

(5) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

K. (1) Prior to March 1 of each year, the board shall determine and report to the superintendent 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 participating small employer carriers.

(b) The amount assessed to each participating small employer carrier will be based on the same type of formula used to determine the initial premium for the small employer carrier, as described in paragraph J(1).

(c) The board may, with approval of the superintendent, change the assessment formula established pursuant to Subparagraph (a) from time to time as appropriate.

(d) Subject to the approval of the superintendent, the board shall make an adjustment to the assessment formula for participating small employer 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 earned by a small employer carrier that are less than an amount determined by the board to justify the cost of assessment 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 superintendent 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 ten (10) percent of the reinsurance premiums earned for the same year, 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 superintendent within ninety (90) days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file a report with the superintendent within ninety (90) days following the end of the applicable calendar year, the superintendent may evaluate the operations of the program and implement such amendments to the plan of operation the superintendent deems necessary to reduce future losses and assessments.

(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 participating small employer 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 small employer 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 participating small employer carrier may seek from the superintendent a deferment from all or part of an assessment imposed by the board. The superintendent may defer all or part of the assessment of a participating small employer carrier if the superintendent determines that the payment of the assessment would place the small employer carrier in a financially impaired condition. If all or part of an assessment against a participating small employer 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 participating small employer carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the

assessments.

L. Neither the participation in the program as small employer 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 small employer carriers either jointly or separately.

Appendix C to Section 5

New York Model

Following is the regulation proposed by the New York State Insurance Department. Its adoption is still pending.

INSURANCE DEPARTMENT OF THE STATE OF NEW YORK

PROPOSED REGULATION NO. 146

(11 NYCRR 361)

ESTABLISHMENT AND OPERATION OF DEMOGRAPHIC AND LARGE CLAIM POOLING MECHANISMS FOR INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE AND MEDICARE SUPPLEMENT INSURANCE

I, Salvatore R. Curiale, Superintendent of Insurance of the State of New York, pursuant to the authority granted by Sections 201, 301, 1109, 3201, 3217, 3231, 3232, 3233, 4235, 4304, 4305, 4317, 4318 and 4501 of the Insurance Law, do hereby propose a new Part 361 (Regulation No. 146) of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York to take effect upon publication in the State Register.

Section 361.1 Preamble.

(a) Chapter 501 of the Laws of 1992 requires that the Superintendent promulgate regulations regarding the orderly implementation of open enrollment and community rating of policies issued to small groups and individuals pursuant to Sections 3231 and 4317 of the Insurance Law. Such regulations are to include provisions designed to encourage insurers to remain in or enter the small group or individual health insurance markets, and are to be designed to promote an insurance marketplace where premiums do not unduly fluctuate, insurers and HMOs are reasonably protected against unexpected significant shifts in the number of persons insured, and other market stability features deemed appropriate by the Superintendent.

(b) Prior to enactment of Sections 3231 and 4317 there was some concern that the open enrollment process would expose insurers to financial losses because the insurers would be enrolling persons for coverage who might be very ill or have a history of high claims costs, and the claims costs of such persons would be higher than the amounts assumed by the insurer when it established its premium rates. Insurers which encountered these situations, or feared they might encounter them, might choose to cease their participation in either the small group health insurance or individual health insurance markets, or both. In order to avoid that result the Legislature enacted Section 3233 which explicitly requires that these regulations include provisions designed to encourage insurers to remain in those markets, and even to expand their efforts in those markets.

(c) Chapter 501 was designed to cause insurers to compete with each other, and provide services to the public, based on administrative efficiency, customer satisfaction, the ability to manage care and cost effective provider agreements, rather than on the basis of avoiding or terminating coverage of persons whose health care costs are high. In order to implement the statutory intent that insurers be prevented from avoiding open enrollment activities in order to obtain a marketplace advantage over their competitors, the stabilization mechanism needs to include all insurers in the individual and small group insurance markets. If the mechanism were voluntary, insurers which did not have a proportionate share of high cost persons would naturally decline to participate and

thus continue to reap benefits from their selective underwriting activities.

(d) The purpose of this regulation is to establish a pooling process which achieves the following goals:

(1) To share among insurers those substantive claims costs variations attributable to significant differences in demographic factors of the persons insured. The protection afforded by this sharing process will facilitate the introduction of open enrollment and community rating by providing some assurance to insurers that their business and competitive interests will be secure because the insurer is itself protected from sudden or significant changes in the proportion of high cost persons they insure, and because other insurers will not obtain a competitive advantage by avoiding or failing to insure a proportionate share of high cost persons;

(2) To promote competition among insurers on the bases of administrative efficiency, customer satisfaction, the ability to manage care, cost effective provider agreements, and to deter competition on the basis of avoiding or terminating coverage of persons whose health care costs are high;

(3) To protect insurers which are subject to the open enrollment and community rating provisions of Chapter 501 from undue variations in claim costs which are not related to differences in operating efficiency, the ability to manage care, or provider agreements.

(4) To encourage insurers to enter, remain in, and compete vigorously in the small group health insurance and/or individual health insurance markets.

(e) The pooling process intended to be implemented by the sections below includes two elements.

The first element is an age/sex relative morbidity table to measure the relative "risk" for each insurer, with respect to the demographic characteristics of the persons insured by that insurer. If one insurer has a relative risk factor greater than the average of all insurers they would receive money from the pool, while insurers with a relative risk factor below the average of all insurers would contribute money to the pool. Insurers which are expected to make contributions would be permitted to include their projected contributions in its premium rates as if the contributions were claims expenses, while insurers which are expected to receive money would treat the projected receipts as if they were offsets to claims and thus reduce premium rates below what those premium rates would otherwise need to be.

(f) The second element is the pooling of large claims which protects insurers from some part of the adverse financial effects of incurring a disproportionate number of large claims because of open enrollment requirements. Each insurer contributes to the pool a pre-set percentage of its premiums, and each insurer receives money from the pool in proportion to the amount of its large claims.

(g) The two adjustment processes are to be based on reasonably available data and factors that account for a significant portion of the cost differences among insurers due to demographics and high cost claims, but they are not expected to account for all differences among insurers. A more precise adjustment process would require a marked increase in administrative effort, yielding marginal improvement in results. Cost variations among insurers based on operational efficiency, ability to manage health care costs and patient care, as well as administration of health insurance policy provisions, are not intended to be neutralized and indeed are encouraged.

Section 361.2 Definitions. As used in this Part, the following words and phrases are defined as follows:

(a) *Article 43 corporation* means a corporation organized under Article 43 of the Insurance Law.

(b) *Average demographic factor* means the weighted average demographic index of each insurer. The index for a particular insurer reflects

the likely relative claims costs for that insurer, based only upon the demographic factors of the persons it insures, compared to the likely average claims costs of other insurers, based only upon the demographic factors of the persons the other insurers insure.

(c) *Demographic pooling fund* for a given calendar year is determined in May of the following year as item (1), plus item (2), minus item (3), minus item (4) below:

(1) the amounts payable to a pool in May of the following year, as stated in paragraph (f)(2) of Section 361.3 and paragraph (b) of Section 361.4;

(2) the amounts carried over from May of that calendar year, in accordance with paragraph (f)(4) of Section 361.3;

(3) the amounts stated in paragraphs (a)(3) and (a)(6) of Section 361.5, with respect to pool operations during that year;

(4) the amounts pool participants are entitled to collect in May of the following calendar year, as stated in paragraph (c) of Section 361.4.

(d) *Earned premium (or premium earned)* is:

(1) for an Article 43 corporation, as defined in the current New York "Instructions To Hospital, Medical, and Dental Service or Indemnity Corporations For Completing Annual Statement Blank."

(2) for a health maintenance organization, as defined in the current "General Information and Instructions For Filing The New York Data Requirements For Health Maintenance Organizations."

(3) for a commercial insurance carrier or a fraternal benefit society, as defined in the current NAIC "Annual Statement Instructions -- Life, Accident and Health."

(e) *Family unit* means the following:

(1) for an Article 43 corporation -- contractholder

(2) for a health maintenance organization -- subscriber

(3) for individual health insurance of a commercial insurance company -- policyholder

(4) for small group health insurance other than that of an Article 43 corporation or a health maintenance organization -- certificateholder

(f) *Health maintenance organization* means an organization or line of business of an Article 43 corporation which has received a certificate of authority from the Commissioner of Health pursuant to Article 44 of the Public Health Law, or, an Article 43 corporation which is qualified within the meaning of section 1310(c) of Title XIII of the Public Health Service Act.

(g) *Incurred claims (or claims incurred)* is:

(1) for an Article 43 corporation, as defined in the current New York "Instructions To Hospital, Medical, and Dental Service or Indemnity Corporations For Completing Annual Statement Blank."

(2) for a health maintenance organization, "Total Medical and Hospital Expenses" incurred, as defined in the current "General Information and Instructions For Filing The New York Data Requirements For Health Maintenance Organizations."

(3) for a commercial insurance carrier or a fraternal benefit society, as defined in the current NAIC "Annual Statement Instructions -- Life, Accident, and Health."

(h) *Individual Health Insurance Policy* means an insurance policy written by an insurer under the provisions of Sections 3216, 4304 and 4501(c) of the Insurance Law, except for policies covering only long term care type benefits, dental or vision care services, hospital or surgical indemnity benefits providing specific dollar amounts unless the dollar amounts exceed the amounts required to meet the definitions of basic hospital and basic medical insurance in 11 NYCRR 52.5 and 52.6, accidental death and dismemberment benefits, prescription drug benefits or disability income benefits.

(i) *Individual claim* means the total claims paid for services rendered during a single calendar year with respect to a single individual under the pooled insurance of a single insurer.

(j) *Insurer* means a commercial insurance carrier, fraternal benefit society, Article 43 corporation, or a health maintenance organization.

(k) *Medicare supplement insurance policy* is as defined in 11 NYCRR 52.11.

(l) *Paid claims (or claims paid)* is:

(1) for an Article 43 corporation, as defined in the current New York "Instructions to Hospital, Medical, and Dental Service or Indemnity Corporations For Completing Annual Statement Blank."

(2) for a health maintenance organization, 'Total Medical and Hospital Expenses" paid, as defined in the current "General Information and Instructions For Filing The New York Data Requirements For Health Maintenance Organizations."

(3) for a commercial insurance carrier or a fraternal benefit society, as defined in the current NAIC "Annual Statement Instructions -- Life, Accident and Health."

(m) *Insurer participating in a pool* means:

(1) With respect to an individual health insurance pool for a particular area, an insurer which has in force one or more individual health insurance policies required to apply a

community rating methodology, as stated in Section 360.11 of Regulation 145, covering individuals residing in that area.

(2) With respect to a Medicare supplement insurance pool for a particular area, an insurer which has in force one or more Medicare supplement insurance policies required to apply a community rating methodology, as stated in Section 360.11 of Regulation 145, covering individuals residing in that area.

(3) With respect to a small group insurance pool for a particular area, an insurer which has in force one or more small group insurance policies covering small groups located in that area.The location of the small group itself shall be used and all persons within that small group shall be considered located in the same region as the group itself, regardless of the various residences of the employees.

(n) *Pooled insurance* means,for a particular period, all insurance in force during that period of a form subject to community rating requirements, as stated in Section 360.11 of Regulation 145, except for individual or group policies issued pursuant to a statutory or contractual right of conversion.

(o) *Regional demographic factor* means the combined average demographic factor for all insurers in that region using the same methodology defined in paragraph (c) of Section 361.3 for a single insurer.

(p) *Small group health insurance policy* means a group remittance policy written pursuant to Section 4304 and a group health insurance policy covering from 3 to 50 employees or members, exclusive of dependents and spouses, and certain policies issued to groups defined in paragraph (1) of subsection (c) of Section 4235, including but not limited to association groups as defined in Section 360.2 of Regulation 145. A small group health insurance policy does not include a policy covering long term care benefits, dental or vision care services, hospital or surgical indemnity benefits providing specific dollar amounts, accidental death or dismemberment benefits, prescription drug benefits or disability income benefits.

Section 361.3 Pooling of Variations In Claim Costs 'Attributable to Variations in Demographics.

(a) Two pools will be established for each of the following areas:

(1) Albany Area -- the counties of Albany, Rensselaer, Washington, Warren, Essex, Clinton, Saratoga, Schenectady, Schoharie, Montgomery and Fulton.

(2) Buffalo Area -- the counties of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

(3) Mid-Hudson Area -- the counties of Putnam, Dutchess, Columbia, Greene, Ulster, Orange, Sullivan and Delaware.

(4) New York City Area -- the counties of Suffolk, Nassau, Kings, Queens, Richmond, New York, Bronx, Rockland and Westchester.

(5) Rochester Area -- the counties of Monroe, Livingston, Ontario, Wayne, Yates and Seneca.

(6) Syracuse Area -- the counties of Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga, and Tompkins .

(7) Utica/Watertown Area -- the counties of Chenango, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison ,Oneida, Oswego, Otsego, and St. Lawrence.

(b) In each area,

(1) one pool will deal with individual health insurance and small group health insurance, excluding Medicare supplement insurance,

(2) one pool will deal with Medicare supplement insurance.

(c) The average demographic factor shall be determined for an individual insurer as follows:

(1) Assign the appropriate age/sex factor to each family unit covered by a particular insurer under a community rated contract during the calendar year, according to the Table Of Age/Sex Factors or the Table Of Age Factors, as appropriate, below:

Table of Age/Sex Factors
(For Other Than Medicare Supplement Insurance)

Age* of Family Unit	Family Units Consisting Of A Single Individual: Male Family Unit	Family Units Consisting Of A Single Individual: Female Family Unit	Family Units Consisting Of More Than One Individual (e.g. Employee plus spouse and Children
Less than 30	0.54	1.06	1.78
30-39	0.70	1.21	2.28
40-44	1.00	1.30	2.67
45-49	1.20	1.40	2.93
50-54	1.50	1.60	3.34
55-59	1.80	1.90	3.81
60-64	2.36	2.17	4.61
over 64	3.14	2.77	5.99
Medicare Primary**	0.89	0.89	1.79

Table Of Age Factors
(For Medicare Supplement Insurance)

Age* Of Family Unit	Age Factor
under 65	?
65-69	0.80
70-74	0.96
75-79	1.08
over 79	1.18

*Age is determined as calendar year for which calculation is being made minus calendar year of birth.

**Use for the over 64 category for policies under which Medicare is primary.

(2) Multiply the age/sex factor for each family unit by the number of months the family unit was covered by that insurer under that community rated contract.

(3) Multiply each product in step (2) above by the monthly billed premium for that contract.

(4) Add the products from step (3) above.

(5) Divide the results of step (4) by the total premium earned by that insurer for all community rated contracts during the calendar year.

(d) The regional demographic factor for all insurers combined shall be determined for each pool, based upon the average demographic factors of all insurers participating in that pool.

(e) Insurers whose average demographic factor varies from the regional demographic factor shall pay to (if less than average) or draw from (if greater than average) the regional pool.

(f) In May of each calendar year after 1993, money will be collected from and paid to pool participants as follows:

(1) Each pool as stated in (a) and (b) above will operate independently; that is, all calculations described below are made for each pool independently of any other pool.

(2) An insurer which must pay to a pool pays a percentage of its premiums earned for pooled insurance during the previous calendar year. The additional percentage of premiums earned during a given calendar year to be paid to the pool in May of the following year is established by approval of the superintendent as a part of the process for approval of premium rates for that calendar year (see Section 360.11, 11 NYCRR 360). The additional percentage is calculated as the product of items (i), (ii) and (iii) below:

(i) -100;

(ii) The ratio of claims projected to be incurred in the period covered by the rate filing to the premiums projected to be earned during that period, without consideration of this additional percentage.

(iii) 1.0 - the ratio of the projected total demographic factor for that pool in the period covered by the rate filing to the projected average demographic factor of the insurer for that pool in that period.

With respect to premium rates for 1993 and 1994, the additional percentage described in this paragraph will be recalculated quarterly for each pool participant.

(3) Subject to the limitation in the next sentence, an insurer which is entitled to collect from a pool may collect the product of items (i) and (ii) below:

(i) the claims incurred under its pooled insurance in the previous calendar year, minus any amounts collectible from the pool, as stated in paragraph (c) of Section 361.4;

(ii) 1.0 minus the ratio of the total demographic factor for that pool in the previous calendar year to the insurer's average demographic factor for that pool in the previous calendar year.

If the demographic pooling fund for the previous calendar year, with accumulated interest thereon, is not sufficient to pay all insurers the amounts they are currently entitled to collect in accordance with this paragraph, the amounts they are entitled to collect are reduced proportionately to match the demographic pooling fund.

(4) Any excess of the demographic pooling fund for the previous calendar year with accumulated interest thereon, over the amounts participants are currently entitled to collect in accordance with paragraph (f)(3) above is carried over to pay insurers which are entitled to collect from the pool in May of the following calendar year, with respect to their operations in the current calendar year.

Section 361.4 Pooling of the cost of high cost claims in order to spread the risk of high cost claims.

(a) Within each of the pools identified in Section 361.3 there shall be a process to spread the risk of high cost claims among the insurers issuing community rated contracts to indiviuals and small group in that region.

(b) Each insurer must pay to a pool a percentage of its premiums earned for pooled insurance during the previous calendar year. (For 1993 only, earned premiums are for community rated insurance from April 1 through December 31; for calendar years after 1993, earned premiums are for community rated insurance from January 1 through

December 31). For each pool, the percentage of premiums earned from April 1, 1993 through December 31, 1993, to be paid to the pool in May, 1994, are stated in Table 1. These percentages are intended to cover the amounts stated in paragraphs (a)(3) and (a)(6) of Section 361.5, with respect to pool operations during 1993, and the amounts stated in paragraph (c) below, with respect to amounts insurers are entitled to collect in May, 1994. For each pool, the percentages of premiums earned during a calendar year after 1993, to be paid to the pool in May of the following year, are established by the Superintendent in July of the previous calendar year and are intended to cover the amounts stated in paragraphs (a)(3) and (a)(6) of Section 361.5, with respect to pool operations during the given calendar year, and the amounts stated in paragraph (c) below, with respect to the amounts insurers are entitled to collect in May of the following year.

(c) Subject to the limitation set forth in the following sentence and to verification of the appropriateness of each individual claim by the pool administrator, an insurer shall be entitled to collect from the applicable pool, with respect to individual claims for services in the previous calendar year, as follows:

(1) for such claims that exceed $25,000 but are less than $50,000, 50% of the portion of the claim which exceeds $25,000; and

(2) for such claims that are equal to or exceed $50,000, $12,500 plus 80% of the amount that exceeds $50,000.*

If the amounts currently payable in accordance with paragraph (b) above and paragraph (f)(2) of Section 361.3, less the amounts stated in paragraphs (a)(3) and (a)(6) of Section 361.5, with respect to pool operations during the previous calendar year, are not enough in total to pay all insurers the amounts they are entitled to collect in accordance with this paragraph, the amounts they are entitled to collect are reduced proportionately to match the total amounts currently payable in accordance with paragraph (b) above and paragraph (f)(2) of Section 361.3, less the amounts stated in paragraphs (a)(3) and (a)(6) of Section 361.5, with respect to pool operations during the previous calendar year.

Section 361.5 Pool Administration.

(a) The pools will be administered by the Superintendent, performing at least the following functions:

(1) choosing a firm or firms to administer the pools, based on an evaluation of competitive bids,

*Note: For an individual claim of $65,000, an insurer would be entitled to collect $24,500 -- i.e., $12,500 plus 80% of the claim in excess of $50,000 (80% of $15,000).

(2) approval of the general systems and procedures used by the firm or firms to administer the pools, including in particular procedures to verify the appropriateness of individual claims for which pool participants seek payment under paragraph (d)(5) below.

(3) payment of reasonable fees from the pools to the firm or firms for administration of the pools,

(4) changing the administrating firm or firms, or the administrative systems and procedures,

(5) the collection from pool participants of the data needed to administer the pool,

(6) the arrangement for an annual audit of the pools, including the participation of each pool participant, and paying from the pools reasonable fees for such audits,

(7) the reporting to the pool participants a summary of the operations of the pools, on a periodic basis, but in no event less often than annually, and

(8) establishing equitable assessments on pool participants as needed to make the payments stated in paragraphs (c)(3) and (c)(6) above, and in paragraphs (d)(2) and (d)(3) below.

(b) The Superintendent may seek advice and recommendations regarding the functions listed above, or regarding other functions, from the Technical Advisory Committee, established in accordance with Section 3233(b) of the Insurance Law.

Section 361.6 Review of pool operations. Commencing on January 1, 1994, the Superintendent shall review the operation of the pooling process described herein to determine whether the process is serving the purposes described in Section 361.1 of these regulations. The administrator appointed by the Superintendent pursuant to Section 361.3(c) of these regulations shall cooperate with the Superintendent in providing the information necessary to properly evaluate the process, and the Superintendent shall seek and accept additional information from the insurers and the technical advisory committee. On or before July 1, 1994, the Superintendent shall prepare a report that analyzes whether and how well the pooling mechanism is fulfilling its intended purposes, and if appropriate, shall recommend changes to these provisions.

Table 1
Percentage of Earned Premium For Pooling Of Large Claims
4/1/93 - 12/31/93

Area (1) - Albany Area

Individual Health Type of Contract	Medicare Supplement Insurance	Small Group Insurance	Insurance
Basic Hospital or Basic Hospital/Surgical	%	%	%
Wrap-around or Supplemental Major Medical	%	%	%
Basic & Supplemental Major Medical or Comprehensive Major Medical	%	%	%

Example

Demographic pooling for calendar year 1995 for a pool with three participants -- insurers A, B and C.

Step 1.

In May of 1994, payments to and from the pool are made with respect to calendar year 1993. At that time, all participants are made aware of the following information:

Insurer	1993 Earned Premium ($ in millions)	Average Demographic Factor for 1993
A	100	2.5
B	600	3.0
C	50	2.4

Total Demographic Factor For 1993 =

$$(100 \times 2.5 + 600 \times 3.0 + 50 \times 2.4) \div 750 = 2.89$$

Step 2.

Insurers A, B and C file for approval of the premium rates they will charge during 1995. These filings are submitted in August, 1994. They include the following assumptions:

Insurer	Incurred Claims Projected For 1995	Earned Premium Projected for 1995 ($ in millions)	Average Demographic Factor Projected For 1995
A	$120	$160	2.6
B	$560	$640	3.0
C	$ 64	$ 80	2.4

Step 3.

Superintendent determines that:

(i) The projected earned premiums and average demographic factors are reasonable.

(ii) Based on these factors, the projected total demographic factor for 1995 will be $(160 \times 2.6 + 640 \times 3.0 + 80 \times 2.4) \div 880 = 2.87$

(iii) Insurers A and C should add the following additional percentages to their premium rates during 1995:

Insurer A: (-100) x (120/160) x (1 - 2.87/2.6) = 7.8%

Insurer C: (-100) x (64/80) x (1 - 2.87/2.4) = 15.7%

(iv) Insurer B should subtract from its premium rates the following percentage during 1995:

Carrier B: (100) x (560/640) (1 - 2.87/3.0) = 3.8%

Step 4.

In May of 1986, insurers submit actual data to the Superintendent, as follows:

Insurer	1995 Incurred Claims*	1995 Earned Premium ($ in millions)	Average Demographic Factor for 1995
A	$135	$180	2.5
B	$567	$630	3.1
C	$ 56	$ 70	2.4

*Reduced by amounts collectible under large claim pooling.

Step 5.

In May of 1996, the total demographic factor for the pool for 1995 is determined as follows:

(180 x 2.5 + 630 x 3.1 + 70 x 2.4) ÷ 880 = 2.92

Step 6.

In May of 1996, insurers A and C pay to the pool the following amounts:

Insurer A: $180,000,000 x 7.8% = $14,040,000

Insurer C: $70,000,000 x 15.7% = $10,990,000

Step 7.

In May of 1996, insurer B is entitled to collect

$567,000,000 x (1 - 2.92/3.1) = $32,922,581

However, since only $25,030,000 has been paid to the pool, insurer B may collect only that amount.

APPENDIX

Following is Maine Public Law 1991, Chapter 861: "An Act to Provide More Affordable Health Insurance for Small Businesses and Community Rating of Health Insurance Providers"

APPROVED | CHAPTER

APR 9 '92 | 861

BY GOVERNOR | PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-TWO

H.P. 507 - L.D. 701

An Act to Provide More Affordable Health Insurance for Small Businesses and Community Rating of Health Insurance Providers

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24 MRSA §2327-A, as enacted by PL 1989, c. 422, §1, is amended to read:

§2327-A. Rating practices in group health insurance

Title 24-A, ~~section~~ sections 2808-A and 2808-B~~,~~ ~~shall~~ apply to nonprofit hospital corporations, nonprofit medical service corporations and nonprofit health care plans to the extent not inconsistent with this chapter.

Sec. 2. 24-A MRSA §2808-B is enacted to read:

§2808-B. Small group health plans

1. **Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Carrier" means any insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue small group health plans in this State. For the purposes of this section, carriers that are affiliated companies or that are eligible to file consolidated tax returns are treated as one carrier and any restrictions or limitations imposed by this section apply as if all small group health plans delivered or issued for delivery in this State by affiliated carriers were

issued by one carrier. For purposes of this section, health maintenance organizations are treated as separate organizations from affiliated insurance companies and nonprofit hospital and medical service organizations.

B. "Community rate" means the rate to be charged to all eligible groups for small group health plans prior to any adjustments pursuant to subsection 2, paragraphs C and D.

C. "Eligible employee" means an employee who works on a full-time basis, with a normal work week of 30 hours or more. "Eligible employee" includes a sole proprietor, a partner of a partnership or an independent contractor, but does not include employees who work on a part-time, temporary or substitute basis.

D. "Eligible group" means any person, firm, corporation, partnership, association or subgroup engaged actively in a business that during at least 50% of its working days in the preceding calendar quarter employed fewer than 25 eligible employees, the majority of whom are employed within the 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 are considered one employer. In the calculation of carrier percentage participation requirements, eligible employees and their dependents who have existing health care coverage may not be considered in the calculation.

E. "Late enrollee" means an eligible employee or dependent who requests enrollment in a small group health plan following the initial minimum 30-day enrollment period provided under the terms of the plan, except that, an eligible employee or dependent is not considered a late enrollee if the eligible employee or dependent meets the requirements of section 2849-B, subsection 3, paragraph A or B.

F. "Premium rate" means the rate charged to an eligible group or eligible individual for a small group health plan.

G. "Small group health plan" means any hospital and medical expense-incurred policy; health, hospital or medical service corporation plan contract; or health maintenance organization subscriber contract covering

an eligible group. "Small group health plan" does not include the following types of insurance:

(1) Accident;

(2) Credit;

(3) Disability;

(4) Long-term care or nursing home care;

(5) Medicare supplement;

(6) Specified disease;

(7) Dental or vision;

(8) Coverage issued as a supplement to liability insurance;

(9) Workers' compensation;

(10) Automobile medical payment; or

(11) Insurance under which benefits are payable with or without regard to fault and that is required statutorily to be contained in any liability insurance policy or equivalent self-insurance.

H. "Subgroup" means an employer with fewer than 25 employees within an association or a multiple employer trust or any similar subdivision of a larger group covered by a single group health policy or contract.

2. Rating practices. The following requirements apply to the rating practices of carriers providing small group health plans.

A. A carrier issuing a small group health plan after the effective date of this section must file the carrier's community rate and any formulas and factors used to adjust that rate with the superintendent for informational purposes prior to issuance of any small group health plan.

B. A carrier may not vary the premium rate due to the health status, claims experience or policy duration of the eligible group.

C. A carrier may vary the premium rate due to family status, smoking status, participation in wellness programs and group size.

D. A carrier may vary the premium rate due to age, gender, occupation or industry, and geographic area only under the following schedule and within the listed percentage bands:

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1995 and July 14, 1996, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1996 and July 14, 1997, the premium rate may not deviate above or below the community rate filed by the carrier by more than 10%.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 15, 1997, the premium rate may not deviate from the community rate filed by the carrier.

Unless continued or modified by law, this paragraph is repealed on July 15, 1994.

E. The superintendent may exempt from the requirements of this subsection an association group organized pursuant to section 2805-A or a trustee group organized pursuant to section 2806 that offers a small group health plan that complies with the premium rate requirements of this

subsection and guarantees issuance and renewal to all persons and their dependents within the association or trustee group.

3. Coverage for late enrollees. In providing coverage to late enrollees, small group health plan carriers are allowed to exclude a late enrollee for 18 months or provide coverage subject to an 18-month preexisting conditions exclusion.

4. Guaranteed issuance and guaranteed renewal. Carriers providing small group health plans must meet the following requirements on issuance and renewal.

A. Coverage must be guaranteed to all eligible groups that meet the carrier's minimum participation requirements, which may not exceed 75%, to all eligible employees and their dependents in those groups.

B. Renewal must be guaranteed to all eligible groups, to all eligible employees and their dependents in those groups except:

(1) For nonpayment of the required premiums by the policyholder, contract holder or employer;

(2) For fraud or material misrepresentation by the policyholder, contract holder or employer or;

(3) With respect to coverage of eligible individuals, for fraud or material misrepresentation on the part of the individual or the individual's representative;

(4) For noncompliance with the carrier's minimum participation requirements, which may not exceed 75%; and

(5) When the carrier ceases providing small group health plans in compliance with subsection 5.

5. Cessation of business. Carriers that provide small group health plans after the effective date of this section that plan to cease doing business in the small group health plan market must comply with the following requirements.

A. Notice of the decision to cease doing business in that market must be provided to the bureau and to the policyholder or contract holder 6 months prior to nonrenewal.

B. Carriers that cease to write new business in that market continue to be governed by this section with respect to business conducted under this section.

C. Carriers that cease to write new business in that market are prohibited from writing new business in that market for a period of 5 years from the date of notice to the superintendent.

6. Fair marketing standards. Carriers providing small group health plans must meet the following standards of fair marketing.

A. Each carrier must actively market small group health plan coverage to eligible groups in this State.

B. A carrier or representative of the carrier may not directly or indirectly engage in the following activities:

(1) Encouraging or directing eligible groups to refrain from filing an application for coverage with the carrier because of any of the rating factors listed in subsection 2; and

(2) Encouraging or directing eligible groups to seek coverage from another carrier because of any of the rating factors listed in subsection 2.

C. A carrier may not directly or indirectly enter into any contract, agreement or arrangement with a representative of the carrier that provides for or results in the compensation paid to the representative for the sale of a small group health plan to be varied because of the rating factors listed in subsection 2. A carrier may enter into a compensation arrangement that provides compensation to a representative of the carrier on the basis of percentage of premium, provided that the percentage does not vary because of the rating factors listed in subsection 2.

D. A carrier may not terminate, fail to renew or limit its contract or agreement of representation with a representative for any reason related to the rating factors listed in subsection 2.

E. A carrier or representative of the carrier may not induce or otherwise encourage an eligible group to separate or otherwise exclude an employee from small group health plan coverage or benefits.

F. Denial by a carrier of an application for coverage from an eligible group must be in writing and must state the reason or reasons for the denial.

G. The superintendent may establish rules setting forth additional standards to provide for the fair marketing and broad availability of small group health plans in this State.

H. A violation of this section by a carrier or a representative of the carrier is an unfair trade practice under chapter 23. If a carrier enters into a contract, agreement or other arrangement with a 3rd-party administrator to provide administrative, marketing or other services related to the offering of small group health plans in this State, the 3rd-party administrator is subject to this section as if it were a carrier.

7. Applicability. This section applies to all policies, plans, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 15, 1993. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

8. Standardized plans. The superintendent shall by rule define 2 standardized small group health plans that must be offered by all carriers offering small group health plans in the State. An association group organized pursuant to section 2805-A or a trustee group organized pursuant to section 2806 may offer one or both plans to its subgroups. The plans must consist of a standard plan and a basic plan. Both plans must meet the requirements for mandated coverage for specific health services, specific diseases and for certain providers of health services under Title 24 and this Title applicable to small group health plans. As used in this subsection:

A. "Standard plan" means a plan that is similar to those plans typically sold to small employers; and

B. "Basic plan" means a plan that emphasizes preventative care and that contains reasonable but lesser benefits than the standard plan to the extent necessary to reduce the anticipated cost of the plan by 20%.

The premium rate charged by a carrier for the basic plan may not exceed 80% of the corresponding premium rate charged by that carrier for the standard plan.

Sec. 3. 24-A MRSA §4222, sub-§4 is enacted to read:

4. Section 2808-B applies to health maintenance organizations except that a health maintenance organization is not required to offer coverage or accept applications from an eligible group located outside the health maintenance organization's approved service area.

Sec. 4. Effective date. The portions of this Act that amend the Maine Revised Statutes, Title 24, section 2327-A and enact Title 24-A, section 4222, subsection 4 take effect on July 15, 1993.

Sec. 5 Report. The Bureau of Insurance shall report to the joint standing committee of the Legislature having jurisdiction over insurance matters on or before January 1, 1993, on the following issues:

1. Standard and basic health insurance plans that include health insurance mandates;

2. Guaranteed issuance and renewability of health insurance and their applicability with and without standardized plans;

3. Data collection regarding health insurance coverage and employer practices for employers of fewer than 25 employees and the self-employed;

4. Wellness programs designed for introduction at places of employment, their usage and effect, any use being made of them in rating by carriers and a definition for them for statutory enactment; and

5. Alternative models for risk sharing in the issuance of small group health plans. In developing alternative models, the Bureau of Insurance shall consult with insurers, nonprofit hospital and medical service organizations, representatives of businesses and consumer groups and other interested parties. The alternative models must include provisions allowing carriers to determine whether they will or will not participate in the risk-sharing mechanism and must be based on the principle that the carriers that participate in the risk-sharing mechanism bear the costs for the obligations of the risk-sharing mechanism.

Sec. 6. Additional report. The Bureau of Insurance shall report to the joint standing committee of the Legislature having jurisdiction over insurance matters by January 30, 1994 on the effects of the rating provisions of the Maine Revised Statutes,

Title 24-A, section 2808-B and on data and experience from other states with community rating statutes.

Sec. 7. Allocation. The following funds are allocated from Other Special Revenue to carry out the purposes of this Act.

1992-93

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Bureau of Insurance

All Other $75,000

Provides funds for consulting services to assist the Bureau of Insurance with a report on several health insurance issues and for the costs associated with rulemaking.