THE MINNESOTA DEPARTMENT OF COMMERCE
STUDY OF SMALL EMPLOYER HEALTH INSURANCE REFORM
January, 1995

EXECUTIVE SUMMARY

The legislature, in the 1992 Laws, has asked the Department of Commerce to study, report, and make recommendations on the following:

- the effects of Chapter 62L, the Minnesota Small Employer Health Benefit Act, on the market for health benefit plans for small employers, and

- the desirability and feasibility of achieving the legislature's goal by phasing out the rate bands by July 1, 1997, according to a specified timetable.

  The referenced goal of the legislature is the elimination of harmful effects in the small employer market such as substantial hardship and unfairness, unnecessary administrative costs, and adverse affects on the health of Minnesotans.

Chapter 62L Effects

Chapter 62L, the Minnesota Small Employer Health Benefit Act, introduced significant reforms to Minnesota's small employer health insurance market. The first year's results suggest that the small employer reforms undertaken to date have been a success. The Chapter 62L reforms are achieving increases in coverage, access, and affordability in Minnesota's small employer health insurance market.

Chapter 62L

The requirements of Chapter 62L were effective July 1, 1993, and apply to health benefit plans offered to Minnesota small employers. A "small employer" is defined as a business entity that employs between 2 and 29 employees working more than 20 or more hours per week. The definition changes as of July 1, 1995 to include employers with between 2 *and 49* employees.

The major provisions include:

- a guaranteed issue and reissue requirement,
- creation of the Minnesota Health Care Reinsurance Association,
- required offer of two defined plans (62L.05),
- restriction on coverage limitations for preexisting conditions,
- requirements for conversion policies,
- prohibition on individual coverage,
- state-run purchasing pools,
- minimum loss ratio standards,
- the requirement that rates be filed and approved, and
- restrictions on premium rate variations from group to group.

Effect on the Small Employer Market

The first year's results indicate that the Chapter 62L reforms undertaken to date are achieving increases in coverage, access, and premium stability in Minnesota's small employer health insurance market.

As part of our study, the Department surveyed all small employer health carriers. The "Small Employer Health Insurance Survey" is included in Appendix B.

The survey identified all health carriers providing group coverage to Minnesota small employers prior to the enactment of small employer reforms and those carriers participating in the small employer market today. Forty-three percent (43%) of the carriers offering health coverage to Minnesota small employers on July 1, 1992, have left the market. Reasons given for leaving the market include the expense of complying with Minnesota requirements and concern about future requirements such as the Regulated All Payer Option and further rate band reductions. There are currently 27 carriers participating in Minnesota's small employer market.

The Department's survey also provides the enrollment in the small employer market prior to the effective date of Chapter 62L and one year after implementation of the small employer reforms. The increased accessibility created by the guaranteed issue requirement and the rating restrictions has resulted in increased enrollment in the small employer market. ***The number of small employer groups enrolled in the small employer market increased by 15% from June 30, 1993 to June 30, 1994.***

The general premium rate band, which limits rate variation between any two groups due to factors other than demographics or area, places strict controls on the renewal rating method known as "tier rating." ***The general premium rate band has thus increased premium stability in the market and has increased access for high risk groups.***

Potential for Market Erosion

The establishment of a defined market is important to the success of small employer reforms. Ideally, movement in and out of the market should be very difficult, if not impossible. ***If "escape hatches" are available, the market itself will be selected against as employers with lower risk groups, able to obtain lower cost coverage elsewhere, are likely to opt out of the market.*** A higher risk and more expensive population would remain in the market causing premium rates to increase. Note that under the guaranteed issue requirement, groups opting out of the small employer market may return at any time.

It is therefore important to identify and monitor any potential sources of market erosion. We have identified the following potential sources of market erosion: association plans, purchasing pools, political subdivisions, self-insurance, and low deductible "stop loss" plans.

Impact of Community Rating

The "rate bands", implemented on July 1, 1993 by the 1992 Laws are restrictions on the variations in premium rates charged to small employers. There are two rate bands, the age rate band and the general premium rate band.

Chapter 625 of the 1994 Laws proposes a specified timetable of rate band reductions resulting in pure community rating on July 1, 1997. (This timetable is slightly different than the specified timetable of the 1992 Laws.) The proposed timetable of rate band reductions will not be implemented unless an effective date is specified in 1995 legislation. Our understanding is that the legislature intends to consider the advisability and feasibility of implementing the rate band reductions during the 1995 legislative session.

Community Rating

The result of phasing out the rate bands is "pure community rating". This is a rating method that recognizes only geographical area, plan design, and overall experience of the "community". Under pure community rating, rates do not vary by age, sex, health status, or claims experience.

The primary effect of community rating is a redistribution of health care costs among insured small employer groups. The rates for groups with higher risk members decrease, and the rates for groups with lower risk members increase. Simply put, community rating is a premium shift.

In a voluntary market, community rating will not merely redistribute health care costs among insured small employer groups, it ***will increase the average cost of health care for insured small employer groups.*** Lower risk groups will be likely to opt out of the system by dropping coverage or choosing to self-insure, leaving a higher risk and more expensive population in the market.

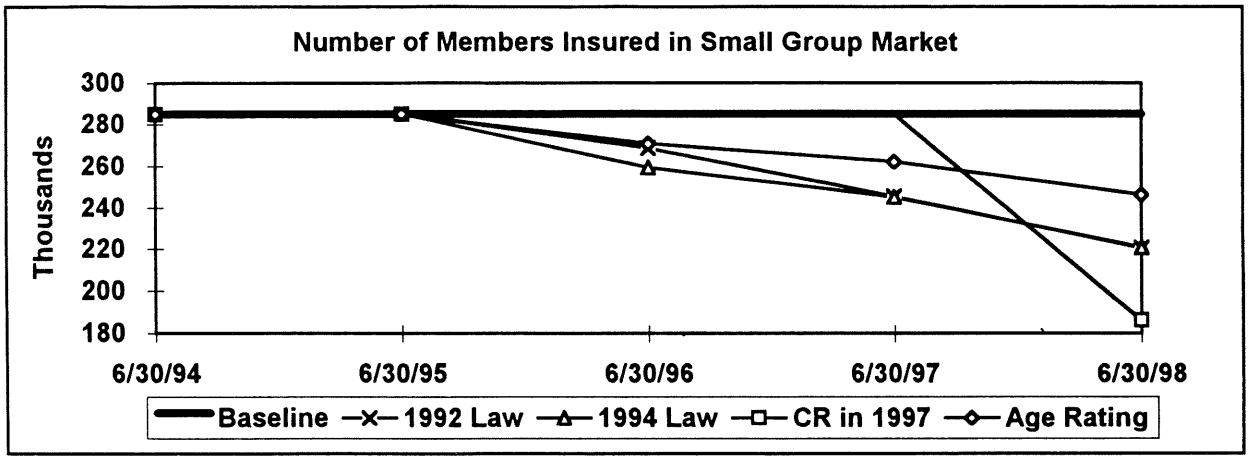
The effects of community rating are not well understood by the public. There are two effects in particular which are often mistakenly attributed to community rating. ***First, community rating does not make health insurance more affordable for all small employer groups. Some groups will see an increase in premiums; some groups will see a decrease in premiums. Secondly, community rating is not necessary for universal coverage.*** Community rating will not lead to universal coverage, nor does universal coverage depend on further rating restrictions.

Impact of Community Rating on the Small Employer Market

As part of our study, we retained the actuarial consulting firm of Milliman & Robertson, Inc. (M&R) to model the impact of further rate band reductions on Minnesota's small employer health insurance marketplace. In addition to the two timetables of rate band reductions described in the 1992 Laws and the 1994 Laws, we defined additional rating scenarios to be projected.

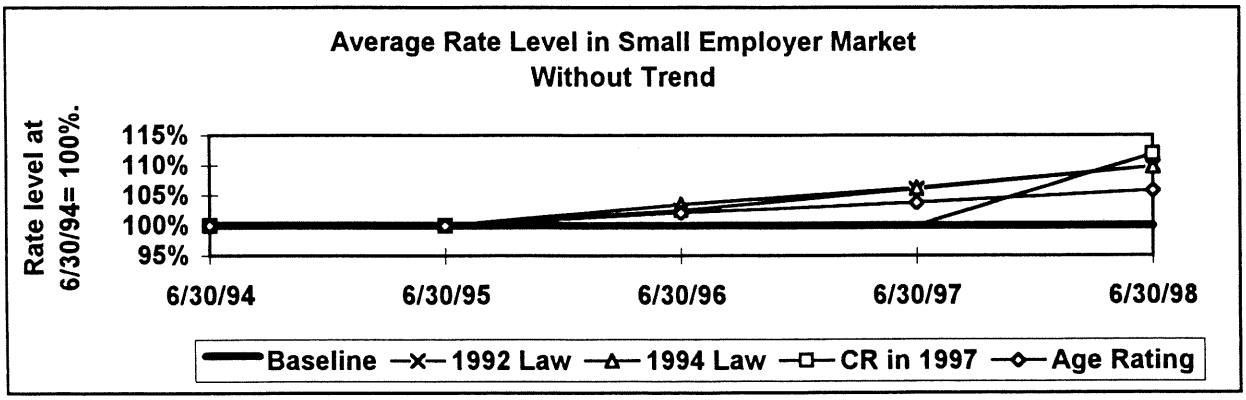
M&R constructed a model to project the impact of various rating limitations on the Minnesota small employer health insurance market. M&R's model starts with an experience base of Minnesota small employer health insurance at June 30, 1994 and projects the market through mid-1998. The experience base was developed from enrollment and rate level data collected from six of the largest Minnesota small employer health carriers covering approximately 80% of the Minnesota small employer health insurance market.

As shown in Graph A, the ***enrollment in the small employer market is projected to drop*** in all scenarios but the baseline. (Under the baseline scenario, the rate bands remain at their current level. Scenario definitions are provided on page 26 of the report.)



GRAPH A

Community rating will not merely redistribute health care costs among insured small employer groups, it will increase the average cost of health care for insured small employer groups. The average rate charged to groups enrolled in the small employer market is projected to increase in all scenarios but the baseline, as shown in Graph B. Note that Graph B shows only the impact of the rate band reductions and does not include rate increases due to trend or other factors.



GRAPH B

As shown in the graphs, under both the 1992 and 1994 timetables of rate band reductions, ***"pure community rating" is projected to result in decreases in enrollment and increases in average premium rates.***

Quite obviously, this is directly opposite the goals for health care reforms.

The total population enrolled in the size 2-29 Minnesota small employer health insurance market is projected to decline by 22% under the 1994 timetable or by 23% under the 1992 timetable. Another way to think about this statistic is that approximately 64,000 Minnesotans, currently covered through the small employer market, will either become covered under self-insured plans or lose their group coverage completely. A further consequence of this loss of enrollment is that the average premium rate for those remaining in the market will rise an additional 10% over and above other increases.

(M&R's model assumes that migration out of the market occurs through employers becoming self-insured or completely dropping coverage. To the extent there are additional sources of market erosion, the loss of enrollment and increase in rates in the market would be greater.)

Individual Market

The rate band reductions proposed in Chapter 625 of the 1994 Laws also apply to the individual market. Although the small employer market is the focus of this report, we have also included a summary of earlier modeling results of the projected impact of community rating on the individual market.

Community rating will have an adverse impact on the individual market. Enrollment is projected to drop by 17% due to the antiselection resulting from pure community rating. The average rate level in the individual market is projected to rise 14% above trend and other increases. (Note that this does not include impacts of a guaranteed issue requirement.) For a sample plan, the rate changes range from -36% to +91%.

Summary and Recommendations

The first year's results suggest that the small employer reforms undertaken to date have been a success. Chapter 62L, the Minnesota Small Employer Health Benefit Act has successfully promoted the availability of health insurance coverage to small employers, prevented abusive rating practices, established rules for continuity of coverage for employers and covered individuals, and improved the efficiency and fairness of the small employer group health insurance marketplace. Enrollment in the small employer market has increased; the number of small employer groups covered in the market increased 15% in the first year of reforms.

The establishment of a defined market is important to the continued success of small employer reforms. It is therefore important to limit and monitor any potential sources of market erosion.

To reiterate, ***the small employer reforms that have taken effect appear to be a public policy success.*** However, it's important to note that ***some of the reforms that have not yet taken effect, principally "pure community rating", may stymie this success.***

Why are some small employer groups uninsured today? Access to coverage is not the issue, as the guaranteed issue requirement and current rate bands guarantee access to all small employers. The reason some small employers are uninsured is cost; insurance is unaffordable to them. Affordability is subjective, depending on an employer's finances, need for health insurance, and other factors. Pure community rating will not make health insurance more affordable for most groups.

Community rating will have an adverse effect on Minnesota's small employer health insurance market. As shown in this chapter, community rating is projected to result in decreases in enrollment and increases in average premium rates. One can not remedy these significant negatives, which are directly contrary to the stated policy goals of health care reform, because in large measure they result from self-insurance and other alternatives outside of state control. Consequently any positives attributable to "Community Rating" are greatly outweighed by the negatives. ***Thus, the Department of Commerce is recommending a repeal of the proposed rate band reductions.***

We hope that this report and analysis will be useful to the legislature in its evaluation of the small employer market reforms enacted in 1992, and its consideration of the future of health care reform during the 1995 session, principally proposed rate band reductions.

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CONCLUSIONS

Effect on the Small Employer Market

The number of small employer groups enrolled in the small employer market increased by 15% from June 30, 1993 to June 30, 1994.

The general premium rate band has thus increased premium stability in the market and has increased access for high risk groups.

The small employer reforms that have taken effect appear to be a public policy success. However, it's important to note that some of the reforms that have not yet taken effect, principally "pure community rating", may stymie this success.

Potential for Market Erosion

If "escape hatches" are available, the market itself will be selected against as employers with lower risk groups, able to obtain lower cost coverage elsewhere, are likely to opt out of the market. A higher risk and more expensive population would remain in the market causing premium rates to increase. It is therefore important to identify and monitor any potential sources of market erosion

Effects of Community Rating

The effects of community rating are not well understood by the public. There are two effects in particular which are often mistakenly attributed to community rating. First, community rating does not make health insurance more affordable for all small employer groups. Some groups will see an increase in premiums; some groups will see a decrease in premiums. Secondly, community rating is not necessary for universal coverage.

In a voluntary market, Community rating will not merely redistribute health care costs among insured small employer groups, it will increase the average cost of health care for insured small employer groups.

Community rating is projected to result in decreases in enrollment and increases in average premium rates. One can not remedy these significant negatives, which are directly contrary to the stated policy goals of health care reform, because in large measure they result from self-insurance and other alternatives outside of state control. Consequently any positives attributable to "Community Rating" are greatly outweighed by the negatives. ***Thus, the Department of Commerce is recommending a repeal of the proposed rate band reductions.***

CHAPTER I. INTRODUCTION AND SCOPE

The Minnesota Department of Commerce conducted a study of small employer health insurance reform and further rate band reductions as assigned by the legislature in Chapter 549 (1992) Article 2, Section 24. This report is the Department's final written report and recommendations, as required. It is intended to assist the legislature in its evaluation of the small employer market reforms enacted in 1992, and in its consideration of the future of health care reform during the 1995 session, principally the proposed rate band reductions.

1992 Laws, Chapter 549, Article 2, Sec. 24 [COMMISSIONER OF COMMERCE STUDY.]

> The commissioner of commerce shall study and provide a written report and recommendations to the legislature that analyze the effects of this article and future measures that the legislature could enact to achieve the purpose set forth in section 62L.01, subdivision 3. The commissioner shall study, report, and make recommendations on the following:
>
> (1) effects of this article on availability of coverage, average premium rates, variations in premium rates, the number of uninsured and underinsured residents of this state, the types of health benefit plans chosen by employers, and other effects on the market for health benefit plans for small employers;
>
> (2) the desirability and feasibility of achieving the goal stated in section 62L.01, subdivision 3, in the small employer market by means of the following timetable:
>
> (i) as of July 1, 1995, a reduction of the age rating bands to 30 percent on each side of the index rate, accompanied by a proportional reduction of the general premium rating bands to 15 percent on each side of the index rate;
> (ii) as of July 1, 1996, a reduction in the bands referenced in the preceding clause to 15 percent and 7.5 percent respectively; and
> (iii) as of July 1, 1997, a ban on all rating bands; and
>
> (3) Any other aspects of the small employer market considered relevant by the commissioner.
>
> The commissioner shall file the written report and recommendations with the legislature no later than April 1, 1995. The commissioner shall file with the legislature a written preliminary progress report no later than December 1, 1994.

There are two major chapters of this report corresponding to items (1) and (2) of the legislature's directions for the study (above). Chapter II contains the study of the effects of Article 2 on the market for health benefit plans for small employers. Article 2 or Chapter 62L, the Minnesota Small Employer Health Benefit Act, introduced significant reforms to Minnesota's small employer health insurance market. Chapter II includes a discussion of the major provisions of Chapter 62L and the resulting changes in Minnesota's small employer health insurance market, as well as a discussion of potential sources of market erosion.

The study of the desirability and feasibility of achieving the legislature's goal by phasing out the rate bands is contained in Chapter III. The referenced goal of the legislature is the elimination of harmful effects in the small employer market such as substantial hardship and unfairness, unnecessary administrative costs, and adverse affects on the health of Minnesotans. The "rate bands" are restrictions on the variations in premium rates charged to small employers. The result of phasing out the rate bands is "pure community rating." As part of our study, the Department retained the actuarial consulting firm of Milliman & Robertson, Inc. (M&R) to model the impact of further rate band reductions on Minnesota's small employer health insurance market. Chapter III includes a discussion of community rating and its effects, a discussion of rating practices and rate variation in the small employer market, a description of M&R's model, and a presentation of the model results. This chapter also briefly addresses the impact of further rate band reductions on the individual health insurance market.

The Department provided a preliminary progress report to the legislature in December, 1994. The preliminary progress report contained a brief description of our study, as well as some preliminary results. It is included as Appendix A.

Appendix B contains the Department's "Small Employer Health Insurance Survey", which was sent to all health carriers that have participated in the small employer market. Results of this survey are included in Chapter II. The Department's "Association Health Insurance Survey", is contained in Appendix C. Appendix D is a description of the data requested from the major small employer carriers and used to develop M&R's model.

CHAPTER II. CHAPTER 62L EFFECTS

Chapter 62L, the Minnesota Small Employer Health Benefit Act, introduced significant reforms to Minnesota's small employer health insurance market. This chapter, enacted as part of the 1992 MinnesotaCare legislation, was effective July 1, 1993.

The legislature, in the 1992 Laws, has asked the Department of Commerce to study, report, and make recommendations on the effects of Chapter 62L on the market for health benefit plans for small employers.

The first year's results indicate that the Chapter 62L reforms undertaken to date are achieving increases in coverage, access, and affordability in Minnesota's small employer health insurance market. This section of the report includes a brief summary of the major provisions of Chapter 62L, an analysis of the effects on the small employer market, and a discussion of potential sources for market erosion.

Chapter 62L, the Minnesota Small Employer Health Benefit Act

The requirements of Chapter 62L apply to health benefit plans offered to Minnesota small employers. A "small employer" is defined as a business entity that employs between 2 and 29 employees working more than 20 or more hours per week. The definition changes as of July 1, 1995 to include employers with between 2 *and 49* employees.

Chapter 62L, the Minnesota Small Employer Health Benefit Act, introduced significant reforms to Minnesota's small employer health insurance market, effective July 1, 1993. The following is a brief summary of the chapter's major provisions:

Guaranteed Issue and Reissue

Health carriers participating in the small employer group market are required to affirmatively market, offer, sell, issue, and renew coverage under any of their health benefit plans to all small employers meeting minimum participation and contribution requirements. All eligible employees and dependents must be offered coverage. The guaranteed issue and reissue requirement assures access to health care coverage for all small employer groups.

Minnesota Health Care Reinsurance Association

The implementation of the guaranteed issue requirement was accompanied by the creation of a reinsurance pool for small employer carriers. The reinsurance association functions as a simple risk adjustment mechanism. Carriers are protected from the effects of covering a disproportionate number of high risks, by ceding these individuals or groups to the reinsurance association.

The reinsurance association was established and is maintained by the small employer carriers, under the supervision of the commissioner of commerce. Carrier participation in the association is voluntary. As of December 31, 1994, there were 147 lives under 116 policies ceded to the association.

Required Offer of Two Defined Plans

Health carriers are required to offer the two standard benefit plans defined in 62L.05, the deductible-type small employer plan and the copayment-type small employer plan. Although few employers have purchased these two plans, standardized plans provide a means of rate comparison between carriers.

Restriction on Coverage Limitations for Pre-existing Conditions

Coverage limitations for pre-existing conditions may not exceed 12 months. Individuals maintaining continuous coverage receive credit for the time covered by qualifying prior coverage. (An individual is only required to meet *one* pre-existing condition limitation.)

Requirements for Conversion Policies

Any individual previously covered under a group health plan must be offered a qualified individual plan. The premium rate must not exceed 90 percent of the premium charged for comparable individual coverage by the Minnesota Comprehensive Health Association (MCHA).

The purpose of a conversion provision is to provide permanent coverage regardless of the status of the group policy or membership in the group. Since conversion policies often experience morbidity which is substantially higher than the group policies, rates for conversion policies were historically much higher than the original group policy and unaffordable to the insureds. This provision requires a reasonable premium for conversion policies, making them a legitimate coverage option for those leaving group coverage.

Prohibition on Individual Coverage

Health carriers may not issue individual health plans to eligible employees of small employers. This requirement prevents the market erosion which could otherwise result if lower cost groups or individuals selected against the small employer market by purchasing individual policies.

State-Run Purchasing Pools

Small employers may purchase health coverage through a state run purchasing pool. (Although not part of Chapter 62L, this is a new coverage option available to small employers which was created by Chapter 549 of the 1992 Laws.) The Minnesota Employees Insurance Program (MEIP) and the Public Employees Insurance Program (PEIP), administered by the Department of Employee Relations, provide coverage to 1,940 members of 140 small employer groups (as of 6/30/94).

Minimum Loss Ratio Standards

A 75% minimum loss ratio, calculated on an aggregate basis, is required for the small employer market. This increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until an 82 percent loss ratio is reached on July 1, 2000. (The loss ratio defines the percentage of premiums that must be paid in benefits to insureds.)

Rate Filing Requirement

Premium rates must be filed with and approved by the commissioner. The rate filing must include demonstration that the premium rates are reasonable, adequate, and in compliance with all provisions of Chapter 62L. Health carriers must also annually file an actuarial certification that the carrier is in compliance with the law.

Restrictions on Rate Variations

Premium rates charged to small employers are subject to the following restrictions:

- The age rate band limits the rate variation due to age between any two insured persons to +/- 50% of the index rate, which is a ratio of 3:1.
- The general premium rate band limits variation by other factors between any two groups to +/- 25% of the index rate, which is a ratio of 1.67:1. General premium variations may be based *only* on health status, claims experience, industry, and duration of coverage.
- Gender-based rates are prohibited.
- The variation in rates between any two geographic regions is limited to 20%. A carrier may establish no more than three geographic regions, with one region being the Mpls./St.Paul metro region.

Index rates for different benefit plans may vary only based on actuarially valid differences in the benefit designs, thus must not reflect any differences in the nature of the groups which select particular benefit plans. The rating restrictions limit the variation between premiums charged to different small employer groups. The restriction on variation by age and gender is discussed further in Chapter III (page 20). The general premium band sets strict controls on the practice of tier rating, discussed on page 9. The restriction on variation between rates for different benefit plans requires that each carrier's small employer business is treated as a single rating pool.

Effect on Small Employer Market

The first year's results indicate that the Chapter 62L reforms undertaken to date are achieving increases in coverage, access, and affordability in Minnesota's small employer health insurance market.

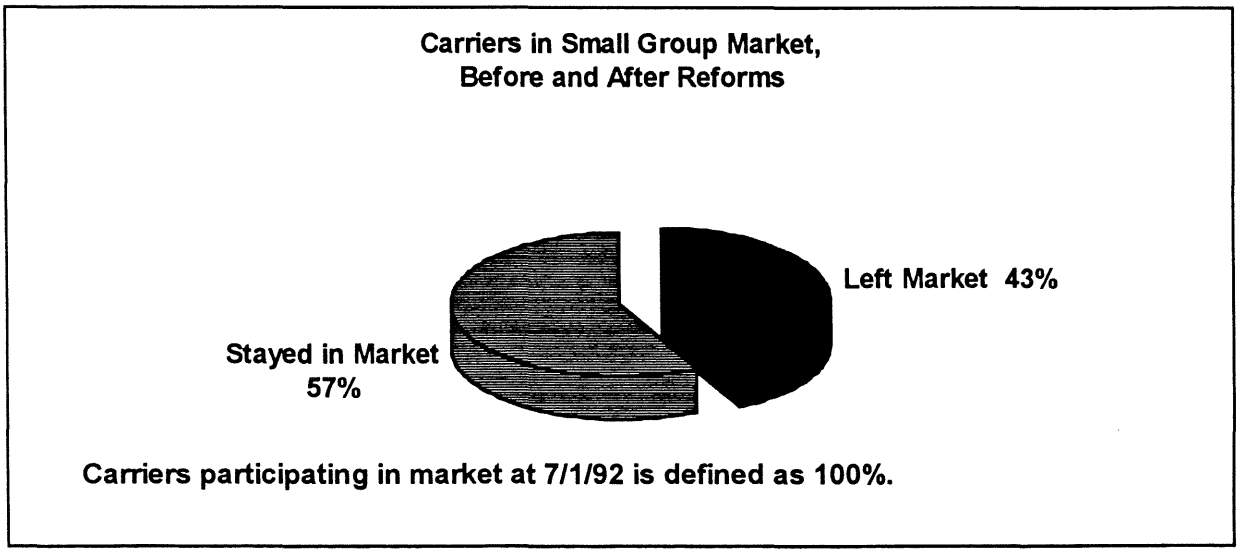
The Department's Small Employer Health Insurance Survey

As part of our study of the small employer health insurance market, the Department surveyed all small employer health carriers. Our "Small Employer Health Insurance Survey" was distributed to all carriers identified as possibly having participated in the small employer health insurance market anytime as recently as 1992. A copy of the survey is included as Appendix B. The Department tentatively intends to repeat this survey annually.

The survey requested enrollment and premium data for the year prior to the effective date of Chapter 62L and for the first year under the provisions of Chapter 62L.

Participating Carriers

The survey identified all health carriers providing group coverage to Minnesota small employers prior to the enactment of small employer reforms and those carriers participating in the small employer market today. Graph 1 illustrates the change in the number of carriers participating in the small employer market following the enactment of small employer reforms. As shown, 43% of the carriers offering health coverage to small employers on July 1, 1992, have left this market. There are currently 27 carriers participating in Minnesota's small employer market.

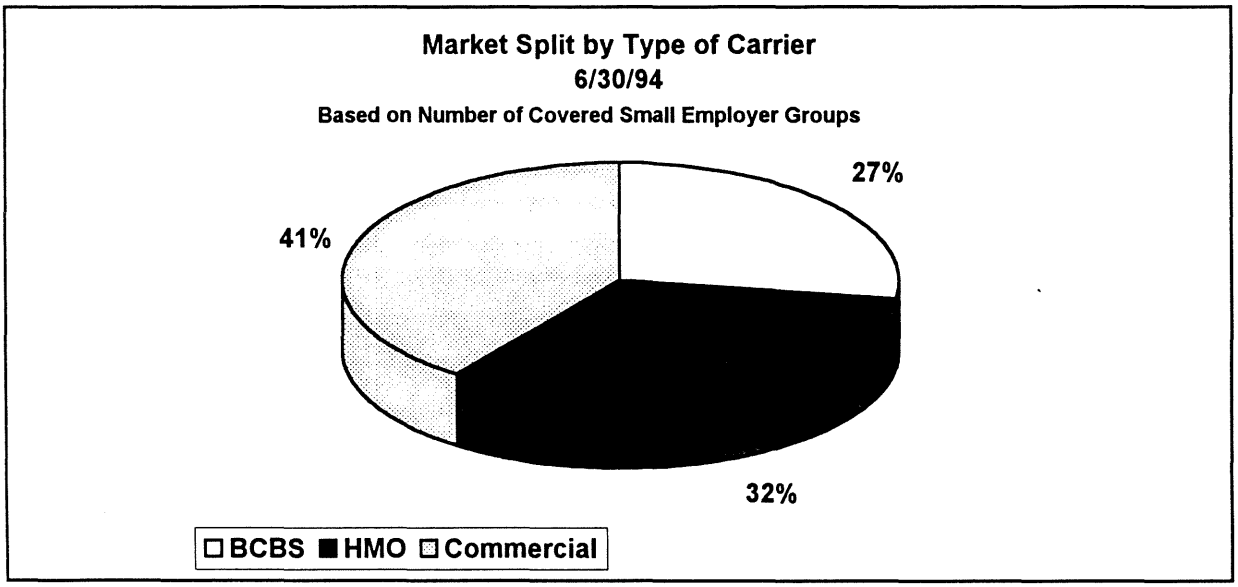


GRAPH 1- CARRIERS IN MARKET

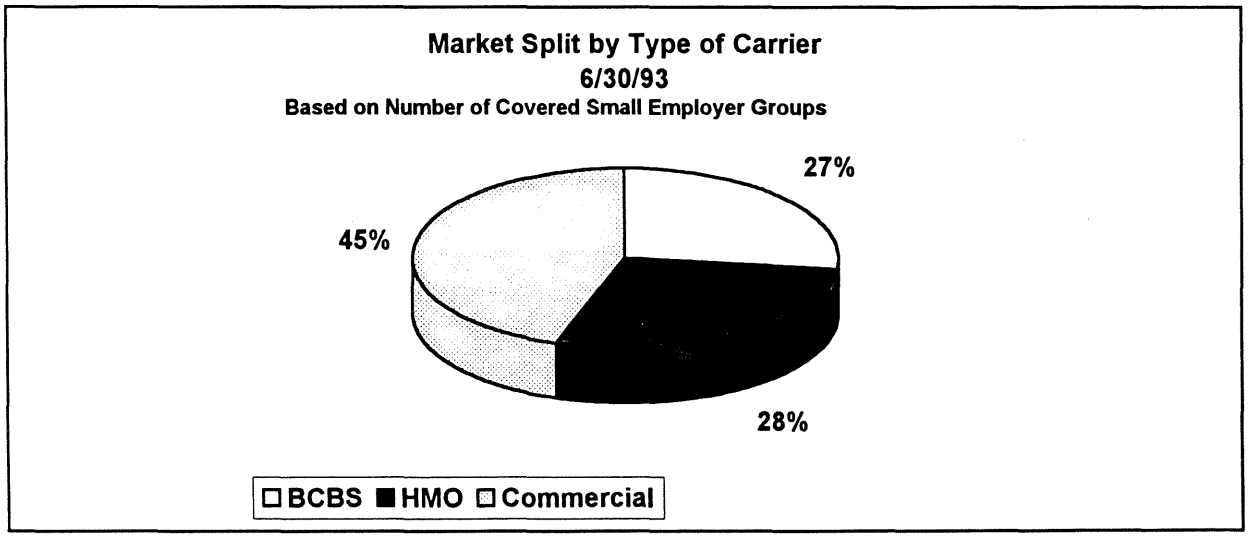
Reasons given for leaving the market include the expense of complying with Minnesota requirements and concern about future requirements such as the Regulated All Payer Option and further rate band reductions. Most of the 20 carriers leaving the market had small blocks of small employer business in Minnesota, making it expensive to develop a separate rating structure and products for use in this state only.

Type of Coverage

Graphs 2 and 3 show the distribution of covered small employer groups by source of coverage. Graph 2 shows the market split as of 6/30/94, while Graph 3 is based on 6/30/93 data. As can be seen, there has been a small increase in the percentage of groups covered by HMO plans.



GRAPH 2



GRAPH 3

Enrollment

The increased accessibility created by the guaranteed issue requirement and rating restrictions has resulted in increased enrollment in the small employer market.

The Department's survey provides the enrollment in the small employer market prior to the effective date of Chapter 62L and one year after implementation of the small employer reforms.

Tables 1 and 2 show the change in enrollment occurring in the first year under small employer reform. Enrollment is shown based on employer groups, employees, and total members. Table 1 includes those small employers purchasing employer group coverage directly from health carriers. Table 2 adds those small employer groups purchasing coverage through MEIP and PEIP, the state-run purchasing pools. (Small employer groups offering self-insured plans or purchasing plans through associations or purchasing pools are not included in the tables.)

Table 1
Small Employer Health Insurance Survey Results
Enrollment in Small Employer Market
Before and After Implementation of Reforms

	Groups	Employees	Members
6/30/93	16,000	119,100	262,700
6/30/94	18,400	129,600	283,400
Increase	***15.0%***	***8.8%***	***7.9%***

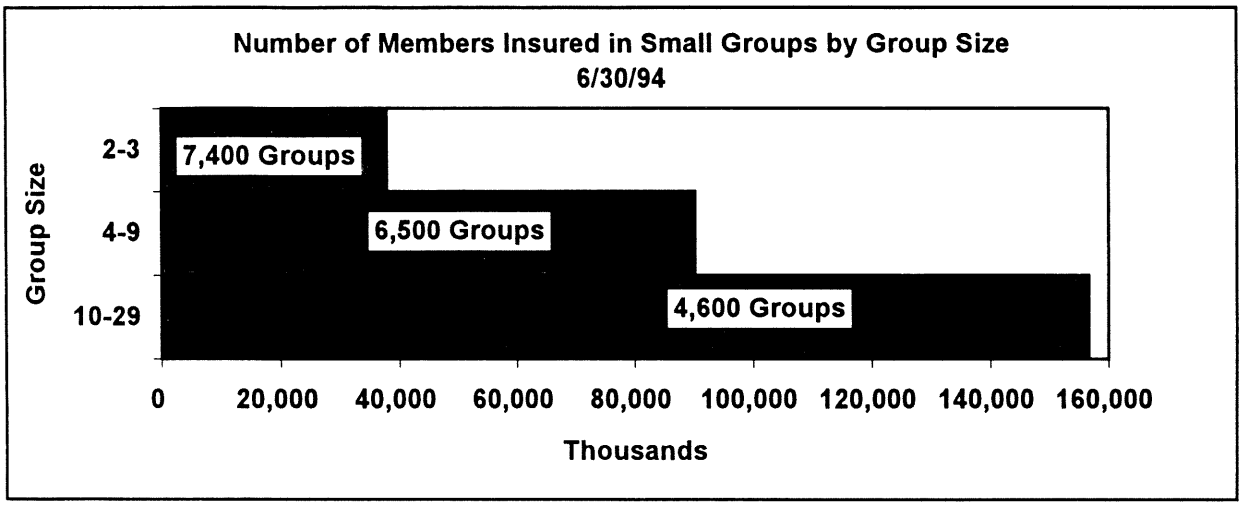
Table 2
Enrollment in Small Employer Market
Enrollment in Small Employer Market and State-run Purchasing Pools
Before and After Implementation of Reforms

	Groups	Employees	Members
6/30/93	16,100	119,500	263,600
6/30/94	18,600	130,400	285,400
Increase	***15.5%***	***9.1%***	***8.3%***

As shown in the tables, the first year under small employer reforms has seen an increase in enrollment in the small employer market. ***The number of small employer groups enrolled in the small employer market increased by 15% from June 30, 1993 to June 30, 1994.*** This is significantly greater than the increase in the number of small employers over this period. According to data from the Minnesota Department of Economic Security, the number of Minnesota establishments of sizes 1 to 19 and 20 to 49 employees increased 3.6% and 3.3% respectively from 3/93 to 3/94.

In reviewing the survey results, it is important to bear in mind that many responses represented estimates. Prior to 7/1/94, many carriers did not maintain data sufficient to identify small employer groups as defined in Chapter 62L. We understand that some carriers based the 6/30/93 enrollment data on those groups with 2 to 29 *covered employees*. As some of these groups may have had more than 29 *total employees*, the 6/30/93 enrollment data is likely somewhat overstated and the increases in enrollment somewhat understated. The impact would be greatest on the number of employees and members. ***Thus, we estimate that the increase in the number of employees and members enrolled in the small employer market is greater than indicated by the survey, and is on the order of 11 to 12%.***

Graph 4 shows the members insured in the small employer market by group size. The number of groups in each size category is also indicated.



GRAPH 4

Premium Stability and Affordability

By limiting the rate variation due to health status and claims experience, the general premium rate band has increased premium stability in the market and has increased access for high risk groups.

The main target of the rating restrictions was to limit the renewal rating practice known as "tier rating". The general premium rate band, which limits rate variation between any two groups due to factors other than demographics or area, places strict controls on this rating method.

Tier rating is a rating method in which a group's expected future claims determine its tier and hence its rate. Each year (or other time period), the overall rate increase needed for the block of business is allocated between the tiers, with the groups in the lowest tier receiving little or no increase while groups in the highest tier may have received very substantial rate increases. This range of rate increases further increased the rate variation between groups in the lowest and highest tiers.

The number of tiers used and the variation in rate increases varied significantly from carrier to carrier. Less aggressive carriers used fewer tiers and/or limited the rate variation between tiers. The method of assigning tiers also varied, with some carriers considering the credibility of a group's experience, while more aggressive carriers applied full credibility to all groups, no matter the size. While not actuarially justifiable, this practice resulted from the level of competition in the marketplace.

The tier rating methodology as applied by some aggressive carriers was criticized as a violation of the pooling concept fundamental to insurance. It also created an uneven playing field, where less aggressive carriers were at a competitive disadvantage in attracting lower risk groups.

The general premium rate band limits variation, for factors other than demographics and geography, to +/- 25% of the index rate The general premium band thus places strict controls on the use of tier rating. The impact of the band varied depending on a carrier's prior rating practices, with some carriers needing to make minor changes in rating methodology and some carriers required to significantly revise their rating methodology. Table 3 is an example of the effect of the general premium band on a hypothetical carrier's rates. (The example is intended to be illustrative, not representative.)

Table 3
Tier Rating Example
Carrier XYZ, Employee Premium Rates

Tier	Before 7/1/93	After 7/1/93
1	40	75
2	55	85
3	70	90
4	85	95
5	100	100
6	110	105
7	120	110
8	130	115
9	145	120
10	160	125

It is difficult to determine the impact of the underwriting and rating reforms on the average premium level in the market, as small employer rates were not filed prior to July 1, 1993. In their July 1, 1993 rate filings, many carriers included adjustments of 5-10% in the rate development to reflect the anticipated impact of the guaranteed issue requirement.

The July 1, 1994 rate filings included rate changes which varied significantly between carriers, with several carriers filing rate decreases. The average rate increase in the small employer market from 7/1/93 to 7/1/94 was less than 5%. These low increases follow the national trend, where low increases in group premiums have been attributed to lower inflation, ongoing success of managed care, and increased competition.

Potential for Market Erosion

The first year's results indicate that the small employer reforms undertaken to date have achieved increases in coverage, access, and affordability. However, market erosion through lower cost groups opting out of the market (antiselection) could threaten these successes. It is therefore important to identify and monitor any potential sources of market erosion.

Defined Market

The establishment of a defined market is important to the success of small employer reforms. Ideally, movement in and out of the market should be very difficult, if not impossible. If "escape hatches" are available, the market itself will be selected against.

As discussed, the current reforms set restrictions on the variations in premium rates charged to small employer groups and increase requirements such as coverage of pre-existing conditions. If employers can choose whether to obtain coverage through the small employer market or through another source, the employers with the lower risk groups, able to obtain lower cost coverage elsewhere, are likely to opt out of the market. A higher risk and more expensive population would remain in the market causing premium rates to increase. Note that under the guaranteed issue requirement, groups opting out of the small employer market may return at any time.

This antiselection problem becomes critical, the closer rating restrictions are to "pure community rating." (This is discussed further in Chapter III.) Significant market erosion, such as may be caused by "pure community rating", could produce the same access and affordability problems that created the need for small employer health care reform originally.

We have identified the following potential sources of market erosion: association plans, purchasing pools, political subdivisions, self-insurance, and low deductible "stop loss" plans.

Associations

Associations are exempted from the requirements of 62L provided they registered with the commissioner by July 1, 1993. Employers that were members of exempted associations as of July 1, 1993, are not considered small employers if their health plan is purchased through the association. These employers may thus purchase health coverage through their association ***or*** through the small employer market. As cost will be the primary consideration in the employer's choice, the lower cost groups will be more likely to purchase through their association, while the higher cost groups will be more likely to purchase coverage through the small employer market where premiums are limited by the rating restrictions.

The Department received registrations for exemption from 121 associations. We surveyed these associations in December, 1994, and received responses from 83 of the 121 exempted associations. A copy of the survey is included as Appendix C.

Of the 83 responses, 38 associations indicated that they currently provide health insurance to small employer members. (According to the responses, 1820 small employers purchase health plans through these 38 associations. Unfortunately, we have little confidence in this number as the data reported in some responses seemed inconsistent.)

Potentially, all small employer members of all exempted associations could purchase health coverage through their associations without falling under the requirements of 62L. According to the survey, the membership of the 83 responding associations includes roughly 7,000 Minnesota employers of 2 to 49 employees that were association members as of July 1, 1993. (Again, the Department would hesitate to rely on this data as more than a rough indicator.)

Private Purchasing Pools

Voluntary, private purchasing pools are advocated as a way for employers to control health care costs. Although there are clearly advantages to purchasing pools, such as a savings of certain administrative costs and an opportunity for employee choice among plans, they may present the same problems to the small employer market as association plans (see above).

The impact of purchasing pools on the small employer market will depend on the rating restrictions, if any. If carriers develop index rates for the pool which differ, without limit, from those charged in the small employer market, the rates will reflect the risk status of the different populations. Even though pools may be required to admit all qualifying groups, a pool's membership requirements may be designed to result in a lower cost population or carriers may steer certain groups into the pool where a lower rate is available.

Chapter 625 of the 1994 Laws authorized the formation of voluntary purchasing pools, formed solely for the purpose of purchasing health plan coverage. The pools must admit any small employer meeting the pool's membership requirements. Purchasing pools are required to submit information to the Information Clearinghouse. To date, the Information Clearinghouse has not received any filings from purchasing pools. The legislature, in Chapter 625, also directed the Health Care Commission to make further recommendations regarding the formation of voluntary purchasing pools.

Political Subdivisions

Political subdivisions, associations of political subdivisions, and educational cooperative service units are partially exempted from the rating restrictions established by 62L. The rates must comply with the rating bands, however, a separate index rate *may* be established. This presents the same potential for market erosion as associations and purchasing pools.

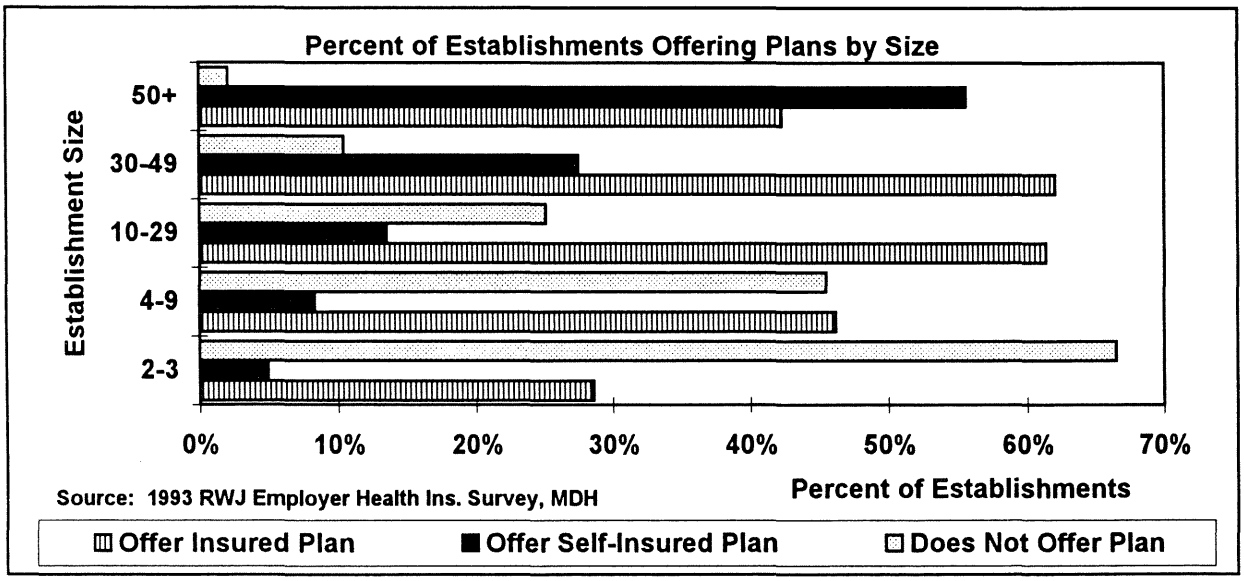
Self-Insurance and ERISA

The federal law known as the Employee Retirement Income Security Act (ERISA), prohibiting state authority over employee benefit plans, creates many hurdles for health care reform efforts. Although ERISA permits states to regulate insured plans through insurance regulation, employers which self-fund are outside of any state authority or state requirements. States cannot impose insurance reforms (such as rating restrictions, mandated benefits, restriction of coverage limitations for pre-existing conditions) on self-funded plans or otherwise protect their enrollees.

As long as ERISA permits employers to self-fund, antiselection by groups that can save premium dollars through self-funding will impact the premium rate needed for the groups that remain in the market. As will be discussed in Chapter III, the antiselection problem increases as rating restrictions increase, and becomes critical in a community rated environment.

This is a particular problem with larger groups, as the availability and attractiveness of self-funding increases substantially with group size. Thus, market erosion through self-insurance will likely increase when the definition of small employer expands to between 2 *and 49* employees.

Graph 5 shows the percentage of establishments offering plans by size in 1993. This information was obtained from the 1993 Robert Wood Johnson Employer Health Insurance Survey, Minnesota Department of Health, Health Economics Program. As can be seen, the percentage of establishments offering a self-insured plan increases with establishment size.



GRAPH 5

Low Deductible "Stop Loss" Plans

Employers choosing to self-insure their health plan often purchase *stop loss* policies which protect the employer from high costs. The stop loss policy pays claims exceeding the *attachment point.* A *specific attachment point* is applied to each individual insured and functions like a deductible. For example, under a plan with a specific attachment point of $50,000, the employer is at risk for all claims up to $50,000 on each insured individual and the stop loss insurer pays any claims exceeding this amount. Many stop loss plans also include an *aggregate attachment point* which applies to the group's total claims, after application of the specific attachment point.

In traditional stop loss plans, the specific stop loss attachment point (deductible) is much higher than typical insured plan deductibles. However, there are stop loss plans with deductibles as low as $1,000 being marketed to small employers. Under these plans, the employer is only at risk for the difference between the deductible charged to the employee (which may be $250 or $500) and the $1,000 stop loss deductible. These so-called "stop loss" plans are a method for the employer to remain outside of the regulated market without assuming the risks involved with true self-insurance. If low risk groups are able to save premium dollars while assuming very little risk through purchase of these so-called "stop loss" plans, the premiums for those groups remaining in the market will increase.

The majority of health carriers do not sell these plans. In fact, the significant interest in restricting these low deductible "stop loss" plans is expressed by the health carriers participating in the small employer market.

Discussions with brokers and with carrier marketing departments indicate that enactment of small employer reform has not produced an increase in small employers choosing these low deductible "stop loss" plans. Although this information is only anecdotal, it is encouraging. However, the brokers have seen an increase in small employers' awareness of these plans, and suggest that their purchase hasn't increased only because the major carrier offering these plans charges higher premiums than are available in the small employer market.

This problem may grow, as additional carriers are beginning to offer these low deductible "stop loss" plans. The Department is currently working with the Attorney General's Office to determine what steps can be taken to address this problem. The state may be able to set reasonable restrictions on what coverage is stop loss and what coverage is primary health insurance.

Appropriate Definition of Small Employer

The current definition of small employer is an employer with between 2 and 29 employees. The definition changes on July 1, 1995 to an employer with between 2 *and 49* employees.

There are two competing considerations in looking at the appropriate definition of small vs. large employers. Employer groups with 50 to 100 (or possibly more) employees are vulnerable to many of the same problems, such as lack of rating stability, affecting small employers prior to reform. This would suggest that these employers should also be included in the small employer market under reforms. However, self-insurance is a viable option for groups of this size. As was indicated in Graph 5, the availability and attractiveness of self-funding increases with group size. Antiselection by groups that can save substantial premium dollars through self-funding could have a significant impact on the premium rate needed for the groups remaining in the market.

Absent a change in the ERISA preemption, the upper limit on the definition of small employer should not exceed 49 employees. Further, if the legislature decides to proceed with the rate band reductions, the upcoming change in definition of a small employer to 2 to 49 employees should be reconsidered.

Summary

The first year's results indicate that the small employer reforms undertaken to date have been a success. Chapter 62L, the Minnesota Small Employer Health Benefit Act has successfully promoted the accessibility of health insurance coverage to small employers, prevented abusive rating practices, established rules for continuity of coverage for employers and covered individuals, and improved the efficiency and fairness of the small employer group health insurance marketplace.

The increased accessibility created by the guaranteed issue requirement and the rating restrictions has resulted in increased enrollment in the small employer market. ***The number of small employer groups enrolled in the small employer market increased by 15% from June 30, 1993 to June 30, 1994.***

The general premium rate band, which limits rate variation between any two groups due to factors other than demographics or area, places strict controls on the renewal rating method known as "tier rating." ***The general premium rate band has thus increased premium stability in the market and has increased access for high risk groups.***

Our study also identified some areas of concern..Forty-three percent (43%) of the carriers offering health coverage to Minnesota small employers on July 1, 1992, have left the market. Reasons given for leaving the market include the expense of complying with Minnesota requirements and concern about future requirements such as the Regulated All Payer Option and further rate band reductions.

The establishment of a defined market is important to the continued success of small employer reforms. It is therefore important to monitor and limit potential sources of market erosion.

CHAPTER III. IMPACT OF COMMUNITY RATING

The legislature, in the 1992 Laws, has asked the Department of Commerce to study, report, and make recommendations on the desirability and feasibility of achieving the legislature's goal by phasing out the rate bands in the small employer market by July 1, 1997, according to a specified timetable.

The referenced goal of the legislature is the elimination of harmful effects in the small employer market such as substantial hardship and unfairness, unnecessary administrative costs, and adverse affects on the health of Minnesotans. The "rate bands", implemented on July 1, 1993 by the 1992 Laws, are restrictions on the variations in premium rates charged to small employers. There are two rate bands, the age rate band and the general premium rate band. The result of phasing out the rate bands is "pure community rating."

Chapter 625 of the 1994 Laws proposes a specified timetable of rate band reductions resulting in pure community rating on July 1, 1997. (This timetable is slightly different than the specified timetable of the 1992 Laws.) The proposed timetable of rate band reductions will not be implemented unless an effective date is specified in 1995 legislation. Our understanding is that the legislature intends to consider the advisability and feasibility of implementing the rate band reductions during the 1995 legislative session.

We hope that the information presented in this chapter will be useful to the legislators in their consideration of this issue.

Discussion of Community Rating

Rating Methods

Standard small employer group rating methods incorporate factors such as the group's age composition, sex composition, geographic region, industry, group size, employer contribution level, and historical claims experience into the rate development. Rates vary across each factor based on the expected costs. For example, groups in the Mpls./St. Paul area may be charged a higher rate than groups in rural areas, reflecting the higher health care costs in the metro area. Similarly, older groups are charged more than younger groups. Differences in expected costs (risk factors) are accounted for in the premiums.

Community rating is a method of rating that produces identical rates for all members of an identified pool or class, based on the expected costs for these members as a group. Compared to standard rating methods, the rates for groups with higher risk members decrease, and the rates for groups with lower risk members increase.

The result of phasing out the rate bands is *"pure community rating"*. This is a rating method that recognizes only geographical area, plan design, and overall experience of the "community". Under pure community rating, rates do not vary by age, sex, health status, or claims experience. Another type of community rating, *"community rating by class"* or *"modified community rating"* adds certain demographic characteristics to the rating method, such as age and sex.

Modifications to these rating methods also occur. A rating method may recognize a risk factor such as age or claims experience, but the variation in rates may be limited to less than the variation in expected costs. Minnesota's current rating restrictions and rate bands are an example of this rating method. Variations of this approach have been adopted in many states as part of their small employer health care reforms.

Effects of Community Rating

The primary effect of community rating is a redistribution of health care costs among insured small employer groups. This can be viewed as an advantage or a disadvantage. The advantage of pure community rating is the lack of a penalty (higher premiums) to small employer groups for high previous claims experience or an older group. The corresponding disadvantage is the increased cost for those small employer groups who are better risks. They subsidize the poorer risks. In general, the young will subsidize the old, males will subsidize females at most ages, and the healthy will subsidize the sick.

The effects of community rating are not well understood by the public. There are two effects in particular which are often mistakenly attributed to community rating.

First, community rating does not make health insurance more affordable for all small employer groups. Some groups will see an increase in premiums; some groups will see a decrease in premiums. Community rating only redistributes costs among groups; it does not reduce the average cost of health care for insured small employer groups. In fact, in a voluntary environment the resulting antiselection will increase the average health care premiums for insured small employer groups. (The antiselection caused by community rating will be discussed further.)

Secondly, community rating is not necessary for universal coverage. Universal coverage and community rating are two very separate proposals. Achievement of universal coverage depends on a coverage mandate and a funding source sufficient to cover subsidies for those unable to afford coverage. Community rating will not lead to universal coverage, nor does universal coverage depend on further rating restrictions.

The indirect effects of community rating include:

- Employment discrimination due to poor health status or age that may be occurring in the current environment may decrease under a pure community rating system.

- The implementation of community rating will cause significant rate dislocations initially, varying with the risk characteristics of each employer group. However, subsequent year rate increases would be more stable than in the current system, as changes in average age or health status of the employees will not lead to a change in the group's premiums.

- Under a community rating system, there will be less incentive for prevention of overuse of health care services. Employers may be less willing to invest in healthy lifestyle programs or safer work conditions, since reductions in health care costs will not lead to reductions in health care premiums.

- Since younger people generally have lower incomes than older people, the poor may subsidize the wealthy in a community rated system. The following table illustrates the relationship between increasing age and increasing income in Minnesota. (Note that the relationship holds until the age 55-64 bracket when many begin spending accumulated assets.) It is based on data from the "1990 Census of Population and Housing summary", provided to the Department of Commerce by the Office of the State Demographer, Minnesota Planning. The table shows, for each age, the cumulative percentage of households by household income level. For example, 69% of householders under age 25 had household incomes less than $25,000 in 1989, while only 22% of householders age 45-54 had incomes this low.

Table 4
Household Income by Age of Householder (1989)
Cumulative Percentages

Household Income	*Age of Householder*				
	< 25	*25-34*	*35-44*	*45-54*	*55-64*
< $5,000	9%	3%	2%	3%	4%
< $10,000	27%	9%	6%	6%	11%
< $15,000	43%	15%	10%	10%	18%
< $25,000	69%	34%	24%	22%	35%
< $35,000	85%	55%	41%	36%	52%
< $50,000	96%	80%	66%	58%	72%
< $75,000	99%	95%	89%	83%	89%
< $100,000	100%	98%	95%	92%	95%
All Incomes	100%	100%	100%	100%	100%

- Community rating will necessitate the development of a risk adjustment mechanism to reduce the effects of selection on premiums by making appropriate financial transfers between health carriers undertaking different levels of risk. When rating factors are limited through community rating, premiums no longer reflect differences in expected costs between purchasers. Without risk adjustment, a carrier with a high proportion of high risk employer groups would have to charge a higher "community rate" than other carriers to cover the higher costs. Carriers would compete based on ability to attract lower risk groups and employers would make decisions based on premium differences reflecting the carrier's risk pool, rather than the carrier's medical and administrative efficiencies.

- If rate variation for health status or claims experience is prohibited, underwriting for rating purposes would not be needed. (Underwriting would still be needed for reinsurance.) In the absence of other new data collection or administrative needs, this may result in a small administrative savings. However, the data collection and administrative needs added by the risk adjustment mechanism would likely more than offset the savings of any administrative costs associated with underwriting.

Community Rating in a Voluntary Market

In a voluntary market, community rating will not merely redistribute health care costs among insured small employer groups, it ***will increase the average cost of health care for insured small employer groups.***

The American Academy of Actuaries states in their monograph, *An Analysis of Mandated Community Rating*, that "If coverage is not mandated there is a significant risk of adverse selection against the insurance system since younger and healthier individuals and employers are likely to migrate out of the system. A higher risk and more expensive population would remain in the system causing premium rates to increase."

Antiselection, or adverse selection, can be defined as the annoying tendency of people to do what's best for themselves. If the rate bands are reduced, lower cost employer groups will see rate increases and higher cost employer groups will see rate decreases. On the premium side, those employers paying a premium that is high relative to last year's premium are more likely to drop coverage than employers that have not received a high rate increase. On the claim side, those employers paying more than their expected costs are more likely to drop coverage. This antiselection leads to a higher cost insured pool and an inadequate rate level overall, unless the health carriers can predict the amount that the average claim cost will go up, and increase premiums accordingly.

Rating in the Small Employer Market

Current and Proposed Rating Restrictions

As discussed, restrictions on the variations in premium rates charged to small employers were implemented on July 1, 1993 by the 1992 Laws. The following limitations on variations in rates are required:

- The age rate band limits the rate variation due to age between any two insured persons to +/- 50% of the index rate, which is a ratio of 3:1.
- The general premium rate band limits variation by other factors between any two groups to +/- 25% of the index rate, which is a ratio of 1.67:1. General premium variations may be based *only* on health status, claims experience, industry, and duration of coverage.
- Gender-based rates are prohibited.

- The variation in rates between any two geographic regions is limited to 20%. A carrier may establish no more than three geographic regions, with one region being the Mpls./St.Paul metro region.
- Index rates for different benefit plans may vary only based on actuarially valid differences in the benefit designs.

Chapter 625 of the 1994 Laws proposes a timetable of rate band reductions resulting in pure community rating on July 1, 1997.

- Proposed age band reductions:

  +/- 25% as of 7/1/95;

  +/- 15% as of 7/1/96; and

  no variation as of 7/1/97.

- Proposed general premium band reductions:

  +/- 12.5% as of 7/1/95;

  +/- 7.5% as of 7/1/96; and

  no variation, except for healthy lifestyle discounts, as of 7/1/97.

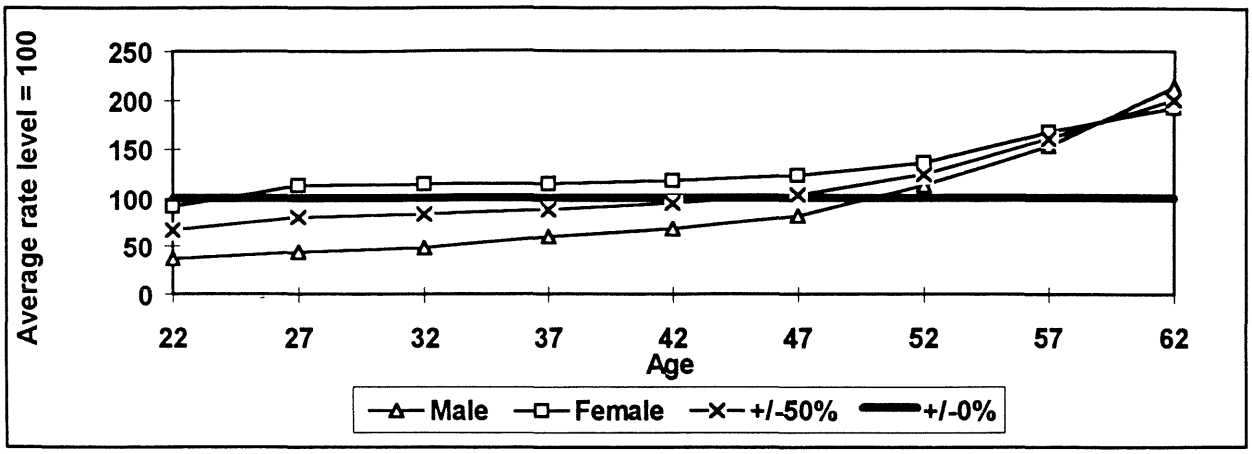
The proposed timetable of rate band reductions will not be implemented unless an effective date is specified in 1995 legislation. Our understanding is that the legislature intends to consider the advisability and feasibility of implementing the rate band reductions during the 1995 legislative session.

Rate Variation by Age

A group's age and sex composition has a material influence on the group's healthcare costs. Under standard rating methods, the differences in expected costs by age and sex are accounted for in the premiums. The relationship of premiums by age and sex is developed to mirror the relationship of expected costs by age and sex.

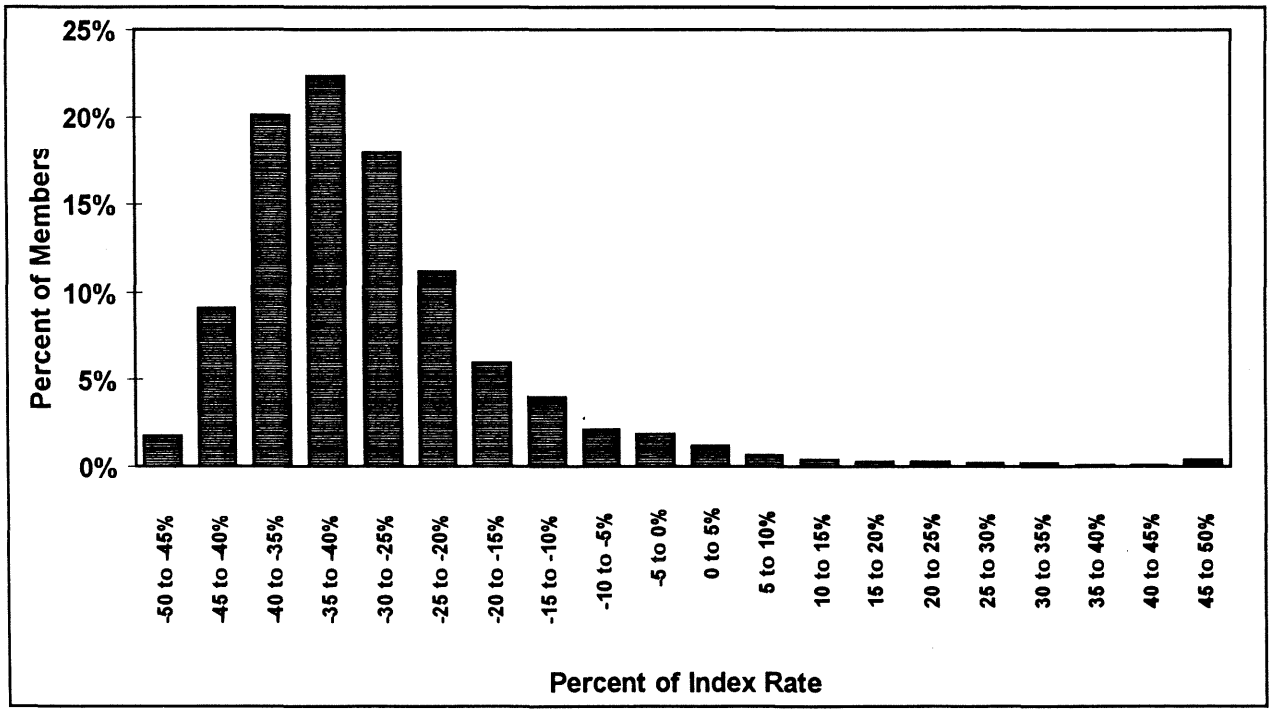
Current rating restrictions prohibit the use of gender as a rating variable and limit rate variation due to age to a ratio of 3:1 (the age band). Under pure community rating, rates may not vary by gender or age.

Graph 6 compares the cost relativities by age and sex with the permitted premium variation by age under the current age rate band and under pure community rating. The cost relativities are based on a typical plan including maternity coverage. For this plan, the expected costs by age and sex vary by a ratio of almost 6:1. When males and females are combined, the variation in expected costs by age is just slightly over the 3:1 ratio allowed by the current age rate band. (I.e. The current age band has very little impact in a gender neutral environment). As can be seen in the graph, moving from the current age rate band to pure community rating will have a significant impact, causing large changes in rates by age. (Note that the effects of antiselection were not included in the comparison.)



GRAPH 6 - COMPARISON OF COST RELATIVITIES AND AGE RATE BANDS

The age rate band is applied on an individual basis, meaning that the individual rates used to build a group's rate are limited by the rate band. A group's age factor is thus the average of the age factors of each of the group's covered members. Graph 7 shows the current (6/30/94) distribution of small employer groups by the group's average age factor.

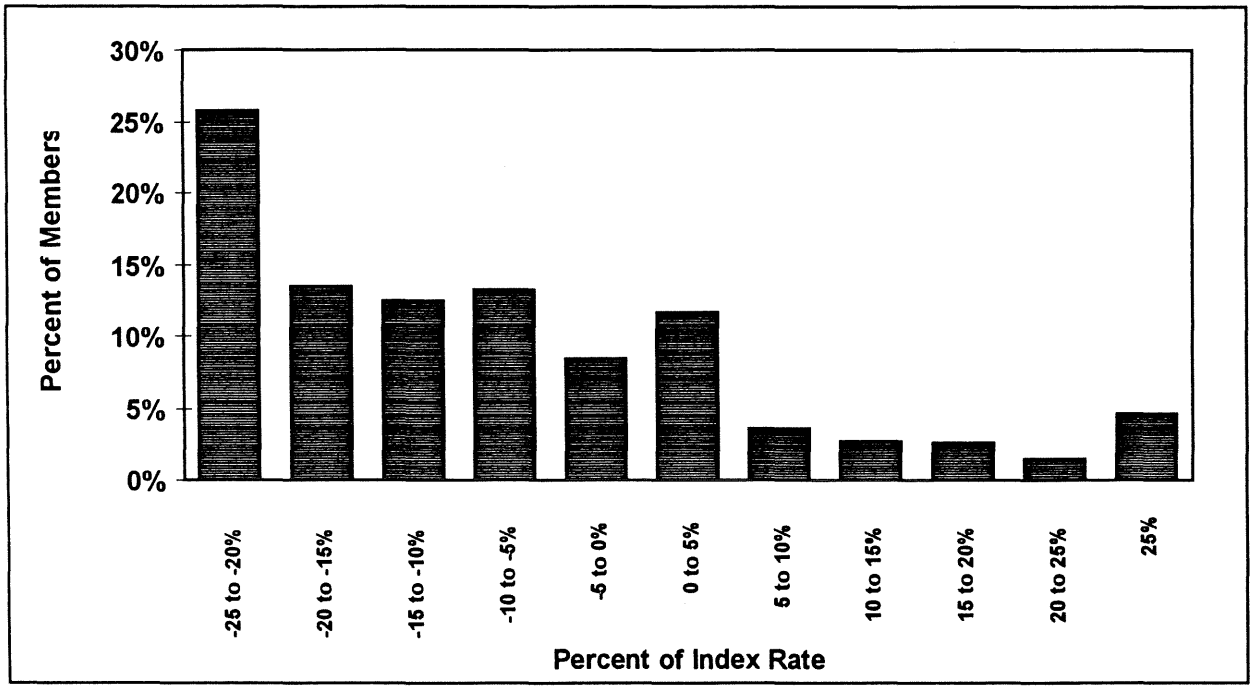


GRAPH 7- DISTRIBUTION OF GROUP AVERAGE AGE FACTOR - 6/30/94

General Premium Variations

In addition to a group's age and sex composition, standard small employer group rating methods incorporate factors such as industry, group size, duration of coverage, employer contribution level, members' health status, and historical claims experience into the rate development. Current rating restrictions limit rate variation by general factors between any two groups to a ratio of 1.67:1 (the general premium rate band). Further, general premium variations may be based only on health status, claims experience, industry, and duration of coverage. As discussed in Chapter II, the current general premium rate band controls the renewal rating practice known as "tier rating". Under pure community rating as defined in the 1994 Laws, general premium variations will be prohibited, except for healthy lifestyle discounts such as refraining from tobacco use.

Graph 8 shows the current (6/30/94) distribution of small employer groups by the group's general premium factor. The average general premium factor is roughly -10% of the index rate. Given the current rate distribution of groups, moving from the current general premium band to pure community rating will have a significant impact on the rates of many groups.



GRAPH 8- DISTRIBUTION OF GROUP GENERAL PREMIUM FACTOR - 6/30/94

Impact of Community Rating on the Small Employer Market

As part of our study, we retained the actuarial consulting firm of Milliman & Robertson, Inc. (M&R) to model the impact of further rate band reductions on Minnesota's small employer health insurance marketplace. In addition to the two timetables of rate band reductions described in the 1992 Laws and the 1994 Laws, we defined additional rating scenarios to be projected.

M&R constructed a model to project the impact of various rating limitations on the Minnesota small employer health insurance market. This section includes a discussion of the model structure and assumptions, and a presentation of the model results.

Model Structure

M&R's model starts with an experience base of Minnesota small employer health insurance at June 30, 1994 and projects the market through mid-1998. The experience base was developed from enrollment and rate level data collected from six of the largest Minnesota small employer health carriers covering approximately 80% of the Minnesota small employer health insurance market. A listing of the requested data is contained in Appendix D.

The model divides the experience base of insured small employers into 1,080 cells in order to separately project the impact on each cell of phasing out the rate bands. The cells vary by number of employees, average age rate factor, and general premium rate factor. The model projects the rate changes, rate level, new business, lapsation, and enrollment separately for each cell for each year until June 30, 1998. (June 30 was chosen as the pivotal date, since the results for each June 30 reflect the full impact of the rate restrictions that were effective the previous July 1.)

Each cell experiences rate increases or decreases due to the narrowing of the rate bands, and lapsation occurs in each cell. In general, the groups lapsing from the market are lower cost groups which experience rate increases due to the reduction of the rate bands. The lapsation thus results in an upward adjustment of the index rates to correspond to the increase in average cost of the remaining total population in all cells. Upward adjustment of the index rates then results in additional lapsation.

For each year from mid-1993 through mid-1998 M&R's model projects the following characteristics for the Minnesota small employer health insurance market: (1) average rate level in the market based on the changes in index rates, (2) the enrollment in the market based on the total of the enrollments in each cell, and (3) the distribution of rate changes (resulting from phasing out the rating bands) based on the rate change in each cell.

Model Assumptions

The following is a summary of the significant assumptions used in M&R's model.

Rate Band Impact is Predictable: The model assumes that health carriers can predict the impact of the rate bands on claim costs, and set their premiums at an adequate level each year.

Enrollment Levels: Underlying lapsation is assumed to be 6%, due to 1) insured employers going out of business and 2) insured employers choosing to drop coverage in the absence of changes in rating methods. This assumption is matched by an underlying new business assumption of 6%.

In addition, the model projects excess lapsation due to the impact of the rate band reductions. Excess lapsation is calculated for each of the 1,080 cells based on:

- the rate changes in the cell, and
- the impact of premium subsidization among groups.

The excess lapsation is assumed to increase with group size, due to the increased attractiveness of self-funding for the larger groups.

There is also a modification to the new business assumption in each cell, to reflect the impact on new business of rate changes that are greater or less than trend.

Universal Benefit Set: The model assumes that the universal benefit set will be roughly equivalent to the average of small employer group benefit plans currently in force. If a richer benefit plan is mandated, the rates will increase over projected levels to reflect the additional benefits. This would likely lead a greater number of low risk groups to drop coverage.

ERISA: The model assumes that stop-loss coverage will be available and that Minnesota will not receive a federal pre-emption of ERISA.

Restrictions on Stop Loss Plans: The model assumes that reasonable restrictions are placed on the availability of stop loss coverage. In particular, it is assumed that available specific stop loss attachment points are restricted to levels that are higher than deductibles of insured plans. If these plans are not subject to reasonable restrictions, the lapsation is likely to be much higher than assumed by the model and future enrollment could be significantly less than that shown in the results.

Groups of Size 30-49: Employer groups of size 30 - 49 will be included in the small employer market as of July 1, 1995. These groups were not included in the model due to the lack of data on groups of this size. The impact of including groups of size 30-49 would result in dampening of the model results due to the reduction in rate variability associated with larger groups *if self-insurance was prohibited.* However, the availability and attractiveness of self-funding to groups of size 30-49 may result in amplifying the effects of community rating on this market. Antiselection by these groups against the market may have a significant upward impact on the premiums for those groups remaining in the market.

Demographic or Economic Trends: The model did not include any trends in demographic or economic variables, such as aging of the population, a change in the number of Minnesota small employers, or any changes in Minnesota's economy.

Overview of Model Results

Under both the 1992 and 1994 timetables of rate band reductions, ***"pure community rating" is projected to result in decreases in enrollment and increases in average premium rates.***

The total population enrolled in the size 2-29 Minnesota small employer health insurance market is projected to decline by 22% under the 1994 timetable or by 23% under the 1992 timetable. Another way to think about this statistic is that approximately 64,000 Minnesotans will have to find other coverage (self-insurance or individual policies) or go without.

A further consequence of this loss of enrollment is that the average premium rate for those remaining in the market will rise an additional 10% over and above other increases. For example, a sample group with a rate which is 20% below the current average rate (due to good experience and/or a younger group) will experience an 81% rate increase in four years. To illustrate, assume that this group has selected a benefit plan with an average monthly rate per person of $100. The monthly rate per person currently paid by this group is thus $80.

Under "pure community rating", phased-in as proposed in the 1994 Laws, this group experiences a 37.50% rate increase above medical claim trend made up of:

i) a 25% increase to bring the group's rate up to the current average rate of $100, and
ii) an additional 10% rate increase due to the increase in the average rate to $110.

When claim trend equal to the growth limits is included, this group experiences an 81% rate increase. Assuming a January 1 renewal date, the sample group's monthly rate per person of $80 in 1994 will rise to $145 per person in 1998. (Note that this sample group does NOT represent the worst-case scenario.)

Scenarios

In addition to the two timetables of rate band reductions described in the 1992 Laws and the 1994 Laws, we defined additional rating scenarios to be projected.

M&R projected the following scenarios (corresponding to the graphs):

Scenario 0 - Baseline

The rate bands remain at their current level.

Scenario 1 - 1992 Law

The rate bands are reduced according to the timetable specified in Chapter 549 of the 1992 Laws. This results in pure community rating on July 1, 1997.

- Age band reductions:
  +/- 30% as of 7/1/95;
  +/- 15% as of 7/1/96; and
  no variation as of 7/1/97.
- General premium band reductions:
  +/- 15% as of 7/1/95;
  +/- 7.5% as of 7/1/96; and
  no variation as of 7/1/97.

Scenario 2 - 1994 Law

The rate bands are reduced according to the timetable specified in Chapter 625 of the 1994 Laws. This results in pure community rating on July 1, 1997.

- Age band reductions:
  +/- 25% as of 7/1/95;
  +/- 15% as of 7/1/96; and
  no variation as of 7/1/97.
- General premium band reductions:
  +/- 12.5% as of 7/1/95;
  +/- 7.5% as of 7/1/96; and
  no variation, except for healthy lifestyle discounts, as of 7/1/97.

Scenario 3 - CR in 1997

"Big Bang" approach - The rate bands remain at their current level until 1997, when pure community rating occurs.

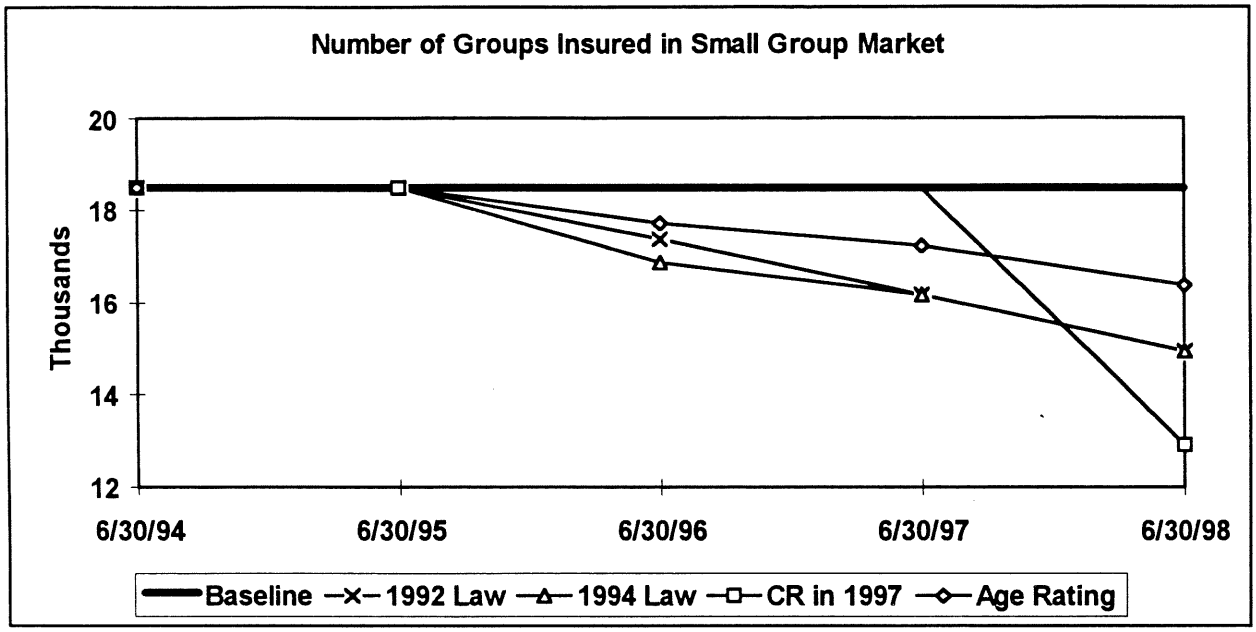
Scenario 4 - Age Rating

Community Rating by Class - The age rate band remains at its current level. The general premium rate band is reduced according to the timetable specified in the 1994 Law.

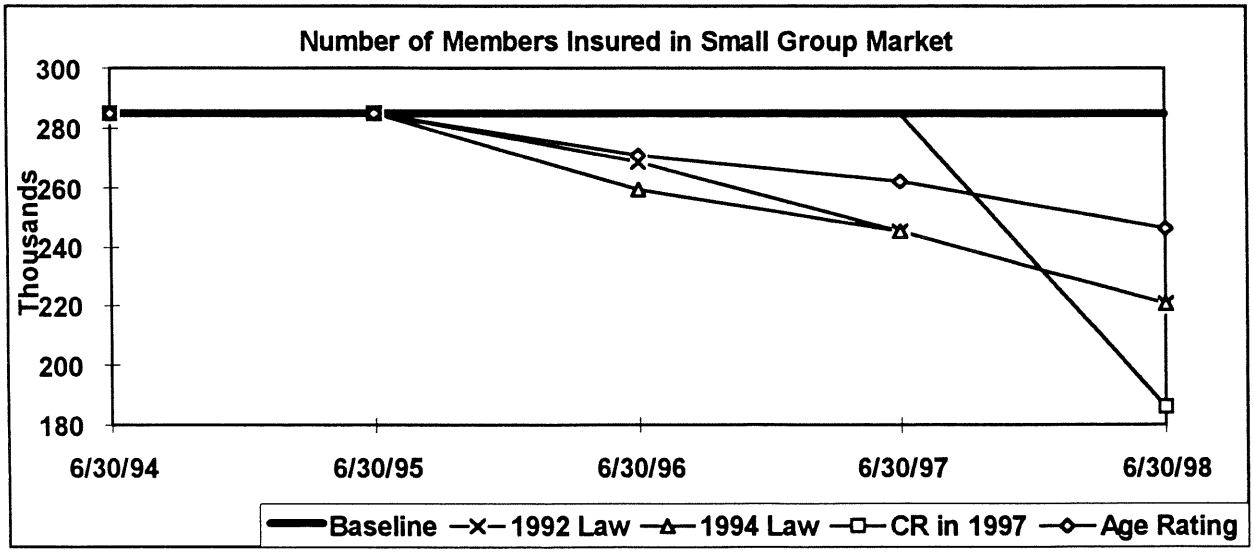
For each scenario, M&R's model projects: (1) the enrollment in the market, (2) average rate level in the market, and (3) the distribution of rate changes.

Enrollment

As shown in Graphs 9 and 10, the enrollment in the small employer market is projected to drop in all scenarios but the baseline. The number of groups enrolled in the market (Graph 9) is projected to decline by 19% in Scenarios 1 and 2, by 30% in Scenario 3, and by 12% in Scenario 4. The members enrolled in insured small employer groups (Graph 10) is projected to drop by 23% in Scenario 1, by 22% in Scenario 2, by 35% in Scenario 3, and by 14% in Scenario 4.



GRAPH 9

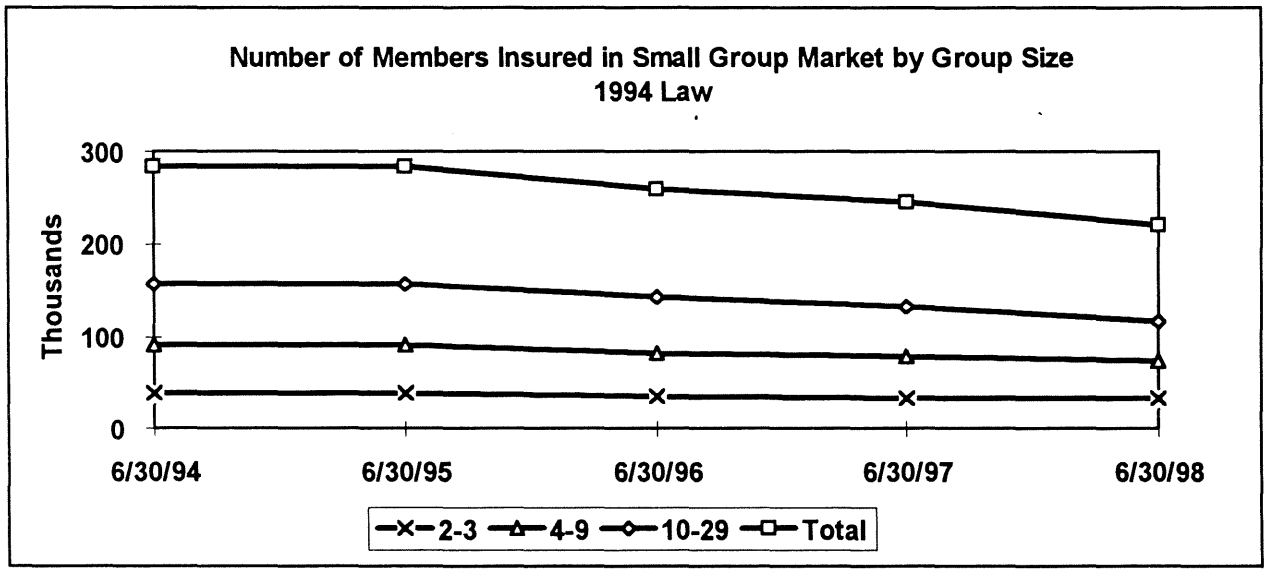


GRAPH 10

The drop in enrollment is higher in the larger groups where self-insurance is a more attractive option. Graph 11 shows the enrollment by group size under Scenario 2, 1994 Law. The following percentages of groups by size drop coverage under pure community rating:

- 15% of groups of size 2-3,
- 20% of groups of size 4-9, and
- 26% of groups size 10-29.

Of the 22% loss in total population enrolled in the small employer market, 63% are in of groups of size 10-29.

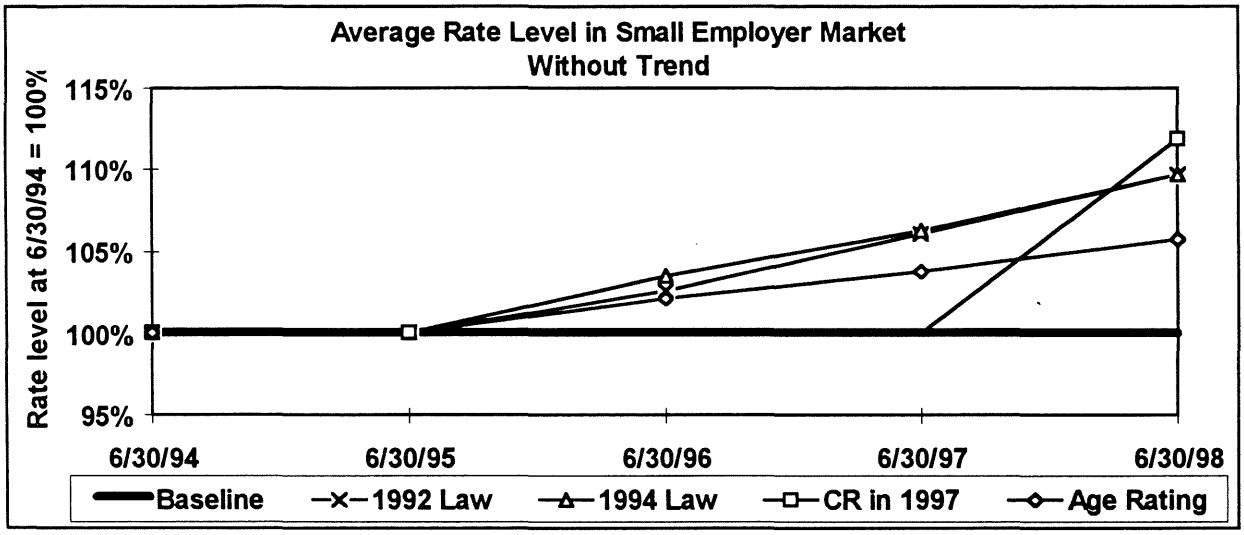


GRAPH 11

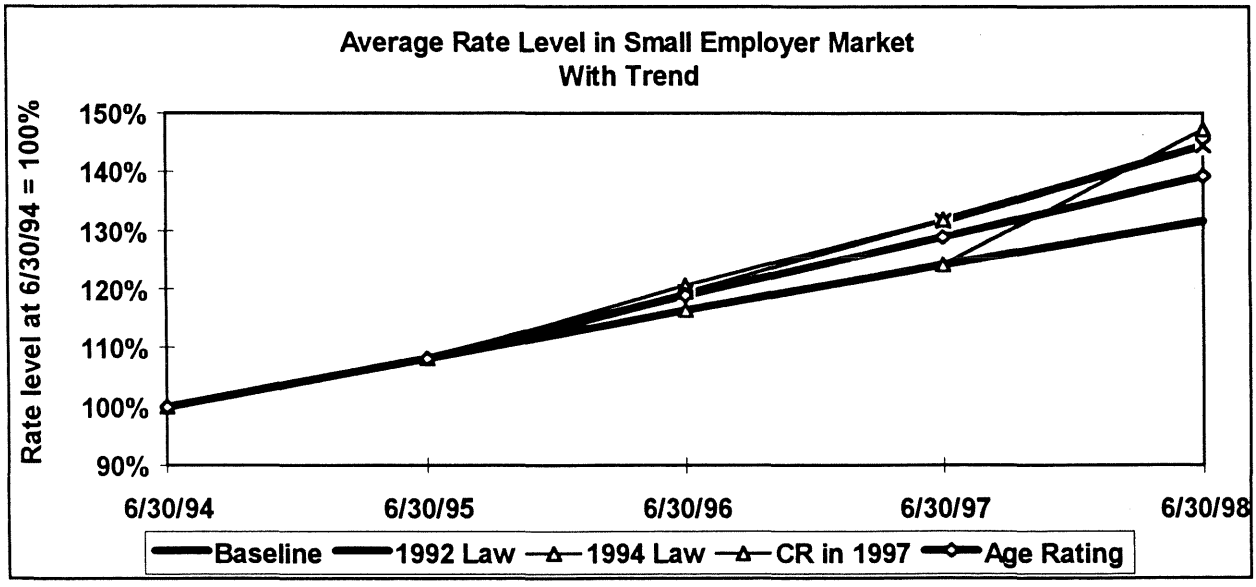
Average Rate

The average rate charged to groups enrolled in the small employer market is projected to increase in all scenarios but the baseline. This is shown in Graphs 12 and 13; Graph 12 assumes no medical cost trend, while Graph 13 includes the effect of trend assumed to be equal to the growth rate limits. The average rate increase beyond trend or other increases is 10% in Scenarios 1 and 2, 12% in Scenario 3, and 6% in Scenario 4.

As shown, ***community rating*** will not merely redistribute health care costs among insured small employer groups, it ***will increase the average cost of health care for insured small employer groups.***



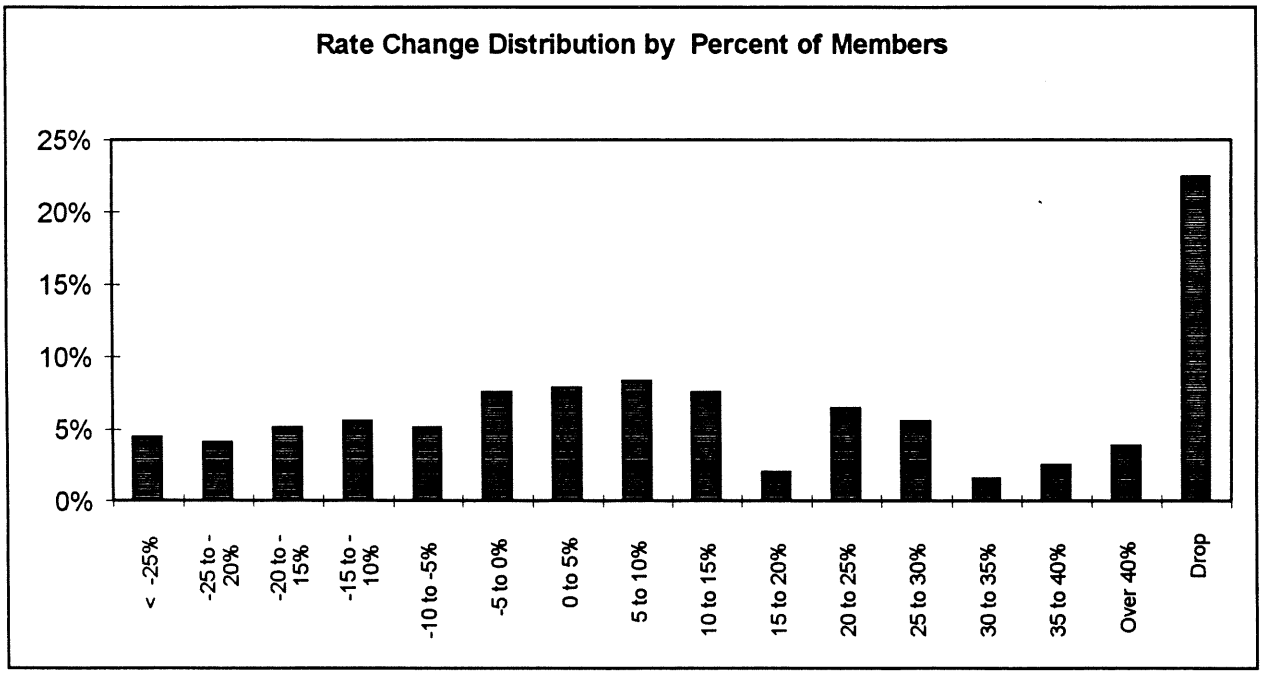
GRAPH 12



GRAPH 13

Distribution of Rate Changes

As discussed, community rating redistributes health care costs among insured small employer groups. Some groups will see an increase in premiums; some groups will see a decrease in premiums. Graph 14 shows the distribution of total rate changes experienced over the phase-in of pure community rating under the timetable specified in the 1994 Laws. The rate changes reflect only the impact of the reduction in the rate bands and do not include medical cost trend or other changes. As shown, the model projects that 32% of the members insured in small employer groups will experience rate decreases, while 68% will experience rate increases or will drop coverage due to the rate changes.



GRAPH 14- RATE CHANGES, 1996 THROUGH 1998 SCENARIO: 1994 LAW

Individual Market

The rate band reductions proposed in Chapter 625 of the 1994 Laws also apply to the individual market. Although the focus of this report is a study of the small employer market, we have briefly addressed the impact of the rate band reductions on the individual market. Our understanding is that the legislature's consideration of the proposed rate band reductions during the 1995 legislative session will also include consideration of the impact on the individual market.

This section includes a summary of the results of some earlier modeling of the projected impact of community rating on the individual market and an illustration of the impact of community rating on rates by age bracket.

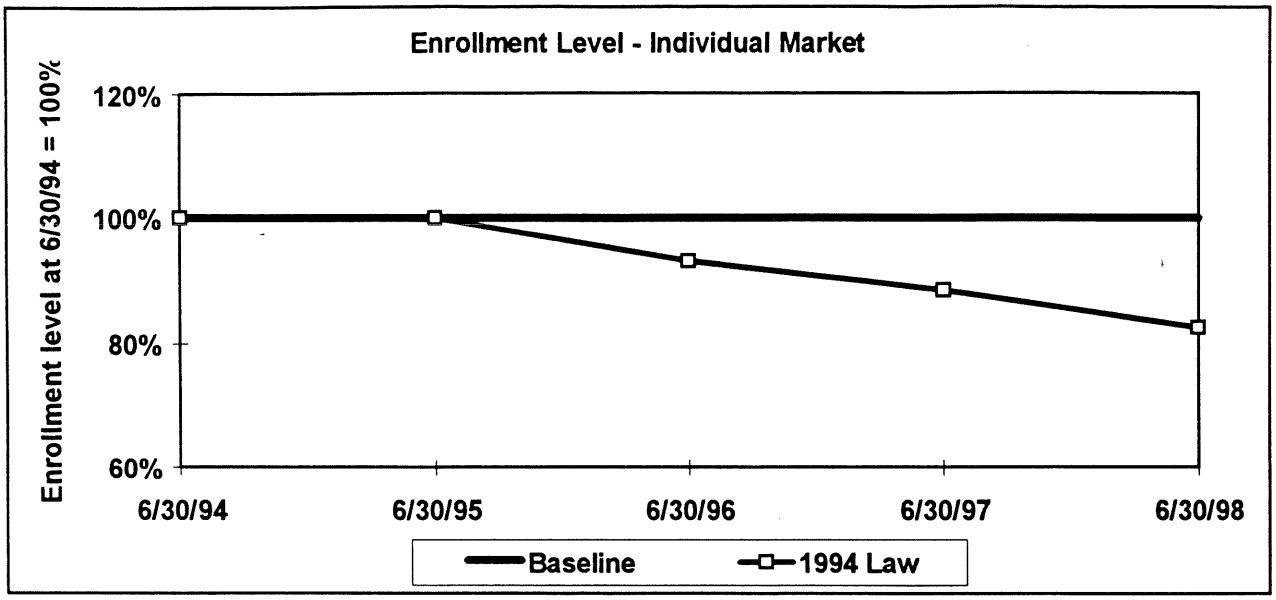
Rating in the Individual Market

The current rating restrictions in the individual market are substantially the same as the current rating restrictions in the small employer market, listed on page 19. The restrictions differ slightly; as in the individual market: a) duration of coverage is not a permitted general premium variation, and b) the variation between index rates for different benefit plans is not limited. However, the general premium variations work differently in the two markets. Although policies may be issued at rates above standard due to poor health status, an individual policy may not be subsequently rerated to reflect any changes in health status. For example, an individual issued a policy at the standard rate, continues to pay the standard rate regardless of changes in health status. (The individual may change rate classes due to changes in factors such as age, geographic region, or smoking status but only if the rate classes were defined at policy issue.) Eliminating the general premium band would thus affect this market differently than the small employer market. It will not increase premium stability for insureds, as rerating is currently prohibited. It may result in carriers declining those applicants that would now be accepted at an increased premium.

Prior Model Results

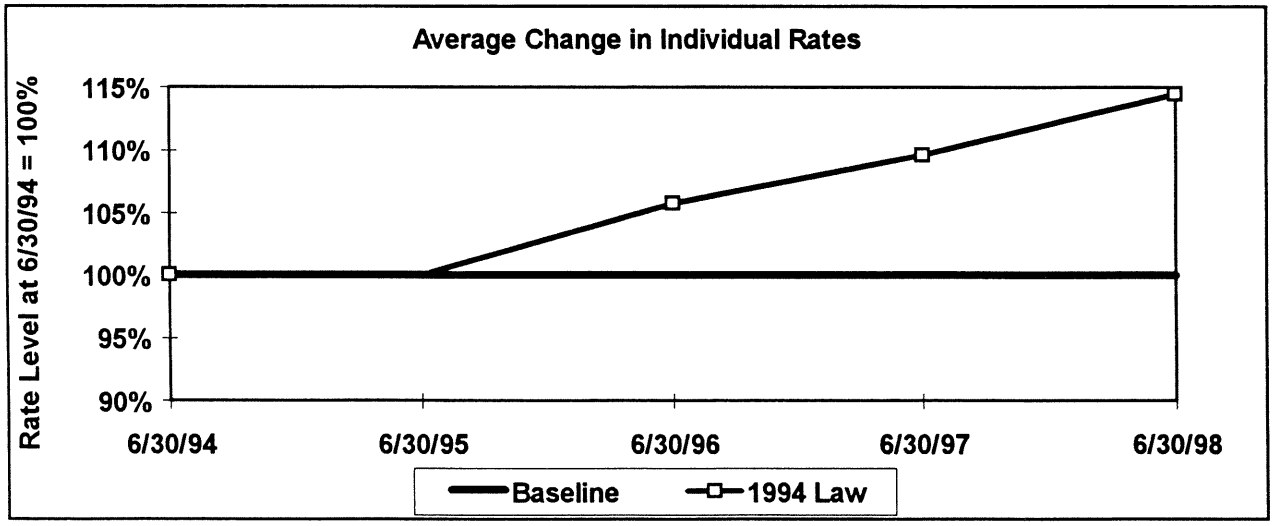
This section summarizes results from two prior studies of the individual market: a) "Study of Individual Health Insurance Rating and Underwriting Reform," done by Milliman & Robertson, Inc. for the Department of Commerce in 1992; and b) further refinement and updating of the 1992 model done by M&R at the request of Blue Cross & Blue Shield of Minnesota and presented at the Health Care Commission in January, 1994.

As these are earlier studies which focused on the impact of a guaranteed issue requirement, there are two factors that must be considered when using these model results to evaluate the impact of community rating on the individual market: a) the model assumed "pure community rating" without the exception for healthy lifestyle discounts included in the 1994 Laws, and b) the model was based on Blue Cross & Blue Shield data only so assumed that there is no substandard rating in the current market. As these two factors have opposite impacts on the model results, we believe that the results shown are substantially correct.

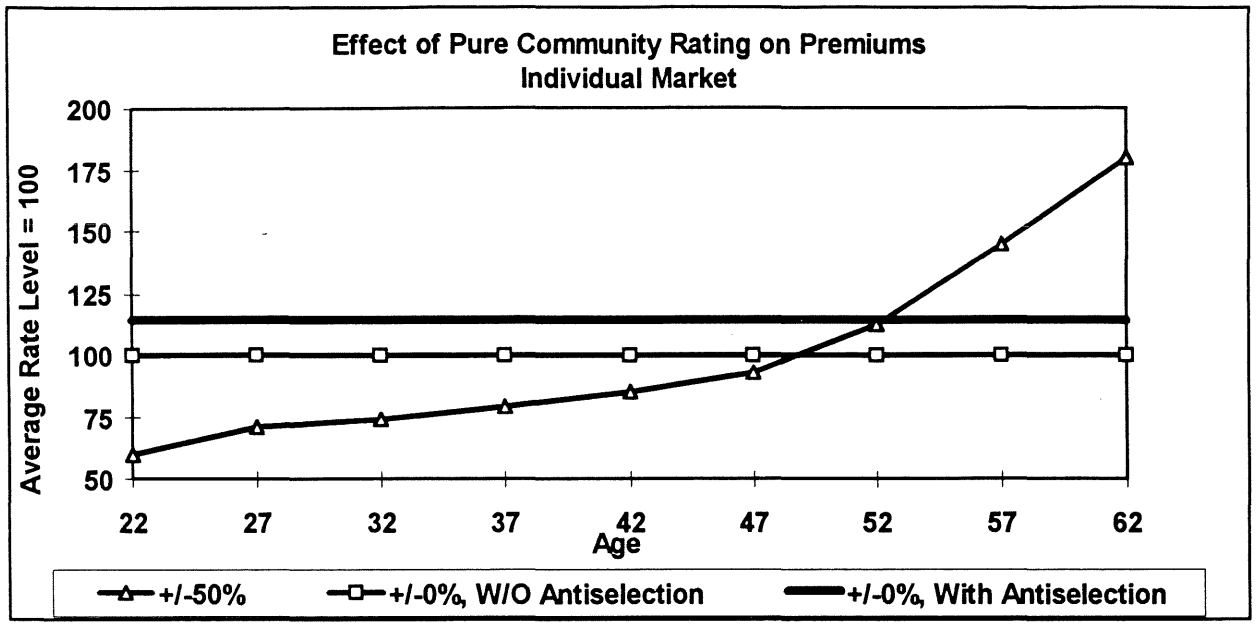


GRAPH 15

As shown in Graphs 15 and 16, community rating will have an adverse impact on the individual market. Enrollment is projected to drop by 17% as a result of the antiselection resulting from pure community rating. The average rate level in the individual market is projected to rise 14% above trend and other increases. (Note that this does not include impacts of a guaranteed issue requirement.)

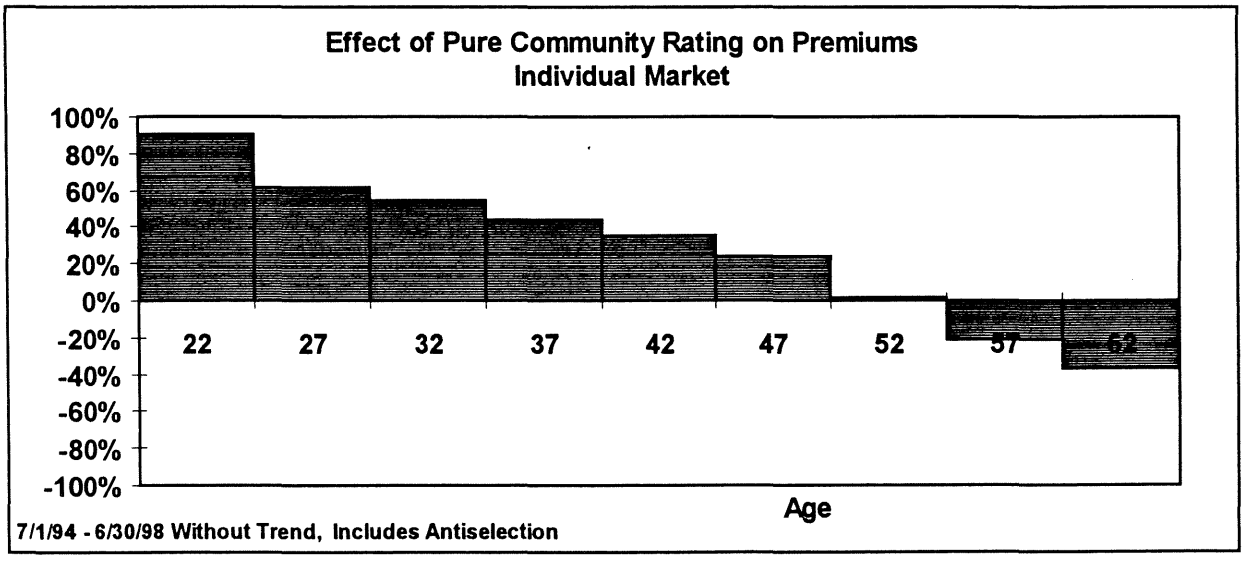


GRAPH 16



GRAPH 17

Graphs 17 and 18 illustrate the effect of pure community rating on premiums by age. Graph 17 compares rate relativities for a sample plan under the current rate bands to pure community rating. The rate level under pure community rating is shown with and without the 14% increase resulting from antiselection. Graph 18 is based on Graph 17, and shows the rate changes that will occur at each age over the phase-in period of pure community rating. The rate changes do not include trend. As can be seen, the rate changes range from -36% to +91%.



GRAPH 18

Summary and Recommendations

Why are some small employer groups uninsured today? Access to coverage is not the issue, as the guaranteed issue requirement and current rate bands guarantee access to all small employers. The reason some small employers are uninsured is cost; insurance is unaffordable to them. Affordability is subjective, depending on an employer's finances, need for health insurance, and other factors. Pure community rating will not make health insurance more affordable for most groups.

Community rating will have an adverse effect on Minnesota's small employer health insurance market. As shown in this chapter, community rating is projected to result in decreases in enrollment and increases in average premium rates. One can not remedy these significant negatives, which are directly contrary to the stated policy goals of health care reform, because in large measure they result from self-insurance and other alternatives outside of state control. Consequently any positives attributable to "Community Rating" are greatly out weighted by the negatives. ***Thus, the Department of Commerce is recommending a repeal of the proposed rate band reductions.*** We hope that this report and analysis will be useful to the legislature when considering this issue during the 1995 session.

APPENDIX A

THE MINNESOTA DEPARTMENT OF COMMERCE
STUDY OF SMALL EMPLOYER HEALTH INSURANCE REFORM
PRELIMINARY PROGRESS REPORT
December 1, 1994

The Minnesota Department of Commerce is conducting a study of small employer health insurance reform and further rate band reductions as assigned by the legislature in Chapter 549 (1992) Article 2, Section 24. This report is the Department's preliminary progress report for the study, as required by the legislature. It includes a brief description of the study, as well as some preliminary results.

The Department's final report and recommendations are due to the legislature no later than April 1, 1995. As the results of our study may be useful to the legislature in its consideration of additional small employer market reforms during the 1995 session, such as the proposed rate band reductions, we are working to complete the study in advance of the due date. At this time, we anticipate completing the study and filing our final report and recommendations to the legislature in a January/February time frame.

Description of the Study

The legislature, in the 1992 Laws, has asked the Department of Commerce to study, report, and make recommendations on the following:

- the effects of Chapter 62L, the Minnesota small employer health benefit act, on the market for health benefit plans for small employers, and

- the desirability and feasibility of achieving the legislature's goal by phasing out the rate bands by July 1, 1997, according to a specified timetable.

  The referenced goal of the legislature is the elimination of harmful effects in the small employer market such as substantial hardship and unfairness, unnecessary administrative costs, and adverse affects on the health of Minnesotans.

Attachment A includes Chapter 549 (1992), Article 2, Section 24.

Chapter 62L, the Minnesota small employer health benefit act, introduced significant reforms to Minnesota's small employer health insurance market. The major provisions of this chapter include:

- a guaranteed issue requirement,
- required offer of two defined plans (62L.05),
- elimination of coverage limitations for preexisting conditions,
- restrictions on premium rate variations from group to group ("rate bands"),
- the requirement that rates be filed and approved,
- minimum loss ratio standards, and
- creation of the Minnesota Health Care Reinsurance Association.

The Department is analyzing the effects of the Chapter 62L reforms on the number of small employer groups and members covered, the availability of coverage, affordability of and variation in premium rates, and other areas of Minnesota's small employer health insurance market. We are utilizing information and data from a variety of sources including small employer rate filings, several surveys of small employers being conducted by other Departments and private associations, and a survey of all small employer health carriers. Our "Small Employer Health Insurance Survey" has been distributed to all carriers identified as possibly having participated in the small

employer health insurance market anytime as recently as 1992. A copy of the survey is included as Attachment B.

Preliminary results suggest that the Chapter 62L reforms undertaken to date are achieving increases in coverage, access, and affordability in Minnesota's small employer health insurance market. To reiterate, **the small employer reforms that have taken effect appear to be a public policy success.** However, it's important to note, as the subsequent discussion points out, that **some of the reforms that have not yet taken effect, principally "pure community rating", may stymie this success.**

The "rate bands", implemented on July 1, 1993 by the 1992 Laws Chapter 549 (1992), Article 2, Section 8 are restrictions on the variations in premium rates charged to small employers. There are two rate bands, the age rating band and the general premium rating bands. The age band limits the rate variation due to age between any two insured persons to +/- 50% of the index rate, which is a ratio of 3:1. The general premium rating band limits variation by other factors between any two groups to +/- 25% of the index rate, which is a ratio of 1.67:1. General premium variations may be based *only* on health status, claims experience, industry, and duration of coverage. In addition to the rating bands, Chapter 62L limits the variation of rates by geographic area and prohibits gender-based rating.

The result of phasing out the rate bands is "pure community rating". This is a rating method that accounts for family size, geographical area, and plan design as the only differentiating variables between employers and individuals. Under "pure community rating," rates do not vary by age, sex, or claims experience. The rates for groups with higher risk members decrease, and the rates for groups with lower risk members increase.

Chapter 625 of the 1994 Laws proposes a specified timetable of rate band reductions resulting in pure community rating on July 1, 1997. (This timetable is slightly different the specified timetable of Chapter 549 of the 1992 Laws, and is also included in Attachment A.) The proposed timetable of rate band reductions is not effective unless an effective date is specified in 1995 legislation. Our understanding is that the legislature intends to consider the advisability and feasibility of implementing the rate band reductions during the 1995 legislative session.

Our final report will include a discussion of rating practices in the small employer market, illustrations showing variations in expected costs by age and other variables, and analyses of both the impact of the current rate bands and the projected impact of phasing out the current rate bands.

Impact of Pure Community Rating, Preliminary Results

As part of our study, we retained the actuarial consulting firm of Milliman & Robertson, Inc. (M&R) to model the impact of further rate band reductions on Minnesota's small employer health insurance marketplace. In addition to the rate band reductions described in Chapter 549 of the 1992 Laws, we defined several additional rating scenarios to be projected, such as the rate band reductions described in Chapter 625 of the 1994 Laws.

M&R constructed a model to project the impact of various rating limitations on the Minnesota small employer health insurance market. We have just received M&R's report and have not yet had a chance to analyze the model results nor to discuss the report with M&R. We are including

the initial results from M&R's model in this preliminary report. Further model results will be shown and explained in our final written report to the legislature.

M&R's model starts with an experience base of Minnesota small employer health insurance at June 30, 1994 and projects the market through mid-1998. The experience base was developed from enrollment and rate level data collected from six of the largest Minnesota small employer health carriers covering approximately 80% of the Minnesota small employer health insurance market. A description of M&R's model and of the requested data is included as Attachment C.

The model was used to project the impact of "pure community rating" on the Minnesota small employer health insurance market, under different scenarios including both the specified timetable of rate band reductions proposed in Chapter 625 of the 1994 Laws, and the specified timetable of rate band reductions described in Chapter 549 of the 1992 Laws.

Under both timetables, **"pure community rating" is projected to result in decreases in enrollment and increases in average premium rates.**

The total population enrolled in the size 2-29 Minnesota small employer health insurance market is projected to decline by 22% under the 1994 timetable or by 23% under the 1992 timetable. Another way to think about this statistic is that approximately 64,000 Minnesotans will have to find other coverage (self-insurance or individual policies) or go without.

A further consequence of this loss of enrollment is that the average premium rate for those remaining in the market will rise an additional 10% over and above other increases. For example, a sample group with a rate which is 20% below the current average rate (due to good experience and/or a younger group) will experience an 81% rate increase in four years. To illustrate, assume that this group has selected a benefit plan with an average monthly rate per person of $100. The monthly rate per person currently paid by this group is thus $80. Under "pure community rating", phased-in as proposed in the 1994 Laws, this group experiences a 37.50% rate increase above medical claim trend made up of:

i) a 25% increase to bring the group's rate up to the current average rate of $100, and
ii) an additional 10% rate increase due to the increase in the average rate to $110.

When claim trend equal to the growth limits is included, this group experiences an 81% rate increase. Assuming a January 1 renewal date, the sample group's monthly rate per person of $80 in 1994 will rise to $145 per person in 1998.

Summary

Although our study is not yet complete, the preliminary work indicates that pure community rating will have an adverse impact on Minnesota's small employer health insurance market. We hope that both this preliminary information and the further analysis and results which will be included in our final report will be useful to the legislature when considering the appropriateness of the proposed phase out of the rate bands during the 1995 session.

Attachment A: Legislation

1992 Laws, Chapter 549, Article 2, Sec. 24 [COMMISSIONER OF COMMERCE STUDY.]

The commissioner of commerce shall study and provide a written report and recommendations to the legislature that analyze the effects of this article and future measures that the legislature could enact to achieve the purpose set forth in section 62L.01, subdivision 3. The commissioner shall study, report, and make recommendations on the following:

(1) effects of this article on availability of coverage, average premium rates, variations in premium rates, the number of uninsured and underinsured residents of this state, the types of health benefit plans chosen by employers, and other effects on the market for health benefit plans for small employers;

(2) the desirability and feasibility of achieving the goal stated in section 62L.01, subdivision 3, in the small employer market by means of the following timetable:

(i) as of July 1, 1995, a reduction of the age rating bands to 30 percent on each side of the index rate, accompanied by a proportional reduction of the general premium rating bands to 15 percent on each side of the index rate;
(ii) as of July 1, 1996, a reduction in the bands referenced in the preceding clause to 15 percent and 7.5 percent respectively; and
(iii) as of July 1, 1997, a ban on all rating bands; and

(3) Any other aspects of the small employer market considered relevant by the commissioner.

The commissioner shall file the written report and recommendations with the legislature no later than April 1, 1995. The commissioner shall file with the legislature a written preliminary progress report no later than December 1, 1994.

1994 Laws, Chapter 625, Article 6, Sec. 3, Subd. 6. [LIMITS ON PREMIUM RATE VARIATIONS.]

(a) Effective July 1, 1995, the premium variations permitted under sections 62A.65 and 62L.08 become:
(1) for factors other than age and geography, 12.5 percent of the index rate; and
(2) for age, 25 percent of the index rate.
(b) Effective July 1, 1996, the premium variations permitted under sections 62A.65 and 62L.08 become:
(1) for factors other than age and geography, 7.5 percent of the index rate; and
(2) for age, 15 percent of the index rate.
(c) Effective July 1, 1997, no health plan company shall offer, sell, issue, or renew a health plan, that is subject to section 62A.65 or 62L.08, for which the premium rate varies between covered persons on the basis of any factor other than:
(1) for individual health plans, differences in benefits or benefit design, and for group health plans, actuarially valid differences in benefits or benefit design;
(2) the number of persons to be covered by the health plan:
(3) actuarially valid differences in expected costs between adults and children;
(4) healthy lifestyle discounts authorized by statute; and
(5) for individual health plans, geographic variations permitted under section 62A.65, and for group health plans, geographic variations permitted under section 621.08.

1994 Laws, Chapter 625, Article 6, Sec. 3 Subd. 9. [CONTINGENCY; FUTURE LEGISLATION]

This section, except for subdivision 7, paragraphs (b), (c), and (d), is not intended to be implemented prior to legislation enacted to achieve the objectives of sections 1, 5, 6, and 7. Subdivision 6 is not effective until an effective date is specified in 1995 legislation.

Attachment B: Small Employer Health Insurance Survey

Small Employer
Health Insurance Survey

Minnesota Department of Commerce
133 East 7th Street
St. Paul, Minnesota 55101

Complete survey & return to the above address by **September 26, 1994**. If you have any questions, contact Dorothy Petersen (612) 296-8949. Response is required pursuant to Minnesota Statute section 45.027.

Name of Health Carrier: _____

Address of Health Carrier: _____

_____

Person Completing Survey: _____ Phone: _____

1. Please check whichever of the following applies:

   _____ A. Our company does not now and has not in the recent past (since July 1, 1992) participated in the "small employer market" as defined in Minnesota Statute section 62L.02 subdivision 27.

   _____ B. Our company has ceased (or has elected to cease, as provided under 62L.09) doing business in the Minnesota "small employer market" as of:
   (date)_____

   _____ C. Our company is currently participating in the "small employer market" as defined in Minnesota Statute section 62L.02 subdivision 27.

If the answer to Question 1 is "A", you need not complete the rest of the survey.

2. Does your company currently offer individual health plans (other than conversion plans) in Minnesota? _____

3. Please respond to the following about your Minnesota small employer business during the period July 1, 1992 to June 30, 1993 (the year prior to the effective date of Minnesota Statute chapter 62L).

   A. Number of Small Employer Groups as of June 30, 1993: _____

   B. Number of Certificate Holders (covered employees) as of June 30, 1993: _____

   C. Number of Covered Persons as of June 30, 1993: _____

   D. Total Gross Earned Premium for July 1, 1992 to December 31, 1992: _____

   E. Total Gross Earned Premium for Janaury 1, 1993 to June 30, 1993: _____

   F. Number of Small Employer Groups as of June 30, 1993, which were new sales between July 1, 1992 and June 30, 1993: _____

4. Please respond to the following about your Minnesota small employer business during the period July 1, 1993 to June 30, 1994 (the first year under the provisions of Minnesota Statute chapter 62L).

   A. Number of Small Employer Groups as of June 30, 1994: _____

   B. Number of Certificate Holders (covered employees) as of June 30, 1994: _____

   C. Number of Covered Persons as of June 30, 1994: _____

   D. Total Gross Earned Premium for July 1, 1993 to December 31, 1993: _____

   E. Total Gross Earned Premium for January 1, 1994 to June 30, 1994: _____

   F. Number of Small Employer Groups as of June 30, 1994, which were new sales between July 1, 1993 and June 30, 1994: _____

5. Please respond to the following about small employer groups covered through an association in existence prior to July 1, 1993, with respect to small employers that were members of the association as of that date. (Note that under 62L.02 subdivision 26, these groups are not considered part of the small employer market.)

   A. Number of Small Employer Groups as of June 30, 1993: _____

   B. Number of Small Employer Groups as of June 30, 1994: _____

Where any responses represent estimates, please indicate.

Attachment C: M&R Model

M&R's model starts with an experience base of Minnesota small employer health insurance at June 30, 1994. The experience base was developed from enrollment and rate level data collected from six of the largest Minnesota small employer health carriers, covering approximately 80% of the Minnesota small employer health insurance market. The following data was requested by the Department for a set of four employer size categories:

- Description of current rating methodology for insured small employer plans.
- Counts of insured small employer business by quarter of issue and by quarter of experience for 1991 through mid-1994.
- Sales of insured small employer business by quarter for 1991 through mid-1994.
- Lapses of insured small employer business by quarter for 1991 through mid-1994.
- Distributions of rate increases to insured small employers by quarter for 1991 through mid-1994, separately for the amount due to the rating bands.
- Distributions of group average rate variations due to the general premium variation, by quarter for mid-1993 through mid-1994, and separately for policies in their first policy year.
- Distributions of group average variations by level of age rate factor, by quarter for mid-1993 through mid-1994, and separately for policies in their first policy year.

The model divides the experience base of insured small employers into 1,080 cells in order to separately project the impact on each cell of phasing out the rate bands. The cells vary by number of employees, average age rating factor, and general rating factor. The model projects the rate changes, rate level, new business, lapsation and enrollment separately for each cell for each year until June 30, 1998. Each cell experiences rate increases or decreases due to the narrowing of the rate bands, and lapsation occurs that is correlated with the rate changes in the cell and the impact of premium subsidization among groups. In general, the groups lapsing from the market are lower cost groups which experience rate increases due to the rate bands. The lapsation thus results in an upward adjustment of the index rates to correspond to the change in average cost of the remaining total population in all cells. Upward adjustment of the index rates then results in additional lapsation.

For each year from mid-1993 through mid-1998 the model projects the following characteristics for the Minnesota small employer health insurance market: (1) average rate level in the market based on the changes in index rates, (2) the enrollment in the market based on the total of the enrollments in each cell, and (3) the distribution of rate changes (resulting from phasing out the rating bands) based on the rate change in each cell.

APPENDIX B

Small Employer
Health Insurance Survey

Minnesota Department of Commerce
133 East 7th Street
St. Paul, Minnesota 55101

Complete survey & return to the above address by **September 26, 1994**. If you have any questions, contact Dorothy Petersen (612) 296-8949. Response is required pursuant to Minnesota Statute section 45.027.

Name of Health Carrier: _____

Address of Health Carrier: _____

_____

Person Completing Survey: _____ Phone: _____

1. Please check whichever of the following applies:

   _____ A. Our company does not now and has not in the recent past (since July 1, 1992) participated in the "small employer market" as defined in Minnesota Statute section 62L.02 subdivision 27.

   _____ B. Our company has ceased (or has elected to cease, as provided under 62L.09) doing business in the Minnesota "small employer market" as of:
   (date)_____

   _____ C. Our company is currently participating in the "small employer market" as defined in Minnesota Statute section 62L.02 subdivision 27.

If the answer to Question 1 is "A", you need not complete the rest of the survey.

2. Does your company currently offer individual health plans (other than conversion plans) in Minnesota? _____

3. Please respond to the following about your Minnesota small employer business during the period July 1, 1992 to June 30, 1993 (the year prior to the effective date of Minnesota Statute chapter 62L).

   A. Number of Small Employer Groups as of June 30, 1993: _____

   B. Number of Certificate Holders (covered employees) as of June 30, 1993: _____

   C. Number of Covered Persons as of June 30, 1993: _____

   D. Total Gross Earned Premium for July 1, 1992 to December 31, 1992: _____

   E. Total Gross Earned Premium for Janaury 1, 1993 to June 30, 1993: _____

   F. Number of Small Employer Groups as of June 30, 1993, which were new sales between July 1, 1992 and June 30, 1993: _____

4. Please respond to the following about your Minnesota small employer business during the period July 1, 1993 to June 30, 1994 (the first year under the provisions of Minnesota Statute chapter 62L).

   A. Number of Small Employer Groups as of June 30, 1994: _____

   B. Number of Certificate Holders (covered employees) as of June 30, 1994: _____

   C. Number of Covered Persons as of June 30, 1994: _____

   D. Total Gross Earned Premium for July 1, 1993 to December 31, 1993: _____

   E. Total Gross Earned Premium for January 1, 1994 to June 30, 1994: _____

   F. Number of Small Employer Groups as of June 30, 1994, which were new sales between July 1, 1993 and June 30, 1994: _____

5. Please respond to the following about small employer groups covered through an association in existence prior to July 1, 1993, with respect to small employers that were members of the association as of that date. (Note that under 62L.02 subdivision 26, these groups are not considered part of the small employer market.)

   A. Number of Small Employer Groups as of June 30, 1993: _____

   B. Number of Small Employer Groups as of June 30, 1994: _____

Where any responses represent estimates, please indicate.

APPENDIX C

Association
Health Insurance Survey

Minnesota Department of Commerce
133 East 7th Street
St. Paul, Minnesota 55101
FAX: (612) 296-4328

Complete survey & return to the above address. Response is required by **December 9, 1994**. If you have any questions, contact Jan Matheson (612) 297-4995.

Name of Association: _____

Address of Association: _____

_____

Person Completing Survey: _____ Phone: _____

1. Please check whichever of the following applies:

   ___ A. Our Association does not currently provide health insurance coverage to Minnesota member employers.

   ___ B. Our Association currently provides health insurance coverage to Minnesota member employers.

   Health Carrier: _____

If the answer to Question 1 is "A", you need not complete the rest of the survey.

2. Please respond to the following about your members who are **Minnesota** employers and were members of your Association as of July 1, 1993.

   A. Total Number of Member Employers (MN): _____

   B. Number of Member Employers Employing 2 to 29 Employees (MN): _____

   C. Number of Member Employers Employing 30 to 49 Employees (MN): _____

3. Please respond to the following about **Minnesota** small employer groups covered through your Association with respect to those small employers that were members of your Association as of July 1, 1993. (Note that under 62L.02 subdivision 26, small employers are currently defined as those employers employing 2 to 29 employees.)

   A. Number of Small Employer Groups Covered as of June 30, 1994 (MN): _____

   B. Number of Covered Employees as of June 30, 1994 (MN): _____

   C. Number of Covered Persons as of June 30, 1994 (MN): _____

Where any responses represent estimates, please indicate.

APPENDIX D

September 12, 1994

Attention:

Re: Data Request
Small Employer Health Insurance Market

Dear:

Pursuant to Minnesota Chapter 549 (1992) Article 2, Section 24, the Minnesota Department of Commerce is conducting a study of the Minnesota small employer market.

As part of our study, we have retained the consulting firm of Milliman & Robertson, Inc. (M&R) to model the impact of further rate band reductions on Minnesota's small employer health insurance marketplace. This information will be essential to the formulation of the Department's recommendations. The model results will be included as a section of the Department's report to the legislature.

The model will be based on data collected from the largest Minnesota small employer health carriers. M&R has developed a template to collect the needed data. The enclosed diskette contains the data template in a Lotus 1-2-3 spreadsheet, saved in both Lotus Version 3 and Lotus Version 4. (A print-out of the template is also enclosed.) The template includes space for the following data to be entered:

- Counts of insured small employer business by quarter of issue and size categories by quarter for 1991 through mid-1994 (Page B of the template).

- Sales of insured small employer business by quarter for 1991 through mid-1994 (Page C of the template).

- Lapses of insured small employer business by quarter for 1991 through mid-1994 (Page C of the template).

- Distributions of rate increases to insured small employers in size categories by quarter for 1991 through mid-1994, separately for the amount due to the rating bands (Page D and E of the template).

September 12, 1994

Attention:

Re: Data Request
Small Employer Health Insurance Market

Dear:

Pursuant to Minnesota Chapter 549 (1992) Article 2, Section 24, the Minnesota Department of Commerce is conducting a study of the Minnesota small employer market.

As part of our study, we have retained the consulting firm of Milliman & Robertson, Inc. (M&R) to model the impact of further rate band reductions on Minnesota's small employer health insurance marketplace. This information will be essential to the formulation of the Department's recommendations. The model results will be included as a section of the Department's report to the legislature.

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- Distributions of rate increases to insured small employers in size categories by quarter for 1991 through mid-1994, separately for the amount due to the rating bands (Page D and E of the template).

- Distributions of rate increases to insured small employers in size categories by quarter for 1991 through mid-1994, separately for the amount due to the rating bands (Pages D and E of the template).

- Distributions of group average rate variations due to the health status rate band and to the age rate band, in size categories by quarter for mid-1993 through mid-1994, and separately for policies in their first policy year. Distributions are of number of employees, earned premiums, and incurred claims (Pages F, I, and J of the template).

- Earned premiums and incurred claims by quarter of issue and quarter of experience (Pages G and H of the template).

Please enter the needed data in the template and return the diskette to me by Tuesday, September 27, 1994. Also include, if applicable, a description of any expected changes in rating methodology for insured small employer plans, or any expected changes in marketing or administering these plans.

If you have any questions, please contact me at (612)296-8949. Also, I will contact you later this week to discuss the availability of the requested data.

Thank you for your help with this project.

Sincerely,

Dorothy G. Petersen, F.S.A.
Health Actuary
(612) 296-8949
DGP:jmb

- Distributions of rate increases to insured small employers in size categories by quarter for 1991 through mid-1994, separately for the amount due to the rating bands (Pages D and E of the template).

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Dorothy G. Petersen, F.S.A.
Health Actuary
(612) 296-8949
DGP:jmb

Client Code: 145MDC30
Worksheet Path: C:\CLIENTS\MDC30\TEMPLATE.WK4
Date: 09/12/94
Prepared by: Julia Philips

Description: Template for Small Group Rate and Enrollment Data

	Macro to Print:	Macro to Preview:
CTL-P>	:prsDOC~g	:prsDOC~pq
	:prsPAGEB~g	:prsPAGEB~pq
	:prsPAGEC~g	:prsPAGEC~pq
	:prsPAGED~g	:prsPAGED~pq
	:prsPAGEE~g	:prsPAGEE~pq
	:prsPAGEF~g	:prsPAGEF~pq
	:prsPAGEG~g	:prsPAGEG~pq
	:prsPAGEH~g	:prsPAGEH~pq
	:prsPAGEI~g	:prsPAGEI~pq
	:prsPAGEJ~g	:prsPAGEJ~pq

Insured Employees by Issue Quarter and Size of Group

Size 2-3

Issue Date		Calendar Date: January 1 1991	April 1 1991	July 1 1991	October 1 1991	January 1 1992	April 1 1992	July 1 1992	October 1 1992	January 1 1993	April 1 1993	July 1 1993	October 1 1993	January 1 1994	April 1 1994	July 1 1994
Prior to	1991															
Jan-Mar	1991															
Apr-Jun	1991															
Jul-Sep	1991															
Oct-Dec	1991															
Jan-Mar	1992															
Apr-Jun	1992															
Jul-Sep	1992															
Oct-Dec	1992															
Jan-Mar	1993															
Apr-Jun	1993															
Jul-Sep	1993															
Oct-Dec	1993															
Jan-Mar	1994															
Apr-Jun	1994															

Size 4-9

Issue Date		Calendar Date: January 1 1991	April 1 1991	July 1 1991	October 1 1991	January 1 1992	April 1 1992	July 1 1992	October 1 1992	January 1 1993	April 1 1993	July 1 1993	October 1 1993	January 1 1994	April 1 1994	July 1 1994
Prior to	1991															
Jan-Mar	1991															
Apr-Jun	1991															
Jul-Sep	1991															
Oct-Dec	1991															
Jan-Mar	1992															
Apr-Jun	1992															
Jul-Sep	1992															
Oct-Dec	1992															
Jan-Mar	1993															
Apr-Jun	1993															
Jul-Sep	1993															
Oct-Dec	1993															
Jan-Mar	1994															
Apr-Jun	1994															

Size 10-29

Issue Date		Calendar Date: January 1 1991	April 1 1991	July 1 1991	October 1 1991	January 1 1992	April 1 1992	July 1 1992	October 1 1992	January 1 1993	April 1 1993	July 1 1993	October 1 1993	January 1 1994	April 1 1994	July 1 1994
Prior to	1991															
Jan-Mar	1991															
Apr-Jun	1991															
Jul-Sep	1991															
Oct-Dec	1991															
Jan-Mar	1992															
Apr-Jun	1992															
Jul-Sep	1992															
Oct-Dec	1992															
Jan-Mar	1993															
Apr-Jun	1993															
Jul-Sep	1993															
Oct-Dec	1993															
Jan-Mar	1994															
Apr-Jun	1994															

Size 30-49

Issue Date		Calendar Date: January 1 1991	April 1 1991	July 1 1991	October 1 1991	January 1 1992	April 1 1992	July 1 1992	October 1 1992	January 1 1993	April 1 1993	July 1 1993	October 1 1993	January 1 1994	April 1 1994	July 1 1994
Prior to	1991															
Jan-Mar	1991															
Apr-Jun	1991															
Jul-Sep	1991															
Oct-Dec	1991															
Jan-Mar	1992															
Apr-Jun	1992															
Jul-Sep	1992															
Oct-Dec	1992															
Jan-Mar	1993															
Apr-Jun	1993															
Jul-Sep	1993															
Oct-Dec	1993															
Jan-Mar	1994															
Apr-Jun	1994															

Sales and Lapses by Size of Group

Size 2-3

Calendar Quarter		Sold Groups	Sold Employees	Lapsed Groups	Lapsed Employees
Jan-Mar	1991				
Apr-Jun	1991				
Jul-Sep	1991				
Oct-Dec	1991				
Jan-Mar	1992				
Apr-Jun	1992				
Jul-Sep	1992				
Oct-Dec	1992				
Jan-Mar	1993				
Apr-Jun	1993				
Jul-Sep	1993				
Oct-Dec	1993				
Jan-Mar	1994				
Apr-Jun	1994				

Size 4-9

Calendar Quarter		Sold Groups	Sold Employees	Lapsed Groups	Lapsed Employees
Jan-Mar	1991				
Apr-Jun	1991				
Jul-Sep	1991				
Oct-Dec	1991				
Jan-Mar	1992				
Apr-Jun	1992				
Jul-Sep	1992				
Oct-Dec	1992				
Jan-Mar	1993				
Apr-Jun	1993				
Jul-Sep	1993				
Oct-Dec	1993				
Jan-Mar	1994				
Apr-Jun	1994				

Size 10-29

Calendar Quarter		Sold Groups	Sold Employees	Lapsed Groups	Lapsed Employees
Jan-Mar	1991				
Apr-Jun	1991				
Jul-Sep	1991				
Oct-Dec	1991				
Jan-Mar	1992				
Apr-Jun	1992				
Jul-Sep	1992				
Oct-Dec	1992				
Jan-Mar	1993				
Apr-Jun	1993				
Jul-Sep	1993				
Oct-Dec	1993				
Jan-Mar	1994				
Apr-Jun	1994				

Size 30-49

Calendar Quarter		Sold Groups	Sold Employees	Lapsed Groups	Lapsed Employees
Jan-Mar	1991				
Apr-Jun	1991				
Jul-Sep	1991				
Oct-Dec	1991				
Jan-Mar	1992				
Apr-Jun	1992				
Jul-Sep	1992				
Oct-Dec	1992				
Jan-Mar	1993				
Apr-Jun	1993				
Jul-Sep	1993				
Oct-Dec	1993				
Jan-Mar	1994				
Apr-Jun	1994				

Annual Rate Change Distributions by Size of Group

Size 2-3

Annual Rate Change	Number of Employees by Calendar Quarter													
	Jan-Mar 1991	Apr-Jun 1991	Jul-Sep 1991	Oct-Dec 1991	Jan-Mar 1992	Apr-Jun 1992	Jul-Sep 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-Jun 1993	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
40.0% and more														
35.0 to 39.9%														
30.0 to 34.9%														
25.0 to 29.9%														
20.0 to 24.9%														
15.0 to 19.9%														
10.0 to 14.9%														
5.0 to 9.9%														
0.0 to 4.9%														
-5.0 to -0.1%														
-10.0 to -5.1%														
-15.0 to -10.1%														
-20.0 to -15.1%														
-25.0 to -20.1%														
Less than -25.0%														

Size 4-9

Annual Rate Change	Number of Employees by Calendar Quarter													
	Jan-Mar 1991	Apr-Jun 1991	Jul-Sep 1991	Oct-Dec 1991	Jan-Mar 1992	Apr-Jun 1992	Jul-Sep 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-Jun 1993	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
40.0% and more														
35.0 to 39.9%														
30.0 to 34.9%														
25.0 to 29.9%														
20.0 to 24.9%														
15.0 to 19.9%														
10.0 to 14.9%														
5.0 to 9.9%														
0.0 to 4.9%														
-5.0 to -0.1%														
-10.0 to -5.1%														
-15.0 to -10.1%														
-20.0 to -15.1%														
-25.0 to -20.1%														
Less than -25.0%														

Size 10-29

Annual Rate Change	Number of Employees by Calendar Quarter													
	Jan-Mar 1991	Apr-Jun 1991	Jul-Sep 1991	Oct-Dec 1991	Jan-Mar 1992	Apr-Jun 1992	Jul-Sep 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-Jun 1993	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
40.0% and more														
35.0 to 39.9%														
30.0 to 34.9%														
25.0 to 29.9%														
20.0 to 24.9%														
15.0 to 19.9%														
10.0 to 14.9%														
5.0 to 9.9%														
0.0 to 4.9%														
-5.0 to -0.1%														
-10.0 to -5.1%														
-15.0 to -10.1%														
-20.0 to -15.1%														
-25.0 to -20.1%														
Less than -25.0%														

Size 30-49

Annual Rate Change	Number of Employees by Calendar Quarter													
	Jan-Mar 1991	Apr-Jun 1991	Jul-Sep 1991	Oct-Dec 1991	Jan-Mar 1992	Apr-Jun 1992	Jul-Sep 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-Jun 1993	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
40.0% and more														
35.0 to 39.9%														
30.0 to 34.9%														
25.0 to 29.9%														
20.0 to 24.9%														
15.0 to 19.9%														
10.0 to 14.9%														
5.0 to 9.9%														
0.0 to 4.9%														
-5.0 to -0.1%														
-10.0 to -5.1%														
-15.0 to -10.1%														
-20.0 to -15.1%														
-25.0 to -20.1%														
Less than -25.0%														

Annual Rate Change Distributions
Due to Rating Bands by Size of Group

Size 2-3

Annual Rate Change	Number of Employees by Calendar Quarter			
	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
40.0% and more				
35.0 to 39.9%				
30.0 to 34.9%				
25.0 to 29.9%				
20.0 to 24.9%				
15.0 to 19.9%				
10.0 to 14.9%				
5.0 to 9.9%				
0.0 to 4.9%				
-5.0 to -0.1%				
-10.0 to -5.1%				
-15.0 to -10.1%				
-20.0 to -15.1%				
-25.0 to -20.1%				
Less than -25.0%				

Size 4-9

Annual Rate Change	Number of Employees by Calendar Quarter			
	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
40.0% and more				
35.0 to 39.9%				
30.0 to 34.9%				
25.0 to 29.9%				
20.0 to 24.9%				
15.0 to 19.9%				
10.0 to 14.9%				
5.0 to 9.9%				
0.0 to 4.9%				
-5.0 to -0.1%				
-10.0 to -5.1%				
-15.0 to -10.1%				
-20.0 to -15.1%				
-25.0 to -20.1%				
Less than -25.0%				

Size 10-29

Annual Rate Change	Number of Employees by Calendar Quarter			
	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
40.0% and more				
35.0 to 39.9%				
30.0 to 34.9%				
25.0 to 29.9%				
20.0 to 24.9%				
15.0 to 19.9%				
10.0 to 14.9%				
5.0 to 9.9%				
0.0 to 4.9%				
-5.0 to -0.1%				
-10.0 to -5.1%				
-15.0 to -10.1%				
-20.0 to -15.1%				
-25.0 to -20.1%				
Less than -25.0%				

Size 30-49

Annual Rate Change	Number of Employees by Calendar Quarter			
	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
40.0% and more				
35.0 to 39.9%				
30.0 to 34.9%				
25.0 to 29.9%				
20.0 to 24.9%				
15.0 to 19.9%				
10.0 to 14.9%				
5.0 to 9.9%				
0.0 to 4.9%				
-5.0 to -0.1%				
-10.0 to -5.1%				
-15.0 to -10.1%				
-20.0 to -15.1%				
-25.0 to -20.1%				
Less than -25.0%				

Rate Variance Distributions by Size of Group--Renewal

Rate Variance Distributions by Size of Group--New Business

Size 2-3

Rate Variance Relative to Index	Health Status: Number of Employees Renewing Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Age: Number of Employees Renewing Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Health Status: Number of Employees Sold Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Age: Number of Employees Sold Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
50.0% and more	NA	NA	NA	NA					NA	NA	NA	NA				
45.0 to 49.9%	NA	NA	NA	NA					NA	NA	NA	NA				
40.0 to 44.9%	NA	NA	NA	NA					NA	NA	NA	NA				
35.0 to 39.9%	NA	NA	NA	NA					NA	NA	NA	NA				
30.0 to 34.9%	NA	NA	NA	NA					NA	NA	NA	NA				
25.0 to 29.9%																
20.0 to 24.9%																
15.0 to 19.9%																
10.0 to 14.9%																
5.0 to 9.9%																
0.0 to 4.9%																
-5.0 to -0.1%																
-10.0 to -5.1%																
-15.0 to -10.1%																
-20.0 to -15.1%																
-25.0 to -20.1%																
-30.0 to -25.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-35.0 to -30.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-45.0 to -40.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-49.9 to -45.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-50.0% and less	NA	NA	NA	NA					NA	NA	NA	NA				

Size 4-9

Rate Variance Relative to Index	Health Status: Number of Employees Renewing Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Age: Number of Employees Renewing Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Health Status: Number of Employees Sold Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Age: Number of Employees Sold Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
50.0% and more	NA	NA	NA	NA					NA	NA	NA	NA				
45.0 to 49.9%	NA	NA	NA	NA					NA	NA	NA	NA				
40.0 to 44.9%	NA	NA	NA	NA					NA	NA	NA	NA				
35.0 to 39.9%	NA	NA	NA	NA					NA	NA	NA	NA				
30.0 to 34.9%	NA	NA	NA	NA					NA	NA	NA	NA				
25.0 to 29.9%																
20.0 to 24.9%																
15.0 to 19.9%																
10.0 to 14.9%																
5.0 to 9.9%																
0.0 to 4.9%																
-5.0 to -0.1%																
-10.0 to -5.1%																
-15.0 to -10.1%																
-20.0 to -15.1%																
-25.0 to -20.1%																
-30.0 to -25.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-35.0 to -30.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-45.0 to -40.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-49.9 to -45.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-50.0% and less	NA	NA	NA	NA					NA	NA	NA	NA				

Size 10-29

Rate Variance Relative to Index	Health Status: Number of Employees Renewing Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Age: Number of Employees Renewing Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Health Status: Number of Employees Sold Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Age: Number of Employees Sold Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
50.0% and more	NA	NA	NA	NA					NA	NA	NA	NA				
45.0 to 49.9%	NA	NA	NA	NA					NA	NA	NA	NA				
40.0 to 44.9%	NA	NA	NA	NA					NA	NA	NA	NA				
35.0 to 39.9%	NA	NA	NA	NA					NA	NA	NA	NA				
30.0 to 34.9%	NA	NA	NA	NA					NA	NA	NA	NA				
25.0 to 29.9%																
20.0 to 24.9%																
15.0 to 19.9%																
10.0 to 14.9%																
5.0 to 9.9%																
0.0 to 4.9%																
-5.0 to -0.1%																
-10.0 to -5.1%																
-15.0 to -10.1%																
-20.0 to -15.1%																
-25.0 to -20.1%																
-30.0 to -25.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-35.0 to -30.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-45.0 to -40.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-49.9 to -45.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-50.0% and less	NA	NA	NA	NA					NA	NA	NA	NA				

Size 30-49

	Health Status				Age				Health Status				Age			
	Number of Employees Renewing				Number of Employees Renewing				Number of Employees Sold				Number of Employees Sold			
Rate Variance	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun
Relative to Index	1993	1993	1994	1994	1993	1993	1994	1994	1993	1993	1994	1994	1993	1993	1994	1994
50.0% and more	NA	NA	NA	NA					NA	NA	NA	NA				
45.0 to 49.9%	NA	NA	NA	NA					NA	NA	NA	NA				
40.0 to 44.9%	NA	NA	NA	NA					NA	NA	NA	NA				
35.0 to 39.9%	NA	NA	NA	NA					NA	NA	NA	NA				
30.0 to 34.9%	NA	NA	NA	NA					NA	NA	NA	NA				
25.0 to 29.9%																
20.0 to 24.9%																
15.0 to 19.9%																
10.0 to 14.9%																
5.0 to 9.9%																
0.0 to 4.9%																
-5.0 to -0.1%																
-10.0 to -5.1%																
-15.0 to -10.1%																
-20.0 to -15.1%																
-25.0 to -20.1%																
-30.0 to -25.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-35.0 to -30.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-45.0 to -40.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-49.9 to -45.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-50.0% and less	NA	NA	NA	NA					NA	NA	NA	NA				

Earned Premiums by Issue Quarter and Size of Group

Size 2-3

Issue Quarter		Calendar Quarter Jan-Mar 1991	Apr-Jun 1991	Jul-Sep 1991	Oct-Dec 1991	Jan-Mar 1992	Apr-Jun 1992	Jul-Sep 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-Jun 1993	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
Prior to	1991														
Jan-Mar	1991														
Apr-Jun	1991														
Jul-Sep	1991														
Oct-Dec	1991														
Jan-Mar	1992														
Apr-Jun	1992														
Jul-Sep	1992														
Oct-Dec	1992														
Jan-Mar	1993														
Apr-Jun	1993														
Jul-Sep	1993														
Oct-Dec	1993														
Jan-Mar	1994														
Apr-Jun	1994														

Size 4-9

Issue Quarter		Calendar Quarter Jan-Mar 1991	Apr-Jun 1991	Jul-Sep 1991	Oct-Dec 1991	Jan-Mar 1992	Apr-Jun 1992	Jul-Sep 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-Jun 1993	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
Prior to	1991														
Jan-Mar	1991														
Apr-Jun	1991														
Jul-Sep	1991														
Oct-Dec	1991														
Jan-Mar	1992														
Apr-Jun	1992														
Jul-Sep	1992														
Oct-Dec	1992														
Jan-Mar	1993														
Apr-Jun	1993														
Jul-Sep	1993														
Oct-Dec	1993														
Jan-Mar	1994														
Apr-Jun	1994														

Size 10-29

Issue Quarter		Calendar Quarter Jan-Mar 1991	Apr-Jun 1991	Jul-Sep 1991	Oct-Dec 1991	Jan-Mar 1992	Apr-Jun 1992	Jul-Sep 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-Jun 1993	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
Prior to	1991														
Jan-Mar	1991														
Apr-Jun	1991														
Jul-Sep	1991														
Oct-Dec	1991														
Jan-Mar	1992														
Apr-Jun	1992														
Jul-Sep	1992														
Oct-Dec	1992														
Jan-Mar	1993														
Apr-Jun	1993														
Jul-Sep	1993														
Oct-Dec	1993														
Jan-Mar	1994														
Apr-Jun	1994														

Size 30-49

Issue Quarter		Calendar Quarter Jan-Mar 1991	Apr-Jun 1991	Jul-Sep 1991	Oct-Dec 1991	Jan-Mar 1992	Apr-Jun 1992	Jul-Sep 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-Jun 1993	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
Prior to	1991														
Jan-Mar	1991														
Apr-Jun	1991														
Jul-Sep	1991														
Oct-Dec	1991														
Jan-Mar	1992														
Apr-Jun	1992														
Jul-Sep	1992														
Oct-Dec	1992														
Jan-Mar	1993														
Apr-Jun	1993														
Jul-Sep	1993														
Oct-Dec	1993														
Jan-Mar	1994														
Apr-Jun	1994														

Incurred Claims by Issue Quarter and Size of Group

Size 2-3

Issue Quarter		Calendar Quarter													
		Jan-Mar 1991	Apr-Jun 1991	Jul-Sep 1991	Oct-Dec 1991	Jan-Mar 1992	Apr-Jun 1992	Jul-Sep 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-Jun 1993	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
Prior to	1991														
Jan-Mar	1991														
Apr-Jun	1991														
Jul-Sep	1991														
Oct-Dec	1991														
Jan-Mar	1992														
Apr-Jun	1992														
Jul-Sep	1992														
Oct-Dec	1992														
Jan-Mar	1993														
Apr-Jun	1993														
Jul-Sep	1993														
Oct-Dec	1993														
Jan-Mar	1994														
Apr-Jun	1994														

Size 4-9

Issue Quarter		Calendar Quarter													
		Jan-Mar 1991	Apr-Jun 1991	Jul-Sep 1991	Oct-Dec 1991	Jan-Mar 1992	Apr-Jun 1992	Jul-Sep 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-Jun 1993	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
Prior to	1991														
Jan-Mar	1991														
Apr-Jun	1991														
Jul-Sep	1991														
Oct-Dec	1991														
Jan-Mar	1992														
Apr-Jun	1992														
Jul-Sep	1992														
Oct-Dec	1992														
Jan-Mar	1993														
Apr-Jun	1993														
Jul-Sep	1993														
Oct-Dec	1993														
Jan-Mar	1994														
Apr-Jun	1994														

Size 10-29

Issue Quarter		Calendar Quarter													
		Jan-Mar 1991	Apr-Jun 1991	Jul-Sep 1991	Oct-Dec 1991	Jan-Mar 1992	Apr-Jun 1992	Jul-Sep 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-Jun 1993	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
Prior to	1991														
Jan-Mar	1991														
Apr-Jun	1991														
Jul-Sep	1991														
Oct-Dec	1991														
Jan-Mar	1992														
Apr-Jun	1992														
Jul-Sep	1992														
Oct-Dec	1992														
Jan-Mar	1993														
Apr-Jun	1993														
Jul-Sep	1993														
Oct-Dec	1993														
Jan-Mar	1994														
Apr-Jun	1994														

Size 30-49

Issue Quarter		Calendar Quarter													
		Jan-Mar 1991	Apr-Jun 1991	Jul-Sep 1991	Oct-Dec 1991	Jan-Mar 1992	Apr-Jun 1992	Jul-Sep 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-Jun 1993	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
Prior to	1991														
Jan-Mar	1991														
Apr-Jun	1991														
Jul-Sep	1991														
Oct-Dec	1991														
Jan-Mar	1992														
Apr-Jun	1992														
Jul-Sep	1992														
Oct-Dec	1992														
Jan-Mar	1993														
Apr-Jun	1993														
Jul-Sep	1993														
Oct-Dec	1993														
Jan-Mar	1994														
Apr-Jun	1994														

Rate Variance Distributions by Size of Group--Renewal

Rate Variance Distributions by Size of Group--New Business

Size 2-3

Rate Variance Relative to Index	Health Status Earned Premiums Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Age Earned Premiums Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Health Status Earned Premiums Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Age Earned Premiums Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
50.0% and more	NA	NA	NA	NA					NA	NA	NA	NA				
45.0 to 49.9%	NA	NA	NA	NA					NA	NA	NA	NA				
40.0 to 44.9%	NA	NA	NA	NA					NA	NA	NA	NA				
35.0 to 39.9%	NA	NA	NA	NA					NA	NA	NA	NA				
30.0 to 34.9%	NA	NA	NA	NA					NA	NA	NA	NA				
25.0 to 29.9%																
20.0 to 24.9%																
15.0 to 19.9%																
10.0 to 14.9%																
5.0 to 9.9%																
0.0 to 4.9%																
-5.0 to -0.1%																
-10.0 to -5.1%																
-15.0 to -10.1%																
-20.0 to -15.1%																
-25.0 to -20.1%																
-30.0 to -25.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-35.0 to -30.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-45.0 to -40.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-49.9 to -45.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-50.0% and less	NA	NA	NA	NA					NA	NA	NA	NA				

Size 4-9

Rate Variance Relative to Index	Health Status Earned Premiums Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Age Earned Premiums Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Health Status Earned Premiums Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Age Earned Premiums Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
50.0% and more	NA	NA	NA	NA					NA	NA	NA	NA				
45.0 to 49.9%	NA	NA	NA	NA					NA	NA	NA	NA				
40.0 to 44.9%	NA	NA	NA	NA					NA	NA	NA	NA				
35.0 to 39.9%	NA	NA	NA	NA					NA	NA	NA	NA				
30.0 to 34.9%	NA	NA	NA	NA					NA	NA	NA	NA				
25.0 to 29.9%																
20.0 to 24.9%																
15.0 to 19.9%																
10.0 to 14.9%																
5.0 to 9.9%																
0.0 to 4.9%																
-5.0 to -0.1%																
-10.0 to -5.1%																
-15.0 to -10.1%																
-20.0 to -15.1%																
-25.0 to -20.1%																
-30.0 to -25.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-35.0 to -30.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-45.0 to -40.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-49.9 to -45.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-50.0% and less	NA	NA	NA	NA					NA	NA	NA	NA				

Size 10-29

Rate Variance Relative to Index	Health Status Earned Premiums Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Age Earned Premiums Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Health Status Earned Premiums Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Age Earned Premiums Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
50.0% and more	NA	NA	NA	NA					NA	NA	NA	NA				
45.0 to 49.9%	NA	NA	NA	NA					NA	NA	NA	NA				
40.0 to 44.9%	NA	NA	NA	NA					NA	NA	NA	NA				
35.0 to 39.9%	NA	NA	NA	NA					NA	NA	NA	NA				
30.0 to 34.9%	NA	NA	NA	NA					NA	NA	NA	NA				
25.0 to 29.9%																
20.0 to 24.9%																
15.0 to 19.9%																
10.0 to 14.9%																
5.0 to 9.9%																
0.0 to 4.9%																
-5.0 to -0.1%																
-10.0 to -5.1%																
-15.0 to -10.1%																
-20.0 to -15.1%																
-25.0 to -20.1%																
-30.0 to -25.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-35.0 to -30.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-45.0 to -40.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-49.9 to -45.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-50.0% and less	NA	NA	NA	NA					NA	NA	NA	NA				

Size 30-49

	Health Status				Age				Health Status				Age			
	Earned Premiums				Earned Premiums				Earned Premiums				Earned Premiums			
Rate Variance Relative to Index	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
50.0% and more	NA	NA	NA	NA					NA	NA	NA	NA				
45.0 to 49.9%	NA	NA	NA	NA					NA	NA	NA	NA				
40.0 to 44.9%	NA	NA	NA	NA					NA	NA	NA	NA				
35.0 to 39.9%	NA	NA	NA	NA					NA	NA	NA	NA				
30.0 to 34.9%	NA	NA	NA	NA					NA	NA	NA	NA				
25.0 to 29.9%																
20.0 to 24.9%																
15.0 to 19.9%																
10.0 to 14.9%																
5.0 to 9.9%																
0.0 to 4.9%																
-5.0 to -0.1%																
-10.0 to -5.1%																
-15.0 to -10.1%																
-20.0 to -15.1%																
-25.0 to -20.1%																
-30.0 to -25.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-35.0 to -30.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-45.0 to -40.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-49.9 to -45.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-50.0% and less	NA	NA	NA	NA					NA	NA	NA	NA				

Rate Variance Distributions by Size of Group--Renewal

Rate Variance Distributions by Size of Group--New Business

Size 2-3

Rate Variance Relative to Index	Health Status Incurred Claims Jul-Sep 1993	Health Status Incurred Claims Oct-Dec 1993	Health Status Incurred Claims Jan-Mar 1994	Health Status Incurred Claims Apr-Jun 1994	Age Incurred Claims Jul-Sep 1993	Age Incurred Claims Oct-Dec 1993	Age Incurred Claims Jan-Mar 1994	Age Incurred Claims Apr-Jun 1994	Health Status Incurred Claims Jul-Sep 1993	Health Status Incurred Claims Oct-Dec 1993	Health Status Incurred Claims Jan-Mar 1994	Health Status Incurred Claims Apr-Jun 1994	Age Incurred Claims Jul-Sep 1993	Age Incurred Claims Oct-Dec 1993	Age Incurred Claims Jan-Mar 1994	Age Incurred Claims Apr-Jun 1994
50.0% and more	NA	NA	NA	NA					NA	NA	NA	NA				
45.0 to 49.9%	NA	NA	NA	NA					NA	NA	NA	NA				
40.0 to 44.9%	NA	NA	NA	NA					NA	NA	NA	NA				
35.0 to 39.9%	NA	NA	NA	NA					NA	NA	NA	NA				
30.0 to 34.9%	NA	NA	NA	NA					NA	NA	NA	NA				
25.0 to 29.9%																
20.0 to 24.9%																
15.0 to 19.9%																
10.0 to 14.9%																
5.0 to 9.9%																
0.0 to 4.9%																
-5.0 to -0.1%																
-10.0 to -5.1%																
-15.0 to -10.1%																
-20.0 to -15.1%																
-25.0 to -20.1%																
-30.0 to -25.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-35.0 to -30.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-45.0 to -40.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-49.9 to -45.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-50.0% and less	NA	NA	NA	NA					NA	NA	NA	NA				

Size 4-9

Rate Variance Relative to Index	Health Status Incurred Claims Jul-Sep 1993	Health Status Incurred Claims Oct-Dec 1993	Health Status Incurred Claims Jan-Mar 1994	Health Status Incurred Claims Apr-Jun 1994	Age Incurred Claims Jul-Sep 1993	Age Incurred Claims Oct-Dec 1993	Age Incurred Claims Jan-Mar 1994	Age Incurred Claims Apr-Jun 1994	Health Status Incurred Claims Jul-Sep 1993	Health Status Incurred Claims Oct-Dec 1993	Health Status Incurred Claims Jan-Mar 1994	Health Status Incurred Claims Apr-Jun 1994	Age Incurred Claims Jul-Sep 1993	Age Incurred Claims Oct-Dec 1993	Age Incurred Claims Jan-Mar 1994	Age Incurred Claims Apr-Jun 1994
50.0% and more	NA	NA	NA	NA					NA	NA	NA	NA				
45.0 to 49.9%	NA	NA	NA	NA					NA	NA	NA	NA				
40.0 to 44.9%	NA	NA	NA	NA					NA	NA	NA	NA				
35.0 to 39.9%	NA	NA	NA	NA					NA	NA	NA	NA				
30.0 to 34.9%	NA	NA	NA	NA					NA	NA	NA	NA				
25.0 to 29.9%																
20.0 to 24.9%																
15.0 to 19.9%																
10.0 to 14.9%																
5.0 to 9.9%																
0.0 to 4.9%																
-5.0 to -0.1%																
-10.0 to -5.1%																
-15.0 to -10.1%																
-20.0 to -15.1%																
-25.0 to -20.1%																
-30.0 to -25.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-35.0 to -30.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-45.0 to -40.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-49.9 to -45.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-50.0% and less	NA	NA	NA	NA					NA	NA	NA	NA				

Size 10-29

Rate Variance Relative to Index	Health Status Incurred Claims Jul-Sep 1993	Health Status Incurred Claims Oct-Dec 1993	Health Status Incurred Claims Jan-Mar 1994	Health Status Incurred Claims Apr-Jun 1994	Age Incurred Claims Jul-Sep 1993	Age Incurred Claims Oct-Dec 1993	Age Incurred Claims Jan-Mar 1994	Age Incurred Claims Apr-Jun 1994	Health Status Incurred Claims Jul-Sep 1993	Health Status Incurred Claims Oct-Dec 1993	Health Status Incurred Claims Jan-Mar 1994	Health Status Incurred Claims Apr-Jun 1994	Age Incurred Claims Jul-Sep 1993	Age Incurred Claims Oct-Dec 1993	Age Incurred Claims Jan-Mar 1994	Age Incurred Claims Apr-Jun 1994
50.0% and more	NA	NA	NA	NA					NA	NA	NA	NA				
45.0 to 49.9%	NA	NA	NA	NA					NA	NA	NA	NA				
40.0 to 44.9%	NA	NA	NA	NA					NA	NA	NA	NA				
35.0 to 39.9%	NA	NA	NA	NA					NA	NA	NA	NA				
30.0 to 34.9%	NA	NA	NA	NA					NA	NA	NA	NA				
25.0 to 29.9%																
20.0 to 24.9%																
15.0 to 19.9%																
10.0 to 14.9%																
5.0 to 9.9%																
0.0 to 4.9%																
-5.0 to -0.1%																
-10.0 to -5.1%																
-15.0 to -10.1%																
-20.0 to -15.1%																
-25.0 to -20.1%																
-30.0 to -25.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-35.0 to -30.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-45.0 to -40.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-49.9 to -45.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-50.0% and less	NA	NA	NA	NA					NA	NA	NA	NA				

Size 30-49

Rate Variance Relative to Index	Health Status Incurred Claims Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Age Incurred Claims Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Health Status Incurred Claims Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994	Age Incurred Claims Jul-Sep 1993	Oct-Dec 1993	Jan-Mar 1994	Apr-Jun 1994
50.0% and more	NA	NA	NA	NA					NA	NA	NA	NA				
45.0 to 49.9%	NA	NA	NA	NA					NA	NA	NA	NA				
40.0 to 44.9%	NA	NA	NA	NA					NA	NA	NA	NA				
35.0 to 39.9%	NA	NA	NA	NA					NA	NA	NA	NA				
30.0 to 34.9%	NA	NA	NA	NA					NA	NA	NA	NA				
25.0 to 29.9%																
20.0 to 24.9%																
15.0 to 19.9%																
10.0 to 14.9%																
5.0 to 9.9%																
0.0 to 4.9%																
-5.0 to -0.1%																
-10.0 to -5.1%																
-15.0 to -10.1%																
-20.0 to -15.1%																
-25.0 to -20.1%																
-30.0 to -25.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-35.0 to -30.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-45.0 to -40.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-49.9 to -45.1%	NA	NA	NA	NA					NA	NA	NA	NA				
-50.0% and less	NA	NA	NA	NA					NA	NA	NA	NA				