RECORD, Volume 24, No. 2*

Maui II Spring Meeting
June 22–24, 1998

Session 23IF
Underwriting and Rating in a Guaranteed Issue Market

Track: Health
Key words: Health Insurance Portability and Accountability Act

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The Health Insurance Portability and Accountability Act (HIPAA) has forced insurers to market their small group plans on a guaranteed issue basis, as well as certain individual plans to qualified individuals. Panelists discuss the strategies various insurers have taken in response to the HIPAA requirements.

Mr. Robert R. McGee: I'm from CONSECO Services, and joining me on the panel are Scott Geske from UniCARE, Jim Wynstra from Star Marketing Administration, and our recorder, Jim Hinds, from CONSECO Services. I want to stress that this is an interactive forum which means there should be lots of audience discussion. We've tried to structure it so that there would be plenty of opportunity for you all to be involved, and we're certainly counting on it.

We're going to start this session by just going over the environment a little, and then get into the approaches that we've used for underwriting and rating and hope to hear what some of you are doing. We will also then be going to what type of experience has been coming out and what's on the horizon. I thought we could start with a couple quotations just to frame the issue a little bit. The first one is from a March 1998 Health Care Financing Administration (HCFA) bulletin: "In addition to the practices discussed in this bulletin, we have been notified that some issuers may be offering coverage to HIPAA-protected individuals at rates well in excess of the general industry maximum in place before HIPAA of 200% of standard risk. In fact, reports indicate premium rates as high as 500-600% of standard risk. This

practice of establishing rates to exclude HIPAA-protected persons is known as rating up. We have been advised that issuers may be intentionally offering coverage at unaffordable rates in order to avoid providing coverage to HIPAA-eligible individuals and small groups while appearing to comply with guaranteed availability provisions of HIPAA. We are continuing to gather information about this problem." That's the risk-rating side.

The next quote is from the *ASOP No. 12* "Concerning Risk Classification:" "Consistent with the risk classification statement of principles, there are three primary purposes of risk classification: (1) to be fair; (2) to permit economic incentives to operate and thereby encourage widespread availability of coverage; and (3) to protect the soundness of the financial security system. In order to achieve these purposes certain basic principles should be present in any sound risk classification system. The system should reflect cost and experience differences on the basis of relevant risk characteristics. The system should be applied objectively and consistently. The system should be practical, cost-effective, and responsive to change. The system should minimize antiselection. Both the design and the use of risk classification systems require the actuary to exercise professional judgment as well as to use statistical tools."

A little more on this from the same *ASOP:* "Effect of Antiselection." Antiselection may result from the design of the classification system, or may be the result of externally mandated constraints on risk classification. Classes that are overly broad may produce unexpected changes in the distribution of risk characteristics. For example, if an insurer chooses not to screen for a specific risk characteristic, or a jurisdiction precludes screening for that characteristic, this may result in individuals with the characteristic applying for coverage in greater numbers and/or amounts, leading to increased overall costs. When antiselection has occurred or is likely to occur, its actual or potential effect should be disclosed to the client, and appropriate measures taken or recommended to minimize
the impact." Statute/Regulation/Adjudication: "The actuary may be constrained by a statute, a regulation, or a court decision from applying certain elements of a risk classification system. The actuary should comply with such constraints, disclose their impact to the client, and take or recommend appropriate action to minimize their impact." Finally, there are Industry Practices: "The actuary should be aware of usual and customary risk classification practices for the type of financial security system under consideration. Effects of departing from those practices should be disclosed to the client." That's the environment that we're talking about, this guaranteed issue where we are looking between risk spreading and risk classification. Jim Wynstra will tell us about the small-group arena and Scott Geske will talk about the individual marketplace.

Mr. James A. Wynstra: I'm going to talk briefly about HIPAA requirements, rating restrictions, and the major concerns with HIPAA. Guaranteed issue was already enacted with a lot of small group reform that started in the early to mid-1990s. Many of the small-group forums just required basic and standard plans to be guaranteed issue, so a lot of states already had guaranteed issue before HIPAA, which was enacted in July 1997. Some states actually had guaranteed issue for all plans such as Florida and Texas, so when HIPAA was enacted there were almost no changes in terms of guaranteed issue. So, we've had guaranteed issue for a long time. The major change now is that all plans and options are guaranteed issue for small groups.

In North Carolina, and this was before HIPAA, we tried an experiment that didn't work for us. We thought, it's guaranteed issue for the basic and standard, so we might be stuck with some groups that are guaranteed issue regardless. Why not give them the option to have any of our plans, so that way we don't have to deal with the administrative hassles of basic and standard? We got hit hard by that because the basic and standard plans, even the guaranteed issue, weren't attractive to many. They weren't nice and neat. There was a stigma. It was something about being put into basic and standard categories, limiting the companies' choices, which made them search for other companies where they might be able to get a normal standard plan of a company. We ended up attracting a lot of bad business because of that, so this idea of all plans and options being guaranteed issue definitely has increased the amount of quotes that we got for all our plans, particularly groups that would be loaded to the maximum.

Another addition of HIPAA was limiting exclusions for pre-existing conditions. That really didn't add much to the environment. That was already in existence. The major difference was that maternity was now excluded as a pre-existing condition, so that was a change. HIPAA also prohibits discrimination against employees or dependents based on health status. Again, a lot of small-group reform already enacted that, and you had to take whole groups. You couldn't exclude people. Guaranteed renewability was already in force in states before HIPAA. An administration hassle that isn't emphasized in our discussion today is the certificates of creditable coverage. The purpose of certificates of creditable coverage was to provide proof for pre-existing conditions and to provide proof that you have guaranteed issue for the individual environment. The individual requirement required that you had some group insurance prior to individual, so a lot of administration was already being done before the certificates of creditable coverage, so that really didn't add anything other than an administrative headache. The special enrollees had the right to enroll on a timely basis. This is a very interesting part of the law where people might not have elected to have coverage, but then

when they got married or their family status changed, they could elect coverage, so it added some flexibility for individuals that they did not have before.

Now I'm going to talk a little bit about rating restrictions. A guaranteed issue is useless without rating restrictions. In Illinois they actually revoked their small-group reform and got rid of rating restrictions when HIPAA came in. They were concerned about the cost of guaranteed issue, but, in essence, if you can rate up 1,000%, or 500%, is that really guaranteed issue? Without rating restrictions, guaranteed issue really doesn't mean anything. It just means that you have to put out a quote. I want to talk briefly about the rating restriction environment. There are some states that still have not really enacted any kind of rate restrictions. Michigan and Pennsylvania don't have any rate restrictions. Illinois used to, but with HIPAA it doesn't. I'm going from least restrictive to most restrictive.

The next level is the NAIC model law, and that's basically where you have plus or minus 25% of your rate manual. You have quite a bit of flexibility and different case characteristics. Some states might limit how much you can load for Standard Industry Classification (SIC) codes and other things like that, but overall the basic formula is that you have plus or minus 25% within a class of business. You're allowed different classes of business on top of that. You might have association business. You might have your normal business through your internal sales and so forth. You're allowed a range of 20%. The highest class can only be 20% higher than the lowest class. That's the basic NAIC model law.

Modified community rating. You're allowed to have different rates based on different case characteristics, but once you have your rate manual set up, you're not allowed to vary at all from that manual. Florida and New Jersey are examples.

Full community rating. You can't vary from your rate manual, but on top of that you can't really vary based on age, so you're very restricted. New York is the only example I can think of with that. I have five states that are in the no-rate-restriction area; 33 have some sort of an NAIC model law. There are 12 states that have modified community rating, and one state has full community rating. So there are four nice, neat packages, but there's still variance within that.

I just want to talk about the major concerns with HIPAA. The first three are really intertwined, but I just wanted to separate them out. First, there's a concern of gaming. With guaranteed issue, groups might buy options or purchase future plans on an as-needed basis, knowing that it's guaranteed issue, so they buy insurance on an as-needed basis. I'm predicting somewhere in the area of 1-3% increase as the cost of guarantee issue. That's just a rough estimate. When HIPAA became enacted we started keeping track of our quotes that were loaded to the maximum and quotes

for which we couldn't really get the full amount that we needed. The underwriters estimate that ended up being about 2-3% of our premium, so it's significant. They might be conservative in their estimate. We haven't checked on the claims to actually see whether those claims, indeed, came about, but we're just basing it on what our underwriters originally thought we would lose on groups-which is somewhere in the neighborhood of 2-3%.

Antiselection. In the past, some options were not available to the smallest groups. Now HIPAA requires that available options must be accessible to all sized groups, so you just have more antiselection available now with HIPAA. The last one is the certificate of creditable coverage, and probably the least of concern. It's mostly an administrative headache, but it doesn't add a lot to the cost. I guess that's it for the environment on small group.

Mr. Scott A. Geske: Compared with the small-group side, HIPAA requires guaranteed issue of a much smaller segment of the individual marketplace. It also allows for more state discretion in meeting these requirements. Specifically, those who meet certain minimum requirements are deemed to be federally eligible, and those who are federally eligible can receive health insurance on the guaranteed-issue basis. In order to be federally eligible you must have had 18 months of prior coverage, the last day of which is in group coverage, and you cannot have more than a 62-day lapse in prior coverage. You must not be eligible for group coverage, government plans, and other health coverage. The individual cannot have lost his or her most recent coverage because of nonpayment of premium or fraud. And, if available, the individual must have elected and exhausted COBRA.

The state mechanism to meet HIPAA must contain these elements. Eligible individuals are to be provided a choice of health insurance. The choice of coverage must include at least one policy form of coverage that is comparable to comprehensive health insurance offered in the individual marketplace. The mechanisms cannot impose any pre-existing conditions. HIPAA allows for three alternatives—these are state alternatives—other than the federal fallback position. One is the adoption of two model acts. There is either the Availability Act as it pertains to individuals or the Portability Act. Another option is for the state to implement a qualified high-risk pool where a qualified pool provides health insurance without pre-existing conditions. The third option is more generic. As long as the state provides for either a risk adjustment, risk spreading, or some sort of a financial subsidization of eligible individuals, this option has been filled with pure guaranteed issue in the marketplace. In the absence of these three options, HIPAA provides for a federal fallback position, and that allows for the carrier to offer two of their most popular plans or two representative plans with benefits that are plus or minus 15% of the average benefit in the marketplace.

Mr. McGee: I'm going to talk briefly about the process of maintaining updated information. When HIPAA first came on the scene, it was a major event for all of us. It spawned myriads of committees and work groups. Probably all of us were involved with company-wide committees, with representatives from all over, putting together answers to questions ranging from details about how to administer creditable coverage requirements, to strategy issues about what states to be in or what states to exit. In our company it certainly required lots of grids, looking at each of the states, reviewing their rating restrictions, and seeing how our own production and profitability stacked up in the states. It's incumbent on us to make sure that these are kept up to date. We need to coordinate with our compliance or legislative areas to make sure that we know what's going on in the states, to be up to date with any changes, and certainly to keep abreast of what's going on with the underwriting decisions and results. I think the real importance of underwriting in a guaranteed issue environment is to be able to understand the underlying risk characteristics of the block of business and use that to make informed decisions.

We're going to move now to more of the nitty-gritty of how we have been handling underwriting and rating in this environment, and what approaches we've used. What we'll do is start with Scott and have each of the panelists talk a little about some of the approaches that we've used at our companies. We would then like to open it up for some more audience participation and discuss the approaches that you're using, particularly if it's an approach that none of us have already mentioned.

Mr. Geske: My company's reaction really deals with how the state reacted to HIPAA. If their approach to HIPAA compliance has been one where it's going to be guaranteed issue of the entire marketplace, we're not playing and haven't entered any of those states. It's been business as usual with the high-risk pool. We're not going to do anything in those states. The company reaction had to deal with the states that had the federal fallback position where we have to guarantee issue either two of our most popular plans or two representative plans versus guaranteed issue of all the plans that we offer

The first reaction was to do a rate-up for the HIPAA loads. We selected a percentage rate-up. It's high enough so we don't get a disproportionate share of HIPAA, but it's low enough so that I can justify it. I have had states come back and ask about our HIPAA load. So, that was an important consideration. I think one of the things we could have probably done is instead of having a percentage rate-up, we could have just used a flat dollar amount if someone is unhealthy. There shouldn't have been much of an age slope at all, but we didn't go down that route. With a product mix, if you have to offer two of your most popular plans and you have the richest benefits in the marketplace, there's a chance that you're going to

attract a disproportionate number of HIPAA eligibles. Our products are perhaps a little less rich than the marketplace.

On the underwriting side we have been trying to put HIPAA eligibles as much as possible in the standard classes. We are taking underwriting information and are reserving the HIPAA load for ones that are truly uninsurable. On the marketing side, one of the things we plan on doing is tracking agents' loss experience. My experience with doing something like this is once you have agents' experience you're left with nothing but a random number generator, but at least it has a sentry effect. The agent knows that we're watching his or her experience and is careful not only with HIPAA-eligible insureds but also all the other risk that he or she is sending. The agent's going to be doing his or her field underwriting better. He or she knows that someone at the home office has his or her experience. Another consideration could be commission levels where, although you're not paying commissions, if you have a couple 100% load you don't have a couple 100% load also on your commissions.

Mr. Wynstra: In terms of the underwriting area and HIPAA, we just started keeping track of more information. We try to estimate the cost of groups that were maxed out or rated at the highest possible rate. We used to not track that information, but with the extra quoting that was going on we just wanted to keep track of that and keep tabs on the cost. In addition, we just had so many more applications of unhealthy groups that it was really quite a burden for the underwriting area, so we started doing a lot more trial applications to give quick estimates of what we think a rate-up for a group should be; consequently, we have a lot more trial applications instead of having them going through all the individual underwriting.

You had to have all options available that you offer to all groups, I know there are several companies dealing with maternity. Do we offer maternity or just include it in all the quotes? Our strategy was to continue with the options and to have different options available because it's better to price it that way. If you have the right to base rates on whether somebody has maternity versus nonmaternity, we felt it was still actuarially sound to continue with that. If you ended up taking away the option of maternity and just force it on everybody, you'd just end up having a lot more people with maternity and without maternity, so that cost would go up for you by not having that option. We stuck with continuing with all options available, and maternity was probably the major issue there. There might have been some other ones, but maternity was definitely the major issue.

I think we also had it priced differently based on the size of the group for those options because the cost of antiselection is definitely involved. With those options

available now the cost is more, especially for the smaller groups, so you have the price of the antiselection. I think those are some of the main things.

Mr. McGee: On our side, on the individual marketplace with the underwriting, we have built into the application six questions to determine if someone is HIPAA eligible, much like the ones that Scott went over before. If the person is HIPAA eligible, we perform standard underwriting, and we basically give the insured a choice. If the person qualified for a standard plan or a rated-up plan, we would give that and we would also provide the option, explaining here are the HIPAA-eligible plans, without pre-existing coverage, whether it's the one of the two most popular plans or if there's a high-risk pool in that state. We give that back and have the insured choose which of those to take. In case the person is declined, we would just offer the HIPAA-eligible plan.

We chose originally to put more of a weight on the risk classification approach. We put in a full rate-up based on the condition for a HIPAA-eligible person, and we also have an additional load for no pre-existing. The risk spreading that we chose to do was to agree to pool the HIPAA eligibles along with the standard block of business for future experience adjustments. Not all the states approved this approach, and, for several, we agreed to cap the rate-ups. We spread the risk by loading the base rates to everyone in that state. Given what we've seen with HCFA and the current mood, we are moving toward capping the HIPAA-eligible rate-ups now in all states. When we first put in HIPAA, we did make some across-the-board adjustments for the guaranteed renewable, particularly age 65 and beyond. So we did do some adjustments for that as well.

In terms of commission we generally pay a somewhat lower commission scale to recognize the higher premium that's usually charged. Going back to the HCFA report, it does say that some carriers are paying no commissions and that there are occurrences of carriers who are unreasonably delaying application processing so that the 63-day break in coverage gets exceeded. On the small-group side we looked state by state and determined what loads we felt were necessary based on the combination of the guaranteed issue and the rating restrictions of each state. The loads ranged from 0% to 20% based on the standard industrial classification range, the allowable rate-ups, the age/gender restrictions, and size loads. On the maternity issue, where HIPAA requires that you provide the same coverage to all groups, since you pretty much have to offer maternity coverage to groups of 15 or more lives, you basically have to offer it down to the two-life and, in some states, one-life groups. We also, as Jim did, chose to leave it as optional coverage for the under-14 life groups. We also, in states that allow rating by size, do charge more for the smaller groups because of the greater risk of antiselection. In states that don't allow size, we raised the maternity load scale.

Our general strategy is to maximize the allowable rate-ups and to use all the allowable case characteristic rating factors to the fullest extent in the states. We took a close look at production and profitability in the legislative environment and the rating restrictions in each of the states to determine the marketing priorities that we were setting for the states and the states we were choosing to exit. That's a summary of what we've been doing. I'd like to get some thoughts from the audience on some of their practices and approaches.

Ms. Joan P. Ogden: I just finished a study of the effects of small employer health-care reform and guaranteed issuance in Utah because we adopted forms of small employer health-care reform essentially for 1996, and in contrast to the costs or expected percentage costs that were identified there, I can tell you that our per-member-per-month claim costs varied somewhat in terms of amount of increase based on the amount of underwriting that a given carrier was using. The low was about 22%, and the high was 37% for a 2-year time period. Pre-existing condition waiting period credit was worth about 4.6 percentage points in a group with about 9% turnover. The increase in the number of people covered under the small group environment was 20.5%. The increase in the number of people covered in the individual market was 14.5%. So, it had a significant effect on availability and cost.

Mr. Bruce A. Carlson: I have a comment and a question on the concept of actively at work as it applies to the small-group environment. HIPAA, as you know, says nothing about actively at work, but you have Section 7702 nondiscrimination requirements that affect HIPAA. Many people have said you can no longer do actively at work, but if you read the requirements, and if you look at your definition of actively at work, I'm not convinced of that position. I think if you apply the concept of actively at work for dependents, it's quite clear that the definition of actively at work for dependents is not hospital-confined, which is a health-status-related condition. Therefore, you cannot apply the actively at work. For employees, it's less clear because a person can not be actively at work for reasons other than health status. There are vacations, leaves of absence, and so forth. We've taken a more aggressive approach with the members in that you still can apply actively at work provided you have complied with the nondiscrimination requirements. My question is, what's your position or the position of anybody else in the audience as it applies to HIPAA and actively at work?

Mr. Wynstra: It'd be quite a hassle not to accept those people. You have to do it without any discrimination. If you didn't accept people who were on vacation or whatever, we didn't think that'd be acceptable to the marketplace, so I think we just stuck with the interpretation of HIPAA that we couldn't do that. I don't think we

thought it was a big cost element. I don't know if you have anything to add on the cost or an estimate of the cost of getting rid of that, but that has been our approach.

Mr. McGee: I think we took a similar approach. The only thing is that on the underwriting we do rate-up for known disabilities and COBRA. If there's anyone on COBRA, they get a rate-up in determining the group rate-up.

From the Floor: We don't have any experience that I can quote or point to quantitatively, but I think there are a lot of applications here, particularly in the HMO world where they're opening themselves up to antiselection. If an HMO doesn't do pre-existing, and they accept all eight entrants, what's to stop, in the small-group world, the president from hiring a spouse dying of cancer and in need of a transplant as a night security guard, or secretary, until the transplant is over? If you apply that to dependents, you can't turn them down, and you can't apply pre-existing. You're really opening yourself up for some huge catastrophic claims and game playing.

Ms. Ogden: As a follow-up to that, how many companies are requiring medical information about individuals who choose to waive coverage? Under the life-event scenario, you can virtually have a life event at any time and come on as a late applicant without the requirements that normally fall with late applicants. Are you getting that information on waivers?

Mr. Wynstra: I think we are, but I can't remember to what extent and what circumstances, but I know we are getting more information. That was an issue.

Mr. McGee: I'm not sure that we are at this time. I don't believe so.

Mr. Michael D. Bahr: We do get all that information. The brokers don't like it because they have to round up more forms. One of the things we ran into and were able to get the legislature to change slightly was the groups that were able to move at will off anniversary. Under HIPAA, there was nothing to tie them into a plan. Our argument was that insurance is the employer making a decision for a period of time. We were able to get the legislature to pass a surcharge of 25% on top of the annual premium for a group if they moved off anniversary. That alleviated a little bit of that going from PPOs to HMOs, where we felt like we were getting antiselected against. We would have liked to have seen it over about a three-year period, but the brokers fought that one.

Mr. Steven P. Clay: Since the beginning of HIPAA, we've seen our small-group claims costs go up 9-12% a year. In the individual market we've had a real struggle with brokers who have taken the attitude that with all the reform that's going on we

don't need to answer these medical questions anymore. We've actually had to take a very hard stance and send applications back. If there's one box left unchecked, it's incomplete, and we send it back. I wanted to ask a question. We're seeing or we're hearing reports in the marketplace that with small group there are carriers out there that are rating either the lowest rate possible, or the highest rate possible, with no in-between. How does that fit with people's thinking as far as risk classification being fair and appropriate?

Mr. Geske: In terms of that last question we do rate between, but I don't know how many carriers are doing that. It still makes sense for us to rate between and rate-up when there's just minor health statuses. So, we don't go to that extreme, but I have heard of that. I've also heard the intermediate step where maybe they have a preferred rate, leave in rate-up to 20%, and leave it in after that rate-up, but there's a jump from preferred to some other level. It might not be the top but some other level. That's another option that carriers have taken.

Mr. McGee: We push for the new business rates, at the lowest level within the state, and we'll underwrite for the allowable limits within the state for the small group. What that means, though, is that with renewals the new business rate is always the lowest rate and there's no room to move on renewal rates. You can't move below that rate.

That was actually a good lead-in. We did want to talk about what we've seen to date. If we look back at when HIPAA first came out, there were a lot of different estimates going around. On the individual side there were reports that the rates would be going up from 2% to 5%, maybe to 15-22%, or as high as 30%. Generally, within those estimates, it was recognized that if there were rating restrictions on the individual side that would put that state's increases into the higher end of that range. There's also quite a wide range of variety or just a wide range in the estimates of what percentage of HIPAA eligibles would be applying. Again, I think most of what I saw ranged from minimal to 15% or so based on the estimate of what the HIPAA eligible would be. Most of the estimates used between 100% and 200% additional cost of standard in putting together the cost estimates.

On the small-group side, there was also a pretty wide range. I saw one estimate of anywhere from 5% to 35% based on the size of the group. Another was 15-20% type increases expected resulting from HIPAA. The panelists will now talk a little about what they're seeing at their companies in terms of experience to date. What type of post-HIPAA versus pre-HIPAA costs are we seeing? Jim, do you want to start this one?

Mr. Wynstra: These groups are loaded to the maximum, and we realize that that maximum still is not going to pay for all the claims we anticipate, so, again, that's about
1-2% of our premium. Other than that, we have not done anything drastic in terms of changing our rates. I think we're much more careful with underwriting and information gathering and making sure that we're rating up when we need to, which may be taking a little bit more discretion away from the underwriters. But I'm not seeing the 10–30% change in rate that some people may have experienced. You just have to be more careful with the sales force, too, because there's a lot more quoting of the unhealthy groups going on, and we've had some salespeople make up ID cards on a group behind our back, so it just seems like there's more room for bad sales activity, and so far, experience has gotten a little worse in terms of the quotes that we get at the upper level, the maximum rate-up.

Mr. Geske: On the individual side, we do not ask if the person is HIPAA eligible on the application, so I'm not sure if we're capturing everyone who is HIPAA eligible in the underwriting process. Those people that we have identified, have been about 2-3% of our applications. By not capturing up front, it has made the underwriting process fairly lengthy. In a typical situation, we'll get an application in, and unknown to us it's HIPAA eligible. We'll either decline or issue/counterissue with waivers. They come back saying, "Oh, you can't do that because it's HIPAA eligible." We look at it again and say, "OK, you're getting a HIPAA rate." And they say, "Well, can we go back to what you had before with the waiver?" My company has held that once they're HIPAA eligible, they're HIPAA eligible at the HIPAA rate. It's something that you can't waive away. I'd like to get some feedback if that's consistent among other carriers.

Out of the 2-3%, 1% or so declined our coverages, presumably to go with another carrier. We were able to issue some at standard rates, and we have about half of 1% at our HIPAA rate. My reaction when I heard that number was that we've spent that much time on that little bit of business. I think I figured out it was five hours of meetings for every person we have. Is there an actuary in the audience who's associated with the state risk plan?

Ms. Ogden: Utah has had a high-risk pool since 1991, but with the advent of HIPAA the high-risk pool accepts no group-covered individuals, only individual-covered individuals, since all group must be covered in the group environment. So, the advent of HIPAA has only removed people from that pool.

Mr. Wynstra: I want to add something more about experience. Of the pre-HIPAA states Florida changed to modified community rating with guaranteed issue for all plans, and Texas also had guaranteed issue for all plans, but they had the NAIC

model law. In Florida with the modified community rating, we definitely saw experience deteriorate quickly, within one or two years, and we lost quite a bit of money in that state. Texas, when it became guaranteed issue for all plans, had the rate flexibility, and, again, that was several years ago, so we did not see the same deterioration as we did in Florida. I really think the rate restrictions sometimes outweigh the guaranteed issue, and I would be more scared if a state suddenly changed their rating restrictions than if they added guaranteed issue. It's really the combination of both, but in Texas I don't think I saw the deterioration that we saw in Florida, and that happened a couple years before HIPAA came in.

Mr. McGee: In our company we are, as Jim said, seeing a lot more rate-ups, for small group which I think is just what we'd expect with more applying under the guaranteed issue and our underwriters being more careful on the underwriting process. There is a little bit of evidence of a potential adverse HIPAA effect. We basically looked at the last six months of 1997 versus the first six months of 1997. The experience was about 2% worse after adjusting for seasonality. We haven't really gone in fully to see if that can be attributed to HIPAA, and that would basically be on top of all the loads that we have already built in. I think that it reflects, that with the rating restrictions and the guaranteed issue environment that we need to watch carefully because even if it's 2%, that's a good chunk of the profit margin right there.

On the individual side what we found is that for the HIPAA eligibles the average rate-up, the full underwriting rate-up would be 330%, and that's 330% of standard. So, we're seeing considerably worse rate-up than the 100-200% that was estimated earlier. But in terms of the number of HIPAA eligibles that take coverage for us, it's well under 5%. I think in terms of the block of business it's probably about 0.5%. There's another report from the General Accounting Office on HIPAA implementation. Essentially, they boiled it down to saying the insurer's health plan, marketing practices, and segregated risk pools negatively affected the access in premiums for eligible individuals. It was interesting to hear Utah's experience on the access. As Jim mentioned before, there is a sizable cost of the administration for the certification of creditable coverage data.

Also, they mention that for the states using the two most popular plan approaches there are concerns that insurers are overreacting on the premiums that are being quoted; similar to the HCFA quote from the beginning of the session. I haven't seen anything on the high-risk pool states talking about that type of a concern. For those of you in the audience, what is your experience looking at high-risk pool states compared to the two most popular plan states? How is that running? Do you have any other pre-HIPAA versus post-HIPAA thoughts or experience? Are the

assumptions playing out as you would expect them to? I'd like to open that up to some discussion.

Ms. Ogden: I have a question in a related but slightly different area. If an individual coming off his or her COBRA or state extension of benefits chooses to take conversion and gives up HIPAA rights of transfer to the individual market, are carriers putting language in their group contract with regard to conversion that warns the person that if he or she chooses conversion, that person has given up his or her HIPAA portability rights?

Mr. McGee: I understand the question. I'm not sure that we have.

Mr. Wynstra: I'm not sure either.

Mr. Geske: I don't think so.

Ms. Valerie Ann Lendt: I'm with World Insurance Company. As a small company, we issue a couple hundred policies a week. We have, since January, issued about 10 HIPAA cases, and they range from AIDS cases to fairly healthy individuals, except for one person. The only healthy people we've gotten have been people whose family members haven't been, so they've taken the whole coverage. I don't think we've been overreacting on our rates. I wonder if anybody has been experiencing anything similar to this. We had a circumstance in South Dakota in which a company cancelled the insurance. It might have been like the NRACA type thing, and we had a lot of cases come through there until we exceeded our cap and were able to stop issuing in South Dakota. We had one case in Arizona where the group cancelled their coverage, and we got two of the people, one of whom was AIDS and one whose condition was also very severe, who was the sister of the owner or something like that. Have other people seen a lot of cancellation of group coverage and a subsequent hit like that?

Mr. McGee: Any responses from the audience on that question? Jim and I are not aware of any major effects like that.

Mr. Frank A. Boeckmann, Jr.: When we look at the HIPAA cases we see that they range anywhere from the very small group size, 2-3 lives, up to 50 lives, and we see that the way groups react and like to be treated is vastly different and at opposite ends of the spectrum. Do you treat all group sizes the same or do you segment the HIPAA cases into, say, small groups, mid-size groups, or larger HIPAA cases and treat them differently in either underwriting or rating, for example. Or, have you seen any experience differences by size of case in that subsegmentation of HIPAA?

Mr. Wynstra: We do different underwriting in the sense that a large claim for a small group is a whole lot different from a large claim for a larger group of 50. Other than that, it's the same individual underwriting, only that you have to spread it across differently for different-sized groups. In terms of size, so far I don't know if we have enough credible information, but it seems as if we have a relatively flat loss ratio by size.

Mr. McGee: Yes. Our company tends to focus on the smaller end of the market, and we really don't have segmentation by size and experience or practices.

Mr. Bahr: We do split it out, although we underwrite them the same way. We do it more for tracking purposes. One of the issues we face is we have a slightly better benefit in the market as a whole. It was the direction our HMO wanted to go. We do have, on the groups of two to six a substantially worse experience than the groups of 15 to 50. We seem to have more antiselection in that category, and we're addressing how to fix the product so we don't have that. That's how it worked in our market.

Ms. Martha M. Spenny: I have a different individual question. It has to do with old blocks of truly guaranteed renewable major medical coverage that were guaranteed renewable to age 65. They were level premium products to age 65. It seems other companies have some of these old blocks as well. Now that they're no longer guaranteed renewable to age 65 (except for life), they're obviously underpriced. If, in fact, they renew beyond age 65, and if they're underpriced, then they're probably underreserved as well in the additional reserve column. What are other people doing with those blocks of business? I know that we ran a test, and it looked as if we would be tripling our active life reserve on those blocks if we didn't do any rating action.

Mr. Geske: You have to actively market in that subpool.

From the Floor: I don't have any rights in the contract to do anything beyond age 65 because the contract says that it terminates at age 65. So, I suppose at that point that we could take that kind of rate action, although there's nothing in the contract that says it terminates at age 65.

Mr. Geske: Is there something in the contract that says that they have to be issued on the issue-age basis?

From the Floor: Yes, the contract says that the premium is based on issue age.

Mr. Geske: That might be a problem.

From the Floor: We would have to increase the premiums on all in order to increase the premium.

From the Floor: I would file an amendment to my contract to change to an attained-age basis beyond age 65

From the Floor: I've seen companies do that.

From the Floor: You've seen that.

Mr. McGee: Yes. I think that's an approach we took. On an older block I think we did that as well, but there was an amendment related to that, and I believe it switched it to an attained age. I don't remember exactly, but I believe so.

Mr. David William Dickstein: Most companies probably use some type of a point system to evaluate their applications on new groups to assign a certain number of points to the conditions as they come in, and of most of the ones I have seen, the worst cases have a maximum point value, whether it be 200 or 500. It would seem that under HIPAA that that system should be modified, and you ought to allow those points to float, however relatively bad that condition is. Then, you could use your point system to help you determine in those states (there are about 33 states that are using the model law that have a reinsurance pool) whether or not you want to send that individual or that group to the reinsurance pool. My question is, has anybody gone back and modified their point system for post-HIPAA to acknowledge that? My second question concerns maternity below size 15. What are people doing about that? Are they eliminating maternity? Are they leaving it optional? Are they forcing it to be on? Are they rating it up? What's happening with maternity? What are people doing in the marketplace on that?

Mr. Wynstra: How many are eliminating maternity as an option?

Mr. McGee: No one is admitting it here. I have heard of at least one company that has mandated maternity on all policies. Is there anybody else doing that?

From the Floor: I think the point needs to be made that any coverage that is available to a bigger group has to be available to a smaller group, and since maternity is mandatory in bigger groups, you cannot eliminate the choice of maternity for small groups.

From the Floor: That's not true.

Mr. Wynstra: You can just include it, but it has to be there. You don't have the option of not including it.

From the Floor: You can include it, but you cannot eliminate coverage.

Mr. Wynstra: Yes.

Mr. McGee: Right.

Mr. Wynstra: That's correct.

Mr. McGee: If it's eliminated, it's a company that is strictly small group that doesn't market above 15 lives. I'm inferring, from no one raising their hands, that most companies do continue to offer it as an optional coverage, and I know that at least for our company we do build in extra cost for that. We do vary that by size so that we charge more for the optional maternity for the smaller groups in states that allow it. For states that don't allow variation by size, we adjusted the maternity slope.

The other issue was the underwriting points. I think that in our company we are looking at that. We are tending—particularly if on the small group—not to use the capping that is in some of the manuals and to get the full amount. As you say, we also use it to determine reinsurance pool submissions.

Mr. Wynstra: I guess we haven't changed our underwriting in response to using a risk pool, but we have been modifying it just to make it more accurate, and we've been working with the medical director. I guess I could make a statement in terms of our risk pool experience. It seems as if we don't make money on that. We end up putting too many people in that risk pool and paying more premium than we get out of it. I guess that just tells me you have to really work with the larger claim groups, so we're not making any fine-tuned underwriting changes to put people on the edge. I think you have to put the groups that are really bad in those risk pools because the premium is so large.

Mr. McGee: Any other comments on experience to date? Is there anything about the high-risk pool states versus others?

Ms. Ogden: Given the provision under HIPAA that a woman's not pregnant until the day she's got coverage and given that the folks at HCFA that I talked with could not believe that anyone would pick up coverage just to cover the delivery and then drop it after the delivery, I think it is incumbent on all carriers to carefully track the maternity costs brought to us by HIPAA. Then, we can accurately report that to

HCFA and give them documented numerical feedback because it might encourage them to listen to the experts next time.

Mr. McGee: I agree. That's an excellent point, and I think that instead of rate-ups being the industry answer to not taking HIPAA individuals, I think we need to appropriately educate that the premiums go with the risk and how that works. As actuaries, I think it's important for us to explain whenever possible that there's a risk taken, and there's a premium for those risks. It doesn't necessarily mean that the transplant person has to be charged $200,000, but that we need to appropriately point out that the greater the risk, the greater the premium.

I guess we'll move on to what's on the horizon. What future fine tuning will we have to do in this guaranteed issue environment? Scott will take the individual side and then Jim will discuss the small-group side.

Mr. Geske: On the individual side, in reaction to the GAO report and the HCFA bulletin, Senator Edward Kennedy (D-MA) introduced a bill that would limit the amount of rate-up to 150%. It doesn't appear to be going anywhere this year, but that's certainly a consideration in future years. With respect to state responses, I've had some questions from one state with respect to the HIPAA rates and I've been asked for justification of the rate-up. It's pretty easy to justify the rate if you're just going to assume that the people being rated up have claims and point out that we try to put people into a standard class, and are truly uninsurable people. Second, I looked at published rate tables in guaranteed issue environments. Fortunately, those were all higher than HIPAA-rate tables. It makes sense when you look at states that have enacted guaranteed issue. What happened to their rate tables? This is for the general marketplace.

Mr. Wynstra: On the federal side we have the Patient Access to Responsible Care Act (PARCA). The original bill was going to combine guaranteed issue with community rating. Again, I don't think that's going to go anywhere at the moment, but it's being introduced, so I know HCFA has been concerned about HIPAA and seen the rate-ups. They're concerned about rating now also, so rating in the future is going to continue being a possible issue. Also on the state side I've seen different bills. I can't remember which state has this, but getting more involved on the provider side for utilization review. I think it might have been Colorado, but they added something where you need to have a Colorado physician working for you who actually gets involved with your decisions, so that's going to be costly if states get involved with that. I think there are two areas that will probably continue to become bigger issues. One is the rating side, and I don't know how involved the federal government will get with that. The other is the managed care side, which could open more lawsuits in the future against companies who may determine that

something's not medically necessary. We might become more liable, in that case, so that would be an additional cost.

Mr. McGee: In terms of future strategies, we need to continue the work that we started when HIPAA came in to review the assumptions that we used. Did we overreact or is the experience showing that it is even worse than we had imagined? I think certainly it's incumbent on us as actuaries to understand the underlying risk, and, as we heard today, we need to be able to explain—whether it's the government or senior management-what's going on and why we're doing the risk classification we're doing.