RECORD, Volume 26, No. 3*

Chicago Annual Meeting
October 15-18, 2000

Session 145PD
Regulatory Update for Health Insurance Company Actuaries

Track: Health

Moderator: WILLIAM F. BLUHM
Panelists: LISA K. JOHNSON†
THOMAS F. WILDSMITH
TOM WILDER‡
Recorder: WILLIAM F. BLUHM

Summary: Regulatory changes in the health field are part of the normal course of business. However, recently there has been a great deal of change as new regulations have been introduced in several areas.

Mr. William F. Bluhm: We have three speakers. Tom Wilder is with the AAA. Tom has been the director of public policy since 1998. Before that he was director of government and public affairs for the Kansas Department of Insurance. Tom has undergraduate degrees in political science and sociology from the University of Kansas, and a law degree from Washburn University Law School. After graduating law school, Tom worked as a lobbyist and attorney with the Kansas League of Savings Institutions and practiced law for ten years with law firms in Washington and Topeka, Kansas.

The second person speaking is Lisa Johnson. Lisa is with Milliman & Robertson in Minneapolis. She is a compliance specialist. She has a degree from Moorhead State University, and is an active member in the Life and Health Compliance Association. She has 12 years of insurance industry experience, specializes in contract and policy drafting and design, regulatory filing, and research for life annuity and health products.

Lastly, Tom Wildsmith will be speaking. One of the purposes for this session is for those of you who have been active in this area to see side-by-side Tom Wilder and Tom Wildsmith. Both are very good at what they do and once you've seen them in action, they're easy to tell apart.

†Ms. Johnson, not a member of the sponsoring organizations, is Compliance Specialist at Milliman & Robertson, Inc. in Minneapolis, MN.

‡Mr. Wilder, not a member of the sponsoring organizations, is Director of Public Policy at the American Academy of Actuaries in Washington, D.C.

Tom Wildsmith is a policy research actuary with the Health Insurance Association of America (HIAA) located in Washington, D.C. His duties include analyzing legislative and regulatory proposals for their potential impact on the insurance industry; estimating cost impact of proposals; representing HIAA on professional actuarial work groups; overseeing studies performed by outside contractors for HIAA; and providing staff support to several association committees. He's been there since 1995. Before that, he was in the actuarial department of Provident Life and Accident in Chattanooga, and was with Provident for about 12.5 years and did pricing, product development, reserving, and group medical and disability. Tom's an FSA, MAAA, and is a CLU chartered financial consultant and a fellow of the Life Management Institute. Tom is a member of the Academy's Federal Health Committee and the Society's Health Benefits Systems Practice Advancement Committee, is Past Chairman of the Society's Health Section Council, and has served on a number of Academy Work Groups.

Mr. Tom Wilder: I'd like to give a 35,000-foot view of health care in this country and where I think it's going, and then hopefully set the stage for Lisa who will discuss some specific state issues, and Tom Wildsmith who will talk about some federal issues. One caveat, I am speaking for myself and not on behalf of the AAA.

My global view will focus on three kinds of broad topics. One is demographic and economic change. The second are some changes in the market, and the third is where I think the legislative and legal environment is going. As far as the demographic changes, and I think you're all very familiar with this in your practices, we have an aging population in this country. Health-care costs are increasing and there are a growing number of uninsured.

As far as the growth of the elderly in this country; today we have 34 million in the U.S. who are considered to be elderly. That's 65 years of age or older. In 2025, that's expected to be 62 million. If you look at the number of people who are 85 years of age or older, what I hear some actuaries and policy makers call the "old old" today, there are 4 million and by 2025 there's expected to 7 million. These figures are significant if you look at the percentages of the elderly compared to the total population.

Today, roughly 12.4% of our population is 65 years or older, and by 2025 we're expected to have 18.4%. This is important because the elderly cost more in terms of consumption of health-care dollars than younger Americans. A study on estimates of annual expenditures per senior was done by Families USA. Their figures show that today on average, senior Americans consume a little over $12,000 per year in health-care expenditures. By 2010, that's expected to go up to $21,000.

The cost figures are significant because there are very important questions about who's going to pay for this segment of the population. Data from the Kaiser Family Foundation looks at retiree health coverage over the past decade by large employers. I must confess I'm not sure what they consider to be a large employer, whether that's 100 employees or more or if there's some other figure. However, the data shows that the number of large employers who are covering retiree

benefits is dropping, and I think you're going to see that trend continue. In addition, we're going to see pressures on Medicare. Medicare disbursements are going to continue to consume an increasing percentage of our gross domestic product.

The other trend is the growing number of uninsured in this country. The U.S. Census Bureau indicates that in 1989 roughly 13.6% of the country or 34.7 million Americans were not covered. By 1998 that figure had gone up to 16.3%. In fact, it's even more significant if you pull out certain segments of the population. For example, in 1989, 19.2% of African Americans or 5.8 million individuals were not covered. By 1998 that figure had risen to 22.2% of the population or 7.7 million.

I know the latest census figures show that the number of uninsured has dropped to 15.5%; 2.6 million Americans are uninsured, and those numbers are trending upward. The percentage of Americans who are covered by Medicaid, which is the primary safety net for the uninsured, has been dropping, in part, because people have gone off the welfare roles. They have gone off of Medicaid and have not found coverage in the private market because they are primarily working for small employers or at service jobs where they just don't have the coverage.

There is a legitimate debate about the definition of an uninsured individual. There's a legitimate debate about whether or not those individuals are between jobs, and whether or not the counts are correct. But whether the figure of uninsured is 35 million or 44 million, the big picture is there is a big chunk of our population that does not have coverage through some third-party payer, either the government or private insurance. As you know, the fact that they're not covered, doesn't mean that they don't get health care, it just means that they get health care and those costs show up somewhere else. We're going to have to figure a way to deal with those costs.

In terms of those demographic or economic trends, we're getting older in this country, it's going to cost more to provide health care, particularly for that older segment, and we're seeing pressure on government and employee coverage because of those trends.

In terms of market changes, we are seeing increasing financial services consolidation. We are seeing globalization of financial services and some interesting changes because of the Internet. *Business Week* showed the biggest financial services deals as of mid-September 2000. In fact, at this time First Star has agreed to acquire US Bancorp. It's about an $18.9 billion deal. From your own businesses, you see the numbers of mergers and consolidations and the entry of non-U.S. insurers into our market and the interest in U.S. insurers in doing business overseas.

I have noticed during actuarial meetings, in the last couple of years, when people get up to ask questions and they state their employer, a lot of people say, "I'm John Smith and I work for XYZ Insurance Company, which used to be ABC Insurance Company, and before that it was something else." This shows that there is a lot of consolidation and globalization of the market. The other change is the

Internet. Online brokerage services offer their services to small employers. They try to hook up small employers with insurance brokerages to help them find health coverage.

One of their other services is to provide online tools that small businesses can use to compare coverages between insurers. I also saw an interesting article the other day in *National Underwriter* about a brokerage firm that is actually the e-bay of health insurance. They are getting small employers together with health and dental insurers in that business, so I think another trend that you're going to see is kind of the increasing impact of the Internet on the health business. To sum up the market changes, more consolidation, more globalization, and more innovation through the Internet and other means on how health care and health coverage is provided.

Finally, I want to talk about the legislative and legal changes in a global view including federal legislation and its impact on some state regulation and also some international changes. Let me talk about Medicare reform and patient protection. Despite all of the wailing and gnashing of teeth by political candidates, nothing is going to happen in 2000. Congress really wants to hurry home so they can campaign for reelection. But I think you will see these issues back again in 2001. There is a lot of public interest in these issues, and that's what Congress is reacting to for better or for worse. In 2001 I think you will see a pretty serious effort to pass prescription drug coverage legislation for seniors. You'll probably see less serious, but some discussion about patient protection and the right to sue your health plan.

The big change to me is Gramm-Leach-Bliley, which was passed in fall 1999. It allows more affiliations between banks, insurance companies and financial services and securities firms. I have heard talk that this really isn't a big change. Congress is recognizing what is going on in the market and if you look at, for example, bank and insurance affiliations, not much is going on right now. I would suggest to you that that is going to become an increasing trend.

There will be an impact on state regulation because Gramm-Leach-Bliley establishes these new financial holding companies. As of June 2000, there were 329 financial holding companies licensed, and they can offer insurance. They can own an insurance company and a bank. We're going to have what's called functional regulation. The insurance regulators on the state level will regulate the insurance operations and the feds will regulate the bank operations which is nice in theory, but nobody really knows what that means. If you look at some of the federal regulators such as the comptroller of the currency, and at state regulators, they have a pretty wide difference of opinion about what is insurance and what is not. There will be some interesting discussions about how that all shakes out.

The National Association of Insurance Commissioners (NAIC), in response to Gramm-Leach-Bliley, has created some commissioner-level task forces to deal with these issues. For the NAIC , these have been put on a fast track. Those of you that have dealt with the NAIC know that it does nothing quickly. It has gotten these groups up and running and coming up with some pretty interesting

developments in the space of about eight or nine months, which for it is light speed.

One of the task forces is dealing with what it calls national treatment of insurers. What they are considering is a framework by which an insurance company that is licensed in one state will be able to automatically be licensed in all states, provided that they meet certain risk-based capital and financial and balance sheet tests. Some insurers say big deal we're already licensed in those states, but I think there are health insurers and others who may be state or regional companies that are going to consider this once it gets up and running.

The other thing they're looking at is a speed to market for insurance products. They are putting together a framework called the Coordinated Advertising Rate and Form Review Board (CARFRA). Again, the idea is that there would be a super-national regulatory body that a company could go to and get approval for advertising, rates, or forms. Once approved, you would be able to sell your products or use your advertising in all the states that belong to this group. There are a lot of details that still remain to be worked out. There are still some serious discussions about where to start: do we start with life products or is health insurance included or excluded, or what to do with property and casualty products? However, they have decided to start this in the first quarter of 2001. The plan is to start with 10 states, including New York, so it's moving along. They're looking at national licensing for agents.

Two task forces are working out the details on how to cooperate with federal regulators. If you have an insurance company that's owned by a financial holding company, how much regulation will the Comptroller or the Federal Reserve Board do? What functions will they leave to the insurance commissioners? If there's a solvency question, what information will the bank regulators get from the state insurance regulators? The other significant thing that they've just passed, and I know Tom will talk a little bit about this, is some model privacy regulations.

My gut feeling on where this is going is that I think the NAIC has a window of opportunity of 5–10 years to get their house in order and to bring more rationality to state regulation of insurance. If they don't do so, and my cynicism leads me to believe that they will not do so, there will eventually be federal charters for insurance companies. I think health insurers will be included. I think there was a meeting in fall 1999, in the U.S., which was attended by some European union and financial services trade representatives. One of the questions they put to the U.S. trade representatives was about the way the European union is going; if we're licensed in one country and can sell in one country, we can sell in all European Union countries. It is confusing to us why if we're licensed in one state in the U.S., we're not licensed in all the other states. We've got to jump through all those hoops, and that's a very reasonable question.

Finally, we're seeing a lot more international activity. There are various international accounting and actuarial standards groups that are starting to consider issues relating to insurance and accounting regulation. You are probably familiar with the discussion about fair value accounting. The International

Accounting Standards Committee is considering some guidelines for fair value accounting. The International Association of Insurance Supervisors is getting a lot more active. The Institute of Actuaries is involved with these groups. Of course, there are European Union issues. They have passed a pretty significant privacy compact that will affect U.S. companies that want to do business in the European Union on how they handle internal consumer records.

There is a joint forum of various international supervisory organizations. The Basal Committee of Bank Supervisors (BCBS) is working on a template for financial reporting by banks, insurance companies, and securities firms. The idea is at some point down the road you would have this kind of common reporting format that insurance companies and others would use to report their financials to the public. There is a multi-disciplinary working group on enhanced disclosure to the regulators.

To sum up in a broad sense of what's going on in health care, costs are going to go up, which will put increasing pressure on payers to try to control those costs. I think that's going to also put pressure on payers to drop coverage. I think you're going to see a lot of consolidation and globalization in the market. Eventually, you will see a lesser emphasis on state regulation of insurance and more federal and international regulation of health care and health coverage.

Ms. Lisa K. Johnson: Where Tom brought you to a 35,000-foot level, I'm going to take you down just a few thousand feet, probably closer to 10,000-12,000. I'm going to talk about two health-care related issues and they really dovetail quite nicely into what Tom talked about with where the aging population is going and where focus is on the two issues that are long-term care (LTC) and mental health parity. We'll talk about some of the recent changes associated with those two issues as well as how those changes may impact you and your company. The first is LTC. We'll do a quick overview, talk about some of the recent changes, and then discuss what are the next steps for both the states and the companies.

At this meeting, I think there were 10-15 LTC sessions. You may have heard that the NAIC adopted a recent or revised model in August 2000, which is focused on rate adequacy and customer disclosure. The impetus to that is really two fold from what I understand. There is a need, the regulators believe, for consumers to fully understand what LTC insurance is, what it covers, and to provide assurance that the product will remain affordable once the individuals get to the point in their lives where they'll actually use the insurance.

What that translates to for carriers is pricing. What does that mean? How will we change things? Realize there were four major issues from these NAIC mandated changes: pricing requirements, actuarial certification and memorandum, consumer disclosure, and commissioner recourse.

As you're aware, the existing LTC model as it is written, has a loss ratio requirement of at least 60%. Under the new law or the new LTC model there is no specific loss ratio requirement for your initial filing, which is, I think, very different thinking for a lot of people. With rate increases, it's 58% for initial lifetime

premiums with a limit of 85% on the increased portion of the premium. The mandate does allow that if you have, for example, a state that has additional mandates related to LTC, the commissioner may approve a larger than 15% increase, but the chances of that again, are up to the commissioner to approve.

Pricing is the second change relating to the actuarial certification and memorandum. The actuarial certification is something that's a little bit new. In initial filings, you will not provide an actuarial memo. The law as written today does say the commissioner may ask for it if they deem it appropriate, but in the initial filing, you would just do an actuarial certification. The certification is also needed for a rate increase as well as an actuarial memorandum.

The next change deals with consumer disclosure. The LTC personal worksheet was something that existed with the original LTC model laws. It did add additional information on rates. It would like to see revised rating information included in that disclosure for the consumer's worksheet.

The potential rate increase disclosure form is new. It is a pretty lengthy form that also requires rate history information. Both of these forms will need your input into the development and publication for consumers.

The final change relates to commissioner recourse. Once you submit an increase and you receive approval, you will be required to submit an actual-to-expected experience comparison for three years. This will be submitted to each of the states that you're doing business in that you've received the approval. The commissioners vary depending on the state review or approval authority. This gives the commissioners something that they didn't have in the past, an opportunity to look at your book of business before you submit your next rate increase. As a result of that review, there are four general categories of administrative action that they may ask you to comply with, from the very low end of reducing your premium to actually prohibiting you from marketing for five years. They're very serious about making sure employers are in compliance with their mandates.

What are the next steps? The first would be adoption by the states. What states will adopt is hard to say, and if they do adopt it, how would it actually be implemented? If you've been on the receiving end of some information relating to a filing that you've submitted, you sometimes get the response that it's a departmental position, and there is nothing written relating to what you're trying to get approved. The same thing could happen with this regulation. It's possible that the law says that you don't have to submit an actuarial memo on your initial filing. The person actually doing the review of your forms may not be comfortable with the new law, may not understand it, and may ask for a lot more information than you would see from someone from another state. It's really up in the air as to how we will actually have to respond to the individual insurance departments. When do the regulations apply? It is written in the model that the effective date is six months after the adoption.

The second issue relates to mental health parity. I'll provide you with a quick overview of mental health parities I've seen on recent surveys from the General

Accounting Office on the impact on companies, and then a summary. I'll break it down into two parts: the Mental Health Parity Act and some of the actual items that are related to that Act, and a summary of what states have adopted and where they are in the spectrum of exceeding or are not even close to what the federal law mandates.

As you know, the Mental Health Parity Act was effective January 1, 1998. It is scheduled to sunset on September 30, 2001, which most likely won't happen. I believe there are a couple of bills already that would continue this particular legislation. As it was written, the original Mental Health Parity Act tried to bring parity between medical, surgical, and mental health. One of the things that it did was require annual lifetime dollar caps. A loophole in the law was that it allowed different inside benefit limits so you could vary your office visits for mental health versus medical. Additionally, this law only applied to employers with 51 or more employees, and had a 1% cost exemption rule. If you had the information to support the fact that implementing or complying with this new law would increase your cost more than 1%, you could be exempted from the rule.

Also, the law doesn't preclude strong state legislation and does not mandate mental health benefits. I'll provide some definitions as they relate to the categories, and then talk about compliance from both the employer and state's standpoints.

The states are all over the place. As of March 2000, most of the states were generally moving toward full parity or were at full parity, exceeding federal law. One thing I do want to point out is that as you're looking at individual states, even though they may have full parity, the things that they cover will differ. The types of mental illness or drugs that they cover will change.

I only will talk a little bit about compliance. Seven states have not passed any mental health act. Actually, as of October 2000, I think there were three additional states that passed some form of that legislation. They are California, New Mexico, and Oregon. It ranged from exceeding to just barely meeting the mandates. The General Accounting Office (GAO) conducted a survey from November 1999 through February 2000 and they found that of most employers responding to the survey were in compliance with the mandates. A separate study by the Department of Labor (DOL) found that there were 12% not in compliance. What it found was that when an employer was not in compliance their major reason for not being in compliance was their lifetime limits were lower for mental health as opposed to medical and surgical benefits.

Next I'd like to talk about what this model has done for companies. How has this impacted them? I'll talk a little bit about plan design as well as cost. Table 1 shows data from a GAO study on how companies or employers have changed the limits they offer in their plan from 1996 to 1999. There was a pretty significant change in what they cover for limits in hospital. They don't limit office visits. This ties to what the GAO survey found in that the majority of the people who responded to this survey found the first designs in their plans contain one or more design features that were more limiting for their mental health versus their medical benefits. Those restrictions were within the visit limits and hospital stays.

TABLE 1
Design Feature Comparison for Plans with Limits

	1996		1999	
Design Feature	**% of Plans**	**Median Limit**	**% of Plans**	**Median Limit**
Annual Dollar Limit	51%	$5,250	28%	$6,300
Life Time Dollar Limit	66%	$50,000	54%	$1,000,000
Annual Inpatient Hospital Day Limit	63%	30 Days	76%	30 Days
Annual Outpatient Office Visit Limit	60%	20 Visits	75%	20 Visits

Source: GAO/T-HEHS-00-113

The majority of the people who responded found they reduced office visits to bring their plans into compliance or to offset the cost of complying with this mandate. What is interesting is only 1% of employers were allowed to drop coverage, which I thought was surprising. One of the statistics that I read is 28% of them did not know the costs relating to compliance.

I'll use an example of four different organizations that provided surveys on a national basis. It ranged from less than 2% for compliance or costs associated with just having the dollar limits to around 4% for full parity. A recent *Medical Benefits* article referenced that the actual cost was between 1–5% for employers.

How do you think your company fits? Do you know if you're in this market how you did: better, worse, don't know? Sixty percent of the people who responded to this survey didn't know. I was shocked by that. How do you not know? I was talking to someone about this. She said that the claims office of one of the companies she worked for decided, when one of the states that they were doing business passed the legislation that provided full parity, that since they had to pay them both the same, they should combine separate codes for mental health and medical surgical because it was easier. That makes it rather difficult to determine what the cost would be. There might be other cases like that in other companies where there are similar situations.

One of the other reasons that it's been hard for people to pin that down is that at the same time that we were implementing or complying with these mental health benefits, employers were also implementing more tightly managed care associated with mental health benefits. The two other statistics that I want to share with you mentioned that 10% of the plans were eligible for the cost exemption, but as of March 2000, only 9 had applied for that exemption. I thought that was rather interesting as well.

From what we are seeing, mental health parities are still at the 2-4% costs. As long as parities are permitted to, they will typically offset that cost associated with compliance in the inside limits. They will increase or decrease the day limits or office visits to offset that cost to them.

Mr. Thomas F. Wildsmith: Things move faster in Washington than we realize and there's more things going on. I think it's important for us to capture an idea of the scope of the regulatory activity that's taking place right now.

What we think of as global health-care reform has been stalled essentially for most of the 1990s. Over the last few years, Congress has engaged in a series of incremental steps that are ultimately going to reach down and touch the way you do your business in almost all of its aspects on a day-to-day level. Developing federal regulations is a long and involved process. What this means is that everything that's been done over the last five years is just now beginning to hit us in terms of final regulations.

One thread that runs through all of this that's becoming increasingly important is the idea of privacy. It is very important that the industry not underestimate just how powerful the issue of privacy is. A recent Gallup survey showed that 82% of adult Americans are opposed to health insurers having access to their medical records without specific authorization. To show you just how powerful this is, 71% were opposed to allowing doctors to have access to these medical records. Privacy is something that people feel very strongly about. Even though we may understand that we need access to the records and we're not going to misuse them, that's not a very satisfying assurance to most people.

The other thing that we need to realize is that all the federal regulatory activity is not going away. Almost everything that Congress is debating today in terms of health care has a huge regulatory tail associated with it, with more details than most of us can possibly imagine.

Administrative simplifications standards were part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) debate, and the goal of more efficient administration and lower costs is good for everyone. Unfortunately, the Health Care Financing Administration is issuing the components of this piecemeal. One of the most significant things coming from this is that the data security rules that deal with how you guard the security of the data you transmit electronically seem to be on a slower time frame than everything else. This is a bit of a problem because you need those data security rules in place before you start transmitting data electronically.

The piecemeal implementation is also a serious problem because implementing these things *a la carte*, if you will, is likely to be significantly more expensive then doing it in one lump. I won't go into the details of the specific components, except to mention that the concept of IDs is very sensitive politically when you start dealing with individuals, and that ties in to the idea of privacy.

The other thing is the industry needs to pay a great deal of attention to the claims attachment rules. The electronic transaction rules that deal with claims are pretty clear. That's basically the information that you'll see on a claim form. The claims attachments are everything else you might ask for to accompany the claim as supporting information when additional information is requested from the provider or a claimant. The provider community wants these regulations to be structured so

that if it's not covered by the standard claims attachments, it's presumed that you don't need to know it. If you get everything that's covered by the standard, you can't ask for anything else, which is potentially a serious problem.

The HIPAA confidentiality rules. There were preliminary rules issued in November 1999 and they were very onerous. One of the most onerous aspects is that they would have required insurers and health plans to police all of their business partners, even though those business partners were not directly addressed by the statutory language. You would be required to police those business partners through the contracts that you enter into with them. Essentially, what is being done in the regulation is to expand the scope of the statutory mandate by requiring you to enter into certain contracts with your business partners that allow you to police their confidentiality rules.

There's a huge overlap with the Gramm-Leach-Bliley privacy rules. There are three very significant differences though. First is the definition of the information that's protected. HIPAA basically protects personally identifiable health information. Gramm-Leach-Bliley protects nonpublic personal information. There's a huge overlap, but philosophically, they're coming at it from different directions. There's a difference in the definition of covered entities: HIPAA is much broader and "HIPAAtites" have opted an approach where you have to get authorization up front, where Gramm-Leach-Bliley allows for an opted out approach. Bottom line, if there's anything that I really want you to understand about the HIPAA rules is that you better assume that all health information is covered. Technically, these only cover electronic information, but the regulations are structured such that if the information is ever faxed, that's enough electronic to bring it within the scope of the regulation. It's simply not safe to assume that the information has not been stored or transmitted in electronic form sometime during its lifetime.

The ERISA appeals rules have become absolutely and completely political. President Clinton is pitching these rules as an end run around Congress on basic protections. There were proposed regulations that were issued in September 1998 that were very far reaching. Frankly, I think they exceeded the statutory authority granted to ERISA. If you read them closely, they were written for typical managed HMOs, but the scope was so expansive that they would have enclosed all sorts of health benefit plans including disability income and LTC. The problem is that when regulations dealing with claims and appeals for HMO coverage is just transplanted wholesale for long-term disability coverage, it simply doesn't make any sense. Fundamentally, what's happening here is that the Clinton Administration is trying to do something with these regulations that was not in Congress's mind back in the early 1970s when they passed ERISA. The concern was that they establish some minimum reasonable standards on a national level, for what we think of as fair claims practices. What the Clinton Administration is trying to do at this point is to enact standards that are more along the lines of what the Patient's Bill of Rights is trying to accomplish.

We don't know what if anything is going to happen with ERISA disclosure rules, but I think many are going to try and pass this again as part of the same debate over patient protections. The DOL is asking about the need for additional rules.

Specifically they're asking about provider financial incentives and utilization review criteria, which again is not what was on the mind of Congress when ERISA was initially passed. While I don't know what's going to happen, I would expect that they would receive many comments saying additional disclosure is needed and that those needs are going to fall in many of the same areas being debated in Congress under that Patient's Bill of Rights legislation.

HIPAA portability and access roles. The law says you can't discriminate based on health status and enrollment or the contribution that an employer health plan requires of any given enrollee. We don't know how broadly the Department of Health and Human Services and the DOL will be inclined to interpret this. My suspicion would be that the Clinton Administration would interpret it more rather than less broadly. Again, it's something we need to know because it touches things like how you price small group health plans, how enrollments are handled, and how employee contributions are established.

There are other HIPAA-associated rules that are waiting in the wings, but the real message I want to give you is that we have federal regulation for health coverage. To be quite frank, the regulations we've talked about are just implementing the temperamental stuff. If we do big-time health-care reform or just think about the Patient's Bill of Rights, the regulations that are going to be necessary to implement are going to be much more extensive than anything we've seen. While we were all raised and educated to think that health insurance is regulated at the state level, and it is in fact regulated at the state level, it is going to be regulated at the federal level. We will need to pay as much attention to federal compliance as we do to state compliance, and I think that's going to be a real change in our culture and in the way we manage our business.

Mr. Laurence R. Weissbrot: Within HIPAA, one of the justifications for the administrative simplification is cost saving. I thought the initial level was assuming it was something like 22%. Now I think it is talking 18%. We're a high-cost operation as a single-line insurer with nowhere else to spread the overhead, and we're down in the 12-13% range. Where does it get its cost figure and are there enough companies whose administration rates are significantly higher than that that there will ever be any cost savings?

Mr. Wildsmith: First of all, it has never regulated health insurance before. That means it doesn't have the background of understanding that you would expect. I think it got those cost figures by looking at fully insured plans for smaller employers and individuals, and just did not recognize the cost levels that you see in larger employers and self insured plans. The other thing is a lot of stuff is batted around as administrative costs, and it was looking at total non-benefit expenses including the marketing and distribution costs, contribution to surplus, and what you need to set up reserves. I think the short answer is, I strongly suspect it mishandled the numbers.