SOCIETY OF ACTUARIES

Article from:

The Actuary

November 1997 – volume 31 - Issue 9

Illinois had enacted the NAIC small group model law but repealed it earlier this year when it implemented HIPAA's provisions. As a result, Illinois insurance carriers must guarantee the issue of all small group products, but they also now have unspecified latitude in setting rates. The Illinois legislature's decision to repeal the small group law was intended to encourage insurance carriers to stay in the state's small group market. Some states that enacted guaranteed issue laws with limited rating flexibility in the early 1990s (e.g., Kentucky and Washington) saw indemnity carriers leave those states' small group markets. Consequently, the only products available to small employers are those offered by managed care organizations.

In Alabama, before HIPAA's provisions were implemented there were no small group rating requirements. Today, the Alabama Small Employer Allocation Program has been created to meet HIPAA's requirements and prevent abusive rating practices. So while some states, such as Illinois, are leaving rating decisions totally unfettered, others such as Alabama are taking steps that might limit increases.

Innovative work ahead

The changes resulting from HIPAA are creating not only more work but more innovative work for health actuaries. Insurance companies, managed care organizations, and their actuaries will want to consider designing new products or sets of products to minimize the potential adverse selection. They will want to find ways to evaluate and price the potential cost of medical conditions that were previously excluded. They also will want to revise the average pre-HIPAA price for small group products and develop new ways to set each small employer's premium rate. State governments also will need the assistance of actuaries as states consider revising limitations after HIPAA.

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Individual insurance after HIPAA: Where the states stand

by Craig S. Kalman

Employer-sponsored health coverage has been the focus of federal regulatory initiatives on health care over the past 30 years. Individual insurance reform has been left largely to the states, and several have acted to increase accessibility to individual health insurance. In 1986, COBRA created the first major expansion of insurance availability to those losing employer-based insurance. A decade later, HIPAA is logically extending that availability.

In the simplest terms (i.e., without a road map through all the rules), HIPAA allows someone who has lost access to employer-based insurance to purchase an individual insurance policy. That person, called an "eligible individual" under HIPAA, must have had creditable coverage for 18 months, not be eligible for other coverage, and have exhausted COBRA. Certain limitations are also placed on pre-existing condition limitations.

What about the type of insurance offered to the "eligible individual"? That depends on what the state has decided. Within the guidelines of HIPAA, the states have several options.

One is to adopt either the "NAIC Small Employer and Individual Health Insurance Availability Model Act" or the "NAIC Health Insurance Portability Model Act." Basically, these model acts limit the variation of rates and rate increases and provide for guaranteed issue of two plans, each with standardized benefits. This has been adopted by one state, Nevada, which chose the NAIC's small employer and individual health insurance availability act.

Another option is to maintain a qualified high risk pool. Basically, this means that those who, after underwriting, are either denied coverage or charged excessive rates may purchase coverage from the state's high risk pool. This has been adopted by 19 states.

States also can choose an option HIPAA labels "Other Mechanism." One of the two mechanisms defined allows a HIPAA-eligible individual to choose from among all policies offered in a state's individual insurance market. The other allows for risk adjustment or risk spreading either by the state among all insurers or by each insurer among its own insureds in the state. The "Other Mechanism" option has been adopted by 15 states and the District of Columbia.

HIPAA also allows states to choose a combination of the above approaches. This has been done by four states. If none of those options are adopted, "federal fallback" will apply. Under federal fallback, a carrier can offer to eligible individuals:

- All the carrier's individual plans offered at the time the individual seeks coverage
- Its two most popular individual plans
- Two representative individual plans

The representative plans, called the "lower level" and "higher level" of coverage, provide benefit levels at, respectively, 85%-100% and 100%-120% of the average value of the benefits of all the individual plans offered (either by that carrier or by all individual carriers

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NAFTA countries support SOA study on social security mortality

A research project led by the Society of Actuaries is seeking to determine the financial impact of the NAFTA countries' growing elderly populations on their social security systems. The project has received substantial cooperation from the three countries' social security administrations.

"Impact of Mortality Improvement on Social Security: Canada, Mexico, and the United States" will perform a detailed analysis of the historical and expected mortality improvement trend in each of the NAFTA countries and study the potential impact on the financial status of their social security systems. This initiative recognizes that the future of those countries' social security systems could be significantly affected by improvements in mortality over the next 50 years and by each country's ability to cope with the changes.

Results and possible implications of the study will be presented at the 150th annual meeting of the American Association for the Advancement of Science (AAAS), Feb. 12-17, 1998, in Philadelphia.

The project is divided into three phases. Phase 1, completed in September with the cooperation of a research firm and the three countries' social security administrations, reviewed the existing literature and analyzed the historical mortality improvement trend for each country.

Phase 2 was a one-day seminar on Thurs., Oct. 30, in which 90 invited participants heard presentations and then provided suggestions on approaches and assumptions to best project the three countries' social security mortality. The participants included actuaries, economists, demographers, and medical researchers. The seminar was held in Washington, D.C., immediately following the SOA's 1997 annual meeting.

In Phase 3, the assumptions and approaches chosen in Phase 2 will be used to analyze the impact of mortality improvement on the financial well-being of each country's social security program.

The three-phase project is being sponsored and funded jointly by the SOA, the SOA Foundation, and the Retirement Research Foundation. Other cosponsors are the social security administrations of Canada, Mexico, and the United States and the Pension Research Council.

More information is available from Judy Yore of the SOA Research Department (phone: 847/706-3573; fax: 847/706-3599; e-mail: *jyore@soa.org*).

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within the state). Also, the higher-level plan must have a benefit value at least 15% higher than the lower-level plan. These plans must also be substantially similar to others offered by that carrier.

The federal fallback currently applies in 10 states. Eight of these have formally adopted the federal fallback, and the other two — Missouri and Rhode Island — did not pass any conforming legislation during their recent legislative sessions. This means the federal government will be enforcing HIPAA provisions in those two states. For the 10 federal fallback states, both the NAIC and HCFA are working to develop guidelines for provisions of the federal fallback that are currently unclear.

That adds up to 49 states. The remaining state, Kentucky, has not had a regular legislative session since the passing of HIPAA and is excluded from the counts given.

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from discriminating based on a provider's licensure or certification. And, plans are prohibited from requiring a provider to indemnify the organization against any liability resulting from the plan's denial of medically necessary care.

For health care providers and managed care plans, the Balanced Budget Act of 1997 represents a threat to traditional ways of conducting business and an unparalleled opportunity to enhance competitive positions through increased market penetration and product innovation. For beneficiaries, the changes introduce dramatically expanded alternatives for coverage.

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