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Trying to adapt

Examining HIPAA's impact on the small group market

by Steele R. Stewart

Some 40 million people in the United States today work for small employers or are self-employed. This represents more than 40% of the U.S. workforce, and these numbers are expected to grow as corporate America continues to downsize and outsource. While the majority of people working for large employers have health care benefits, those engaged by small employers have been more likely to find themselves, a family member, or a specific medical condition excluded from coverage.

To address these and other perceived inequities of the health insurance market, President Bill Clinton signed the Health Insurance Portability and Accountability Act of 1996 (known as HIPAA or the Kassebaum-Kennedy bill). In doing so, he extended the principles of accessibility and portability, underlying the state-by-state small group health insurance reform of the early 1990s, to small employers in all states. This article will describe the pre-HIPAA small group market and identify some of the key changes to this market resulting from HIPAA.

Change started before HIPAA

Before 1990, most states did little to regulate the small group insurance market. Carriers could underwrite and price as they desired. Many added on large surcharges or denied coverage if anyone insured by the plan had a history of significant health problems. They also strictly enforced pre-existing condition exclusions, which made individuals with health problems reluctant to change jobs and, thus, lose coverage.

In January 1991, the NAIC issued a model law, "Small Groups Health Insurance Rating Law," which tried to address the issues of availability and affordability. This model law defined a small group employer as one with up to 25 employees. The model law set standards to ensure the renewability of coverage, disclosure in solicitation and marketing materials, and maintenance of business records detailing rating and renewal underwriting requirements.

The model rating law also suggested that carriers be allowed to determine an employer's premium using the employer's case characteristics and the employees' general medical condition. To develop a premium rate, an insurer would first adjust its manual rate, the expected average small group premium, to reflect the employer's case characteristics (e.g., the employer's industry or geographic location and the age,

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gender, and family composition of the employees). The adjusted manual rate would then be increased or decreased based on the underwriter's assessment of the general medical condition of the employees. To determine this, the underwriter would review an employer's claim history, the duration since the group was last fully underwritten, and employee health surveys that would indicate the employees' current health status. The NAIC model law limited the underwriter's ability to vary the rates for groups with identical case characteristics to no more than 25% from the index rate for that class of business. The index rate for one class of business could not exceed that for another class by more than 20%. The model law also limited the maximum annual adjustment to 15% for changes in a group's medical condition.

In July 1992, the NAIC issued the "Small Employer Health Insurance Availability Model Act," which expanded on the 1991 model rating law. The 1992 model act suggested limiting pre-existing condition exclusions, developing "basic" and "standard" health benefit plans to be offered to all small employers (i.e., two guaranteed issue products), and establishing a state reinsurance pool.

Throughout the early 1990s, many states followed the guidance of NAIC model laws but modified them to meet the states' own market and political environments. Table 1 summarizes the percentage of states that allow with unspecified limits, allow with specified limits, or disallow the use of each of the NAIC's case characteristics. Table 2 summarizes the percentage of states that allow deviations for claims experience, duration, or health status by the size of the deviation allowed within a class of business.

Table 1: Percentage of states with unspecified limits, specified limits, or prohibitions against the use of case characteristics to price small group health insurance products, March 1997

Characteristic	Limits not set	Limits Set	Prohibit
Family composition	88%	12%	0%
Age of employee	72%	26%	2%
Gender	62%	16%	22%
Size of employer	48%	28%	24 %
Geographic area	62%	34%	4%
Industry	22%	56%	22%

Source: Towers Perrin

According to the article "Federal Insurance Reform: A Drop in Your State's Bucket?" in *Business & Health* (October 1996), 37 states enacted guaranteed issue laws and 45 states passed laws that limited the pre-existing condition exclusions.

Small group pricing in a post-HIPAA world

Unlike the NAIC model laws, HIPAA does not address the issue of affordability. Instead, its intent is to guarantee access and continuation of coverage to those who already are insured and to minimize the barriers preventing those who do not have coverage from obtaining it. (See story, "Overview," page 4.)

While many states have modified their small group health laws to comply with HIPAA, most states have not altered their small group rating laws. Therefore, HIPAA's provisions will affect each state's small group market differently. Depending on how much flexibility exists within a state's rating limitations, the pricing actuary will want to reflect the cost of HIPAA as an adjustment to the manual rate or to the case characteristics used or as an additional adjustment for a group's medical condition.

Table 2: Percentage of states by maximum allowed rate difference due to health status/claims experience/duration, March 1997

Not Specified	8%
+/- 60%	2%
+/- 50%	2%
+/- 35%	10%
+/- 33%	2%
+/- 30%	4%
+/- 25%	36%
+/- 20%	12%
+/- 10%	4%
Not Allowed	20%

Source: Towers Perrin

Three HIPAA provisions that might affect the pricing of products are:

- The guaranteed issue and renewability of all small group products to all small employers
- The limitations on pre-existing condition exclusions
- The health status nondiscrimination rule

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The guaranteed issue requirement: This provides employers with the assurance that they can buy health insurance. Even employers who have avoided purchasing insurance for financial reasons can now purchase insurance when a medical need arises and the financial need for the insurance becomes apparent. This adverse selection could result in an increase in claim costs for the existing small group pool. The guaranteed issue requirement also allows employers with a greater need for health coverage to choose the highest-option benefit plan available. This adverse selection will result in an increase in claim costs for high-option products.

Pre-existing condition exclusions (PCEs): Under HIPAA, PCEs are now based on conditions that received a medical professional's recommendation or care within the six months prior to enrollment. Coverage for a PCE may be denied for up to 12 months (18 months for a late enrollee). Group health plans may not impose a pre-existing condition exclusion for newborns, adopted children, and pregnancy. This is a significant change from the "prudent person rule" that many states had, which defines a pre-existing condition as that for which a prudent person would have sought care prior to enrollment. Under HIPAA, employees can decide to decline coverage and not pay the employee premium until they suspect a medical need. If a medical professional was not consulted prior to enrollment, the condition is not considered to be pre-existing.

The health status nondiscrimination rule: This prohibits an employer or health insurer from singling out high-risk individuals in the group and charging them higher premiums, declaring them ineligible for coverage, or dropping their coverage completely. This rule gives each employee the peace of mind that comes from knowing he or she will be covered at the same level as any other employee. However, insurance carriers will need to refine their pricing methodologies so they can appropriately price those groups previously denied coverage because of health status.

States taking different approaches

Many states have passed laws to implement HIPAA while leaving their small group rating laws intact. Two states that have passed HIPAA reforms and had very different small group marketplaces prior to the enactment of HIPAA are Illinois and Alabama. Their situations show two different ways states are approaching the small group market in light of HIPAA.

Overview: HIPAA's provisions and the group insurance market

Here is a quick look at some of HIPAA's provisions.

1. Guaranteed issue and renewal are required in the small group market except under certain conditions. All insurers in this market are required to issue all small health insurance products to all small employers and to accept every eligible individual. Exceptions can be made for products sold to "bona fide" associations. A "small employer" is defined as an employer with between two and 50 employees.
2. Insurers may use certain underwriting requirements to deny small group coverage, such as:
   - Minimum employee enrollment or minimum employer contribution levels
   - Employees must live, reside, or work in the insurer's service area
3. The new law restricts the ability of group health plans to impose pre-existing condition exclusions (PCEs), except for conditions for which a medical professional recommended or provided treatment within the six months prior to enrollment. Coverage for a PCE may be denied for up to 12 months (18 months for a late enrollee). This applies to plan years beginning on or after July 1, 1997.
4. Group health plans may not impose a pre-existing condition exclusion for newborns, adopted children, or pregnancy.
5. HMOs may require that an employee be affiliated with the HMO for up to two months before coverage becomes effective. No PCEs may be imposed, and the affiliation period may not be based on health status factors.
6. Special enrollment periods must be made available to employees and their dependents when any family member loses other health coverage or a new dependent is added.
7. Plans are permitted to exclude coverage across the board for specific conditions or include lifetime caps on specific benefits.
8. The health status nondiscrimination rule prohibits an employer or insurer from singling out individuals in the group to be charged higher premiums, declared ineligible for coverage, or dropped from coverage completely. It does not limit an insurer from charging a group a higher premium based on health status factors.
9. HIPAA imposes disclosure requirements on health insurers' small group solicitation and sales material. Literature must describe the benefits and premiums for the health insurance coverage being offered and the availability of benefit and premium information on all products for which the employer is qualified.
10. Plans must now give each member a written certification of creditable coverage upon enrollee termination.

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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