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# Dealing with the puzzle

## How one state is facing the post-HIPAA world's complexity

*by John Hartnedy*

Insurance regulation has long been a complex process. This complexity has continued to grow with the enactment of HIPAA (Health Insurance Portability and Accountability Act of 1997). HIPAA and the many NAIC model laws affecting health insurance have, perhaps, doubled the "fun" for state insurance departments, employers, and consumers alike. One gets the feeling that more laws to make our lives better is something like tax return simplification — an oxymoron.

Nonetheless, we in Arkansas have gone bravely forward. Health actuaries might find it valuable to see what one state's insurance department has done to comply with HIPAA and what challenges some of us see ahead.

### A jigsaw puzzle of laws

Actuaries working on state filings often think complying with the law is difficult. We regulatory actuaries can understand, given the mixture of laws enacted — for which we then have to provide rulings. Small group rating laws are a prime example.

In 1991, Arkansas passed NAIC model law 115, "Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups." This was the NAIC's first small group rating model law and, as such, it did not include provisions for community rating and guaranteed issue. Since 1991, the NAIC has developed model laws 115, 116, 117, and 118. Fifteen states have model law 115, which primarily addresses premium rates, renewability, and disclosure. No states have passed models 116 or 117. Eighteen states have passed model 118, which added community rating and guaranteed issue. Ten more states have combinations of models 115 and 118.

In 1997, we passed an "alternative mechanism" under HIPAA, which means we updated our state high risk pool (comprehensive health insurance pools, or CHIPS) to comply with HIPAA and passed our own HIPAA legislation — Act 997 — so we are the regulators of insured plans. At that time, we had to alter the Arkansas Small Group Rating Law, which was (and still is) essentially the NAIC model law 115. Our law:

A. Defines a small group as 1-25 employees
B. Sets the maximum difference at ±25% from the index rate for rates for groups with the same characteristics and within a class
C. Sets the maximum difference between classes at 20% (guaranteed issue is a separate class not subject to the 20% maximum)
D. Sets the maximum rate increase as the change in new business rates plus 15% (within the limits set in point B above)

To be consistent with HIPAA, we dropped model law 115's disclosure and renewability descriptions in favor of those of our Act 997, which was derived from HIPAA. We did not change our small group definition of 1-25 employees for premium rating purposes; we did not see this as inconsistent with HIPAA's 2-50 definition for guaranteed issue. Also, we chose not to increase our rate regulatory authority to groups of 26-50 employees because we had not had complaints in that area; at the same time, we realized that guaranteed issue could change that.

I can see at least four possible classes arising under our law:

1. Pre-HIPAA underwritten (2-25 employees) but must take new entrants under guaranteed issue
2. Post-HIPAA guaranteed issue groups not previously insured
3. Post-HIPAA previously insured "portable" groups
4. Self-employed individuals (who are treated as "groups of 1" under Arkansas law; this class, as it is defined here, is untouched by HIPAA)

If these classes develop, there are two main implications for actuaries to be aware of if they're working on health plans in Arkansas.

First, premiums for groups in prospective classes 2 and 3 would have to be within 20% of each other, but premiums in those classes could exceed a 20% difference from class 4's premiums.

Second, the lines would blur between groups that are now underwritten and those that aren't. For example, because of HIPAA's guaranteed issue provision, class 1, probably a highly preferred group, is likely to resemble classes 2 and 3 as time goes on rather than class 4, which it resembled when HIPAA took effect on July 1, 1997.

### Challenges are brewing

Some companies are reducing commissions or threatening to terminate agent contracts if they submit business (guaranteed issue or portable) that is substandard. This seems to be a violation of the spirit of HIPAA. Arkansas is one of several states with guaranteed issue provisions that have prohibited these types of actions.

We still hope to not have to regulate rates in the 26-50 employee market. However, we're keeping an eye on the marketplace to see whether guaranteed issue is causing too much havoc.

All products and benefits offered in the small group market must be available to all groups (2-50 employees) at guaranteed issue under Act 997, which essentially duplicates HIPAA. This includes all variations in deductibles and all co-payments. Companies must

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ratio less accumulated claims. The interest rate would be statutorily determined each year; adjustments would be allowed for dividends and claim reduction expenses (e.g., access fees). For example, dividends below 5% of premiums could be treated as claims, while dividends over 5% could be treated as a reduction to premiums. After all policies in a pool terminate, a final benefit reserve would be calculated, and this amount could be transferred to either the state or the policyholders.

The NAIC and individual states are addressing some of the issues raised in this proposal. They're doing so in a variety of ways, such as limiting rate differentials between classes of policyholders, making it difficult to enact large rate increases, establishing high risk pools, and improving portability of coverage. Also, HIPAA makes it more difficult to cancel coverage in all states. What seems to be missing is a unified approach that simultaneously protects policyholders against large rate increases while encouraging companies to stay in the market.

I believe that if the above proposal was enacted, some insurers would be willing to provide guaranteed renewable major medical policies and that insureds would receive meaningful, long-term protection. By pooling all policies into one rate base, insurers could only charge select rates for the first few years after enactment (or after they entered the market). Then as each year passed, rates would rise so that all insureds, even newly selected ones, would be paying rates that would allow prefunding of the high costs that will come as insureds become nonselect. Under the second part of my suggestion, if states gave up the right to approve rates, insurers could charge appropriate rates and thus be more likely to stay in the market.

So, for now, as I join the ranks of the uninsured, I look forward to the day when insurers again offer meaningful medical insurance to individuals with long-term needs.

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offer maternity benefits for groups of any size in the 2-14 range or for no groups at all in that range; they cannot choose to offer maternity benefits only, for example, for groups of five and up. (Federal law mandates maternity coverage for groups of 15 or more.) Participation and contribution requirements are the only permitted rating variables; they can vary by several factors, including group size, benefit, and marketing method (direct versus agent sales). Our older group law still exists and provides for, among other things, 120 days' continuation of coverage (mini-COBRA) and a conversion policy. Conversion policies — with their minimum benefits and potential cost of 200% of normal individual policy premiums — don't seem to make any sense under HIPAA's portability requirements. This has caused us to question whether the conversion policy requirement should remain.

### Arkansas' alternative mechanism

Our comprehensive health insurance pool (CHIPS) covers federally eligible individuals (those covered by a group health plan for at least 18 months) whose coverage, including COBRA but not conversion policies, has terminated with no other eligibility for coverage. Our rates are 150% of unloaded new business rates (gross premiums minus profit and marketing costs), or about 112.5% of actual market rates.

### Trying to support the marketplace

An amazing number of new laws have been passed that affects the future of small group health insurance. HIPAA may be the most dramatic, but it's just one among many laws and regulations implemented in the 1990s. Coordinating all of it has been difficult at best. Some of the law was good and needed; portability and guaranteed renewability, for example. Other parts, such as guaranteed issue, were destructive; costs are being imposed, and some companies already have decided they will not play, so they are leaving the small group market.

We hope our group rating law, adjusted for HIPAA, will help support the Arkansas market. We want to hear your ideas.

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## Rate making under pressure (continued from page 2)

with the actuary being "sent out of the room while the marketing people set the rates" as long as the actuary has properly communicated the results of his or her work and the implications of adjusting the recommended rate levels.

In this issue, actuaries address this principle from their own perspectives. Richard Lake describes his experiences with the premium rate setting process for individual health insurance coverage and his suggested solutions to the perceived issues. We also gain a legislator's perspective into compliance with small group reform legislation through an article by John Hartnedy. Happy reading.