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## Session 101OF

### Health Insurance Portability and Accountability Act—One Year Later

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**Moderator:** Donna C. Novak

**Panelists:** Cecil D. Bykerk  
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*Summary: Panelists and attendees discuss the ongoing influence of the Health Insurance Portability and Accountability Act on the health insurance market in the U.S. The long-term implications of this legislation—now with the help of a little hindsight—are revisited.*

**Ms. Donna C. Novak:** I am with Deloitte & Touche and I am vice chair of the Health Practice Council for the AAA. I also chair the Health Committee for the AAA, which has been following Health Insurance Portability and Accountability Act (HIPAA) since it started. Also speaking today are Julia Walton, who is a health specialist for the Health Care Financing Administration (HCFA) and has been responsible for much of the implementation and regulation of the HIPAA, especially in the states where HCFA is actually the regulator for this law. Cecil Bykerk, who is the executive vice president and chief actuary of Mutual of Omaha, will be telling us about HIPAA from the perspective of a carrier that is in multiple states where each state has the potential of doing its own thing.

I think many of you are familiar with the different aspects of this regulation but just to refresh our memories, I'm going to go through this quite quickly. Then I will talk about one state that was creative in its implementation of HIPAA in the individual market.

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HIPAA, a federal regulation, was passed in 1996. States can be more liberal in their implementation and can include their own requirements on top of HIPAA. The HIPAA reforms include group insurance, individual insurance medical savings accounts (MSAs), COBRA, and long-term care, but all we'll really be speaking to here are the group and individual insurance aspects of HIPAA.

In the group reform area, there are three basic requirements under HIPAA. One concerns preexisting condition exclusions. The second is the availability of coverage and antidiscrimination, and the third is the renewability of coverage requirements.

Preexisting condition exclusions are not allowed if you have an individual who has more than 18 months of creditable coverage. They are allowed on a reduced basis if there is creditable coverage since the last break in service of 63 days. There are certification requirements. HIPAA requires that an individual leaving a group plan be given a certificate that proves his or her creditable coverage.

The preexisting condition exclusions allowed must give credit for creditable coverage since the last break in coverage of more than 63 days. Coverage that would qualify as creditable under HIPAA includes almost any type of group coverage, individual coverage, Medicare, Medicaid, and state high-risk pool.

Small groups include groups from 2 to 50 members. These members must be guaranteed-issued. There were some exceptions, which primarily revolved around a carrier not having the financial capacity to take on new groups or bona fide associations. I think Julie will speak a little bit about the complications that have been generated from the bona fide association rules and exceptions.

All group plans and group insurance must have guaranteed-issue to individuals including ERISA groups, so an individual who is qualified to be a member of the group must be given insurance coverage on a guaranteed-issue basis.

You cannot deny coverage for medical reasons, and you cannot have contribution rates charged to the employee that differentiate based upon health status for an individual within the group. You also cannot deny coverage for high-risk activities such as skydiving. Again, there were some exceptions on guaranteed renewability such as not paying premiums or fraud associated with the application.

The individual market reforms include guaranteed-issue to all eligible individuals. The guaranteed-issue is a group to individual portability. There are a number of ways that states can implement this guaranteed-issue—one is using the federal fallback, or the state can create its own mechanism to cover individuals coming

from groups covered that are eligible. To be eligible, an individual has to have the 18 months of creditable coverage since the last 3-day break in coverage. There is no prorated eligibility. The individual has to come from a group plan and have completed all of his or her COBRA. The initial enrollment for HIPAA-eligible individuals may have decreased because of this COBRA requirement. Individuals who did not know they were eligible for COBRA and didn't sign up would lose their rights under HIPAA.

The default option required that a carrier either guaranteed-issue all of their products or guaranteed-issue two products—either their two most popular products or a high benefit/low benefit plan with some actuarial equivalents built into the definition of how those had to be structured. With the initial implementation of HIPAA with many carriers as well as states, we have struggled with how to do the actuarial calculations associated with the two plan options. I think both speakers will talk a little bit about how that played out in reality.

A state alternative mechanism had to have certain characteristics. It had to provide a choice of two options, one of which was comprehensive, and it had to have no preexisting condition exclusion. The mechanisms could include either the NAIC availability or portability laws with a few minor changes; qualified high-risk pool, which many states did; risk-setting mechanism that would subsidize eligible individuals; or a guaranteed-issue of all coverages.

I'll give an example of one state that implemented HIPAA in a creative way. Georgia designed a plan where HIPAA-eligible individuals who were coming from group insurance would be offered what they called an enhanced-conversion option, which was two benefit packages that the state defined. HIPAA-eligible from the self-insured marketplace, though, were eligible to go into an assignment system where they applied to the state. If they were found eligible, they would be assigned to a carrier to cover them.

The enhanced-conversion option had to have two plans that were comparable to what the state designed for the assignment system. The Department of Insurance in Georgia designed the legislature passed. I'm familiar with this because I helped them design the plans and the rating structure for these benefits. If you're familiar with how the legislative process works in many states as well as the federal government, the legislators pass laws and then the departments of insurance or federal-level HIPAA have to try to figure out what they mean, which is always an interesting process.

With the enhanced-conversion option, the rates could be no more than 150% of the pooled rate for all the insurers in the state of Georgia. Under the assignment

system, there were two mechanisms—one for individuals who had not been under a managed care option who were assigned to nonmanaged care carriers and another for individuals who had been under a group managed care option and were assigned to managed care entities. This created an interesting situation in Georgia, where a company could have managed care options for a line of business—for instance, a Blue Cross/Blue Shield plan that had a line-of-business HMO. Individuals covered by those who were in the self-insured marketplace were not assigned to Blue Cross/Blue Shield because they were not a managed care organization. They had to be assigned to an HMO that offered individual coverage, so it meant that the HMOs offering individual coverage were having to cover individuals coming out of plans that they had no actual participants in.

The benefit structure was defined by law as being at least 85% of the average actuarial value of individual benefit coverage in the state for the low option and the high option being at least 100% of the same. Again, premiums were a maximum of 150% of similar coverage in the individual marketplace, so a survey of individual rates in the marketplace had to be done and the benefits actuarially adjusted in order to determine the 150%. The benefit plan that we designed had some safety mechanisms built into it such as high deductibles for emergency room (ER) visits to discourage ER use and those types of utilization controls.

With that brief introduction to HIPAA and an example of one state that became very creative in its implementation, I will turn the podium over to Julie, who will talk a little bit about the federal fallback mechanism, especially how it is being regulated by HCFA.

**Ms. Julie Walton:** Donna has already told you a bit about what HIPAA does. It creates major health reform that helps many individuals by eliminating job lock and helping people move through the system and not be afraid of being resubjected to preexisting condition restrictions for themselves or other dependents. It builds on existing authorities under ERISA, COBRA, and the Public Health Service (PHS) Act. It has made a lot of changes to the group and individual markets. It provides for new provisions related to portability of health coverage, administrative simplification, MSAs, fraud, and abuse. I'm only going to talk about the first of these, portability of health insurance coverage, because that's all that my unit, the Insurance Standards Team, deals with. There are other areas within HCFA that deal with administrative simplification. MSAs are primarily under the Treasury Department. Fraud and abuse are largely under the Inspector General, but there's also a unit within HCFA that deals with those provisions of HIPAA. If you have questions about those areas, I can refer you to other people.

The scope of HIPAA is very broad indeed. It affects states because all states had to come into compliance with HIPAA with respect to insured products in both the individual and group markets. It creates a federal floor, and the states were expected to adopt at least that. It affected the federal government because, as I mentioned, three statutory authorities were amended—the Internal Revenue Code, the PHS Act, and ERISA. All three departments—Health and Human Services (HHS), the Department of Labor (DOL), and Treasury—are involved in the group market provisions so that the HIPAA standards can apply to both the insured and self-insured markets and to virtually all employers, both public and private. HIPAA also affects many employees. This is its aim—to help employees, especially those with poor health histories and chronic illnesses. And HIPAA helps individuals who are losing coverage by creating a special enrollment that interrupts the general plan rules in terms of when they can get into a plan if they weren't already in by creating special enrollment situations for individuals who lose coverage, get a new dependent, or have other change-in-life circumstances.

It limits the extent to which plans and issuers in the group market may exclude coverage for preexisting conditions by providing for the crediting of prior coverage. Donna has already talked about some of this, so maybe we should move on. Donna also already mentioned prohibiting discrimination and guaranteeing availability of coverage for small employers and guaranteed renewability in both the small and large group market and the individual market.

I think the most important thing is that in terms of the role of the states in regulating insurance markets and particularly the individual market, HIPAA gave states a great deal of flexibility to experiment with how best to achieve guaranteed availability of coverage for individuals transitioning from the group market into the individual market.

Cecil particularly asked me to mention something about rates and the fact that HIPAA does not directly address rates. In fact, there are certain provisions that say that federal laws in no way can be construed to place any limit on the rates that can be charged. Yet there are a couple of places where risk spreading is clearly required. When we started seeing rating-up problems in some of the states under direct enforcement (Missouri, Rhode Island, and California so far and possibly Massachusetts and Michigan), we investigated whether there was enough basis in the statutes for us to build an argument for doing something. However, our administrator made the decision that she didn't want us to address this issue. Therefore, you won't hear much more from me about rating authority under HIPAA.

Among other things that HIPAA does not do, it does not mandate specific benefits, nor does it require employers to offer the same benefits to all employees. That's

one of the most common misconceptions we've heard from the public. People think that they can take the same benefits that they had from their old job to their new job, or they're very surprised when they move to a new employer and that new employer doesn't even offer a plan. They think that they will have some sort of a permanent COBRA extension. HIPAA also does not provide for individual-to-individual portability. Probably one of the chief drawbacks is that we don't have a comprehensive system. Because HIPAA provides only incremental reform, we've seen a lot of instances of "state lock" as the result of, for instance, a state selecting a high-risk pool as its mechanism. The eligible individuals cannot move out of state without losing coverage because they got sick. Maybe their kids are across the country or something like that. These are early retirees. They get to the point where they need to move somewhere else to have the kind of support system that they need, but they're land-locked into the coverage they have. Being an eligible individual is a one-time chit. You get to use it only once. After that, whatever coverage you got that was provided by the state that you were in is all you're going to get because there's no general individual-to-individual portability, even for those who initially were covered as eligible individuals.

"State lock" isn't just a problem peculiar to high-risk pools. Being land-locked is also a problem with network plans. It's very common since so much of the industry is managed care now. If a person gets coverage in such a plan in a guaranteed-issue state, for instance in a federal fallback state or one of the states that chose to do an even broader form of guaranteed-issue, that someone gets into a particular plan as an eligible individual and if he or she needs to move out of the network's services area he or she has the same problem.

In terms of HCFA's involvement in HIPAA, we got involved because there was a new Title 27 created within the PHS Act. We were the agency within HHS that had the most experience dealing with health insurance issues. Let me give a little bit of background. Particularly with Medigap regulation, we've been involved since 1980 through our Medicare managed care program. We've had a lot of contracts with issuers and with HMOs through our cost and risk plans under Section 1876 of the Social Security Act. When HCFA received responsibility in the summer of 1996, we formed a HIPAA task force and then, of course, the three departments also formed a task force. We, as you know, developed the regulations that were published in April 1997. They were interim final rules so they are in effect, but we do intend eventually to come out with final rules. I'll talk more about that later.

In terms of recent accomplishments, in December 1997 we published the mental health parity rules. We are also about to release the mothers and newborns regulation. I was hoping I would be able to say that it's actually out now. If you're looking for it we hope it's going to be out in the next few days. It's been at the

Office of Management and Budget since last month, and I think the final hang-up now has been trying to decide whether there will be a White House rollout or not; that is, whether there will be a mammography rollout that Hillary Clinton might be involved with. They might want to throw mothers and newborns in with it. Whether or not that happens in the next few days or over the next week or so, the mothers and newborns regulation will be coming out.

We've also published two federal register notices on a couple of issues for which we thought we could provide further clarification. We thought that we had said enough in the regulations in April of last year to be able to do this without having to issue a whole new regulation. These dealt with flexible spending accounts and individuals who were previously denied coverage. Particularly in the latter case, we said if a person had been denied coverage in the past or even if they thought he or she would have been denied because he or she knew that the plan rules said "we underwrite" when the plan becomes subject to HIPAA, upon that effective date, the person has to be let in. Since publication of that notice, an issue has come up—does that mean only people who were initially denied? What if they didn't apply initially because they were in another plan but later they wanted to apply? It was at the later enrollment opportunity that they encountered the problem. That's been very common in the past. Plans let them in initially, but if they didn't take the initial opportunity, the plan would underwrite for late enrollment. Now the nondiscrimination provisions in the act have altered things. They have had the effect of making a lot of plans drop late enrollment opportunities.

We also issued a bulletin last March to state insurance commissioners and to issuers. We sent that bulletin out ourselves to every issuer selling in California. We also had the Missouri and the Rhode Island departments send it out for us. As for the issues that we addressed in that bulletin, we mentioned rating up as a serious problem that we were going to continue to study, but we were primarily concerned about reduction of agent commissions that were so great as to make it totally undesirable for an agent to try to serve an eligible individual or a small group who had some high risks. We took the position that if a company's agent commissions were being lowered to the extent that there was little or no incentive to sell, then we considered that a violation of guaranteed availability. However, we didn't say, as many states that have unfair trade practice acts have been able to say, that any change in commission structures was a violation. We felt that in the past where carriers hadn't had to accept people above a certain level of risk, say 200%, but now have to take people with higher risk than that, the carriers might need to protect themselves against that. So, we said as long as eligible individual or small groups with high-risk individuals were being treated at least as well as standard risks that they'd be OK, but if the carrier drops below that, that's what we would consider a violation.

We had a long, hard struggle to get some funding. We finally got \$2.2 million last spring. We got it in late May and then had to rush to spend it by September, so that kept us busy all summer long hiring staff. Everything we did was in response to the need to do a direct enforcement. Most of that money went to hiring 24 new staff members, 22 of them in our regional offices, concentrated in those regions where we had to do direct enforcement. Most of the people who we hired are people either from state departments of insurance or with industry background, so we're developing some real expertise. We had some very interesting conferences in September working on an enforcement regulation and having a training program for all the new staff.

One of the big tasks in terms of what we're immediately working on is, as I mentioned a little earlier, our enforcement regulation. This deals with the issue of how we are going to make the determinations that a state is failing to substantially enforce and how we are going to impose civil money penalties, which are the weapons that the statute gives us to deal with abuses. That regulation is due to the Office of the Secretary by the end of November, so we've been working very, very hard on that. Also, now that the mothers and newborns regulation is pretty well out the door, the interagency group has been working on the nondiscrimination regulation. I'm involved with that, as well as several others from our team.

Let me give you an idea of what we intend to do in terms of final regulations for both the individual and group markets. We decided after the horrendous feat of getting the two regulations published by the April 1 deadline last time around that never again would we keep the two coupled together. There were just too many things in the individual market, which was ours alone, to deal with that were dependent on decisions that were made by the interagency group. The very last night we worked very late in Washington, D.C. When we finished at about 2:00 or 3:00 in the morning, I had to call the person in Baltimore who was responsible for the individual market regulation. She worked until 8:00 a.m. to make sure that regulation went to the Federal Register at the same time as the group regulation. Never again are we going to do that. We're going to chop it up and turn out smaller pieces at a time.

One of the most critical issue areas that we've found is that of associations in both markets. I don't want to take too much time talking about it now, but we were finding a lot of problems with associations.

The main effort, in terms of operations, that we're involved with is first developing the plan or process for monitoring compliance of the states that are enforcing the standards to make sure that they're enforcing all of the standards the way they're supposed to and then also carrying out our responsibilities in connection with direct

enforcement in the states that have not done that. Three states let us know right away after the July 1 deadline, or actually before that, that their legislature had failed to act. Missouri informed us a year ago in May, and Rhode Island told us just before the July deadline too. California had applied for an alternative mechanism so that they would have had a grace period until January 1, but in October they ran into trouble with their legislature. They let us know that, at least with respect to guaranteed availability in the individual market, they weren't going to be able to do it either.

We have now gone ten months past the January 1, 1998 implementation deadline for an alternative mechanism. Since the Massachusetts and Michigan legislatures still have not acted, we're now starting to take steps. Letters have been sent to both governors and insurance commissioners, telling them that we're starting the determination process. These are two very, very politically sensitive states. Senator Ted Kennedy is, of course, one of the two sponsors of the bill and Michigan Congressman John Dingell is the ranking Republican on the House Commerce Committee.

Some of the other immediate tasks involve developing a memorandum of understanding what the statute requires among the three departments. You'd think because we all work for the same federal government that there would be a whole lot more commonality than there is among the three departments in how we do our business, but there have been many, many considerations and concerns. Every time we turn around we're just totally buffaloed by something new that we've discovered about one of the other agencies and how they do things. I think the funniest example I've run into is when it came to doing the final regulations in April 1997. Treasury balked at doing the required impact statement. They had never done an impact statement for any regulation they had ever done before, and they didn't want to set a precedent with HIPAA. They claimed that they did not impose burdens; they only collected revenue.

Because of how we go about doing our business, we have to say, "We're all joined at the HIPAA." We're having to work very closely with the states. Something like 50% of the complaints that states get on health coverage deal with self-funded plans. Treasury has involvement in a lot of these issues as well because of the COBRA piece of it. The three agencies all have their own forms of penalties. We have civil money penalties that we can only impose on issuers in states that are not substantially enforcing. The DOL has ERISA penalties that they can use. There's also a private right-of-action, and there are excise taxes under the IRS that can be levied against an employer that's noncomplying. The opportunities are right for the plan, the issuer, and the employer all merging together and not everybody being totally clean. Figuring out how to work out the jurisdictional overlap and how to

deal with caseload problems is a big task. Many times these situations are complex enough that we end up running several conference calls. Another of the issues, too, is our differing relationships with our regional offices. HCFA uses its regional offices in a much more collaborative way than some of the other agencies do. DOL delegates much less responsibility to their regional offices. These differences are all things we're having to work out. How we handle inquiries is another matter. Treasury and DOL have not been wanting to give written answers the way we do in individual case situations. We've had to use a standard disclaimer saying, "You can't really rely on what we're telling you. Read the long regulation." We don't think that's too helpful. We've always been a consumer-friendly kind of organization at HCFA. The stresses and strains of working out issues on how we're going to respond to consumer complaints is another area of enforcement coordination.

Outreach is probably the biggest need. Now that we have a budget for this year and it includes funding for HIPAA, I guess in the next few months we're going to be finding out how much we're going to be able to do with this, but ultimately I think enforcement of HIPAA is going to rest on informed consumers knowing their rights. Right now the indications that we have are that people really don't understand much about HIPAA, don't know what they're entitled to, and don't even know where to complain to. In part, the complexity of the system is responsible for the fact that they don't know where to go. But that complex system is a reflection of the 25-year history of ERISA, the separation of funded and self-funded plans, and the committee jurisdictions in Congress. None of that is going to change, but we are looking at how we might improve the system.

Another issue at HCFA has to do with the nonfunded governmental plans and how we're going to deal with them. One of the regulations that we'll be putting out will provide more information on how to apply for opt-outs because a lot of the opt-out applications, we have 600 or 700 of those in-house already, have not contained all of the information that we need. That's one area in which we're going to be doing further regulation.

There are a lot of other areas, like the interplay among HIPAA and the Balanced Budget Act and managed care reforms and how to deal with the new kinds of entities like Provider Sponsored Organizations and PPOs that are created or allowed to play a role in Medicare and Medicaid and how that fits into the HIPAA world and how the interface of all these laws works. We're encountering a lot of questions about interfaces between HIPAA and the Children's Health Insurance Program (CHIP), and both Medicare and Medicaid. How to simplify this very complex situation, which is a product of the environment out of which it grew, as I mentioned, is a major challenge.

One of the things that we're having to do is a report to the President over the next six months. Also, part of the enforcement strategy that the White House came up with is to use the federal government's purchasing power to insure HIPAA compliance. We and the states are supposed to report to the Office of Personnel Management (OPM) any issuers who are not complying with HIPAA. OPM is then supposed to either not allow them to get contracts for the Federal Employees Health Benefit Plan (FEHBP) or, if they have a contract already, to cancel it. The idea is, as I mentioned, to use the federal purchasing power to ensure compliance. I don't know how well this is going to work. The question is knowing what's a "violation."

The other really big question is to what extent can this model, that is as problematic and difficult to operate as the HIPAA structure is, be improved? It's about the only vehicle around for applying standards all across the board to the entire employer sector, both insured and self-insured. Of course, we all are aware of the debate this fall that will probably be picked up with the new Congress as to whether they're going to have some sort of a patient's bill of rights. HIPAA is the structure that would be used to enforce it in virtually every one of the bills that was put forward in this session. Then there was a lot of "body parts" legislation. Senator Al D'Amato's mastectomy bill apparently failed to make it. That was one we were watching pretty closely to see whether that was going to show up in the final budget deal, but it appears that it didn't (a narrower bill did, however, get enacted). But there's always the potential in the future that there will be that kind of legislation. This is the way to apply mandates. Congress has figured out that this is how to impose the national standard. That leads us to what might happen next year.

**Mr. Cecil D. Bykerk:** I had the opportunity of spending a couple of days with Julie about a month ago when she made a similar presentation to the National Association of CHIP pools, which at the time I was chair of. I'm going to present, as Donna mentioned, some perspectives from a company or an individual who works for a company that's still in the individual major medical business. Along those lines I'd like to find out, either in the consulting capacity or as an individual working for a company, how many people here are related to or work with some institution that's on the receiving end of these portability individuals? Can we have a show of hands? Maybe a third. The other thing that I thought about a bit when Donna asked me to join this presentation was that we always have this antitrust thing lurking around out there that we read admonishments about from time to time.

That sort of jumped out at me a little bit, so I think we do have to be a little bit careful in that regard when we start talking about rating or whatever, but hopefully somebody will jump up in the back and say, "Don't go there."

Today I'm going to quickly run through some of the requirements. You've heard them a couple of times here. I'm going to focus just on the ones that are relative to this impact issue: insurer practices in states with legislation and insurer practices in fallback states and CHIP-pool states. There are some implications even in fully guaranteed-issue states in what I perceive to be some of the unintended consequences. Whether they were unintended or not is a different issue and might pose other questions we can ask.

With respect to the HIPAA legislation requirements, of course, the two most significant ones are that companies have to guaranteed-issue certain individuals unless the state has a CHIP pool or a carrier of last resort or is a full guaranteed-issue state, or if they have some other approved mechanism that HCFA has approved as an alternative mechanism. That clearly is the keynote of all of this. The second is, from my company's perspective and that's really the way I'm trying to present this as a chief actuary of a company in reacting to this legislation, is the guarantee of renewability provisions that override even contractual language with respect to determination of coverage. For example, at age 65 those guarantee renewability provisions that are covered in HIPAA have created some issues from our perspective. Of course, there is a way out of it. You can withdraw the coverage from the state, cancel all the business, and so on, but there's no other way out of this guarantee renewability requirement.

Now, some unwritten requirements, I believe, in spite of comments that HCFA isn't going to write all sorts of things about rating. Clearly, insurers and the industry are under the gun to constrain premiums for individuals coming in to portability provisions. The General Accounting Office (GAO) report that came out hammered on that issue and if we see rate-ups of 20 times standard, clearly those are huge and prohibitive from the point of view that the coverage is there. It's available, but the person can't afford to pay it.

Now where that dividing line falls is an issue we could probably debate for the rest of this week because it depends on the perspective of the individual making the comments. From a company perspective, we might easily see two times, three times, or four times. Others might say higher, as reasonable premiums in view of the fact that the people coming in have identifiable actuarially demonstrable higher costs. On the other hand, having been in Washington a number of times over the last seven or eight years, I can assure you that most staff people would not consider three times anywhere close to being a reasonable premium, so that issue is lurking out there. It's especially lurking out there in view of what Julie mentioned a little bit ago concerning FEHBP companies. The President announced that such companies have to meet not only the letter of the law, but the spirit of the law. When you start thinking about what spirit means and how that is enforced and what can be done

there, it certainly poses some questions for insurance companies. My firm sells individual major medical, small group, and true group coverage. It has several plans in the FEHBP program. That's a real concern to us. Are we doing things that are going to—even though we've tried to meet the letter of the law and do all the things right—cause someone to say that's beyond the spirit of the law? Clearly the spirit of the law is to provide continuing coverage, not identical coverage, to individuals as they move out of that employment setting into a setting where they are not getting coverage through employers.

Now let's talk about states where we have some legislation. I didn't do an extensive survey on what carriers are doing because, again, I was a little bit concerned about whether that could be perceived as violating some antitrust requirements. These are gleaned from casual, anecdotal conversations. It seems that most carriers are using the two most popular plans to provide the coverage to the individuals. In some cases they've altered their two most popular plans. For example, if they had an extremely low deductible in the state, that may or may not have been one of the two most popular plans, but if it was one of the two most popular plans, they might have stopped selling that low deductible plan out of concern that plan was going to get all the antiselection from the individuals through the guaranteed-issue mechanism. For the most part I don't know if that happened, but most of the plan carriers are taking that approach of the two most popular plans. Some carriers are developing two representative plans, as was mentioned earlier as one of the options.

Clearly one of the issues here is the pricing practices and how the prices are developed. Are the rates of those plans what I would call standard rates or are the rates already in-and-of-themselves substandard rates since the only people who might buy them would be coming through the portability mechanism, even though they would be available for people coming in through normal applications and being underwritten? Again, there's an issue there of pricing that has to be looked at. The question is whether subsidization is present as well. If subsidization is required in these plans, what does subsidization mean? That's a very big issue and one that most companies have discussed in trying to deal with this particular approach to the legislation. I'm going to go on but that's something that we might want to discuss today: What does subsidization mean? This is clearly an actuarial question. In some cases, in certain states, carriers are just guaranteed-issuing everything they sell, figuring that's the easiest way to deal with it.

Now, I want to give you an example of a state with legislation. We'll pick on Florida. I wanted to mention two issues here. One is that Florida has issued a bulletin that forces us to use standard rates; no rate-ups at all for any individuals coming out under HIPAA, i.e., those coming out with the portability requirements

are federally eligible. They're holding fast that we have to issue these plans at standard rates.

As far as I can tell, there's nothing in the federal law that says we have to do that, and nothing in Florida law that says they can do that to us. At the current time, they're suggesting that if we want rate increases on other things, we might want to go along with this. We've succumbed for the moment. But clearly this is an issue. I think this is going beyond what Congress intended. I think the fact that Congress inserted into the HIPAA legislation that to be a qualifying risk pool under HIPAA the risk pool couldn't charge more than two times standard sets a benchmark for what should be a safe harbor for premiums. I think if you're not charging over two times standard, it ought to be considered that you meet the spirit of the HIPAA law, but that's Cecil Bykerk speaking, not someone else.

Another problem in Florida is that Florida has a small group law that goes down to one life and a lot of companies—small group companies in the state of Florida—have a lot of trouble with their experience. As a result, a number of carriers are getting out of the small group marketplace in Florida. This will mean that there will be a considerable number of individuals who may get dumped into the individual market through the portability provisions. They met their 18 months. They got into small group when they were guaranteed-issued into that plan in Florida. There's real concern about what's going to happen there if all of these people get dumped into the individual market. Will there be an individual market left in the state of Florida? But at any rate, that's another issue.

Again, what about states with legislation? I've talked a little bit about Mutual of Omaha's experience. For policy issues under the HIPAA guarantees, we're seeing right now about 2.2% of our issues as HIPAA issues. By the way, the approach that we've taken in, I think, every state is to sell our two most popular plans. Talking to other insurers, being at other meetings, and so forth, our anecdotal surveys indicate that other carriers are getting about 0.5% of their new issues as HIPAA-related. I don't know if Marlin Perkins is lurking out there and causing us to be seen as a more viable carrier or something. It doesn't seem to help when it's regular sales, but I don't know. But at any rate, that's what we're seeing. Fortunately, so far, we haven't seen the huge or large claim. Fear of large claims is where we're at, but we haven't really seen that happen yet. On the other hand, there's another carrier whose home office is in Omaha who has had some extremely poor experience with large claims in the state of Florida, so they are out there. When I get into risk pools, I can talk a little bit more about that too.

Now, fallback states. Basically insurers are doing the same thing they're doing in other states that have legislation. Clearly, there's more uncertainty. As Julie

mentioned, the states are to cover certain issues and HCFA is supposed to cover other issues. Again, pricing is a bit of a concern here. The state does have responsibility. In our own case, I know we're trying to file policy forms in the state of Missouri. We file them with the Kansas City HCFA office and the state of Missouri. If one of them requests a change, we have to refile them with both of them again. It does add a level of uncertainty in view of the dual regulation, but all I can say is those states had alternatives to take and they haven't chosen to take them yet.

For CHIP-pool states, the biggest impact, of course, is the funding assessment for the pools. Some states have other ways of paying for their pools, but most of them assess the carriers who are there. Some of them give premium tax offsets. In some cases those premium tax offsets were taken away when the laws were amended to meet HIPAA requirements, and in some cases we're still in a situation where we get offsets for non-HIPAA pools, but not an offset for HIPAA-eligible individuals.

One issue here, of course, is that the individual insurers do, in most cases, sit on the pool boards, and they get an opportunity to be involved in what's happening and how we're meeting the requirements. One of the potential impacts is if we start to see the experience go south on us. Will carriers withdraw from the state if they see what they feel are excessive assessments? As was pointed out, we have people coming out of the employer market and going into the individual market. The insured market, in these cases, is paying the tab, but the ERISA plans pay nothing. If that shift gets too much, it could cause carriers to pull out of the marketplace. However, given all of that, I'm still an advocate of the CHIP pool approach to solving this issue. Julie brought up one issue that we've discussed. The NASCHIP organization discussed it at the national level as well. Should we try and push for some reciprocal agreements between CHIP pools so that we can let people move from one state to another and get in? I think in just about every case, that would require legislation at the state level for states to be allowed to do that.

Another approach would be to do regional CHIP pools. Could we pull several states together and do it on a compact basis?

I'm chair of the Alaskan CHIP pool. There are no domestic carriers in the state of Alaska. It's nice to get up there and be exposed to some people who are benefiting from the work you're doing. It's very reassuring and helpful. In Alaska there's been very little impact in responding to HIPAA. The state law was already written so that if anyone could prove that they couldn't get a policy elsewhere and if they were involuntarily terminated from their previous coverage, whatever the coverage was for however long it was, we had to take them guaranteed-issue in effect with no preexisting exclusion. That's the way the Alaskan law was written from the time it

was originally passed in 1991 or 1992. That in effect covers almost all of the HIPAA-eligible people, plus a whole bunch of other people. Alaska, for example, doesn't have to worry about people moving up there from Montana or somewhere else and being terminated in that state from their CHIP pool because they'd be involuntarily terminated and be eligible in Alaska, so that's an issue that hasn't impacted Alaska too much.

We've developed a special application so we could keep track of people and make sure that we were getting everybody right. It's the same plan that the regular CHIP-pool people get with the same rates, and we couldn't offset assessments before anyway so that had no impact. So far we haven't seen any real significant increase since July 1997, when we started taking in eligible individuals.

In Montana, where I'm vice chair of the board, it is an entirely different situation. There the state chose to put through new legislation. We have two separate new plans with different rate structures. These assessments covering those plans could not be offset, while the regular plan assessments could have been offset. Right now the regular plan rates are set at about 150% of the market, while the HIPAA plans have one set at 120% and the other at 135%. The industry is concerned about how low those HIPAA plan rates are getting or how close they're getting to standard, because, after all, standard is an average of 5 companies so that means there are some companies closer to those HIPAA rates than 20% away or 35% away. Montana has seen significant growth. Our regular plan has about 700 members. It's been going up steadily for the last few years for various reasons. We had upgraded the benefits. We've cut the rates from 200% down to 150% to revitalize the pool, so that seems to be going about as we had hoped. On the other hand, the HIPAA pool has just gone through the ceiling. We're now at 425 members. We keep asking questions. How can this be happening? It's totally inconsistent with what's going on elsewhere. We've asked the administrator what's going on. We did find one issue: They had misunderstood or misinterpreted the COBRA rule and thought people could decide if they took COBRA or went to the CHIP pool. Clearly, that has generated a lot of these 425 people. We changed that about two months ago, but we still seem to be getting a lot of people. Some of those might have been in the pipeline and so forth.

The state insurance department, however, may have something to say about us changing and interpreting the COBRA rule in the correct way. The commissioner plans to introduce legislation in 1999 that will in effect put us back to where we had misinterpreted the law to say that people will have the option of going to COBRA or going through the HIPAA pool plan. That's allowable. States can do more than what HIPAA says.

I also might mention that in Alaska, the 63 days were not used; 90 days were used in the state law, and that was to facilitate the fact that sometimes people don't have contact with individuals for more than 90 days in the state of Alaska. At any rate, they did extend the 63 days to 90 days. Those kinds of extensions are totally allowed under HIPAA, as far as I understand it.

As you can imagine, a huge increase in assessments has now resulted in the state of Montana, where previously we were making very modest assessments. We just had a conference call last week and I think we're estimating that 1999 will see us assessing somewhere between \$4 million and \$5 million between the two pools—the HIPAA and the other. And while I'm talking about that, in my home state of Nebraska we're going to assess \$17 million in 1999. For 1998, we assessed \$8.5 million. We're trying to figure out what's happened there as well, but clearly the assessment levels are jumping.

There has also been an impact in guaranteed-issue states. Specifically, the guaranteed portability provision and the requirement for certification of coverage have an impact. Even though an individual coming out of an individual plan isn't eligible under HIPAA for portability, the coverage does count toward some subsequent federal qualification if he or she goes into an employer plan. Those requirements still apply to the individuals, and that's true in all the states.

Now for unintended consequences. I personally think that the guaranteed renewability provision was not contemplated. I may be wrong there. We are concerned about duplication of Medicare when people reach age 65. There are some ongoing discussions about what happens when children become eligible or get to the point where they're no longer eligible as a dependent. Do we have to continue them? I know in Mutual of Omaha's case, we offer those people standard coverage on their own policy. Will that be OK or do we have to continue them under the original policy?

Withdrawal of insureds from an unstable marketplace is obviously unintended, but it can happen. Group dumping in Florida frequently means you're selectively culling people out and dumping them. That's not what I meant here. This is due to some marketplace situations. There are just lots of people being put into that sector. Ultimately, the uneven distribution of issues among carriers may be a problem. We're getting 2.2%; others are getting 0.5%. I have no idea what's really going on out there. That's all anecdotal information except our 2.2%.

**Ms. Novak:** Does anyone have a question?

**Mr. Thomas J. Stoiber:** I'm very fearful that the impact analysis is going to be nothing more than how many people are going into their pools who are HIPAA eligibles. We're going to see that thousands of people have gotten coverage because now we have thousands of people who are HIPAA eligibles in risk pools in these states. One of the offsetting impacts was what I call the Great Group Conversion Relief Act of 1996, in that there was a paternalistic attitude out there that group insurance carriers would provide group insurance coverage without a law with self-insurers or self-funded plans. The larger players, after COBRA expired, would provide these group conversion plans anyway. What I've heard now anecdotally, and I've seen information like this in the state of Maine, is that these group carriers have stopped providing coverage where they otherwise might have, so my fear is that what we're seeing is increased eligible members on the HIPAA side as nothing more than a shifting of people who were covered prior to this law. I'm wondering, Cecil or Julie, if there's any sort of information out there that says how much of this HIPAA impact is nothing more than a shifting of people who were covered under group conversion in the past? I mentioned Maine specifically. I know that there's really only one carrier in Maine to speak of and that's Blue Cross. My understanding is that they in essence don't even offer group conversion anymore to any of their employers because they don't need to. Everybody has taken the HIPAA individual plans, so do you have any feel for that Cecil or Julie?

**Mr. Bykerk:** I don't have any information or any feel for that other than just the general impression that you get from reading any articles or statistics that there continues to be an erosion of employer-provided coverage, conversion coverage, and so forth. Those I think are probably state-isolated issues. But clearly, we're still in a fairly good economy, yet the number of employers and the number of people being covered, is going down and I don't know what's going to happen if we hit a recession. I think we're going to see huge numbers of people dumped.

**Mr. Stoiber:** I've done recently a rather extensive study of the state impacts on this, and the states that have alternative mechanisms where they adjusted their conversion laws and made them stronger have seen fewer people going into the eligible program, which indicates to me that in the federal fallback states where you don't have that, and certainly under the self-insured ERISA exempt groups, it seems to indicate that employers are saying, "Hurrah, I can save myself a few bucks," and no longer offer group conversation requirements. I think there's indirect empirical evidence and direct evidence, and it might be more of a shifting than anything else.

Julie, I thought there was a provision in the law that said after a couple of years there was a report due to congress whether HIPAA is working, and I thought it was more than just the MSAs. Am I wrong on that or do you know? Is that your department?

**Ms. Walton:** Yes, there is a report that's due. I don't know if it's a couple of years, but it's a little further down the pike. GAO is also required to do reports. I don't think I mentioned the urgent need for baseline data. One of the problems, especially in the guaranteed-issue states, is that we have no idea how many HIPAA eligibles there are. Some of the risk-pool states are keeping track of it separately so they know how many HIPAA eligibles there are. Some risk-pool states are not carefully distinguishing between them. I know Richard Carlson in Illinois comes to our NAIC federal fallback meetings every quarter and gives a lovely update of how many they're seeing because they're doing a good job of tracking it. We're hoping that more states will do this through their risk pools where they're all funneling into one place so you can count them if the state set up your system to do it that way. But in the guaranteed-issue environment or the federal fallback situation, there's no easy way of knowing.

Again, I guess it gets into antitrust problems in terms of trying to figure out who's getting what percentage of this population and the uneven distribution among carriers. But I think you very well may be right. I'm just thinking in terms of employer plans dropping the conversion option that they may have offered in the past because now HIPAA creates a bridge to somewhere after COBRA. Previously COBRA was a bridge to nowhere unless the plan provided a conversion plan. The question is, how stringently was the conversion option regulated by the state? A lot of conversions provide pretty crummy coverage, but some states chose to use conversions as their mechanism, or as a mixed mechanism, for people coming out of insured plans, and the state has regulated what conversion policy has to look like in terms of benefits and perhaps price as well. I think this is one of the areas in which states have a lot of flexibility to do more. As Cecil mentioned, some states did improve their conversion laws. If you go to that Georgetown University Web site, (I know our Web site has a hyperlink to it and so does DOL's), the database that Nicole Teppe and Karen Polis have set up looks at more than just the HIPAA requirements under a state. They had information as well about what the state requires under conversion options. That's another piece of the pie to look at. But I think you're right.

**Mr. H. Lee Michelson:** In Florida the definition of eligible insured is one who is entitled to guaranteed-issue of the two most popular plans of each individual marketer, which specifically excludes insureds who are eligible for group conversion. Florida has very strict legislation on what plans must be available and at what rates for group conversions. Now, if someone had group coverage in Florida and was terminated for any reason with very few exceptions like fraud or nonpayment of premiums including the companies exiting the small-group market (which happens sometimes) the company would be required to have available group conversion policies that might be individual policies, but they're policies

issued by or for the group insurer. There is no dumping on the individual market, so I don't understand the potential for small group dumping. I'd like to have that explained.

**Mr. Bykerk:** It's probably a poor choice of words to begin with. Typically, dumping means some covert way that the employers are trying to shift people out of their coverage into some other marketplace. That was not what I was referring to here. I was referring to a number of carriers that have exited or are exiting or plan to exit the small group marketplace in the state of Florida. What happens? In dumping, large numbers of people are suddenly going out into the marketplace needing to buy coverage. And if those people are one-life groups, because one-life groups are allowed under Florida Small Group law, who is going to provide them with a group conversion policy?

**Mr. Michelson:** The group insurer would be required to have available a group conversion policy conforming with Florida law. We would not approve the group's policy if the insurer did not have a conversion policy available.

**Mr. Bykerk:** So even though they're withdrawing from the marketplace. . . .

**Mr. Michelson:** Even though they're withdrawing from the marketplace they would have to provide conversion policies to those who were terminated from their group coverage.

**Mr. Bykerk:** At what rate structure?

**Mr. Michelson:** The rate structure is bounded by the 200% morbidity rates that were developed for the high-risk pool, adjusted for benefits differences. There's also a 120% loss-ratio requirement.

**Mr. Bykerk:** Please note that it was later determined that Mr. Michelson's reference applied to policies filed in Florida, but does not apply to policies filed on an out-of-state trust issued in Florida.