Testimony for the Record

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by

Janet Stokes Trautwein, Director of Federal Policy Analysis
THE NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS
2000 North 14th Street, Suite 450
Arlington, VA 22201
(703) 276-3806
www.nahu.org

The National Association of Health Underwriters is an 18,000-member association of insurance professionals involved in the sale and service of health insurance, long-term care insurance and related products, serving the insurance needs of over 100 million Americans. We would like to take this opportunity to present information on the health insurance underwriting process and the effect well-intended genetic discrimination legislation could have on the cost of health insurance. We are extremely concerned about pending legislation on employment discrimination based on genetic information due to its cost impact on the critical role employers play in providing benefits such as health insurance for their employees. NAHU believes health insurance affordability is the most important component of access to health care.

Advances in the field of genetics have increased so dramatically that we are now able to clone animals. These dramatic advances and the recent announcement of the mapping of the Human Genome have also provided new ways to check for the probability of certain illnesses. The possibilities for treatment and prevention of illness based on the availability of this new information are truly exciting. In light of these rapid advances in the field of genetic research, some people have expressed concern about whether their genetic information might be used improperly to prevent them from obtaining health insurance or by employers for hiring or firing purposes. NAHU believes that health insurance or employment discrimination based on the genetic information of an otherwise healthy individual should be prohibited, provided that the definition of the prohibited information is carefully, clearly, and narrowly defined. Inappropriate disclosures of <u>all</u> health information, not just genetic information, should also be prohibited, and regulations on disclosure should apply consistently to all types of health information. But any action taken on these prohibitions should be carefully balanced with the medical promise offered by genetics. In our race to protect the rights of Americans against unlawful discrimination and disclosure, we must be careful not to legislate away our ability to use advances in genetic science to improve our health and eradicate illness.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislated many new protections for health insurance consumers, and among those protections was

a provision stating that group health insurers cannot consider any individual employee's genetic information in the group health insurance underwriting process**,** unless that genetic information has already resulted in a diagnosis. For example, if a generally healthy person had some genetic tests run to see if he or she had markers for any particular illnesses, that information would be prohibited from use. The law prohibits denial of benefits or increases in premium to individual members of a group health plan due to health status. HIPAA does not address the issue of genetic information in the individual health insurance underwriting process, nor does it address employment discrimination based on genetic information.

In the individual health insurance market where there is not an adequate mechanism to spread risk, a requirement to issue coverage without regard to health status will increase the cost for everyone. This is also the market most sensitive to those cost increases, because individual health insurance consumers do not have employers subsidizing the cost of their health plans. Many individuals and families are faced at some point in their lives with purchasing coverage in the individual health insurance market, and it is critical that the cost be affordable. If it is not, the ranks of the uninsured will rise, and costs in the small group market will also increase as people attempt to game the system to somehow change their status from an individual market buyer to a "group."

The use of health status information in the underwriting process keeps costs down and offsets the impact of adverse selection. In states where individual health insurance policies must be issued without regard to health status, premiums are much higher, coverage choices are limited, and fewer insurance carriers operate in the individual health insurance market.

To start out, it may be helpful to explain what underwriting is. Underwriting is a basic evaluation of risk. Applicants for all types of insurance go through a risk evaluation process, or underwriting, as do applicants for credit cards, bank loans and mortgages. A bank would be very reluctant to issue a loan to someone who appears unlikely to be able to repay it, and an insurer would be unlikely to insure a house that was already on fire. If

banks were unable to ask the information necessary to ensure the financial stability of applicants, they would either stop issuing loans or increase the interest rate to account for the increased likelihood of losses. Similarly, if an insurer couldn't ask whether a home was already on fire, the insurer would likely not insure homes or dramatically increase the cost to cover the cost of those who waited until their house was on fire to purchase coverage. On the other hand, if the bank and insurer are able to ask the questions needed to accurately assess the risk of an applicant or homeowner, applicants may enjoy a "preferred" rate based on their good credit history, and homeowners may be able to receive discounts for certain safety and security features in their homes. Health insurance underwriting works the same way – the more information the underwriter has, the better rates will be for most applicants overall.

Underwriting of Health Plans

The Individual Health Insurance Market

Although most people who are insured are covered through employer-sponsored plans, some people do not have access to employer coverage and must buy in the individual health insurance market. The individual health insurance market offers a wide range of policy coverage options in many states, depending on the regulatory environment. Coverage is available in a wide range of deductibles and plan types, and most people can find a policy suitable for their needs, although coverage for maternity and mental health expenses is often limited and prescription drug benefits tend to be more restrictive than those found in the group market.

In most states, individual health insurance is rated based on the age and health status of the applicant and requires the completion of a health questionnaire. Occasionally a paramedical examination and/or a blood and urine sample are required. Questions about genetic tests are not currently asked by any insurance carrier that we have been able to determine, although a small number of insurers ask questions about medical history of the parents and siblings of the applicant.

Applicants are asked a variety of questions about their current and past medical history including height and weight, smoking status and details about recent physical exams, including the results of lab work. Complete information allows the underwriter to evaluate the risk of the applicant accurately and provides for greater rate stability. Any missing information can result in the applicant being turned down for coverage. At best, missing information will result in the underwriter assuming the worst, and the consumer will either pay more for coverage or have coverage excluded.

Depending on the state, an applicant for individual health insurance coverage will have coverage issued as applied for, have coverage issued with a rider for certain conditions or body parts, or have coverage "rated up" or issued at a premium higher than the standard rate. The majority of states don't have limits on rate-ups for individual coverage, but if an applicant's health history is such that a large rate-up is indicated, it is more likely that the person would be declined for coverage.

Applicants who are declined for coverage in many states are eligible for coverage through their state high-risk pool. In other states there is an annual open enrollment period for uninsurable individuals through one insurance carrier in the state. A few states guarantee issue coverage in the individual market, although the cost is high and choices significantly limited. Several states provide coverage through a carrier of last resort, which means that the designated insurance carrier must accept an individual regardless of health status. Usually there is one month per year when this happens, although in some states applicants are accepted all year. A very small number of states have no option for medically uninsurable individuals. A summary of high-risk pool coverage and other mechanisms for uninsurable individuals across the country is attached.

Small Employer Groups of 2-50[1]

Although many people refer to employer self-funded health plans as ERISA plans, small employer health insurance plans are also ERISA plans. Small employers can select from a variety of plans in most states, including HMOs, PPOs and indemnity plans. The selection depends largely on the regulatory environment in the state in both the small employer **and** individual market, and can vary dramatically from state to state.[2] Availability of coverage is also impacted by the location of the business. In general, rural businesses have less selection than businesses in metropolitan areas, largely due to the reluctance of rural providers to participate in managed care plans.

Even though HIPAA and state laws provide that small employer health insurance coverage must be issued regardless of the health status of employees and dependents, many states allow rates to vary for the group based on overall health status. To determine the health status of the group, each employee is required to complete an individual questionnaire with detailed health information on the employee and all family members to be covered. The underwriter normally uses only information obtained from the application, but sometimes the underwriter will request additional information from an applicant's physician or may telephone the applicant to clarify an item on the application. If an underwriter is unable to obtain information necessary to accurately determine the risk of a particular applicant, he or she will underwrite more conservatively, meaning that the assumption relative to the missing information will be negative rather than positive.

So, for example, if an underwriter sees that a person has a history of high blood pressure that appears to be normal with medication and has a weight within normal limits, but is unable to determine whether or not the individual smokes and has a normal cholesterol level, the underwriter will assume that the missing information is negative.

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[1] When we refer to group size, we are referring to the number of employees, not the total number of covered persons, which would include dependents.

[2] Availability in the individual market impacts the small employer market dramatically. People who have difficulty qualifying for individual coverage in the individual market often try to find ways to make themselves eligible as a group, sometimes by enrolling family members as employees who may not be

Each employee application is considered individually, usually using a point system, and the overall negative points determine whether the group will be issued at the rates quoted or with a rate-up. On a very small group, one applicant with a health history that would have resulted in a "decline" prior to guaranteed-issue laws will result in a maximum rate-up for the group in most circumstances. It is very important, therefore, that each employee's application be as complete as possible in order to ensure that initial rates are accurate.

The most common type of state rating law allows groups to be rated 25% above or 25% below an "indexed" rate. The indexed rate is determined by averaging the lowest possible rate and the highest possible rate. Most insurance carriers offer the lowest legal rate on their initial quotes, or 25% below the indexed rate, in states that employ this maximum. If a group's health status is such that they would be rated at the maximum level, this means that their final rate could be 67% higher than the rate initially quoted to them. Most states that have this type of rating system also have a limit on rate increases due to the health status of the group, which is helpful in stabilizing rates over time. Even with these initial rate fluctuations for a new group, small employer rates in these states tend to be lower than in states where health status rating is not allowed. A group that is rated correctly up front is much less likely to have a very large increase at renewal, and in order to rate the group correctly, the correct information on the initial application is essential. A chart showing the rating laws in each state is attached.

Legislation under Consideration

The issue surrounding prohibition of discrimination by health insurance carriers due to genetic information has evolved over the past few years. Legislation to expand the prohibition on the use of genetic information in underwriting has resulted in a variety of opinions as to how genetic information should be defined. The definition of genetic

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actually eligible, for example. This gaming of the system is a type of adverse selection and causes rates to increase for small employer plans.

information has been broadened in S318 in a way that could include items that go beyond what is normally considered a genetic test. Using too broad a definition could disrupt and prevent normal underwriting procedures, resulting in unaffordable health insurance premiums for employers and consumers.

The first issue regarding the definition of genetic information relates to **when** information should be considered genetic information. HIPAA prohibits discrimination by any individual within a group based on health status, including genetic information, in the absence of a diagnosis. Genetic information when no diagnosis or symptoms of illness are present is called "predictive" genetic information. In contrast to S382, S318 removes all reference to predictive genetic information, and replaces it with the term "protected" genetic information. This, in effect, goes far beyond the HIPAA standard and would prevent genetic information from being used in health insurance underwriting even when a diagnosis of illness is otherwise present.

Because HIPAA did not adequately define **what** "genetic information" is, it is extremely important that any new legislation clearly specify what should be included in the term "genetic information." NAHU believes the definition of genetic information should be limited to DNA and related gene testing done for the purpose of predicting risk of disease in asymptomatic or undiagnosed individuals, and that it should clearly exclude such items as age, gender and information from physical exams and lab work, including items like cholesterol tests performed to detect symptoms, clinical signs, or a diagnosis of disease.

Finally, in contrast to the definitions in S382, S318 does not include specific tests in its exceptions, such as cholesterol screening, but it is specific tests such as these where we have serious concern. Cholesterol screening, for example, is a metabolite test. Other legitimate genetic tests are also metabolite tests. Cholesterol screening is currently used as a diagnostic tool and, as such, a "high" result is considered a diagnosis. Changing the status of an item such as cholesterol screening to be included as a genetic test would remove it from the diagnostic category, along with the diagnostic code that allows

millions of Americans to have their cholesterol lowering medications covered by their health insurance.

The combination of these provisions of S318 would significantly reduce the amount of health information available during the underwriting process. This reduction in the ability to underwrite would have the same result it has had in the states that have tried it, including carrier withdrawal due to excessive losses, significantly reduced choice in benefits, few carriers from which to select coverage, and significantly higher cost of the coverage that is available.

Further, the employment discrimination provisions allow an individual who believes that he or she has been discriminated against in employment on the basis of genetic information to sue for unlimited damages. However, an individual who is discriminated against on the basis of disability or race can only recover compensatory and punitive damages up to the level set for in the Civil Rights Act of 1991. There is no justification for providing greater remedies to someone who is discriminated against on the basis of genetic information.

S318 also allows an individual to bypass the EEOC and directly pursue a private lawsuit. Someone claiming employment discrimination on the basis of genetic information should not be allowed to do this when someone claiming disability or race discrimination is required to first exhaust administrative remedies.

The EEOC plays a critical role in investigating and pursuing claims of employment discrimination. Of particular importance is the effort the EEOC is taking to mediate disputes providing for a quicker resolution, and easing the backlog of cases in the courts. Allowing individuals claiming genetic discrimination to bypass the EEOC and go directly to court, as S328 would do, undermines these beneficial activities and the expertise the EEOC has developed in investigating and resolving employment discrimination claims.

Finally, under S318, employers are prohibited from requesting, requiring or collecting an employee's genetic information. However, an employer might need to gather such information in order to comply with other laws, such as the Family and Medical Leave Act or the Americans with Disabilities Act. If S318 were enacted, employers would be placed in the impossible position of violating one law in order to comply with another.

In spite of these hurdles, employers need and want to continue to provide the health insurance and other benefits that are of such great value to their employees. Most people today have health insurance through their employers, and prefer to continue to obtain their coverage in this manner. In addition, there is no evidence that employers have broadly engaged in any discriminatory action based on genetic information. Employers, in fact, have not suggested that discrimination based on genetic information be allowed, but rather that there be equity in the rules and remedies that apply to all forms of employment discrimination.

Conclusion

Health insurance underwriting is a complicated process. It is a combination of art and science, and is highly dependent on not only the risk of the applicant but also on other market conditions that may be beyond the applicant's control. The most important component of underwriting is complete information to allow for a thorough evaluation of risk.

Good underwriting at the inception of any health insurance policy won't prevent premium increases, but it does result in more stable rates over time. This stability allows families and businesses to plan and budget for their health care expenses and helps keep coverage affordable and accessible.

There is no question that advances in genetics will increase exponentially in the coming decades. Changes in the accuracy and absolute predictability of the information that will be provided will also improve, and the use of this information to diagnose current illness

may become as common as taking a blood pressure reading is today. It is extremely important that lawmakers recognize this changing dynamic, and proceed thoughtfully on issues related to genetic discrimination, as well as privacy of all health information, to allow the medical field to advance treatments and find cures for those suffering with disease. Additionally, lawmakers must realize the impact their actions will have on the cost of health insurance today and in the years ahead. Great care should be taken to craft legislation that is very specifically related to a prohibition of the use of legitimate genetic tests. Overly broad definitions will impede the normal underwriting process and increase the cost of coverage, resulting in reduced access to quality health care.

Janet Stokes Trautwein is director of federal policy analysis for the National Association of Health Underwriters, an 18,000-member association of insurance professionals involved in the sale and service of health insurance and related products. Her responsibilities include monitoring and analyzing federal legislation, writing and revising legislation, and developing policy for NAHU. She is also the director of state government affairs for all 50 states. She has a particular interest in issues related to the uninsured and in health insurance markets around the United States. Prior to joining NAHU in 1997, Janet was the legislative director of the Texas branch of NAHU for four years; before that, for 17 years she was a principal in an insurance agency specializing in health insurance, employee benefits, and related products.

For further information, contact:

Janet Stokes Trautwein, Director of Federal Policy Analysis
National Association of Health Underwriters
2000 N. 14th Street, Suite 450
Arlington, VA 22201
(703) 276-3806
jtrautwein@nahu.org

Additional Information on Health Insurance Underwriting
Mid-size Employers of 50-300 Employees

This market is considered to be the "medium" size market. Most employers in this category purchase fully insured health insurance or HMO policies that are regulated by state departments of insurance or another state regulatory body. Many employers of this size offer PPO plans, and a large number offer more than one plan choice for employees. It is quite common for an employer to "shop" his health insurance plan every year to be sure he is getting the best value for his dollar. This is normally done with the assistance of an insurance broker.

In order to obtain bids for coverage, employers that have a current health plan or plans are required to provide three years of claims experience to the carriers from which they are soliciting a bid for coverage. Claims experience is a listing of paid premiums vs. paid claims, and includes a calculation for anticipated claims that have not yet been received by the in-force carrier.[3] The claims experience will typically include a list of large claims by amount and the diagnosis associated with the claim. If this is not included with the claims experience, the bidding insurance carrier will request the large claim information. The bidding carrier will also ask about any known serious illnesses, to the best of the employer's knowledge, such as cancer, heart problems, AIDS, and the prognosis of each, to the best of the employer's knowledge. Names of the employees with these conditions are not requested, but gender and age for the employee or dependent with the condition may be requested, as it may better enable the underwriter to assess the risk.

Sometimes other questions are asked as well. For example, if a person has had recent heart surgery, questions about current blood pressure, weight, smoking status and cholesterol level might be asked. Supplying this information can have a very positive impact on the rates the employer pays for coverage. For example, if an employee who had a large claim is now deceased or is no longer employed, or if the large claim was due

to an accident from which the employee has completely recovered, the amount of the large claim is adjusted out of the overall claims experience. If a person had bypass surgery early in the previous plan year, has recovered well and now has normal lab work and blood pressure readings, the chances of another large claim occurring soon are very low, and the underwriter will take that into consideration in setting the plan rates.

If the employer is not able to supply large claim and serious illness information, the insurance carrier may either underwrite more conservatively[4] to be sure it covers its bases on the risk assessment or, in some instances, may decline to write coverage on the group. Groups over 50 lives are **not** guaranteed issue. Even though a larger group has more employees over which to spread risk, a group of 50-300 is not considered large enough to spread all possible risks it may contain, and it is necessary to identify particularly high risks in order to establish rates that are adequate to sustain the cost of claims and administration. If the employer is unaware of a serious condition, the health plan will not come back mid-year and penalize the employer for not reporting the condition during the bid process, but an adjustment based on the actual risk will be made at the plan's renewal.

In addition to the claims experience, a list of employees, including gender, date of birth and the type of family members to be covered,[5] is required to calculate an average age for the group and male and female content. Age has an obvious impact on the level of claims since older individuals statistically have higher medical expenses. Females tend to incur higher costs than males until about age 50, and that is the reason for the calculation on gender.

A group of 300 is considered to be 100% credible for its claims experience by most insurance companies. This means that if an employer has three years of available claims experience, an accurate rate can be calculated even without information on age or gender of the employees, just based on the group's past experience. Statistically, most groups

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[3] Claims that have been incurred but not reported are referred to as IBNR claims.
[4] When an underwriter underwrites more conservatively, they put a "load" on the rates to account for an expected margin of error.
[5] Spouse only, children only or the entire family

follow a fairly predictable three-year pattern if they are large enough. Of the three years of claims experience, the most weight is given to the most recent year. In addition, insurance carriers have a "book rate" based on their experience with other groups of employees of similar age, gender and industry. The book rate is used for newer groups that haven't had previous coverage and also for groups that are a little smaller and not fully credible with their own claims experience. For example, a group of 200 might be considered 75% credible for its claims experience. Therefore, in calculating the rate, claims experience would be given 75% weight and the book rate would be given 25%. A group of 150 might be considered 50% credible and a group of 100 might be 25% credible. A group of 50 would receive a 100% book rate, modified by any known serious health conditions. This can vary slightly from carrier to carrier, but the general process is the same.

Rate Stability

A number of things can impact a group's rates from year to year. A group may have a large number of maternity cases in a single year, or one or more persons may have large claims that cause the group's claims experience to be abnormally high. New state or federal laws that require payment for specific items and services are not without cost. This cost adds to the total cost of claims paid under the plan, which in turn causes premiums to increase. The cost of prescription drugs is increasing for all employers, as is the cost of medical care in general. Even if nothing unusual happens in a group in a given year, these increasing costs may cause a group's claims experience to go up, and its rates to be increased at the plan's renewal. This is why it is so critical that the rates be as accurate as possible from the start. A plan with rates that are set too low initially will simply recoup its losses at renewal with a very large increase. These large fluctuations in premium are very unsettling for employers and employees, and can result in some employees dropping coverage, as they become unable to pay their share of premiums.

Self-Insured Plans

Self-funded or self-insured plans are plans where the employer takes the risk for the cost of health claims, rather than purchasing a plan from an insurance company. The employer often buys stop-loss coverage to protect against excessive losses, but retains financial responsibility for the plan. Underwriting in self-funded plans works just like it does for fully insured plans in this market, primarily because of the stop-loss insurance. Although most employers in this category are fully insured, a large number are partially self-funded and are subject to federal rather than state regulation. In a self-funded plan, an employer usually selects an insurance carrier or third-party administrator to administer claims, a PPO or HMO network of physicians, hospitals and other providers for preferred-provider benefits, a pharmacy benefit manager to manage prescription drug benefits, and a utilization review organization if this service is not performed by the preferred provider network. Each of these services is normally purchased on a separate monthly fee per employee basis, although the cost of some services may be combined if purchased from the same vendor.

The self-funded employer also normally purchases what is called specific stop-loss insurance to protect against large claims of any one individual covered by the plan, and aggregate stop-loss insurance to protect against excessive utilization by the group as a whole. Once an individual or group's claims reaches the stop-loss level, the reinsurance carrier is responsible for the claims for the individual or the group, depending on the type of loss, for the balance of the contract year. In order for an employer to know how much stop-loss coverage is appropriate for its group, the same information asked of fully insured cases relating to overall claims experience, large claims and serious illnesses is required. Since stop-loss levels are established based on expected claims, it is very important to be as accurate as possible in anticipating future claims. Complete information during the underwriting process is extremely important or an employer may be forced to set stop-loss levels too high, resulting in inadequate protection in the event of a year of high claims.

Groups of 300 or More Employees

Larger group underwriting works in a manner similar to that described for medium-size employer groups. The differences are a matter of degree. Claims experience is required during the underwriting process, but for a larger group, a claim may not be considered large until it reaches $25,000, $30,000 or even larger.

For this reason, the number of claims that must be reported in the large claim listing may be fewer. Information on serious illnesses will be requested, but detailed information on prognosis is less important. The reason fewer questions are asked is that the larger the group becomes, the more credible its past claims experience is, even with some large claims thrown into the mix. Even large employers, however, have difficulty anticipating and budgeting for cost increases due to new technology and the cost of prescription drugs.

The other thing that changes is that the larger the group is, the more likely it is to be partially self-funded and, if really large, fully self-funded. Stop-loss coverage is usually purchased, but with a higher trigger point for claims as the group becomes larger and better able to handle cash flow fluctuations. Third-party administrators, brokers and consultants use formulas to help employers determine the level of stop-loss coverage that is appropriate based on expected claims, group size and the employer's level of risk tolerance.

Large employers also have greater ability, due to volume purchasing, to offer variety to employees including multiple plan options. Large employers are also increasing their use of disease management programs, wellness programs and options for alternative medicine.

One thing that should be noted is that not all employers that self-fund use administrators and insurance carriers. Although it is not very common, there are employers who self-administer their benefits plans. Not all of these employers are "jumbo" employers, and

some are in the 50-300 size category. Self-administration is done to save money, and many of the employers that employ this method would not be able to afford to offer a plan if they didn't administer it themselves. The smaller employers that self-administer usually offer decent coverage without complicated provisions. These employers take great care to pay claims accurately, and actually understand the stop-loss provisions of their reinsurance contracts very well. The reinsurance coverage they purchase requires all of the same information gathering required under other arrangements, although it is sometimes more difficult for them to obtain reinsurance without the "official" prior claims documentation provided by a third-party claims administrator or insurance carrier.

Additional Information about Rates on Health Plans

Rates are also obviously impacted by plan design and type. Rates for PPO plans are usually, but not always, higher than HMOs, partly because the way providers are paid impacts the ultimate claims cost. PPO plans pay preferred providers based on a discounted fee for service, or in some cases, on a previously agreed to per diem rate for things like hospital stays. Sometimes "case" rates are paid for maternity or similar types of common expenses. A case rate is a lump sum paid for a certain types of expenses. For example, an uncomplicated vaginal delivery might have a "case" rate of $1,000. Out-of-network providers are paid based on a percentile of the usual and customary (UCR) cost of a service in the zip code of the provider. Some plans pay out-of-network providers based on the 80th percentile of UCR, some on the 70th percentile, and some on the 90th percentile. The percentile used is important because on out-of-network claims, the insured is responsible for all charges the insurance plan doesn't pay for, and because it impacts the dollar amount of total claims paid.

Example: Employee is covered by a plan that pays for services at 90% in network and 70% out of network. Out-of-network charges are paid on the 90th percentile. Employee has surgery by an out-of-network physician who charges $1,000. Ninety percent of physicians in the area charge $900 or less for the procedure, so the physician the employee selected is above the 90% percentile of usual and customary charges by $100.

Here is how the claim is paid at both the 80th and 90th percentiles:

	At 90th Percentile	At 80th Percentile
Surgery	$1,000	$1,000
Minus amount over Usual & Customary Charges	$ 100	$ 150
Covered fee	$ 900	$ 850
Insurance pays 70%	$ 630	$ 595
Employee pays 30% plus amount over UCR	$ 370	$ 405

If the insured uses an in-network PPO provider, then the insured would not be responsible for charges in excess of the contract rate. Example:

	Charges
Regular rate for the surgery	$1,000
Contract rate for the surgery	$ 650
Insurance pays 90%	$ 585
Employee pays 10% of contract rate	$ 65

As you can see, because of the PPO discount, both the plan and the employee pay less with the PPO provider, even though the plan is paying at 90%. This means claims payments will be less and premiums lower if most employees use preferred providers. It also is an incentive for plans to develop full networks of providers. In this instance, if the plan did not have an adequate network and had to pay the full undiscounted rate to the surgeon at 90%, the plan would have paid $900 for a service that should have cost them $585.[6]

[6] One of the reasons rural areas have fewer PPO and other managed care plan options is that PPOs and HMOs frequently experience difficulty in getting physicians in rural areas to participate. This results in the problem described above, where the plan is forced to pay for a service at the full undiscounted rate at the highest applicable percentage, while the employee's cost-sharing is not allowed to be more than it would have been with an in-network provider, because of rules on network adequacy. Network adequacy rules require plans to include providers in each specialty that might be required by people insured under the plan, as well as provide for adequate facilities for lab, x-ray and hospital care. In this case, a plan may decide it's

Premiums on PPO plans are also impacted by the ability of the plan to negotiate discounted fees with preferred providers. In rural areas, it is often difficult to negotiate a discounted fee with a physician who may be the only specialist of that type in town, and many physicians in rural areas don't negotiate at all. In those situations, there may be few PPOs available, and for those that are available, it is much more likely that out-of-network claims will be paid at a lower percentile of UCR and that the percentage payable will be less. If you go back to the example above, you will note that the out-of-network claim paid at the 80th percentile resulted in a payment by the plan similar to the payment made to the PPO provider. The difference in this situation is that for out-of-network claims, the insured takes on all of the responsibility for the amount not paid by the carrier, while with preferred providers, the provider absorbs the cost.

In addition, even though the flexibility of a PPO is attractive, there are few barriers to utilization and, as a result, costs may be higher than they would be under an HMO. All rates are based on claims, whether it is the group's own claims experience or a book rate. Therefore, anything that increases the ultimate cost of claims paid out will impact the rate paid. This includes the cost of prescription drugs; for this reason many employers who want to retain as high a level of benefits as possible for non-pharmaceutical benefits are requiring increasingly larger copays for drugs, especially those not on the formulary.

HMOs pay providers in a variety of ways. Some HMOs actually pay physicians the same way PPOs do, based on a discounted fee for service. This is especially common when an HMO enters a new area and doesn't yet have a significant market share. But more commonly, the HMO pays a primary care physician a fixed rate, called a capitated rate, per member per month regardless of the number of times a person may or may not have seen the physician that month. Some specialists are capitated the same way, and others are paid a discounted fee for service. Certain specialties are very likely to be capitated,

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not economically feasible to offer coverage in the area, or may attempt to control costs with a "hospital only" PPO, or an indemnity plan where it can have some control over reimbursements by lowering the percentile it uses for usual and customary charges.

such as anesthesia, pathology and radiology. Hospitals are usually paid on a per diem basis, although they may be capitated or paid a "case" rate for some types of admissions.

HMOs usually require a referral from the primary care physician for a patient to see a specialist, and only cover care from network providers. The idea of referrals is to ensure that only patients who actually require specialty care are seen by plan specialists. Because primary care physicians are capitated, the cost of non-hospital care is more predictable and is usually lower than under a PPO where costs are more impacted by the rate of utilization. Most services require authorization from the primary care physician, and this more tightly managed care results in greater cost efficiencies.

In spite of this management of care, a sick person will result in high costs regardless of the type of plan. How high the costs are will vary by degree with the plan type. HMO rates are typically based on the "community" of members in their pool; however, they are permitted to make adjustments based on the demographics of the actual group to be insured. Again, it is essential that the bidding HMO have accurate information on the actual group to be insured in order to establish adequate initial rates.

One other type of common option is a point of service plan (POS). This type of plan option is often confused with a PPO, because it looks similar on the surface. In reality, a POS plan is simply an HMO with an option to use out-of-network providers. Usually the out-of-network option is significantly less attractive than an out-of-network option on a PPO plan, and the in-network portion of the plan is an HMO. This means that in the network, all HMO rules must be followed, including rules on referrals for in-network specialty care. While not quite as flexible as a PPO plan, a POS plan offers a good value for the dollar, especially if HMO providers will be used most of the time, while still allowing a safety net for people who want to retain the option of using non-network providers.

National Association of Health Underwriters
State-Level Health Insurance Reforms
As of August 1, 2001

State	Individual Market Reforms			Small-Group Market Reforms				S-CHIP Approach			Medically Uninsurable				MSA
	Guaranteed Issue	Pre- Ex Conditions (look back/ exclusion period)	Rating Structure	Guaranteed Issue	Pre-Ex Conditions (look back/ exclusion period)	Rating Structure	Group Size	Medicaid	Combination	Other	Risk-Pool	Guaranteed Issue	Open Enrollment	Other	
Alabama		none	NRS	•	6/12	RB	2-50		•		•				
Alaska		none	NRS	•	6/12	35%	2-50	•			•				
Arizona		none	NRS	•	6/12	RB/MC	2-50			•	None				•
Arkansas		none	NRS	•	6/6	25%	2-50	•			•				•
California		12/12	NRS	•	6/12	10%	2-50		•		•		•		•
Colorado		none	NRS	•	6/12	MC	1-50			•	•				•
Connecticut		12/12	NRS	•	6/12	MC	1-50		•		•				
Delaware		none	NRS	•	6/12	35%	1-50			•	None				
District	•*	none	NRS	•	6/12	NRS	2-50	•					•		•
Florida		6/12	NRS	•	6/12	MC	1-50		•		•				•
Georgia		none	NRS	•	6/12	25%	2-50			•	None				
Hawaii	•*	none	NRS/C	•	0	NRS/C	1-50	•						•	
Idaho	•*	6/12	25%	•	6/12	50%	2-50	•			•				•
Illinois		none	NRS	•	6/12	25%	2-50		•		•				•
Indiana		12/12	35%	•	6/9	35%	2-50		•		•				•
Iowa	•*	12/12	20%	•	6/12	25%	2-50		•		•	•			
Kansas		none	NRS	•	6/3	25%	2-50			•	•				•
Kentucky	•*	12/12	35%	•	6/12	35%	2-50		•		•				
Louisiana		12/12	20%	•	6/12	20%	2-50	•			•				•
Maine	•	12/12	MC	•	6/12	MC	1-50		•			•			•
Maryland	•*	6/12	NRS	•	0	MC	1-50		•				•		•
Massachusetts	•*	6/6	MC	•	6/12	MC	1-50		•			•			
Michigan	•*	6/6	NRS	•	6/12	NRS/C	2-50		•				•		•
Minnesota	•*	6/12	25%	•	6/12	25%	2-50		•		•				•
Mississippi		12/12	NRS	•	6/12	25%	1-50		•		•				•
Missouri		none	NRS	•	6/12	25%	3-25	•			•				•
Montana		36/12	NRS	•	6/12	RB	2-50			•	•				•
Nebraska		none	NRS	•	6/12	RB	2-50	•			•				•
Nevada		none	RB	•	6/12	30%	2-50			•	None				•
New Hampshire		3/9	RB	•	3/9	MC	1-100		•		•				
New Jersey	•	6/12	C	•	6/6	MC	2-50		•			•			•
New Mexico		6/6	MC	•	6/6	20%/ MC	2-50	•			•				•
New York	•	6/12	C	•	6/12	C	1-50		•			•			
North Carolina		none	NRS	•	6/12	RB	1-50			•			•		
North Dakota		6/12	MC	•	6/12	20%	2-50		•		•				

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Ohio	•*	6/12	NRS	•	6/12	35%	2-50	•				•			•
Oklahoma		none	NRS	•	6/12	25%	2-50	•			•				•
Oregon	•*	6/6	MC	•	6/6	MC	2-50			•	•				•
Pennsylvania	•*	none	NRS/C	•	6/12	NRS/C	2-50			•			•		•
Rhode Island	•*	0	NRS	•	0	10%	1-50	•					•		
South Carolina		none	NRS	•	6/12	25%	2-50	•			•				
South Dakota	•*	12/12	RB	•	6/12	25%	2-50	•			None				
Tennessee		none	NRS	•	6/12	25%-35%	2-50	•						•	
Texas		none	NRS	•	6/12	25%	2-50		•		•				•
Utah		6/12	RB	•	6/12	30%	2-50			•	•	•			•
Vermont	•	12/12	C	•	6/12	C	1-50			•		•			
Virginia	•*	12/12	NRS	•	6/12	NRS/ 20%	2-50			•			•		•
Washington		3/9	MC	•	3/9	MC	1-50			•	•	•			•
West Virginia	•*	none	RB	•	6/12	30%	2-50		•		None				•
Wisconsin		none	NRS	•	6/12	35%	2-50		•		•				•
Wyoming		6/12	NRS	•	6/12	25%	2-50			•	•				•

Explanation of Terms

Individual Market Reforms
Indicates the reforms each state has adopted concerning their individual health insurance markets. Notes whether or not the state requires guaranteed issue in the individual market. (States marked with an asterisk "*" either have one or more carriers voluntarily offering guaranteed issue or have mandated that there be a carrier of last resort in the state.) Also indicates how many months a pre-existing condition may be excluded from coverage, and the rating structure in the state. "NRS" means no rating structure, "C" means community rating, "MC" means modified community rating, and "RB" means rate bands are used in the state but the actual indexed rate was not available. If a percentage is indicated, that is the percentage a carrier is allowed to increase rates based on medical underwriting criteria.

Small-Group Market Reforms
Indicates the reforms each state has adopted concerning their small-group health insurance markets. Notes whether or not the state requires guaranteed issue in the small-group market, and also indicates how many months a pre-existing condition may be excluded from coverage, and what the rating structure for small employers with similar characteristics for the same or similar coverage is in the state. "NRS" means no rating structure, "C" means community rating, "MC" means modified community rating, and "RB" means rate bands are used in the state but the actual indexed rate was not available. If a percentage is indicated, that is the percentage a carrier is allowed to increase rates based on medical underwriting criteria. Finally, this section notes how many lives are considered to be a "small group" in the state.

S-CHIP Approach
Describes the approach the state has taken to insuring children under the State Childrens' Health Insurance Program (S-CHIP). Indicates if the state has chosen to expand coverage under the Medicaid program, develop its own approach, or use a combination of Medicaid expansion and its own alternative method.

Medically Uninsurable
Describes the state's mechanism for providing access to health insurance to people with pre-existing medical conditions so severe they are considered to be uninsurable. Notes if the state has established a high-risk health insurance pool for people with catastrophic medical conditions, or if it offers coverage through either guaranteed issue or open enrollment. Also indicates if the state employs another method (e.g., TennCare or employer mandate).

Medical Savings Accounts
Indicates whether or not medical savings accounts are allowed as a health insurance option in the state.