

### **Portability act harms most small employers -October 1997**

The Health Insurance Portability Act of 1996, or HIPAA, has been in effect only since July, but its impact on small employers has been most regrettable.

Originally, HIPAA was designed, among other things, to make it easier for people to get and maintain their health insurance coverage. This would be accomplished by ensuring people who are moving from one job to another, or from employment to unemployment, are not denied health insurance because of a pre-existing condition.

This “portability” issue means once you obtain health insurance, you will be able to use evidence of this insurance to reduce or eliminate possible pre-existing condition exclusion periods that might otherwise be imposed when one moves to a new group health plan, or in certain circumstances, to an individual policy.

The concept is to be able to maintain health coverage and being given credit for having been insured when changing plans.

Another key issue of HIPAA, which is closely aligned with “portability” is that as of July, health care insurers no longer can reject these small employers, but they can charge more premium to offset any known risk(s).

Of guaranteed acceptance by the health care provider for employers of from two to 50 employees, regardless of what pre-existing conditions are present.

The law limits pre-existing condition waiting periods in the group market to 12 months and 18 months for people who don’t enroll in the plan immediately. These waiting periods for pre-existing conditions can be shortened by the length of coverage the worker had before, as long as there has not been a break of more than 63 consecutive days.

In this small-group market, health care providers/insurers are requiring individual medical questionnaires to be completed by each employee, regardless if they are eligible for immediate coverage. This is because there always will be either a potential risk for an employee to seek coverage when a medical condition manifests itself, or due to a “qualifying event” an employee decides he/she now wants the group coverage.

Some providers are requiring quarterly wage statements and/or payroll records to ensure the plan participation requirements are being met.

In a “guaranteed acceptance” environment, it is essential to properly spread the risk over as many people as possible in any one group. One way a provider can assure a proper risk distribution is to strictly follow the participating requirements and premium contribution levels outlined in a health insurance contract. It also means group health plans no longer are permitted to deny coverage or surcharge extra premiums to *individuals* within the group because of a health factor.

In the process of conforming Arizona’s insurance statutes to that of HIPAA, one of the “hidden” complexities deals with premiums and rate restrictions placed on health care providers. The origins of this complexity were put into place back in 1993 under SB1109. Health insurance providers were labeled as “accountable health plans” and there were stipulations involving premiums that could be charged for “new” business and “renewal” business.

Prior to HIPAA, health care providers could either accept or reject a small employer if there were any “notable” health conditions within the group. AS of July, health care insurers no longer can reject these small employers, but they can charge *more* premium to offset any known risk(s).

What the providers can charge and are charging, according to Arizona statutes, is where the “rub” comes in.

These are representative of employees of several groups, before and after HIPAA:

	<b>Before</b>	<b>After</b>
Employee, age 30, single	\$113.50	\$173.43
Employee, 44, w/spouse	\$238.30	\$515.59
Employee w/family, any age	\$356.10	\$800.60
Employee, any age	\$125.67	\$343.60
Employee, 21, w/child	\$322.00	\$67.00
Employee, 38, w/family	\$411.00	\$788.00
Employee, 25, w/spouse	\$218.00	\$419.00
Employee, 28, w/spouse	\$300.00	\$568.00
Employee, 42, single	\$151.00	\$384.74
Employee, less than 30	\$114.00	\$184.00
Employee, 54, single	\$172.00	\$275.00
Employee w/family, any age	\$408.00	\$1,075.00
Employee w/children, any age	\$226.00	\$596.00
Employee w/spouse, any age	\$301.00	\$795.15

Prior to the implementation of HIPAA, I received several proposals for small employers, not knowing of any health conditions present in the groups. After HIPAA went into effect, I subjected these same employers to a list of health questions and resubmitted them for proposal from the same health care providers. The before and after effect is, needless to say, startling.

These rate scenarios are not just isolated to Arizona, but are being experienced nationally.

HIPAA has created an insurance climate of risk avoidance, but, in some ways, unavoidable.

If you have a small employer with one or more “notable” health conditions within the group, and treatment for the condition(s) will probably exceed the monthly group premium, you are basically asking health care provider(s) to insure a burning building. The state of Kentucky asked its insurers to do just that and now they have only one health care provider.

On the other hand, insurers do not know what the long-term effect of HIPAA will be, and are purposely avoiding some risks that, prior to HIPAA, they would have accepted and covered.

In essence, HIPAA is another example of lawmakers determined to correct presumed imperfections in the “free market” health care system.

Unfortunately, it may overshadow further federal intervention, which is what some people would like to see anyway.