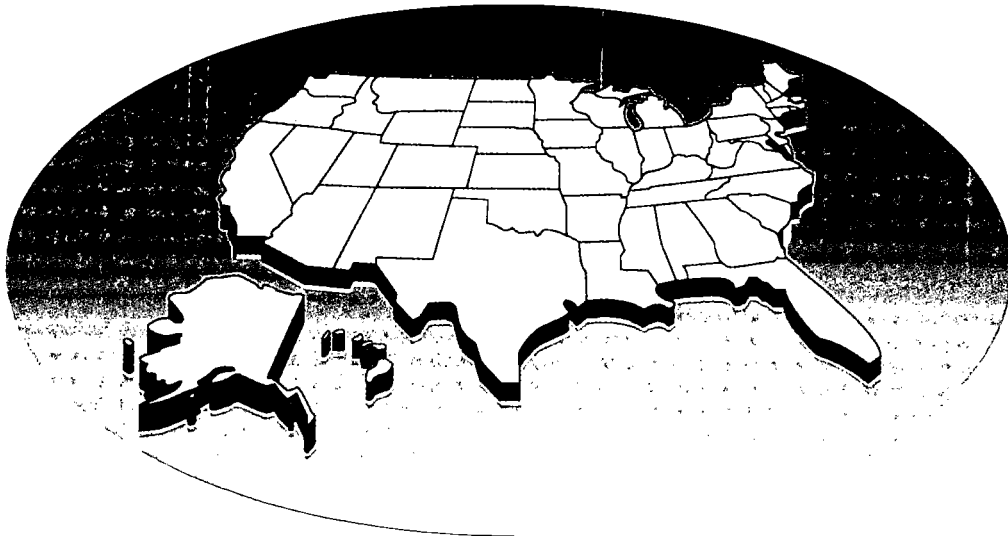


State Legislature Health Care and Insurance Issues

1997 Survey of Plans



**BlueCross BlueShield
Association**

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1997 Survey of Plans

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**BlueCross BlueShield
Association**

**An Association of Independent
Blue Cross and Blue Shield Plans**

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OVERVIEW

The Blue Cross and Blue Shield Association's Office of Policy and Representation monitors state legislative activity through its Department of State Services. An annual survey is sent to each of the 55 independent Blue Cross and Blue Shield Plans at the close of their state legislative sessions. The survey highlights significant health legislation enacted in 1997 and identifies issue trends of greatest importance to the Plans for 1998.

This report presents the survey findings and is designed to assist member Plans in preparing for the 1998 state legislative sessions. The first page of each state chapter contains a summary of key 1997 health laws, while the succeeding pages present a cumulative snapshot of major health reform laws enacted over the years in that state. The Appendix contains reference tables that summarize state legislation in major issue areas on a state-by-state basis.

1997 Trends in State Health Care Reform

State health officials deliberated against the backdrop of rapid and unprecedented market-driven changes in the health care delivery system. Managed care plans achieved a near-monopoly of employer-based health plans during 1997. Fully 85 percent of U.S. employees with health insurance now belong to some kind of managed care plan (HMO, PPO or Point-of-Service). This is up from just half of the workforce only four years ago. Moreover, the shift to managed care and its efficiencies helped keep employee health costs flat last year - - after a decade of mostly double-digit inflation. Paradoxically, managed care's success in building ties to the workplace and making care more affordable also gave rise to consumer confusion and frustration at the speed of these changes.

Health care reform actions in 1997 reveal two major trends. Many state legislators searched for ways to further the quality of health care in response to perceived abuses in the managed care industry. In the name of quality, lawmakers enacted a variety of regulations on managed care networks, as well as new mandated benefits that impose clinical practice standards.

Another dominant theme was improved access to health care, which, due to the financial and political realities, continued to be limited to incremental measures. Expanded access was pursued through adoption of state insurance market reforms complementing federal portability legislation and "reinventing Medicaid" in an effort to cover as many uninsured children as possible.

Regulation of Managed Care Networks

State legislators pushed for safeguards for enrollees of managed care networks, often in response to anecdotal complaints. These purported “safeguards” included legislation to: (1) ban the use of so-called “gag clauses” in provider contracts; (2) allow enrollees to have direct access to health care specialists; and (3) require health plans to establish an external review process to resolve enrollee grievances. These issues were most commonly addressed in piecemeal legislation, although 15 states cobbled together such contracting issues along with benefit mandates and pronounced the result a “comprehensive consumer protection bill.”

As indicated in the following table, two dozen states enacted “gag clause” bills in 1997 designed to prevent health plans from prohibiting or restricting health providers from discussing alternative treatment options with their patients. In addition, a few of these laws also require health plans to disclose their system of financial incentives for providers (**CO, MI, MT and OR**). This brings the total number of “gag clause” laws nationwide to 39 states. Meanwhile, an August 1997 study by the U.S. General Accounting Office of over 500 HMOs concluded that none used contracts that contained “gag clauses.”

Bills that would require health plans to allow subscribers to have direct access to designated specialists without referral from a primary care physician were popular again in 1997. Of the 14 such measures passed, nine were directed at obstetrician-gynecologists (**AR, DE, ID, MN, MO, MT, NV, RI and TX**). Direct access proposals were also championed by legislators sympathetic to other specialty groups such as dermatologists (**FL**), eye care providers (**GA and SC**), and acupuncturists (**NM**). Increasingly, primary care physicians are joining health plans in speaking out against the inflationary impact that such “turf wars” produce.

A new trend in the state capitals is for laws that create a formal external grievance process to review coverage and claims denials. During 1997, nine states enacted such legislation. With the exception of **Ohio**, which limits the basis of review to appeals involving experimental treatments, virtually any denial can be referred for outside review. For example, in **Connecticut** and **Missouri**, an enrollee can appeal to the Department of Insurance after exhausting a health plan’s internal mechanism for appealing the denial of a claim. The Departments are empowered to assign the case to an impartial entity which selects medical experts whose recommendation on coverage is binding on the health plan. In several states, the decision of the external review panel is advisory (**FL, NJ, NC and TN**).

MAJOR 1997 STATE HEALTH CARE REFORM LAWS

	Managed Care Regulation			Mandated Benefits		
	Patient Disclosure - "Gag Clause"	External Grievance Review	Direct Access	Mastectomy Stay	ER Services	Mental Health Parity
Arizona	✓	✓				
Arkansas			✓	✓		✓
Colorado	✓				✓	✓
Connecticut	✓	✓		✓	✓	✓
Delaware			✓			
Florida	✓	✓	✓	✓		
Georgia			✓		✓	
Idaho	✓		✓		✓	
Illinois				✓		
Indiana						✓
Iowa						
Kansas	✓				✓	
Louisiana	✓				✓	
Maine				✓		
Maryland						
Michigan	✓				✓	
Minnesota	✓		✓			
Missouri	✓	✓	✓		✓	✓
Montana	✓		✓	✓		
Nebraska	✓				✓	
Nevada	✓		✓		✓	
New Hampshire					✓	
New Jersey	✓	✓		✓	✓	
New Mexico	✓		✓	✓		
New York				✓		
North Carolina	✓	✓		✓	✓	✓
North Dakota	✓					
Ohio	✓	✓			✓	
Oklahoma	✓			✓	✓	
Oregon	✓				✓	
Pennsylvania				✓		
Rhode Island	✓		✓	✓		
South Carolina			✓			
South Dakota						
Tennessee		✓			✓	
Texas	✓	✓	✓	✓	✓	✓
Utah	✓		✓			
Vermont						✓
Virginia					✓	
Washington					✓	
Wyoming	✓					
TOTALS	24	9	14	14	20	8

Source: Blue Cross Blue Shield Association, December 1997

A controversial issue that emerged in 1997 involves proposals to make health plans directly liable for medical malpractice. These new liabilities would be cumulative to rights under general civil and common law and would not abrogate existing rights to bring civil suit against physicians or hospitals for damages or other relief. Last year these measures were debated in 18 state legislatures, but only enacted in two. The **Texas** law creates the following new causes of action: (1) health plans are liable for damages caused by a failure to exercise that degree of care that a health plan of ordinary prudence would use under the same or similar circumstances; and (2) health plans are liable for harm caused to enrollees by health care treatment decisions made by their employees, agents or representatives. In **Missouri**, the law simply removes HMOs' exemption from liability for poor medical outcomes by repealing a current statute that deems them not to be practicing medicine. The chief advocates of extending malpractice liability to health plans are physician and trial lawyer groups. The business community is generally opposed to such a step, fearing that higher health care costs and diminished quality would ensue.

"Clinical Practice" Benefit Mandates

Lawmakers in nearly every state introduced one or more bills that would mandate the medical coverage policies of health plans. Although politically popular, decisions to legislate what is clinically appropriate are often based on emotional appeals and devoid of an appreciation of the economic and social ramifications.

Requiring a minimum hospital stay for mastectomy patients was the most visible "clinical practice" mandate working its way through the statehouses last year. Most of these 14 laws provide for a minimum stay of 48 hours following a mastectomy (**AR, CT, NJ, NM, NY, OK, RI and TX**) and a stay of 24 - 48 hours following a lymph node dissection. A different approach was taken in the remaining states (**FL, IL, ME, MT, NC and PA**), which did not impose fixed time limits in favor of calling on physicians to determine length-of-stay in consultation with their patients. The enthusiasm for "legislating by body part" appears to have subsided somewhat in 1997, as only 14 mastectomy stay mandates were enacted compared to 1996 when 30 states approved maternity stay bills.

The most prevalent new mandate was to cover certain services delivered in an emergency room (i.e., initial screening exam and stabilization services). Twenty states enacted this requirement (see the attached table). In addition, 12 of these statutes also impose a "prudent layperson" standard that typically defines an emergency medical condition to exist if the condition manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in serious jeopardy to health (**CT, GA, ID, LA, MO, NV, NC, OH, OR, TX, VA and WA**).

Several other states simply required coverage and left the determination of whether an emergency condition existed in the hands of medical professionals.

Legislation to mandate parity in the treatment of mental and physical illness was approved in eight states during 1997 (**AR, CO, CT, IN, MO, NC, TX** and **VT**). These laws are often limited in scope and require health plans to offer equivalent or similar coverage only for enrollees with serious, biologically-based mental illnesses (**CO, CT, TX**). In two other states (**IN** and **NC**), the laws only apply to the state employee health plan.

State and Federal Reform of the Private Insurance Market

A major portion of the legislative calendar was devoted to crafting legislation to conform existing state insurance market statutes to the federal Health Insurance Portability and Accountability Act of 1996 or HIPAA. With the exception of Kentucky which did not meet in regular session during 1997, the states enacted legislation that included the following HIPAA requirements in the small group market: (1) changing the definition of small group size to 2 - 50 employees; (2) requiring guaranteed issue of all small group products; (3) requiring guaranteed renewal of all group products including those sponsored by large group plans; (3) limiting the preexisting condition exclusion period to 12 months with a six-month look-back; and (4) eliminating pregnancy as a preexisting condition.

States were also active in determining how best to implement HIPAA's group-to-individual portability requirements. The majority of states notified the U.S. Health Care Financing Administration (HCFA) that they will seek a federal waiver to implement an alternative state mechanism. Medical high-risk pools were the most popular alternative mechanism, having been chosen by 21 states. In addition, nine states that have guaranteed issue laws in the individual market (**ID, MA, ME, NH, NJ, NY, SD, VT** and **WA**) will use these statutes to implement the federal requirement. Accordingly, all of these states devoted considerable legislative effort last year to modifying their existing high-risk pool or individual market laws to qualify as alternative mechanisms.

In contrast, several states (**FL, GA, NM, OH, PA, UT** and **VA**) pursued unique approaches to conforming with HIPAA's group-to-individual portability requirement. For example, **Georgia** created an assigned risk pool in which HIPAA-eligible individuals may apply for coverage to the Insurance Commissioner who then "assigns" eligible persons to health plans based on a plan's pro rate volume of individual health insurance business in the state. **Utah's** approach combines its medical high-risk pool with its existing individual market guaranteed issue requirement. An individual denied coverage by a health plan is referred to that state's high-risk pool, which then determines whether that person is "too healthy" for the pool based on objective guidelines.

An individual found “too healthy” must be covered by the health plan that had previously denied coverage.

While state alternative mechanisms are the most popular device for implementing the federal group-to-individual portability requirements, 14 states (**AZ, CA, CO, DC, DE, HI, MD, MI, MO, NV, NC, RI, TN and WV**) have chosen the “federal fall-back” provision. Under this scenario, health plans in these states are required to: (1) guarantee issue at least two products to HIPAA-eligible individuals; (2) guarantee renewal of coverage; and (3) refrain from applying any preexisting condition waiting periods. Most states that are relying on the “federal fall-back” for group-to-individual portability have enacted enabling legislation to preserve state enforcement authority. However, **California, Michigan, Missouri and Rhode Island** did not and, therefore, HCFA will be enforcing the provision in these states.

Expanding Children’s Access to Health Care

During 1997, lawmakers in virtually every state either enacted, proposed or initiated a formal planning process to devise initiatives to extend insurance coverage to children in low-income families. Although the states are united in their goal of increased access, there is no consensus on how many more individuals to cover or how to do it. These efforts would normally be modest due to continued fiscal austerity in many states.

However, 1997 was not an ordinary year because it was marked by passage of the federal Children’s Health Insurance Program (CHIP). This program will be funded by a \$24 billion block grant to the states. States must submit plans to HCFA for approval and may file for funding for periods beginning on October 1, 1997. To encourage participation, the program includes an enhanced state matching rate which is 30 percent more favorable than the states’ respective Medicaid matching rate.

States can use federal CHIP funds to purchase private health insurance (including subsidizing group coverage), expand Medicaid eligibility, provide direct medical services, or any combination of these options. In general, approved state plans must have a value at least equal to one of the following “benchmark” plans: the Federal Employees Health Benefits Program Blue Cross-Blue Shield Preferred Provider Option; a plan offered to state employees of the respective state; or the commercial HMO plan with the largest enrollment in the state. Cost-sharing requirements for children whose family incomes are higher than 150 percent of the federal poverty level will be limited to a sliding scale, based on income.

To date, states have expressed preliminary interest in the following approaches to implementing the federal CHIP program: (1) Medicaid expansion only (**AK, ID, IL, MA, MD, MO, NM and OH**); (2) a state-subsidized private insurance program (**CO, MI, MT, NV, NY, PA, UT, VA and WV**); or (3) a combination of both approaches (**AL, AZ, CA, CT, FL, KY, NC, NJ, OK, OR, SC, VT and WI**). The remaining states are studying their options and have not announced a particular strategy or submitted a plan to HCFA.

Prospects for State Health Reform in 1998

The survey of Blue Cross and Blue Shield Plans indicates that lawmakers in a number of states will continue efforts to regulate managed care plans in response to pressure from provider and consumer groups. Some states are likely to take a comprehensive approach in 1998 by bundling the issues of provider contracting, grievance procedures and quality assurance into a single reform proposal. In states with broad oversight laws already on the books, only minor modifications are anticipated.

- Proposals to extend malpractice liability to health plans will likely be debated in the following 21 states: **CA, CO, CT, FL, GA, HI, IA, ID, IN, KY, MD, MS, ND, NH, NM, NY, OH, OK, RI, TN and WA**.
- Plans also anticipate a legislative push to enact mandatory external grievance review laws in the following 15 states: **CA, DC, DE, FL, GA, HI, MD, MS, NH, ND, NY, OK, PA, VT and WA**.
- Bills to enact a framework of quality standards for managed care plans are expected in 16 states: **CA, DE, FL, HI, IA, ID, IL, IN, KY, MD, ND, OK, PA, SC, TN and WA**.
- An assortment of proposals to allow enrollees to self-refer directly to health care specialists are likely in 15 states: **CA, CO, FL, IL, IN, ME, MO, MS, NE, OK, PA, SC, TN, VT and WA**.

The lure of mandated benefits will continue in 1998, as they appear to offer a simple solution to anecdotal health problems and involve limited government expenditures. Among the politically popular mandates that are expected to be introduced are:

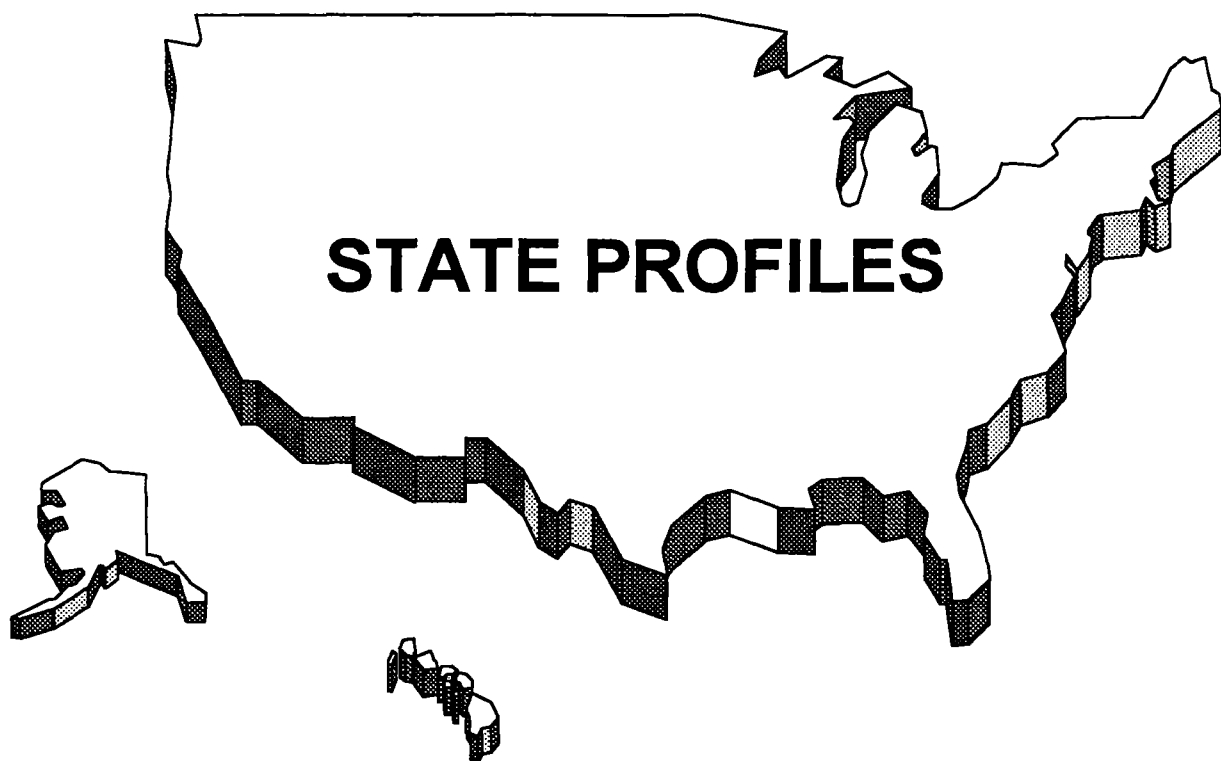
- A requirement to cover treatment for mental illnesses on a parity or equivalent basis as physical illnesses in the following 19 states: **AL, CA, DE, FL, GA, HI, ID, IL, KY, MO, ND, NE, NM, OH, OK, PA, TN, UT and WA**.

- A requirement to pay for health care services delivered in the emergency room if a “prudent layperson” believes it is an emergency in the following 10 states: **DC, DE, IL, IN, KY, MS, OK, PA, RI** and **SC**.

It is anticipated that state officials will continue to develop strategies for the regulation of provider sponsored organizations (PSOs) that seek to contract directly with employer groups. Legislation to address financial solvency and other standards as they relate to PSOs is predicted in several states (**CT, FL, MD** and **NM**).

In addition, Blue Cross and Blue Shield Plans indicated that at least four states (**CA, KY, NH** and **TN**) will probably return to the area of small group and individual insurance reform to address continuing problems with implementation of both state and federal market requirements.

Finally, 1998 will be characterized by continued state efforts to receive approval for federal children’s health funding and to implement state-specific programs to expand access in line with local needs and practices.



ALABAMA: 1997 LEGISLATIVE ACTIVITY

Lawmakers enacted a bill creating the Alabama Small Employer Allocation Program to comply with the guaranteed issue and other requirements of HIPAA regarding the small group market. Regulations to implement this market reform are under development by the Commissioner of Insurance. The program will be patterned after the NAIC Small Employer Health Insurance Availability Model Act. The Alabama act defines small group size as from 2 to 50 employees. This legislation also created a medical high-risk pool that will provide coverage to HIPAA-eligible individuals only.

The legislature enacted a measure to require health plans to cover mammography screenings every two years for women in their forties and annually for women beginning at age 50.

Alabama received federal approval of a Medicaid Section 1115 managed care waiver. Under the demonstration project, known as BAY Health Plan, Medicaid recipients will choose a primary care provider from a network consisting of traditional Medicaid providers and any provider who meets the criteria set by the state. The demonstration will provide all of the mandatory Medicaid benefits with no cost-sharing requirements.

ALABAMA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	Alabama received federal approval in 1997 for a Medicaid Section 1115 managed care waiver. Under the demonstration project, known as BAY Health Plan, Medicaid recipients will choose a primary care provider from a network consisting of traditional Medicaid providers and any provider who meets the criteria set by the state. The demonstration will provide all of the mandatory Medicaid benefits with no cost-sharing requirements.
BROAD INSURANCE MARKET REFORM	In 1997, lawmakers created the Alabama Small Employer Allocation Program to comply with the guaranteed issue requirement of HIPAA regarding the small group market. The act defines small group size as from 2 to 50 employees. This legislation also created a medical high-risk pool which will provide coverage to HIPAA-eligible individuals only.
REGULATION OF SMALL GROUP MARKET	Same as above
REGULATION OF INDIVIDUAL MARKET	Since the state did not enact a guaranteed renewal provision in the individual market to conform with HIPAA standards, HIPAA's guaranteed renewal requirement is in force.

MANAGED CARE	A 1988 law that allowed any pharmacist willing to accept the terms of participation the right to participate in a health plan was preempted by the federal ERISA statute, according to a U.S. District Court ruling in January 1996. A 1994 law that required insurers to honor assignment of benefits by a subscriber to nonparticipating providers was preempted by the federal ERISA statute, according to a U.S. District Court ruling in January 1996. A 1994 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements, minimum operational standards, and appeals procedures. It also stipulates that the standards may be considered met if the UR firm receives accreditation by URAC. A 1996 law allows subscribers to have direct access to participating OB-GYNs without obtaining a referral. The law also allows women to designate an OB-GYN as the primary care physician.
CORPORATE RESTRUCTURING	— — —

ALASKA: 1997 LEGISLATIVE ACTIVITY

The legislature acted to incorporate the HIPAA small group requirements into its existing market reform statute. In addition, the existing medical high-risk pool was modified to meet the group-to-individual portability requirements of HIPAA.

A new law prohibits health plans from refusing to issue, renew, cancel, or increase the premium on an insurance policy if the action results only from the fact that the person was a victim of domestic violence. A health plan may still underwrite for a medical condition based on domestic violence in the same manner as it would for a person who is not a victim of domestic violence.

Lawmakers passed legislation to limit the amount of time an injured party has to file a lawsuit against a health care provider and caps the amount of money that can be recovered in a damage award.

ALASKA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1992.
BROAD INSURANCE MARKET REFORM	The legislature acted to incorporate the HIPAA small group requirements into its existing market reform statute. In addition, the existing medical high-risk pool was modified to meet the group-to-individual portability requirements of HIPAA.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1993 include: guaranteed issue to small employers (2-25 employees); voluntary reinsurance; limits on rate variations for experience, health status and duration to a 15 percent adjustment; guaranteed renewal; and limits on pre-existing condition waiting periods. A 1996 amendment changed the definition of small employer size from 2-25 to 2-50 employees.
REGULATION OF INDIVIDUAL MARKET	Since the state did not enact a guaranteed renewal provision in the individual market to conform with HIPAA standards, HIPAA's guaranteed renewal requirement is in force.
MANAGED CARE	— — —
CORPORATE RESTRUCTURING	— — —

ARIZONA: 1997 LEGISLATIVE ACTIVITY

Under the Governor's leadership, lawmakers enacted a bill that established a grievance procedure for HMO subscribers who wish to appeal coverage decisions, including a mechanism for taking disagreements to an outside medical expert. The law stipulates that if a health care plan denies an enrollee's request for a covered service or claim after a two-tiered internal appeals process, the enrollee may initiate an external review. In that event, the health plan would choose one or more independent reviewers from a list compiled by the Department of Insurance. The decision of the external reviewer would be binding. Health plans and medical associations may provide recommended lists of reviewers to the DOI on an annual basis.

The grievance review law also contains a provision barring so-called "gag clauses" that would restrict physicians from informing patients of medical treatment options from health plan contracts.

New legislation conformed Arizona's existing small group market statute with HIPAA requirements. This included expanding the small group size from 3 - 40 to 2 - 50 employees. Lawmakers chose to satisfy federal requirements on group-to-individual portability by adopting the federal fall-back standards.

Another new measure replaced the state's existing medical savings account (MSA) program with the federal MSA demonstration program, with exceptions. A key exception is that there are no limitations on the size of eligible employers or the number of taxpayers that may participate.

ARIZONA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	The Arizona Health Care Cost Containment System (AHCCCS) was created in 1982 and operates a competitively bid, capitated health insurance program for Medicaid eligibles and other indigent citizens. The state operates the unique program under a Medicaid Section 1115 managed care waiver that allows it to place all participants into managed care networks. Enrollment is mandatory and payment is on a capitated basis. The Blue Cross and Blue Shield Plan is a participating managed care organization. Evaluations show that AHCCCS has significantly reduced both emergency room and inpatient hospital utilization rates. In addition, in 1988 the Arizona Long Term Care System (ALTCS) began and is fully integrated with AHCCCS. The state has been able to achieve significant cost savings by coordinating acute and LTC services offered under Medicaid and Medicare.
BROAD INSURANCE MARKET REFORM	1997 legislation conformed the state's existing small group market statute to HIPAA standards. Lawmakers chose to satisfy federal requirements on group-to-individual portability by adopting the federal fall-back standards. A 1994 law permits tax-free medical savings accounts (MSAs) and state tax deductions by employers paying into accounts on behalf of their employees. In 1997, legislation replaced this program with the federal MSA demonstration program, with exceptions. A key exception is that there are no limitations on the size of eligible employers or the number of taxpayers that may participate.

REGULATION OF SMALL GROUP MARKET	In 1993, Arizona enacted the first accountable health plan (AHP) law based on the Blue Cross and Blue Shield Association's health care reform proposal. All entities providing group health insurance must be approved by the Director of Insurance as AHPs and meet minimum standards in business practices, cost management and administrative simplification. Reforms enacted in 1993 include: guaranteed issue to small employers (3-40 employees); voluntary reinsurance; limits on rate variations for experience, health status, duration and most demographics to a total range of 4:1; guaranteed renewal; and limits on pre-existing condition waiting periods. (Carriers in the large group market must also renew coverage.) A 1997 amendment expanded small group size from 3-40 to 2-50 employees.
REGULATION OF INDIVIDUAL MARKET	A 1997 law established guaranteed renewal for individual coverage that conforms to HIPAA.

MANAGED CARE	A 1993 law established a system of comprehensive regulation of the UR industry. Firms wishing to conduct UR must be certified either through the Department of Insurance or a recognized private accreditation program. A 1995 law requires insurers and HMOs to distribute disclosure forms to all employers considering the purchase or renewal of a health plan that would include: premium costs and related cost-sharing; covered benefits; service limitations; and provider compensation programs and incentives. A 1996 law established a utilization review process for emergency room care. It requires managed care plans to provide coverage for an initial screening exam and any necessary stabilizing treatment. In addition, it allows plans to seek reimbursement from enrollees for screening exams in non-emergency situations. A 1997 law established a grievance procedure for HMO subscribers who wish to appeal coverage decisions, including a mechanism for taking disagreements to an outside medical expert. If a health care plan denies an enrollee's request for a covered service or claim after a two-tiered internal appeals process, the enrollee may initiate an external review. In that event, the health plan would choose one or more independent reviewers from a list compiled by the Department of Insurance. The decision of the external reviewer would be binding. A 1997 provision was enacted that bars so-called "gag clauses" from health plan contracts that would restrict physicians from informing patients of medical treatment options.
CORPORATE RESTRUCTURING	— — —

ARKANSAS: 1997 LEGISLATIVE ACTIVITY

A federal district judge held in January that the state's broad any willing provider law (The Patient Protection Act of 1995) is preempted by the federal Employee Retirement Income Security Act (ERISA). The lawsuit was filed by an HMO affiliated with Arkansas Blue Cross and Blue Shield, along with several insurers, employers and unions who sought to have the law declared unconstitutional. According to the judge's order, "The Court agrees with the plaintiffs that a reading of this statute has the effect of taking away the gatekeeper function from the provider designated by the plan fiduciary and placing it in the control of the plan beneficiary. ...The gatekeeper function and limited provider panels are undeniably significant features of ERISA plans and their negation by the PPA favors a finding of preemption."

Lawmakers enacted a bill to comply with the guaranteed issue and other requirements of HIPAA regarding the small group market. The act raises small group size from 1 - 25 to 2 - 50 employees. In addition, the existing medical high-risk pool was modified to meet the group-to-individual portability requirements of HIPAA.

The Governor signed a limited mental health parity bill that applies only to groups of more than 50 employees. The statute contains an exemption clause that voids the requirement if a health plan's actuary determines that the added costs of complying with the mandate would raise average premium rates for employers by more than 1.5 percent.

Arkansas imposed the following new mandated health benefits: (1) a minimum mastectomy stay requirement of 48 hours, with earlier discharges permitted after physician consultation with a patient; (2) reconstructive breast surgery to restore symmetry following a mastectomy; and (3) diabetic equipment, supplies and self-management training. Also approved with a requirement that health plans allows enrollees to self-refer directly to OB-GYNs.

The federal government approved Arkansas' proposal to expand health coverage to 80,000 uninsured children. Operating under a Section 1115 Medicaid waiver, the ARKids First Program will cover children through age 18 with family incomes up to 200 percent of the federal poverty level. Children will be enrolled in a primary care case management system and will receive a benefit package that is almost as comprehensive as the traditional Medicaid package.

ARKANSAS: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1996. In 1997, the federal government approved Arkansas' proposal to expand health coverage to 80,000 uninsured children. Operating under a Section 1115 Medicaid waiver, the ARKids First Program will cover children through age 18 with family incomes of up to 200 percent of the federal poverty level. Children will be enrolled in a primary care case management system and will receive a benefit package that is almost as comprehensive as the traditional Medicaid package.
BROAD INSURANCE MARKET REFORM	A 1997 law was enacted to comply with the guaranteed issue and other requirements of HIPAA regarding the small group market. In addition, the existing medical high-risk pool was modified to meet the group-to-individual portability requirements of HIPAA.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1991 include: limits on rate variations for experience, health status and duration to a range of 2:1; and guaranteed renewal for small groups (1-25 employees). A 1997 law established a guaranteed issue requirement in the small group market (2-50 employees), and limits on preexisting condition exclusion periods.
REGULATION OF INDIVIDUAL MARKET	Since the legislature did not enact a guaranteed renewal provision in the individual market, HIPAA's guaranteed renewal requirement is in force.

MANAGED CARE	A 1989 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements, minimum operational standards, appeals procedures, confidentiality requirements, and penalties for non-compliance. A 1991 law allows any pharmacist willing to accept the terms of participation set forth by a non-federally qualified HMO to participate in the network. A broad any willing provider law enacted in 1995 allows licensed health care providers willing to accept the terms of participation set forth by a PPO or HMO network to participate. In 1997, a federal district judge preempted this law on ERISA grounds. A 1995 law allows any primary eye care provider willing to accept the terms of participation set forth by a PPO or an HMO network to participate. A 1995 law created a new definition of emergency room services based on a "prudent layperson" definition of emergency care. A 1997 law requires health plans to allow enrollees to self-refer directly to OB-GYNs.
CORPORATE RESTRUCTURING	— — —

CALIFORNIA: 1997 LEGISLATIVE ACTIVITY

The legislature's health agenda was characterized by an anti-managed care focus which resulted in the passage of a number of bills targeting the practices of managed care plans. These bills were sent to the Governor who, true to his word, vetoed them. Earlier in the year, the Governor had announced that he would not act on managed care reform until receiving the recommendations of his Managed Health Care Improvement Task Force in January 1998.

The vetoed legislation included bills that would have: (1) mandated minimum stay requirements for mastectomy patients; (2) required health plan employees to personally examine a patient before making a decision not to authorize a procedure; and (3) required health plans to publicly disclose the criteria used for authorizing or denying payment for patient care.

Lawmakers adjourned without taking final action on implementation of the HIPAA requirements for group-to-individual portability. (The Governor called for a federal fall-back mechanism with state enforcement, while Democratic leaders sought a more far-reaching bill that would have extended the guarantee issue requirement to groups of up to 100.) Consequently, the U.S. Health Care Financing Administration (HCFA) will be enforcing the federal fall-back requirements. A measure was enacted, however, that conforms the state's existing small group market laws to HIPAA.

A new child health initiative will provide coverage to 580,000 low-income children through creation of a private purchasing pool and a purchasing credit. The Healthy Families program covers children in families with incomes between 100 and 200 percent of the federal poverty level for a 12-month period. Families will make premium contributions based on a sliding income scale. The state Managed Risk Medical Insurance Board (MRMIB), which administers the state's existing purchasing pool, will administer the Healthy Families program. In addition, the MRMIB will implement a purchasing credit mechanism to help parents pay for employer-based dependent coverage. Under this mechanism, the state will give employers a credit so they may add dependent coverage to the health insurance coverage that they currently offer to their employees.

CALIFORNIA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1991. The state-sponsored Access for Infants and Mothers health care program covers individuals who do not qualify for existing public or private health insurance plans and whose household income falls below 250% of the federal poverty level. Participating health plans must ensure coverage of comprehensive primary care services. Funding for this initiative comes, in part, from the Cigarette and Tobacco Products Surtax Fund. In 1996, the state received federal approval of a Medicaid managed care demonstration that enables it to move Medicaid (Medi-Cal) enrollees into managed care plans. When fully implemented in the participating 12 counties, the project will cover 2.3 million Medi-Cal recipients, making it one of the largest managed care demonstrations in the country. A 1997 initiative will provide coverage to 580,000 low-income children through creation of a private purchasing pool and a purchasing credit. The Healthy Families program covers children in families with incomes between 100 and 200 percent of the federal poverty level for a 12-month period. Families will make premium contributions based on a sliding income scale. The state Managed Risk Medical Insurance Board (MRMIB), which administers the state's existing purchasing pool, will administer the Healthy Families program. In addition, the MRMIB will implement a purchasing credit mechanism to help parents pay for employer-based dependent coverage. Under this mechanism, the state will give employers a credit so they may add dependent coverage to the health insurance coverage that they currently offer to their employees.
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BROAD INSURANCE MARKET REFORM	A 1992 law established a voluntary health purchasing pool program. Participating health plans are allowed to submit bids to the state to offer coverage on a region-by-region basis. Some plans are available in only part of the state, while others can be purchased in most regions. The pool negotiates and enters into contracts with health plans in a geographic area to provide coverage to small employers that elect this option. A 1996 law authorized the creation of private, competing purchasing alliances. These alliances can be formed by individuals, partnerships, and both non-profit and for-profit corporations in six geographic service regions. Products must be offered statewide. Lawmakers adjourned in 1997 without taking final action on implementation of the HIPAA requirements for group-to-individual portability. Consequently, HCFA will be enforcing the federal fall-back requirements. A measure was enacted, however, that conforms the state's existing small group market laws to HIPAA.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1992 include: guaranteed issue to small employers (3-50 employees); voluntary reinsurance; a community rating system with demographic adjustments that limits rate variations to a range of 1.2:1; guaranteed renewal; and limits on preexisting condition waiting periods. A 1996 amendment expands the small group size from 3-50 employees to include groups of two.
REGULATION OF INDIVIDUAL MARKET	Reforms enacted in 1993 prohibit health plans that cover individuals from excluding coverage based on preexisting conditions for longer than 12 months. The 1997 law to implement HIPAA created a guaranteed renewal provision in the individual market.

MANAGED CARE	A 1994 law requires health plans to: (1) disclose to providers the process they use to authorize or deny services; (2) refrain from rescinding an authorization for treatment if the provider renders the service in good faith and pursuant to the authorization; and (3) provide the reasons for terminating a provider's contract. Several laws were enacted in 1995 regulating health plans in the areas of public disclosure and consumer protection by: (1) mandating disclosure to enrollees of the process used to authorize or deny services; (2) requiring plans to seek to resolve grievances within 30 days whenever possible; (3) requiring plans to provide enrollees with a written statement of the disposition or pending status of the grievance within 30 days, and to submit a quarterly report to the Department of Corporations for grievances unresolved within 30 days; and (4) allowing enrollees to request mediation of a dispute, with the cost split evenly by the enrollee and the health plan. A 1995 law established a utilization review process for emergency room care. It requires managed care plans to provide coverage for an initial screening exam and any necessary stabilizing treatment. Three 1996 laws address the "gag clause" issue by: (1) strengthening existing laws ensuring open communication between providers and patients on treatment options; (2) making any violation of the "gag clause" laws a violation of the Insurance Code and the Health and Safety Code; and (3) prohibiting retaliation against providers who advocate on behalf of their patients. Additional legislation added requirements for health plans to disclose the basic method of reimbursement of providers and whether financial bonuses or incentives are used.
CORPORATE RESTRUCTURING	A 1995 law created a process for non-profit health care service plans that wish to restructure or convert to for-profit status. Health plans restructuring their operations must submit a public benefit program for approval by the Department of Corporations.

COLORADO: 1997 LEGISLATIVE ACTIVITY

The legislature approved a measure establishing regulatory standards for managed care plans dealing with network adequacy, accessibility and quality of care issues. The law requires health plans to: (1) have that networks sufficient in numbers and types of providers to assure that all services will be accessible without unreasonable delay; (2) arrange for a referral to a provider with the necessary expertise at no greater cost to the enrollee where the plan does not have a participating provider; (3) monitor the ability, clinical capacity and financial capability of networks to furnish contracted benefits; and (4) refrain from penalizing a provider who discusses the financial incentives between the provider and the managed care plan.

The Governor signed a limited mental health parity mandate that requires health plans to provide coverage for biologically-based mental disorders (e.g., schizophrenia, affective and bipolar disorders, major depression, obsessive-compulsive and panic disorders) no differently than for other physical ailments.

New legislation created a children's basic health program to provide comprehensive coverage to children under 19 whose family income does not exceed 185 percent of the federal poverty level and who are ineligible for Medicaid. The program will be funded primarily through savings and efficiencies achieved in other state health care programs. Premiums based on a sliding income scale will be collected from participants.

A new law requires Colorado to enroll 75 percent of its Medicaid population in capitated managed care products by July 2000. This effort is expected to reduce the state's Medicaid expenditures and savings are slated for subsidies to purchase private insurance for low-income children.

The legislature acted to incorporate HIPAA's small group requirements into its existing market reform statute. It also chose to implement the group-to-individual portability provisions of HIPAA by opting for the federal fall-back.

The Colorado Corporations and Associations Act of 1997 modified the rules for conversion of entities from one organizational form to another to respond to new federal tax rules classifying business organizations. The law also created a standard procedure for mergers that apply to all forms of business or non-profit entities recognized by Colorado law.

A new law classifies the following as unfair trade practices: (1) denying, refusing to issue, renew or cancel a policy or restrict coverage solely because a person may be a victim of domestic abuse; and (2) adding any surcharge or rating factor to a premium. An insurer must be able to prove to a victim of domestic abuse that any adverse action (e.g., underwriting, refusal to issue a policy) is not related to the domestic abuse status.

COLORADO: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1991. 1997 legislation created a children's basic health program to provide comprehensive coverage to children under 19 whose family income does not exceed 185 percent of the federal poverty level and who are ineligible for Medicaid. The program will be funded primarily through savings and efficiencies achieved in other state health care programs. Premiums based on a sliding fee scale will be collected from participants. A 1997 law requires Colorado to enroll 75 percent of its Medicaid population in capitated managed care products by July 2000. This effort is expected to reduce the state's Medicaid expenditures. These savings are slated for subsidies to purchase private insurance for low-income children and for grants to essential community providers.
BROAD INSURANCE MARKET REFORM	A 1994 law allows small employers (1-50 employees) to band together for the purpose of purchasing insurance. A 1994 law permits employers to offer tax-free medical savings accounts to their employees, in conjunction with catastrophic coverage. A 1997 law incorporated HIPAA's small group requirements into the existing market reform statute. Colorado implemented the group-to-individual portability provisions of HIPAA by opting for the federal fall-back.

REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1991 include: limits on rate variations; guaranteed renewal; and limits on preexisting condition waiting periods. Reforms enacted in 1994 built on existing law by: expanding the definition of small group from 2 to 25 employees to groups of 1 to 50; requiring guaranteed issue; establishing a voluntary reinsurance program; and phasing-in modified community rating by the year 2000 (with adjustments permitted for age and geography, but not gender).
REGULATION OF INDIVIDUAL MARKET	A 1996 law requires guaranteed renewal of policies. Also, if a health plan leaves the individual market, it cannot re-enter the market for five years.

MANAGED CARE	Since 1992, the Blue Cross and Blue Shield Plan must honor assignment of benefits by a subscriber to nonparticipating providers. The law applies to all types of licensed providers. Under a voluntary agreement in 1994, HMOs allow all pharmacies in rural communities (population less than 25,000) to join any prescription drug network and will provide advance public notice. In 1995, the Colorado managed care industry negotiated a voluntary agreement with the state medical society on physician affiliation/disaffiliation. Key provisions include: (1) providing a disaffiliated physician with the criteria for the decision when it occurs because of change in network size or composition; and (2) joint development and adoption of a voluntary procedure for implementing a mediation program for physicians involved in the affiliation/disaffiliation process. A 1996 law allows subscribers to have direct access to participating OB-GYNs without going through a primary care gatekeeper. Another 1996 law prohibits health plans from including "gag clauses" relating to treatment options in their provider contracts. During 1996, Blue Cross and Blue Shield of Colorado and other health plans voluntarily agreed to comply with proposed maternity length of stay standards. Health plans provide up to 48 hours of inpatient care following a routine delivery without requiring prior authorization. Also, health plans follow clinical standards set by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology in conducting reviews of medical necessity. A 1997 measure established regulatory standards for managed care plans dealing with network adequacy, accessibility and quality of care issues. The law requires health plans to: (1) have networks sufficient in numbers and types of providers to assure that all services will be accessible without unreasonable delay; (2) arrange for a referral to a provider with the necessary expertise at no greater cost to the enrollee where the health plan does not have a participating provider; (3) monitor the ability, clinical capacity and financial capability of networks to furnish contracted benefits; and (4) refrain from penalizing a provider who discusses the financial incentives between the provider and the managed care plan.
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CORPORATE RESTRUCTURING	A 1996 law created a process for not-for-profit health corporations to convert to for-profit stock companies which involves submitting a conversion plan to the Insurance Division for approval. It also repeals a law allowing not-for-profit health care entities to convert to mutual insurance companies. The Colorado Corporations and Associations Act of 1997 modified the rules for conversion of entities from one organizational form to another to respond to new federal tax rules classifying business organizations. The law also created a standard procedure for mergers that applies to all forms of business or non-profit entities recognized by Colorado law.
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CONNECTICUT: 1997 LEGISLATIVE ACTIVITY

The Governor signed a comprehensive managed care oversight bill that allows a health plan subscriber to apply to the Insurance Commissioner for an outside review when a claim is denied. Specifically, an enrollee who has exhausted all internal appeals may appeal any decision concerning medical necessity to the commissioner whose decision is binding. Some legal analysts believe there is a chance the legislation will be preempted by ERISA.

This legislation also includes (1) a mandate to provide coverage for biologically-based mental conditions on an equal basis with other medical conditions; (2) a requirement to pay for emergency room services based on a subscriber's presenting symptoms and using a "prudent layperson" standard; and (3) a ban on "gag clauses" that restrict a provider's ability to discuss treatment options with patients.

The legislature acted to incorporate the HIPAA small group requirements into its existing market reform statute. In addition, the existing medical high-risk pool was modified to meet the group-to-individual portability requirements of HIPAA.

Several mandated benefit bills were enacted. Health plans must cover a minimum hospital stay of 48 hours following a mastectomy or lymph node dissection, and a longer stay if recommended by the treating physician in consultation with the patient. Such procedures may not be required to be performed on an outpatient basis. However, outpatient surgery or a shorter inpatient stay is allowed if recommended by the treating physician. Other new mandates are for diabetic equipment and supplies, and low-protein modified food products used for the treatment of inherited metabolic diseases such as phenylketonuria (PKU).

The Governor signed legislation creating a two-part system to provide coverage to almost 90,000 uninsured children. The state will pursue an aggressive outreach campaign to enroll children currently eligible for Medicaid but not yet participating and will extend the eligibility age to 18. In addition, a new program will enable families with incomes under 300 percent of the federal poverty level to purchase private health insurance. Families would contribute to the cost of premiums based on a sliding income scale.

CONNECTICUT: CUMULATIVE REFORM LAWS

COMPREHENSIVE ACCESS	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1976, the first in the country. A 1997 law created a two-part system to provide coverage to almost 90,000 uninsured children. The state will pursue an aggressive outreach campaign to enroll children currently eligible for Medicaid but not yet participating, and will extend the eligibility age to 18. In addition, a new program will enable families with incomes under 300 percent of the federal poverty level to purchase private health insurance. Families would contribute to the cost of premiums based on a sliding income scale.
BROAD INSURANCE MARKET REFORM	A 1994 law promotes managed competition by freeing insurers, PPOs and self-funded employers to negotiate payment rates and methods directly with hospitals. Previously, the Commission on Hospitals and Health Care had set rates without successfully curbing the growth of overall expenditures. 1997 legislation incorporated the HIPAA small group requirements into the existing market reform statute. In addition, the existing medical high-risk pool was modified to meet the group-to-individual portability requirements of HIPAA.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1990 include: guaranteed issue to small employers (1-25 employees); mandatory reinsurance; limits on rate variations between new and old groups not to exceed a range of 2:1; guaranteed renewal; and limits on preexisting condition waiting periods. Subsequent amendments in 1992 prohibited experience-rating after July 1995. A 1994 amendment raised the definition of small employer to 1-50 employees.

REGULATION OF INDIVIDUAL MARKET	A 1993 law placed limits on preexisting condition waiting periods. The 1997 law to implement HIPAA created a guaranteed renewal requirement in the individual market and amended the preexisting condition exclusion period provision.
MANAGED CARE	Since 1981, insurers have been required to accept as a contracting provider any pharmacist willing to accept the terms of participation. A 1989 law prohibits insurers from requiring subscribers to use mail-order pharmacies. A 1991 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements, minimum operational standards, appeal and enforcement procedures, and civil sanctions. It also stipulates that the standards may be considered met if the UR firm receives accreditation from an approved private organization. A 1995 law requires insurers and HMOs to allow subscribers direct access to in-network OB-GYNs for certain obstetrical and gynecological services. A controversial 1997 managed care oversight law allows subscribers to apply to the Insurance Commissioner for an outside review when a claim is denied. Specifically, an enrollee who has exhausted all internal appeals may appeal any decision concerning medical necessity to the commissioner whose decision is binding. The following provisions were enacted in 1997: (1) a mandate to provide coverage for biologically-based mental conditions on an equal basis with other medical conditions; (2) a requirement to pay for emergency room services based on a subscriber's presenting symptoms and using a "prudent layperson" standard; and (3) a ban on "gag clauses" that restrict a provider's ability to discuss treatment options with patients.

CORPORATE RESTRUCTURING	-----
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DELAWARE: 1997 LEGISLATIVE ACTIVITY

The Governor signed legislation bringing the state into compliance with HIPAA's group-to-individual portability requirements by adopting federal fall-back standards. The state Health Care Commission is studying alternative reforms of the individual market and will draft legislation for consideration in 1998. The law also incorporated HIPAA small group requirements into existing market reform statutes.

A new law requires managed care plans to allow subscribers direct access to participating OB-GYNs for selected services (e.g., annual exam, pregnancy-related care). In addition, it allows subscribers to designate an OB-GYN as their primary care physician.

DELAWARE: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	In 1995, the state received federal approval of a statewide Medicaid managed care demonstration under Section 1115 waiver authority. The waiver enables the state to require Medicaid recipients to enroll in managed care plans and to expand coverage to certain low-income individuals. The Blue Cross and Blue Shield Plan is a participating managed care organization.
BROAD INSURANCE MARKET REFORM	1997 legislation brought the state into compliance with HIPAA's group-to-individual portability requirements by adopting federal fall-back standards. The state Health Care Commission is studying alternative reforms of the individual market and will draft legislation for consideration in 1998. The law also incorporated HIPAA small group requirements into existing market reform statutes.
REGULATION OF SMALL GROUP MARKET	Reforms enacted over the last several years include: guaranteed issue to small employers (1-50 employees); voluntary reinsurance; rate variations limited to 20% between classes and 35% within classes, with adjustments for specified demographics; elimination of gender as a rating factor; guaranteed renewal; and limits on preexisting condition waiting periods.
REGULATION OF INDIVIDUAL MARKET	The 1997 law implementing HIPAA created a guaranteed renewal provision in the individual market.

MANAGED CARE	A 1994 law requires insurers to accept any willing pharmacy; prohibits health plans from imposing on a beneficiary any copayment or condition that is not equally imposed on all pharmacy providers; and prohibits health plans from requiring beneficiaries to purchase pharmacy services exclusively through a mail-order pharmacy. A 1996 law prohibits health plans from including "gag clauses" relating to treatment options in their provider contracts. A 1997 law requires managed care plans to allow subscribers direct access to participating OB-GYNs for selected services (e.g., annual exam, pregnancy-related care). In addition, it allows subscribers to designate an OB-GYN as their primary care physician.
CORPORATE RESTRUCTURING	_____

DISTRICT OF COLUMBIA: 1997 LEGISLATIVE ACTIVITY

Lawmakers enacted a bill to comply with the guaranteed issue and other requirements of HIPAA regarding the small group market. The law also adopted the federal fall-back standards to satisfy HIPAA's group-to-individual portability requirements. Previously, the District of Columbia had not enacted any insurance market reform legislation.

Federal legislation amended Blue Cross and Blue Shield of the National Capital Area's charter to allow another non-profit corporation to be a corporate member of BCBSNCA.

DISTRICT OF COLUMBIA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	— — —
BROAD INSURANCE MARKET REFORM	In 1997, the D.C. City Council enacted legislation to comply with the guaranteed issue and other requirements of HIPAA regarding the small group market. The law also adopted the federal fall-back standards to satisfy HIPAA's group-to-individual portability requirements.
REGULATION OF SMALL GROUP MARKET	Same as above
REGULATION OF INDIVIDUAL MARKET	Same as above
MANAGED CARE	A 1996 law requires HMOs to offer a POS option as an additional benefit to a closed-panel HMO at the employer's option. A 1996 law bars HMOs from adopting contract provisions that prohibit providers from communicating to patients about treatment alternatives (so-called "gag clause)."

CORPORATE RESTRUCTURING	The Hospital and Medical Services Corporations Regulatory Act of 1996 provides the framework to regulate non-profit hospitals and medical service corporations operating in the District. The legislation also contains provisions governing conversions to a mutual or stock insurer. In 1997, Federal legislation amended Blue Cross and Blue Shield of the National Capital Area's charter to provide authorization for the board of trustees to determine that BCBSNCA should have a class of corporate members, to designate the members, and to prescribe the rights and qualifications of the corporate members. The amendment makes clear that another non-profit corporation may be a corporate member of BCBSNCA.
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FLORIDA: 1997 LEGISLATIVE ACTIVITY

A comprehensive managed care regulatory law was enacted that includes the following provisions: (1) prohibits health plans from restricting a provider's ability to communicate with patients regarding treatment options; (2) requires written policies and procedures be made available to enrollees about an HMO's process for authorizing referrals for unique medical needs; (3) requires HMO medical directors to be licensed in Florida; and (4) authorizes the state's Agency for Health Care Administration to collect information and publish HMO "report cards."

This law also requires HMOs to have internal grievance procedures available to enrollees who wish to appeal a coverage or claims denial. If an internal review does not resolve differences between the HMO and the enrollee, the grievance may be submitted to the public Statewide Provider and Subscriber Assistance Program. This agency is empowered to review the grievance and to issue a non-binding recommendation.

Another new law requires managed care plans to allow enrollees direct access to participating dermatologists. Health plans must develop compliance criteria, which include a limit of five office visits without prior authorization for a dermatologic condition within a 12-month period.

The Governor signed a bill that prohibits health plans from denying benefits to insured persons who have had breast cancer within two years of the effective date of their health coverage. In addition, it mandates that the length of a hospital stay following a mastectomy, as well as follow-up care, be determined by the treating physician in consultation with the patient and in accordance with prevailing medical standards. The legislation also requires coverage for reconstructive breast surgery to achieve symmetry.

The legislature acted to incorporate the HIPAA small group requirements into existing market reform statutes. To satisfy the group-to-individual portability requirements, Florida required guaranteed issue to HIPAA-eligible individuals. Health plans are required to offer a choice of conversion plans, one of which is the state approved "standard" policy currently offered in the small group market. In addition, to help offset potential cost increases, the state is empowered to create an individual insurance pool for health plans that choose to reinsure HIPAA-eligibles. The pool would be funded by reinsurance premiums paid by participating health plans.

A new law allows domestic mutual insurers to form mutual insurance holding companies or to merge with previously created mutual insurance holding companies.

FLORIDA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	Florida's voluntary approach to achieving universal access to a basic benefit package has not met with success. The Health Reform Act of 1993 puts in place a market-based, managed competition system with voluntary health purchasing alliances to work with businesses and accountable health plans. The initial target date of reaching universal coverage by the end of 1994 was not met. According to a 1996 state audit, Florida's Community Health Purchasing Alliances have not lived up to expectations. They provided coverage to a total of 74,000 people, but the monthly enrollment had begun to decline. In 1994, the state received federal approval of a statewide Medicaid managed care demonstration under Section 1115 waiver authority. Under the program, current Medicaid eligibles would be allowed to enroll in either an HMO or a fee-for-service case management program. This waiver has not yet been implemented. A medical high-risk pool for individuals who are otherwise uninsurable was established in 1983. Florida Healthy Kids is a model program providing school-based health insurance coverage for uninsured children at several sites. The method of funding is left to local discretion, and may include premiums and local health district tax support.
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BROAD INSURANCE MARKET REFORM	A 1996 law requires all Medicaid prepaid health plans to be licensed as HMOs as well as meet heightened standards for financial solvency and quality of care. It requires these plans to establish an 80 percent minimum loss ratio and cap at 3,000 the number of active patients for each primary care physician in a health plan. A 1997 law authorized four Medicaid demonstration projects with provider sponsored networks to test direct contracting. A PSN reimbursed on a prepaid basis must meet appropriate financial and quality standards as established by the state. The legislature acted in 1997 to incorporate the HIPAA small group requirements into existing market reform statutes. To satisfy the group-to-individual portability requirements, Florida required guaranteed issue to HIPAA-eligible individuals. Health plans in the individual market are required to offer a choice of plans, one of which is the state approved "standard" policy currently offered in the small group market.
REGULATION OF SMALL GROUP MARKET	Beginning in 1992, market reform laws were enacted that include: guaranteed issue to small employers (1-50 employees); voluntary reinsurance; community rating with limited demographic adjustments; guaranteed renewal; and limits on preexisting condition waiting periods. A 1996 state COBRA - type law requires health plans providing coverage to groups of less than 20 people to offer continued coverage for workers and their dependents for 18 months after leaving the job at 115% of the group rate. It puts the notification responsibility on health plans, rather than employers.
REGULATION OF INDIVIDUAL MARKET	Florida passed limited reform of the individual market which prohibits the practice of "durational" rating. A 1996 law requires guaranteed renewal and limits preexisting condition waiting periods. A 1997 law created a statewide individual insurance pool for health plans that choose to reinsure HIPAA-eligibles. The pool would be funded by reinsurance premiums paid by participating health plans.

MANAGED CARE	A 1990 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements, minimum operational standards, appeals procedures, confidentiality requirements, and penalties for non-compliance. A 1992 law limits PPOs to a 50% payment differential between in-network and out-of-network providers. A 1993 law allows any pharmacist with 12 or fewer branches willing to accept the terms of participation to participate as a contracting provider in an insurance plan or HMO. A 1996 law requires health plans to provide coverage for an initial screening and any necessary stabilizing treatment. Health plans are not responsible for any subsequent treatment costs if a medical determination by the provider finds the case not to be an emergency. The Governor vetoed a 1996 bill that would have created new civil causes of action against commercial HMOs that engage in deceptive marketing or business practices or that fail to provide medically necessary care. A comprehensive 1997 law includes the following provisions: (1) prohibits health plans from restricting a provider's ability to communicate with patients regarding treatment options; (2) requires written policies and procedures be made available to enrollees about an HMO's process for authorizing referrals for unique medical needs; (3) requires HMO medical directors to be licensed in Florida; and (4) authorizes the state's Agency for Health Care Administration to collect information and publish HMO "report cards." It also requires HMOs to have internal grievance procedures available to enrollees who wish to appeal a coverage or claims denial. If an internal review does not resolve differences between the HMO and the enrollee, the grievance may be submitted to the public Statewide Provider and Subscriber Assistance Program for a non-binding recommendation. A 1997 law requires managed care plans to allow enrollees direct access to participating dermatologists. Health plans must develop compliance criteria, which include a limit of five office visits without prior authorization for a dermatologic condition within a 12-month period.
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CORPORATE RESTRUCTURING	A 1997 law allows domestic mutual insurers to form mutual insurance holding companies or to merge with previously created mutual insurance holding companies.
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GEORGIA: 1997 LEGISLATIVE ACTIVITY

Lawmakers enacted a bill to comply with some of the HIPAA requirements for the small group market. The law also sets up an assigned risk pool as an alternative state mechanism to satisfy the group-to-individual portability rules. Under this provision, HIPAA-eligible persons may apply for coverage to the Commissioner of Insurance, who then "assigns" eligible individuals to health plans based on a plan's pro rata volume of individual health insurance business done in the state.

A new law allows health plan enrollees to directly access an eye care provider without seeking referral from a primary care physician. Both vision and eye care services are covered when provided by either a participating optometrist or ophthalmologist.

The Commissioner of Insurance was authorized to issue certificates of authority to non-profit corporations that wish to operate as health plan purchasing cooperatives for members located within particular geographic areas of the state. A purchasing cooperative must accept for membership any eligible small employer (2 to 50 employees) that agrees to pay the membership fee and premium for coverage. Large employers and the self-employed may join at the option of the health plan cooperative.

GEORGIA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	_____
BROAD INSURANCE MARKET REFORM	A 1997 law brought the state into compliance with some of HIPAA's requirements for the small group market. However, since the legislature did not enact a guaranteed issue provision in the small group market, the HIPAA provision is in force. The 1997 law sets up an assigned risk pool as an alternative state mechanism to satisfy the group-to-individual portability rules. Under this provision, HIPAA-eligible persons may apply for coverage to the Commissioner of Insurance, who then "assigns" eligible individuals to health plans based on a plan's pro rata volume of individual health insurance business done in the state. 1997 regulations require provider-sponsored networks (PSNs) to obtain a certificate of authority from the commissioner. They must have a net worth of at least \$1 million, carry reinsurance to protect against excessive claims, and file quarterly and annual financial statements with the insurance department. The initial capital requirements for PSNs are significantly less than the \$3 million required of HMOs. The Commissioner of Insurance was authorized in 1997 to issue certificates of authority to non-profit corporations that wish to operate as health plan purchasing cooperatives for members located within particular geographic areas of the state. A purchasing cooperative must accept for membership any eligible small employer (2 to 50 employees) that agrees to pay the membership fee and premium for coverage. Large employers and the self-employed may join at the option of the health plan cooperative.

REGULATION OF SMALL GROUP MARKET	Rate regulations in place since 1991 (and amended in 1994 and 1997) allow health plans to apply age, sex, group size, geography, industry and occupational factors, as well as any other factors deemed appropriate by the Insurance Commissioner. A 1995 law places limits on preexisting condition waiting periods for carriers in the group market. A 1997 law provides for guaranteed renewal for groups of 2-50 employees and amends the limits on preexisting condition exclusion periods. However, since the law did not enact a guaranteed issue provision in the small group market, the HIPAA provision is in force.
REGULATION OF INDIVIDUAL MARKET	A 1995 law provides for guaranteed renewal and was amended in 1997 to conform to HIPAA's guaranteed renewal requirement.

MANAGED CARE	A 1988 law limits PPOs to a 40% payment differential between in-network and out-of-network providers. A 1991 law allows any pharmacist willing to accept the terms of participation for mail-order pharmacists set forth by a health plan to be a participating provider. Health plans also have been prohibited from requiring subscribers to use mail-order pharmacies since 1991. A 1991 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements, minimum operational standards, and appeals procedures. Also, UR entities must be accredited by the URAC. Since 1992, the Blue Cross and Blue Shield Plan must honor assignment of benefits by a subscriber to nonparticipating providers. The law applies to all types of providers. A 1995 direct access law allows subscribers to self-refer to dermatologists without seeing a primary care gatekeeper. A 1996 law requires health plans to provide coverage for an initial screening exam and any necessary stabilizing treatment, based on a "prudent layperson" definition of emergency care. It allows for retroactive denial of claims for any continuing care if the condition was later found to be non-emergency. A 1996 law prohibits health plans from containing "gag clauses" relating to discussions about medical treatments. A modified point-of-service (POS) measure passed in 1996 requires HMOs contracting with employers that only offer a closed-panel product to make available a POS option at the employee's expense. A 1996 direct access law allows subscribers to self-refer to participating OB-GYNs. A 1997 law allows health plan enrollees direct access to an eye care provider without seeking referral from a primary care physician. Both vision and eye care services are covered when provided by a participating optometrist or ophthalmologist.
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CORPORATE RESTRUCTURING	A 1995 law allows non-profit health care corporations to convert to for-profit shareholder-owned health care corporations with the approval of the Insurance Commissioner. The law gives the Attorney General the option of appearing before the Commissioner at a hearing on the conversion at issue and representing the public interest.
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HAWAII: 1997 LEGISLATIVE ACTIVITY

Lawmakers enacted legislation to comply with the HIPAA small group requirements, including guaranteed issue and renewal. The Commissioner of Insurance may exempt a health plan if he determines that the plan does not have the capacity to deliver services adequately to enrollees of additional groups given its obligation to existing employer groups. Hawaii had not previously enacted small group market reforms.

The state complied with HIPAA provisions on group-to-individual portability by adopting the federal fall-back standards. In addition, the Commissioner will convene a Task Force to, among other things, recommend mechanisms for achieving access to a satisfactory level of affordable individual coverage for HIPAA eligibles. The Task Force will submit a report of its findings and recommendations to the legislature prior to the convening of the regular session in 1998.

HAWAII: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	Hawaii is the only state to implement an employer mandate to provide comprehensive coverage to employees. The "Prepaid Health Care Act of 1974" requires most employers to contribute at least 50% of the cost of coverage for employees who work a minimum of 20 hours per week. With an employer mandate in place, as well as the targeted state insurance programs to cover "gap groups" described below, Hawaii comes close to the goal of universal coverage for all residents. The State Health Insurance Program (SHIP) was enacted in 1989 to provide access to a basic benefit package for low-income residents who are not eligible for the employer mandate (e.g., unemployed, part-time workers, seasonal workers, dependents). The state has established a system of income-related premium subsidies to fund the program. In 1993, Hawaii received federal approval of a statewide Medicaid managed care demonstration. The project was implemented under Section 1115 waiver authority, and combines public programs for low-income individuals (Medicaid, SHIP, General Assistance) into a single, publicly funded program known as Hawaii Health QUEST. The Blue Cross and Blue Shield Plan is a participating managed care organization.
BROAD INSURANCE MARKET REFORM	Lawmakers enacted legislation in 1997 to comply with the HIPAA small group requirements, including guaranteed issue and renewal. The state complied with HIPAA provisions on group-to-individual portability by adopting the federal fall-back standards.
REGULATION OF SMALL GROUP MARKET	Same as above

REGULATION OF INDIVIDUAL MARKET	The 1997 law implementing HIPAA required health plans to guarantee renew individual coverage.
MANAGED CARE	A 1991 law authorized the Department of Health to establish standards for utilization review (UR) agents who conduct reviews of mental health, alcohol or drug abuse treatment services. It requires insurers to disclose UR criteria to providers upon request.
CORPORATE RESTRUCTURING	— — —

IDAHO: 1997 LEGISLATIVE ACTIVITY

The Governor signed the "Managed Care Act of 1997," which substantially revised the existing HMO enabling statute and applied uniform licensure standards to all risk-bearing entities. The key provisions of the bill: (1) establish specific standards for managed care plans (including PSNs) pertaining to capital requirements, information disclosure and grievance procedures; (2) require all health plans (including HMOs) to offer a point-of-service option; (3) prohibit "gag clauses" in provider contracts; and (4) require health plans to adopt a "prudent layperson" standard to determine the presence of an emergency medical condition.

The Act makes Idaho the first state to legislate a mandatory POS requirement. This provision could eliminate all in-network managed care plans in the state, frequently the lowest cost option available to residents.

Another measure modified state law to bring existing small market reforms into compliance with HIPAA. Key provisions include raising the small group size from 2 - 49 employees to 2 - 50 employees. The state amended its individual market reform statutes to comply with the group-to-individual portability requirements of HIPAA.

IDAHO: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	— — —
BROAD INSURANCE MARKET REFORM	In 1995, the legislature authorized medical savings accounts in which employers and employees can choose to set aside pre-tax dollars up to \$2,000 annually for employee medical expenses. A 1997 measure modified state law to bring existing small group and individual market reforms into compliance with HIPAA. The state is using existing individual market reforms as the alternative mechanism to satisfy HIPAA's group-to-individual portability provision. A 1997 law applied uniform licensure standards to all risk-bearing entities. It established specific requirements for managed care plans (including PSNs) pertaining to capital reserves, information disclosure and grievance procedures.

REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1993 include: guaranteed issue to small employers (2-49 employees); mandatory reinsurance; limits on rate variations for experience, health status and duration to a range of 2:1; guaranteed renewal; and limits on preexisting condition waiting periods. 1995 amendments required that a catastrophic plan must also be offered as a third guaranteed issue product; and that coverage will not have to be renewed if the majority of employees in a small group has moved out of state. A 1996 law instituted a large group portability requirement that credits preexisting condition waiting periods for large groups, defined as 50 or more employees. A 1997 provision raised the small group size from 2 - 49 employees to 2 - 50 employees.
REGULATION OF INDIVIDUAL MARKET	Reforms enacted in 1994 include: guaranteed renewal; mandatory reinsurance; limits on preexisting condition waiting periods; and guaranteed issue. For individuals without previous qualifying coverage, health plans only have to guarantee issue during two 45-day annual open enrollment periods; individuals with previous qualifying coverage have year-round guaranteed issue. 1994 rating reforms limit rate variations to a range of 1.67:1 for age, gender and tobacco use. Effective July 1998, geography will be added as a case characteristic or rating factor. Other factors can be used with the approval of the Director of Insurance. Claims experience, health status and duration cannot be used as rating factors. 1995 amendments required that a catastrophic plan must be offered as a third guaranteed issue product; and that coverage will not have to be renewed if the individual has moved out of state.

MANAGED CARE	A 1991 law allows any pharmacist willing to accept the terms of participation set forth by a managed care network to participate. Since 1992, both the Blue Cross and Blue Shield Plans must honor assignment of benefits by a subscriber to nonparticipating providers. The law applies to dental care services only. In 1994, the state enacted a broad any willing provider law that requires health plans to enter into contracts with all qualified health providers who desire to participate and meet the terms and conditions. Also, health plans must establish a grievance system for providers that allows for arbitration or other system that ensures reasonable due process. The "Managed Care Act of 1997" substantially revised the existing HMO enabling statute. Key provisions of the bill: (1) require all health plans (including HMOs) to offer a point-of-service option; (2) prohibit "gag clauses" in provider contracts; and (3) require health plans to adopt a "prudent layperson" standard to determine the presence of an emergency medical condition.
CORPORATE RESTRUCTURING	A 1994 law governs the mutualization process for hospital service corporations, combined professional service and hospital service corporations, or professional service corporations whose articles of incorporation specify particular licensee services are to be provided by physicians and surgeons.

ILLINOIS: 1997 LEGISLATIVE ACTIVITY

The legislature enacted modifications to the existing small group market reform statute to bring it into compliance with HIPAA, including guaranteed issue and renewal and defining group size as from 2 to 50 employees. The law also conforms the existing medical high-risk pool to the group-to-individual portability requirements of HIPAA.

The Governor signed mandated benefit legislation that requires minimum hospital stays for mastectomy patients. It specifically allows treating physicians to determine the duration of a hospital stay and requires a follow-up visit no later than 48 hours after a mastectomy patient is discharged. Two other mandates were passed that require coverage for annual cervical cancer screenings for women and prostate cancer screenings for men upon the recommendation of a physician.

A new law authorized the creation of voluntary Health Care Purchasing Groups to include two or more employers with up to 2,500 covered individuals. More than one purchasing group may operate in any geographic area of the state. No insurance risk may be borne by a purchasing group.

Health plans may not deny, refuse to issue or renew, or cancel coverage because an individual is or has been the subject of domestic abuse. Nor may health plans charge a different rate for the same coverage because an individual has a history of or is subject to abuse.

ILLINOIS: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1989. In 1996, the state received approval for a federal Medicaid Section 1115 managed care waiver. Illinois hopes to use this statewide demonstration project to move 1.1 million Medicaid recipients into managed care plans. Under the program, known as MediPlan Plus, non-institutional Medicaid recipients will choose from a mix of HMOs, provider-sponsored community networks, and providers that offer case management services.
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BROAD INSURANCE MARKET REFORM	A 1994 law allows employers to establish medical savings accounts for employees, allowing tax-free contributions of up to \$3,000 per year. A 1997 law modified the existing small group market reform statute to bring it into compliance with HIPAA requirements, including guaranteed issue and renewal and defining group size as 2 - 50 employees. The law also conforms the existing medical high-risk pool to the group-to-individual portability requirements of HIPAA. In 1996, the Department of Insurance (DOI) announced that "certain provider-based market systems" such as PSOs would not be subject to regulation where there is no direct contractual obligation to the employees covered under a self-insured agreement. According to the DOI, such arrangements leave the employer with the "full and direct responsibility" to the individual. The DOI newsletter stated: "The Department has regulatory jurisdiction when any health care provider group becomes the ultimate risk bearer and is directly obligated to individuals to provide, arrange or pay for medical services. In these situations, the provider group must be appropriately licensed as an HMO, limited health service corporation or insurance company." A 1997 law authorized the creation of voluntary Health Care Purchasing Groups to include two or more employers with up to 2,500 covered individuals. More than one purchasing group may operate in any geographic area of the state. No insurance risk may be borne by a purchasing group.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1993 include: limits on rate variations for experience, health status and duration to a range of 2:1; guaranteed renewal to small employers (3-25 employees); and limits on preexisting condition waiting periods. A 1997 law required guaranteed issue and expanded the small group size from 3-35 to 2-50 employees.
REGULATION OF INDIVIDUAL MARKET	Since the legislature did not enact a guaranteed renewal provision as required under HIPAA, the HIPAA guaranteed renewal provision is in force.

MANAGED CARE	State law allows any non-institutional health care provider (e.g., physicians, osteopaths, chiropractors, pharmacists) willing to accept the terms of participation set forth by a PPO network to participate. A 1996 law requires health plans to allow subscribers direct access to participating OB-GYNs, without having to go through a primary care gatekeeper.
CORPORATE RESTRUCTURING	A 1994 law allows domestic mutual companies to demutualize and form stock companies with the approval of the Director of Insurance.

INDIANA: 1997 LEGISLATIVE ACTIVITY

Lawmakers did not enact HIPAA-conforming modifications to the existing small group market reform statute. Conforming legislation will be introduced in the 1998 session. In the meantime, HIPAA's requirements are in force. However, the legislature did conform the existing medical high-risk pool to the group-to-individual portability requirements of HIPAA.

A new law requires HMOs to establish and the Commissioner of Insurance to approve an internal grievance system to assist enrollees in filing complaints. HMOs must have written policies and procedures for the timely resolution of filed grievances. It stipulates that a grievance must be resolved as expeditiously as possible, but not more than 20 business days after the grievance is filed, unless there are circumstances beyond the HMO's control.

Lawmakers adopted a limited mental health parity mandate that applies to state employees only. It equalizes the health coverage between biologically-based mental illnesses and other physical illnesses. Other mandates were enacted that require health plans in the private market to: (1) cover reconstructive surgery or prosthetic devices for mastectomy patients; and (2) cover medically necessary diabetic supplies and equipment, as well as self-management training.

A new law allows the merger of domestic insurance corporations without a vote of the shareholders, members or policyholders under certain circumstances. It requires a domestic insurer that is a primary company that establishes a subsidiary that is not an insurance company to file with the Insurance Commissioner a summary of the business to be carried on by the subsidiary.

INDIANA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1982.
BROAD INSURANCE MARKET REFORM	A 1995 law authorized an employer to establish medical savings accounts for employees that are exempt from state taxation. Lawmakers did not enact HIPAA-conforming modifications to the existing small group market reform statute. Conforming legislation will be introduced in the 1998 session. In the meantime, HIPAA's requirements are in force. However, the legislature did conform the existing medical high-risk pool to the group-to-individual portability requirements of HIPAA.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1992 include: limits on rate variations for experience, health status and duration to a range of 2:1; and guaranteed renewal to small employers (3-25 employees). A 1995 law expanded the definition of small employer to 3-50 employees and placed limits on preexisting condition waiting periods. A 1996 amendment established a voluntary reinsurance program.
REGULATION OF INDIVIDUAL MARKET	A 1995 law placed limits on preexisting condition waiting periods. A 1996 amendment to the individual market reform statute credits waiting periods, provided that coverage did not lapse for more than 30 days. Since the legislature did not enact a guaranteed renewal provision as required under HIPAA, the HIPAA guaranteed renewal provision is in force.

MANAGED CARE	A 1984 law allows any provider willing to meet the terms of participation set forth by a PPO network to participate. In 1994, the legislature modified the existing any willing provider law to support the use of a gatekeeper in PPOs established by health plans. The revision permits a PPO provider to limit a subscriber's reimbursement in certain situations on the grounds that the subscriber either received or was referred for services by a nonparticipating provider. A 1992 law established a system of comprehensive regulation of the utilization review (UR) industry, including a state certification requirement. It also stipulates that the standards may be considered met if the UR firm receives accreditation by a recognized private UR organization. A 1996 law bans a health plan from using "gag clauses" that prohibit providers from discussing treatment options and financial incentives with their patients. A 1996 law requires health plans to allow subscribers direct access to an OB-GYN and to designate an OB-GYN as a primary care provider if the provider meets the conditions for participation. A 1996 law requires health plans to furnish providers with the reasons for denying an application to join a network. A 1997 law requires HMOs to establish and the Commissioner of Insurance to approve an internal grievance system to assist enrollees in filing complaints. HMOs must have written policies and procedures for the timely resolution of filed grievances. It stipulates that a grievance must be resolved as expeditiously as possible, but not more than 20 business days after the grievance is filed, unless there are circumstances beyond the HMO's control.
CORPORATE RESTRUCTURING	A 1997 law allows the merger of domestic insurance corporations without a vote of the shareholders, members or policyholders under certain circumstances.

IOWA: 1997 LEGISLATIVE ACTIVITY

A new managed care law requires health plans to offer a point-of-service option to employers. Employers with 50 or fewer employees are not required to pass insurance plan options along to employees. Employers with 51 or more employees are required to offer employees a choice of health plans.

Lawmakers satisfied the small group requirements of HIPAA by modifying existing small group market reform laws. In addition, the state's medical high-risk pool was designated as the alternative mechanism to comply with HIPAA's group-to-individual portability requirements.

IOWA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A state-administered insurance program for the unemployed was created in 1993. A medical high-risk pool for individuals who are otherwise uninsurable was established in 1987.
BROAD INSURANCE MARKET REFORM	A 1993 law authorized demonstration projects for health insurance purchasing cooperatives (HIPCs) under the direction of the Department of Insurance. A 1997 law satisfied the small group requirements of HIPAA by modifying existing small group market reform laws. In addition, the state's medical high-risk pool was designated as the alternative mechanism to comply with HIPAA's group-to-individual portability requirements.
REGULATION OF SMALL GROUP MARKET	Reforms enacted over the past several years include: guaranteed issue to small employers (2-25 employees); voluntary reinsurance; limits on rate variations for experience, health status and duration to a 2:1 range; guaranteed renewal; and limits on preexisting condition waiting periods. A 1994 law expanded the definition of small employer to 2-50 employees and established a modified community rating system. Carriers may not use experience and health status in determining rates for the basic and standard benefit packages.
REGULATION OF INDIVIDUAL MARKET	Requirements enacted in 1995 include guaranteed issue of a standard and a basic product to individuals with one year of qualifying coverage (group, individual or high-risk pool) or with a qualifying event in the previous 30 days. Reforms also include: limits on rate variations to a total range of 2:1; mandatory reinsurance; guaranteed renewal; and limits on preexisting condition waiting periods.

MANAGED CARE	A 1990 law prohibits health plans from requiring subscribers to use mail-order pharmacies. In 1996, health plans reached a voluntary agreement with the Iowa Medical Society and the Iowa Hospital Association on a set of principles to protect patients and providers under managed care. Principles include: disclosing non-proprietary criteria by which providers are evaluated for network membership; furnishing reasons for rejecting an application; and giving providers an opportunity to appeal a decision to terminate. A 1997 law requires health plans to offer a point-of-service option to employers. Employers with 50 or fewer employees are not required to pass insurance plan options along to employees. Employers with 51 or more employees are required to offer employees a choice of health plans.
CORPORATE RESTRUCTURING	A 1996 law allows mutual or service corporations to form mutual insurance holding companies or merge with existing domestic mutual insurance holding companies upon approval of the Insurance Commissioner.

KANSAS: 1997 LEGISLATIVE ACTIVITY

A managed care bill was enacted that bans health plans from imposing a "gag clause" on physicians regarding the communication of treatment options with patients. It also mandates coverage for initial screening and stabilization services delivered in an emergency room without prior authorization. However, once an enrollee is stabilized, health plans may require as a condition of further coverage that a hospital ER facility promptly contact the health plan for prior authorization for continuing treatment.

Lawmakers complied with the HIPAA small group requirements by modifying the existing small group market reform statute. The state's medical high-risk pool was chosen to be the alternative mechanism to satisfy HIPAA's group-to-individual portability requirements.

A new law allows mutual insurance companies to demutualize and form stock insurance companies with the approval of the Insurance Commissioner. It also allows mutual insurance companies to form mutual insurance holding companies with the Commissioner's approval.

KANSAS: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	The state-run Healthy Kids program provides preventive and primary care services to uninsured children through school-based clinics. A medical high-risk pool for individuals who are otherwise uninsurable was established in 1992.
BROAD INSURANCE MARKET REFORM	A 1997 law complies with the HIPAA small group requirements by modifying the existing small group market reform statute. The state's medical high-risk pool was chosen to be the alternative mechanism to satisfy HIPAA's group-to-individual portability requirements.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1992 include: guaranteed issue to small employers (3-25 employees); voluntary reinsurance; limits on rate variations for experience, health status and duration to a 2:1 range; guaranteed renewal; and limits on pre-existing condition waiting periods. Amendments in 1994 extend the definition of small employer to 3-50 employees and reduce the maximum pre-existing condition waiting period from one year to 90 days. A 1997 law revised the definition of small employer to 2-50 employees.
REGULATION OF INDIVIDUAL MARKET	A 1997 law required health plans to guarantee renew individual coverage.

MANAGED CARE	A limited any willing pharmacy law was enacted in 1994. Health plans must permit participation of a limited number of pharmacies in medically underserved counties. A 1994 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements, minimum operational standards, appeals procedures, confidentiality requirements, and penalties for non-compliance. It also stipulates that the standards may be considered met if the UR firm receives accreditation from a recognized private organization. A 1996 law bans health plans from imposing a "gag clause" on physicians regarding the communication of treatment options with patients. It also mandates coverage for initial screening and stabilization services delivered in an emergency room without prior authorization. However, once an enrollee is stabilized, health plans may require as a condition of further coverage that a hospital ER facility promptly contact the health plan for prior authorization for continuing treatment.
CORPORATE RESTRUCTURING	A 1997 law allows mutual insurance companies to demutualize and form stock insurance companies with the approval of the Insurance Commissioner. It also allows mutual insurance companies to form mutual insurance holding companies with the Commissioner's approval.

KENTUCKY: 1997 LEGISLATIVE ACTIVITY

The legislature did not meet in regular session during 1997. However, the Governor called a Special Session to address problems in the Kentucky insurance market. The session ended in a stalemate. An earlier report by the Insurance Commissioner described the state's insurance market as "unstable" and concluded that it "cannot sustain itself over the long-term."

The Commissioner's report attributed most of the negative impact to Kentucky's 1994 law requiring guaranteed issue and modified community rating for all employer groups and individuals. Since reforms were enacted in 1994, all but two health plans have withdrawn from the individual market. The remaining health plans, Anthem Blue Cross and Blue Shield and Kentucky Kare (the state employee plan), have been experiencing significant losses in the individual market.

In an attempt to make the insurance market competitive again, the Governor backed a Senate proposal which would have created a high-risk pool for individuals and allowed health status to be used as a rating factor in the individual market. The proposal ultimately failed in the House on a close vote. Both the Governor and the Insurance Commissioner continue to support changes aimed at restructuring the insurance market and reform will be a priority when the General Assembly convenes for its regular session in January 1998.

After the failure of the Special Session, the Governor extended an executive order allowing Kentuckians who purchased health insurance prior to July 15, 1994 (the effective date of the reform act of 1994) to renew coverage at the old rates until December 1997. He did this in order to give health plans time to file new rate requests and to switch enrollees over to one of the state's five standard plans required under the 1994 law.

Kentucky is exempted from implementing HIPAA requirements until July 1998 because the legislature did not meet in regular session this year.

KENTUCKY: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	In 1995, Kentucky significantly altered the design of its statewide Medicaid managed care demonstration to be conducted under Section 1115 waiver authority. Under the project, Kentucky will develop a statewide system of capitated, comprehensive-risk managed care partnerships bringing together providers from both the public and private sectors. The goal is to enroll all non-institutionalized Medicaid recipients in one of the regional partnerships by 1998.
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BROAD INSURANCE MARKET REFORM	In 1994, Kentucky enacted a far-reaching health care reform law that created an independent state agency with broad regulatory powers over the private insurance market. It did not impose new coverage requirements on employers or individuals, but sought to expand access by: establishing a statewide Health Purchasing Alliance for government employees, Medicaid recipients and others; requiring broad reform of the entire group and individual markets; and authorizing the issuance of coverage to alliance members by provider sponsored networks. This controversial law was significantly altered in 1996 to permit the use of gender and occupation as rating factors; to allow discounts up to 10% for healthy lifestyles; and to increase the maximum rate spread from a 3:1 to a 5:1 ratio. Separate rates can be established for individual and group coverage. The community rating program does not apply to association groups. In 1997, the Governor extended an executive order allowing Kentuckians who purchased small group or individual products prior to July 15, 1994 (the effective date of the reform act of 1994) to renew coverage at the old rates until December 1997. He did this in order to give health plans time to file new rate requests and to switch enrollees over to one of the state's five standard plans required under the 1994 law. The Health Purchasing Alliance became operational July 1995. Membership is mandatory for state employees and school district employees; participation is voluntary for individuals, employers with 50 or fewer employees, and associations of 50 individuals or less.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1994 include: guaranteed issue to any employer or individual who elects to be covered; modified community rating for groups of 50 or fewer employees and individuals with adjustments for age, geography, family composition and benefit plan design; guaranteed renewal; and limits on preexisting condition waiting periods. Amendments enacted in 1996 permit the use of gender and occupation as rating factors; increase the maximum rate spread from a 3:1 to a 5:1 ratio; establish a 12-month residency requirement for renewal and portability; and double the preexisting condition exclusion.

REGULATION OF INDIVIDUAL MARKET	Reforms enacted in 1994 and 1996 are the same as for the group market described above.
MANAGED CARE	A 1990 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements, minimum operational standards, appeals procedures, confidentiality requirements, and penalties for non-compliance. A 1994 law requires insurers and HMOs to accept any licensed provider who is willing to accept the terms and conditions of participation. A 1996 law requires health plans to allow subscribers direct access to participating chiropractors without referral from a primary care gatekeeper.
CORPORATE RESTRUCTURING	_____

LOUISIANA: 1997 LEGISLATIVE ACTIVITY

The session produced a number of new laws imposing a variety of restrictions on managed care plans. An "any willing rural provider" law went into effect in August without the Governor's signature. An earlier 1984 AWP law was overturned in 1996 by a federal appeals court on the grounds that it was preempted by ERISA. This time, the AWP requirement is the centerpiece of the "Rural Hospital Preservation Act," which requires managed care plans to offer rural hospitals and physicians participation on the same terms and conditions that apply to other providers.

New HMO oversight laws impose the following additional requirements: (1) a ban on the use of "gag clauses;" (2) a description of enrollee grievance and quality review procedures; (3) a list of provider compensation mechanisms including incentive arrangements; and (4) accreditation by a private organization recognized by the Commissioner of Insurance. Other laws dictated the speed with which HMOs must pay clean claims (within 30 days, under penalty of double the amount of benefits due and attorneys fees); and must approve or disapprove a pre-authorization request for coverage (within 2 working days for "urgent" conditions and 5 working days for elective treatments).

The Governor also signed numerous mandated benefits bills into law requiring coverage for: (1) screening and stabilization services for emergency medical conditions as defined by a "prudent layperson" standard; (2) prostate cancer screening; (3) reconstructive breast surgery following a mastectomy; (4) diabetic equipment, supplies and self-management training; and (5) off-label use of drugs for cancer treatment. Paradoxically, lawmakers also enacted a requirement that a cost impact report be done before any future committee hearings on mandated benefits bills (a committee may waive this requirement).

Louisiana complied with HIPAA small group requirements by modifying its existing statute to require guaranteed issue, but did not revise the current statutory definition of small group from 3-35 to 2-50 employees as specified in HIPAA. The state will use its medical high-risk pool to satisfy the group-to-individual portability provisions.

A 1997 law allows mutual insurers to convert to stock insurers and transfer the ownership interests of the mutual insurer's policyholders to an ownership interest in a mutual holding company. The mutual holding company would hold the stock of the converted insurer. The new law prohibits Blue Cross and Blue Shield of Louisiana from demutualizing in this manner.

LOUISIANA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1992.
BROAD INSURANCE MARKET REFORM	A 1996 law exempts from state income tax any moneys deposited by an employer or employee into a qualified medical savings account (MSA), provided the employee also has a catastrophic policy. MSA policies are subject to the same rules as indemnity policies and managed care plans. A 1997 law modified the existing small group statute to require guaranteed issue, but did not revise the current statutory definition of small group from 3-35 to 2-50 employees as specified in HIPAA. The state will use its medical high-risk pool to satisfy the group-to-individual portability provisions.
REGULATION OF SMALL GROUP MARKET	Reforms enacted over the past few years include: guaranteed renewal to small employers (3-35 employees); limits on rate variations for experience, health status and duration to a range of 1.2:1; and limits on preexisting condition waiting periods. 1997 amendments required guaranteed issue in the small group market and eased the rating bands from a range of 1.2:1 to a range of 1.25:1.
REGULATION OF INDIVIDUAL MARKET	Reforms enacted in 1993 include: mandated offering of renewal; and limits on rate variations for experience, health status and duration to a range of 1.2:1. A 1995 law imposed limits on preexisting condition waiting periods. It also established group-to-individual, individual-to-group and individual-to-individual portability. A 1997 law required health plans to guarantee renew individual coverage.

MANAGED CARE	A 1984 law allowed any non-hospital provider willing to meet the terms of participation set forth by a PPO network to participate. In 1996, a federal appeals court ruled that this law is preempted by ERISA. Subsequently, the U.S. Supreme Court refused to hear the state's appeal in <i>Louisiana v. Cigna</i>. As a result, Louisiana cannot enforce the any willing provider law with respect to ERISA plans, both insured and self-funded. A 1991 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements, minimum operational standards, appeals procedures, confidentiality requirements, and penalties for non-compliance. Since 1992, state law prohibits health plans from requiring subscribers to use specifically designated pharmacies. Also, any pharmacist willing to accept the terms of participation has the right to participate as a contracting provider for an insurance plan or HMO. A 1995 law allows subscribers direct access to an OB-GYN for two visits annually and any care related to a pregnancy. It also permits the inclusion of OB-GYNs as primary care physicians. An "any willing rural provider" law went into effect in 1997 without the Governor's signature. The AWP requirement is the centerpiece of the "Rural Hospital Preservation Act," which requires managed care plans to offer rural hospitals and physicians participation on the same terms and conditions that apply to other providers. New HMO oversight laws enacted in 1997 impose the following requirements: (1) a ban on the use of "gag clauses;" (2) a description of enrollee grievance and quality review procedures; (3) a list of provider compensation mechanisms including incentive arrangements; and (4) accreditation by a private organization recognized by the Commissioner of Insurance. Other laws dictated the speed with which HMOs must pay clean claims (within 30 days, under penalty of double the amount of benefits due and attorneys fees); and must approve or disapprove a pre-authorization request for coverage (within 2 working days for "urgent" conditions and 5 working days for elective treatments).
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CORPORATE RESTRUCTURING	A 1997 law allows mutual insurers to convert to stock insurers and transfer the ownership interests of the mutual insurer's policyholders to an ownership interest in a mutual holding company. The mutual holding company would hold the stock of the converted insurer. The new law prohibits Blue Cross and Blue Shield of Louisiana from demutualizing in this manner.
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MAINE: 1997 LEGISLATIVE ACTIVITY

The legislature approved a measure to provide greater procedural protections to health care providers. It requires health plans to furnish a detailed explanation of their reasons for seeking to terminate a participating provider and to give the provider an opportunity for a hearing. The requirement does not apply in cases involving imminent harm to a patient.

Several new mandated benefit bills were enacted. Health plans must ensure that inpatient coverage for patients following a mastectomy, lumpectomy or a lymph node dissection is determined by the attending physician, in consultation with the patient. It allows for a shorter length of stay if recommended by the physician. Health plans must also provide coverage for reconstructive breast surgery.

Lawmakers chose to satisfy HIPAA requirements for small groups and individuals by modifying the existing market reform statutes. Most notably, the definition of small employer was revised from 1 - 24 employees to 1 - 50 employees.

A 1997 law repeals the 1994 mutualization statute for not-for-profit health service corporations and puts in its place a stock for-profit conversion statute that provides for virtually all of the value of the company to be dedicated to charitable purposes at the time of such a for-profit conversion. In addition, it more specifically defines Blue Cross and Blue Shield of Maine's continuing charitable obligations while in its current form and permits "for-profit" joint ventures if they have a suitable charitable orientation.

MAINE: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	The legislature created the Maine Health Care Reform Commission in 1994 to develop alternative proposals to guarantee universal access to all residents by 1997. The Commission was charged with developing and submitting at least three models for health care reform: single payer, multi-payer, and one based on managed competition. However, due to the potentially high price tag of these options, in 1995 the Commission instead recommended only the creation of a voluntary purchasing alliance for businesses and individuals.
BROAD INSURANCE MARKET REFORM	A 1996 law allowed the establishment of private, voluntary health purchasing alliances to provide coverage through multiple participating health plans. An alliance is required to offer one health plan providing catastrophic coverage for inpatient hospital benefits only and one health plan providing catastrophic coverage for outpatient benefits only. A 1997 law satisfied HIPAA requirements for small groups and individuals by modifying the state's existing market reform statutes.
REGULATION OF SMALL GROUP MARKET	Reforms enacted over the past few years include: guaranteed issue to small employers (1-24 employees); voluntary reinsurance; community rating by July 1997 with adjustments only for family composition, smoking status and wellness programs; guaranteed renewal; and limits on preexisting condition waiting periods. A 1995 amendment removes the requirement to move to pure community rating. Instead, existing restrictions will continue, which limit rate variations to a total range of 1.5:1 with adjustments for family composition, age, smoking status, occupation or industry, and geographic area. In 1997, the definition of small employer was revised from 1-24 employees to 1-50 employees.

REGULATION OF INDIVIDUAL MARKET	Reforms enacted in 1993 include: guaranteed issue; community rating by July 1997 with adjustment only for family composition; guaranteed renewal; limits on preexisting condition waiting periods; and a minimum loss ratio of 65%. A 1995 amendment removes the requirement to move to pure community rating. Instead, existing restrictions will continue, which limit rate variations to a total range of 1.5:1 with adjustments for family composition, age, smoking status, occupation or industry, and geographic area.
MANAGED CARE	State law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements, minimum operational standards; disclosure of medical UR criteria; appeals procedures; confidentiality requirements, and penalties for non-compliance. A 1991 law limits PPOs to a 50% payment differential between in-network and out-of-network providers. In 1994, the legislature adopted a requirement that drug manufacturers offer their "best price" to all wholesalers or purchasers of health care services. A 1995 law requires HMOs to allow subscribers to have direct access to chiropractors under certain conditions. A 1996 law requires health plans to allow subscribers direct access to a participating physician, nurse practitioner or nurse midwife without prior approval from a plan gatekeeper for an annual gynecological exam. In addition, health plans are required to permit OB-GYNs to serve as PCPs if they meet credentialing criteria. A 1996 act requires health plans to: (1) use objective standards for credentialing providers; (2) provide written statements of all decisions regarding credentialing; (3) maintain an appeal process for providers; and (4) refrain from terminating or disciplining a provider who advocates for medically appropriate health care for plan enrollees ("gag clause"). A 1997 measure gave greater due process protections to health care providers. It requires health plans to furnish a detailed explanation of their reasons for seeking to terminate a participating provider and to give the provider an opportunity for a hearing.

CORPORATE RESTRUCTURING	A 1997 law repeals the 1994 mutualization statute for not-for-profit health services corporations and puts in its place a stock for-profit conversion statute which provides for virtually all of the value of the company to be dedicated to charitable purposes at the time of such a for-profit conversion. In addition, it more specifically defines Blue Cross and Blue Shield of Maine's continuing charitable obligations while in its current form and permits "for-profit" joint ventures if they have a suitable charitable orientation.
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MARYLAND: 1997 LEGISLATIVE ACTIVITY

The legislature enacted two oversight bills relating to the health care industry. One law required health plans to establish or contract to provide a systematic and scientific process for evaluating emerging medical and surgical treatments. The evaluation process must include a comprehensive review of the medical literature and input from clinical experts in the field. The other law required health plans to disclose to the public their methodology for reimbursing physicians.

Maryland continued its tradition of mandating benefits by adopting requirements to cover the following health care services: (1) prostate cancer screening; (2) diabetic equipment, supplies and self-management training; and (3) bone mass measurement to screen for osteoporosis.

Lawmakers modified the existing small group reform law to comply with HIPAA requirements. The state also adopted the federal fall-back provisions to provide group-to-individual portability for HIPAA-eligibles.

A 1997 law alters the manner in which mutual insurers may convert to stock insurers. It repeals the mandatory hearing requirement before the Insurance Commissioner may approve a conversion plan under specified circumstances. It also requires a conversion plan to include specified provisions concerning a holder of a surplus note participating in the conversion under specified circumstances.

MARYLAND: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	In 1996, the state received federal approval for a Medicaid managed care demonstration under Section 1115 waiver authority. Under the project, all non-institutional Medicaid recipients will be required to enroll in managed care plans.
BROAD INSURANCE MARKET REFORM	The state Health Services Cost Review Commission has operated an all-payer hospital rate-setting system since 1977. The 1993 reform act created a Health Care Access and Cost Commission to, among other duties, create a payment system for physicians and other health care practitioners. The payment system does not set mandatory rates for health services, but serves as a guideline for proper payment levels among specialties. In 1997, lawmakers modified the existing small group reform law to comply with HIPAA requirements. The state also adopted the federal fall-back provisions to provide group-to-individual portability for HIPAA-eligibles.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1993 include: guaranteed issue to small employers (2-50 employees); voluntary reinsurance; modified community rating with adjustments only for age, geography and family composition with total variations of 1.38:1; guaranteed renewal; and limits on preexisting condition waiting periods. A 1995 amendment expanded the definition of eligible employee to include part-time employees, sole employees of a non-profit organization and the self-employed. A 1996 amendment set a minimum loss ratio requirement of 75 percent.

REGULATION OF INDIVIDUAL MARKET	The 1993 reform act would expand the small group market reforms to the entire insured market (individual and group) if one of the following conditions were met: at least 60% of the population under 65 years of age were receiving coverage through an insurer or HMO; or ERISA is amended to allow states to control employee health benefit plans. A 1996 amendment set a minimum loss ratio requirement of 60 percent. A 1997 law required health plans to guarantee renewal of individual coverage.
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MANAGED CARE	The state established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements, minimum operational standards, appeals procedure, confidentiality requirements, and penalties for non-compliance. A 1977 law prohibits insurers from requiring subscribers to use specifically designated pharmacies. In 1995, a point-of-service (POS) law was enacted that requires HMOs to offer a POS option as an additional benefit to a closed-panel HMO at the employer's option. The measure also requires health plans to implement the following procedural protections for providers: (1) give written notice of affiliation/disaffiliation decisions within specified time frames; (2) allow an enrollee to receive services from a terminated primary care provider for up to 90 days following the termination notification; and (3) end the use of withholds, but allow the use of bonuses as a positive incentive. A 1996 law requires health plans to provide coverage for an initial screening exam based on a "prudent layperson" definition of emergency care. A 1996 measure bars health plans from adopting contract provisions that prohibit providers from communicating to patients about treatment alternatives (so-called "gag clause"). In 1996, the legislature required health plans to allow their subscribers direct access to participating OB-GYNs, and to designate an OB-GYN as a primary care physician. In 1997, the Association of HMOs and the Medical and Chirurgical Faculty of Maryland reached a voluntary agreement that includes the following points: (1) to oppose any willing provider and direct access proposals; (2) to cover medically necessary emergency services, even when not authorized, if the enrollee's presentation to the emergency room meets a "prudent layperson" standard as defined in existing law; (3) to oppose increased reporting and disclosure requirements of HMO financial relationships and profits; and (4) to disclose economic profiling criteria used in the renewal process to participating physicians. A 1997 law requires health plans to establish a systematic and scientific process for evaluating emerging medical and surgical treatments. Also, health plans are required to disclose their methodology for reimbursing physicians.
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CORPORATE RESTRUCTURING	A 1997 law alters the manner in which mutual insurers may convert to stock insurers. It repeals the mandatory hearing requirement before the Insurance Commissioner may approve a conversion plan under specified circumstances. It requires a conversion plan to include certain provisions concerning a holder of a surplus note participating in the conversion under specified circumstances.
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MASSACHUSETTS: 1997 LEGISLATIVE ACTIVITY

Faced with a budgetary crisis in funding the state's uncompensated care pool, the legislature approved a new surcharge on health plans and other third-party payers. Beginning in January 1998, all third-party payers will be required to pay a surcharge on hospital and ambulatory surgicenter payments sufficient to generate \$100 million. Hospitals and the state are also responsible for contributing to the pool. Because the law requires surcharges to be paid to the state's Division of Health Care Finance and Policy instead of to the hospitals, and is not being imposed on self-funded plans, it faces potential ERISA challenges.

Massachusetts did not enact HIPAA conforming legislation during the 1997 legislative session. Such legislation will be introduced in 1998. The Department of Insurance notified the U.S. Health Care Financing Administration that it would use existing individual market reform laws to satisfy HIPAA's group-to-individual portability requirements. Since HIPAA conforming changes have yet to be made, Massachusetts may end up using the federal fall-back with HCFA enforcement.

Lawmakers expanded the Medicaid program to provide coverage to children through age 18 in families with incomes up to 200 percent of the federal poverty level. Previously, eligibility was cut off at the 133 percent level.

MASSACHUSETTS: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES

The Massachusetts Universal Health Care Act of 1988 was repealed in 1996 before it was ever implemented due to changes in the economic and political climate. The first "play or pay" employer mandate in the country, it would have required employers to either provide coverage directly to their employees or make payments to a public fund that would finance coverage for employees.

In 1995, the state received federal approval of a statewide Medicaid managed care demonstration under Section 1115 waiver authority. The waiver enables the state to require Medicaid recipients to enroll in managed care plans, and to expand coverage to about 170,000 low-income individuals. Under the terms of the Section 1115 waiver: (1) low-income residents will be served in managed care networks; (2) Medicaid eligibility will be expanded from 100 to 200 percent of the poverty level; (3) tax credits will be extended to employers who pay at least 50 percent of premium costs for low-income employees; and (4) direct subsidies will be offered to low-income employees to purchase coverage.

A 1997 law expanded the Medicaid program to provide coverage to children through age 18 in families with incomes up to 200 percent of the federal poverty level. Previously, eligibility was cut off at the 133 percent level.

Faced with a budgetary crisis in funding the state's uncompensated care pool, the legislature approved a new surcharge on health insurers and other third-party payers. Beginning in January 1998, all third-party payers will be required to pay a surcharge on hospital and ambulatory surgicenter payments sufficient to generate \$100 million. Hospitals and the state are also responsible for contributing to the pool. Because the law requires surcharges to be paid to the state's Division of Health Care Finance and Policy instead of to the hospitals, and is not being imposed on self-funded plans, it faces potential ERISA challenges.

BROAD INSURANCE MARKET REFORM	A 1991 law modified the hospital rate setting system that had been in place since 1975. Under the new law, the state Rate Setting Commission continues to regulate the new payment system. However, the Blue Cross and Blue Shield Plan became empowered to negotiate its own discounts with individual hospitals on a selective contracting basis, similar to what other health plans have been doing. Individual hospitals are subject to an annual revenue cap for two years calculated by the Commission. Massachusetts did not enact HIPAA conforming legislation during the 1997 legislative session. Such legislation will be introduced in 1998. The Department of Insurance notified HCFA that it would use existing individual market reform laws to satisfy HIPAA's group-to-individual portability requirements. Since HIPAA conforming changes have yet to be made, Massachusetts may end up using the federal fall-back with HCFA enforcement.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1991 include: guaranteed issue to small employers (1-25 employees); mandatory reinsurance (from which the Blue Cross and Blue Shield Plan is exempt); community rating with demographic adjustments that limit rate variations to a total range of 2:1; guaranteed renewal; and limits on preexisting condition waiting periods. 1996 amendments raised the definition of group size from 1 to 25 employees to 1 to 50 employees; and revised the community rating system to remove adjustments for gender and to phase-in rate bands of 1.5:1. Since the state did not enact HIPAA conforming legislation, HIPAA's guaranteed renewal provision is in force.

REGULATION OF INDIVIDUAL MARKET	A 1996 individual market reform law required health plans to: (1) guarantee issue three health plans (HMO, PPO, indemnity) during a 30-day open-enrollment period; (2) guarantee renewal; (3) implement modified community rating that allows adjustments for age of 2:1 and geographic region of 1.5:1; and (4) eliminate use of preexisting condition waiting periods. Furthermore, it contains a unique requirement that all health plans participating in the small group market with 5,000 or more members must participate in the individual market. Since the state did not enact HIPAA conforming legislation, HIPAA's guaranteed renewal provision is in force.
MANAGED CARE	A 1988 law limits PPOs to a 20% payment differential between in-network and out-of-network providers. A 1994 law allows any pharmacist willing to accept the terms of participation set forth by an insurer or HMO to be a participating provider. The nation's first so-called "gag clause" was enacted in 1996 that prohibits health plan contracts from containing clauses that restrict communications by physicians to patients. Under the law, health plans cannot refuse to contract with or compensate providers who communicate with their patients regarding the provisions, terms or requirements of a health policy or plan as it relates to patient needs.
CORPORATE RESTRUCTURING	_____

MICHIGAN: 1997 LEGISLATIVE ACTIVITY

The legislature adjourned without adopting a law to implement HIPAA. It falls to the U.S. Health Care Financing Administration to enforce the small group and individual market requirements contained in HIPAA.

A new law bans health plans from imposing so-called "gag clauses" by prohibiting or discouraging providers from discussing treatment options or financial arrangements with their patients. Lawmakers acted in spite of a Senate report which concluded that "gag clauses" do not seem to be a current problem in Michigan.

The Governor signed legislation that mandates HMOs to pay for emergency health services up to the point of stabilization based on the final diagnosis, or in the event that prior authorization was not given.

MICHIGAN: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	---
BROAD INSURANCE MARKET REFORM	A 1994 law permits employers to establish medical savings accounts and exempts employer contributions from taxation. A companion measure allows a state income tax deduction and exclusion for individual medical savings account deposits. The legislature adjourned in 1997 without adopting a law to implement HIPAA. It falls to the U.S. Health Care Financing Administration to enforce the small group and individual market requirements contained in HIPAA.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1996 prohibit the Blue Cross and Blue Shield Plan and HMOs from setting preexisting condition waiting periods for groups of any size. Commercial insurers can only impose a 6-month waiting period with a 12-month look back on small groups (2-50 employees), and a 6-month waiting period with a 6-month look back for groups over 50. A 1996 law required health plans to guarantee renew coverage.
REGULATION OF INDIVIDUAL MARKET	A 1996 law limits the Blue Cross and Blue Shield Plans and HMOs to a 6-month preexisting condition waiting period with a 6-month look back; while commercial insurers must comply with a 6-month waiting period and a 12-month look back. A 1996 required health plans to guarantee renew coverage.

MANAGED CARE	A 1988 law required health plans that offer PPO coverage to a group to offer a traditional coverage option also. A 1996 law requires health plans to comply with state-defined grievance procedures and appeals processes (i.e., disputes over claims or coverage must be resolved within 90 days; disputes over emergencies with 72 hours). Health plans must also give notification to providers of the opening of networks, and a written explanation of the reasons for deselection, upon request. A 1997 law bans health plans from imposing so-called "gag clauses" that prohibit or discourage providers from discussing treatment options or financial arrangements with their patients. 1997 legislation mandated HMOs to pay for emergency health services up to the point of stabilization based on the final diagnosis, or in the event that prior authorization was not given.
CORPORATE RESTRUCTURING	A 1995 law allows mutual insurance companies to demutualize and form stock insurance companies upon approval from the Insurance Commissioner.

MINNESOTA: 1997 LEGISLATIVE ACTIVITY

The Governor signed a modest Patient Protection Act that includes the following requirements: (1) a ban on "gag clauses" that prohibit providers from discussing treatment options with their patients; (2) disclosure of health plan reimbursement methodologies, upon request; and (3) creation of a process by which enrollees could have standing referrals to specialists, if such referral is required for coverage.

The legislature approved a bill to require health plans to offer enrollees direct access to OB-GYNS for limited health care services (i.e., annual exam, maternity care, and treatment for acute gynecological conditions).

Efforts to comply with HIPAA included changing the definition of group size from 2 - 49 to 2 - 50 employees. Minnesota will rely on its medical high-risk pool to fulfill the federal group-to-individual portability requirements.

A new mandated benefit requires coverage for diabetic equipment, supplies and self-management training.

The state Medicaid program (MinnesotaCare) was amended to expand eligibility for individuals and families without children to up to 175 percent of the federal poverty level. Also, the current 1 percent premium tax on Blue Cross and Blue Shield of Minnesota and HMOs was eliminated. The program will continue to be funded, in part, through a provider tax (which was reduced from 2 to 1.75 percent).

MINNESOTA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	During 1995, the legislature scaled back earlier commitments to comprehensive health care reform. In repealing significant portions of the MinnesotaCare Act, originally passed in 1992, a majority of lawmakers opted for a pragmatic, incremental approach to reform that places more emphasis on the marketplace and less on government regulations. The 1995 law removes the July 1997 deadline for achieving universal coverage, but reaffirms the legislature's commitment to achieve it. Those supporting a delay in universal coverage said the market was effectively managing costs and meeting consumer demands. Fiscal conservatives also argued that the state should not be expanding programs at a time when reductions in federal spending may shift more costs to Minnesota taxpayers. Other key 1995 amendments included: (1) repealing the individual mandate to obtain health insurance; (2) eliminating the requirement to adopt guaranteed issue and community rating in the individual market by 1997; and (3) deleting the standard benefit set language for health plan coverage. In 1995, the state received federal approval for a Medicaid managed care demonstration under Section 1115 waiver authority. The waiver enables Minnesota to integrate three public programs for low-income children and families: MinnesotaCare, Medicaid and the medical component of General Assistance. Under the terms of the waiver, Medicaid eligibility is being expanded and recipients are being enrolled in managed care networks. A medical high-risk pool for individuals who are otherwise uninsurable was established in 1976.
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**BROAD
INSURANCE
MARKET
REFORM**

Originally, the state's prime strategy for reducing costs was to use integrated service networks or ISNs (networks of providers responsible for managing their total costs within the growth limits set by law), combined with a requirement that services not covered by ISNs be subject to price controls set by an all-payer system. However, in 1995 the state indicated that it no longer wants ISNs to be the only health plan option available to purchasers, and it also deleted authority for a residual all-payer regulatory program.

A 1994 law allows employers, groups and individuals to form voluntary purchasing pools for the purpose of negotiating and purchasing health care coverage. The experience of pool members must be pooled and the rates blended across all groups within the pool. Purchasing pools must comply with all small group reform laws. The law also established health care provider cooperatives.

Legislation enacted in 1995 builds on the 1994 law by authorizing a demonstration project that permits one health care provider cooperative, under specified circumstances, to contract directly with self-insured employers and to bear a limited amount of risk. A 1996 amendment expanded the scope of the demonstration to include two additional provider cooperatives.

1997 efforts to comply with HIPAA included amendments to the existing small group market reform statute and modifications to the existing medical high-risk pool to fulfill the federal group-to-individual portability requirements.

REGULATION OF SMALL GROUP MARKET	Reforms enacted in the early 1990s include: guaranteed issue to small employers (2-29 employees); voluntary reinsurance; limits on rate variations for experience, health status, duration and industry to a range of 1.67:1 (outside of this band, carriers can make limited adjustments for age (3:1) and geography (1.2:1); guaranteed renewal; limits on preexisting condition waiting periods; and a minimum loss ratio of 82% to be phased-in. 1994 amendments extended requirements by: expanding the definition of small employers to 2-49 employees; requiring health plans to guarantee issue approved products to large employer groups, effective July 1997; and phasing-in a modified community rating system by 1997, subject to approval of the legislature. However, 1995 actions eliminated all of these requirements except the redefinition of small group size. A 1997 amendment changed the definition of group size from 2 to 49 to from 2 to 50 employees.
REGULATION OF INDIVIDUAL MARKET	Earlier reforms enacted include: limits on rate variations for experience, health status, duration and industry to a range of 1.67:1 (outside of this band, carriers can make limited adjustments for age (3:1) and geography (1.2:1); guaranteed renewal; limits on preexisting condition waiting periods; and a minimum loss ratio of 72% to be phased-in. 1994 amendments to the market reform law called for guaranteed issue and phasing-in modified community rating by July 1997. However, 1995 action by the legislature eliminated these requirements.

MANAGED CARE	A 1992 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements, minimum operational standards, appeals procedures, confidentiality requirements, and penalties for non-compliance. A 1994 law requires health plans to establish an expanded network of allied independent health providers (e.g., chiropractors, pharmacists, nurse practitioners, podiatrists, psychologists, therapists, social workers, optometrists) and to accept any such provider willing to meet the terms of participation. Insurers and HMOs must pay each allied provider in the expanded network the same rate as paid to allied providers in their preferred network. The 1994 law also requires health plans to offer a contract for a five-year period to any designated essential community provider located within their service area. A 1996 law requires each health plan operating in the small group or large group market to offer at least one point-of-service (POS) option in each market in which it operates. The provision exempts health plans with fewer than 50,000 enrollees. In 1997, the Governor signed a modest Patient Protection Act that includes the following requirements: (1) a ban on "gag clauses" that prohibit providers from discussing treatment options with their patients; (2) disclosure of health plan reimbursement methodologies, upon request; and (3) creation of a process by which enrollees could have standing referrals to specialists, if such referral is required for coverage. A 1997 law required health plans to offer their enrollees direct access to OB-GYNS for limited health care services (i.e., annual exam, maternity care, and treatment for acute gynecological conditions).
CORPORATE RESTRUCTURING	A 1996 law allows mutual insurance companies to reorganize as mutual insurance holding companies or merge with an existing mutual insurance holding company upon approval from the Insurance Commissioner.

MISSISSIPPI: 1997 LEGISLATIVE ACTIVITY

Lawmakers adopted guaranteed issue in the small group market and expanded the existing definition of employer from 2 - 35 employees to 1 - 50 employees to conform with HIPAA. In addition, the state will use its existing medical high-risk pool to comply with HIPAA's group-to-individual portability requirements.

A new law prohibits discriminatory pricing of pharmaceuticals. Specifically, health plans may not impose upon a beneficiary any copayment or other condition relating to purchasing pharmacy services from any pharmacy that is more costly or restrictive than would be imposed if such services were purchased from a mail-order pharmacy or a pharmacy that is willing to provide the same services for the same cost.

MISSISSIPPI: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1992.
BROAD INSURANCE MARKET REFORM	A 1994 law authorizes employers and resident individuals to establish a medical savings account to supplement a high deductible health plan. A 1997 law adopted guaranteed issue in the small group market and expanded the existing definition of employer from 2 to 35 employees to 1 to 50 employees to conform with HIPAA. In addition, the state will use its existing medical high-risk pool to comply with HIPAA's individual portability requirements.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1993 imposed limits on preexisting condition waiting periods. Reforms were expanded in 1994 to require health plans in the small group market (2-35 employees) to restrict premium rates for experience, health status and duration to a range of 2:1, and to renew coverage. A 1997 law adopted guaranteed issue in the small group market and expanded the existing definition of employer from 2 to 35 employees to 1 to 50 employees.
REGULATION OF INDIVIDUAL MARKET	A 1997 law adopted guaranteed renewal in the individual market and imposed limits on preexisting condition exclusion periods.

MANAGED CARE	A 1990 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements, minimum operational standards, appeals procedures, confidentiality requirements, and penalties for non-compliance. (The law was amended in 1994 to repeal the prohibition on public disclosure of medical review criteria.) A 1994 law allows any pharmacy willing to accept the terms of participation set forth by a health plan to be a participating provider; allows subscribers to select any pharmacy that agrees to accept the terms of participation; and prohibits health plans from granting financial incentives to subscribers to encourage them to use participating pharmacies. A 1995 law requires HMOs, PPOs and other prepaid health benefit plans to obtain state certification. It also includes several provider contracting provisions, including requirements that health plans establish an appeals process to review decisions on provider denials and terminations. A 1995 law requires health plans to recognize OB-GYNs as primary care providers, and allows subscribers direct access to OB-GYNs who otherwise meet contract requirements.
CORPORATE RESTRUCTURING	_____

MISSOURI: 1997 LEGISLATIVE ACTIVITY

The Governor signed a comprehensive measure that imposes tough new restrictions on managed care plans. In an unprecedented step, it removed HMOs' exemption from liability for poor medical outcomes by repealing the existing provision that deems them not to be practicing medicine. This action leaves the door open to future legislation to create new causes of action against health plans. Moreover, the law established an external grievance process for patients to bring complaints against health plans for any coverage or claims denial. It calls for an independent review panel to be set up by the Department of Insurance with the authority to issue binding decisions.

This significant legislation imposes several added requirements which will raise health costs further: (1) an HMO must also offer a POS option to employers whenever it markets a gatekeeper group plan; (2) health plans must provide coverage for emergency medical conditions defined by a "prudent layperson" standard; and (3) health plans may not impose a "gag clause" on physicians restricting the discussion of medical treatment options with their patients.

The legislature considered several HIPAA implementation bills, none of which could command a legislative majority. The insurance industry supported achieving compliance with HIPAA's group-to-individual portability requirements by modifying the state high-risk pool to make it qualify as an alternative mechanism. Neither the Governor nor the Director of Insurance supported this approach, preferring more far-reaching provisions such as community rating instead. Consequently, the U.S. Health Care Financing Administration will enforce HIPAA requirements in Missouri for both the small group and individual markets.

Finally, two new mandated health benefits were enacted which require health plans to cover reconstructive breast surgery for mastectomy patients, as well as formula for the treatment of a patient with phenylketonuria (PKU).

MISSOURI: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A 1993 law established a school-based primary health care initiative. A medical high-risk pool for individuals who are otherwise uninsurable was established in 1992.
BROAD INSURANCE MARKET REFORM	A 1994 law authorized the creation of medical savings accounts that are tax exempt for employers and tax free for individuals. During 1997, the legislature considered several HIPAA implementation bills, none of which could command a legislative majority. Consequently, the U.S. Health Care Financing Administration will enforcing HIPAA requirements in Missouri for both the small group and individual markets.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1992 include: guaranteed issue to small employers (3-25 employees); mandatory reinsurance; limits on rate variations for experience, health status and duration to a range of 2:1; guaranteed renewal; and limits on preexisting condition waiting periods. Since the legislature failed to act on HIPAA implementation legislation in 1997, HIPAA's guaranteed issue, guaranteed renewal and preexisting condition exclusion provisions are in force.
REGULATION OF INDIVIDUAL MARKET	Since the legislature failed to act on HIPAA implementation legislation in 1997, HIPAA's guaranteed renewal provision is in force.

MANAGED CARE	Since 1990, the Blue Cross and Blue Shield Plan has been required to honor assignment of benefits by a subscriber to nonparticipating providers. The law applies to pharmacists only. A 1991 law established a system of comprehensive regulation of the utilization review (UR) industry, including minimum operational standards, appeals procedures and confidentiality requirements. A 1997 law removed HMOs' exemption from liability for poor medical outcomes by repealing the existing provision that deems them not to be practicing medicine. This action leaves the door open to future legislation to create new causes of action against health plans. Moreover, the law established an external grievance process for patients to bring complaints against health plans for any coverage or claims denial. It calls for an independent review panel to be set up by the Department of Insurance with the authority to issue binding decisions. A 1997 law imposed the following requirements: (1) an HMO must also offer a POS option to employers whenever it markets a gatekeeper group plan; (2) health plans must provide coverage for emergency medical conditions defined by a "prudent layperson" standard; and (3) health plans may not impose a "gag clause" on physicians restricting the discussion of medical treatment options with their patients.
CORPORATE RESTRUCTURING	A 1996 law allows domestic mutual companies to reorganize as a mutual insurance holding company or merge with an existing mutual insurance holding company upon approval of the Director of Insurance.

MONTANA: 1997 LEGISLATIVE ACTIVITY

A measure to establish financial and quality assurance standards for managed care plans was enacted. The Managed Care Oversight Act requires HMOs to: (1) file an audited financial statement each year; (2) pay a first-year financial deposit of \$200,000 in order to begin operations in Montana; and (3) meet detailed network adequacy standards encompassing such matters as the ratio of specialty and primary care providers to covered persons.

The legislature approved a bill that requires all health plans with 10,000 or more members to offer employer groups a point-of-service option. This mandatory POS law could eliminate the ability of employees to choose closed-panel HMO network coverage. Also approved was a "gag clause" bill that bars health plans from limiting communications between physicians and their patients, including discussions of medical treatment options and financial arrangements.

The Governor signed two women's health care bills. Female enrollees now have direct access to participating network OB-GYNs for health care services and health plans must accept OB-GYNs as primary care physicians if they meet all of the credentialing standards. New mandates provide coverage for inpatient care following a mastectomy, lumpectomy or lymph node dissection for a period of time as determined by the attending physician, in consultation with the patient. Coverage for reconstructive surgery following a mastectomy is also required.

Compliance with HIPAA's small group requirements was achieved by amendments to existing statutes (e.g., expanding the definition of group size from 3 to 25 to 2 to 50 employees). The state's medical high-risk pool was designated as the alternative mechanism to comply with the federal group-to-individual portability requirements.

Finally, a new law bans discriminatory practices against victims of domestic or child abuse. Prohibited practices include denying, refusing to issue or renew, canceling a contract, or adding a premium differential based on the applicant's status as a victim of abuse.

MONTANA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1987. In 1993, Montana enacted a comprehensive health care reform law that created the state Health Care Authority to study and make recommendations concerning two universal access proposals (a multi-payer and a single-payer option) for consideration by the legislature in 1995. However, because of the high price tags on both proposals, in 1995 state lawmakers opted for an incremental reform approach that would not require major new state spending. The powerful Health Care Authority was repealed and replaced with a Health Care Advisory Committee charged with developing less sweeping reform initiatives.
BROAD INSURANCE MARKET REFORM	A 1995 law allows small employers (3 or more employees) to form a state purchasing pool. A 1995 law established medical savings accounts and provided for a state tax exemption of up to \$3,000 deposited into an MSA. Compliance with HIPAA's small group requirements was achieved in 1997 by amendments to existing statutes. The state's medical high-risk pool was designated as the alternative mechanism to comply with the federal group-to-individual portability requirements.

REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1993 include: guaranteed issue to small employers (3-25 employees); mandatory reinsurance; limits on rate variations for experience, health status and duration to a range of 2:1; guaranteed renewal; and limits on preexisting condition waiting periods. 1995 amendments define a minimum level of benefits (called the "uniform" plan) that is not required to be offered on a guaranteed issue basis. Products that offer additional benefits up to a defined standard established by each carrier are considered "basic" and must be offered on a guaranteed issue basis. A 1997 amendment expanded the definition of group size from 3 to 25 to 2 to 50 employees.
REGULATION OF INDIVIDUAL MARKET	A 1997 law required health plans to guarantee renewal of individual coverage.

MANAGED CARE	Since 1987, state law has limited PPOs to a 25% payment differential between in-network and out-of-network providers. A 1991 any willing provider provision was allowed to sunset by the legislature in 1993. Subsequently, a revised law requires health plans to open up for bid any new preferred provider network. A 1992 law established a system of comprehensive regulation of the utilization review (UR) industry, including minimum operational standards, periodic filings of descriptions of review criteria, appeals procedures and confidentiality requirements. This statute has been interpreted by the Insurance Department as requiring full disclosure of review criteria, which could then be made public under state law. A measure to establish financial and quality assurance standards for managed care plans was enacted. The Managed Care Oversight Act of 1997 requires HMOs to: (1) file an audited financial statement each year; (2) pay a first year financial deposit of \$200,000 in order to begin operations in Montana; and (3) meet detailed network adequacy standards encompassing such matters as the ratio of specialty and primary care providers to covered persons. A 1997 law requires all health plans with 10,000 or more members to offer employer groups a point-of-service option. This mandatory POS law could eliminate the ability of employees to choose closed-panel HMO network coverage. Also approved was a "gag clause" bill that bars health plans from limiting communications between physicians and their patients, including discussions of medical treatment options and financial arrangements. Under a 1997 law, female enrollees have direct access to participating network OB-GYNs for health care services. It also requires health plans to accept OB-GYNs as primary care physicians if they meet all of the credentialing standards.
CORPORATE RESTRUCTURING	— — —

NEBRASKA: 1997 LEGISLATIVE ACTIVITY

Lawmakers decided to comply with HIPAA requirements by modifying the existing small group reform statute and designating the medical high-risk pool as the state alternative mechanism for HIPAA's group-to-individual portability requirement.

A new law bans health plan contracts from including "gag clauses" that would prevent a physician from discussing medical treatment options with patients.

A 1997 law amends the Insurers Demutualization Act by clarifying procedures; providing more specific requirements and safeguards in the case of a hostile takeover of a new stock insurer; and by providing for more specific enforcement remedies by the Director of Insurance. Another law allows mutual insurance companies to reorganize as mutual insurance holding companies or to merge into existing mutual insurance holding companies upon approval from the Director.

NEBRASKA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1986.
BROAD INSURANCE MARKET REFORM	The Health Care Purchasing Pool Act of 1995 directs the legislature to determine whether there should be a coordinated purchasing process for public health insurance programs, and whether such a pool should be made available to private employers and individuals. In 1997, lawmakers complied with HIPAA requirements by modifying the existing small group reform statute and designating the medical high-risk pool as the state alternative mechanism for HIPAA's group-to-individual portability requirement.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1991 include: limits on rate variations for experience, health status and duration to a range of 2:1; and guaranteed renewal. Reforms enacted in 1994 include: guaranteed issue to small employers (3-25 employees); mandatory reinsurance; and limits on preexisting condition waiting periods. A 1995 amendment raises the size of small employer groups to 3-50 employees. This was subsequently changed in 1997 to be from 2-50 employees.
REGULATION OF INDIVIDUAL MARKET	A 1997 law established a guaranteed renewal provision in the individual market.

MANAGED CARE	A 1992 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements. It also requires that a UR firm receive approval by a recognized private accreditation organization. A 1995 law on provider contracting requires PPOs to: (1) allow providers to apply for credentials at any time; (2) make credentialing standards available to providers and subscribers upon request; (3) allow providers to appeal denials or terminations to a committee that is chosen by both sides; and (4) give providers the chance to enter into and complete a corrective action plan. This proposal was drawn up at the initiative of Blue Cross and Blue Shield of Nebraska and the state medical association. A 1996 law allows OB-GYNs to act as primary care gatekeepers if they are credentialed and agree to treat the whole-body system. A 1997 law bans health plan contracts from including "gag clauses" that would prevent a physician from discussing medical treatment options with patients.
CORPORATE RESTRUCTURING	A 1997 law amends the Insurers Demutualization Act by clarifying procedures; providing more specific requirements and safeguards in the case of a hostile takeover of a new stock insurer; and by providing for more specific enforcement remedies by the Director of Insurance. Another law allows mutual insurance companies to reorganize as mutual insurance holding companies or to merge into existing mutual insurance holding companies upon approval from the Director.

NEVADA: 1997 LEGISLATIVE ACTIVITY

The Governor signed a health care reform bill that sets broad requirements for managed care plans. Among its major provisions are requirements that plans: (1) establish written policies for denial of care and utilization review; (2) set up quality assurance programs and an internal system for resolving subscriber complaints; (3) remove "gag clauses" that restrict communications between providers and patients regarding medical treatment options; and (4) require prior authorization for medically necessary emergency services defined according to a "prudent layperson" standard.

Lawmakers conformed with HIPAA requirements in the small group market by amending the existing statute to expand group size from 2 - 25 to 2 - 50 employees and requiring health plans to guarantee issue coverage. Nevada chose to adopt federal fall-back provisions to implement the HIPAA group-to-individual portability requirements.

A limited direct access measure was passed that prohibits a health plan from requiring an enrollee to obtain prior authorization for cervical cancer screening tests and mammograms.

Two new mandates were enacted that call for coverage of diabetic equipment, supplies and self-management training; and formula used in the treatment of phenylketonuria (PKU).

NEVADA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	— — —
BROAD INSURANCE MARKET REFORM	A 1995 law authorized the formation of voluntary purchasing alliances by small employer groups (2-25 employees). A 1995 law provided for the regulation of medical savings accounts. The law does not offer exemption from state taxes. In 1997, the state conformed with HIPAA requirements in the small group market by amending the existing statute to expand group size from 2 - 25 to 2 - 50 employees and requiring health plans to guarantee issue coverage. Nevada chose to adopt federal fall-back provisions to implement the HIPAA group-to-individual portability requirements.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1995 include: limits on rate variations for experience, health status and duration to a range of 2:1; guaranteed renewal for small employers (2-25 employees); and limits on preexisting condition waiting periods. A 1997 amendment expands the definition of group size from 2-25 to 2-50 employees and required health plans to guarantee issue coverage.
REGULATION OF INDIVIDUAL MARKET	A 1997 law created a guaranteed renewal requirement in the individual market.

MANAGED CARE	Since 1983, the Blue Cross and Blue Shield Plan must honor assignment of benefits by a subscriber to nonparticipating providers. The law applies to all types of licensed health care providers. State law limits PPOs to a 30% payment differential between in-network and out-of-network providers. A 1991 law requires utilization review (UR) firms to register with the Department of Insurance, and to provide a summary of their UR plan and appeals procedures. A 1997 law requires health plans to: (1) establish written policies for denial of care and utilization review; (2) set up quality assurance programs and an internal system for resolving subscriber complaints; (3) remove "gag clauses" that restrict communications between providers and patients regarding medical treatment options; and (4) require prior authorization for medically necessary emergency services defined according to a "prudent layperson" standard. A limited direct access measure was passed in 1997 that prohibits a health plan from requiring an enrollee to obtain prior authorization for cervical cancer screening tests and mammograms.
CORPORATE RESTRUCTURING	— — —

NEW HAMPSHIRE: 1997 LEGISLATIVE ACTIVITY

The Governor signed an oversight bill that requires health plans to:
(1) establish written procedures for resolving subscriber grievances consistent with NCQA standards; (2) set up a written quality assessment and improvement program; and (3) provide an adequate network of health care providers.

Also signed was a measure putting the state in compliance with HIPAA requirements by modifying existing statutes governing the small group and individual markets, which already require guaranteed issue.

Blue Cross and Blue Shield of New Hampshire announced in July that it will withdraw from the under-65 individual market, effective January 1998. The move will affect less than one percent of the Plan's total enrollment. Prior to the individual market reforms enacted in 1995, the Plan had guaranteed issue coverage to all individuals, while its competitors did not. This resulted in the Plan enrolling a disproportionate share of high-risks, and adverse selection has continued to be a problem. To help the five health plans remaining in the individual market charge affordable rates, the Insurance Commissioner issued an order creating a mandatory risk-sharing plan effective January 1, 1998. Health plans participating in the group market will be assessed \$2.16 per enrollee per year to subsidize the individual market.

A new mandated benefit law requires coverage for emergency medical services if they are preauthorized by a health plan and take into account the patient's presenting symptoms. Also mandated are coverage for breast reconstructive surgery following a mastectomy; and diabetic equipment, supplies and self-management training.

A 1997 law clarifies the procedure for acquisition transactions involving health care charitable trusts. It sets forth standards that trustees must follow during the transaction with oversight by the Director of Charitable Trusts in the Attorney General's office and specifies standards for the transfer of health care charitable assets.

NEW HAMPSHIRE: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	The Healthy Kids Program contracts with private insurers to provide children with health care benefits at selected school sites.
BROAD INSURANCE MARKET REFORM	A 1997 measure brought the state into compliance with HIPAA requirements by modifying existing statutes governing the small group and individual markets, which already require guaranteed issue. Blue Cross and Blue Shield of New Hampshire announced in July that it will withdraw from the under-65 individual market, effective January 1, 1998. The move will affect less than one percent of the Plan's total enrollment. Prior to the individual market reforms enacted in 1995, the Plan had guaranteed issue coverage to all individuals, while its competitors did not. This resulted in the Plan enrolling a disproportionate share of high-risks, and adverse selection has continued to be a problem. To help the five health plans remaining in the individual market charge affordable rates, the Insurance Commissioner issued an order creating a mandatory risk-sharing plan effective January 1, 1998. Health plans participating in the group market will be assessed \$2.16 per enrollee per year to subsidize the individual market.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1992 include: limits on rate variations for experience, health status and duration to a range of 2:1; guaranteed renewal; and limits on preexisting condition waiting periods. Reforms enacted in 1994 include: guaranteed issue to small employers (from 1 to 100 employees); and community rating with adjustments permitted only for age within a 3:1 range, and for family size.
REGULATION OF INDIVIDUAL MARKET	Reforms enacted in 1994 include: an annual 60-day open enrollment period; community rating with adjustments as permitted in the small group market; and limits on preexisting condition waiting periods.

MANAGED CARE	State law allows any pharmacy willing to accept the terms of participation set forth by an insurer or HMO to participate. A 1991 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements. It also stipulates that the standards may be considered met if the UR firm receives approval by a recognized private UR accreditation body. A 1996 law prevents HMOs from entering into exclusive contracts with physicians. HMOs are required to pay non-participating physicians the same fee as participating providers for a five-year period for enrollees who switch plans. The New Hampshire Supreme Court ruled in 1996 that health plans cannot terminate physicians from managed care contracts without cause. A 1996 law prohibits health plans from including "gag clauses" in agreements with providers. Contract language cannot limit what information (except for trade secrets) a provider may disclose to current or prospective patients regarding the provisions, terms or requirements of the health plan. A 1997 law required health plans to: (1) establish written procedures for resolving subscriber grievances consistent with NCQA standards; (2) set up a written quality assessment and improvement program; and (3) provide an adequate network of health care providers. A 1997 mandated benefit law requires coverage for emergency medical services if they are preauthorized by a health plan and take into account the patient's presenting symptoms.
CORPORATE RESTRUCTURING	A 1997 law clarifies the procedure for acquisition transactions involving health care charitable trusts. It sets forth standards that trustees must follow during the transaction with oversight by the Director of Charitable Trusts in the Attorney General's office and specifies standards for the transfer of health care charitable assets.

NEW JERSEY: 1997 LEGISLATIVE ACTIVITY

Lawmakers imposed stringent new requirements on managed care plans through a combination of legislative and regulatory initiatives. In March, a major overhaul of the state's rules governing HMOs took effect. Key provisions require HMOs to: (1) allow physicians to discuss all treatment options with patients; (2) disclose physician payment arrangements; (3) pay for emergency room screenings; and (4) allow patients to appeal to an external review organization, certified by the state, which can make non-binding recommendations.

In June, the legislature approved a comprehensive bill that codified the 1997 regulations and extended them to PPOs and POS products. The legislation added new requirements that: (1) health plans offer a POS product to small employers and individuals; and (2) health plans give providers the reasons for and the right to a hearing before termination.

Two mandates for women's health care services were imposed. Health plans must pay for at least 72 hours of inpatient care following a modified radical mastectomy and 48 hours following a simple mastectomy. A shorter stay is allowable if the patient and physician determine it is medically appropriate. Following a mastectomy, reconstructive breast surgery to restore symmetry must be covered.

Minor amendments to existing laws governing the small group and individual markets were made to comply with HIPAA. Lawmakers also eliminated the requirement to move to pure community rating in the small group market in 1998, in favor of keeping the current modified community rating system.

The Governor won approval for a public-private initiative that will use new federal funds to expand access to health care. Medicaid eligibility will be expanded to cover about 34,000 children in families with incomes below 133 percent of the federal poverty level. In addition, a new program known as "KidCare" will provide coverage in a managed care setting for about 68,000 children with family income between 133 and 200 percent of the poverty level. Families with incomes above 150 percent will be required to contribute to insurance premiums based on a sliding income scale.

Finally, lawmakers saved the state's system of financing hospital care for the poor by doubling the cigarette tax from 40 to 80 cents per pack. The tobacco revenues will gradually replace an unemployment trust fund which has been a temporary vehicle for funding the charity care pool.

NEW JERSEY: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES

In 1992, after a federal judge outlawed New Jersey's system of financing hospital care for the poor with a 19% surcharge on all inpatient bills because it was preempted by ERISA, the legislature enacted the Health Care Reform Act to pay for this care. The law created a new health care payroll tax designated for the state's unemployment trust fund, and temporarily lowered unemployment taxes by the same amount.

A state-subsidized health insurance program for low-income workers and temporarily unemployed persons was also created in 1992. Known as Health Access New Jersey, it became operational in 1995. All participants pay a monthly fee, based on a sliding income scale; the income cutoff for benefits is 250% of the federal poverty level.

A 1997 law saved the state's system of financing hospital care for the poor by doubling the cigarette tax from 40 to 80 cents per pack. The tobacco revenues will gradually replace the unemployment trust fund.

The Governor won approval in 1997 for a public-private initiative that will use new federal funds to expand access to health care. Medicaid eligibility will be expanded to cover about 34,000 children in families with incomes below 133 percent of the poverty level. In addition, a new program known as "KidCare" will provide coverage in a managed care setting for about 68,000 children with family income between 133 and 200 percent of the federal poverty level. Families with incomes above 150 percent will be required to contribute to the cost of private insurance premiums for children based on a sliding income scale.

BROAD INSURANCE MARKET REFORM	The Health Care Reform Act of 1992 dismantled the state's long-standing multi-payer hospital rate-setting system. Health plans are free to negotiate rates and conditions of participation with hospital providers. In 1997, the state boards that administer the individual and small group health insurance programs reported that more than 100,000 people who had been previously uninsured have received coverage through New Jersey's individual health coverage program. In addition, under the auspices of the Small Employer Health Benefit Plan, 3,000 small businesses now offer health insurance to their employees that did not previously do so. In 1997, amendments to existing laws governing the small group and individual markets were made to comply with HIPAA.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1992 include: guaranteed issue to small employers (2-49 employees); voluntary reinsurance; a pure community rating system to be phased-in by January 1997; guaranteed renewal; limits on preexisting condition waiting periods; and a minimum loss ratio of 75%. Amendments enacted in 1994 clarify that association groups, MEWAs and out-of-state trusts are not required to guarantee issue coverage to small employers that are not members of their organization. Also, during the three-year phase-in of community rating, the only allowable rating adjustments are for age, gender and geography. A 1996 law eliminated the requirement that health plans convert all business into five standardized benefit products, and allowed health plans to keep their current health insurance products for small employers. In addition, the law postpone the move to pure community rating by one year. In 1997, lawmakers eliminated the requirement to move to pure community rating in the small group market, in favor of keeping the current modified community rating system which limits variations for age, gender and geography to a range of 2:1.

REGULATION OF INDIVIDUAL MARKET	Reforms enacted in 1992 include: guaranteed issue; assessments on carriers that do not choose to offer coverage; a pure community rating system; guaranteed renewal; limits on preexisting condition waiting periods; and a minimum loss ratio of 75%.
MANAGED CARE	A 1994 law requires insurers and HMOs to accept as contracting providers any pharmacy willing to accept the terms of participation. It also prohibits insurers and HMOs from requiring subscribers to use mail-order pharmacies. In March 1997, a major overhaul of the state's rules governing HMOs took effect. Key provisions require HMOs to: (1) allow physicians to discuss all treatment options with patients; (2) disclose physician payment arrangements; (3) pay for emergency room screenings to determine if a patient has an emergency condition; and (4) allow patients to appeal to an external review organization, certified by the state, which will make non-binding recommendations. In 1997, the legislature approved a comprehensive bill that codified the March regulations and extended them to PPOs and POS products. In addition, the legislation added new requirements that: (1) health plans offer a POS product to small employer and individual contract holders; (2) health plans give providers the reasons for and the right to a hearing before termination; and (3) self-funded employers notify employees that they are covered by a self-insured health plan that is not subject to state regulation.
CORPORATE RESTRUCTURING	A 1995 law allows health service corporations to convert to mutual insurers. A health service corporation must file a proposal with the Department of Insurance.

NEW MEXICO: 1997 LEGISLATIVE ACTIVITY

Regulations for health plans operating within the state established new standards, including a ban on the use of "gag clauses" in provider contracts that prohibit discussions of treatment options with patients. Health plans must implement a continuous quality improvement program and a utilization management program. Also, an access plan must be submitted to the Superintendent of Insurance demonstrating that each health plan maintains an adequate network of primary care physicians and that services are geographically accessible to enrollees.

The Governor signed a bill that exempts provider sponsored networks (PSNs) from obtaining a state license in order to contract with government agencies and provide services to Medicaid and Medicare eligibles. Under this law, PSNs must meet the same requirements as HMOs, except for financial standards. However, in a bow to concerns about inadequate consumer protections, a requirement was added to establish a PSN reinsurance pool to be funded through assessments on PSNs.

Lawmakers amended the existing small group reform statute to require guaranteed issue, among other changes, to bring the state into compliance with HIPAA. The medical high-risk pool was amended to qualify as an alternative state mechanism for the HIPAA group-to-individual portability requirement.

Several new mandated benefits were enacted. Health plans must cover minimum hospital stays of not less than 48 hours following a mastectomy and 24 hours after a lymph node dissection. Shorter stays are allowed if determined to be appropriate by the physician in consultation with the patient. Coverage for diabetic equipment, supplies and self-management training is required, along with childhood immunizations.

A unique law provides health plan enrollees with direct access to a licensed doctor of oriental medicine for treatment within his scope of practice. "Doctor of Oriental Medicine" includes acupuncturists and homeopaths.

A new law prohibited health plans from denying, refusing to issue, canceling or charging a higher premium for a policy on the basis of domestic abuse.

The Governor vetoed the "Patient Protection Act" that would have imposed a mandatory POS provision and banned prior authorization requirements for emergency services. His veto message stated: "The Act provides overly severe penalties against insurers which violate its provisions. Issues between insurance plans and their customers should be resolved through negotiations, rather than strict regulation by the state."

NEW MEXICO: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1988. State officials developed plans to convert the financially-strapped Medicaid program to a managed care system in 1997. The state intends to employ a competitive bidding process to select participating health plans. Implementation depends upon receiving approval of a federal Medicaid Section 1115 demonstration waiver.
BROAD INSURANCE MARKET REFORM	The New Mexico Health Insurance Alliance, a nonprofit independent public corporation, was established in 1994. Participation by small employers (2-50 employees) is voluntary. Health plan participation is required for those plans who insure government entities. A 1995 law authorized the creation of medical savings accounts that are tax exempt for employers and tax deductible for individuals who deposit up to \$3,000 annually. A 1997 law exempts provider sponsored networks (PSNs) from obtaining a state license in order to contract with government agencies and provide services to Medicaid and Medicare eligibles. Under this law, PSNs must meet the same requirements as HMOs, except for financial standards. However, in a bow to concerns about inadequate consumer protections, a requirement was added to establish a PSN reinsurance pool to be funded through assessments on PSNs. 1997 amendments to the existing small group reform statute required guaranteed issue, among other changes, to bring the state into compliance with HIPAA. The medical high-risk pool was amended to qualify as an alternative state mechanism for the HIPAA group-to-individual portability requirement.

REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1991 include: limits on rate variations for experience, health status and duration to a range of 2:1; and guaranteed renewal. Reforms enacted in 1994 include: defining small groups to include 2-50 employees; use of community rating with limited adjustments for age, gender, geographic area and smoking practices until 1998 (thereafter, variations limited to under or over 19 years of age); and limits on preexisting condition waiting periods. A 1997 amendment required guaranteed issue in the small group market.
REGULATION OF INDIVIDUAL MARKET	A 1994 law placed limits on preexisting condition waiting periods. Since the state did not enact a guaranteed renewal provision as required under HIPAA, the HIPAA provision is in force.
MANAGED CARE	Regulations promulgated in 1997 established new standards on health plans, including a ban on the use of "gag clauses" in provider contracts that prohibit discussions of treatment options with patients. Health plans must implement a continuous quality improvement program and a utilization management program. Also, an access plan must be submitted to the Superintendent of Insurance demonstrating that each health plan maintains an adequate network of primary care physicians and that services are geographically accessible to enrollees. A unique 1997 law provides health plan enrollees with direct access to a licensed doctor of oriental medicine for treatment within his scope of practice. "Doctor of Oriental Medicine" includes acupuncturists and homeopaths.
CORPORATE RESTRUCTURING	— — —

NEW YORK: 1997 LEGISLATIVE ACTIVITY

The legislature continued efforts begun last year to comprehensively regulate managed care plans. However, the session ended before agreement could be reached on two controversial health reform bills that were strongly opposed by the managed care industry and business groups. A bill that sought to hold health plans liable for injury caused by a delay or failure to approve claims passed the Assembly, but died on the Senate floor due to concerns about its cost impact. Also, lawmakers could not agree on legislation that would have established a binding external grievance process to review health plans' decisions to deny coverage of experimental treatments.

One controversial bill that did pass requires health plans to pay claims within 45 days of receiving all necessary information. It subjects late payment to interest at the rate of one percent per month. Violations are also subject to an added penalty of \$500 per day for each day in excess of the permitted time period up to a total penalty of \$5,000 per violation. Additional provisions added at the request of the Insurance Department impose even more severe penalties on health plans that fail to respond to any DOI inquiry in a timely manner: \$500 per day up to \$10,000 for each late response.

The Governor signed several mandated benefits bills. One requires health plans to cover inpatient care following a mastectomy, lumpectomy and lymph node dissection for a period of time determined by the attending physician in consultation with the patient. Other measures require coverage for reconstructive breast surgery, and chiropractic care.

New York complied with HIPAA requirements in both the small group and individual markets by amending its existing market reform statutes.

The state finally received approval from HCFA for its ambitious Medicaid managed care waiver program. The demonstration project is the largest of the Section 1115 waivers ever approved, and will allow New York to enroll some 2.4 million Medicaid recipients in capitated managed care plans over the next three years.

NEW YORK: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES

There is a state-subsidized private insurance program known as Child Health Plus for low-income children up to the age of 18 who do not qualify for other insurance coverage.

The state finally received approval in 1997 from HCFA for its ambitious Medicaid managed care waiver program. The demonstration project is the largest of the Section 1115 waivers ever approved, and will allow New York to enroll some 2.4 million Medicaid recipients in capitated managed care plans over the next three years.

BROAD INSURANCE MARKET REFORM	The U.S. Supreme Court ruled in May 1995 that ERISA does not preempt New York's law requiring hospitals to add surcharges to the bills of patients who are insured by commercial carriers and HMOs. The ruling opens the door for states to tax employer-sponsored health plans as a way of funding state health reforms. The Court's unanimous opinion in <i>New York State Conference of Blue Cross and Blue Shield Plans, et al., v. Travelers Insurance Company</i> held that the New York surcharge law does not "relate to" employee benefit plans within the meaning of ERISA. (A federal appeals court subsequently found no statutory basis to treat self-insured plans differently from other plans in deciding whether ERISA preempts state law.) In 1996, lawmakers gave final approval to a bill supported by the managed care industry that scraps New York's long-standing hospital rate-setting system in favor of allowing insurers and HMOs to negotiate inpatient rates directly with hospitals. Under the bill, \$1.3 billion will be raised for uncompensated care by imposing a new 8.18 percent surcharge on all hospital bills. Health care payers could either make the surcharge payments directly to the state pool administrator or pay the hospital. A 1997 law created a new licensure category for provider sponsored networks (PSNs) and subjects them to all requirements that HMOs are subject to under existing insurance and public health laws. The one exception is that the Superintendent of Insurance is given flexibility to set different solvency requirements for a PSN based on the size and structure of the network. The proposal also requires a PSN to use community rating for all its business and to cover at least 75% of its services using its member providers. A 1997 law complied with HIPAA requirements in both the small group and individual markets by amending its existing market reform statutes.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1992 include: guaranteed issue to small employers (3-50 employees); mandatory reinsurance or other risk-sharing mechanism; a pure community rating system with adjustments only for family composition and geography; guaranteed renewal; and limits on preexisting condition waiting periods.

REGULATION OF INDIVIDUAL MARKET	Reforms enacted in 1992 include: guaranteed issue; mandatory reinsurance; a pure community rating system with adjustments only for family composition and geography; guaranteed renewal; and limits on preexisting condition waiting periods.
MANAGED CARE	A 1994 law gave HMO enrollees direct access to care by : (1) permitting female enrollees to choose an OB-GYN as their primary care gatekeeper; or (2) allowing female enrollees direct access to an OB-GYN for at least two visits annually for routine services and pregnancy-related care. A 1995 measure requires all HMOs to offer both a standardized, comprehensive closed panel product and a mandatory POS plan in the individual market. The benefit package in the POS option would be the same as the HMO product, but with the addition of an out-of-network benefit, which would be subject to higher copayments and deductibles. Under the provisions of a 1996 law, providers are entitled to notice and a review before being terminated from a network plan. However, the termination does not have to be "for cause." (This only applies to a provider's participation in the "in-network" provider panel under a POS product.) In addition, health plans are prohibited from including "gag clauses" in provider contracts that restrict communication on treatment options. Also, health plan contracts were amended to include a "prudent layperson" standard in determining whether a medical condition constitutes an emergency. Finally, health plans have to meet utilization review (UR) certification standards similar to URAC regarding time frames, reviewer qualifications and appeal rights.
CORPORATE RESTRUCTURING	— — —

NORTH CAROLINA: 1997 LEGISLATIVE ACTIVITY

Lawmakers enacted several managed care oversight bills. One key measure established a uniform system for health plans to consider subscriber grievances. It set standards for both an internal and an external review process to consider any coverage or claims denial. Decisions reached by the external review panel are advisory to the health plan. This law further requires health plans to report annually to the Department of Insurance on network adequacy, methods of provider compensation, and outcomes data.

The Governor also signed a regulatory bill that: (1) prohibits health plans from limiting physicians' discussions of treatment options with patients; (2) mandates coverage of emergency room screening and stabilization services without prior authorization; and (3) establishes a "prudent layperson" standard to define an emergency medical condition.

Several new mandated benefits bills were enacted. The length of stay following a mastectomy must be determined by the attending physician in consultation with the patient. Health plans are also required to cover reconstructive breast surgery, and diabetic equipment, supplies and self-management training. Finally, a new law pertaining only to the state employees' medical plan adds parity for chemical dependency services to the existing mandate for mental health parity.

Lawmakers chose to comply with HIPAA by amending the small group market statute and adopting federal fall-back provisions for group-to-individual portability.

NORTH CAROLINA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	During 1995, the legislature disbanded the state Health Planning Commission, which had been created in 1993 to design and implement a universal coverage system based on a managed competition reform model. It was replaced by the Health Reform Commission, which was charged with assessing the impact of ongoing health market reform initiatives.
BROAD INSURANCE MARKET REFORM	A 1993 law allows small groups of 2-49 employees to form purchasing alliances. The Attorney General issued an opinion in 1997 that a provider sponsored organization (PSO) that contracts directly with an employer under a self-insured employee benefit plan is not subject to state regulation as an HMO. However, the Department of Insurance subsequently issued a contrary ruling. The situation is not likely to be clarified until the matter is reviewed by the courts. In 1997, lawmakers chose to comply with HIPAA by amending the small group market statute and adopting federal fall-back provisions for group-to-individual portability.
REGULATION OF SMALL GROUP MARKET	Reforms enacted over the past few years include: guaranteed issue to small employers (2-49 employees); voluntary reinsurance; community rating with demographic adjustments; guaranteed renewal; and limits on preexisting condition waiting periods. An amendment adopted in 1995 allows an additional rate adjustment factor of plus/minus 20 percent for any reason, including experience. A 1997 amendment expands group size from 2-49 to 2-50 employees.

REGULATION OF INDIVIDUAL MARKET	A 1997 law required health plans to guarantee renewal of individual products.
MANAGED CARE	A 1987 law limits PPOs to a 20% payment differential between in-network and out-of-network providers. A 1991 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements, minimum operational standards, appeals procedures, confidentiality requirements, and penalties for non-compliance. A 1993 law allows any pharmacist willing to accept the terms of participation the right to participate as a contracting provider in a health plan. A 1995 law allows subscribers to have direct access to any participating OB-GYN without a referral. There is no limit on the number of visits that a subscriber can make. A 1997 law set standards for both an internal and an external review process to consider any coverage or claims denial. Decisions reached by the external review panel are advisory to the health plan. This law further requires health plans to report annually to the Department of Insurance on network adequacy, methods of provider compensation, and outcomes data. A 1997 regulatory bill: (1) prohibits health plans from limiting physicians' discussions of treatment options with patients; (2) mandates coverage of emergency room screening and stabilization services without prior authorization; and 3) establishes a "prudent layperson" standard to define an emergency medical condition. A 1997 law pertaining only to the state employees' medical plan adds parity for chemical dependency services to the existing mandate for mental health parity.
CORPORATE RESTRUCTURING	— — —

NORTH DAKOTA: 1997 LEGISLATIVE ACTIVITY

Lawmakers chose to comply with HIPAA's group-to-individual portability requirements by modifying the existing medical high-risk pool. The small group market statute was also amended to conform by expanding the definition of employer from 3 - 25 to 2 - 50 employees. In addition, the law limits existing state rating reforms to the 3 - 25 market.

A new law prohibits health plans from restricting medical communications between health care providers and their patients.

New mandated benefits laws were enacted for prostate cancer screening and formula for the treatment of phenylketonuria (PKU).

A 1997 law allows a not-for-profit health services corporation to form a not-for-profit mutual insurance company that may not subsequently demutualize or form a mutual holding company. Another law allows domestic mutual insurers to form mutual insurance holding companies or merge with existing mutual insurance holding companies upon approval of the Commissioner of Insurance.

NORTH DAKOTA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1982. After studying comprehensive reform options (single-payer and an employer mandate), the North Dakota Health Care Task Force concluded in 1994 that there was insufficient support for either.
BROAD INSURANCE MARKET REFORM	In 1997, lawmakers complied with HIPAA's group-to-individual portability requirements by modifying the existing medical high-risk pool. The small group market statute was also amended to conform to HIPAA.
REGULATION OF SMALL GROUP MARKET	Reforms enacted over the past few years include: guaranteed issue to small employers (3-25 employees); mandatory reinsurance; limits on rate variations for experience, health status and duration to a range of 1.7:1; guaranteed renewal; limits on pre-existing condition waiting periods; and minimum loss ratio standards of 75%. 1995 amendments limited allowable rate variations to a total range of 4:1, with adjustments for experience, health status, age, geography, family composition and duration. The law also imposed limits on preexisting condition waiting periods for carriers in the large group market. A 1997 amendment expanded the definition of employer group from 3 - 25 to 2 - 50 employees. At the same time, state rating reforms were limited to the 3 - 25 market.

REGULATION OF INDIVIDUAL MARKET	A 1993 law required health plans to meet a minimum loss ratio standard of 65%. Reforms enacted in 1995 include: modified community rating with adjustments for age and industry within a range of 5:1 plus adjustments for geography, family composition, healthy lifestyles and benefit design (use of gender and duration are prohibited after January 1997); guaranteed renewal; and limits on preexisting condition waiting periods.
MANAGED CARE	A 1989 law allows any pharmacist willing to accept the terms of participation set forth by a PPO network to participate. It also prohibits insurers from requiring subscribers to use designated pharmacies. A 1991 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements. It stipulates that the standards may be considered met if the UR agent receives approval from a recognized private UR accreditation organization. It also requires UR agents to furnish to providers, upon request, the general medical criteria used in evaluation. A 1991 law, applying to indemnity products only, states that physicians and other non-institutional providers have any willing provider rights. A 1997 law prohibits health plans from restricting medical communications between health care providers and their patients.
CORPORATE RESTRUCTURING	A 1997 law allows a not-for-profit health services corporation to form a not-for-profit mutual insurance company that may not subsequently demutualize or form a mutual holding company. Another law allows domestic mutual insurers to form mutual insurance holding companies or merge with existing mutual insurance holding companies upon approval of the Commissioner of Insurance.

OHIO: 1997 LEGISLATIVE ACTIVITY

All managed care entities in Ohio were brought under one statutory umbrella when the Governor signed the Managed Care Uniform Licensure Act. The new law protects consumers by assuring the financial soundness of health plans, including those that are engaged in the business of insurance and are currently unregulated (e.g., provider sponsored organizations). The statute accommodates the changing nature of health care delivery by allowing freedom for innovation in the marketplace.

The Act defines a "Health Insuring Corporation" (HIC) to include HMOs, health care corporations, PPOs and any PSO that is directly contracting on a risk basis. A PSO is defined as a corporation that is at least 80 percent owned by hospitals and physicians. It allows PSOs to have slightly lower solvency standards than other HICs.

Also enacted was a broad regulatory bill known as the Physician-Health Plan Partnership Act that: (1) establishes a binding external review process for grievances dealing with experimental treatments; (2) mandates coverage for emergency services based on a "prudent layperson" standard; (3) prohibits "gag clauses" that would restrict physician communications with patients about treatment options; (4) requires that physicians be given a chance to take corrective actions prior to termination from a health plan; and (5) mandates standing referrals to specialists for enrollees with chronic conditions.

A 1997 law revised existing small group market statutes to comply with HIPAA. The state chose to implement HIPAA's group-to-individual portability requirement by amending the current individual market guaranteed issue requirement to require a separate open-enrollment period for HIPAA-eligible individuals. However, a health plan will not be required to accept HIPAA-eligibles beyond 0.5 percent of its total number of covered individuals in the state per year.

A new law adds discrimination based on domestic violence to the list of unfair trade practices. Health plans are prohibited from denying, refusing to renew, canceling or charging higher premiums for these individuals.

A 1997 law gives the Attorney General authority to review transfers of ownership or control of assets of a nonprofit health care entity if: (1) 20 percent or more of the assets are involved; or (2) any of the assets are involved if the entity is unable to fulfill its stated or actual purpose without the assets. Another law provides that a mutual insurance company shall not proceed with a reorganization plan approved by its policyholders until it has been reviewed and approved by the Superintendent of Insurance.

OHIO: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	In 1995, Ohio received federal approval of a statewide Medicaid managed care demonstration under Section 1115 waiver authority. The project will enable the state to place all of its Medicaid recipients into managed care plans and, potentially, to extend Medicaid eligibility to additional low-income, uninsured individuals.
BROAD INSURANCE MARKET REFORM	A 1993 law allows small groups of 2-150 employees to form purchasing alliances. A 1996 law authorized the creation of tax-free MSAs by employers or individuals. Ohio residents may put up to \$3,000 a year in a tax-free account to cover major medical expenses. All managed care entities in Ohio were brought under one statutory umbrella when the Governor signed the Managed Care Uniform Licensure Act in 1997. The new law protects consumers by assuring the financial soundness of health plans, including those that are engaged in the business of insurance and are currently unregulated (e.g., PSOs). The Act defines a "Health Insuring Corporation" (HIC) to include HMOs, health care corporations, PPOs and any PSO that is directly contracting on a risk basis. A PSO is defined as a corporation that is at least 80 percent owned by hospitals and physicians. It allows PSOs to have slightly lower solvency standards than other HICs. A 1997 law revised existing small group market statutes to comply with HIPAA. The state chose to implement HIPAA's group-to-individual portability requirement by amending the current individual market guaranteed issue requirement to require a separate open-enrollment period for HIPAA-eligible individuals. However, a health plan will not be required to accept HIPAA-eligibles beyond 0.5 percent of its total number of covered individuals in the state per year.

REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1993 include: guaranteed issue up to an enrollment cap; limits on rate variations for experience, health status and duration to a range of 2:1; guaranteed renewal to small employers (2-50 employees); and limits on preexisting condition waiting periods. A 1995 amendment directed only at HMOs expanded the definition of small group size from 2-25 to 2-50 employees.
REGULATION OF INDIVIDUAL MARKET	Reforms enacted in 1993 include: guaranteed issue up to an enrollment cap; guaranteed renewal; a voluntary reinsurance program; and limits on preexisting condition waiting periods.
MANAGED CARE	The Physician-Health Plan Partnership Act of 1997 does the following: (1) establishes a binding external review process for grievances dealing with experimental treatments; (2) mandates coverage for emergency services based on a "prudent layperson" standard; (3) prohibits "gag clauses" that would restrict physician communications with patients about treatment options; (4) requires that physicians be given a chance to take corrective actions prior to termination from a health plan; and (5) mandates standing referrals to specialists for enrollees with chronic conditions.
CORPORATE RESTRUCTURING	A 1997 law gives the Attorney General authority to review transfers of ownership or control of assets of a nonprofit health care entity if: (1) 20 percent or more of the assets are involved; or (2) any of the assets are involved if the entity is unable to fulfill its stated or actual purpose without the assets. Another law provides that a mutual insurance company shall not proceed with a reorganization plan approved by its policyholders until it has been reviewed and approved by the Superintendent of Insurance.

OKLAHOMA: 1997 LEGISLATIVE ACTIVITY

The Oklahoma Managed Care Act imposed the following new requirements: (1) employers with 50 or more employees that only offer an HMO product must also offer a POS option at the employee's expense; (2) a mandate for emergency screening and stabilization services for conditions that reasonably appear to constitute a life or limb-threatening emergency based on the presenting symptoms of the patient; and (3) health plans may not preclude or discourage providers from informing patients about medical treatment options.

Lawmakers complied with HIPAA small group requirements by modifying the existing small group market statute. The state's medical high-risk pool will be used to satisfy the group-to-individual portability requirements.

New mandates for breast cancer patients require a minimum inpatient stay of 48 hours following a mastectomy and 24 hours for a lymph node dissection. A shorter stay is allowed at the discretion of the attending physician in consultation with the patient. Coverage for reconstructive breast surgery to restore symmetry was also mandated.

The legislature approved a Medicaid expansion for families with children under six and who earn up to 185 percent of the federal poverty level. It also provided a cost-sharing option for coverage with premiums based on a sliding income scale for families who do not receive cash assistance but have incomes below 250 percent of the poverty level.

OKLAHOMA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1996. In 1995, the state received federal approval for a statewide Medicaid managed care demonstration under Section 1115 waiver authority. The goal of the project is to place all Medicaid eligibles in managed care plans and test different types of delivery systems in rural areas. The Blue Cross and Blue Shield Plan is a participating managed care organization. In 1997, the legislature approved a Medicaid expansion for families with children under six and who earn up to 185 percent of the federal poverty level. It also provided a cost-sharing option for coverage with premiums based on a sliding income scale for families who do not receive cash assistance but have incomes below 250 percent of the poverty level.
BROAD INSURANCE MARKET REFORM	A 1995 law provided for the establishment of medical savings accounts for employees, allowing tax-free contributions of up to \$2,000 per year. A 1997 law directed the state Board of Health to promulgate rules regarding the establishment and operation of provider sponsored networks (PSNs) that address: (1) procedures to allow providers within a service area to enter into voluntary agreements to improve access to care; (2) procedures for reviewing a PSN's plan of operation; and (3) financial solvency and network capacity standards. The law also stipulated that PSNs should be subject to the same quality assurance standards established by the Board for HMOs. In 1997, lawmakers complied with HIPAA small group requirements by modifying the existing small group market statute. The state's medical high-risk pool will be used to satisfy the group-to-individual portability requirements.

REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1992 include: limits on rate variations for experience, health status and duration to a range of 2:1; guaranteed renewal to small employers (2-25 employees); a requirement that health plans insure employees who change employers, without regard to health status, if they had coverage with their former employer; and limits on preexisting condition waiting periods. Reforms enacted in 1994 include: guaranteed issue to small employers (increased to 2-50 employees); a voluntary reinsurance program; and tighter limits on preexisting condition waiting periods. Since the state did not bring the existing guaranteed renewal provision into compliance with HIPAA, the HIPAA guaranteed renewal provision is in force.
REGULATION OF INDIVIDUAL MARKET	Since the state did not enact a guaranteed renewal provision in the individual market, the HIPAA guaranteed renewal provision is in force.
MANAGED CARE	A 1991 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements, minimum operational standards, appeals procedures, confidentiality requirements, and penalties for non-compliance. In 1994, the legislature approved a measure that requires health plans to provide a pharmacy with the right to bid on a periodic basis on any contract to provide pharmacy services. The Oklahoma Managed Care Act of 1997 imposed the following new requirements: (1) employers with 50 or more employees that only offer an HMO product must also offer a POS option at the employee's expense; (2) a mandate for emergency screening and stabilization services for conditions that reasonably appear to constitute a life or limb-threatening emergency based on the presenting symptoms of the patient; and (3) health plans may not preclude or discourage providers from informing patients about medical treatment options.
CORPORATE RESTRUCTURING	— — —

OREGON: 1997 LEGISLATIVE ACTIVITY

The Governor signed the Patient Protection Act of 1997 which requires health plans to file annual summaries of their utilization review (UR) policies, quality assurance activities, network adequacy and grievance and appeals data. The appeals process for grievances must include two levels of internal review.

Health plans were required to provide coverage without prior authorization for emergency screening and stabilization services, as defined by a "prudent layperson" standard. The Act also stipulates that health plans may not terminate or penalize providers for communicating with patients about treatment alternatives or financial arrangements.

The legislature complied with HIPAA's small group requirements by amending the small group market statute to expand group size from 2 - 25 to 2 - 50 employees. The state's medical high-risk pool was selected as the alternative mechanism to extend group-to-individual portability to HIPAA-eligibles.

Two laws were enacted that expand access to coverage for the low-income population. A subsidy program for low-income workers and their dependents was established, whereby the state will provide subsidies for the purchase of private health coverage at the workplace. The subsidy program will cover those earning up to 150 percent of the federal poverty level and premium contributions will be based on a sliding income scale. The other expansion was accomplished by raising the Medicaid eligibility threshold for pregnant women and children under 12 years of age from 133 percent to 170 percent of the poverty level.

A 1997 law requires the Department of Consumer and Business Services to approve a plan of conversion or reorganization from a mutual insurer to a stock company. It also allows mutual insurance companies to reorganize as mutual insurance holding companies upon approval from the Department.

OREGON: CUMULATIVE REFORM LAWS

COMPREHENSIVE ACCESS

In 1989, Oregon enacted a universal coverage program. However, the employer "play or pay" mandate, which was supposed to go into effect by 1998, was never implemented. In 1995, the legislature voted to repeal the mandate in favor of voluntary, market-based reforms. State officials allowed the employer mandate to "sunset" on January 1, 1996.

A medical high-risk pool for individuals who are otherwise uninsurable was established in 1990.

In 1994, the state received federal approval for a statewide Medicaid managed care demonstration. The Medicaid program is being expanded under Section 1115 waiver authority to cover all of the state's indigent population based on a prioritized list of health care services. The lowest ranked services on the priority list that fall below the funding line will not be covered. Enrollment is mandatory and payment is generally on a capitated basis. Regence Blue Cross and Blue Shield of Oregon is a participating managed care organization. Although this waiver program has been controversial outside the state, there is widespread consensus in Oregon that it is a success. An independent evaluation found that emergency room visits declined, and hospital charity care and bad debt fell.

Two laws were enacted in 1997 that expand access to coverage for the low-income population. A subsidy program for low-income workers and their dependents was established, whereby the state will provide subsidies for the purchase of private health coverage at the workplace. The subsidy program will cover those earning up to 150 percent of the federal poverty level and premium contributions will be based on a sliding income scale. The other expansion was accomplished by raising the Medicaid eligibility threshold for pregnant women and children under 12 years of age from 133 percent to 170 percent of the federal poverty level.

BROAD INSURANCE MARKET REFORM	A 1997 law complied with HIPAA's small group requirements by amending the small group market statute to expand group size from 2 to 25 to 2 to 50 employees. The state's medical high-risk pool was selected as the alternative mechanism to extend group-to-individual portability to HIPAA-eligibles.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1991 include: guaranteed issue to small employers (3-25 employees); voluntary reinsurance; rate variations for demographics and experience limited to a total range of 2:1; guaranteed renewal; and limits on preexisting condition waiting periods. Reforms enacted in 1995 include: expansion of small group size to 2-25 employees; new rating bands limited to a total range of 2:1 with adjustments only for age; and a requirement to guarantee issue all products, not just a basic health care plan. A 1997 amendment raised the employer group size from 2-25 to 2-50 employees.
REGULATION OF INDIVIDUAL MARKET	Reforms enacted in 1995 include: guaranteed renewal; modified community rating with adjustments only for age; limits on pre-existing condition waiting periods; and required portability from insured group coverage to standardized individual products under certain conditions.

MANAGED CARE	A 1983 law established the utilization review (UR) criteria that must be followed by reviewers of chemical dependency and mental/nervous conditions. Health plans must make these criteria available to providers upon request. A 1995 law on provider contracting requires insurers and HMOs to: make available a POS product to groups of 25 or more employees (if they have a gatekeeper requirement); disclose general criteria for selecting/terminating providers; provide notice and a hearing prior to provider termination based on quality of care; have a two-level grievance procedure for providers; and disclose UR criteria to participating providers. A 1995 law allows subscribers direct access to participating OB-GYNs for an annual health exam and maternity care. It also permits OB-GYNs to act as primary care providers if they meet certain standards established by health plans. Two 1996 ballot initiatives were soundly defeated that would have substantially impeded managed care in Oregon. The Patient Protection Act would have effectively prohibited capitated arrangements in the state. The so-called "Health Care Freedoms" Constitutional Amendment would have required health and workers' compensation insurance policies to provide coverage for every category of alternative medical provider including acupuncturists and naturopaths. The Governor signed the Patient Protection Act of 1997 which requires health plans to file annual summaries of their UR policies, quality assurance activities, network adequacy and grievance and appeals data. (The appeals process for grievances must include two levels of internal review.) Health plans were required to provide coverage without prior authorization for emergency screening and stabilization services, as defined by a "prudent layperson" standard. The Act also stipulates that health plans may not terminate or penalize providers for communicating with patients about treatment alternatives or financial arrangements.
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CORPORATE RESTRUCTURING	A 1997 law requires the Department of Consumer and Business Services to approve a plan of conversion or reorganization from a mutual insurer to a stock company. It also allows mutual insurance companies to reorganize as mutual insurance holding companies upon approval from the Department.
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PENNSYLVANIA: 1997 LEGISLATIVE ACTIVITY

Lawmakers implemented the HIPAA small group requirements by enacting guaranteed issue and renewal requirements in the small group market (2 - 50 employees). Blue Cross and Blue Shield Plans in the state were designated as the insurers responsible for offering coverage to HIPAA-eligible individuals. The law provides for a protective mechanism trigger to avoid undue financial hardship to the Plans.

A new law prohibits health plans from requiring that mastectomy-related procedures be performed on an outpatient basis. It leaves the decision on length of inpatient stay up to the treating physician. The law permits one home health care visit if the patient is discharged within 48 hours following admission for a mastectomy. It also requires coverage for reconstructive surgery to achieve symmetry following a mastectomy.

PENNSYLVANIA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	The state-run Children's Health Insurance Program (CHIP) contracts with private organizations to provide free health insurance benefits to children through age 16 who are not eligible for Medicaid coverage and whose family income is up to 185% of the federal poverty level. Subsidized benefits are also available to children up to age 6 whose families earn between 185% and 235% of the federal poverty level. The program is funded primarily by a tobacco tax.
BROAD INSURANCE MARKET REFORM	A 1996 law provided for the establishment of medical savings accounts for employees, allowing tax-free contributions of up to \$3,000 per year. A 1997 law implemented the HIPAA small group requirements by creating guaranteed issue and renewal requirements in the small group market (2 to 50 employees) and limiting preexisting condition exclusion periods. Blue Cross and Blue Shield Plans in the state were designated as the insurers responsible for offering coverage to HIPAA-eligible individuals. The law provides for a protective mechanism trigger to avoid undue financial hardship to the Plans.
REGULATION OF SMALL GROUP MARKET	Same as above
REGULATION OF INDIVIDUAL MARKET	— — —
MANAGED CARE	A 1996 law prohibits so-called "gag clauses" in provider contracts that interfere with physician-patient communications regarding medical treatment options.

CORPORATE RESTRUCTURING	A 1995 law allows mutual insurers to demutualize and form stock insurers with the approval of the Director of Insurance.
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RHODE ISLAND: 1997 LEGISLATIVE ACTIVITY

Rhode Island is one of a handful of states that adjourned without having enacted legislation to implement the market reforms required by HIPAA. Therefore, both the required market reforms and the federal fall-back standards for group-to-individual portability will be enforced by the U.S. Health Care Financing Administration. The state already has guaranteed issue and renewal requirements in the small group market (3 to 50 employees) and prohibits health plans from applying any preexisting condition exclusion periods.

A new mandate law requires health plans to cover a minimum inpatient stay of 48 hours following a mastectomy and 24 hours following an axillary node dissection. Another women's health care bill was passed that allows direct access to an in-network OB-GYN for an annual visit.

Health plans were prohibited from discriminating against victims of domestic abuse. They may not deny, refuse to issue or renew, cancel or add a premium differential based on a person's status as a victim of domestic abuse.

RHODE ISLAND: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	In 1994, the state received federal approval of a statewide Medicaid managed care demonstration. The Rlte Care program, implemented under Section 1115 waiver authority, is expanding access to primary care and preventive services for low-income children and their families. The program provides expanded Medicaid eligibility through a fully capitated managed care system. The Blue Cross and Blue Shield Plan is a participating managed care organization. In 1996, the Department of Human Services concluded that the Rlte Care program is a success: "Everyone who should be enrolled is, and providers and the four participating health plans have been very responsive to patients' needs and concerns." The program fulfilled the following goals: (1) primary care visits have increased significantly; (2) emergency room visits have fallen off; and (3) the number of primary care physicians participating in Medicaid has jumped from 50 percent to over 90 percent.
BROAD INSURANCE MARKET REFORM	Legislators adjourned in 1997 without having enacted legislation to implement the market reforms required by HIPAA. Therefore, the required market reforms and the federal fall-back standards for group-to-individual portability will be enforced by HCFA. The state already has guaranteed issue and renewal requirements in the small group market (3 - 50 employees).

REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1992 include: guaranteed issue to small employers (3-50 employees); voluntary reinsurance; limits on rate variations for experience, health status and duration to a range of 2:1; guaranteed renewal; and limits on preexisting condition waiting periods. A 1995 law prohibits health plans in the group market from imposing any preexisting condition waiting periods or from denying coverage if enrollees can document that they have been insured for the previous 12 months. Since the legislature did not enact HIPAA-conforming legislation, HIPAA's market reforms are in force.
REGULATION OF INDIVIDUAL MARKET	A 1995 law prohibits health plans from imposing any pre-existing condition waiting periods or from denying coverage if enrollees can document that they have been insured for the previous 12 months. It also established a guaranteed renewal provision. Since the legislature did not enact HIPAA implementation legislation, HIPAA's guaranteed renewal provision is in force.
MANAGED CARE	A 1992 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements. It also stipulates that the standards may be considered met if the UR firm receives approval by a private UR accreditation organization. A 1996 law imposed: (1) a "gag clause" provision that bans health plans from prohibiting providers from discussing treatment options with their patients; (2) added reporting requirements for state certification of HMOs; and (3) new state certification standards for health plans to be set by the Department of Health. A 1997 law allows female enrollees to have direct access to an in-network OB-GYN for an annual visit.

CORPORATE RESTRUCTURING	A 1996 law allows mutual insurance companies to demutualize and form stock insurance companies with approval from the Insurance Commissioner.
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SOUTH CAROLINA: 1997 LEGISLATIVE ACTIVITY

The legislature approved a measure to bring the existing small group market statute into compliance with HIPAA. The state designated its medical high-risk pool as the alternative mechanism to comply with the federal group-to-individual portability requirements.

The Governor signed a measure that bans health plans that contract with a network of ophthalmologists or optometrists to provide eye care from prohibiting a participating optometrist from performing medical services within his scope of practice, in accordance with the terms of the benefit plan.

SOUTH CAROLINA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1990. In 1994, South Carolina received preliminary federal approval of a statewide Medicaid Section 1115 waiver which would allow it to place existing recipients in managed care plans and to expand eligibility to most of the state's low-income uninsured. However, the state decided not to proceed with development of the demonstration project.
BROAD INSURANCE MARKET REFORM	A 1994 law allows small groups of 2-50 employees to form purchasing alliances. Alliances would have to provide coverage to all eligible employers, and have at least 1,000 members. A 1997 measure brought the existing small group market statute into compliance with HIPAA. The state designated its medical high-risk pool as the alternative mechanism to comply with the federal group-to-individual portability requirements.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1991 include: limits on rate variations for experience, health status and duration to a range of 2:1; guaranteed renewal to small employers (2-25 employees); and limits on preexisting condition waiting periods. Reforms enacted in 1994 include: guaranteed issue to small employers (expanded to include 2-50 employees); and a voluntary reinsurance program.

REGULATION OF INDIVIDUAL MARKET	Reforms enacted in 1991 include: a minimum loss ratio at least equal to the most recent loss ratio recommended by the NAIC (usually 55%); and a requirement that carriers insure employees who change employers, without regard to health status. The law also permits individuals to move from one individual policy (of equal or lesser benefits) to another policy issued by the same health plan without medical underwriting. A 12-month preexisting condition waiting period is applied. A 1997 law required health plans to guarantee renewal of individual coverage.
MANAGED CARE	A 1990 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements, minimum operational standards, appeals procedures, confidentiality requirements, and penalties for non-compliance. A 1994 law allows any pharmacist willing to accept the terms and conditions of the contract to be a participating provider in a health plan. A 1997 measure prohibits health plans that contract with a network of ophthalmologists or optometrists to provide eye care from prohibiting a participating optometrist from performing medical services within his scope of practice, in accordance with the terms of the benefit plan.
CORPORATE RESTRUCTURING	_____

SOUTH DAKOTA: 1997 LEGISLATIVE ACTIVITY

Lawmakers modified the existing small group and individual market statutes to bring them into compliance with HIPAA. Under the alternative mechanism for group-to-individual portability, each health plan in the state must guarantee issue to individuals until these enrollees represent two percent of its annual earned premium.

A new law prohibits health plans from refusing to pay benefits for injuries sustained by an enrollee because the enrollee was under the influence of alcohol or drugs while operating a motor vehicle.

SOUTH DAKOTA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	---
BROAD INSURANCE MARKET REFORM	A 1994 law allows voluntary purchasing alliances to be established for individuals, employers, unions, and associations. An alliance would be subject to small group rating rules and exempt from state anti-trust law. A 1997 law modified the existing small group and individual market statutes to bring them into compliance with HIPAA. Under the alternative mechanism for group-to-individual portability, each health plan in the state must guarantee issue to individuals until these enrollees represent two percent of its annual earned premium.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1991 include: limits on rate variations for experience, health status and duration to a range of 2:1; and guaranteed renewal for small employers (1-25 employees). Reforms enacted in 1994 include: limits on preexisting condition waiting periods; and a minimum loss ratio requirement of 75%. Amendments approved in 1995 raised the size limit of small groups from 25 to 50 employees; imposed a guaranteed issue requirement; and limited the adjustment for age and gender to a 3:1 band. Experience, health status and duration cannot be used as rating factors.

REGULATION OF INDIVIDUAL MARKET	Reforms enacted in 1994 require health plans to meet a minimum loss ratio of 65%. A 1996 law furthers portability by requiring coverage to be provided without waiting periods to individuals who had coverage and lost it. Persons who are covered under a health plan that continues to offer individual health care products must continue with that plan (or fulfill eligibility and underwriting requirements with another plan). A person who is covered or eligible to be covered under a plan containing benefits equal to or greater than the basic product, must continue with a health plan that does business in the state (or fulfill eligibility and underwriting requirements with another plan). Health plans must guarantee issue coverage until these individuals represent five percent of earned premium. The law limits rating adjustments for health status and claims experience to a range of 2.2:1. A 1996 law prohibits health plans from circumventing existing small group reform statutes by selling individual policies to employers for their employees. A 1997 law amended the guaranteed issue requirement by lowering the enrollment cap to two percent.
MANAGED CARE	Since 1989, Wellmark Blue Cross and Blue Shield must honor assignment of benefits by a subscriber to non-participating hospital providers. A 1990 law allows any pharmacist willing to accept the terms of participation the right to participate as a contracting provider in a health plan. A 1996 law required all utilization review (UR) firms operating within the state to register with the state Health Department. A second law required both UR entities and managed care plans to establish grievance procedures for their members and to allow the state access to written records of filed grievances.
CORPORATE RESTRUCTURING	— — —

TENNESSEE: 1997 LEGISLATIVE ACTIVITY

Legislators approved a managed care oversight law that requires HMOs to establish a standardized process for responding to enrollee grievances. After exhausting the proscribed internal review process, an enrollee may appeal any coverage or claims denial to an external review entity approved by the Department of Insurance. Recommendations of the external reviewers are advisory in nature.

Tennessee complied with HIPAA's small group market requirements by modifying its current market reform statute. It chose to adopt the federal fall-back standards to satisfy the group-to-individual portability provision.

A new law requires health plans to cover stabilization services in the emergency room without prior authorization if an enrollee's presenting symptoms as recorded by the attending physician indicate an emergency condition could exist.

Several additional mandates were enacted: (1) reconstructive breast surgery following a mastectomy; (2) prostate cancer screening; (3) the use of off-label drugs that have been approved by the FDA; and (4) diabetic equipment, supplies and self-management training.

The Governor approved an expansion in the TennCare program that allows it to accept new non-Medicaid enrollees for the first time in two years. The program will be open to children under 18 years of age, adding an estimated 68,000 people. Coverage will be free to children with family incomes below the federal poverty level.

TENNESSEE: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	In 1994, the state received federal approval for a statewide Medicaid managed care demonstration. The TennCare waiver program was implemented under Section 1115 waiver authority and guarantees Medicaid recipients and most uninsured residents access to health care through participation in managed care networks. Enrollment is mandatory and payment is on a capitated basis. The Blue Cross and Blue Shield Plan is a participating managed care organization. Although quite controversial initially, the program covers 1.2 million people and has reduced Tennessee's uninsured rate to the lowest in the nation. A 1995 GAO study concluded that TennCare was meeting its objectives to extend coverage while controlling costs. The state is estimated to have saved over \$500 million since 1994 through a marked decline in emergency room usage, among other factors. Even though many of its early problems have been worked out, some providers complain that TennCare's capitation rate is inadequate.
BROAD INSURANCE MARKET REFORM	A 1997 law complied with HIPAA's small group market requirements by modifying its current market reform statute. It chose to adopt the federal fall-back standards to satisfy the group-to-individual portability provision.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1992 include: guaranteed issue to small employers (3-25 employees); voluntary reinsurance; limits on rate variations for experience, health status and duration to a range of 2.6:1; guaranteed renewal; and limits on pre-existing condition waiting periods. A 1997 law modified the group size from 3-25 employees to 2-50 employees.

REGULATION OF INDIVIDUAL MARKET	A 1997 law required health plans to guarantee renewal of individual coverage.
MANAGED CARE	A 1990 law prohibits health plans from requiring subscribers to use mail-order pharmacies. Since 1992, the Blue Cross and Blue Shield Plan must honor assignment of hospital and physician benefits by a subscriber to a nonparticipating provider. In 1993, the law was amended to add pharmacies, home health agencies, medical equipment suppliers and entities providing infusion therapy. A 1992 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements. It also stipulates that the standards may be considered met if the UR firm receives approval by a private UR accreditation organization. A 1996 law prohibits health plans from restricting medical personnel from informing patients of alternative medical treatments, programs or pharmaceuticals which may be available, whether or not covered by the organization (so-called "gag clause"). A 1997 law requires HMOs to establish a standardized process for responding to enrollee grievances. After exhausting the proscribed internal review process, an enrollee may appeal any coverage or claims denial to an external review entity approved by the Department of Insurance. Recommendations of the external reviewers are advisory in nature. A 1997 law requires health plans to cover stabilization services in the emergency room without prior authorization if an enrollee's presenting symptoms as recorded by the attending physician indicate an emergency condition could exist.

CORPORATE RESTRUCTURING	_____
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TEXAS: 1997 LEGISLATIVE ACTIVITY

Texas consumers are able to sue health plans using two new causes of action under an unprecedented law that took effect in September 1997. A health plan is liable for damages for harm to an enrollee caused by: (1) the health care treatment decisions made by its employees, agents or representatives; and (2) its failure to exercise ordinary care (i.e., that degree of care that a health plan of ordinary prudence would use under the same or similar circumstances). Although troubled by its potential to drive up costs and increase the number of frivolous lawsuits, the Governor decided to allow the liability bill to become law without his signature. The Governor explained that by withholding his signature, he was signaling the need to carefully monitor its effects to make sure that the benefits do outweigh any unintended consequences.

The Governor did sign several bills that extend regulation of managed care plans. The major bill codifies existing rules governing quality and access to care, and transfers oversight of quality of care from the Department of Health to the Department of Insurance. Other provisions impose the following requirements: (1) a ban on "gag clauses" that restrict physician communications with patients on treatment options; (2) the use of a "prudent layperson" standard for emergency medical services; (3) continuity of care for patients whose providers have been removed from a network; and (4) direct access for female enrollees to an OB-GYN for specified services.

A limited mental health parity law was enacted that requires health plans to provide the same cost-sharing requirements for enrollees with serious, biologically-based mental illnesses as for other physical illnesses. This is a mandated requirement for groups with 50 or more employees and a mandated offering for smaller groups.

A new law requires health plans to cover inpatient care for at least 48 hours following a mastectomy and 24 hours following a lymph node dissection. Lawmakers also endorsed a variety of other mandated benefit bills: reconstructive breast surgery; childhood immunizations through age six; prostate cancer screening; and diabetic equipment, supplies and self-management training.

The legislature modified the current small group market statute to comply with HIPAA and designated its medical high-risk pool as the alternative mechanism to provide group-to-individual portability.

TEXAS: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A 1993 child health initiative guarantees that every child will be immunized and expands existing school-based primary health care services. A medical high-risk pool for individuals who are otherwise uninsurable was established in 1989.
BROAD INSURANCE MARKET REFORM	A 1993 law encouraged the establishment of both private and public voluntary purchasing cooperatives to increase the availability of affordable coverage. A 1995 law created a pilot program that would use Medicaid funds to establish medical savings accounts for some Medicaid recipients. A 1997 law modified the current small group market statute to comply with HIPAA and designated its medical high-risk pool as the alternative mechanism to provide group-to-individual portability.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1993 include: guaranteed issue to small employers (3-50 employees); voluntary reinsurance; limits on rate variations for experience, health status and duration to a range of 2:1; guaranteed renewal; and limits on preexisting condition waiting periods. A 1997 amendment revised group size from 3-50 to 2-50 employees.
REGULATION OF INDIVIDUAL MARKET	A 1997 law required health plans to guarantee renewal of individual coverage.

MANAGED CARE

A 1991 law established a system of comprehensive regulation of the utilization review (UR) industry, including state certification requirements and minimum operational standards, appeals procedures, confidentiality requirements, and penalties for non-compliance.

A 1991 law prohibits insurers from requiring subscribers to use out-of-state mail-order pharmacies.

A 1991 law requires HMOs to give providers a written explanation of the reason for non-acceptance to participate in a network.

In 1995, the Commissioner of Insurance issued rules for HMOs and PPOs that address a number of due process and quality assurance issues, including requiring that: (1) HMOs pay for a screening to determine if a patient really has a medical emergency; (2) patients in special circumstances (i.e., disability, acute condition, life-threatening illness or third-trimester pregnancy) be allowed to continue treatment for a maximum of 90 days with a physician or dentist dropped from the network; (3) managed care plans make application information available to any provider, upon request; and (4) managed care plans provide written reasons for non-acceptance or termination of a physician or dentist, upon request.

In 1996, the Insurance Commissioner adopted a second set of patient protection regulations that: (1) require HMOs to allow referrals to out-of-network providers when medically necessary covered services are not available from network providers; (2) require HMOs to pay for medically necessary services delivered by a non-preferred provider at the preferred provider reimbursement level, if covered services are not available through a preferred provider; and (3) under contract provisions, ban physicians and other providers from seeking additional payment from HMO enrollees beyond those authorized in the health plan description.

In addition, HMOs are required to maintain a standardized internal system for resolving complaints from their enrollees under new rules adopted by the Department of Health in 1996. The rules establish a 30-day deadline for HMOs to acknowledge, investigate and resolve complaints with any aspect of an HMO's operation (except emergency care). Complaints that are not resolved may be appealed to an advisory panel of HMO staff, providers and enrollees assembled by the HMO.

MANAGED CARE	Under a 1997 law, health plans are liable for damages for harm to an enrollee caused by: (1) the health care treatment decisions made by its employees, agents or representatives; and (2) its failure to exercise ordinary care (i.e., that degree of care that a health plan of ordinary prudence would use under the same or similar circumstances). This law also contains a requirement for external review of enrollee grievances. A 1997 law codifies existing rules governing quality and access to care, and transfers oversight of quality of care from the Department of Health to the Department of Insurance. Other provisions impose the following requirements: (1) a ban on "gag clauses" that restrict physician communications with patients on treatment options; (2) the use of a "prudent layperson" standard for emergency medical services; (3) continuity of care for patients whose providers have been removed from a network; and (4) direct access for female enrollees to an OB-GYN for specified services. A limited mental health parity law was enacted in 1997 that requires health plans to provide the same cost-sharing requirements for enrollees with serious, biologically-based mental illnesses as for other physical illnesses. This is a mandated requirement for groups with 50 or more employees and a mandated offering for smaller groups.
CORPORATE RESTRUCTURING	A 1997 law allows mutual insurance companies to demutualize and form stock insurance companies with the approval of the Insurance Commissioner. It also allows mutual insurance companies to reorganize as mutual holding companies upon approval.

UTAH: 1997 LEGISLATIVE ACTIVITY

Lawmakers complied with HIPAA group-to-individual portability requirements by devising an alternative mechanism that combines the existing individual market guaranteed issue requirement with the state high-risk pool. A HIPAA-eligible individual denied coverage by a health plan is to be referred to the high-risk pool which would then determine whether that person is "too healthy" for the pool based on objective guidelines to be established. An individual who is found to be "too healthy" must be covered by the health plan that had previously denied coverage. Anyone who is not "too healthy," is eligible for coverage in the high-risk pool.

Also enacted was a law that bans health plan contracts from including "gag clauses" pertaining to discussions between providers and patients about medical treatment options. In other activity, the legislature repealed the state's existing direct access to rural providers law and replaced it with a narrower requirement. Under the revised terms, only those HMOs operating in the most rural counties must allow their enrollees to self-refer to providers under certain circumstances.

Another law prohibits health plans from discriminating against victims of domestic abuse by refusing to issue or renew a policy, or by charging a different rate for coverage.

UTAH: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	The Utah Health Policy Commission was created in 1994 with responsibility for making recommendations to the legislature to implement the Governor's strategic plan for market-oriented reform, leading eventually to universal access. There is a timetable for studying and submitting reports each year through 2001. A medical high-risk pool for individuals who are otherwise uninsurable was established in 1991.
BROAD INSURANCE MARKET REFORM	A 1995 law authorizes the creation of medical savings accounts that are tax exempt for employers and individuals. MSAs are to be administered in conjunction with high-deductible catastrophic policies for employees. A 1996 law allows voluntary purchasing alliances to be established for employer groups. Certain activities by alliances would be exempt from state anti-trust laws. Lawmakers complied with HIPAA requirements in 1997 by devising an alternative mechanism for group-to-individual portability that combines the existing individual market guaranteed issue requirement with the state high-risk pool. A HIPAA-eligible individual denied coverage by a health plan is to be referred to the high-risk pool which would then determine whether that person is "too healthy" for the pool based on objective guidelines to be established. An individual who is found to be "too healthy" must be covered by the health plan that had previously denied coverage. Anyone who is not "too healthy," is eligible for coverage in the high-risk pool.

REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1994 include: guaranteed renewal to small employers (1-50 employees); limits on rate variations to a range of 2:1; and limits on preexisting condition waiting periods. Reforms enacted in 1995 require health plans to offer a basic benefit plan on an open enrollment basis under certain circumstances. Reforms enacted in 1995 -1997 allow health plans to use the following case characteristics without rate limitations: age, gender, family composition, group size, industry and geographic area. Health plans are required to limit adjustments for experience and health status to a range of 1.85:1.
REGULATION OF INDIVIDUAL MARKET	Reforms enacted in 1995 extend small group market reform provisions to the individual market. Open enrollment provisions went into effect in 1997 and there is a cap on the number of "uninsurables" that health plans would have to accept on an open enrollment basis. The law also requires health plans to guarantee renewal of individual coverage and places limits on preexisting condition waiting periods. A 1997 law that amended 1995 individual market rate regulations continues to peg the upper limit of individual rates to the small group market, but eliminates the floor for individual coverage. Individual rates cannot be higher than small group rates for the same benefit package. Thus, an individual can be rated at 30 percent more than the index premium rate, but there are no limits on how low the individual rate can be.

MANAGED CARE	A 1985 law allows any provider willing to accept the terms of participation set forth by a PPO network to participate. The state fundamentally changed the law in 1994 by amending the statute to permit PPOs to discriminate within, but not between, classes of licensed health care providers. This effectively turned in into an "any willing class of provider" law. State law limits PPOs to a 25% payment differential between in-network and out-of-network providers. A 1996 rural direct access law permits health plan enrollees to choose a non-participating provider if a participating provider is not located within 30 paved road miles of the enrollee's residence. Health plans are required to pay a non-participating provider on the same terms as those used for contract providers who deliver covered services. The legislature repealed the 1996 direct access to rural providers law and replaced it with a narrower requirement in 1997. Under the revised terms, only those HMOs operating in the most rural counties must allow their enrollees to self-refer to providers under certain circumstances. A 1997 law bans health plan contracts from including "gag clauses" pertaining to discussions between providers and patients about medical treatment options.
CORPORATE RESTRUCTURING	_____

VERMONT: 1997 LEGISLATIVE ACTIVITY

The legislature enacted a mental health parity bill that mandates coverage for mental health and substance abuse treatment equal to benefits for physical health. It stipulates there be parity in lifetime and annual payment limits, cost-sharing, and visit and day limits. Health plans may require members to receive these benefits through a managed care system.

Other new mandated benefits call for health plans to provide coverage for medically necessary growth cell stimulating factor injections taken as part of a prescribed chemotherapy regimen; and for diabetic equipment, supplies and self-management training.

Vermont relied on modifications to its existing small group and individual market statutes to satisfy HIPAA requirements. The definition of employer group was expanded from 1 to 49 to 1 to 50 employees.

The Governor signed a bill giving the state authority to review mergers and acquisitions of nonprofit health care service corporations. It prohibits any licensed corporation from merging with, selling or transferring more than a 10 percent interest in the corporation or its assets to any other person without the prior written approval of the Commissioner of Banking, Insurance, Securities and Health Care Administration. Under the law, a corporation must satisfy the commissioner that any transaction meets "the general good of the state."

VERMONT: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES

In 1992, Vermont enacted a comprehensive health care reform law that created the state Health Care Authority to recommend two universal access proposals (a multi-payer and a single payer option) for consideration by the legislature in 1994.

In 1997, the once powerful state Health Care Authority was merged with the Department of Banking, Insurance and Securities and a new division was created within the department to handle the duties of the authority.

Having failed to reach a consensus on a comprehensive health care reform plan, the legislature agreed in 1995 to a more modest proposal to extend coverage to the uninsured. Under the Governor's initiative, Medicaid will cover up to 15,000 low-income working residents who are not currently eligible for the program. Traditional and new Medicaid recipients will be phased into private managed care plans. The measure will pay for expanded care by continuing a special hospital/nursing home tax and through a hike in cigarette taxes.

As part of the reform initiative discussed above, the state received federal approval in 1995 of a statewide Medicaid managed care demonstration project. The project will be implemented under Section 1115 waiver authority. Under the first phase of the project, coverage will be extended to people with incomes up to 100 percent of the federal poverty level who do not meet current eligibility standards. Under the second phase, coverage will be expanded to people with incomes up to 150 percent of the poverty level.

The Doctor Dynasaur program provides basic coverage for uninsured children up to age 18 with family incomes above the Medicaid limit and below 225% of the federal poverty level.

BROAD INSURANCE MARKET REFORM	Under the 1992 reform law, Vermont established a health care purchasing pool for state employees that may be made available to private employer groups. 1997 modifications to existing small group and individual market statutes were made to satisfy HIPAA requirements.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1991 include: guaranteed issue to small employers (1-49 employees); mandatory reinsurance for commercial carriers; a modified community rating system that limits variations to a range of 1.5:1; and limits on preexisting condition waiting periods. A 1997 amendment changed the definition of employer group was expanded from 1 - 49 to 1 - 50 employees and required guaranteed renewal.
REGULATION OF INDIVIDUAL MARKET	Reforms enacted in 1992 include: guaranteed issue; voluntary reinsurance for commercial carriers; a modified community rating system that limits variations to a range of 2.3:1 for two years and 1.5:1 thereafter; limits on preexisting condition waiting periods; and a minimum loss ratio of at least 70%. Reforms enacted in 1997 required health plans to guarantee renewal of individual coverage.

MANAGED CARE	A 1997 law established quality assurance guidelines and review mechanisms for managed care plans and allows the Commissioner to establish rules. It also requires health plans to disclose financial inducements, utilization review processes and credentialing procedures to their members. The measure also prohibits managed care plans from including contract provisions that prohibit providers from disclosing treatment options and financial incentives to their patients ("gag clause"). A 1997 mental health parity law mandates coverage for mental health and substance abuse treatment equal to benefits for physical health. It stipulates there be parity in lifetime and annual payment limits, cost-sharing, and visit and day limits. Health plans may require members to receive these benefits through a managed care system.
CORPORATE RESTRUCTURING	Under a 1996 law, a domestic stock insurer may become a mutual insurer upon approval of the Commissioner of Banking, Insurance, Securities and Health Care Administration. In addition, a mutual insurer may demutualize and form a stock insurer upon receiving approval. A 1997 law gave the state authority to review mergers and acquisitions of nonprofit health care service corporations. It prohibits any licensed corporation from merging with, selling or transferring more than a 10 percent interest in the corporation or its assets to any other person without the prior written approval of the Commissioner.

VIRGINIA: 1997 LEGISLATIVE ACTIVITY

The legislature passed a bill to implement the HIPAA group-to-individual portability rules by creating a requirement to guarantee issue to HIPAA-eligibles all currently offered non-group products. The definition of small employer group was revised from 2 - 99 employees to 2 - 50 employees.

Several new mandated benefit bills were enacted. The nation's first mandated offering for prescription drugs and devices approved by the FDA for use as contraceptives was signed into law. In other action, HMOs must reimburse hospital emergency facilities and providers for screening and stabilization services if the enrollee is referred by a participating physician. Coverage is also mandated for the services of certified nurse-midwives who can be reimbursed directly.

Legislators also declined to act on several mandated benefit proposals, instead referring them to the Special Advisory Commission on Mandated Benefits for a cost-benefit analysis. The results of these impact studies will be made available for consideration in the 1998 session. Evaluations will be conducted on the following suggested mandates: minimum mastectomy stay; reconstructive breast surgery; acupuncture; prostate cancer screening; and hemophilia services.

A new law requires the state to develop a Children's Medical Security Insurance Plan to provide coverage for individuals up to age 18 in families with incomes up to 200 percent of the federal poverty level. Funding would be provided through a trust fund to be generated through an increase in the premium taxes levied on health plans with open enrollment periods. The proposal is to be developed in time for consideration during the 1998 session.

A 1997 law requires that any nonprofit, tax-exempt HMO, health service plan or hospital provide the Attorney General and the community with written notice of its intent to dispose of assets at least 60 days before such action.

VIRGINIA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A 1997 law requires the state to develop a Children's Medical Security Insurance Plan to provide coverage for individuals up to age 18 in families with incomes up to 200 percent of the federal poverty level. Funding would be provided through a trust fund to be generated through an increase in the premium taxes levied on health plans with open enrollment periods. The proposal is to be developed in time for consideration during the 1998 session.
BROAD INSURANCE MARKET REFORM	A 1995 law provides for the establishment of medical savings accounts if MSA legislation is enacted at the federal level. A 1997 law implemented the HIPAA group-to-individual portability rules by creating a requirement to guarantee issue to HIPAA-eligibles all currently offered non-group products. Also, the definition of small employer group was revised from 2 - 99 employees to 2 - 50 employees.
REGULATION OF SMALL GROUP MARKET	Reforms enacted include: guaranteed issue to small employers (2-49 employees); limits on rate variations for experience, health status and duration to a range of 1.5:1; guaranteed renewal; and limits on preexisting condition waiting periods. A 1996 amendment raised the definition of small employer from 2-49 employees to 2-99 employees. The definition of employer group was revised again in 1997 from 2-99 employees to 2-50 employees.
REGULATION OF INDIVIDUAL MARKET	In 1995, the legislature enacted a bill that requires health plans in the individual market to limit preexisting condition waiting periods. Exceptions to this requirement exempt short-term policies and open enrollment policies. Reform enacted in 1996 required guaranteed renewal.

MANAGED CARE	Since 1983, state law allows any provider willing to meet the terms and conditions offered for participation in a PPO network to participate. Trigon Blue Cross and Blue Shield must honor assignment of benefits by a subscriber to nonparticipating providers. The law applies only to health insurance products where benefits are less than 80% of charges. A 1990 law established a system of comprehensive regulation of private utilization review (UR) agents, including state certification requirements, minimum operational standards, appeals procedures, confidentiality requirements, and penalties for non-compliance. The following entities are exempt: not-for-profit health service corporations, insurers, HMOs and PPOs. A 1994 "freedom of choice" law prohibited health plans from requiring subscribers to use participating pharmacies or ancillary service providers and from imposing financial penalties on subscribers who select non-participating pharmacies or ancillary service providers. A 1995 amendment exempted ancillary services. A 1995 utilization review law that applies to health plans established standards for UR staffing and procedures, including timeframes and quality standards for the appeals process. A 1995 law required a definition of emergency medical condition based on a "prudent layperson" standard. A 1996 law requires health plans to allow subscribers direct access to participating OB-GYNs for an annual exam and certain follow-up procedures. A 1996 law prohibits "gag clauses" in provider contracts that interfere with provider-patient communications regarding medical treatment options. A 1997 law requires HMOs to reimburse hospital emergency facilities and providers for screening and stabilization services if the enrollee is referred by a participating physician.
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CORPORATE RESTRUCTURING	A 1996 law requires the State Corporation Commission (SCC) to approve a plan of conversion from a domestic mutual insurer to a domestic stock insurer if, among other criteria, the SCC finds that: (1) the terms and conditions of the plan are fair and equitable to the policyholders of the mutual insurer; and (2) in the case of a domestic mutual insurer that converted from a health services plan that was in existence prior to December 31, 1987, the conversion plan allocates and distributes to the Treasurer of the Commonwealth shares of stock or cash or both equal to the surplus as of December 31, 1987 plus \$10 million. A 1997 law requires that any nonprofit, tax-exempt HMO, health service plan or hospital provide the Attorney General and the community with written notice of its intent to dispose of assets at least 60 days before such action.
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WASHINGTON: 1997 LEGISLATIVE ACTIVITY

The Governor vetoed most of the provisions of a reform bill that would have significantly modified the state's insurance market reform laws. This action means that current law regarding guaranteed issue, renewability and portability in the individual market remains in place. Specific sections vetoed would have replaced the guaranteed issue requirement with a two-month open enrollment period; adjusted the guaranteed renewal provision; and established minimum loss ratios in all markets. The result of the veto is that health plans will continue to have difficulty in getting adequate rate increases and in modifying or discontinuing outmoded products.

The Governor did sign the provision to impose a coverage mandate for emergency screening and stabilization services based on a "prudent layperson" definition of emergency medical condition. In an effort to ensure that future mandated benefit proposals receive thorough review, a new law requires an evaluation to be performed prior to consideration by the legislature. Each mandated benefit bill must be assessed for its financial and social impact, as well as health care efficacy. The Insurance Commissioner is directed to evaluate the reasonableness and actuarial accuracy of the cost estimates that are provided by the bill's sponsor or other interested parties.

Washington chose to comply with HIPAA requirements in the small group and individual markets by use of its current market reform statutes. No amendments to the existing statutes were needed.

In May, a federal district court overturned the state's alternative provider law by ruling that it was preempted by ERISA. The 1995 law had required health plans to cover the services of all licensed categories of providers (e.g., naturopaths, nutritionists, massage therapists). The judge stated that because the statute was "...not a valid exercise of the state's authority to regulate health service entities," the state is barred from enforcing either the law or the Commissioner's interpretation of it.

Finally, a controversial anti-managed care ballot initiative was soundly defeated in November. Initiative 673 would have required health plans to contract with "any willing doctor and nurse practitioner." This was broadly defined to include licensed doctors of medicine, osteopathic, psychology, pharmacy, chiropractic, podiatric, naturopathy and optometry. The initiative was pushed by allied health care provider groups and labor unions. It was opposed by a coalition of business and medical groups, including both the state medical and hospital associations.

WASHINGTON: CUMULATIVE REFORM LAWS

COMPREHENSIVE ACCESS

The Health Services Act of 1993 created a universal coverage program for all residents. By 1999, all employers would have been required either to offer their employees and dependents a choice of certified health plans, join a health insurance purchasing cooperative or obtain coverage through a state-sponsored health plan. All individuals would have had to purchase coverage through a certified health plan by 1999. However, opposition by employers and consumers pushed the legislature to pass a measure repealing most of the law in 1995, in favor of an incremental, market-oriented approach to health reform. Gone are the following requirements: the employer mandate, the individual mandate, the minimum package of benefits, the premium cap, health insurance purchasing cooperatives, and any willing provider guarantees.

The state-subsidized Basic Health Plan provides coverage for certain low-income uninsured residents. Enrollment was capped at 130,000 in September 1996 because of budget limitations -- some 70,000 enrollees short of the 200,000 goal.

A medical high-risk pool for individuals who are otherwise uninsurable was established in 1988. It was closed to new enrollees during 1996 due to the state's guaranteed issue requirement in the individual market.

BROAD INSURANCE MARKET REFORM	In 1995, the legislature enacted a measure authorizing the establishment of medical savings accounts. However, no guidelines have been set to implement the law because Washington does not have a state income tax. The Governor vetoed most of a 1997 reform bill that would have significantly modified the state's insurance market reform laws. This action means that current law regarding guaranteed issue, renewability and portability in the individual market remains in place. Specific sections vetoed would have replaced the guaranteed issue requirement with a two-month open enrollment period; adjusted the guaranteed renewal provision; and established minimum loss ratios in all markets. In 1997, the state complied with HIPAA requirements in the small group and individual markets by use of its current market reform statutes. No amendments to the existing statutes were needed.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1993 include: guaranteed issue to all employer groups; pure community rating with adjustments only for family composition and geography; guaranteed renewal; and limits on preexisting condition waiting periods. Reforms enacted in 1995 for small groups (50 or fewer employees) require modified community rating. Health plans may vary rates only for geographic area, family composition, age (based on 5-year increments from ages 20-65) and wellness activities. Compression factors cannot exceed 4.25:1 after January 1996; 4:1 after January 1997; and 3.75:1 after January 2000. Health plans may allow actuarially justified discounts up to 20% for wellness activities, such as smoking cessation and weight reduction.

REGULATION OF INDIVIDUAL MARKET	Reforms enacted in 1993 include: guaranteed issue; pure community rating with adjustments only for family composition and geography; guaranteed renewal; and limits on preexisting condition waiting periods. Reforms enacted in 1995 allow health plans to vary rates only for geographic area, family composition, age (based on 5-year increments from ages 20-65) and wellness activities. Compression factors cannot exceed 4.25:1 after January 1996; 4:1 after January 1997; and 3.75:1 after January 2000. Health plans may allow actuarially justified discounts up to 20% for wellness activities, such as smoking cessation and weight reduction.
MANAGED CARE	The comprehensive reform law of 1993 included any willing provider language as well as so-called "patient protection" provisions that would have required health plans to admit licensed health providers willing to accept the terms of participation. In 1995, the legislature repealed the AWP and "patient protection" provisions of the earlier law. However, regulations adopted in 1994 to implement these sections continue in effect. The rules allow health plans to selectively contract with individual providers, as long as they contract with each type or class of provider. A 1995 law requires health plans to allow subscribers direct access to providers of women's health care services without requiring prior referral from a primary care physician. A limited patient disclosure bill passed in 1996 that: (1) prohibits health plans from precluding or discouraging providers from informing patients of treatment options and discussing the comparative merits of different health plans (so-called "gag rule"); and (2) requires health plans to disclose non-proprietary information about their policies on referrals and prior authorization. A 1997 law imposed a coverage mandate for emergency screening and stabilization services based on a "prudent layperson" definition of emergency medical condition.

CORPORATE RESTRUCTURING	_____
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WEST VIRGINIA: 1997 LEGISLATIVE ACTIVITY

Lawmakers satisfied HIPAA requirements by enacting a guaranteed issue requirement in the small group market and adopting the federal fall-back provisions for HIPAA-eligible individuals to satisfy the group-to-individual portability requirement. The Insurance Commissioner was directed to perform a study on the feasibility of alternatives to guaranteed issue and their impact on the individual market in time for consideration during the 1998 session.

A new law prohibits health plans from discriminating against victims of domestic or child abuse by denying, refusing to issue or renew, canceling or charging higher premiums because an individual has been or may be a victim of abuse.

WEST VIRGINIA: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	---
BROAD INSURANCE MARKET REFORM	In 1995, lawmakers passed medical savings account legislation that allows employers (including self-funded employers) to offer benefit plans associated with an MSA. Amounts deposited in an MSA account would be tax free for individuals and tax exempt for employers. Lawmakers satisfied HIPAA requirements in 1997 by enacting a guaranteed issue requirement in the small group market and adopting federal fall-back provisions for HIPAA-eligible individuals to satisfy the group-to-individual portability requirement. The Insurance Commissioner was directed to perform a study on the feasibility of alternatives to guaranteed issue and their impact on the individual market in time for consideration during the 1998 session.
REGULATION OF SMALL GROUP MARKET	Reforms enacted over the past few years include: limits on rate variations for experience, health status and duration to a range of 2:1; guaranteed renewal to small employers (2-60 employees); and a minimum loss ratio of 70% for commercial carriers and 73% for the Blue Cross and Blue Shield Plan. A 1997 law requires guaranteed issue to small employer groups.

REGULATION OF INDIVIDUAL MARKET	A 1993 law requires all health plans to maintain a minimum loss ratio of 65%. Reforms enacted in 1995 include: guaranteed renewal; and limits on rate variations for new major medical policies to no more than 30% above the current market rate (to be phased-in over three years). Under the law, health plans that wish to exit the individual market are required to obtain approval from the Commissioner of Insurance.
MANAGED CARE	Revisions to the state's HMO enabling act were passed that require HMOs to have a quality assurance program. By 1998, HMOs in existence for at least three years must have submitted an application to a national accreditation organization for quality assurance. In addition, all HMOs are required to comply with utilization management requirements to be established by the Commissioner of Insurance.
CORPORATE RESTRUCTURING	— — —

WISCONSIN: 1997 LEGISLATIVE ACTIVITY

The legislature satisfied the group-to-individual portability requirements of HIPAA by utilizing the existing medical high-risk pool as the state alternative mechanism. In addition, the definition of small employer groups was changed from 2 - 25 employees to 2 - 50 employees to comply with HIPAA.

Two new mandated benefit laws require health plans to cover reconstructive breast surgery for mastectomy patients, and treatment for TMJ disorders.

A new access program known as "Badger Care" will expand Medicaid eligibility to uninsured children in families with incomes below 185 percent of the federal poverty level. Under the initiative, state subsidies will also be provided for the purchase of private health insurance based on a sliding income scale.

WISCONSIN: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1981. A new access program known as "Badger Care" will expand Medicaid eligibility to uninsured children in families with incomes below 185 percent of the federal poverty level. Under the 1997 law, state subsidies will also be provided for the purchase of private health insurance based on a sliding income scale.
BROAD INSURANCE MARKET REFORM	A 1996 law created medical savings accounts (MSAs). The bill precludes portability from an MSA to a more comprehensive plan in cases where employers offer a choice among health benefit plans. The measure cannot take effect unless the federal government also enacts MSA legislation. A 1997 law satisfied the group-to-individual portability requirements of HIPAA by utilizing the existing medical high-risk pool at the state alternative mechanism. In addition, the definition of small employer groups was changed from 2 to 25 employees to 2 to 50 employees to comply with HIPAA.
REGULATION OF SMALL GROUP MARKET	Reforms enacted over the past few years include: guaranteed issue to small employers (2-25 employees); limits on rate variations for experience, health status and duration to a range of 2.1:1; guaranteed renewal; and limits on preexisting condition waiting periods. A 1996 law extends group-to-group and individual-to-group portability requirements to insured groups of all sizes. It also places limits on pre-existing condition waiting periods on groups of all sizes. A 1997 amendment expanded the definition of small employer groups from 2 - 25 employees to 2 - 50 employees.

REGULATION OF INDIVIDUAL MARKET	A 1997 law required health plans to guarantee renewal of individual coverage.
MANAGED CARE	A 1990 law allows any pharmacist willing to accept the terms of participation set forth by a PPO or HMO network to participate.
CORPORATE RESTRUCTURING	_____

WYOMING: 1997 LEGISLATIVE ACTIVITY

The Governor signed legislation that brings the state into compliance with HIPAA's small group requirements by modifying the current market reform statute. Under the state's alternative mechanism for group-to-individual portability, HIPAA-eligible individuals will be enrolled in the medical high-risk pool.

Lawmakers also adopted a law that prohibits health plans from refusing to contract with or compensate an eligible provider because that provider has communicated with a current or prospective patient regarding the requirements of the plan's products as they relate to patient needs (so-called "gag clause").

WYOMING: CUMULATIVE REFORM LAWS

ACCESS INITIATIVES	A medical high-risk pool for individuals who are otherwise uninsurable was established in 1991.
BROAD INSURANCE MARKET REFORM	Legislation enacted in 1997 brings the state into compliance with HIPAA's small group requirements by modifying the current market reform statute. Under the state's alternative mechanism for group-to-individual portability, HIPAA-eligible individuals will be enrolled in the medical high-risk pool.
REGULATION OF SMALL GROUP MARKET	Reforms enacted in 1992 include: guaranteed issue to small employers (2-25 employees); mandatory reinsurance; limits on rate variations for experience, health status and duration to a range of 2:1; guaranteed renewal; and limits on preexisting condition waiting periods. Reforms enacted in 1995 expand the definition of small employer to include groups of 2 to 50 employees; require health plans in all markets to renew coverage; and further limits preexisting condition waiting periods. The statute also provides for continuation of coverage for up to 12 months for employees who lose their jobs.
REGULATION OF INDIVIDUAL MARKET	Reforms enacted in 1995 require health plans in all markets to renew coverage and limit preexisting condition waiting periods.

MANAGED CARE	A 1990 law allows any provider willing to meet the terms of participation set forth by a PPO network to participate. A 1995 any willing provider law prohibits HMOs from denying membership to any provider willing to meet the terms and conditions of participation. A 1995 measure creates a state action doctrine to grant state and federal antitrust relief to health care cooperative agreements. The law calls for active regulation and supervision of collaborative health care arrangements, such as providers who get together to form a risk-assuming group and to share information. A 1997 law prohibits health plans from refusing to contract with or compensate an eligible provider because that provider has communicated with a current or prospective patient regarding the requirements of the plan's products as they relate to patient needs (so-called "gag clause").
CORPORATE RESTRUCTURING	— — —

APPENDIX

STATE SMALL GROUP INSURANCE REFORM LAWS

STATE	NAIC RATING BANDS	VERY TIGHT RATING BANDS	COMMUNITY RATING	GUARANTEED RENEWAL	GUARANTEED ISSUE	VOLUNTARY REINSURANCE	MANDATORY REINSURANCE	PREEXISTING CONDITIONS
AL ¹								
AK	93 LAW			93, 97 LAW	93, 97 LAW		93 LAW	93, 97 LAW
AZ	93 LAW			93, 97 LAW	93, 97 LAW	93 LAW		93, 97 LAW
AR	91 LAW			91, 97 LAW	97 LAW			97 LAW
CA		92 LAW		92, 97 LAW	92 LAW	92 LAW		92, 97 LAW
CO	91 LAW ²		94 LAW	91, 97 LAW	94, 97 LAW	94 LAW		94, 97 LAW
CT	90 LAW		93 LAW	90, 97 LAW	90, 97 LAW		90 LAW	90, 93, 97 LAW
DE	91, 92 LAW ²			91, 97 LAW	92, 97 LAW	92 LAW		92, 97 LAW
FL	91, 92 LAW		93 LAW	91, 92, 97 LAW	92, 93 LAW	92 LAW		92, 97 LAW
GA	91, 94, 97 LAW ²			97 LAW	HIPAA			95, 97 LAW
HI				97 LAW	97 LAW			97 LAW
ID	93 LAW			93, 97 LAW	93, 95, 97 LAW		93 LAW	93, 97 LAW
IL	93 LAW			93, 97 LAW	97 LAW			93, 97 LAW
IN ³	92 LAW			HIPAA		96 LAW		95, 97 LAW
IA	91 LAW		94 LAW	91, 97 LAW	92, 97 LAW	92 LAW		92, 97 LAW
KS	91, 92 LAW ²			92, 97 LAW	92, 97 LAW	92 LAW		91, 94, 97 LAW
KY ⁴			94, 96 LAW	HIPAA	94 LAW			94, 96 LAW
LA	91 LAW	93 LAW		97 LAW	97 LAW			93, 97 LAW
ME			92, 95 LAW	92, 97 LAW	92 LAW	93 LAW		90, 97 LAW
MD			93, 96 LAW	93, 97 LAW	93 LAW	93 LAW		93 LAW
MA ³			91, 96 LAW	HIPAA	91 LAW		91 LAW ⁴	91 LAW
MI ³				96 LAW				96 LAW
MN	92, 94 LAW ²			92, 97 LAW	92 LAW	92 LAW		92, 97 LAW
MS	94 LAW			94, 97 LAW	97 LAW			93, 97 LAW
MO ⁵	92 LAW			HIPAA	HIPAA		92 LAW	HIPAA
MT	93 LAW			93, 97 LAW	93, 95, 97 LAW		93, 95 LAW	93, 95, 97 LAW
NE	91, 94 LAW			91, 94, 97 LAW	94, 97 LAW		94 LAW	94, 97 LAW
NV	95, 97 LAW			95, 97 LAW	97 LAW			95, 97 LAW
NH	92 LAW		94 LAW	92, 94 LAW	94 LAW		97 LAW	92, 94, 97 LAW
NJ			92 LAW	92, 97 LAW	92 LAW	92, 97 LAW		92, 97 LAW
NM	91 LAW		94 LAW	91, 97 LAW	97 LAW			94, 97 LAW
NY			92 LAW	92, 97 LAW	92 LAW		92 LAW	92, 97 LAW
NC	91 LAW ²	95 LAW	93 LAW	91, 97 LAW	91, 93, 97 LAW	91 LAW		91, 97 LAW
ND	91, 93, 95 LAW ²			91, 93, 97 LAW	93, 97 LAW		93 LAW	93, 97 LAW
OH	93 LAW			93, 97 LAW	93, 97 LAW ⁷	93 LAW		93, 97 LAW
OK	92 LAW			HIPAA	94, 97 LAW	94 LAW		92, 94, 97 LAW
OR		91 LAW	95 LAW	91, 95 LAW	91, 95 LAW	91 LAW		91, 97 LAW
PA				97 LAW	97 LAW			97 LAW
RI	92 LAW			95 LAW	92, 97 LAW	92 LAW		92, 95 LAW
SC	91, 97 LAW			91, 97 LAW	94, 97 LAW	94 LAW		91, 97 LAW
SD	91, 95 LAW			91, 94, 97 LAW	95, 97 LAW ⁷			94, 97 LAW
TN	92 LAW ²			92, 97 LAW	92, 97 LAW	92 LAW		92, 97 LAW
TX	93 LAW			93, 97 LAW	93, 95 LAW	93 LAW		93, 97 LAW
UT	94, 97 LAW			94, 97 LAW	95, 97 LAW			94, 97 LAW
VT			91 LAW	97 LAW	91 LAW		91 LAW ⁴	91, 95, 97 LAW
VA	93 LAW			92, 97 LAW	93, 97 LAW			92, 93, 96, 97 LAW
WA			93, 95 LAW	93, 95 LAW	93 LAW			93 LAW
WV	91 LAW			91, 97 LAW	97 LAW			93, 97 LAW
WI	91 LAW ²			91, 97 LAW	92, 97 LAW			92, 97 LAW
WY	92 LAW			92, 95 LAW	92, 97 LAW		92 LAW	92, 97 LAW
Total		46		50	47	20	12	49

¹HIPAA conforming regulations are still under development.

²Alternate rating limits from NAIC

³HIPAA conforming legislation was not enacted during the 1997 session but has been introduced for the 1998 session.

⁴Kentucky is exempt from implementing HIPAA-required changes to small group reform law until July 1, 1998 because the legislature did not meet in regular session in 1997.

⁵BCBS Plan exempt from participating in the reinsurance program.

⁶HIPAA supersedes existing state small group reform law since Missouri did not pass HIPAA implementation legislation in 1997.

⁷There is a cap on how much business health plans have to write on a guaranteed issue basis.

STATE SMALL GROUP INSURANCE REFORM LAWS

Definitions

NAIC Rating: Laws that restrict small group rates based on the NAIC model act adopted in December 1991. This model act limits premiums charged to small groups to a range of 2:1 for experience, health status, or duration of coverage.

Very Tight Rating Bands: Laws that only allow very limited use of experience, health status, or duration in setting premium rates for small groups.

Community Rating: Laws that prohibit the use of experience, health status or duration in setting premium rates for small groups. Some community rating laws also prohibit use of demographic factors.

Guaranteed Renewal: The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 supersedes the guaranteed renewal requirement in states that had less far-reaching guaranteed renewal provisions. Prior to the enactment of HIPAA, 43 states had guaranteed renewal provisions in their small group reform laws. HIPAA requires health plans to guarantee renewal of all group products to groups of any size. Health plans are specifically allowed to modify benefits as long as provided uniformly. A health plan may non-renew a product provided it: 1) complies with state requirements; 2) withdraws the product from the large or small group market; 3) gives affected groups and beneficiaries 90 days notice; 4) offers the option of purchasing any product offered in the respective markets; and 5) acts uniformly and without regard to health status. HIPAA allows termination of coverage for fraud, nonpayment, noncompliance with contribution requirements, market exit, and service area limitations.

Guaranteed Issue: These provisions require health plans offering coverage in the small group market to offer coverage to any small group regardless of the health status or claims experience of the group's members. HIPAA requires that health plans guarantee issue all products. Health plans may impose participation or contribution requirements as well as limit their geographic service area (consistent with state law). The federal guaranteed issue provision does not require bona fide associations to issue coverage to non-association members but does prohibit them from basing eligibility for membership or participation in the health plan on health status. (See also "Addendum to State Small Group Insurance Reform Laws".)

Reinsurance: Many laws that require guarantee issue also establish either voluntary or mandatory health plan participation in a reinsurance program to spread the cost of covering high-risk groups among small group health plans in a state. Under a voluntary program, health plans may elect to opt-out of the reinsurance program and become a "risk assuming" carrier. "Risk assuming" health plans are not subject to reinsurance assessments. Under a mandatory program, all health plans must participate in the reinsurance program and are subject to assessments for losses in the program.

Preexisting Conditions Exclusions: HIPAA allows health plans to impose a preexisting condition exclusion only if (1) such exclusion relates to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date; and (2) such exclusion extends for a period of not more than 12 months (or 18 months for late enrollees) after the enrollment date. Genetic information or domestic abuse cannot be used as the basis of a preexisting condition. Preexisting condition exclusion periods cannot be applied to pregnancy, newborns or adopted children as long as the child is covered within 30 days of birth or adoption. States may implement look-back periods and preexisting condition exclusion periods that are shorter than those specified by HIPAA. The federal law also requires any preexisting condition exclusion period to be reduced by the aggregate of the periods of creditable coverage applicable to the individual as of the enrollment date in new coverage provided that the lapse between periods of coverage is not more than 63 days. States can require health plans to give credit for prior coverage even if the lapse in coverage was longer than 63 days. (See also "Addendum to State Small Group Insurance Reform Laws".)

ADDENDUM TO STATE SMALL GROUP INSURANCE REFORM LAWS

State	Group Size		Guaranteed Issue		Preexisting Condition Exclusions		
	min.	max.	selected products	all products	limit exclusion periods	credit exclusion periods	creditable coverage gap
AL ¹	2	50					
AK	2	50		X	6/12	X	90 days
AZ	2	50		X	6/12	X	63 days
AR	2	50		X	6/12	X	63 days
CA	2	50		X	6/6	X	62 days
CO	1	50		X	6/6	X	90 days
CT	1	50		X	6/12	X	63 days
DE	1	50		X	6/12	X	63 days
FL	1	50		X ²	6/12 ³	X	63 days
GA ⁴	2	50			6/12	X	62 days
HI	1	50		X	No preexisting condition exclusion period allowed.		
ID	2	50		X	6/12	X	63 days
IL	2	50		X	6/12	X	63 days
IN ⁵	3	50			9/9	X	30 days
IA	2	50		X	6/12	X	63 days
KS	2	50		X	6/90 days	X	63 days
KY ⁶	all groups and individuals ⁷			X	12/12	X	60 days
LA	2	35		X	6/12	X	63 days
ME	1 ⁸	50		X	6/12	X	90 days
MD	1	50		X ⁹	No preexisting condition exclusion period allowed.		
MA ⁵	1	50		X	6/6	X	30 days
ME ⁸					12/6 ¹⁰		
MN	2	50		X	6/12	X	63 days
MS	1	50		X	6/12	X	63 days
MO ¹⁰	3	25	X		6/12	X	30 days
MT	2	50		X	6/12	X	63 days
NE	2	50		X	6/12	X	63 days
NV	2	50		X	6/12	X	63 days
NH	1	100		X	3/9	X	63 days
NJ	2	50		X	6/6	X	90 days
NM	2	50		X	6/6	X	63 days
NY	1	50		X	6/12	X	63 days
NC	1	50		X ¹²	6/12	X	63 days
ND	2	50		X	6/12	X	63 days
OH	2	50		X ¹³	6/12	X	63 days
OK	2	50		X	6/12	X	63 days
OR	2	50		X	6/6	X	63 days
PA	2	50		X	6/12	X	63 days
RI	1 ¹⁴	50		X	No preexisting condition exclusion period allowed.		
SC	2	50		X	6/12	X	63 days
SD	2	50		X ¹³	6/12	X	63 days
TN	2	50		X	6/12	X	63 days
TX	2	50		X	6/12	X	63 days
UT	2	50		X	6/12	X	62 days
VT	1	50		X	6/12	X	90 days
VA	2	50		X	6/12	X	63 days
WA	1	50 ¹⁵		X	3/3	X	90 days
WV	2	50		X	6/12	X	63 days
WI	2	50		X	6/12	X	63 days
WY	2	50		X	6/12	X	90 days

Source: Blue Cross Blue Shield Association, December 1997

ADDENDUM TO STATE SMALL GROUP INSURANCE REFORM LAWS

Footnotes

1. HIPAA conforming regulations are still under development.
2. For groups of 1 or 2, the guaranteed issue requirement only applies to selected products.
3. For groups of 1 or 2 without continuous coverage, waiting periods are limited to 24/24.
4. Since Georgia does not have a guaranteed issue provision in the small group market HIPAA's guaranteed issue provision is in force.
5. HIPAA conforming legislation was not enacted during the 1997 session but has been introduced for the 1998 session.
6. Kentucky is exempted from implementing HIPAA-required changes to the small group reform law until July 1, 1998 because the state legislature did not meet in regular session in 1997.
7. The community rating requirement does not apply to association groups.
8. Health plans are permitted to establish a minimum small group size of two employees.
9. Groups of 1 can only enter the market during two 30-day open-enrollment periods.
10. HIPAA supersedes existing state small group reform law since Missouri did not pass HIPAA implementation legislation in 1997.
11. This limit applies to groups of 2-5 employees: preexisting condition exclusion periods are not permitted for small groups of more than 5 employees.
12. The guaranteed issue all products requirement applies to groups 2-50. For self-employed individuals, health plans are only required to guarantee issue standard and basic comprehensive, HMO and PPO products.
13. There is a cap on how much business health plans have to write on a guaranteed issued basis.
14. The guaranteed issue requirement applies to groups of 2-50.
15. The adjusted community rate applies only to individuals and small groups. Guaranteed issue, guaranteed renewability and portability provisions apply to individual and all groups.
16. Only commercial insurers allowed to apply preexisting condition waiting periods.

ADDENDUM TO STATE SMALL GROUP INSURANCE REFORM LAWS

Definitions

Group Size: Each state defines the size of a small employer group. Many states have changed the small group size to conform to HIPAA's definition of small groups as 2-50 lives. Some states define small groups to include groups of one (e.g., self-employed individuals).

"Tiers" of regulation have been created in states that did not change their small group definition to conform to HIPAA. For example, state rating regulation would apply to coverage sold to small groups as defined under state law, but the federal provisions requiring guaranteed issue of all products to small groups would apply to group size 2-50. Federal provisions requiring guaranteed renewal and limiting the use of preexisting condition exclusions would apply to groups of any size.

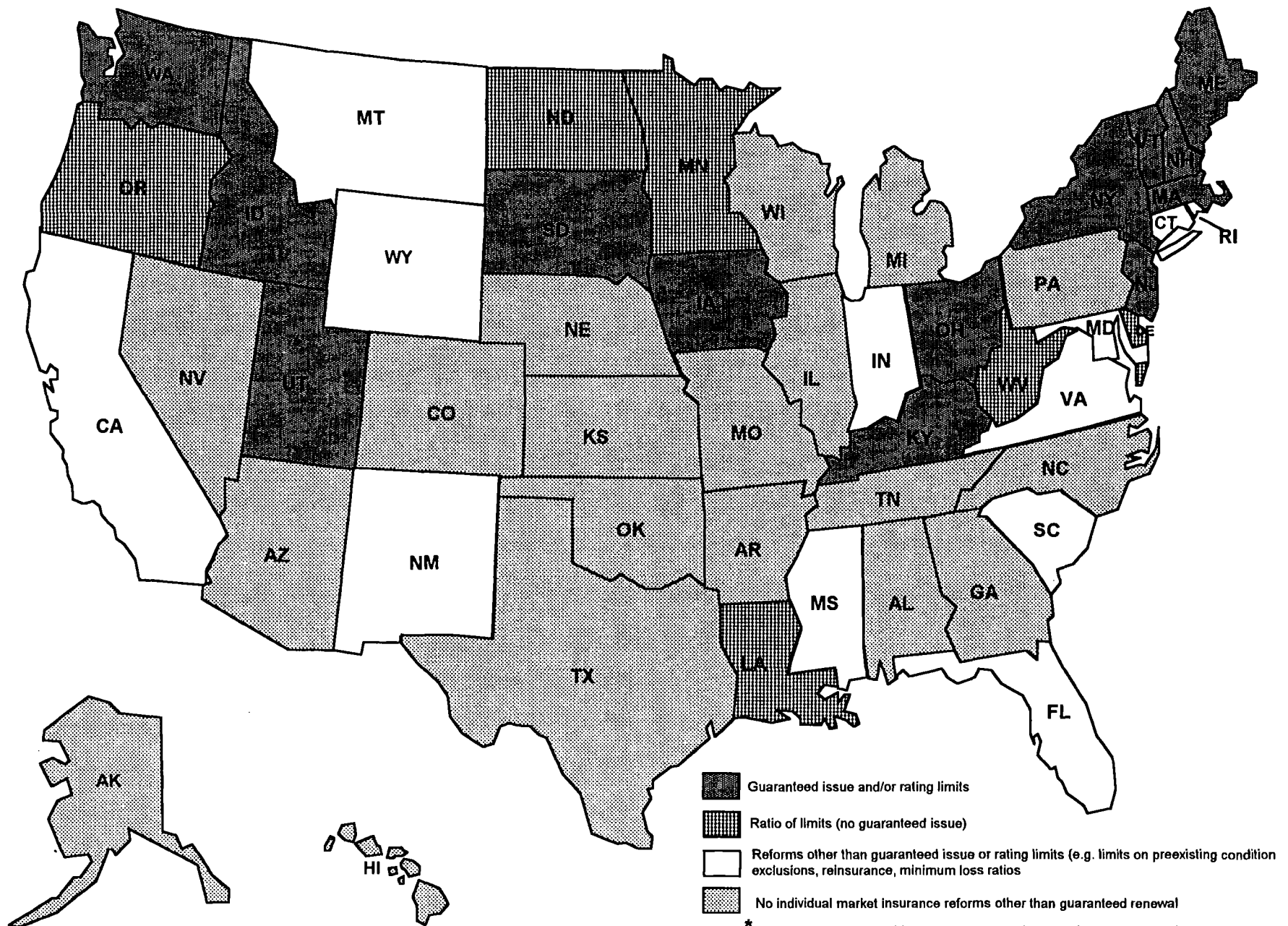
Guaranteed Issue: These provisions require health plans offering coverage in the small group market to offer coverage to any small group regardless of the health status or claims experience of the group's members. HIPAA requires that health plans guarantee issue all products. Health plans may impose participation or contribution requirements as well as issue provision does not require bona fide associations to issue coverage to non-association members but does prohibit them from using health status as a basis for eligibility for membership or participation in the health plan.

Preexisting Condition Exclusions:

- **limit exclusion periods:** The table denotes this provision "x/y" with "x" being the look-back period and "y" being the exclusion period. HIPAA allows health plans to impose a preexisting condition exclusion only if (1) such exclusion relates to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date; and (2) such exclusion extends for a period of not more than 12 months (or 18 months for late enrollees) after the enrollment date. Genetic information or domestic abuse cannot be used as the basis of a preexisting condition. Preexisting condition exclusion periods cannot be applied to pregnancy, newborns or adopted children as long as the child is covered within 30 days of birth or adoption. States may implement look-back periods and preexisting condition exclusion periods that are shorter than those specified by HIPAA.
- **credit exclusion periods:** HIPAA requires any preexisting condition exclusion period to be reduced by the aggregate of the periods of creditable coverage applicable to the individual as of the enrollment date in new coverage. HIPAA defines creditable coverage to include coverage under individual or group health plans, Medicare, Medicaid, military health, the Indian Health Service, state high risk pools, the Federal Employee Health Benefits Program, the Peace Corps plan, any public health plan or other health insurance coverage.

creditable coverage gap: These provisions require all periods of creditable coverage to be aggregated or combined, provided that the lapse between periods of coverage is not more than 63 days. States can require health plans to give credit for prior coverage even if the lapse in coverage was longer than 63 days.

STATE INDIVIDUAL MARKET INSURANCE REFORM LAWS



STATE INDIVIDUAL MARKET INSURANCE REFORM LAWS¹

STATE	RATING BANDS	VERY TIGHT RATING BANDS	COMMUNITY RATING	GUARANTEED RENEWAL	GUARANTEED ISSUE	VOLUNTARY REINSURANCE	MANDATORY REINSURANCE	PREEXISTING CONDITIONS	MINIMUM LOSS RATIO
AL				HIPAA					
AK				HIPAA					
AZ				97 LAW					
AR				HIPAA					
CA				97 LAW				93 LAW	
CO				96, 97 LAW					
CT				97 LAW				93, 97 LAW	
DE				97 LAW					
FL				96, 97 LAW		97 LAW		98 LAW	
GA				95, 97 LAW				97 LAW	
HI				97 LAW					
ID	94 LAW			94, 97 LAW	94, 95 LAW		94 LAW	94 LAW	
IL				HIPAA					
IN				HIPAA				95, 96 LAW	
IA	95 LAW			95, 97 LAW	95 LAW		95 LAW	95 LAW	
KS				97 LAW					
KY			94, 96 LAW	HIPAA	94 LAW			94, 96 LAW	
LA		93 LAW		93, 97 LAW				95 LAW	
ME			93, 96 LAW	93, 97 LAW	93 LAW			93 LAW	93 LAW
MD				97 LAW				97 LAW	96 LAW
MA			96 LAW	HIPAA ²	96 LAW	96 LAW		96 LAW	
MI				96 LAW				96 LAW	
MN	92 LAW			92 LAW				92, 97 LAW	92, 93 LAW
MS				97 LAW				97 LAW	
MO				HIPAA					
MT				97 LAW				95 LAW	
NE				97 LAW					
NV				97 LAW					
NH			94 LAW	94 LAW	94 LAW		97 LAW	94 LAW	
NJ			92 LAW	92, 97 LAW	92 LAW	92, 97 LAW		92, 97 LAW	92 LAW
NM				HIPAA ²				94 LAW	
NY			92 LAW	92, 97 LAW	92 LAW		92 LAW	92, 97 LAW	
NC				97 LAW					
ND			95 LAW	95, 97 LAW				95 LAW	93 LAW
OH				93, 97 LAW	93 LAW ³	93 LAW		93 LAW	
OK				HIPAA					
OR			96 LAW	95, 97 LAW				95 LAW	
PA				97 LAW					
RI				95 LAW				95 LAW	
SC				97 LAW				91 LAW	91 LAW
SD	96 LAW			97 LAW	96 LAW ⁴			96, 97 LAW	94 LAW
TN				97 LAW					
TX				97 LAW					
UT	95, 97 LAW			95, 97 LAW	95 LAW ²			95 LAW	
VT			92 LAW	97 LAW	92 LAW	92 LAW		92, 97 LAW	92 LAW
VA				96, 97 LAW				95 LAW	
WA			93, 95 LAW	93, 95 LAW	93 LAW			93 LAW	
WV	95 LAW			95, 97 LAW					93 LAW
WI				97 LAW					
WY				95 LAW				95 LAW	
Total		17		60	13	6	4	31	9

¹Only the guaranteed renewal provision applies to HIPAA-eligibles, except in those states utilizing existing individual market insurance reforms as the alternative mechanism to satisfy HIPAA's group-to-individual portability requirement.

²The HIPAA conforming legislation was not enacted during the 1997 session but has been introduced for the 1998 session.

³There is a cap on how much business health plans have to write on a guaranteed issue basis.

STATE INDIVIDUAL MARKET INSURANCE REFORM LAWS

Definitions

Rating Bands: Laws that restrict health plans' use of experience, health status or duration of coverage in setting premium rates for individuals.

Very Tight Rating Bands: Laws that allow very limited adjustment for experience, health status or duration.

Community Rating: Laws that prohibit health plans' use of experience, health status or duration of coverage in setting premium rates for individual coverage. Some community rating law also prohibit use of demographic factors.

Guaranteed Renewal: The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 supersedes the guaranteed renewal requirement in states that had less far-reaching renewal provisions. Prior to the enactment of HIPAA, 21 states required health plans offering individual coverage to renew coverage except for specified reasons unrelated to health status or experience (e.g., nonpayment of premium or fraud). HIPAA requires health plans to guarantee renewal of individual coverage for all individuals, not just federally-defined eligible individuals. Health plans are specifically allowed to modify benefits as long as provided uniformly. A health plan may non-renew a product provided it: 1) complies with state requirements; 2) withdraws the product from the market; 3) gives affected beneficiaries 90 days notice; 4) offers the option of purchasing any product offered in the individual market; and 5) acts uniformly and without regard to health status. HIPAA allows termination of coverage for fraud, nonpayment, noncompliance with contribution requirements, market exit, and service area limitations.

Guaranteed Issue: These provisions require health plans to offer coverage to all individuals regardless of their health status or claims experience. HIPAA requires health plans to guarantee issue coverage with no preexisting condition exclusion period for individuals leaving group health plans (including governmental and church plans) who meet the following criteria: (1) has at least 18 months of continuous creditable coverage without a lapse of 63 or more days with the most recent coverage obtained under a group health plan; (2) is ineligible for group coverage, Medicare, Medicaid or other health insurance; and (3) has exhausted COBRA (or similar state coverage).

HIPAA allows health plans to choose among the following product combinations to offer on a guarantee issue basis to eligible individuals:

- all products;
- the health plans' two most popular products (based upon premium volume); or
- "low" and "high" level coverage with benefits similar to other individual coverage offered by the health plan. The "low" product is defined as 85% to 100% of the value of the weighted actuarial average and the "high" product is defined as 100% to 120% of the value of weighted actuarial average (and at least 15% greater than "low" product.) This option requires health plans to implement a risk spreading mechanism. Note that these products must also be marketed to and enroll individuals who are not eligible for HIPAA portability.

A state may opt-out of the federal individual portability requirements by adopting an acceptable alternative mechanism. The alternative mechanism must provide a choice of products for eligible individuals and offer eligible individuals at least one comprehensive product or one comparable to the standard product of the state's health insurance reform laws. (See also "State Implementation: HIPAA Group to Individual Portability Provision".)

Reinsurance: Many laws that require guarantee issue also establish either voluntary or mandatory health plan participation in a reinsurance program to help health plans bear the risk of accepting all individuals. Under a voluntary program, health plans may elect to opt-out of the reinsurance program and become a "risk assuming" carrier. "Risk assuming" health plans are not subject to reinsurance assessments. Under a mandatory program, all health plans must participate in the reinsurance program and are subject to assessments for losses in the program. **Florida** expands the small group reinsurance program to include HIPAA-eligible individuals. **Idaho** expands the small group reinsurance program to include individuals. **Iowa** requires all health plans to participate in a reinsurance program. **Massachusetts** includes provisions authorizing a voluntary reinsurance program if 5 or more health plans agree to participate. **New Jersey** requires all health plans in the state to guarantee issue coverage or pay an assessment to help finance this coverage. **New York** provides a risk adjustment mechanism. Health plans with below average age and sex distributions pay a percentage of their claims costs to a regional pool; health plans above the average receive a percentage of their claims costs from the regional pool. In addition, there is a mandatory reinsurance program for specified, high-cost medical conditions. **Ohio** establishes an Open Enrollment Reinsurance Fund for coverage provided to individuals on an open enrollment basis. **Vermont** authorizes commercial health plans to establish a reinsurance pool if they agree to assume the entire financial liability of the pool; Blue Cross and Blue Shield of Vermont and nonprofit HMOs are not required to participate.

Preexisting Condition Exclusions: Laws that require health plans to limit preexisting condition exclusion periods to a specified number of months following either the enrollment date or the effective date of coverage. The table denotes this provision "x/y" with "x" being the look-back period and "y" being the exclusion period. The majority of states regulating preexisting condition exclusion periods also require health plans to credit the time an individual was covered by qualified previous coverage in determining whether a preexisting condition exclusion period has been satisfied.

HIPAA does not allow health plans to impose any preexisting condition exclusion period for a federally-defined eligible individual. However, it does not limit a health plan's ability to impose a preexisting condition exclusion period of any length for non-HIPAA eligible individuals. States that choose to opt-out of federal portability requirements by implementing an alternative mechanism must provide a HIPAA-eligible person with access to coverage that does not impose a preexisting condition exclusion period. Here again, it does not limit a state's ability to allow or limit through regulation preexisting condition exclusion periods for non-eligible individuals.

Minimum Loss Ratio: These laws establish a minimum percentage of aggregate premiums that must be paid out in claims. The following minimum loss ratios are required: 60 percent in **Maryland**, 65 percent in **Maine**, **North Dakota**, **South Dakota** and **West Virginia**; 70 percent in **Vermont**; and 75 percent in **New Jersey**. In **Minnesota**, the required minimum loss ratio is 66 percent in 1994 and will increase one percent per year until it reaches 72 percent in 2000. **South Carolina** requires health plans' combined individual business to meet a target loss ratio at least equal to the most recent loss ratio recommended by the NAIC for individual coverage.

ADDENDUM TO STATE INDIVIDUAL MARKET INSURANCE REFORM LAWS¹

State	Guaranteed Issue		Preexisting Condition Exclusions		
	selected products	all products	limit exclusion periods	credit exclusion periods	creditable coverage gap
AL					
AK					
AZ					
AR					
CA			12/12	X	30 days
CO					
CT			12/12	X	63 days
DE					
FL			6/12	X	63 days
GA			(not specified)/24	—	—
HI					
ID	X		6/12	X	63 days
IL					
IN			12/12	X ²	30 days
IA	X		12/12	X	63 days
KS					
KY		X	12/12	X	60 days
LA			12/12	X	60 days
ME		X	12/12	X	90 days
MD			6/12	X	63 days
MA ³	X ⁴		6/6 ⁵	X	30 days
MI			12/6 ⁶ or 6/6	—	—
MN			6/12	X	60 days
MS			12/12	—	—
MO					
MT			3 years/12	X	30 days
NE					
NV					
NH		X ⁷	3/9	X	63 days
NJ	X ⁸		6/12	X	31 days
NM			6/6	X	31 days
NY		X	6/12	X	63 days
NC					
ND			6/12	X	63 days
OH		X ⁹	6/12	X	30 days
OK					
OR			6/6	X ¹	60 days
PA					
RI			No preexisting condition exclusion period allowed.		
SC					
SD	X ⁹		12/12	X	63 days
TN					
TX					
UT		X ⁸	6/12	X	62 days
VT		X	12/12	X	63 days
VA			12/12	X	30 days
WA		X	3/3	X	90 days
WV					
WI					
WY			6/12	X	90 days

¹ These individual market reform provisions do not apply to HIPAA-eligibles except in those states utilizing existing individual market insurance reforms as the alternative mechanism to satisfy HIPAA's group-to-individual portability requirement.

² Only exclusion periods satisfied under group coverage can be credited.

³ HIPAA conforming legislation was not enacted in the 1997 session. Such legislation is expected to be introduced in the 1998 session.

⁴ Health plans required to offer an annual open enrollment period of 30 days for the three guaranteed issue products.

⁵ Preexisting condition exclusion periods cannot be applied to guaranteed issue products.

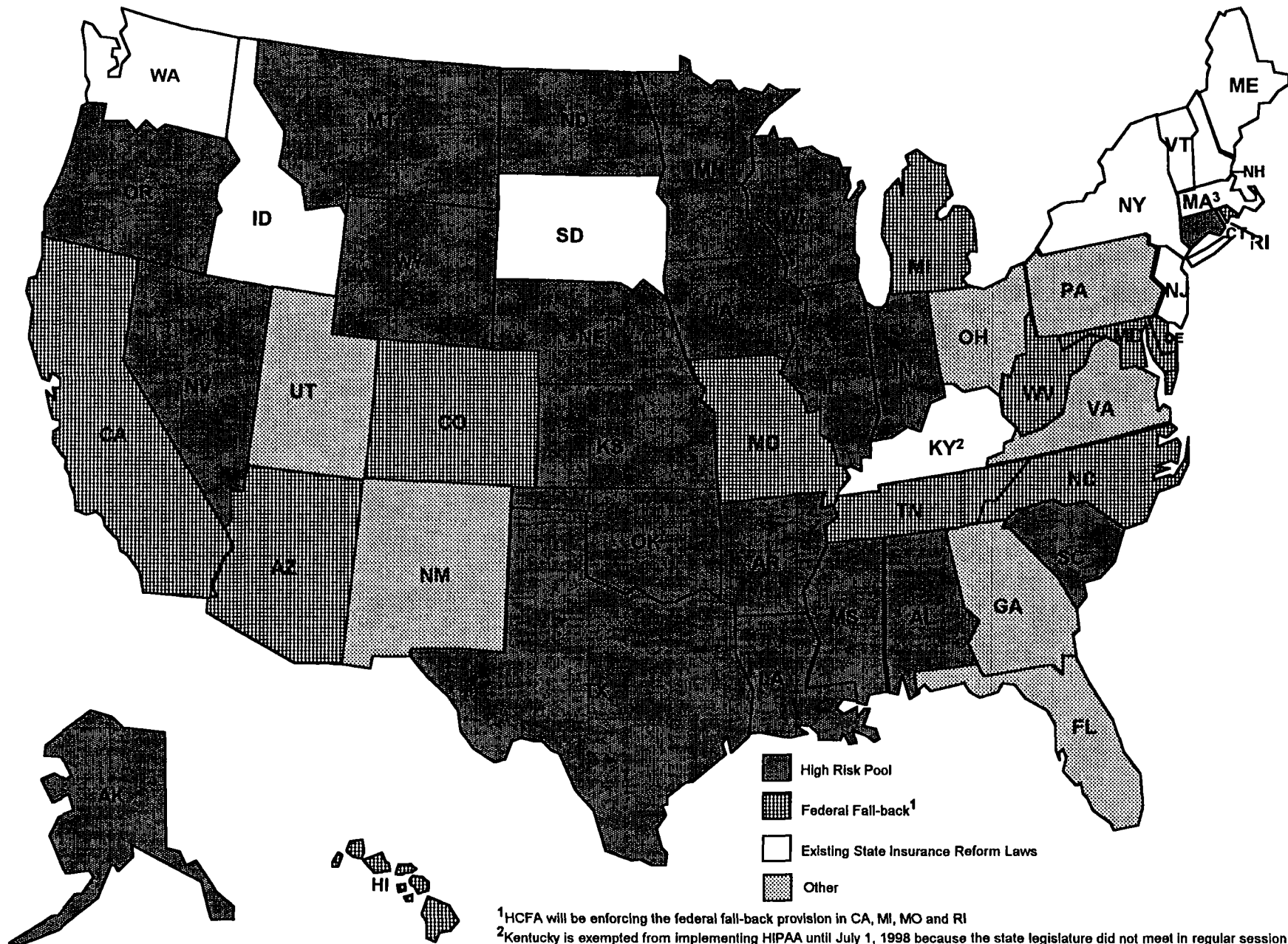
⁶ Commercial insurers: 12/6, BCBSMI and HMOs: 6/6

⁷ Health plans required to offer an annual open enrollment period of 60 days for all products.

⁸ Health plans required to guarantee issue five standardized products and five rider products. The rider products are under development.

⁹ Health plans required to offer coverage on a guaranteed issue basis until they reach an enrollment cap.

STATE IMPLEMENTATION: HIPAA GROUP-TO-INDIVIDUAL PORTABILITY PROVISION



Source: Blue Cross and Blue Shield Association, December 1997

¹HCFA will be enforcing the federal fall-back provision in CA, MI, MO and RI

²Kentucky is exempted from implementing HIPAA until July 1, 1998 because the state legislature did not meet in regular session in 1997.

³Provisions that would bring Massachusetts individual market reforms into compliance with HIPAA and allow the state to use it as the alternative mechanism have not yet been enacted. If the legislature does not enact these reforms, the state will use the federal HCFA enforcement.

State Implementation: HIPAA Group-to-Individual Portability Provision

State	Group-to-Individual Portability Provision
Alabama	Alternative mechanism: High Risk Pool.
Alaska	Alternative mechanism: High Risk Pool.
Arizona	Federal Fall-back.
Arkansas	Alternative mechanism: High Risk Pool.
California	Federal Fall-back with HCFA enforcement.
Colorado	Federal Fall-back.
Connecticut	Alternative mechanism: High Risk Pool.
Delaware	Federal Fall-back.
District of Columbia	Federal Fall-back.
Florida	Alternative mechanism: guaranteed issue to HIPAA-eligible persons; health plans required to offer a choice of conversion plans, mandating that one of them be the state approved "standard" policy currently offered in the small group market.
Georgia	Alternative mechanism: assigned risk pool. HIPAA-eligible persons may apply for coverage to the Insurance Commissioner who then "assigns" eligible individuals to health plans based on a health plan's pro rata volume of individual health insurance business done in the state.
Hawaii	Federal Fall-back.
Idaho	Alternative mechanism: existing state insurance reform laws: • guarantee issue: 3 products (basic, standard and catastrophic) • guarantee renewal • pre-existing conditions: note that SB 1249 leaves in place the 12/6 pre-existing condition waiting period in the individual market; pregnancy is also retained as a pre-existing condition in the individual market; coverage gap: 63 days • rating bands: limits rate variations to a range of 1.7:1 for experience, health status and duration and allows demographic adjustments for age and gender.
Illinois	Alternative mechanism: High Risk Pool.
Indiana	Alternative mechanism: High Risk Pool.
Iowa	Alternative mechanism: High Risk Pool.
Kansas	Alternative mechanism: High Risk Pool.

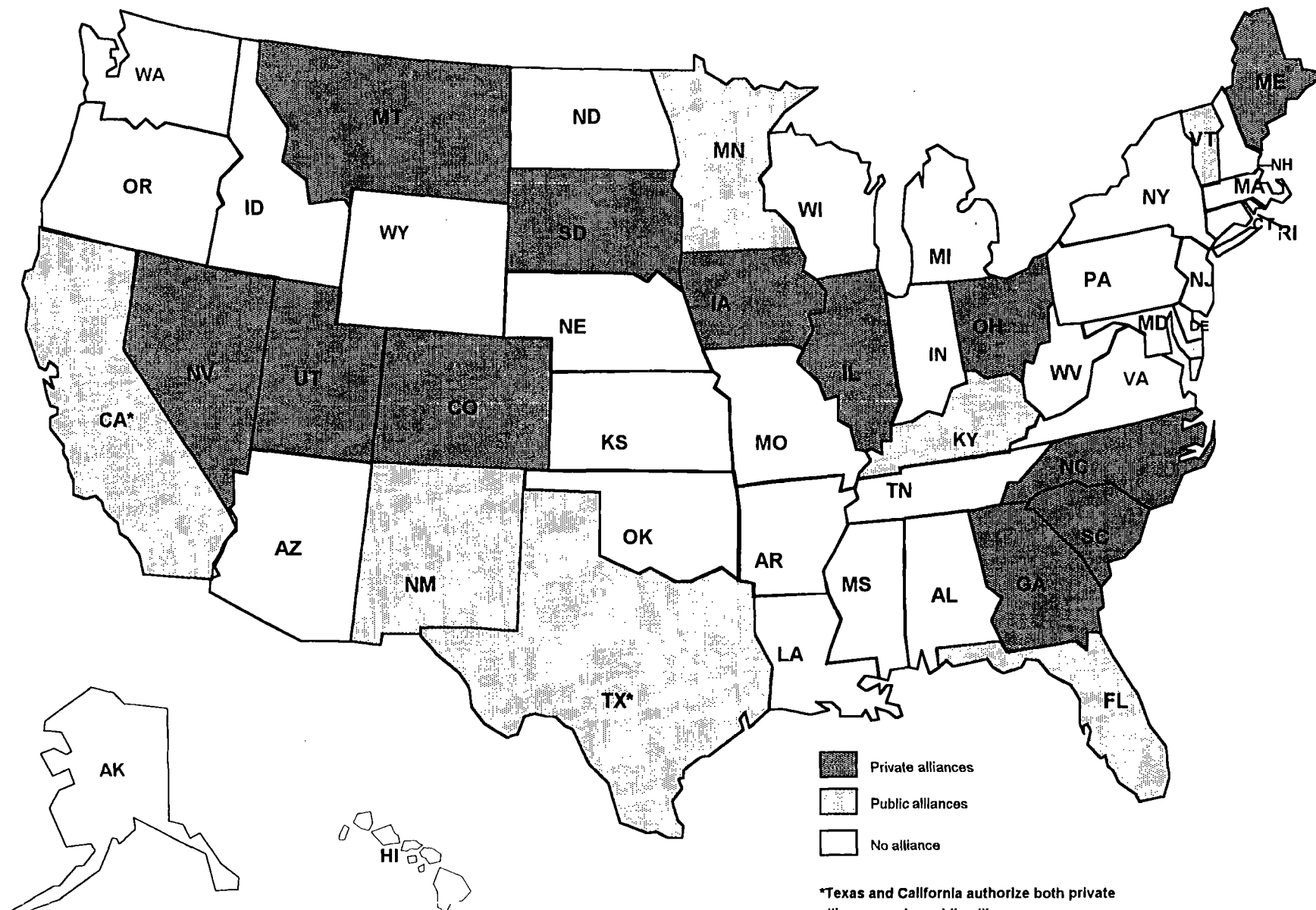
State	Group-to-Individual Portability Provision
Kentucky	Kentucky is exempted from implementing group to individual portability until July 1, 1998 because the state legislature did not meet in regular session in 1997. Given the insurance market reforms in place, it is likely that the state would seek a waiver to implement an alternative mechanism.
Louisiana	Alternative mechanism: High Risk Pool.
Maine	Alternative mechanism: existing state insurance reform laws: • guarantee issue: all products • guarantee renewal • pre-existing conditions: no pre-existing condition waiting period applied to HIPAA-eligibles; 12/6 for non-HIPAA-eligibles; coverage gap: 63 days • rating reform: community rating with adjustments limited to a range of 1.5:1 for age, smoking status, industry and geography
Maryland	Federal Fall-back.
Massachusetts¹	Alternative mechanism: existing state insurance reform laws: • guarantee issue: 3 standardized products (managed care, indemnity and preferred provider) • guarantee renewal • pre-existing conditions: 6/6; coverage gap: 30 days • rating reform: modified community rating with adjustments for age (2:1 until 11/30/99 then 1.5:1) and geography (1.5:1)
Michigan	Federal Fall-back with HCFA enforcement
Minnesota	Alternative mechanism: High Risk Pool.
Mississippi	Alternative mechanism: High Risk Pool.
Missouri	Federal Fall-back with HCFA enforcement.
Montana	Alternative mechanism: High Risk Pool.
Nebraska	Alternative mechanism: High Risk Pool.
Nevada	Federal Fall-back.

¹ Provisions that would bring individual market reforms into compliance with HIPAA and allow the state to use it as the alternative mechanism have not yet been enacted. If the legislature does not enact these reforms, the state will use the Federal Fallback with HCFA enforcement.

State	Group-to-Individual Portability Provision
New Hampshire	Alternative mechanism: existing state insurance reform laws: • guarantee issue: all products • guarantee renewal • pre-existing conditions: 9/3; coverage gap: 63 days • rating reform: community rating with 3:1 adjustments for age; upon renewal, a health plan is prohibited from increasing the premium rate by more than 25 percent of the rate which applied in the preceding year. Such rate increase limitation will not include any premium rate increase which is based on a health carrier's annual cost and utilization trends; changes in the number of covered members in the group; or changes in group composition due to members moving to a different age bracket. This subparagraph will expire on January 1, 2000.
New Jersey	Alternative mechanism: existing state insurance reform laws: • guarantee issue: 5 standardized products • guarantee renewal • pre-existing conditions: no pre-existing waiting period applied to HIPAA-eligibles; all other individuals: 12/6; coverage gap: 30 days • rating reform: pure community rating
New Mexico	Alternative mechanism: HIPAA-eligibles can choose to obtain coverage through either the High Risk Pool or the Purchasing Alliance.
New York	Alternative mechanism: existing state insurance reform laws: • guarantee issue: all products • guarantee renewal • pre-existing conditions: no pre-existing condition waiting period applied to HIPAA-eligibles; all other individuals: 12/6; coverage gap: 63 days • rating reform: community rating; permits adjustments for family composition and geographic regions
North Carolina	Federal Fall-back.
North Dakota	Alternative Mechanism: High Risk Pool.
Ohio	Alternative Mechanism: Separate open-enrollment period for HIPAA-eligibles until health plans meet their enrollment caps.
Oklahoma	Alternative mechanism: High Risk Pool.
Oregon	Alternative mechanism: High Risk Pool.
Pennsylvania	Alternative mechanism: Blue Cross and Blue Shield Plans in Pennsylvania as the guaranteed issue carrier. The Pennsylvania Blues Plans are currently the insurers of last resort.
Rhode Island	Federal Fall-back with HCFA enforcement.
South Carolina	Alternative mechanism: High Risk Pool.

State	Group-to-Individual Portability Provision
South Dakota	Alternative mechanism: existing state insurance reform laws: • guarantee issue to HIPAA-eligibles until these enrollees represent 2% of annual earned premium • guarantee renewal • pre-existing conditions: 12/6; coverage gap: 63 days • rating reform: limit adjustments for health status and claims experience to 2.2:1
Tennessee	Federal Fall-back
Texas	Alternative mechanism: High Risk Pool.
Utah	Alternative mechanism: combines High Risk Pool and existing individual market guaranteed issue requirement. An individual denied coverage by a health plan would be referred to the high risk pool which would determine whether that person is "too healthy" for the pool based on objective guidelines to be established. An individual who is "too healthy" must be covered by the health plan that had previously denied coverage. An individual who is not "too healthy" is eligible for coverage in the high risk pool.
Vermont	Alternative mechanism: existing state insurance reform laws" • guarantee issue: all products • guarantee renewal • pre-existing conditions: no pre-existing condition waiting period for HIPAA-eligibles; 12/12 for non-HIPAA-eligibles; coverage gap: 63 days • rating reform: community rating; health plans required to limit rating adjustments to a range of 1.5:1 for one or more factors approved by the Commissioner
Virginia	Alternative mechanism: guarantee issue all currently offered non-group products to HIPAA-eligibles.
Washington	Alternative mechanism: existing state insurance reform laws: • guarantee issue: all products • guarantee renewal: note that Washington state law is more far-reaching than HIPAA • pre-existing conditions: 3/3, however HIPAA-eligibles would have immediate portability because of the 90-day coverage gap • rating reform: health plans allowed to vary rates for geography, family size and age. Compression factors cannot exceed 4:1 after 1/1/97 and 3.75:1 after 1/1/00.
West Virginia	Federal fall-back
Wisconsin	Alternative mechanism: High Risk Pool
Wyoming	Alternative mechanism: High Risk Pool

STATE LAWS ESTABLISHING VOLUNTARY HEALTH ALLIANCES



Source: Blue Cross and Blue Shield Association, December 1997

STATE LAWS ESTABLISHING VOLUNTARY HEALTH ALLIANCES

State	Enacted	Governance	Number of Alliances	Alliance Design	Employer Group Size	Non-group individuals eligible	Medicaid eligible	Subject to small group regulations	Alliance Powers Health plan participation	Alliance Powers Negotiate discount	Alliance Powers Require standard benefit package
CA	1992	public	1	non-competing	2-50	no	no	yes ¹	select health plans	yes	yes
CA	1996	private	6	competing	all groups	no	no	yes ¹	accept all qualified health plans	yes	no
CO	1994	private	multiple	competing	all groups	yes	no	yes	select health plans	yes	yes
FL	1993	public	11	non-competing	1-50	no	yes	yes	accept all qualified health plans	no	yes
GA	1997	public	multiple	competing	2-50 ²	no	no	yes	accept all qualified health plans	no	no
IL	1997	private	multiple	competing	2-2500 ³	no	no	yes	accept all qualified health plans	yes	no
IA	1993	private	multiple	competing	2-50 ⁴	yes	no	yes	accept all qualified health plans	no	yes
KY	1994	public	1	non-competing	2-49 ⁵	yes	yes	yes	N/A	yes	yes
ME	1996	private	multiple	competing	all groups	yes	no	yes	at least 3 unaffiliated and qualified health plans	yes	yes
MN	1992	public	1	non-competing	2 or more	no	no	yes	select health plans	yes	yes
MT	1995	private	multiple	competing	2-50 ⁶	no	no	yes	select health plans	no	yes
NV	1995	private	multiple	competing	2-50	no	no	yes	select health plans	yes	yes
NM	1994, 1997	public	1	non-competing	2-50	no ⁷	no	yes	accept all qualified health plans	no	yes ⁸
NC	1993	private	4-12	non-competing	2-50	no	no	yes	accept all qualified health plans	no	yes
OH	1993	private	multiple	competing	2-150	no	no	yes	select 1 or more	no	no
SC	1994	private	multiple	non-competing	2-50	no	no	yes	accept all qualified health plans	no	yes
SD	1994	private	multiple	competing	N/A	yes	no	yes	N/A	N/A	no
TX	1993, 1997	public/ private ⁹	1	competing	all groups	no	no	yes	accept all qualified health plans	yes	yes
UT	1996	private	multiple	competing	all groups	no	no	yes	at least 3 unaffiliated health plans	no	yes
VT	1992	public	1	non-competing	N/A	N/A	yes ¹⁰	N/A	N/A	N/A	N/A

Source: Blue Cross and Blue Shield Association, December 1997

¹ Health plans can establish separate community rates inside and outside the alliance.

² The self-employed and large employers may join the cooperative at the option of the health plan.

³ May also include self-employed individuals.

⁴ May be offered to large employers (more than 50), association groups, state/local government units, and any other purchaser on a voluntary basis.

⁵ Voluntary for individuals, small employers, association groups of 50 or fewer; mandatory for state employees.

⁶ May accept large employees (51 or more employees). State and local government employees may also purchase health insurance coverage through health alliances.

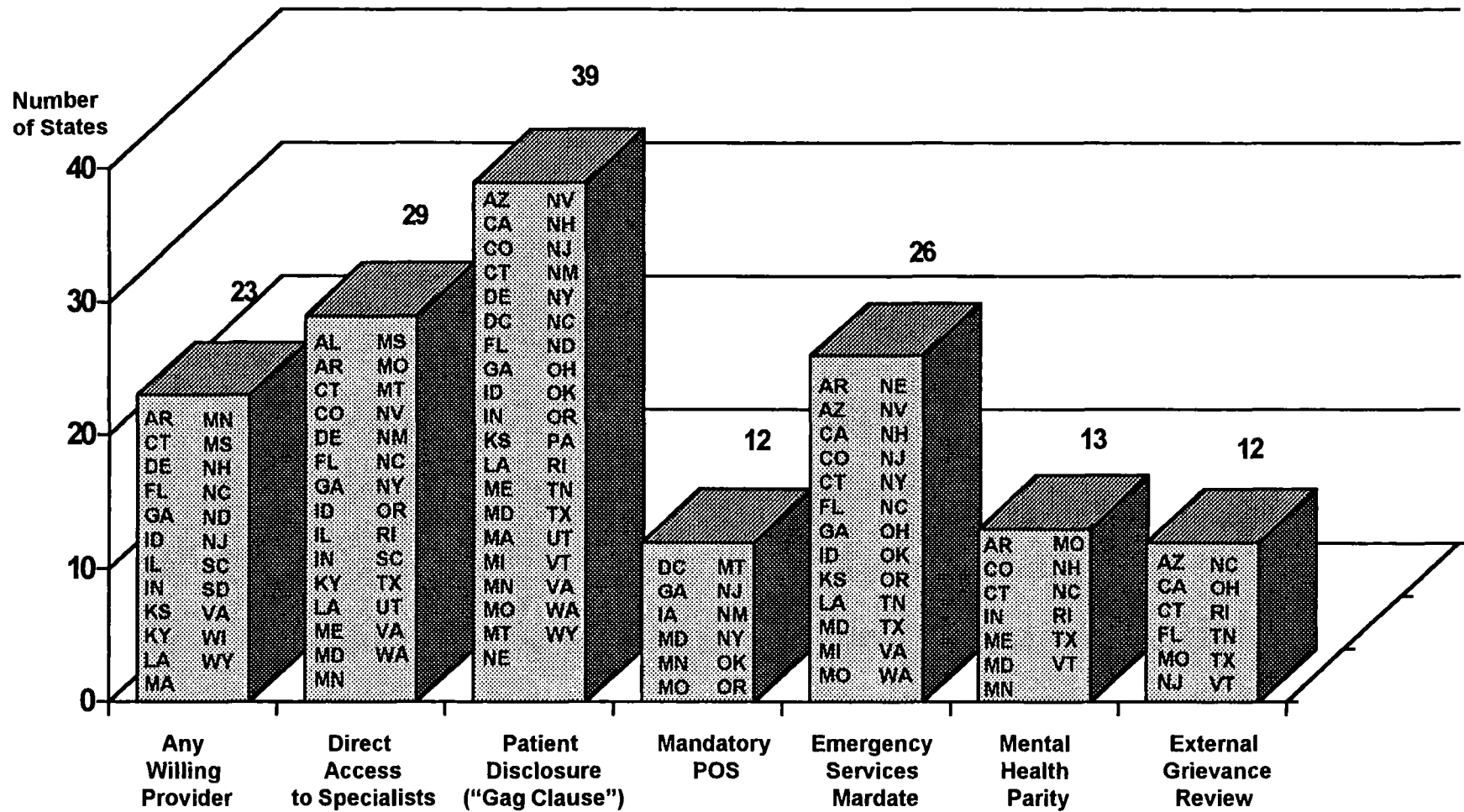
⁷ May also include individuals who meet HIPAA eligibility requirements.

⁸ An approved plan shall, at a minimum, reflect coverage levels generally available in small employer group policies.

⁹ The law also allows for the establishment of multiple, private alliances that can compete with other or the public alliance.

¹⁰ In addition to Medicaid, the Secretary of Administration can expand eligibility to certain public employers or any employer group, association or trust.

STATE LAWS REGULATING MANAGED CARE



Source: Blue Cross and Blue Shield Association, December 1997

STATE LAWS REGULATING MANAGED CARE

Definitions

1. **Any Willing Provider:** Laws that compel health plans to admit to their networks any provider willing to abide by the terms and conditions of the contract. Only applies to pharmacies, except in 5 states where scope includes most providers (i.e., ID, IN, KY, VA, WY).
2. **Direct Access to Specialists:** Laws that allow subscribers to go directly to a specialist without prior referral from the health plan's primary care physician (e.g., primarily applies to OB-GYNs, but also can refer to chiropractors, dermatologists, etc.).
3. **Patient Disclosure/"Gag Clause":** Laws that ban health plans from including so-called "gag clauses" in provider contracts that prohibit or discourage a provider from discussing alternative treatment options and appropriate care with patients.
4. **Mandatory Point-of-Service (POS):** Laws that require health plans to offer a POS product to employer groups at the employer's option, in addition to a gatekeeper product like an HMO. However, two states (ID and MT) go further by imposing a mandatory POS requirement (i.e., an HMO must transform itself into a POS plan).
5. **Emergency Services Mandate:** Laws that impose new requirements to pay for certain care delivered in an emergency room (e.g., initial screening exam, stabilization services). Several of the laws also impose a "prudent layperson" standard to define what constitutes a medical emergency.
6. **Mental Health Parity:** Laws that require health plans to provide equivalent benefits and cost-sharing requirements for mental and physical illnesses. These states generally have limited parity mandates that either limit the definition of mental illness, the scope of benefits, and/or allow increased cost-sharing.
7. **External Grievance Review:** Laws that require health plans to allow enrollees to appeal a coverage or claims denial to an outside medical expert or panel, if dissatisfied with the outcome of the plan's internal appeals process.

1997 State External Grievance Review Laws

	SCOPE OF REVIEW	WHO INITIATES REVIEW?	BASIS FOR REVIEW	WHO PERFORMS REVIEW?	DECISION
AZ SB 1098	Managed Plans Insurers	Enrollee, Treating MD Health Plan	Any Coverage/Claims Denial	Plan Selects Reviewer(s) from DOI Approved List	Binding
CA* AB 1663	Managed Plans Insurers	Enrollee	Denials of Experimental Treatments	DOI/DOC Accredits Review Entity which Selects Expert(s)	Binding
CT HB 6883	Managed Plans	Enrollee, Provider	Any Coverage/Claims Denial	DOI Assigns to Review Entity which Selects Expert(s)	Binding
FL HB 297	HMOs	Enrollee, Provider	Any Coverage/Claims Denial	State Provider and Subscriber Assistance Program	Advisory
MO HB 335	Managed Plans	Enrollee, Provider, Health Plan	Any Coverage/Claims Denial	DOI Assigns to Review Entity which Selects Expert(s)	Binding
NJ SB 269	HMOs	Enrollee, Provider	Any Coverage/Claims Denial	DOI Assigns to Review Entity which Selects Expert(s)	Advisory
NC SB 932	Managed Plans Insurers	Enrollee, Provider	Any Coverage/Claims Denial	Plan Selects 3 Reviewers (One Plan employee only)	Advisory
OH HB 361	Managed Plans Insurers	Enrollee, Provider	Denials of Experimental Treatments	Plan Retains Review Entity which Selects 1-3 Experts	Binding
RI* HB 7683	Managed Plans Insurers	Enrollee, Provider	Any Coverage/Claims Denial	DOH Accredits Review Entity which Selects Expert(s)	Binding
TN SB 1587	HMOs	Enrollee	Any Coverage/Claims Denial	DOI or Designee Selects Expert(s)	Advisory
TX SB 386	Managed Plans Insurers	Enrollee, Provider, Health Plan	Denials Based on Medical Necessity	DOI Accredits Review Entity which Selects Expert(s)	Binding
VT* HB 171	Managed Plans Insurers	Enrollee, Provider	Denials of Mental Health Care Treatments	DOI Appoints Review Panel of Experts	Binding

*CA and RI laws enacted in 1996; VT enacted in 1995

Source: Blue Cross and Blue Shield Association, December 1997

STATE MANDATED BENEFITS AND PROVIDERS

	AL	AK	AZ	AR	CA	CO	CT	DC	DE	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT	
BENEFITS																												
Alcoholism Treatment	79	88		87	88	76	74	90		83	76	88		82			86	78	80	74	88	73	82	82	74	81	79	
Ambulatory Surgery			71	81						77		74						78							76		81	
Breast Reconstruction			81	97	78					97				80	97				97	97	96			85	80		97	97
Cervical Cancer Screening		96			90			90	88		92			97					91	96		87		88				
Diabetic Supplies				97	81		97			95					97	84			97	96	97				97			
Drug Abuse Treatment	79	88		87	88		90	90		83	75	88					86		80	83	88		82	82		81	81	
Home Health Care			82		78	84	75			87								82		77	82	86					81	
Hospice Care						84															82		84					
Invitro Fertilization				87			88					87		91							89	87						
Off-Label Drug Use	94			95	92		94			95	93			92	93				97		94	92			91			
Mammography Screening	97	91	88	88	87	89	88	90	93	88	92	90	92	89	81	89	88	90	91	90	91	87	89	88		90	91	
Minimum Maternity Stays	96	96	97	97	97	97	96	96	97	96	96	97	97	96	96	96	96	96	97	96	96	95	97	96	97	96	97	
Mental Health Care				83	92*	76	90	90		83	84	88		77			86	86	76	93	93	81		87	81	91	81	
Minimum Mastectomy Stays				97			97			97				97						97						97	97	
TMJ Disorders										96	94			94				90						87	91			
Well-Child Care				95	92	95	89	92		86	95	88				93	95		92		92	88		88		89	91	
PROVIDERS																												
Acupuncturists					84					89																	91*	
Chiropractors	75	83	87	75	76		89		93	86	80			82	90	86	73	86	75	89	73	87	79	73	80	78	67*	
Dentists	75	92	89	79	76		75			86		74			74	88	73		89	75	73	75	85*	73	74	78	83	
Licensed Health Prof.				75										82	90						83							
Nurses						90										89												
Nurse Midwives		83	85		91	90	84		88	83									84		78	85	91	83	80		87	
Nurse Anesthetists			85			90									95		90				84	93		83	80		87	
Nurse Practitioners		88	85		91	90	84		90							96	90				79			88	80		87	
Nurse, Psychiatric					82	90	84			83										83	83	86		88				
Occupational Therapists		87			78		82			87									90		83			87				
Optometrists	67	92	77	93	80		75		65*	89	88			80	74	83	73			82	73	75	85*	73	66	78		
Osteopaths		83		75						87				82							73							
Physical Therapists		87					75														83			73				
Podiatrists	76		77	79	76				65*	74				89	74		73				73	75	85*	73		78		
Professional Counselors				91	81					83										96	85	96					87	
Psychologists	82		77	79	80	79	75			83	80	84		82	85		74		76	75	73	75	85*	89	74	83	81	
Public & Other Facilities			87	81	84		84			89			90		85					79	82		68	73	68		73	
Social Workers					76	91	74			84				90			89			83	77	81	83	93	92		85	
Speech/Hearing Therapists		92		86	78														90		83					84		
PERSONS COVERED																												
Continuation/Dependents				85	97	90	75			96	81			85			86	84	80	93	86	77			77	95	69	
Continuation/Employees				85	97	90	75			96	92	74	75	84			86	84	80	93	86	79	96		73	72	85	81
Conversion to Non-Group			85	85	83	90				78	86		96	83	95	86	80	74	92	82	79		85	77		81	81	
Dependent Students							82			92	78									78				93				
Handicapped Dependents			77	69	71		71			70	72	68	72	67	86					72		77	56	66	69	72		71
TOTAL	10	14	16	26	29	17	26	7	8	31	17	12	6	21	15	12	17	11	21	21	33	21	16	29	17	18	22	

Notes: The date refers to year enacted or revised. Mandated offerings are shaded. Mandates that do not apply to BCBS Plans are asterisked.

Source: Blue Cross and Blue Shield Association, December 1997

STATE MANDATED BENEFITS AND PROVIDERS

	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	TOTAL
BENEFITS																									
Alcoholism Treatment	80	83		77	83	83	84	89	78		87	86	80	84	79	82	89	86	85	83	87	82	88		43
Ambulatory Surgery									76																8
Breast Reconstruction		83	97	97		97	97		97		97	96				97	97				85		97		25
Cervical Cancer Screening		89			92	92	91		92		93	94	88							96					19
Diabetic Supplies		97	97	95	97	93	97		96	87		96				97	97		97			96	84		24
Drug Abuse Treatment		83				87	84	89			87	89	87	84		82	89	85		87	87		88		31
a Health Care				77	77	75							84*				87		76		83		78		18
Hospice Care		89				85															83				6
Invitro Fertilization												91					87								8
Off-Label Drug Use				94		90	93		94	93			94	96		97				97					21
Mammography Screening	95	89	88	91	90	89	91	89	92	89	93	89	88		91	89	87		91	96	89	89	90		47
Minimum Maternity Stays	97	97	96	95	95	96	95	97	96	96	97	96	96	96	96	96	97	97	97	96	96	97	97	97	51
Mental Health Care			83			77		89	83		87			84		80	81		76	97	83	90	88		32
Minimum Mastectomy Stays				97	97	97	97			97		97	97												14
TMJ Disorders		89			89		95	89									89			95	89	89	97		15
Well-Child Care	94				97	83			93	94		92	88				97	85		90		94	75		28
PROVIDERS																									
Acupuncturists		75			89						89														6
Chiropractors	67	82		80	84	97	73	89	80	89		80	87	80		81	79	75		88	83	96	87		42
Dentists	75	75		79	77*	75	75		73	89	80	49				74	83			68			75		34
Licensed Health Prof.															80			85					71		7
Nurses		85		84	84		85					86									81				8
Nurse Midwives	84	90		82	85	82	93	85	84	71		81	90		80	94		79		97	81	83			31
Nurse Anesthetists							85					88			89										12
Nurse Practitioners			85				93	85			79	88	91		80	96					81				21
Nurse, Psychiatric		90					93	89				88	91							89		77			15
Occupational Therapists																									7
Optometrists	69	75		67	77*	75	73		80	71	71	78		85	80	65	79	75		77			75		37
Osteopaths	67	75			77*				80	89		49			80		88			77					14
Physical Therapists				75	89	73						82								87			71		10
Podiatrists	69	75			77*	75	73		80	89		67		72	80	65	77	75		79	83		75		30
Professional Counselors			83										93			94	89	96		87					13
Psychologists	74	80	75	73	77*	71	77	87	74	71	75	88		94	89	92	77	75		77			94	85	41
Public & Other Facilities	84						75		76		81						83				87		80	75	21
Social Workers		87	94			85	93	89			89				88	95	87	75		87					24
Speech/Hearing Therapists						93						94				86	83			89					11
PERSONS COVERED																									
Continuation/Dependents	89	95	81		83	92	83	87		86	83		83	78	80	86	79	86	85	79	85	83	80		35
Continuation/Employees	89	95	85			92		81		86	85					86	77	86	85	79	84	82	80	95	38
Conversion to Non-Group	78	95			83	81	82	83	84		81	76*	78	78	79	80	77	79	85	88	84		80	83	39
Dependent Students	76							81																	7
Handicapped Dependents			69	66	69	89	73	83	71			68		70	69	69	81	75	83	74	69		75	71	35
TOTAL	16	23	12	16	21	27	23	19	17	17	17	23	19	12	16	22	25	16	10	25	19	12	20	8	

Notes: The date refers to year enacted or revised. Mandated offerings are shaded. Mandates that do not apply to BCBS Plans are asterisked.

Source: Blue Cross and Blue Shield Association, December 1997

ADDITIONAL MANDATED BENEFITS

AK Naturopaths (87) Formula for PKU (92) Prostate cancer screening (96)	MD Blood products (75) Catastrophic (78+) Cleft palate (82) Alzheimers (86+) Physician assistants (86) Formula for PKU (95) Bone mass measurement (97)	NC Prescription drugs (79) Cleft palate (92) Prostate cancer screening (93) Pastoral counselors (95)
AR Psych. examiners (91)		NV Formula for PKU (97)
CA Prenatal care (79+) Infertility services except IVF (89) Blood lead screening (91+) Experimental treatments (96)	MA Blood lead screening (88) Enteral formula (93) Bone marrow transplants (94) Formula for PKU (94)	ND Prescription drugs (79+) Formula for PKU (97) Prostate cancer screening (97)
CO Cleft palate (87+) Prostate cancer screening (95)	MI Oral surgeons (85) Physician assistants (91)	OK Bone mass measurement (96)
CT Tumor/leukemia (79) Marriage/family therapists (92) Formula for PKU (97)	MN Formula for PKU (85) Hair prostheses (87) Cleft palate (88) Elimination of port-wine stains (93) Marriage/family therapists (93) Bone marrow transplants (95) Lyme's disease (96) Prostate cancer screening (96)	PA Birthing centers (82) Chemotherapy (89) Formula for PKU (96)
DE Prostate cancer screening (92)	MO Pharmacists (78) Bone marrow transplants (95+) Formula for PKU (97)	RI Newborn sickle cell testing (88) Blood lead screening (91) Newborn hearing test (92) Marriage/family therapists (93) Investigational cancer therapies (94)
FL Oral surgeons (87) Bone marrow transplants (92) Marriage/family therapists (92) Massage therapists (92) Infertility services except IVF (94) Formula for PKU (95)	MT Denturists (85) Formula for PKU (89) Physician assistants (89) Infertility services except IVF (95)	SD Formula for PKU (92+)
GA Prostate cancer screening (92) Bone marrow transplants (95+)		TN School psychologists (82) Bone mass measurement (96) Formula for PKU (96) Chemotherapy (96) Prostate cancer screening (97)
HI Contraceptives (95)	NH Oral surgeons (75) Bone marrow transplants (92) Hair prostheses (92) Formula for PKU (95)	TX Dieticians (87) Alzheimers (89) Formula for PKU (89) Bone mass measurement (95) Prostate cancer screening (97)
ID Cleft palate (85)	NJ Chiropodists (53) Wilm's tumor (90) Bone marrow transplants (95+) Blood lead screening (95) Prostate cancer screening (96) Formula for PKU (97)	VA Chiropodist (77) Opticians (77) Bone marrow transplants (94+) Contraceptives (97)
IL Oral surgeons (82) Pharmacists (89) Prostate cancer screening (97)	NM Lay midwives (85) Infertility services except IVF (94)	WA Formula for PKU (88) Neurodevelopment therapy (89)
IN Cleft palate (85)		WV Infertility services except IVF (93)
IA Physician assistants (96)	NY Ambulatory cancer treatment (82) Formula for PKU (93) Infertility services except IVF (94)	WI Kidney disease (74)
KY Bone marrow transplants (96)		WY Dieticians (91+)
LA Cleft palate (89) Prostate cancer screening (97)		
ME Prescription drugs (83) Formula for PKU (95) Marriage/family therapists (96+) Pastoral counselors (96+)		

Notes: The date refers to year enacted or significantly revised.

+ indicates that the mandate only has to be offered to groups/individuals, as opposed to a mandated requirement.

Source: Blue Cross and Blue Shield Association, December 1997

STATE MEDICAL SAVINGS ACCOUNT LAWS

State	Key Features	Enacted
Arizona	• tax exemption for individuals and employers • annual contributions up to \$2,000 for account holder and \$1,000 per dependent up to two	1994, 1997
Arkansas	• tax deduction for individuals and tax exemption for employers • annual contribution: 65% of the annual deductible under a high deductible health plan for individual coverage; 75% of the annual deductible under a high deductible health plan for family coverage	1997*
California	• tax deduction for individuals and employers • annual contribution: 65% of the annual deductible under a high deductible health plan for individual coverage; 75% of the annual deductible under a high deductible health plan for family coverage	1996*
Colorado	• tax exemption for individuals and employers • annual contribution up to \$3,000 for account holder	1994
Florida	• tax deduction for individuals and tax exemption for employers • annual contribution: 65% of the annual deductible under a high deductible health plan for individual coverage; 75% of the annual deductible under a high deductible health plan for family coverage • HMOs allowed to offer MSAs	1997*
Idaho	• tax exemption for individuals • annual contribution up to \$2,000 for account holder	1995
Illinois	• tax exemption for individuals • annual contribution up to \$3,000 for account holder	1994
Indiana	• tax exemption for individuals and employers • annual contribution up to \$5,000 for account holder	1995
Louisiana	• tax deduction for individuals and tax exemption for employers • annual contribution: 65% of the annual deductible under a high deductible health plan for individual coverage; 75% of the annual deductible under a high deductible health plan for family coverage	1996, 1997*
Maryland	• tax deduction for individuals and tax exemption for employers • annual contribution: 65% of the annual deductible under a high deductible health plan for individual coverage; 75% of the annual deductible under a high deductible health plan for family coverage	1997*

STATE MEDICAL SAVINGS ACCOUNT LAWS

State	Key Features	Enacted
Michigan	• tax exemption for individuals and employers • annual contribution up to \$3,000 for account holder	1994
Mississippi	• tax exemption for individuals and employers • annual contribution: 65% of the annual deductible under a high deductible health plan for individual coverage; 75% of the annual deductible under a high deductible health plan for family coverage • 1996 law expanded MSAs to state employees	1994, 1996, 1997*
Missouri	• tax exemption for individuals and employers • annual contributions levels set at the employers' discretion	1993
Montana	• tax exemption for individuals and employers • annual contribution up to \$3,000 for account holder • establishes MSA pilot project for Medicaid recipients to begin January 1999	1995, 1997
Nevada	• provides for regulation of MSAs • does not exempt funds in MSAs from state taxes	1995
New Jersey	• tax deduction for individuals and tax exemption for employers • annual contribution: 65% of the annual deductible under a high deductible health plan for individual coverage; 75% of the annual deductible under a high deductible health plan for family coverage	1997*
New Mexico	• tax deduction for individuals and tax exemption for employers • annual contribution: 65% of the annual deductible under a high deductible health plan for individual coverage; 75% of the annual deductible under a high deductible health plan for family coverage	1995, 1997*
Ohio	• tax exemption for individuals • annual contribution up to \$3,000 per year	1996
Oklahoma	• tax exemption for individuals and employers • annual contribution up to \$2,000 for account holder, \$2,000 for spouse and \$1,000 per dependent	1995, 1996
Pennsylvania	• tax exemption for individuals and employers • annual contribution up to \$3,000 for account holder • tax treatment provisions designed to be consistent with provisions for the federal MSA demonstration project	1996
South Dakota	• resolution to Congress	1995
Texas	• establishes MSA pilot project for Medicaid recipients	1995

Source: Blue Cross and Blue Shield Association, December 1997

STATE MEDICAL SAVINGS ACCOUNT LAWS

State	Key Features	Enacted
Utah	• tax exemption for individuals and employers • annual contribution up to \$2,000 for account holder	1995
Virginia	• contingent on enactment of MSAs at federal level • would be available solely to working poor and Medicaid recipients	1995
Washington	• authorizes creation of MSAs • no guidelines set because state does not have an income tax	1995
West Virginia	• tax exemption for individuals and employers • annual contribution: 65% of the annual deductible under a high deductible health plan for individual coverage; 75% of the annual deductible under a high deductible health plan for family coverage	1995, 1997*
Wisconsin	• tax exemption for individuals and employers • annual contribution up to \$2,000 for account holder, \$2,000 for spouse and \$1,000 per dependent • contingent on enactment of broad federal law	1996
Wyoming	• resolution to Congress	1995

*Conforms to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). For individual coverage, HIPAA defines a high deductible health plan as having an annual deductible which is not less than \$1,500 and not more than \$2,250; and for family coverage, a high deductible health plan has an annual deductible which is not less than \$3,000 and not more than \$4,500. Beginning in 1999, deductible limits will be adjusted annually in \$50 increments for increases in the cost of living, as measured by the medical costs component of the Consumer Price Index.

The MSA provisions under HIPAA allow for a limited demonstration project. States may pass MSA laws to conform to the HIPAA MSA provisions, but are not required to. The MSA law contains no preemption provision. As a result, a state that permits or requires an MSA with features that are not permitted by HIPAA is creating a situation where an insurer could market an MSA, but the MSA would not be entitled to the federal tax preferences.

**STATE LAWS REGULATING
HEALTH PLAN RESTRUCTURING**

State	For-Profit Conversion	Mutualization/ Demutualization	Mergers & Acquisitions/ Consolidations
Alabama			
Alaska			
Arizona			
Arkansas			
California	1995, 1996 LAW	1996 LAW*	
Colorado	1996, 1997 LAW		1997 LAW
Connecticut			
Delaware			
District of Columbia	1996 LAW	1996 LAW*	1997 LAW
Florida		1997 LAW*	
Georgia	1995 LAW		
Hawaii			
Idaho		1994 LAW	
Illinois		1994 LAW	
Indiana			1997 LAW
Iowa		1996 LAW*	
Kansas	1997 LAW	1997 LAW*	1997 LAW
Kentucky			
Louisiana		1997 LAW*	
Maine	1997 LAW	1997 LAW	
Maryland	1997 LAW	1997 LAW	
Massachusetts			
Michigan			
Minnesota		1996 LAW*	
Mississippi			
Missouri		1996 LAW*	
Montana			
Nebraska	1997 LAW	1993, 1997 LAW**	1997 LAW
Nevada			
New Hampshire	1997 LAW		1997 LAW
New Jersey		1995 LAW	
New Mexico			
New York			
North Carolina			
North Dakota	1997 LAW	1997 LAW**	
Ohio	1997 LAW	1996, 1997 LAW*	1997 LAW
Oklahoma			

STATE LAWS REGULATING HEALTH PLAN RESTRUCTURING

State	For-Profit Conversion	Mutualization/ Demutualization	Mergers & Acquisitions/ Consolidations
Oregon	1997 LAW	1997 LAW*	
Pennsylvania	1995 LAW	1995 LAW	
Rhode Island		1996 LAW*	
South Carolina			
South Dakota			
Tennessee			1997 LAW
Texas	1997 LAW	1997 LAW*	
Utah			
Vermont		1996 LAW*	1997 LAW
Virginia	1996, 1997 LAW	1996 LAW	1997 LAW
Washington			
West Virginia			
Wisconsin			
Wyoming			
Total	15	21	10

* Enacts Mutual Holding Company statute. The **California** statute only applies to mutual life insurers.
The **Oregon** statute also allows mutual insurance companies to demutualize.

** Enacts both the mutualization statute and the Mutual Holding Company statute.

Source: Blue Cross and Blue Shield Association, December 1997

STATE HIGH-RISK HEALTH INSURANCE POOLS

	Year Operational	Current Enrollees	Premium Cap ¹	Funding Source
Alabama ²	1998	0	125-200%	Assessment
Alaska	1993	179	200%	Assessment
Arkansas	1996	401	150%	Assessment
California ³	1991	19,919	125%	Tobacco Tax
Colorado	1991	1,227	150%	Tax Surcharge
Connecticut	1976	1,477	125-150%	Assessment
Florida ³	1983	1,418	200-250%	Assessment
Illinois ³	1989	4,986	125-150%	Gen Revenue ⁴
Indiana	1982	4,313	150%	Assessment
Iowa	1987	810	150%	Assessment
Kansas	1993	976	—	Assessment
Louisiana	1992	677	150-200%	Gen Revenue/ Patient Surcharge
Minnesota	1976	27,552	125%	Assessment/ Provider Surcharge
Mississippi	1992	1,250	150-175%	Assessment
Missouri	1992	1,076	150-200%	Assessment
Montana	1987	321	150-400%	Assessment
Nebraska	1986	3,627	135%	Assessment
New Mexico	1988	811	150%	Assessment
North Dakota	1982	1,302	135%	Assessment
Oklahoma	1996	355	125%	Assessment
Oregon	1990	5,144	125%	Assessment
South Carolina	1990	964	200%	Assessment
Texas	1998	0	150-200%	Assessment
Utah ³	1991	714	150%	Gen Revenue
Washington	1988	712	150%	Assessment
Wisconsin	1981	8,099	150-200%	Assessment/ Lower Provider Reimbursement
Wyoming	1991	349	125-150%	Assessment

¹ Refers to state-imposed limits that cap premiums at no more than a fixed percentage above the standard premium charged by private health plans for individual coverage in the state.

² Enrollment is limited to HIPAA-eligibles.

³ Risk Pool currently operates with periodic enrollment caps.

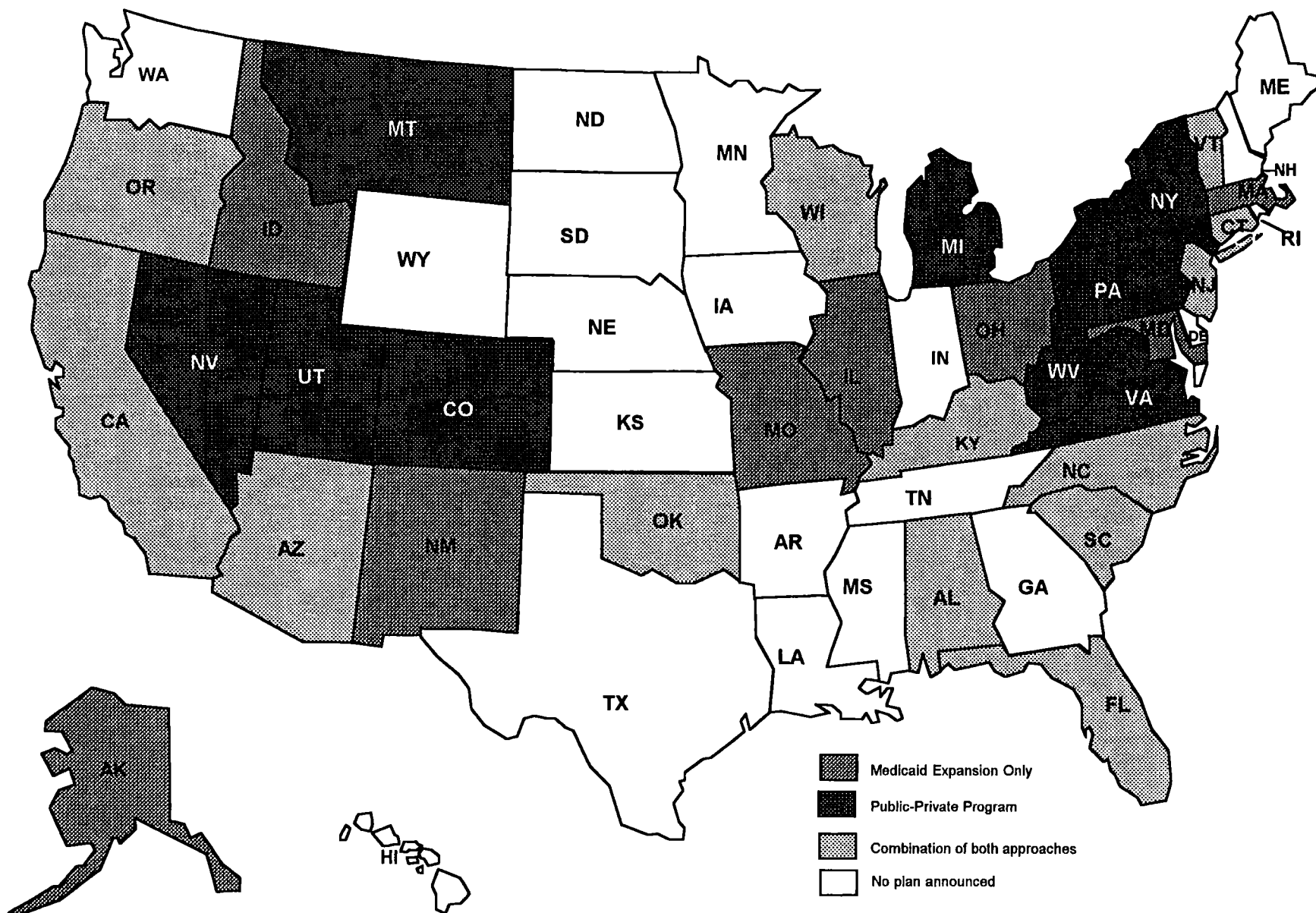
⁴ The new HIPAA-CHIP risk pool for HIPAA-eligibles is funded by an assessment of all health plans.

STATE MEDICAID SECTION 1115 MANAGED CARE WAIVERS

	Implemented	Approved	Under Review by HCFA
Alabama	1997		
Arizona	1982		
Arkansas	1997		
Delaware	1996		
Florida		1994	X
Georgia			X
Hawaii	1994		
Illinois		1996	
Kentucky	1997		
Louisiana			X
Maryland	1997		
Massachusetts	1997		
Minnesota	1995		
Missouri			X
New Hampshire			X
New Jersey			X
New York	1997		
Ohio	1996		
Oklahoma	1996		
Oregon	1994		
Rhode Island	1994		
Tennessee	1994		
Texas			X
Utah			X
Vermont	1996		
Washington			X
TOTALS	16	2	9

Source: Blue Cross and Blue Shield Association, December 1997

PRELIMINARY STATE APPROACHES TO IMPLEMENTING THE 1997 FEDERAL CHILDREN'S HEALTH INSURANCE PROGRAM



Source: Blue Cross and Blue Shield Association, December 1997

**STATE IMPLEMENTATION: 1997 FEDERAL CHILDREN'S HEALTH INSURANCE PROGRAM
(TITLE XXI OF THE SOCIAL SECURITY ACT)**

State	Expected Approach	Status
Alabama	- Medicaid expansion to 100% FPL through age 18. - Also considering state-subsidized private insurance program.	SB 35 enacted Plan sent to HCFA
Alaska	Medicaid expansion to 200% FPL through age 18.	Governor's proposal
Arizona	New state-designed program similar to state's Medicaid managed care initiative.	Governor's proposal
Arkansas	May not apply for Title XXI; ARKids program does not qualify.	Under consideration
California	- Medicaid expansion to 100% FPL through age 19. - Private purchasing pool for children from 100%-200% FPL.	AB 1126 & SB 903 enacted Plan sent to HCFA
Colorado	Expanding existing state-subsidized insurance program (Child Health Plan Plus) to 185% FPL through age 17.	SB 5 enacted Plan sent to HCFA
Connecticut	- Medicaid expansion to 185% FPL through age 18. - State-subsidized insurance program from 185%-300% FPL.	HB 8601 enacted
Delaware	Commission established to examine options.	Under consideration
Florida	- Medicaid expansion to 100% FPL through age 18. - Expansion of existing state-subsidized insurance program (Healthy Kids) to 185% FPL.	Plan sent to HCFA
Georgia	Examining options (including Healthy Kids implementation).	Under consideration
Hawaii	Examining options (likely to focus on Medicaid expansion)	Under consideration
Idaho	Medicaid Expansion to 160% FPL to age 19.	Under consideration
Illinois	Medicaid expansion to 133% FPL for children ages 1-18 and to 200% FPL for pregnant women and infants, as first step.	Governor's proposal
Indiana	Work group examining options.	Under consideration
Iowa	Work group examining options.	Under consideration
Kansas	Work group examining options.	Under consideration
Kentucky	- Considering state-subsidized insurance program. - May expand Medicaid to all children under 100% FPL.	Under consideration
Louisiana	Task force examining options.	Under consideration
Maine	Commission examining options.	Under consideration
Maryland	Medicaid expansion to 200% FPL through age 18.	Governor's proposal
Massachusetts	Medicaid expansion to 200% FPL through age 19.	Chpt. 170 enacted
Michigan	New program to 200% FPL offered through qualified plans.	Plan sent to HCFA
Minnesota	Exploring options for funding state Medicaid program (MinnesotaCare).	Under consideration

State	Expected Approach	Status
Mississippi	• Work group examining options.	Under consideration
Missouri	• Medicaid expansion to 300% FPL.	Plan sent to HCFA
Montana	• Examining options (likely to create a public-private pilot).	Under consideration
Nebraska	• Work group examining options.	Under consideration
Nevada	• New state-subsidized insurance program for children 0-18.	Governor's proposal
New Hampshire	• Work group examining options.	Under consideration
New Jersey	• Medicaid expansion to 133% FPL and new state-subsidized private insurance program from 133%-200% FPL.	Governor's proposal
New Mexico	• Medicaid expansion to 235% FPL.	Under consideration
New York	• Child Health Plus expansion to 222% FPL through age 19.	Plan sent to HCFA
North Carolina	• New state-designed program similar to Medicaid.	Governor's proposal
North Dakota	• Work group examining options.	Under consideration
Ohio	• Medicaid expansion to 150% FPL through age 18.	SB 215 enacted
Oklahoma	• Medicaid expansion for children through 185% FPL. • Examining a separate state-designed insurance program.	Under consideration
Oregon	• Medicaid expansion to 150% FPL through age 18. • May expand insurance subsidy program to 170% FPL.	Under consideration
Pennsylvania	• Expansion of existing state-subsidized insurance program (CHIP) to 185% FPL from ages 1-17.	Plan sent to HCFA
Rhode Island	• Examining options (including a family subsidy program).	Under consideration
South Carolina	• New program similar to existing Medicaid managed care program for children to 150% FPL through age 19.	Plan sent to HCFA
South Dakota	• No formal planning initiated.	Under consideration
Tennessee	• Examining options.	Under consideration
Texas	• Work group examining options.	Under consideration
Utah	• State-subsidized insurance program to 200% FPL up to 19.	Governor's proposal
Vermont	• Exploring Medicaid expansion to 300% FPL through age 18. • Exploring options for subsidized private insurance program.	Under consideration
Virginia	• State-subsidized insurance program up to 175% FPL.	Governor's proposal
Washington	• State exploring possible Medicaid expansion.	Under consideration
West Virginia	• Exploring new state-subsidized private insurance program.	Under consideration
Wisconsin	• New program combines Medicaid expansion and new state-subsidized insurance program for children below 185% FPL.	AB 100 enacted
Wyoming	• Work groups examining options.	Under consideration

Note: Information on many states is preliminary and may change before plans are submitted to HCFA.

Source: Blue Cross and Blue Shield Association, December 1997