>> GOOD AFTERNOON AND THANK YOU FOR STANDING BY.
ALL PARTICIPANTS ARE IN A LISTEN-ONLY MODE.
AFTER THE PRESENTATION, WE WILL CONDUCT A QUESTION-AND-ANSWER SESSION.
AT THAT TIME, IF YOU'D LIKE TO ASK A QUESTION, YOU MAY PRESS *1.
AS A REMINDER, TODAY'S CALL IS BEING RECORDED.
IF YOU HAVE ANY OBJECTIONS, YOU MAY DISCONNECT.
SIR, YOU MAY BEGIN.
>> WELCOME.
I'M JIM MAYHEW, DIRECTOR OF THE DIVISION OF PRIVATE HEALTH INSURANCE AT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, OTHERWISE KNOWN AS CMS.
THANK YOU FOR JOINING US.
I'D LIKE TO START OFF BY PROVIDING SOME BACKGROUND ON WHO WE ARE AT CMS
THE DIVISION OF PRIVATE HEALTH INSURANCE, FORMERLY KNOWN TO MANY
OF YOU AS THE PRIVATE HEALTH INSURANCE GROUP, WAS RELOCATED IN FEBRUARY 2006 TO THE EMPLOYER POLICY AND OPERATIONS GROUP IN THE CENTER FOR BENEFICIARY CHOICES IN CMS.
THE EMPLOYER POLICY OPERATIONS GROUP ALSO OVERSEES THE RETIREE DRUG SUBSIDY PROGRAM AND EMPLOYER MEDICARE PLANS.
THIS IS A GOOD FIT FOR OUR DIVISION SINCE WE DEAL WITH, AMONG OTHER THINGS, EMPLOYER GROUP HEALTH PLAN ISSUES.
THE DIRECTOR OF THE EMPLOYER POLICY OPERATIONS GROUP—BRENDA TRANCHIDA--IS ALSO VERY SUPPORTIVE OF OUR WORK, GOALS, AND MISSION.
AS MOST OF YOU KNOW, THE DEPARTMENT OF LABOR, THE DEPARTMENT OF TREASURY, AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES HAS CONCURRENT JURISDICTION OVER THE HIPAA TITLE 1 PROVISIONS.
THE DIVISION OF PRIVATE HEALTH INSURANCE OVERSEES THE DEPARTMENT OF HEALTH AND HUMAN SERVICES RESPONSIBILITIES ARISING FROM TITLES 22 AND 27 OF THE PUBLIC HEALTH SERVICE ACT.
TITLE 22 GOVERNS THE COBRA PROGRAM FOR NON-FEDERAL GOVERNMENTAL PLANS, AND TITLE 27 SPELLS OUT THE HIPAA PORTABILITY AND NONDISCRIMINATION REQUIREMENTS FOR HEALTH INSURANCE ISSUERS.
WE HAVE DIRECT ENFORCEMENT IN THE HIPAA AREA OF THE NON-FEDERAL GOVERNMENTAL PLANS AND WE ALSO OVERSEE STATE ENFORCEMENT OF THE HIPAA PROVISIONS OVER THE HEALTH INSURANCE ISSUERS IN THE PRIVATE INDIVIDUAL AND GROUP MARKETS.
WE ALSO HAVE RESPONSIBILITY OVER THE MEDIGAP PROGRAM AND WORK WITH THE STATES AND THE NAIC ON MEDIGAP ISSUES.

IN RELATION TO MEDICARE PART D, WE ALSO OVERSEE THE CREDITABLE COVERAGE NOTICE REQUIREMENTS.
WE RECOGNIZE THAT IT IS IMPORTANT TO WORK WITH STATE REGULATORS IN ALL THESE AREAS, AND WE WORK HARD TO MAKE OURSELVES AVAILABLE TO RESPOND TO QUESTIONS AND ISSUES THAT ARE RAISED TO US BY THE STATES ON AN INDIVIDUAL BASIS EITHER BY CONTACTING US DIRECTLY OR THROUGH OUR HIPAA HELP LINE.
YOU ARE ON THE FRONTLINES OF ENFORCEMENT OF IMPORTANT CONSUMER PROTECTION SUCH AS HIPAA PORTABILITY, NON-DISCRIMINATION, THE WOMEN'S HEALTH AND CANCER RIGHTS ACT, AND THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT.
IT'S HARD WORK, AND WE AT CMS APPRECIATE THE WORK THAT YOU ALL DO.
WE'RE HOPING THAT THIS CALL WILL BE INFORMATIVE TO EVERYONE AND THAT WE CAN HAVE MORE OF THESE CALLS IN THE FUTURE.
NOW I'D LIKE TO INTRODUCE THE SPEAKERS IN TODAY'S TELECONFERENCE CALL.
FIRST ADAM SHAW WILL BE DISCUSSING THE RECENTLY PUBLISHED HIPAA NON-DISCRIMINATION RULES GOVERNING THE WELLNESS PROGRAMS.
THEN JOAN KRAL WILL BE DISCUSSING THE CMS REVIEW OF THE STATE ALTERNATIVE MECHANISMS.
DAVE HOLSTEIN WILL BE DISCUSSING SOME ISSUES THAT HAVE ARISEN RECENTLY CONCERNING GUARANTEED AVAILABILITY AND RENEWABILITY IN THE INDIVIDUAL AND SMALL GROUP MARKETS.
AND LOUIS BLANK WILL BE PROVIDING IMPORTANT CONTACT INFORMATION.
THIS IS THE ENTIRE DIVISION OF PRIVATE HEALTH INSURANCE STAFF WITH
THE ADDITION OF CATHY WINDFIELD-JONES, WHO IS OUR MEDIGAP AND CREDITABLE COVERAGE SUBJECT MATTER EXPERT.
IT'S A GREAT GROUP OF HARDWORKING PEOPLE, AND I'M PROUD TO BE THEIR DIRECTOR.
AFTER THE PRESENTATIONS ON THE TOPIC,
WE WILL OPEN THE REST OF THE HOUR TO QUESTIONS FROM YOU.
SO PLEASE HOLD ANY QUESTIONS YOU MAY HAVE TO THE END.
THANKS FOR JOINING US.
WE LOOK FORWARD TO CONTINUE TO WORK WITH ALL OF YOU ON THESE IMPORTANT AND EVOLVING PRIVATE HEALTH INSURANCE ISSUES.
WITH THAT, I'LL TURN IT OVER TO ADAM SHAW.
>> THANKS VERY MUCH, JIM, AND GOOD AFTERNOON.
THE HIPAA WELLNESS RULES, AS JIM NOTED, WERE FINALIZED IN DECEMBER OF '06.
THEY CAN BE FOUND AT 45CFR146.121(f), PART OF A PACKAGE OF REGULATIONS WITH OTHER REQUIREMENTS.
BUT "F" IS THE SUBSECTION THAT DEALS WITH WELLNESS.

THE GENERAL EFFECTIVE DATE FOR THESE PROVISIONS ARE PLAN YEARS BEGINNING ON OR AFTER JULY 1, 2007.
AND WE'RE GONNA FOCUS IN MY REMARKS ABOUT WHAT WE INFORMALLY CALL THE (f)(2) WELLNESS PLAN.
IT'S THE MORE COMPLICATED VARIETY OF WELLNESS PLANS, (f)(2) BEING THE SUBSECTION OF THE REGULATIONS WHERE THEY ARE.
BUT BEFORE WE DO THAT, THINK IT'S IMPORTANT, ESPECIALLY IMPORTANT HERE, TO BE CAREFUL OF THE NOMENCLATURE.
AND ONE TAKEAWAY I'D LIKE TO EMPHASIZE IS IGNORE LABELS.
THERE ARE ARRANGEMENTS OUT THERE THAT CAN BE CALLED WELLNESS PLANS, BUT THEY ARE NOT IN THE TECHNICAL SENSE OF (f)(2) OF
THE REGULATION OF WELLNESS PLANS.
THEY CAN BE CALLED DISEASE MANAGEMENT, CASE MANAGEMENT.
SO IT'S REALLY--THE IMPORTANT THING IS WHAT THE ARRANGEMENT DOES AND DOESN'T DO, WHO IT APPLIES TO, NOT WHAT IT'S CALLED.
AND BEFORE WE GET--THE SECOND TYPE TAKEAWAY I'D LIKE TO GIVE YOU IS WE FIND ANALYTICALLY SOMETIMES PEOPLE JUMP RIGHT INTO THE (f)(2) WELLNESS PLAN ANALYSIS--THE FIVE REQUIREMENTS, WHICH WE'LL
GO OVER IN A FEW MOMENTS.
BUT YOU DON'T NECESSARILY GET THERE.
THERE'S OTHER--THESE OTHER TYPES OF ARRANGEMENTS OUT THERE THAT ARE ALSO INTENDED TO ENCOURAGE HEALTHY LIFESTYLES AND ENCOURAGE EMPLOYEES TAKING MORE CONTROL OVER THEIR HEALTHCARE, BUT THEY ARE NOT A TECHNICAL WELLNESS PLAN.
AND ONE OF THE MAIN ONES WE'VE SEEN IS WHAT IS CALLED BENIGN DISCRIMINATION.
AND THOSE RULES CAN BE FOUND IN 146.121(g) OF THE REGULATIONS.
AND WHAT THEY DO, AS THE NAME IMPLIES--THEY DO DISCRIMINATE BASED ON HEALTH FACTOR, BUT THE DISCRIMINATION IS IN FAVOR OF THE PEOPLE WITH THE HEALTH FACTOR, AND THIS CAN BE PERMISSIBLE.
AND AN EXAMPLE OF THIS COULD BE--THEY'RE IN THE REGULATIONS.
EXAMPLE WOULD BE IF A PLAN HAS DEPENDENT BENEFITS.
AND THE DEPENDENTS USUALLY AGE OUT AT 23, BUT DISABLED DEPENDENTS ARE ALLOWED TO CONTINUE TO PARTICIPATE BEYOND AGE 23.
SO THERE IS A HEALTH FACTOR THERE--DISABILITY.
THERE IS DISCRIMINATION.
YOU'RE TREATING TWO CLASSIFICATIONS OF PEOPLE--DISABLED AND NON-DISABLED--DIFFERENTLY, BUT YOU'RE FAVORING THE DISABLED CLASS.
AND SO THAT IS ALLOWED.
AND SO AT TIMES ANALYTICALLY, THAT'S PROBABLY ONE OF THE FIRST THINGS TO ASK IS THAT--WHAT IS GOING ON IN THE ARRANGEMENT?
'CAUSE IF IT IS, THAT'S NOT AN (f)(2) WELLNESS PROGRAM.

IT'S A DIFFERENT ANALYSIS.
AND THE CAVEAT THERE WITH THE NON-DISCRIMINATION IS IT'S NOT AVAILABLE IF THE ARRANGEMENT IS REQUIRING PEOPLE TO MEET A STANDARD RELATED TO THE HEALTH FACTOR IN ORDER TO GET SOME TYPE OF REWARD.
THAT'S NOT BENIGN DISCRIMINATION.
AND THAT GETS US INTO THE MAIN THRUST OF WHAT WE'RE GONNA COVER IN MY REMARKS, WHICH IS THE (f)(2) WELLNESS PROGRAMS.
AND THE WELLNESS PROGRAM IS BROADLY DEFINED AS ANY PROGRAM--ANY PROGRAM DESIGNED TO PROMOTE HEALTH OR PREVENT DISEASE.
AND GOING BACK TO THE RED FLAG ABOUT NOMENCLATURE, THESE USED TO BE CALLED IN THE PROPOSED REGULATIONS BONA FIDE WELLNESS PROGRAMS, BUT THEY'RE NOT CALLED THAT ANYMORE.
THEY'RE JUST CALLED WELLNESS PROGRAMS.
SO THE ESSENTIAL WAY THESE--THERE'S MANY DIFFERENT VARIETIES OUT THERE, BUT THE ESSENTIAL FEATURE IS THAT THE WELLNESS PROGRAM EXEMPTION IN 146.121(f)(2) ALLOWS LIMITED DISCRIMINATION BASED ON HEALTH FACTORS IN THAT PLANS MAY VARY PREMIUMS AND COST SHARING FOR PARTICIPANTS WHO MEET A STANDARD RELATED TO A HEALTH FACTOR.
AND THEN IN ORDER TO FALL WITHIN THIS EXCEPTION TO NON-DISCRIMINATION, THERE'S FIVE PRONGS THAT HAVE TO MET THAT ARE SET
FORTH IN THE REGULATIONS.
SOME ARE STRAIGHTFORWARD, AND SOME ARE MORE COMPLEX.
THE FIRST OF THE FIVE IS THE REWARD BY AMOUNT MUST BE LIMITED.
AND THERE'S A 20% RULE IN THE FINAL REGULATIONS SO THAT THE TOTAL REWARDS FOR ALL THE PLAN'S WELLNESS PROGRAMS THAT REQUIRE SATISFACTION OF THE STANDARD RELATED TO A HEALTH FACTOR MUST NOT EXCEED 20% OF THE COST OF THE COVERAGE.
AND IF DEPENDENTS ARE INVOLVED, THEN THE 20% RULE SAYS THAT THE REWARD CANNOT EXCEED 20% OF COST OF COVERAGE IN WHICH AN EMPLOYEE AND ANY DEPENDENTS ARE ENROLLED.
THE SECOND OF THE FIVE REQUIREMENTS IS THE PROGRAM MUST BE REASONABLY DESIGNED TO PROMOTE HEALTH OR PREVENT DISEASE.
THIS WAS INTENDED TO BE AN EASY REQUIREMENT TO MEET, AND IT IS.
AND THE POINT WAS TO EXCLUDE BIZARRE, EXTREME, OR ILLEGAL TYPES OF ARRANGEMENTS THAT MIGHT BE REPORTED TO BE A
WELLNESS PROGRAM.
THE THIRD OF THE FIVE REQUIREMENTS IS THE PLAN MUST GIVE INDIVIDUALS—THAT ARE ELIGIBLE TO PARTICIPATE AN OPPORTUNITY TO QUALIFY FOR THE REWARD AT LEAST ONCE A YEAR.
THE FOURTH IS THE UNIFORMITY AVAILABLE REQUIREMENT, AND THIS HAS--THIS IS, I WOULD SAY, THE MOST COMPLICATED OF THE FIVE.
THE REWARD WAS UNIFORMLY AVAILABLE TO ALL SIMILARLY SITUATED INDIVIDUALS.

AND WHAT THIS--THE REGULATION GOES ON TO OPERATIONALIZE, IS TO SAY THAT IF AN INDIVIDUAL CANNOT MEET A STANDARD DUE TO A MEDICAL CONDITION OR IF IT'S MEDICALLY INADVISABLE TO ATTEMPT TO MEET THE STANDARD, THEN THE INDIVIDUAL MUST BE OFFERED A REASONABLE ALTERNATIVE STANDARD AS A CHANCE TO QUALIFY FOR THE REWARD.
SO A PLAN HAS VARIOUS OPTIONS HERE.
THEY COULD HAVE A LOWER THRESHOLD OF A STANDARD FOR SUCH A PERSON, SUBSTITUTE A DIFFERENT STANDARD, OR WAIVE THE STANDARD ENTIRELY.
IT'S IMPORTANT THAT WHEN THESE PLANS ARE DESIGNED AND OPERATIONALIZED THERE BE--A REASONABLE ALTERNATIVE STANDARD DOES NOT HAVE TO BE WORKED OUT AHEAD OF TIME.
THAT ALLOWS FLEXIBILITY DIFFERENT SITUATIONS INDIVIDUALS MIGHT HAVE.
SO IF AND WHEN IT COMES UP THAT SOMEONE NEEDS A REASONABLE ALTERNATIVE STANDARD, THE PLAN CAN FASHION ONE AT THAT TIME.
AND THE FIFTH AND FINAL OF THE REQUIREMENTS IS THE PLAN MUST DISCLOSE THE AVAILABILITY OF THE REASONABLE ALTERNATIVE STANDARD IN ALL PROGRAM MATERIALS THAT DESCRIBE THE INITIAL STANDARD.
THERE'S SAMPLE LANGUAGE IN THE REGULATION AT 146.121(f)(2) ROMAN NUMERAL V CAPITAL B THAT CAN BE USED.
AND ANOTHER IMPORTANT POINT IS THE STANDARD DOES NOT--IN A DISCLOSURE, YOU DO NOT HAVE TO IDENTIFY THE REASONABLE ALTERNATIVE STANDARD IN ADVANCE.
YOU DON'T--AS WE SAID IN PRONG FOUR, YOU DON'T HAVE TO ACTUALLY COME UP WITH THE STANDARD IN ADVANCE, AND THEREFORE YOU DON'T HAVE TO IDENTIFY IT IN ADVANCE IN THE DISCLOSURE REQUIREMENT.
AND THEN TO WRAP UP, WE'RE JUST GONNA BRIEFLY CONSIDER ONE EXAMPLE TO SEE HOW THESE FIVE ELEMENTS WOULD PLAY OUT.
AND THIS COMES FROM EXAMPLE FIVE IN THE REGULATION ITSELF.
THERE'S SIX EXAMPLES ABOUT (f)(2) WELLNESS ARRANGEMENT.
SO THE EXAMPLE IS A PLAN HAS A PREMIUM SURCHARGE FOR SMOKERS.
INDIVIDUALS WHO CERTIFY THEY HAVE NOT USED TOBACCO IN THE LAST 12 MONTHS PAY A REDUCED PREMIUM COMPARED TO SMOKERS.
SO THAT'S THE REWARD--A PREMIUM REDUCTION.
SO IS THIS AN (f)(2) WELLNESS PROGRAM?
THE ANSWER IS IT DEPENDS.
IF THE REWARD IS LIMITED--THAT'S THE 20% RULE THAT WE DISCUSSED A FEW MOMENTS AGO--THEN YOU'D BE OVER THAT HURDLE.
IT MEETS THE SECOND PRONG--REASONABLE DESIGN REQUIREMENT.
YOU KNOW, SMOKING IS CLEARLY HAZARDOUS TO EVERYONE'S HEALTH, AND THIS IS TO PREVENT SMOKING.
END OF STORY.

NEXT WOULD BE IF INDIVIDUALS WOULD NEED TO BE ABLE TO QUALIFY FOR THE PREMIUM DISCOUNT AT LEAST ONCE PER YEAR.
THE FOURTH ONE--THE UNIFORM AVAILABILITY REASONABLE ALTERNATIVE STANDARD REQUIREMENT.
HERE YOU MAY HAVE INDIVIDUALS THAT HAVE NICOTINE ADDICTION TO THE MEDICAL CONDITION, AND THEY CAN'T QUIT SMOKING.
SO THERE WOULD HAVE TO BE OTHER REASONABLE ALTERNATIVES AVAILABLE IF SUCH AN INDIVIDUAL COMES FORWARD SUCH AS THE PATCH, GUM, TAKING A CLASS, ETC.
AND THEN IF SOMEONE WHO CANNOT QUIT--WANTS TO QUIT SMOKING TRIES
AND CAN'T, IF HE DOES--HE OR SHE DOES WANT ONE OF THESE REASONABLE ALTERNATIVES, THEN THEY CAN ALSO QUALIFY FOR THE REWARD.
AND THEN THE LAST REQUIREMENT AGAIN IS DISCLOSURES.
THE PLAN MATERIALS THAT DISCUSS THE STANDARD, YOU KNOW, HAVE TO MAKE NOTE THAT THEIR REASONABLE ALTERNATIVE STANDARD WILL BE AVAILABLE.
SO THAT IS A QUICK RUN-THROUGH OF THE FINAL WELLNESS REGULATIONS.
AND THANK YOU FOR YOUR ATTENTION.
>> THANKS, ADAM.
AND WE THOUGHT THAT IT WAS REAL IMPORTANT TO DISCUSS THIS TODAY 'CAUSE SOME OF YOU MAY KNOW THE ISSUERS--MORE AND MORE ISSUERS ARE COMING OUT WITH PRODUCTS WITH THEIR WELLNESS PROGRAM PROVISIONS IN THE PRODUCTS.
AND SOME OF THESE ISSUERS ARE CLAIMING THAT SOME OF THESE PRODUCTS--THE WELLNESS PROGRAM PRODUCTS ARE NOT SUBJECT TO THE HIPAA NON-DISCRIMINATION REQUIREMENTS BECAUSE THEY MIGHT BE WHAT THEY CALL AN EXCEPTED BENEFIT.
AND AN EXAMPLE WOULD BE A ISSUER TELL AN EMPLOYER THAT HAVE A HIGH DEDUCTIBLE HEALTH PLAN AND, SAY, WITH A $5,000 DEDUCTIBLE, AND THE ISSUER ISSUES A SUPPLEMENTAL PLAN--THEY'LL COVER THE FIRST $5,000
DEDUCTIBLE.
AND THE SUPPLEMENTAL PLAN HAS WELLNESS PROGRAM PROVISIONS IN THEM.
AND THEY'RE SAYING THAT THEY'RE NOT SUBJECT TO HIPAA BECAUSE IT'S A SUPPLEMENTAL PLAN THAT IS NOT COVERED BY THE HIPAA PROVISIONS.
AND ALL THREE DEPARTMENTS--CMS AND DEPARTMENT TREASURY AND DEPARTMENT OF LABOR--HAVE SOME CONCERNS ABOUT THIS.
AND WE HAVE BEEN IN DISCUSSIONS WITH THE OTHER DEPARTMENTS, AND WE MAY BE SPEAKING OUT ABOUT THIS ISSUE IN THE NEAR FUTURE.
SO IF YOU HAVE ANY CONCERNS OR YOU SEE ANY PRODUCTS IN THIS STATE THAT--THAT DRAW YOUR ATTENTION AND YOU'D LIKE TO

DISCUSS THEM WITH US, BY ALL MEANS, FEEL FREE TO GIVE US A CALL.
NOW WITH THAT, I'M GONNA TURN IT OVER TO JOAN KRAL, WHO'S GONNA TALK ABOUT THE CMS REVIEW OF THE STATE ALTERNATIVE MECHANISM.
>> THANKS, JIM.
ADAM, OF COURSE, REPORTED ON ONE OF THE PROVISIONS RELATED TO THE GROUP MARKET.
AND I WOULD LIKE TO LOOK FOR A MOMENT AT THE INDIVIDUAL MARKET REFORM BEFORE GOING INTO AN IN-DEPTH REPORT ON THE STATUS OF THE SAMs AND--EXCUSE ME--THE STATUS OF THE STATE ALTERNATIVE MECHANISM AND SOME OF THE ISSUES THAT WE ARE FINDING IN THE REVIEW.
YOU WILL HEAR ME OCCASIONALLY SAY SAMs.
I APOLOGIZE FOR THAT, WE USE A SHORTHAND HERE BECAUSE THE OFFICIAL TITLE IN THE LAW IS SOMEWHAT CUMBERSOME.
THE REFORMS THAT HIPAA PRESENTED IN THE INDIVIDUAL MARKET STILL
HAD THEIR NEXUS IN EMPLOYMENT.
THE SPECIFIC AREA THAT WE'RE GOING TO LOOK AT CENTERS AROUND PORTABILITY FROM AN EMPLOYMENT-BASED PLAN TO INDIVIDUAL COVERAGE.
NOW, IN LOOKING AT HOW ONE ACQUIRES THAT PORTABILITY, I'M GOING TO TAKE OUT A DOCUMENT WHICH WE USE WHEN WE INTERVIEW PEOPLE.
IT'S CALLED OUR DRAFT INTERVIEWER'S CHART.
SOME OF YOU FOLKS WHO'VE BEEN ON BOARD HERE WITH US FOR YEARS MAY REMEMBER THAT AT ONE TIME WE HAD THIS COPY OF THIS CHART IN OUR PACKET.
WE DISTRIBUTED IT TO STATE REGULATORS.
BUT IT WAS A LONG TIME AGO.
AND AFTER MY REMARKS AND RUNNING THROUGH THIS CHART, ANYBODY WHO WOULD LIKE TO GET A COPY OF IT, PLEASE FEEL FREE TO E-MAIL ME, AND I'LL SHIP ONE OUT.
I DON'T THINK WE HAVE IT ELECTRONICALLY AT THIS POINT.
ADAM WAS TALKING ABOUT HURDLES IN THE WELLNESS PROGRAM.
WELL, WE HAVE HURDLES, TOO, OR RATHER THE LAW HAS HURDLES.
AND PEOPLE HAVE TO BE ABLE TO JUMP THESE HURDLES IN ORDER TO QUALIFY FOR PORTABILITY.
OF COURSE, THE MOST IMPORTANT ONE--AND I'LL START WITH THE ONE THAT KEEPS MOST PEOPLE FROM ACQUIRING THIS ELIGIBILITY, AND THAT IS IF THEY ARE OFFERED COBRA OR STATE CONTINUATION COVERAGE OR, I'D LIKE TO ADD, CONTINUATION COVERAGE UNDER THE FEDERAL GOVERNMENT CALLED TEMPORARY CONTINUATION COVERAGE, THEY MUST TAKE IT AND EXHAUST IT BEFORE QUALIFYING FOR HIPAA INDIVIDUAL PORTABILITY.

THIS WHOLE QUESTION OF EXHAUSTION OF CONTINUATION COVERAGE IS ONE THAT I'D LIKE TO SPEND
A MOMENT ON.
A LOT OF FOLKS MIGHT HAVE OR BE IN AN EMPLOYER PLAN AND THEN GO INTO A COBRA ARRANGEMENT IN AN HMO.
SUBSEQUENTLY, THEY MAY MOVE OUTSIDE OF THE SERVICE
AREA, OF THE HMO.
AT THAT POINT IN TIME, THEY HAVE EXHAUSTED THEIR COBRA.
WE GET THAT QUESTION QUITE OFTEN.
THE OTHER REQUIREMENTS--18 MONTHS--AN AGGREGATE OF 18 MONTHS OF HEALTH COVERAGE DURING WHICH THERE IS NOT A BREAK OF
63 OR MORE COMPLETE DAYS IN A ROW, AND THAT 63-DAY SIGNIFICANT BREAK--SEVERAL OF THE STATES ARE MORE GENEROUS, AND THEY ALLOW A LONGER PERIOD OF TIME.
THE KEY THING IN LOOKING AT THE REQUIREMENTS IS TO REMEMBER THE STATE MAY ALWAYS BE MORE GENEROUS.
THE SECOND POINT WOULD BE THE--A MATTER OF ELIGIBILITY FOR OTHER EMPLOYMENT-RELATED GROUP COVERAGE.
NOW, THIS AT ITS FACE SOUNDS VERY SIMPLE, BUT IN INTERVIEWING PEOPLE, I AM CONSTANTLY AMAZED AT HOW OFTEN THIS IS A STUMBLING BLOCK, AND THIS IS THE REASON.
PERHAPS THEIR SPOUSE HAS AN EMPLOYER PLAN THAT IS REALLY NOT VERY GOOD, OK.
BUT THEY'RE ON THE PLAN.
YOU KNOW, THEY CAN BE ELIGIBLE.
OR EVEN IF THE SPOUSE IS NOT CURRENTLY ELIGIBLE, THEY COULD SIGN UP AT THE NEXT OPEN ENROLLMENT, AND THEN THEY WOULD QUALIFY.
OK.
SO THEY'RE ELIGIBLE FOR THIS OTHER PLAN.
WELL, LOT OF PEOPLE THINK, "WELL, IT'S NOT A VERY GOOD PLAN.
THEREFORE, I'M NOT ELIGIBLE FOR ANY OTHER GROUP INSURANCE."
UNFORTUNATELY, CONGRESS INTENDED THE HIPAA PROVISIONS TO BE, IF YOU WILL, A KIND OF INSURANCE FOR THOSE WHO REALLY HAVE PROBLEMS FINDING COVERAGE OTHERWISE.
SO IF THEY ARE ELIGIBLE FOR ANY OTHER EMPLOYMENT-BASED GROUP COVERAGE, THEY ARE NOT HIPAA ELIGIBLE.
AND HERE AGAIN, WE ARE AWARE THAT SOME OF THE STATES ARE MORE GENEROUS, AND WE WOULD ENCOURAGE THAT.
THEY ALSO CANNOT BE ELIGIBLE FOR EITHER MEDICARE OR MEDICAID.
AND AGAIN, IN INTERVIEWS, PEOPLE SAY, "WELL, GEE, I DON'T KNOW WHETHER I QUALIFY FOR MEDICAID.
I REALLY HAVEN'T CALLED MY LOCAL MEDICAID STATE AGENCY, AND I DON'T KNOW WHETHER I MEET THEIR GUIDELINES."
WELL, AT THAT POINT, I GENERALLY REFER THEM TO A VERY GOOD WEBSITE.
GEORGETOWN UNIVERSITY SCHOOL OF PUBLIC POLICY HAS A WEB SITE.

IT'S WWW.HEALTHINSURANCEINFO.NET.
AND ON THIS WEB SITE, THEY HAVE STATE-SPECIFIC BOOKLETS, AND THEY COVER SUCH MATTERS AS ELIGIBILITY FOR MEDICAID WITHIN A STATE.
NOW THESE BOOKLETS ARE UPDATED PERIODICALLY, BUT I'D LIKE TO EMPHASIZE THAT WHATEVER INFORMATION IS IN THERE, THE INDIVIDUAL NEEDS TO CALL AND FIND OUT IF THOSE RESOURCE AND INCOME LIMITATIONS ARE STILL CURRENT.
THOSE BOOKLETS ARE GREAT THOUGH.
THEY HAVE A WEALTH OF RESOURCES.
SO THAT'S WHAT WE GET MOSTLY ABOUT QUESTIONS ABOUT MEDICAID.
PEOPLE KNOW IF THEY'RE ELIGIBLE FOR MEDICARE.
WAS YOUR LAST COVERAGE THROUGH AN EMPLOYER GROUP OR UNION GROUP?
NOW, THIS IS IMPORTANT.
THIS CAN COME UP IF A PERSON, FOR EXAMPLE, HAS TAKEN OUT COVERAGE THROUGH AN ASSOCIATION, BUT IT WAS REALLY AN INDIVIDUAL POLICY THROUGH THE ASSOCIATION.
JUST GIVE YOU AN EXAMPLE, A SILLY EXAMPLE.
I ACTUALLY HEARD THIS ONCE AT SOME POINT.
THE SOCIETY FOR ENVIRONMENTALISTS.
WELL, FAR AS I KNOW, I DON'T KNOW IF THERE'S A MEMBERSHIP OR WHATEVER, BUT THERE ARE A COUPLE KEY QUESTIONS HERE.
WAS THERE A GROUP HEALTH PLAN INVOLVED?
NO.
THERE WASN'T A GROUP HEALTH PLAN.
WELL, IF THERE WASN'T A GROUP HEALTH PLAN INVOLVED, THEN IT IS NOT EMPLOYMENT-BASED COVERAGE.
OF COURSE, COBRA DOES COUNT AS EMPLOYMENT-RELATED COVERAGE.
AND THEN THE EASY ONE, EASY QUALIFICATION IS WAS YOUR COVERAGE LOST BECAUSE OF FRAUD OR NONPAYMENT OF PREMIUMS, AND MOST PEOPLE ARE NEARING THE END OF THEIR COBRA, SO THIS IS NOT AN ISSUE.
SO THAT'S WHAT'S ON THE CHART.
AND IF, AGAIN, ANY OF YOU WOULD LIKE A COPY OF IT, I'D BE HAPPY TO SEND A COPY TO YOU.
AND IF ANY OF YOU ARE INTERESTED, WE DO ALSO HAVE A BOOKLET CALLED PROTECTING YOUR HEALTH INSURANCE COVERAGE, AND IT IS PUBLICATION NUMBER 10199.
IF YOU CALL 1-800-MEDICARE, YOU CAN ORDER COPIES.
AND AGAIN, IF YOU E-MAIL ME, I'LL BE HAPPY TO PLACE AN ORDER WITH THE WAREHOUSE FOR A QUANTITY.
THE USE THAT I SEE FOR BOTH THE CHART AND FOR
THE BOOKLET IS THAT I THINK THESE WOULD BE VERY GOOD FOR USE BY THE CONSUMER HOTLINE FOLKS AT THE STATE LEVEL.
I KNOW THAT THERE ARE MANY, MANY TOPICS THAT THEY HAVE TO BE

EXPERTS IN.
SO IT'S GOOD TO HAVE SOMETHING THAT PULLS THE INFORMATION TOGETHER IN ONE PLACE.
OK.
WELL, LET'S TAKE A QUICK LOOK AT WHAT WE HAVE WITH THE STATE ALTERNATIVE MECHANISM.
WE HAVE HAD SUBMITTED TO US 39 JURISDICTIONS.
JUST THIS POINT OF INFORMATION.
CURRENTLY, WE HAVE 13 JURISDICTIONS AS FEDERAL FALLBACK JURISDICTIONS.
SO WE HAVE 39 STATE ALTERNATIVE MECHANISMS IN HOUSE.
OF THESE, WE'VE COMPLETED 34, AND THE REST ARE IN REVIEW.
WE ARE ANTICIPATING AN ADDITIONAL TWO STATES THAT WILL FILE ALTERNATIVE MECHANISMS WITH US.
OUR GOAL IS TO COMPLETE ALL THE PROGRAMS BY THE END OF THE CALENDAR YEAR.
THIS WOULD BE PROVIDED THAT THE TWO STATES THAT PLANNED ON SENDING MATERIALS DO SO IN THE NEAR FUTURE.
NOW, DURING THIS REVIEWING CYCLE, WE'VE SEEN A NUMBER OF ISSUES CROP UP, AND THEY'RE BASICALLY NOT INVOLVED WITH THE STATUTES BUT WITH MATERIALS POSTED ON STATE WEB SITES, WHICH WOULD INCLUDE DESCRIPTIONS OF ELIGIBILITY, APPLICATIONS, AND POLICY PROVISIONS.
SO BRIEFLY, I'D LIKE TO LOOK AT SOME OF THE ISSUES THAT WE HAVE SPOTTED, AND OF COURSE WE DEAL WITH THE STATES ON A ONE-ON-ONE BASIS AND WORK WITH THEM TO TRY TO ADDRESS THESE.
YOU RECALL THAT IN LOOKING AT THE QUALIFICATIONS FOR A HIPAA-ELIGIBLE INDIVIDUAL THAT THEY COULD NOT BE ELIGIBLE FOR OTHER EMPLOYMENT-RELATED GROUP COVERAGE.
SOME OF THE WEB MATERIALS, BECAUSE OF WHAT I WOULD CALL IMPRECISE WORDING, WOULD GIVE THE IMPRESSION THAT YOU--THAT YOU WERE DISQUALIFIED IF YOU WERE ELIGIBLE FOR ANY OTHER HEALTH COVERAGE.
SO THAT IS ONE IMPORTANT THING THAT WE'RE LOOKING FOR THAT THE PERSON MAY BE ELIGIBLE FOR INDIVIDUAL COVERAGE, BUT THEY MAY NOT BE ELIGIBLE FOR EMPLOYMENT-BASED COVERAGE.
ANOTHER AREA IS THAT THE LAST COVERAGE MUST BE EMPLOYMENT-BASED COVERAGE.
THAT AGAIN IS A SIMPLE MATTER IF THE INDIVIDUAL HAS COME OFF OF COBRA AND THEY HAVE EXHAUSTED COBRA, THEY'VE HAD THEIR 18 MONTHS.
WELL, YOU KNOW, THAT'S A VERY EASY SCENARIO.
BUT SOMETIMES THE SCENARIO IS A BIT MORE COMPLEX.
TAKE THE EXAMPLE OF A PERSON WHO HAS JUST FINISHED WORKING FOR A SMALL EMPLOYER.
MAYBE THE SMALL EMPLOYER ONLY EMPLOYED FOUR PEOPLE.

OK.
SO OBVIOUSLY THERE WAS NO COBRA.
BUT THERE WAS ALSO NO STATE COMMUNICATION COVERAGE--
CONTINUATION COVERAGE.
SO AT THAT POINT, THEIR LAST COVERAGE WAS GROUP, OK.
NOW, PRIOR TO THIS, THEY HAD--THEY DIDN'T HAVE ANY BREAKS OF 63 OR MORE COMPLETE DAYS IN A ROW, BUT THEY SORT OF STRUNG TOGETHER DIFFERENT KINDS OF HEALTH COVERAGE.
THEY MIGHT, FOR EXAMPLE, EVEN HAVE HAD A SHORT-TERM LIMITED DURATION POLICY.
OK.
AGAIN, THEY CAN COUNT THAT IN THEIR 18 MONTHS.
THE USE OF THE WORD "CONTINUOUS" ON THE WEB IN DESCRIBING PRIOR COVERAGE.
AGAIN, WE'RE CONCERNED ABOUT THE USE OF THAT WORD BECAUSE OF THE FACT THAT IT SUGGESTS THAT YOU CAN'T HAVE ANY BREAK.
IN HIGH-RISK POOL STATES, WE'RE CONCERNED ABOUT THE REQUIREMENT THAT A PERSON CAN'T HAVE ENTRANCE INTO THE POOL AGAIN BEFORE 12 MONTHS HAS ELAPSED.
THE LENGTH OF RESIDENCY REQUIREMENT, AGAIN, IN HIGH-RISK POOL STATE, THE STATUTES ARE RIGHT, BUT SOMETIMES THE WEB PAGE IS WRONG.
AND THE VERY IMPORTANT ISSUE IN ESTABLISHING PROOFS OF COVERAGE, ALLOWING PEOPLE TO USE FORMS OTHER THAN THE CERTIFICATES, INCLUDING TELEPHONE.
>> OK.
GREAT.
THANKS, JOAN.
AND I HOPE THAT SOME OF YOU WILL FOLLOW UP AND GET THOSE REQUESTS--GET THE INFORMATION THAT JOAN HAS OFFERED BECAUSE IT IS INVALUABLE.
NEXT IS DAVE HOLSTEIN.
GONNA TALK ABOUT THE GUARANTEED RENEWABILITY AND AVAILABILITY ISSUES.
DAVE?
>> OK.
THANKS, JIM.
HI.
I'M GONNA VERY BRIEFLY DISCUSS A COUPLE OF ISSUES THAT--
REGARDING GUARANTEED AVAILABILITY, GUARANTEED RENEWABILITY THAT HAVE RECENTLY ARISEN.
TO REITERATE THE PERTINENT BACKGROUND, IN GENERAL, HIPAA'S SMALL GROUP MARKET GUARANTEED AVAILABILITY PROVISION REQUIRES THAT ISSUERS MAKE ALL THEIR SMALL GROUP MARKET PRODUCTS AVAILABLE TO ALL SMALL EMPLOYERS IN A STATE.
AND HIPAA'S GUARANTEED RENEWABILITY PROVISIONS PROVIDE THAT

GROUP COVERAGE RENEWS AT THE OPTION OF THE PLAN SPONSOR AND INDIVIDUAL COVERAGE RENEWS AT THE OPTION OF THE POLICYHOLDER.
NOW, OVER THE PAST SEVERAL MONTHS, SEVERAL SITUATIONS HAVE COME TO OUR ATTENTION THAT CONFLICT WITH THESE PROVISIONS.
IN ONE CASE, AN ISSUER ATTEMPTED TO TERMINATE AN INDIVIDUAL MAJOR MEDICAL POLICY BECAUSE THE INDIVIDUAL BECAME ENTITLED TO MEDICARE.
THAT PLAINLY VIOLATES THE GUARANTEED RENEWABILITY REQUIREMENTS IN SECTION 2742 OF THE PHS ACT, WHICH LISTS IN PARAGRAPH (b) THE BASES FOR DISCONTINUING OR NON-RENEWING INDIVIDUAL COVERAGE.
THAT LIST IS EXCLUSIVE.
IT DOES NOT INCLUDE MEDICARE ELIGIBILITY OR ENTITLEMENT.
MOREOVER, IMPLEMENTING REGULATIONS AT 45CFR SECTION 148.122(b)(2) EXPRESSLY PROVIDE THAT MEDICARE ELIGIBILITY OR ENTITLEMENT IS NOT A BASIS FOR TERMINATING OR NON-RENEWING HEALTH INSURANCE COVERAGE IN THE INDIVIDUAL MARKET.
THUS, THE ISSUER'S ACTIONS WERE PLAINLY PROHIBITED BY HIPAA.
HOWEVER, ISSUERS IN THE INDIVIDUAL MARKET ARE FREE TO COORDINATE THEIR POLICIES WITH MEDICARE.
THAT IS, MEDICARE WOULD BE THEIR PRIMARY PAYER, AND THE INDIVIDUAL POLICY WOULD PAY SECONDARY TO MEDICARE.
OTHER SITUATIONS INVOLVED RECENT DISCUSSIONS WE HAVE HAD WITH SEVERAL STATES REGARDING UNIQUE PRODUCTS THAT THOSE STATES WOULD LIKE TO ALLOW ISSUERS TO OFFER IN THE INDIVIDUAL AND SMALL GROUP MARKETS THAT FALL SHORT OF COMPLIANCE WITH HIPAA'S GUARANTEED AVAILABILITY AND GUARANTEED RENEWABILITY REQUIREMENTS.
FOR INSTANCE, SEVERAL STATES WERE EXPLORING THE POSSIBILITY OF MAKING SMALL GROUP MARKET COVERAGE AVAILABLE ONLY TO CERTAIN EMPLOYERS THAT HAVE NOT HAD COVERAGE FOR THEIR EMPLOYEES FOR A CERTAIN PERIOD OF TIME AND THE COVERAGE WOULD TERMINATE AUTOMATICALLY AFTER A PRESCRIBED PERIOD OF TIME.
THIS TYPE OF ARRANGEMENT WOULD VIOLATE BOTH THE SMALL GROUP MARKET GUARANTEED AVAILABILITY REQUIREMENTS AND GUARANTEED RENEWABILITY REQUIREMENTS.
AGAIN, ISSUERS MUST MAKE SMALL GROUP MARKET COVERAGE AVAILABLE TO ALL SMALL EMPLOYERS IN A STATE.
SO THEY CAN'T JUST MAKE IT AVAILABLE TO A CERTAIN SELECT GROUP OF SMALL EMPLOYERS.
AND COVERAGE CANNOT AUTOMATICALLY END AFTER A PRESCRIBED PERIOD OF TIME BECAUSE COVERAGE RENEWS AT THE OPTION OF THE PLAN SPONSOR.
SO THE POINT--THE POINT HERE IS TO AVOID POTENTIAL PROBLEMS DOWN THE ROAD, WE'RE REQUESTING THAT STATE REGULATORY AUTHORITIES CONTACT US BEFORE ANY HIPAA-RELATED LEGISLATION IS

ENACTED OR STATE REGULATIONS ARE PROMULGATED IN ORDER TO GIVE US A CHANCE TO WEIGH IN ON AN ISSUE AND PERHAPS SUGGEST CHANGES IF WE DETERMINE THAT LEGISLATION OR REGULATIONS ARE IN CONFLICT WITH HIPAA.
WE'RE NOT LOOKING TO MICROMANAGE STATE HEALTH INSURANCE LEGISLATION AND REGULATIONS, AND WE WOULD BE AS FLEXIBLE AS POSSIBLE IN REVIEWING AND COMMENTING ON ANY PENDING HIPAA-RELATED LAW OR REGULATIONS.
BUT IT JUST SEEMS TO US, AT LEAST IN THEORY, THAT IT WOULD BE EASIER TO CHANGE PENDING LAWS AND REGULATIONS TO ENSURE HIPAA COMPLIANCE WHILE THEY ARE IN THE FORMATIVE STAGE RATHER THAN TRYING TO ACCOMPLISH THAT AFTER THE FACT.
SO, AGAIN, WHEN STATE REGULATORY AGENCIES BECOME AWARE THAT LEGISLATION IS PENDING AND THERE MAY BE AN ISSUE AS TO WHETHER OR NOT IT'S FULLY COMPLIANT WITH HIPAA, WE'D REALLY APPRECIATE IT IF YOU, YOU KNOW, GIVE US A HEADS-UP ON THAT AND GIVE US A CHANCE TO WEIGH IN ON IT BEFORE IT BECOMES FINAL.
THANK YOU.
>> THANKS, DAVE.
YEAH.
I THINK THAT'S AN IMPORTANT POINT IS THAT, WE REALLY UNDERSTAND THAT SOME STATE--THEY REALLY SPEND MONEY IN TRYING TO EXPAND COVERAGE.
AND WE APPRECIATE AND WE SUPPORT THAT EXCEPT FOR WHEN THEY DEVELOP THESE PROPOSALS.
WE HAVE TO KEEP IN MIND THERE ARE IMPORTANT CONSUMER PROTECTIONS IN HIPAA THAT NEED TO BE COMPLIED WITH.
SO WITH THAT, I'M GONNA TURN IT OVER TO LOUIS BLANK.
HE'S GONNA GIVE US SOME GOOD INFORMATION ON HOW YOU CAN GET SOME INFORMATION AND HOW TO CONTACT US.
>> THANK YOU, JIM.
FIRST I'M GONNA REMIND EVERYONE ABOUT THE ADDRESSES FOR THE PRIVATE HEALTH INSURANCE GROUP OR PHIG MAILBOX.
YOU CAN SEND AN E-MAIL TO THE MAILBOX INSTEAD OF WRITING DOWN THESE LONG WEB ADDRESSES.
AND WHAT I'LL DO IS I'LL REPLY WITH THE ADDRESSES OF THE HIPAA WEB SITES ALONG WITH THE OTHER CONTACT INFORMATION.
SO IF YOU'D LIKE, YOU CAN SEND AN E-MAIL TO PHIG@CMS.HHS.GOV, AND YOU'LL GET AN E-MAIL BACK FROM ME SAYING THAT HIPAA HAS TWO WEB SITES.
ONE IS THE HEALTH INSURANCE REFORM FOR CONSUMERS, AND THAT ADDRESS IS WWW.CMS.HHS.GOV/.
AND THEN THE NEXT WORD IS ALL ONE WORD.
IT'S HEALTHINSREFORMFORCONSUME.
AGAIN, THAT'S ALL ONE WORD, AND IT'S HEALTHINSREFORMFORCONSUME.

AND OUR SECOND WEB SITE IS HEALTH INSURANCE REFORM FOR EMPLOYERS, AND THAT ADDRESS IS
WWW.CMS.HHS.GOV/, ALL ONE WORD, HEALTHINSREFORMFOREMPS.
AGAIN, THAT'S ALL ONE WORD.
HEALTHINSREFORMFOREMPS.
ONCE YOU'RE ON EITHER ONE OF THOSE TWO WEB PAGES FOR HIPAA, YOU'LL SEE A TOOLBAR UP AT THE TOP OF THE PAGE, AND THE FIRST ITEM ON THE LEFT IS GONNA SAY, "PEOPLE WITH MEDICARE AND MEDICAID."
RIGHT NEXT TO THAT, YOU'LL SEE ANOTHER ITEM THAT SAYS, "QUESTIONS."
AND WHAT YOU CAN DO IS YOU CAN CLICK ON THAT "QUESTIONS" BAR, AND IT'LL TAKE YOU TO OUR FREQUENTLY ASKED QUESTIONS SITE WHERE YOU CAN ENTER A PHRASE IN THE BOX THAT SAYS, "ENTER A SEARCH TERM."
SO FOR INSTANCE, IF YOU WANTED TO KNOW MORE ABOUT OUR FAQ--FREQUENTLY ASKED QUESTIONS--ABOUT HIPAA PORTABILITY, WHAT YOU
WOULD DO IS YOU WOULD TYPE THE WORD "HIPAA PORTABILITY," AND THEN YOU WOULD HIT "ENTER," AND IT WOULD BRING YOU TO A PAGE WITH 26 FREQUENTLY ASKED QUESTIONS THAT HAVE BOTH THE WORD "HIPAA" AND "PORTABILITY" EITHER IN THE QUESTION OR THE ANSWER.
SO YOU COULD SEARCH FOR ANY TOPIC, NOT JUST HIPAA TOPICS.
IN ADDITION TO THE WEB SITE INFORMATION, IF YOU'D LIKE CONTACT INFORMATION FOR A DIVISION OF PRIVATE HEALTH INSURANCE STAFF MEMBER, CONTACT MYSELF—LOUIS BLANK--AT 410-786-5511.
AND I'D LIKE TO STRESS--PLEASE DON'T FORWARD STAFF TELEPHONE NUMBERS TO THE GENERAL PUBLIC.
THEY'RE FOR YOUR PROFESSIONAL USE ONLY.
THE GENERAL PUBLIC SHOULD CALL THE HIPAA HOTLINE, AND THAT'S TOLL-FREE.
THE NUMBER IS 877-267-2323 EXTENSION 61565, OR YOU CAN CALL LOCALLY, AND THAT NUMBER IS 410-786-1565.
SO ONCE AGAIN, IF YOU'D LIKE TO RECEIVE AN E-MAIL WITH THE WEB SITE AND CONTACT INFORMATION, SEND AN E-MAIL TO THE P.H.I.G. MAILBOX, AND THAT IS PHIG@CMS.HHS.GOV, AND I'LL REPLY TO YOU.
>> THANKS, LOUIS.
WITH THAT WE'RE GONNA TURN IT OVER TO THE OPERATOR, WHO'S GONNA THEN,
YOU KNOW, OPEN IT UP FOR QUESTIONS AND ANSWERS.
AND I STRESS IT'S REALLY IMPORTANT THAT SINCE THIS IS AN INVITATION-ONLY CALL THAT YOU IDENTIFY YOURSELF AND YOUR ORGANIZATION BEFORE YOU ASK YOUR QUESTION.
AND IF IT'S A QUESTION THAT WE MAY NOT BE ABLE TO ANSWER, WE'LL CERTAINLY GET BACK TO YOU, OR WHAT WE MAY DO IS HAVE YOU E-MAIL THE QUESTION TO THE PHIG MAILBOX, TO THE ADDRESS LOUIS

JUST GAVE YOU, AND WE WILL CERTAINLY RESPOND WHEN WE ARE ABLE.
SO WITH THAT, LET'S TURN IT OVER FOR QUESTIONS.
>> THANK YOU.
AT THIS TIME, IF YOU'D LIKE TO ASK A QUESTION, PLEASE PRESS *1.
YOU WILL BE PROMPTED TO RECORD YOUR FIRST AND LAST NAME.
ONCE AGAIN, AT THIS TIME, IF YOU'D LIKE TO ASK A QUESTION, PLEASE PRESS *1.
ONE MOMENT FOR OUR FIRST QUESTION.
>> WHILE WE'RE WAITING FOR OUR FIRST QUESTION, THIS IS LOUIS BLANK.
I JUST WANT TO GIVE EVERYONE THAT TOLL-FREE NUMBER AGAIN.
IT'S 877-267-2323, AND THE EXTENSION IS 61565.
>> THANK YOU.
AND OUR FIRST QUESTION COMES FROM ANN BISHOP.
PLEASE STATE YOUR ORGANIZATION.
>> SOUTH CAROLINA DEPARTMENT OF INSURANCE.
>> HI, ANN.
>> HEY, JIM.
I WAS JUST WONDERING IF SINCE THIS IS BEING RECORDED, ARE YOU GONNA SUMMARIZE IT, AND CAN WE GET A COPY OF THE SUMMARY?
>> WELL, IT WON'T BE SUMMARIZED, BUT YOU'LL CERTAINLY BE ABLE TO GET A COPY OF THE TRANSCRIPT OF THE CALL.
>> OK.
THANK YOU.
>> OK.
ALL RIGHT.
THANK YOU, ANN.
WHILE WE'RE WAITING FOR THE NEXT QUESTION, I WILL REALLY THROW OUT A QUESTION THAT WE GET A LOT, AND THAT IS: WHAT IS THE DIFFERENCE BETWEEN THE DEFINITION OF CREDITABLE COVERAGE AND HIPAA CONTEXT AND THE DEFINITION OF CREDITABLE COVERAGE IN THE MEDICARE CONTEXT?
OBVIOUSLY SINCE THEY BOTH INVOLVED THE SAME TERM, PEOPLE GET VERY CONFUSED ABOUT HOW IT APPLIES TO TWO DIFFERENT PROGRAMS.
WELL, AS MOST OF YOU KNOW, CREDITABLE COVERAGE IN THE HIPAA CONTEXT IS CLARIFIED UNDER 45CFR146113.
AND IT'S JUST A LAUNDRY LIST OF DIFFERENT TYPES OF COVERAGES THAT CONSIDERED TO BE CREDITABLE
AND THAT INCLUDES EMPLOYER GROUP HEALTH PLAN, INDIVIDUAL HEALTH INSURANCE, MEDICARE, MEDICAID, HIGH-RISK POOL, COVERAGE THROUGH HIGH-RISK POOL, COVERAGE THROUGH PUBLIC HEALTH SERVICE PROGRAM, ETC.
AND REALLY IN THE HIPAA CONTEXT, THE CREDITABLE COVERAGE REALLY PERTAINS TO THE TYPE OF COVERAGE.

AND THERE'S ALSO IN THE REGULATION A LIST OF CERTAIN TYPES OF COVERAGE THAT'S NOT CONSIDERED TO BE CREDITABLE SUCH AS SPECIFIC BENEFITS INSURANCE OR DENTAL, VISION AND SOME SUPPLEMENTAL POLICIES.
HOWEVER, IN THE MEDICARE CONTEXT, CREDITABLE COVERAGE REALLY PERTAINS ONLY TO PRESCRIPTION DRUG COVERAGE, AND IT REALLY ONLY PERTAINS--IT REALLY PERTAINS TO THE VALUE OF THAT COVERAGE.
IN OTHER WORDS, IN ORDER TO BE CREDITABLE COVERAGE UNDER THE MEDICARE PART D ARENA, THE EXPECTED AMOUNT OF CLAIMS UNDER THE PRESCRIPTION DRUG PLAN HAS TO BE EQUAL OR ABOVE THE EXPECTED AMOUNT OF CLAIMS TO BE PAID UNDER A MEDICARE PART D PLAN.
SO IT CERTAINLY PERTAINED TO THE VALUE OF COVERAGE, WHETHER IT IS AS GOOD AS TO THE MEDICARE BENEFICIARY AS A STANDARD PART D COVERAGE.
SO DO WE HAVE ANY OTHER QUESTIONERS ON THE LINE?
>> YES.
OUR NEXT QUESTION COMES FROM VAN MOURADIAN.
PLEASE STATE YOUR ORGANIZATION.
THIS IS VAN MOURADIAN FROM NEVADA DIVISION OF INSURANCE.
>> HI, VAN.
HOW YOU DOING?
>> GOOD, JIM.
AND YOU?
>> YEAH.
PRETTY GOOD.
>> COULD WE GET JOAN'S E-MAIL ADDRESS?
'CAUSE WE DON'T HAVE IT.
>> JOAN
JOAN.KRAL@CMS.HHS.GOV.
>> THANK YOU, JOAN.
>> OK.
THANK YOU, VAN.
>> THANK YOU.
OUR NEXT QUESTION COMES FROM CATHY WINDFIELD-JONES.
PLEASE STATE YOUR ORGANIZATION.
>> I'M WITH CMS IN THE DIVISION OF PRIVATE HEALTH INSURANCE.
AND JIM HAS ALREADY COVERED ONE OF THE FREQUENTLY ASKED QUESTIONS THAT WE HEARD, AND SO I WILL JUST LISTEN IN.
THANK YOU.
>> AND ONCE AGAIN, IF YOU'D LIKE TO ASK AN AUDIO QUESTION, PLEASE PRESS *1 AND RECORD YOUR FIRST AND LAST NAME.
>> JIM, I WAS WONDERING--THERE WAS A BULLETIN RELEASED ABOUT THE ENLARGEMENT OF THE DEFINITION OF THIS PUBLIC HEALTH SERVICE PLAN, YOU KNOW, IN THE DECEMBER 2004 REGS BUT MAYBE JUST

AS A REMINDER.
>> OK.
>> THE DEFINITION OF PUBLIC HEALTH SERVICE PLAN WAS ENLARGED IN THE FINAL PORTABILITY REGS.
ACTUALLY, THEY WERE FINAL PORTABILITY REGS FOR GROUP COVERAGE, BUT WITHIN THE GROUP COVERAGE, YOU HAVE A DEFINITION SECTION.
AND IT'S IMPORTANT TO NOTE THAT THE DEFINITIONS HOLD TRUE BOTH FOR THE GROUP MARKET AND FOR THE INDIVIDUAL.
BUT AT ANY RATE, THE MOST PRACTICAL POINT WAS THAT IF AN INDIVIDUAL HAD COVERAGE THROUGH THE NATIONAL HEALTH SERVICE OF A FOREIGN COUNTRY THAT THAT COUNTED AS CREDITABLE COVERAGE.
SO WE HAVE GOTTEN A LOT OF QUESTIONS ON THAT.
>> THANK YOU, JOAN.
DO WE HAVE ANY OTHER QUESTIONS?
>> YES, SIR.
OUR NEXT QUESTION COMES FROM RUTH CASE.
PLEASE STATE YOUR ORGANIZATION.
>> HI.
GOOD AFTERNOON.
IT'S WYOMING DEPARTMENT OF INSURANCE.
>> HI.
GOOD AFTERNOON.
>> HI, JIM.
THANK YOU IN THE PAST FOR ALL YOUR HELP, BUT I HAVE A QUESTION THAT--IT'S PRETTY MUCH A MOOT POINT, BUT I JUST WANTED TO HEAR SOME DISCUSSION ON IT IF YOU HAD ANY INFORMATION AVAILABLE.
UNDER THE STATE ALTERNATIVE MECHANISM FOR THE STATE OF WYOMING, WE EXCLUDE PEOPLE WHO HAVE ELIGIBILITY UNDER INDIAN HEALTH SERVICE AS ANOTHER GOVERNMENTAL PLAN.
ARE THERE ANY OTHER STATES THAT PROVIDE COVERAGE FOR INDIAN HEALTH SERVICE RECIPIENTS, OR DO YOU THINK THAT'S JUST ENTIRELY GOING TO CONTINUE TO BE AN EXCLUDED POPULATION?
>> ONE STATE WE'RE AWARE OF IS ALASKA.
>> IF THEY INCLUDE--
>> THEY INCLUDE THEM.
RIGHT.
THEY INCLUDE THEM.
I'M SORRY.
YOU'RE TALKING ABOUT INCLUDING THEM IN THE DEFINITION OF CREDITABLE COVERAGE OR--
>> NO.
WE ACCEPT THEM FOR CREDITABLE COVERAGE.
WE JUST WANT TO ALLOW THEM TO BE ELIGIBLE TO APPLY FOR THE STATE'S ALTERNATIVE MECHANISM BECAUSE OF THEIR ELIGIBILITY

UNDER INDIAN HEALTH SERVICES.
>> WELL, SO YOU'RE SAYING THAT THEY AREN'T HIPAA ELIGIBLE?
>> WE DON'T CARE IF THEY'RE HIPAA ELIGIBLE OR NOT.
JUST BECAUSE THEY HAVE ELIGIBILITY UNDER INDIAN HEALTH SERVICES, THEY'RE--
>> OH, I SEE.
OK.
I GOT YOU NOW.
SO YOU'RE SAYING THAT SINCE THEY'RE ELIGIBLE FOR THE INDIAN HEALTH SERVICE THAT THEY'RE NOT ELIGIBLE FOR THE HIGH-RISK POOL.
>> RIGHT.
>> YEAH.
WELL, WE WOULD SEE THIS.
>> JIM, I'LL BE HAPPY TO GO OVER SOME DOCUMENTATION IN OUR STATE FILES.
WE'VE DEALT WITH THIS ISSUE BEFORE.
>> THAT WOULD BE HELPFUL.
>> YEAH.
WHY DON'T YOU SEND US AN E-MAIL?
YOU HAVE MY E-MAIL ADDRESS?
>> I DO, JIM.
>> OK.
JUST SEND ME AN E-MAIL.
WE'LL CERTAINLY DISCUSS THIS WITH YOU.
>> THANK YOU.
>> OK.
>> THANK YOU.
OUR NEXT QUESTION COMES FROM JOHN GROSS.
>> HI.
THIS IS JOHN GROSS WITH THE MINNESOTA INSURANCE DEPARTMENT.
THIS GOES BACK TO THE WELLNESS PROGRAM.
DO YOU HAVE ANY IDEA WHEN YOU'RE GONNA COME BACK WITH SOME CONSENSUS ON WHAT SUPPLEMENTAL BENEFITS ARE OR ARE NOT?
>> WELL, WE'RE WORKING ON THAT, AND HOPEFULLY IT--YOU KNOW, I CAN'T PUT A TIMEFRAME ON THIS.
WE'RE WORKING ON GETTING SOMETHING OUT.
AND SO IT COULD BE WEEKS, OR IT COULD BE A MONTH.
I JUST CAN'T BE PINNED DOWN ON A TIMEFRAME, BUT I CAN--WE'LL TELL YOU THAT WE ARE WORKING ON SOMETHING CONCURRENTLY WITH THE DEPARTMENT, AND WE'RE WORKING TO GET SOMETHING OUT.
>> OK, JIM.
I JUST WANT TO LET YOU KNOW THAT WE'VE BEEN EXTENSIVELY HAVING SOME CONVERSATION WITH AMY TURNER AND HER STAFF.
AND VERY APPRECIATIVE OF WHAT THEY'VE BEEN ABLE TO PROVIDE MINNESOTA.
>> RIGHT.

I WAS--YEAH.
I BELIEVE I WAS INVOLVED IN SOME OF THOSE DISCUSSIONS OVER THE PHONE.
YEAH.
SO I KNOW THAT AMY IN DEPARTMENT OF LABOR--THEY'RE REALLY ON TOP OF THIS, AND THEY'VE PROVIDED A LOT OF GOOD INFORMATION ON THIS ISSUE.
>> AT THIS TIME, WE HAVE NO FURTHER QUESTIONS.
OK.
ADAM SHAW WANTED TO MAKE A FEW OTHER POINTS ABOUT THE NON-DISCRIMINATION AND WELLNESS PROGRAMS WITH YOU.
>> YES.
THANKS, JIM.
AS I THINK I ALLUDED TO, THE WELLNESS RULES ARE PART OF A LARGER PACKAGE OF REGULATIONS, AND THERE WERE OTHER NON-DISCRIMINATION ISSUES ADDRESSED, AND I JUST WANTED TO RUN DOWN THOSE VERY QUICKLY IN THE REMAINING TIME.
SOME OR ALL OF THOSE MIGHT BE OF INTEREST TO THIS AUDIENCE.
ONE WAS THE SOURCE OF INJURY ISSUE.
AND THE GROUP HEALTH PLAN OR GROUP HEALTH INSURANCE--IF A GROUP HEALTH PLAN, GROUP HEALTH INSURANCE COVERAGE GENERALLY COVERS A SPECIFIC INJURY, IT CANNOT DENY BENEFITS IF THE INJURY IS A RESULT OF DOMESTIC VIOLENCE OR A MEDICAL CONDITION, PHYSICAL OR MENTAL.
AND THIS IS TRUE EVEN IF THE MEDICAL CONDITION IS NOT DIAGNOSED BEFORE THE INJURY.
ANOTHER IS NON-CONFINEMENT CLAUSES AND THE ABILITY TO ENGAGE IN NORMAL LIFE ACTIVITIES.
SO THE REGULATIONS CONTINUE THE TRADITION—NON-CONFINEMENT CAUSES
ARE NOT ALLOWED, AND A PLAN CANNOT TAKE INTO ACCOUNT WHETHER OR NOT SOMEONE IS CONFINED TO A HOSPITAL OR HEALTH INSTITUTION IN DECIDING ELIGIBILITY OR RATES.
AND A PLAN CANNOT TAKE INTO ACCOUNT A PERSON'S ABILITY TO ENGAGE IN NORMAL LIFE ACTIVITIES IN ELIGIBILITY OR RATE.
>> OK.
ALL RIGHT.
THANKS, ADAM.
AND JUST BE PERFECTLY CLEAR.
WE'RE TALKING ABOUT THE GROUP HEALTH PLANS REQUIREMENTS, THE NON-DISCRIMINATION PROVISIONS AND THE WELLNESS PROGRAMS PERTAIN TO THE GROUP HEALTH PLAN.
I THINK THAT'S ALL WE HAVE.
ARE THERE ANY MORE QUESTIONERS ON THE LINE?
>> WE DO HAVE ANOTHER QUESTION FROM MR. JOHN GROSS.
>> JIM AGAIN.

MINNESOTA.
ON THE ALTERNATIVE MECHANISM, ONE OF THE REQUIREMENTS WE'RE HAVING PROBLEMS WITH IN MINNESOTA IS WITH OUR ALTERNATIVE MECHANISM AND OUR RISK POOL IS THEY'RE QUESTIONING HOW WE'RE GIVING OUT INFORMATION ABOUT THE PLACE THAT PEOPLE CAN GO AFTER THEY'VE EXHAUSTED COBRA.
AND DOES THE FEDERAL LAW REQUIRE A SELF-FUNDED EMPLOYER TO DISCLOSE THAT INFORMATION?
OBVIOUSLY, THE EMPLOYER'S GONNA TELL YOU ALL ABOUT COBRA IF, FOR EXAMPLE, WHEN YOU TERMINATE YOUR EMPLOYMENT, BUT DOES THE DOCUMENT THAT THE EMPLOYEES RECEIVE WITH A SELF-FUNDED EMPLOYER HAVE TO DISCLOSE WHERE THE NEXT STEP IS AFTER COBRA FOR THE CONVERSION POLICY?
>> JOHN, I'M--THIS IS DAVE HOLSTEIN.
I'M NOT SURE I UNDERSTAND THE QUESTION.
ARE YOU TALKING ABOUT A CERTIFICATE OF CREDITABLE COVERAGE, OR YOU TALKING ABOUT THE COBRA REQUIREMENT THAT THE GROUP HEALTH PLAN NOTIFY THE QUALIFIED BENEFICIARY OF THE RIGHT TO PURCHASE A CONVERSION POLICY HAS TO GIVE THEM THAT NOTIFICATION WITHIN 180 DAYS BEFORE THE EXPIRATION OF THE COBRA COVERAGE?
>> WE'RE TALKING ABOUT THAT--THE LATTER PART.
BECAUSE WE GET A LOT OF QUESTIONS.
PEOPLE TERMINATE THEIR EMPLOYMENT.
FOR EXAMPLE, THEY'RE WELL AWARE OF THE 18-MONTH EXTENSION, BUT THEY ENTER THE 18 MONTHS.
THEY HAVE NO IDEA WHERE TO GO NEXT.
NOW WE REQUIRE IN MINNESOTA FOR ANY PRODUCT THAT WE APPROVE, YOU
KNOW, THROUGH THE PRIVATE HEALTHCARE MARKET--WE REQUIRE WITHIN THAT CERTIFICATE OF COVERAGE OR IN THE POLICY ITSELF VERY DETAILED INFORMATION ABOUT THE COBRA AND THEN ALSO ABOUT WHERE YOU GO FOR THE CONVERSION POLICY.
>> WELL, THE COBRA RULE APPLIES TO SELF-FUNDED PLANS BECAUSE IT APPLIES TO A GROUP HEALTH PLAN THROUGH WHICH AN INDIVIDUAL IS RECEIVING COBRA CONTINUATION COVERAGE.
AND THE COBRA LAW DOESN'T DIFFERENTIATE BETWEEN A SELF-FUNDED PLAN AND AN INSURANCE PLAN.
SO WHILE THEY MAY NOT BE SUBJECT TO THE MINNESOTA STATE LAW REQUIREMENTS BECAUSE THEY'RE A SELF-FUNDED PLAN, THEY'RE STILL SUBJECT TO THE REQUIREMENTS OF THE FEDERAL COBRA LAW, WHICH WOULD--WHICH REQUIRES THEM TO--IF THERE IS A CONVERSION POLICY AVAILABLE.
NOW, IN A LOT OF CASES, I WOULD ASSUME THAT A SELF-FUNDED PLAN WOULDN'T HAVE A CONVERSION OPTION.
IT WAS JUST--AND SO IT WOULD BE A MOOT POINT.

BUT IF, FOR THE SAKE OF DISCUSSION, A SELF-FUNDED PLAN DOES HAVE A GENERALLY APPLICABLE CONVERSION OPTION, THEN IT WOULD BE OBLIGATED TO NOTIFY THE INDIVIDUAL OF THAT--OF THE AVAILABILITY OF THAT CONVERSION POLICY WITHIN THE LAST 6 MONTHS OF COBRA COVERAGE.
NOW, THE COBRA RULES NOT GONNA GET INTO THE MINUTIAE OF SAYING, "WELL, YOU GOTTA LET THEM KNOW THAT, YOU KNOW, IF THEY TAKE THIS, THEN THEY'RE GONNA FORFEIT THEIR ELIGIBILITY, THEIR INELIGIBILITY.
YOU KNOW, THEY CAN'T GET--THEY CAN'T QUALIFY THEN AS HIPAA ELIGIBLE BECAUSE THEN THEIR MOST RECENT PERIOD OF COVERAGE IS GONNA BE INDIVIDUAL COVERAGE RATHER THAN EMPLOYER-SPONSORED GROUP COVERAGE."
THE COBRA LAW DOESN'T ADDRESS THAT.
IT JUST SIMPLY IMPOSES A STRAIGHTFORWARD REQUIREMENT THAT THEY--YOU KNOW, IF THERE IS A CONVERSION OPTION AVAILABLE, THEN IT HAS TO BE MADE--THE PLAN HAS TO NOTIFY THE QUALIFIED BENEFICIARY OF THAT.
BUT AGAIN, IF YOU'RE DEALING WITH A SELF-FUNDED PLAN, THEN, YOU KNOW, UNLESS YOU HAVE SOME UNIQUE PROVISION IN YOUR STATE INSURANCE LAW THAT WOULD ALSO ENCOMPASS SELF-FUNDED PLANS, THEY'RE NOT GONNA BE SUBJECT TO WHATEVER REQUIREMENTS AN ISSUER WOULD BE SUBJECT TO UNDER MINNESOTA STATE INSURANCE LAW.
>> THANK YOU, JIM.
I UNDERSTAND, BUT I WAS HOPING THAT MAYBE THE FEDERAL COBRA LAW HAD SOME KIND OF A INFORMATION OR REQUIREMENT FOR SELF-FUNDED EMPLOYERS TO MAKE SURE THAT THEY AT LEAST WOULD NOTIFY THOSE EMPLOYEES OR HAVE IT IN THEIR BENEFIT PLAN, SOME INFORMATION THAT THEY SHOULD CONTACT THE STATE INSURANCE COMMISSIONER OR WHATEVER SO THE PEOPLE WOULD BE WELL AWARE OF WHAT TO DO NEXT.
>> NOT AWARE OF ANY SUCH REQUIREMENT.
YEAH.
IT'S NOT THERE.
IT'S JUST BASIC FUNDAMENTAL OBLIGATION TO TELL THE INDIVIDUAL IF THERE IS A CONVERSION OPTION AVAILABLE UNDER THAT SELF-FUNDED PLAN.
AND THERE MAY NOT--AND THERE MAY NOT BE.
MY GUESS IS, YOU KNOW, MOST CASES EMPLOYERS THAT SELF-FUND AREN'T
GONNA BOTHER WITH THAT, YOU KNOW.
IT'S GONNA BE MOSTLY OR MAYBE ALMOST EXCLUSIVELY INSURED PLANS 'CAUSE THEN THE--YOU KNOW, THE ISSUERS CAN PROVIDE POLICIES THAT, YOU KNOW, WOULD CONSTITUTE INDIVIDUAL COVERAGE, WHEREAS A SELF-FUNDED PLAN'S NOT GONNA HASSLE WITH

THAT.
>> OK.
THANK YOU.
OK.
>> AND WE DO HAVE ANOTHER QUESTION FROM LANNY CRAFT.
PLEASE STATE YOUR ORGANIZATION.
>> I'M WITH THE MISSISSIPPI HEALTH POOL.
HI, JIM.
>> HEY, LANNY.
HOW ARE YOU?
>> GOOD.
GOOD.
I'M DIRECTING THIS QUESTION TO JOAN.
I BELIEVE THAT SHE COMMENTED SOMETHING TO THE EFFECT THAT IN THE INSTANCE OF DETERMINING AN INDIVIDUAL'S HIPAA ELIGIBILITY THAT IN LIEU OF THE CERTIFICATE OF GROUP HEALTH PLAN COVERAGE, CERTAIN SUBSTITUTES WOULD BE ACCEPTABLE, WHICH WE'RE AWARE OF.
BUT SHE ALLUDED, I BELIEVE, TO TELEPHONE, AND I'M NOT CERTAIN THAT I FOLLOWED THAT.
>> WELL, LANNY, I DON'T HAVE MY CODE OF FEDERAL REGULATIONS WITH ME, BUT I CAN CERTAINLY PROVIDE THAT SITE BY E-MAIL TO YOU.
YES, IT'S SPECIFICALLY MENTIONED.
>> WHAT I'M A LITTLE BIT CONFUSED ABOUT IS WHAT DOES THAT MEAN? DOES THAT MEAN THAT THE POOL IS OBLIGATED TO MAKE THE TELEPHONE CONTACT, OR IS IT THE OBLIGATION OF THE APPLICANT TO PUT THE APPROPRIATE PARTY IN TOUCH WITH THE POOL?
>> WELL, BASICALLY WHAT WE'RE CONCERNED ABOUT--AND I REALIZE THIS IS A TIMING PROBLEM AND OFTEN A RESOURCE PROBLEM--IS THAT AT THE TIME THE PERSON MAKES APPLICATION AND THEY ATTEST TO THE FACT THAT THEY DO HAVE QUALIFYING CREDITABLE COVERAGE AND THEY NEED--AND FOR WHATEVER REASON THEY ARE UNABLE TO OBTAIN A CERTIFICATE, IN FEDERAL REGULATION, YOU HAVE A LONG LIST OF WRITTEN SUBSTITUTES BUT THEN ALSO TELEPHONIC.
NOW, IT DOES NOT SAY WHO DOES WHAT, BUT IT INDICATES THAT, YOU KNOW, THE TWO PARTIES WOULD BE ABLE TO COMMUNICATE THE SUBSTANCE OF THE CREDITABLE COVERAGE.
THANK YOU, DAVE.
I'M LOOKING AT 45CFR148.124.
PROBABLY C2--C23.
OTHER EVIDENCE, CREDITABLE COVERAGE, AND WAITING PERIOD OR AFFILIATION PERIOD INFORMATION MAY BE ESTABLISHED THROUGH MEANS OTHER THAN DOCUMENTATION SUCH AS BY TELEPHONE CALLS FROM THE ISSUER TO A THIRD PARTY VERIFYING CREDITABLE COVERAGE.
SO THE THIRD PARTY IN THAT INSTANCE WOULD BE THE RISK POOL

STAFF, BUT AGAIN, THAT WOULD BE THE CASE OF THE RISK POOL STAFF GETTING WITH THE APPLICANT AND, YOU KNOW, TRYING TO MAKE THIS HAPPEN.
>> OK.
THAT MAKES SENSE TO ME.
I WAS THINKING THAT THERE MIGHT BE SOME PRIVACY ISSUES THERE IF THE RISK POOL ATTEMPTED TO MAKE DIRECT CONTACT.
>> NO.
THE APPLICANT WOULD BE--YOU KNOW, THEY WOULD REQUEST IT.
>> THEY HAVE TO COOPERATE WITH IT AND ESSENTIALLY AUTHORIZE IT.
AND IF THEY DON'T, WELL, THEN, YOU KNOW, THAT'S THEIR PROBLEM.
>> OK.
THAT MAKES SENSE.
THANK YOU.
>> YEAH.
THANKS, LANNY.
>> THANK YOU.
OUR NEXT QUESTION COMES FROM RUTH CASE.
>> HI.
I JUST THOUGHT OF SOMETHING ADDITIONAL I WANTED TO GET SOME INFORMATION ON.
>> OK.
WHAT ORGANIZATION ARE YOU WITH, RUTH?
>> OH, I'M SORRY.
WYOMING DEPARTMENT OF INSURANCE.
OUR STATE'S ALTERNATIVE MECHANISM HAS AN EXCLUSION FOR STARTUP COVERAGE THAT'S BASED ON CONFINEMENT.
SO IF YOU'RE CONFINED TO A HOSPITAL OR OTHER INSTITUTION, YOU'RE NOT ELIGIBLE TO BEGIN COVERAGE.
AND I KNOW NON-CONFINEMENT APPLIES TO GROUP, BUT DO OTHER STATES TYPICALLY ALSO HAVE NON-CONFINEMENT LANGUAGE UNDER THE RISK POOL?
>> WE'RE NOT SURE ABOUT THAT.
SO AGAIN, WE CAN DISCUSS THAT WITH YOU OFFLINE.
>> OK.
THANK YOU.
I CAN JUST INCLUDE THAT IN MY E-MAIL TO YOU, JIM.
>> YES.
THAT'D BE FINE.
>> GREAT.
THANK YOU.
>> THANK YOU.
>> AT THIS TIME, THERE ARE NO FURTHER QUESTIONS.
>> OK.
SINCE WE WENT OVER ABOUT 7 MINUTES PAST THE HOUR, I THINK IT'S A GOOD TIME TO WRAP UP.

AGAIN, THANKS FOR EVERYBODY'S PARTICIPATION.
AND WE LOOK FORWARD TO CONTINUING TO WORK WITH EVERYONE ON THESE IMPORTANT ISSUES.
AND JUST WANT TO REMIND PEOPLE IF THEY CAN THINK OF A QUESTION LATER, THEY CAN CERTAINLY SEND IT TO THE PRIVATE HEALTH INSURANCE GROUP, PHIG MAILBOX.
>> THANKYOU THAT CONCLUDES THE CONFERENCE, YOU CAN DISCONNECT AT THIS TIME.