[Chapter Five]

State Regulation of Health Insurance

The goal of this chapter is to examine the role of state regulation of health insurance in improving access to affordable and adequate coverage. It begins by summarizing those characteristics of the uninsured in Texas. The chapter then discusses the role of states in health insurance regulation and reviews state powers and limitations. This discussion is limited to the regulation of licensed health insurance products. The information found in this chapter was taken from the white paper "State Regulation of Health Insurance: Implications for Health Care Access," which can be found in Appendix F of this report.

Key Characteristics of the Uninsured Population in Texas

Texas leads the nation in the proportion of uninsured working age adults. Even when actual employment status is taken into account, Texas leads the nation in the percentage of individuals without coverage (RWJF, 2005). In data from the U.S. Census Bureau published in 2005, 25.1 percent of all working age adults in Texas were uninsured, compared to 8.5 percent in Minnesota, the state with the lowest percentage (U.S. Census Bureau, 2005). Texas' status persists regardless of state ranking criteria such as race and ethnicity, the presence in the household of children, and employment status.

The Texas dilemma effectively offers a "worst case" scenario of the fragility of the U.S. health insurance system for working age adults and children. For non-elderly persons not yet completely disabled by a condition that prevents work, U.S. policy offers three basic pathways to health insurance: voluntary employer-sponsored benefits, individually purchased coverage, and coverage through a public program (IOM, 2004). Statistics suggest that in Texas the employer market is particularly weak and neither the individual market nor public insurance are sufficiently vigorous to overcome this deficit. If employer-sponsored health insurance coverage rates in Texas were equal to the U.S. average, 2003 coverage rates would have been 6 percent higher (54 percent versus 48 percent). This translates to approximately 1 million additional residents who would have had employer coverage in 2003 (KFF, 2004).

Data prepared by the Texas Department of Insurance (TDI) offer important insight into the characteristics of uninsured Texans (TDI, 2003). The uninsured span all ages, but persons, ages 18 to 44, appear to be at particular risk for lack of coverage (TDI, 2003). Unemployment exponentially increases the risk of insurance among working age adults, but, as noted, the uninsured rate even for employed adults is significantly elevated (TDI, 2003). Immigration status affects coverage rates, but the lack of coverage among native and naturalized citizens also is notable (TDI, 2003).

Certain Texas industries are associated with reduced health insurance coverage (TDI, 2003):

- Construction
- Personal Services
- Entertainment and Recreation
- Agriculture

• Wholesale and Retail Trade
• Health Care Services
• Social Services

Industries associated with low coverage rates typically are characterized by part-time and seasonal employment, cyclical work patterns with frequent layoffs, relatively low cash wages, and limited non-cash compensation (including even basic non-cash compensation such as sick leave). These employment characteristics are recognized predictors of reduced access to employer-sponsored coverage (IOM, 2004).

Furthermore, considerable data suggest that low levels of employer-sponsored coverage are by and large attributable to employers' failure to offer coverage at all, rather than employees' failure to take up coverage that is offered (Hoffman et al., 2004; IOM, 2004). Smaller and lower wage firms face particular challenges in finding affordable coverage and subsidizing the coverage they offer (IOM, 2004). By 2004 only 63 percent of small firms surveyed nationally offered coverage, down from 68 percent in 2001 (Gabel et al., 2004). Cost appears to be the driver, both for the employer and the employee. It is estimated that virtually all of the decline between 1988 and 2001 in employee take-up rates among full-time male workers could be attributed to increases in the employee share of the premium over this time period (Cutler, 2002).

Working age adults not in the labor market face especially challenging health insurance access problems because individual insurance is limited and costly. Non-working adults are more likely to experience elevated poverty and reduced health status, both of which predict coverage rates. Unless they qualify for Medicare or Medicaid, their coverage options may be exceedingly limited, even with insurance market regulatory interventions, such as guaranteed issue and high-risk pools (TDI, 2003).

Taken together, these statistics suggest a weak employer insurance market in the state, compounded by inadequate alternatives to employer-sponsored coverage. This is attributable to the cost of coverage in relation to employee compensation and family income. TDI cites the total average monthly cost of employer-sponsored family coverage exceeds $800, while the cost of single coverage hovers at the $300 mark (TDI, 2003). For older persons in poor health and dependent on the individual market, the monthly figure is much higher. Even for younger workers with no serious conditions, coverage under a limited individual plan can exceed $200 (post-tax) monthly with no employer contribution.

In view of the relationship between family income and health insurance coverage, the extent to which regulatory intervention alone can open up a market and/or make it more affordable becomes the central question. Even the most energetic proponents of a market driven approach assumes subsidization through tax credits (Pauley, 2005). In the absence of a subsidy program, expectations from regulation alone may be modest. A more appropriate way to approach the issue might be to consider which regulatory interventions, in combination with subsidies, might do the most to aid the market.

Two basic types of regulatory interventions are relevant: interventions aimed at creating more affordable and attractive employer-sponsored benefits and interventions aimed at strengthening the individual coverage market. The underlying drivers of insurance costs are a consideration when assessing the relative value of interventions into the individual and group market.

The United States depends on a voluntary coverage system. In this system, the cost of coverage is generally higher due to adverse selection (Merlis, 2005). Employer coverage helps mitigate higher costs because of the worker profile, enrollment constraints (i.e. timing), and incentives for healthy workers paid by the employer.

Regulatory models aimed at building the individual system will have limited impact without heavy subsidies, or they must strive to replicate the market characteristics of voluntary group products.

The Role of States in the Regulation of Health Insurance

The assessment of state regulatory powers in the health insurance market must consider two fundamental factors underlying the basic architecture of the market: pooling and design.

- *Insurance pooling* Who enrolls in an insurance pool greatly affects the market. The greater the proportion of younger, healthier members, the lower the cost of coverage for the group as a whole.
- *Coverage design* Health insurance coverage design considerations are complex and intricate. Coverage can be limited or comprehensive in design in terms of deductibles, coinsurance, copayments, the application of annual and lifetime maximum coverage limits, and the presence of stop-loss on out-of-pocket payments for covered benefits. Beyond these factors, design involves other considerations: the classes and categories of covered benefits and array of services and procedures covered within each class; applicable limitations and exclusions on coverage; the use of waiting periods and pre-existing condition exclusions to apply post-enrollment coverage limits on specific services; the rigor of certain key terms and definitions such as "medical necessity;" and the scope of discretion accorded insurers to make final and binding coverage determinations with broad discretion to construe the terms of the agreement (Rosenblatt et al., 1997).

Any assessment of state health insurance regulatory options in the context of enrollment and design inevitably brings into sharp relief the paradoxical nature of insurance regulation: as state regulators use their powers to expand and improve coverage, costs may rise for persons who are already adequately covered members of the insurance pool. These concepts of using regulatory powers to broaden and strengthen insurance pools are sometimes referred to as risk solidarity. These types of regulatory interventions tend to generate fierce opposition from the insurance industry.

The Legal and Political Limits of State Insurance Regulatory Powers

Under principles of U.S. law, states play the primary role in regulating health insurance (Rosenblatt et al., 1997). However, there are a host of federal laws with a limiting and pre-emptive effect on state insurance regulatory powers. The Employee Retirement Act of 1974 (ERISA) governs virtually all benefit plans offered by private employers. While ERISA pre-emption principles "save" state laws that regulate insurance, self-insured employer-sponsored health plans are not considered "insurance" (GAO, 2003a). Of the 11.4 million Texans with some form of private coverage, 5 million are members of self-insured plans (TDI, 2003).

Other federal laws have a similar pre-emptive effect. Depending on the state's labor patterns, federal law may have a considerable impact on limiting a state's power to affect insurance regulation.

Two important examples of other pre-emptive laws are TriCare and the Federal Employee Health Benefit Act, both of which regulate insurance sold or furnished to the federal, civilian, and military workforce. Another relevant example of preemptive law is Medicare standards for insurance products sold to beneficiaries.

Federal law also directly affects certain state insurance regulatory practices. The most important of these laws, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), establishes minimum federal standards for state regulated insurance markets in several critical areas, all of which may affect coverage costs to some degree. HIPAA requires state licensed health insurers to make their small group products available to all small employers (i.e., employers with between 2 and 50 employees) regardless of their claims experience or employee health status (Claxton, 2002). HIPAA does not regulate the rates that can be charged for these products, although many states regulate rates in the small group market (Claxton, 2002).

HIPAA also requires state licensed insurers to accept persons transitioning from group to individual coverage and who meet a series of strict conditions, such as ineligibility for any other coverage and continuous coverage in the group market for at least 18 months (Claxton, 2002). Persons protected under these transitional rules are known as HIPAA-eligible persons, because they are considered to have continuous and "creditable" coverage prior to entering the individual market. They also must have exhausted their group continuation coverage (known as "COBRA" coverage) and must apply for individual coverage within 63 days of leaving group coverage (Claxton, 2002).

In addition, HIPAA requires licensed insurers to guarantee renewal of coverage sold to multiple employers, although the level of the renewal premium is left to insurer discretion (Claxton, 2002). Finally, HIPAA prohibits discrimination based on health-related factors in rates charged to members of an employee group (GAO, 2003b).

The extremely fragmented and segmented nature of the health insurance market, coupled with a raft of pre-emptive statutes, poses both financial and legal challenges to states. Even where state regulators can access employer plans, as with products sold by licensed health insurers, insurers may strongly resist regulation to avoid what they perceive as changes that will affect both their employer-insured and self-insured markets.

An important consideration is one sizable group of insured residents who are members of a pool fully accessible to state regulation, either directly or indirectly, depending on the legal structure of the relationship between state and local government. This group consists of residents who are public employees of a state, its localities, and the governmental units and instrumentalities of the state. The size and range of this group in Texas is considerable. If state regulators were to use this large pool of relatively healthy workers and their families as the basis to more broadly restructure the group and individual markets, the impact might be substantial. However, reforms based on public employees may have more operational and political constraints than legal ones.

An Inventory of State Insurance Regulatory Powers

State insurance laws essentially are designed to accomplish three basic goals:

1. Ensure financial standards for licensure that guarantee the stability and solvency of insurance products.
2. Ensure appropriate market conduct and guard against marketing fraud or unfair business practices.
3. Regulate the accessibility, affordability, structure, and content of licensed products.

The third power of state regulators is most relevant to this analysis. All states have laws that fall into all three categories; however, state laws vary enormously in their scope, range and specific requirements. Some states, such as New York, tend to be cited in the literature for their comparatively regulatory approach to insurance; other states, (notably Texas) tend to be identified as states that engage only in limited regulatory practices (GAO, 2003b). Whether these regulatory differences account for most, or even much, of state-to-state variation in the cost of health insurance is not known. Numerous factors (such as the underlying cost of medical care, the insurance markets in particular states, the nature of the industry operating in any particular state, and even the unique health care culture of states with coverage) play important roles in determining the cost of coverage. It is worth noting again that TDI insurance costs parallel national norms. To the extent that Texas falls into the deregulated end of the regulation spectrum, this fact does not seem to have produced major cost differences (TDI, 2003).

Three basic classes of licensed health insuring organizations can be found in most, if not all, states: commercial insurers; Blue Cross and Blue Shield plans (which may or may not continue to operate as non-profit organizations as opposed to licensed insurers); and health maintenance organizations (HMOs) (Claxton, 2002). State regulatory activities may be aimed at one, two, or all three license holders, which in turn may sell in both the group and individual market. Regardless of their licensure category, all three classes of insurer share an interest in attracting a coverage pool that parallels the general population and is not disproportionately comprised of adverse risks. Insurers also may segment their markets by both purchaser (individuals, small groups, large groups, and trade associations) and by product type (e.g., different products made available to specific markets). Common factors used to segment the market are age, occupation, gender, health status and geographic location (Claxton, 2002).

Insurers also may use underwriting to keep pools stable. Underwriting is the process by which insurers accept applicants for coverage and set the terms and price of coverage. Even when state laws require an insurer to accept applicants in the small group and individual market, companies may have broader underwriting discretion in setting the coverage terms for enrollees. These terms are part of the product design (itself) and offer insurers additional safeguards against adverse selection.

States typically exercise various types of regulatory powers over health insurance products. These powers have been concisely chronicled by Gary Claxton, an expert in health insurance regulation. He also notes that the exercise of these powers varies considerably by insurance product and by state (Claxton, 2002).

Premium Regulation

States can regulate premiums in numerous respects. They can establish "rate bands" that limit the discretion of insurers to adopt wide ranges between the lowest and highest premiums charged for the same product. Rate band laws can be limited or broad in scope and may set strict or limited ranges (e.g., restricting the highest rate to no more than 150 percent of the lowest rate for the same product.) Premium regulation also can consist of community rating standards, which can be strict or modified to permit some variation in the rates. States also may establish "loss ratios" to ensure a reasonable ratio of benefit payments to premiums charged. Regulation of loss ratios acts both as a check on premium costs and as an indirect form of benefit design regulation.

Medical Underwriting

The state also may regulate the extent insurers can engage in medical underwriting, either at the point of application or following enrollment as a means of limiting adverse selection. Medical underwriting is particularly common in the individual market. Medical underwriting can lead to high levels of applicant rejection rates and a very limited number of "clean offers", (e.g. offers without a host of riders and exclusions limiting the terms of coverage) (Merlis, 2005; Pollitz et al., 2001). Similar to premium banding, the regulation of medical underwriting practices is distinct from direct regulation of how much can be charged to any particular purchaser (or group of purchasers) for any particular product.

Renewability and Guaranteed Issue

Renewability is designed to ensure that an individual or small group purchaser is not denied contract renewal at the end of a coverage term. Guaranteed issue is designed to ensure initial access to the market. HIPAA regulates guaranteed issue for transitioning small employers and individuals who are HIPAA-eligible. Since HIPAA does not regulate rates, neither renewability nor guaranteed issue alone ensures affordable rates.

Coverage Continuation

Under federal law (COBRA), states frequently require insurers to allow former members of a covered employee or association group to continue coverage under certain circumstances. In this sense, COBRA, like many federal laws, represents an evolution of state insurance law.

Benefit Design

All states regulate benefit design to some degree and require benefits to be specified. A 2001 GAO study found that Texas fell into the group of states with the highest number of mandates. However, the study did not appear to group mandates by anticipated cost, and grouped all forms of mandates (small group, large group, and individual market) together (GAO, 2003b).

Review and Appeals

An insurer's discretion to make final and non-reviewable decisions is typically the subject of state regulation, with all states permitting some level of review for at least certain types of denials.

HIPAA's Provisions in Context

HIPAA represents an effort on the federal government's part to set minimum standards for non-group products. Beyond the issue of portability for persons transitioning from group to group or from group to individual markets, HIPAA requires guaranteed issue for persons who are "HIPAA-eligible.") These are persons with group coverage who are transitioning without significant break in "creditable

coverage" from the group to the individual market. HIPAA permits states to choose between requiring their insurers to offer guarantee issued products or establishing an alternative approach, such as high-risk pools. The critical issue is that HIPAA protects only persons transitioning from group to individual markets, not individuals seeking individual coverage for the first time. Furthermore, individuals who experience a break in "creditable coverage" (e.g., who cannot pay their COBRA continuation premiums) lose their HIPAA guaranteed issue protections.

HIPAA's guaranteed renewal provisions are more generous than its limited guaranteed issue protections. Regardless of an individual's HIPAA eligibility status, HIPAA protects against denial of a renewal. But as noted previously, HIPAA does not regulate the rates that are charged upon renewal, just as it does not regulate guaranteed issue rates.

State Intervention in the Individual Market

Over the past 20 years, states have begun more actively regulating the small group market (employers between 2 and 50 persons; in some states, the self-employed are treated as a small group) (GAO, 2003b). A few states have begun to apply regulatory tools to the non-group (i.e., individual) market, but these incursions are often quite controversial because of their impact on lower risk individual purchasers (GAO, 2003b).

Table I summarizes Texas' regulations in the non-group market as of April, 2004. In some states, the level of regulatory protection exceeds minimum HIPAA requirements. A more detailed list of options from other states can be found in Appendix F. Texas has opted for few of these added protections. One important "HIPPA +" protection is a "guaranteed issue" rule that protects all applicants, HIPAA-eligible or otherwise, but this protection is rare (5 states only – Massachusetts, Maine, New Jersey, New York and Vermont). Twelve states, excluding Texas, provided at least a limited additional level of guaranteed issue protection for certain classes of non-HIPAA qualified persons. Some states have elected to make guaranteed issue a rule for self-employed persons (as well as) and small groups; Texas did not extend this protection.

Table I – Summary of Key Consumer Protections in Texas' Health Insurance Markets (April 2004)

Guaranteed Issue	*All Products/ Carriers/ Residents*	*No*
	Other Protections	*No*
Preexisting Conditions	*Elimination Rider Permitted*	*Yes*
	Maximum Exclusion Period/ Lookback Period (months)	*24/60* *0/0 (HMOs)*
	Credit for Prior Coverage Required	*Yes, if 18 months of creditable coverage*
Rating Restrictions	*Community Rating (Pure or Adjusted)*	*No*
	Health Status Rate Band	*No*
Other Options	*High-Risk Pool*	*Yes, with rate limits*
	Mandatory Group Conversion Required	*No*
	Self Employed Individuals Guaranteed Issue Small Group Plans	*No*

Source: Georgetown University Health Policy Institute

A much larger group of states offers conversion coverage. Conversion coverage differs from HIPAA portability protections because it covers persons who may not meet HIPAA qualification standards. A conversion rule requires an insurer to offer an individual product to a person losing coverage under a group plan offered by the insurer. Texas offers a high risk pool, but does not offer conversion protection. While many states establish conversion protections, very few regulate the rate that can be charged for a conversion policy.

Some states offer continuation coverage for persons employed by firms not covered by COBRA protections that employ fewer than 20 persons on a full-time basis. With respect to regulation of exclusionary provisions and premiums, Table I also shows that Texas has not elected to pursue options used in some states in the non-group market. About one-third of all states either totally or partially restrict the use of post-enrollment exclusion riders based on underwriting. Texas does place limits on the period of time that insurers can "look back" in setting exclusion riders, but limits this protection to HMO enrollment. The state also limits individuals who can benefit from this "lookback" protection to persons with HIPAA-creditable coverage.

Direct rate regulation is, of course, the most far-reaching form of regulatory intervention, since it directly affects the rate that an issuer can charge. The rate spread between high and low risk enrollees in any particular product can be enormous. While rate banding and rate restrictions would make coverage affordable to persons with higher risks, it would also elevate the price for lower risks. Furthermore, as rates for the lowest risk enrollees rise, the rates at the highest end would fall, but not always appreciably in context with affordability. Rating restrictions could send products into a death spiral, as the lowest risks abandon the pool because of the rate increase (GAO, 2003b). Compulsory membership with tax subsidies might avert this result.

Many states, including Texas, have established high risk pools as of 2003. Because these pools cover very high risk persons, exceedingly high individual premium payments must be supplemented (typically by an assessment on insurers) to meet the coverage costs. Even this assessment (typically 1 percent) may not be enough to make coverage affordable. In order to avoid outright rate regulation, states supplement with group insurance assessments. Whether ERISA would pre-empt a similar assessment on self-insured group health plans is an issue that has never been litigated. In order to avoid a direct assessment on an ERISA benefit plan, the Maryland State Legislature recently placed an assessment on large employers whose health expenditures for workers fall below a certain threshold.

Finally, creating a broader insurance pool that extends well beyond high risks and includes large numbers of healthy and well-covered individuals might have an impact. A state could use its own public employee pool as the basis for such an intervention, with regulation of rates and premiums pegged to the pool. Of course, this type of intervention is beyond the traditional limits of state regulatory powers and would require a fundamental rethinking of the relationship between small groups, and individuals and public employee pools.

One approach highly dependent on federal law is small group market reforms. Federal legislation to establish "Association Health Plans" would exempt such plans from state insurance regulation, just as self-insured ERISA plans are exempt. Proponents

argue that pre-emption of state insurance laws regulating products sold to small groups would help reduce the cost of coverage, although there appears to be no definitive evidence to confirm this viewpoint. Opponents argue that the legislation would pre-empt more active state efforts to make small group coverage more affordable and accessible (GAO, 2003b).

More Active State Intervention in the Small Group Market

Texas is one of 47 states that in 2003 maintained some restrictions on rate setting in the small group market. Texas uses a rating band approach, which allows for variation within limits in premiums among types of small businesses based on factors such as age, group size, and industry. Twelve states use either pure or modified community rating, which prohibits the use of health status to set premiums. This ensures greater affordability for small firms with sicker employees, while potentially elevating rates charged firms with healthy employees during a particular contract year.

Texas, like 40 other states, required insurers to offer continuation coverage to former members of employer groups of fewer than 20 full-time employees (state COBRA). However, Texas did not elect to tighten HIPAA standards regarding the use of pre-existing condition exclusions. HIPAA limits these exclusions to 12 months, and some states have established shorter periods.

Hybrid Insurance Products

Individual coverage typically is subject to high deductibles. Hybrid insurance products offering health savings accounts coupled with high-deductible plans may be relevant to increase coverage in the small employer group market where affordability is a major barrier. Growth of these products in the employer group market has been slow, although employer interest may increase as costs continue to escalate. (Fuch & James, 2005). Whether a state would want to take aggressive steps to encourage a more robust market for this type of hybrid product is worth considering. The introduction of such a product into the group market could further segment existing coverage arrangements and elevate premiums for higher risk individuals. Without a companion initiative to stabilize premium rates for small groups with higher risk individuals, these hybrid products carry risks that may ultimately impact coverage affordability for the highest risk state residents (Kofman, 2004). It is also unclear whether the lower rates for hybrid products would be sufficiently low to attract large numbers of small low wage firms. Even if these products are appreciably less expensive than standard insurance, firms may find they cannot afford even lower rates of incremental compensation associated with offering subsidized high deductible health products.

Summary

Texas' extensive health insurance problem appears to be primarily attributable to the weakness of the state's employer-based insurance system for workers and their families. Many factors dictate the strength of employer-sponsored insurance markets, and an assessment of their relative contribution to the state's insurance dilemma is beyond the scope of this chapter. Even if the state pursued Medicaid expansions and encouraged a far more dynamic individual market (one quite limited at best, based on national individual coverage estimates), the coverage shortfall produced by a weak employer market is still too great. Reforms that stimulate greater employer participation appear to be a critical part of the challenge.

The ability to stimulate and increase employer participation appears to be directly related to the degree to which the employer views the coverage as affordable. Aside from direct financial subsidies to employers and employees, there are regulatory interventions worth considering. One intervention is the use of premium controls, such as modified community rating that eliminates rating based on health experience. Another might be to place smaller employers into larger pools by restructuring the public employee system to include smaller groups. In this way, the state might create a single and very large "state purchasing group" to give small employers the benefit of a far larger group membership with more choices and better rates. Enlarging the group also would make the concept of using a modified community rating system more feasible.

Furthermore, Texas has made only modest use of its power to regulate products purchased in the non-group market when compared to other states. Most notably, the state does not appear to have extended certain basic protections to self-employed individuals that are in use in other states. Texas also does not provide basic conversion protection or other bridging arrangements for persons losing group coverage who do not qualify for HIPAA protections. Finally, Texas does not offer the premium controls and cross subsidies available in other states.

Whether a more aggressive approach to regulation and pooling reform would significantly alter the insurance picture in the absence of considerable subsidization is not certain. States with radically different insurance patterns have different experiences for many reasons that affect their willingness to regulate the market. At the same time, certain reforms in the individual and small group market are worthy of consideration, as is a more comprehensive approach to create a "state purchasing pool" using the state's considerable power to affect market conditions through the purchase of health benefit plans for public employees.

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