

## Health Insurance Regulation in the United States

*"Modern health insurance is an odd endeavor."* —William Sage

The recent presidential election in the United States illustrated the different, and sometimes overlapping, roles of the Federal Government, State governments, and the judiciary (up to the level of the Supreme Court of the United States) in an area of interest to most Americans. The same kind of complexity—and the same levels of government—are involved in another realm of interest to most Americans, the realm of health insurance regulation in the United States.

The source of health care in the United States for most people is through the private market place, rather than through a government insurance or health care system (though these government systems do exist in the form of public programs such as Medicare, Medicaid and the State Children's Health Insurance Program (public programs with private sector components) and the Veterans' Administration and military health systems (which also has private components)). What has evolved in the last 55 years is a system in which the major source of health insurance coverage for those who have coverage in the private sector is coverage sponsored, and primarily paid for, by a person's employer through a voluntary, market-based system. As of 1998 the number of people with employer-sponsored coverage was 152 million, or 93 percent of the privately insured.<sup>i</sup>

As a recent Interstudy report notes, "America's health plan policy is not anywhere explicitly stated" but to the extent that there is a national health policy in America it "supports the contention that employer-based health plans are good social policy. As 'natural groups' they provide voluntary coverage to a wide group of people including those from all wage levels, ages, and health statuses." The report points out that "National policy encourages people to obtain health care coverage from employer-based plans and discourages them from obtaining it themselves through the individual market." In particular, national tax policy encourages this approach to health insurance by making benefits non-taxable for both employers and employees, while "persons obtaining health insurance directly for themselves do not receive the same levels of tax protection."<sup>ii</sup>

Although the authors of the Interstudy report may be correct to say that the current system represents a kind of national health policy, a recent article by Jon Gabel (cited above) serves as a reminder that the American health care "system" is an "accidental" system. Gabel points out that "The U.S. employer-based system cannot trace its heritage to any legislation. Instead, our 'accidental system' grew out of actions by the executive and judicial branches to address labor shortages during World War II." During the imposition of wage controls in World War II and a labor shortage, federal officials deemed that increasing employee health benefits would not violate the wage controls, and the Internal Revenue Service ruled, in 1943, that the benefits were "tax-exempt for workers and tax deductible for employers." As a result, one effect was a rise in enrollment in the most commonly available plans, Blue Cross/Blue Shield plans, from 1.4 million enrollees before World War II to sixty million in 1951.

The InterStudy report goes on to say that "it may be vigorously argued at a philosophical level, pragmatically, [that the Federal and State]...levels of government exhibit private health insurance policy that is consistent with the premise that private entities operating in competitive markets will produce the best results for consumers in terms of service, quality, and cost." However, the system is not an entirely unregulated system, though one component of the system is regulated only to a limited degree. The limited regulation of that one component—self-insured employer coverage—can also be thought of as an accident of history, as explained below.

### **The Emergence, and Submergence, of the Federal Government as Insurance Regulator**

As the result of a long and changing history, both the Federal Government and 50 State governments (and the District of Columbia) participate in the regulation of insurance in the United States. The authority for determining which level of Government regulates insurance lies in the Constitution of the United States and in the Bill of Rights (the first ten amendments to the Constitution), and in the Supreme Court's interpretation, over the years, of how the Constitutional provisions apply. The Constitution gives the Federal Government the authority to regulate interstate commerce among the States, while the Tenth Amendment clarifies that "the powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people."

An early US Supreme Court decision (in 1868) established that the "business of insurance" was not interstate commerce, and therefore would be regulated by the States. Later Supreme Court decisions defined situations in which insurance could be regulated as interstate commerce (e.g., an insurance company in one State providing insurance to the resident of another State). Eventually, the Court changed course and in a 1944 case determined that the business of insurance was subject to the "commerce clause" of the Constitution, and Federal anti-trust laws did apply to insurance companies. As Klein has noted, "This decision prompted the states and the [insurance] industry to join forces behind the passage of the McCarran-Ferguson Act in 1945 which delegated regulation of insurance to the states, except in instances where federal law specifically supersedes state law."<sup>iii</sup> That is, although Congress and the Federal Government could have assumed responsibility for the regulation of insurance, based on the Supreme Court decision, Congress chose to have the States continue to regulate the business of insurance—except in those instances where the Congress might choose to exercise its new-found regulatory power.

### **The Re-Emergence of the Federal Government, or Submergence of State Governments: ERISA**

In 1974, the US Congress did in fact choose to supersede, or preempt, State laws regulating insurance when it enacted the Employee Retirement and Income Security Act of 1974 (ERISA). ERISA was enacted as a means of protecting the solvency of employee pension plans, through Federal regulation and oversight of those plans, in the wake of the failure of State regulation to prevent workers from losing their pensions as a result of "well-documented problems of fraud and mismanagement."<sup>iv</sup> In addition to providing for Federal preemption of State laws in the area of pensions, ERISA imposed Federal preemption with regard to any employee benefit plan.<sup>v</sup>

The preemption was viewed as a means of streamlining the administration of such plans and reducing their costs for multi-State employers and unions that would have otherwise have had to deal with differing requirements in different States. It was almost as an afterthought that ERISA also affected employee health benefit plans, having been decided on “late in the process of debating ERISA, and with little discussion.”<sup>vi</sup> The little-discussed legislation has become what William Sage says “may be the most important law affecting health care in the United States.”<sup>vii</sup>

Although ERISA is held up as an example of what goes wrong when the Federal government acts as a regulator (e.g., by those who advocate a greater role for the States), ERISA’s deficiencies in regulating health plans, as opposed to pension plans, are more a consequence of the provisions of the law itself, and court interpretations of the law, rather than the manner in which the law is administered. The law has a preemption provision that the Supreme Court has called “perhaps...not a model of legislative drafting” and that other courts have called “a veritable Sargasso Sea of obfuscation.”<sup>viii</sup>

**ERISA Provisions.** ERISA, which is very detailed in its regulation of pension plans, is breathtaking in its lack of standards for health plan coverage as compared to standards common among State-regulated plans and standards imposed on Medicare and Medicaid contractors. As Mariner has described this “ERISA vacuum”:

When the federal government takes over the regulation of an industry from the states, it ordinarily creates a federal regulatory system with uniform standards and mechanisms of enforcement, such as the Food and Drug Administration. ERISA established uniform standards for pension plans (which work reasonably well) but did not do so for health plans. Although health plans governed by ERISA are often described as federally regulated, the law does not prescribe any substantive standards for them. It requires only that a health plan provide employees with a brief summary of the main terms and conditions of the plan, invest its funds prudently, and report to the Department of Labor. ERISA does not require health plans to offer any specific benefits or meet any standards for contracting with physicians, setting payment rates, or deciding about patient care. The result is an anomalous law that precludes state regulation of ERISA health plans without substituting federal standards, leaving the plans in a regulatory vacuum.<sup>ix</sup>

Some of the complexities of the regulation of health care coverage in the US have not been known to the general public until recently. Since the passage of ERISA, the awareness of the public regarding its provisions, and the number of court cases dealing with ERISA have increased, for a number of reasons. One of the reasons is that there are more people covered by "self-insured" employer health plans that are subject to ERISA regulation. At the time ERISA was enacted its effect on health benefits offered through employers and unions was negligible. Estimates are that in 1976 only four percent of coverage was through employee health benefits plans to which the ERISA pre-emption applied (self-insured plans).<sup>x</sup> That is not the case today. According to the GAO, in 1993, 44 million people, representing 40% of individuals with employer or union health care coverage, had coverage governed by ERISA provisions.<sup>xi</sup> By 1998, 51 percent of workers were covered by self-insured plans regulated only by ERISA, though there has recently been a decline in self-insured coverage, in part because of requirements imposed by the

Health Insurance Portability and Accountability Act of 1996 which affected self-insured plans (Gabel (1999), 70).

Another reason for the renewed attention given to ERISA has to do with the type of health care coverage that is currently prevalent in the United States. The "managed care revolution" of the mid-1990s changed the relationship between consumers and the health care system. Before HMOs became the prevalent form of health care coverage in the non-public sector, and before the types of practices used by managed care organizations to contain costs became more prevalent (even in non-HMO plans), the majority of individuals had indemnity health insurance coverage, in which an insurance paid claims submitted by policy holders (or through providers) for services that were covered under the insurance policy. That is, health care insurance was, like other insurance, indemnification for a financial expense or loss. Some of the most recent ERISA-related court cases deal with the question of the extent to which there are legal remedies for members of ERISA-covered health plans who have a claim regarding medical care treatment decisions (for which ERISA might not preclude a State court liability case) and eligibility decisions under an employer health plan (governed exclusively by ERISA). (See articles by Bloche and by Sage (2000).)

### **Apart from ERISA: Typical Regulatory Standards**

In many respects, ERISA, though it is a law applicable to the health care coverage of so many individuals, is an anomaly as a model for regulation of health care coverage and insurance. In other circumstances, when either the Federal Government or State governments regulate health plans, the laws and regulations deal with a range of standards and requirements that are believed to be necessary in overseeing health plans and health insurance.

Typically, at either the Federal or State level, regulation of health insurers addresses a number of concerns, including

- ◆ Financial solvency, stability and viability of organizations that provide insurance or directly provide health care coverage
- ◆ "Fair" disclosure of information in contracts and marketing for health care consumers, including licensing of agents
- ◆ Adequate are provisions for transition to other coverage in the event of the failure of an insurance entity
- ◆ The adequacy of the provider network, if a closed system is involved (e.g., an HMO that requires the use of contracted providers)
- ◆ Approval of insurance premium rates to ensure that they are adequate and/or "fair"
- ◆ Prohibition of certain discriminatory practices

Regulations might also address the following issues:

- ◆ Standards intended to improve access to health care for certain populations
- ◆ Mandated benefits
- ◆ Procedures to appeal decisions
- ◆ Mandated inclusion of certain types of providers
- ◆ Mandated care (e.g., a minimum stay of 48 hours in the hospital post-partum)

**Solvency Regulation.** Perhaps the most important aspect of State or Federal regulation is the regulation of the solvency of insurers and health care plans. In the case of HMOs, for example, organizations have gone into bankruptcy because of their inability to judge their own financial condition—all too often due to what is famously known as IBNR liabilities. As Kongstvedt puts it in defining IBNR: "Incurred but not reported. The amount of money that the plan had better accrue for medical expenses that it knows nothing about yet. These are medical expenses that the authorization system has not captured and for which claims have not yet hit the door. Unexpected IBNRs have torpedoed more managed care plans than any other cause."

For the purpose of solvency regulation, as Klein states, "Capital standards are the linchpin of solvency regulation. Capital and surplus provide a cushion against unexpected increases in liabilities and decreases in the value of assets. Capital also is intended to fund the expenses of a rehabilitation or liquidation of an insurer with minimal losses to policyholders and claimants. Insurers are required to have a certain amount of capital and surplus to establish and continue operations.... Regulators...may seize a company if they can show that it is in hazardous condition and will ultimately be unable to meet its obligations to policyholders." Klein also notes that "Insurers are subject to other regulatory requirements with respect to their financial structure and operations. Insurance companies are required to maintain records and file annual and quarterly financial statements with regulators in accordance with statutory accounting principles (SAP) which differ somewhat from Generally Accepted Accounting Principles (GAAP). Statutory accounting seeks to determine an insurer's ability to satisfy its obligations at all times, whereas GAAP measures the earnings of a company on a going-concern basis from period to period. Under SAP, most assets are valued conservatively and certain non-liquid assets, e.g., furniture and fixtures, are not admitted in the calculation of an insurer's surplus."

A somewhat recent development in solvency standards is the use of "risk-based capital" requirements, by which required capital varies depending on the level of various types of risk assumed by an insurer. In developing such standards for health insurance, one issue of relevance is the extent to which provider-based health insuring organizations—those primarily or owned or operated by health care providers—and entities which own providers, can have lower levels of minimum capital. For example, an organization such

as the Kaiser Foundation Health Plan, which owns its own hospitals and which contracts for physician services through a related entity of salaried physicians, would argue that its financial risk when health care utilization increases is less than that of an organization that pays health care claims on a fee-for-service basis as services are provided. The risk-based capital approach does recognize such distinctions among types of health insurers.

Another issue in solvency standards that has received significant attention in the recent past, because of the bankruptcy of physician practice management companies or large medical groups, is how to determine at which level of an organization the solvency standards should be applied. States such as California have addressed this issue by requiring that medical groups or other providers that assume a high level of risk passed on by an HMO (referred to as "downstream" risk) must themselves meet the kind of solvency standards that are required of HMOs licensed in California.

### **The Mechanics of Regulation**

Klein may be stating the obvious when he says that "regulatory requirements are of little value if there is no mechanism to monitor insurers' compliance with those requirements." There are a variety of means by which government regulators enforce the laws and regulations through:

- ◆ Health plans and insurers being required to submit "filings" or reports on a periodic basis
- ◆ Audits and reviews of filings
  - ◆ *These "filings" may include copies of subscriber contracts that regulators would review to ensure that there is "full and fair disclosure" of the terms and conditions of coverage*
  - ◆ *Health plans may also "file" their proposed premium rates, which can be subject to approval, sometimes after public hearings*
- ◆ Periodic or as-needed on-site inspection of records and facilities
- ◆ Monitoring of deficiencies or problem areas
- ◆ Investigation of complaints from subscribers or members, or complaints from the general public or competing firms
- ◆ Supervision or direct control of organizations that are insolvent or risk becoming insolvent or cannot otherwise manage their business

Some organizations that provide health insurance must meet both Federal and State standards and may also have to meet standards imposed by private sector purchasers, such as large employers or groups of employers. Sometimes dual or multiple departments within a State, such as the Department of Insurance for financial regulation, and the Department of Health for quality-related concerns, in addition to any requirements or monitoring by the State as a purchaser for Medicaid or as a buyer of health care coverage for State employees.

One result, if not a purpose, of the ERISA preemption of State laws is that it avoids duplicative or conflicting regulations for employers operating in multiple States.

Similarly, this duplication is avoided through the preemption for the Federal Employees Health Benefits Program and recent Federal preemption laws enacted for Medicare HMOs. The States themselves have also sought to avoid duplicative regulation among States and, in some cases, between the States and the Federal Government. The States have also attempted to promote uniformity across States and improved quality in regulatory enforcement. This has been done in part through the efforts of the National Association of Insurance Commissioners (NAIC), which undertakes activities such as the development of standardized “model” acts that are the basis for statutes in each of the States.

**Third-Party Entities and Public-Private Partnerships.** Another approach to “regulation” is through the use of third-party entities that may have roles that are, or could be, State or Federal regulatory roles. This approach is particularly suited for the evaluation of the quality of health care. A government entity may “deem” that organizations meet certain standards based on an evaluation made by a private entity, such as the Joint Committee on Accreditation of Healthcare Organizations (JCAHO), or the National Committee for Quality Assurance (NCQA). Similarly, private purchasers such as large employers may require the health plans it deals with to have outside accreditation. In many cases, the standards developed for health plans by the deeming organizations have been developed with the participation of the Government as a purchaser, as well as private sector participation. What is also becoming more common is the use of independent, outside entities to decide disputes between health plans and their members (appeals and grievances).

### **Why Laws and Regulations Exist**

The private insurers are regulated for a number of reasons. As Klein points out, “The public interest argument for the regulation of insurer solvency derives from inefficiencies created by costly information and agency problems.... Owners of insurance companies have diminished incentives to maintain a high level of safety to the extent that their personal assets are not at risk for unfunded obligations to policyholders that would arise from insolvency. It is costly for consumers to properly assess an insurer's financial strength in relation to its prices and quality of service. Insurers also can increase their risk after policyholders have purchased a policy and paid premiums. Thus, in the absence of regulation, imperfect consumer information and agency problems would result in an excessive number of insolvencies.”

Historically in the United States we have seen the following uses of regulatory powers of government in the area of health care, *de jure* or *de facto*:

- Consumer protection
- Control or influence of market entry
- Market correction
- Rate regulation
- Achievement of other public policy objectives
- Accommodation of special interests (e.g., “any willing provider” laws specifying the kinds of providers an HMO must include in its network)

These aims sometimes conflict with each other, intentionally or through unintended consequences. For example, requiring health plans to have a high reserve requirement or initial capitalization requirement may be intended to protect consumers by ensuring that only financially strong organizations operate in a given market. At the same time, such a requirement may create a bar to market entry for organizations that would otherwise meet all requirements, would compete with existing organizations, and might lead to more efficient markets.

One reason to enact laws and regulations that apply to insurance entities in a market-based environment is for the purpose of advancing public policy goals that are not achieved through the current system because of market failure or imperfections in the market. For example, in most States, insurance companies are not required to have "guaranteed issue" policies—that is, they are not required to offer insurance coverage to any individual wishing to purchase such coverage. Insurers may not participate at all in the individual insurance market, or they might impose prohibitive requirements, such as very restrictive health screening before allowing a person to purchase a policy. They may also limit coverage of pre-existing medical conditions, and the required premiums may be prohibitively expensive.

States have tried to deal with the lack of availability or affordability of health insurance for their populations in a number of ways. One way to deal with the failure of the market to insure certain individuals is to establish high risk pools in which the State, or particular insurers, cover very high-cost individuals but the premiums the individuals pay are subsidized by contributions (taxes or levies) from health plans operating in the State. According to the Communicating for Agriculture web site (<http://www.cainc.org/riskpools/states.html>), 29 states use high risk pools as a means of covering classes of individuals that would otherwise have difficulty obtaining insurance or would not be able to obtain insurance at all in the State. By generally financing these high-risk pools through levies on insurers operating in the market, States look to the participants in the market as the parties responsible for addressing what is viewed as a failure of the market. However, one complaint have about ERISA is that its preemption provision often serves to exempt self-insured health plans from being taxed and contributing towards the State's attempt to address the needs of the uninsured.

## **The Second Re-Emergence of the Federal Role**

With the failure of the Clinton effort at wholesale reform of the American health care system in 1993, reformers sought to undertake less drastic, "incremental" reforms at the national level. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) expanded the availability of health insurance for various types of individuals in the group insurance market (the employment-based market) and in the individual market. The provisions of HIPAA, as Federal legislation, were applied to self-insured health plans covered by ERISA, as well as health plans regulated by State insurance departments.

## **What the Future May Hold for the US System**

By most accounts, the principal weakness of the American health care system that relies on health insurance is that a large number of Americans do not have health insurance. The InterStudy report cited above noted that the employment-based health care system provides health care coverage “to a wide group of people including those from all wage levels, ages, and health statuses.” However, a large segment of the population (about 15 percent) does not have health care coverage, including a significant segment of the working population. As Gabel notes, small enterprises and those employing low-wage workers are less likely to offer health care coverage. He cites estimates that 20 percent of the decline in coverage between 1977 and 1996 is due to the movement in employment away from high-wage industries to low-wage industries, and that economic trends “will exacerbate disparities in health care coverage and income among skilled and unskilled Americans.”

## **Summary: Lessons from the United States**

This brief historical sketch and description of health insurance regulation in the United States and the “accidental system” that makes employer-based coverage the principal component of the system illustrates a variety of points:

- Health care policy and policy related to health care may have unintended consequences (Did the Congress, in 1974, understand the consequences ERISA would have for the health care system?)
- It can be difficult to strike a balance between competing public policy goals (Would regulation of employer-based health care if left to the States have resulted in less availability of coverage?)
- There are cycles and trends in health care and insurance (The movement to managed care has presented different issues for consumers and regulators.)
- Regulations should change over time to meet changing conditions (HIPAA has attempted to address some of the shortcomings resulting from ERISA and the system that it helped create.)

## Endnotes

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- <sup>i</sup> Jon Gabel, "Job-Based Health Insurance, 1977-1998: The Accidental System," *Health Affairs*, vol. 18, no. 6, Nov/Dec 1999.
- <sup>ii</sup> *National Policy and Employer-based Health Plans*, InterStudy (June 2000), available at [www.hmodata.com](http://www.hmodata.com).
- <sup>iii</sup> Robert W. Klein, "Structural Change and Regulatory Response in the Insurance Industry," unpaginated draft dated June 19, 1995; available at [www.naic.org](http://www.naic.org).
- <sup>iv</sup> Patricia Butler and Karl Polzer, *Private Sector Health Care Coverage: Variations in Consumer Protections Under ERISA and State Law* (Washington, D.C.: The George Washington University, National Health Policy Forum, 1996).
- <sup>v</sup> The only preemption comparable to the ERISA preemption is the Federal Employees Health Benefits Act, preemption for employees of the Federal Government. The State of Hawaii was exempted from the ERISA preemption provision.
- <sup>vi</sup> Wendy K. Mariner, "State Regulation of Managed Care and the Employee Retirement Income Security Act," *New England Journal of Medicine*, vol. 335, no. 2, December 26, 1996. (Used unpaginated Web site document.)
- <sup>vii</sup> William M. Sage, "'Health Law 2000': The Legal System and the Changing Health Market," *Health Affairs*, vol. 15, no. 3, fall 1996, p. 11.
- <sup>viii</sup> Quoted in U.S. General Accounting Office, *Employer-Based Health Plans: Issues, Trends and Challenges Posed by ERISA* (HEHS-95-167, July 25, 1995), p. 6, footnote 6.
- <sup>ix</sup> Mariner.
- <sup>x</sup> Butler and Polzer, citing an estimate by the Health Insurance Association of America.
- <sup>xi</sup> United States General Accounting Office, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance*, GAO-HEHS-96-161, August 1996, p. 4.