

Congressional Health Care Reform Education Project  
October 17, 2008  
Standards for Private Health Insurance

### House Summary

**Beth Fuchs**, a principal at Health Policy Alternatives and a veteran of the Congressional Research Service, presented an introduction to health insurance regulation. She explained that Congress turned over most regulation of health insurance to the states in the McCarran Ferguson Act of 1945 (while reserving the right to reacquire regulatory authority later). Congress did pass some later federal laws governing health insurance through the Employee Retirement Income Security (ERISA) Act of 1974, the Consolidated Omnibus Budget Reconciliation (COBRA) Act of 1986 and the Health Insurance Portability and Accountability (HIPAA) Act of 1996, plus additional amendments such as the mental health parity provisions of the financial rescue package passed this month.

ERISA preempts states from regulating self-funded employer health plans, in which the employer pays some or all of employees' health care expenses directly. This is important to those proposing state-level health reforms, since some state reforms can be blocked by ERISA. Some 55 percent of people covered under employer-sponsored plans are in such self-funded plans, Dr. Fuchs said. Thus, state regulators are able to affect directly only the 45 percent who are in "fully insured" plans, meaning the employer buys coverage from (and transfers risk to) an insurance company.

Dr. Fuchs said states have many goals in mind when they regulate insurers. They want to make sure that the companies remain financially solvent, and that they pay claims promptly. States want to promote the spreading of risk through pooling a large number of people who are relatively healthy with a smaller number who are likely to develop serious, expensive illnesses. They want to protect consumers against fraud.

She noted that in a voluntary insurance market, insurers try to avoid having too many people in their insured pool who will need expensive care. If too many sick people are in the pool, premiums go up and healthier people drop the coverage or avoid buying it. (In a state with "guaranteed issue" of health insurance and where coverage is mandated, such as Massachusetts, avoiding "adverse selection" is not as much of a factor.)

Dr. Fuchs listed three major types of health insurance reforms, those designed to improve:

- Availability of insurance – Guaranteed issue of insurance, guaranteed availability, open enrollment, restrictions on the use of exclusions or waiting periods for pre-existing conditions
- Affordability – use of rating bands (in which the highest and lowest premiums can vary by a limited amount), pure community rating (in which everyone pays the same premium), and modified community rating (in which premiums can vary by age or geography, but not because of a person's health status), and
- Risk spreading – establishing an insurer of last resort (sometimes the Blue Cross Blue Shield plan in a state), high-risk pools and reinsurance pools

The key questions involved in reforming insurance regulation, she said, are these: Is insurance available? To whom? Will it always be available? Are risks spread broadly? Is the risk spreading scheme stable over time? Is insurance affordable? At what price today? At what price tomorrow? Is coverage adequate? Are the rules for regulation transparent and understandable? Do they provide for a reasonable return for the premiums collected? Who sets the rules?

**Tom Wildsmith**, an actuary with the Hay Group, then described how regulators make decisions about health insurance premium pricing. He said the premiums must be high enough to allow the insurer to remain solvent. But they must be reasonable in relation to the benefits the customer receives. The definition of “reasonableness,” Mr. Wildsmith said, varies from state to state and is often tied to the insurer’s loss ratio (the portion of premium revenue that is paid out in claims).

Regulators rarely question the pricing of health insurance offered through large employers, he said. This is because the pool of insureds is large enough that prices are almost always reasonable. Regulators do get involved in the individual market, he added, and in the small group coverage market.

In addition to being affected by solvency and reasonableness concerns, rates are also affected by HIPAA and COBRA rules and by the Actuarial Standards of Practice, guidelines followed by actuaries throughout the nation, Mr. Wildsmith said. (Among those guidelines: the rate charged must be objective and clearly related to the likely cost of providing coverage.)

Mr. Wildsmith noted that the price of coverage can vary by a factor of four or five for older people in the individual market compared to younger people (an average premium of \$5,090 yearly in 2007 for those 60 – 64 years old vs. \$1,359 for those 18 – 24). This is considered both reasonable for the consumer and adequate for the insurer to remain solvent, since older people need more health care. However, the expense of premiums is by far the main reason so many in the U.S. are uninsured, he noted later.

Pooling people together from the small group market and individual markets can make these markets behave more like the large employer market, with the resulting pricing effects (down for older people compared with the individual market, generally up for younger people).

A major challenge for insurers, Mr. Wildsmith said, is to keep healthier people in the insured pool to balance the smaller number of sick people who will have expensive medical situations. Healthy people can be enticed to get into, or remain in, the pool by subsidizing the cost of coverage for low-income people. (It is assumed that the lower expenses of healthier low-income people joining the pool will more than balance the higher expenses of less healthy.) Premiums can also be kept reasonable through reinsurance (in which an insurer buys protection against unusually high claims) or through high-risk pools (which provide coverage for those denied coverage through regular channels). Also, healthy people can be forced to get and keep coverage through an individual mandate.

**Guenther Ruch**, head of the Division of Regulation and Enforcement with the Wisconsin Office of the Commissioner of Insurance, discussed some important trends and concepts in the regulation of health insurance.

He noted that the number of people in Wisconsin covered through self-insured companies is growing, now reaching about 60 percent of those in the state with health coverage. This means the state regulates only the other 40 percent.

He emphasized how adverse selection can create a “death spiral” for an insurance program. If too many healthy people opt out of insurance, the expense of caring for the less healthy people remaining will go up, causing premiums to rise and more people to drop out. The highest risk of adverse selection occurs in the individual market, Mr. Ruch said, followed by the small group market. In the large group market, there is little risk caused by adverse selection, since the insured pools are so big.

Mr. Ruch explained some key terms used in insurance regulation:

Community rating – everyone pays the same premium; no adjustments for health or any other factors.

Adjusted community rating – rates can vary from one person to another to account for age and geography, but not for health status

Rating bands – limits the total highest and lowest rates that can be charged for coverage and/or limits rate variation in premiums based on health, age or other factors.

Actuarially justified rating – a term common in the non-group insurance market meaning that insurers must justify the use of rating factors.

During the question and answer session, a question was raised about whether health insurance should be used to pay for predictable expenses. Mr. Wildsmith said that health insurance is both protection against unpredictable health care expenses, and also a way of pre-paying for predictable expenses. High-deductible plans, he said, are designed to cover only the unpredictable expenses. Paying for these predictable risks, said Dr. Fuchs, is a way of keeping healthier people in the insured pool.

Another questioner asked why the U.S. Department of Labor doesn’t get more involved in regulating self-funded employer health plans. The panelists agreed that an employee with a dispute in a self-funded plan would be better off contacting state regulators, rather than the Labor Department. If a company has many complaints of this type, Labor will order an investigation. Mr. Wildsmith noted that employers with self-funded plans have a “fiduciary responsibility” to employees covered by the plan. This can be an avenue for federal intervention in disputes.