

An hourglass-shaped graphic with a globe inside. The top bulb is dark blue, and the bottom bulb is light blue. The globe is a darker shade of blue. The hourglass is centered on the page.

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*Standardizing State Health Insurance Regulation*

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**Abstract.** H.R. 4460, the Health Care Choice Act, is intended to "harmonize" the state insurance laws that multi-state insurance carriers and other providers of individual health coverage would be subject to. By harmonizing insurance laws across state lines, the bill's supporters anticipate an increase in the number of health plan choices and a reduction of the cost of plans. Opponents raise concerns that the consequences of reducing states' regulatory authority over insurance products in each state could include a loss of important patient protections and complicate the enforcement of rules designed to protect consumer interests.

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## CRS Report for Congress

# Standardizing State Health Insurance Regulation

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### Summary

H.R. 4460, the Health Care Choice Act, is intended to “harmonize” the state insurance laws that multi-state insurance carriers and other providers of individual health coverage would be subject to. By harmonizing insurance laws across state lines, the bill’s supporters anticipate an increase in the number of health plan choices and a reduction of the cost of plans. Opponents raise concerns that the consequences of reducing states’ regulatory authority over insurance products in each state could include a loss of important patient protections and complicate the enforcement of rules designed to protect consumer interests. This report will be updated periodically.

The 110<sup>th</sup> Congress, as well as earlier Congresses, has grappled with issues raised by insurance carriers and other providers of health insurance that offer coverage across state lines. Carriers and health plan providers have appealed to Congress for relief from a complicated array of 50 states’ and the District of Columbia’s health insurance laws. States are the primary regulators of the business of health insurance, a right clarified by the 1945 McCarran-Ferguson Act, and all states have a large body of laws that apply to health insurance.

States’ insurance requirements number in the thousands — there are more than 1,900 laws on benefits alone — and can be complicated. Even the laws of two states addressing the same matter can differ on many dimensions. In addition to the benefits that comprise health insurance products, state laws and regulations require patient protections; address how insurance carriers develop the rates charged for their products; and describe procedures for approval of those rates. State laws and regulations address how entities in the business of selling health insurance fund their enterprises and prepare against the risk of insolvency. They are subject to fair marketing practice laws, requirements related to the filing of grievances against the plans, and appealing plan decisions. Entities selling health insurance may also be subject to state taxes. In addition, state laws form the basis for lawsuits against providers of health care for malpractice and professional negligence.

Sometimes significant financial judgements have extended from individual medical providers to health plans under which those providers are contractually related.

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In general, a different set of state laws applies to the employer group market<sup>1</sup> than to the individual market for insurance. Further, different laws generally apply to insurance products sold to small employers than to certain products offered to workers of very large employers. When large employers self-insure or self-fund their coverage, state insurance laws are preempted from applying by federal law.<sup>2</sup>

**Table 1. The “Markets” for Health Insurance**

“Market” for insurance	Characteristics of health insurance <sup>a</sup>	Regulation <sup>b</sup>
Individual	-Purchased by individuals separate from employer groups. -Almost 7 million people.	Some benefit mandates apply; 17 states with rate regulation.
Small group	-Sponsored by small employers — most state regulation applies to firms with 50 or fewer employees. -About 21 million privately insured people in plans sponsored by firms with 50 or fewer employees.	More than 1,900 benefit mandates; 47 states with rate regulation.
Large group	-Sponsored by larger employers — can be traditional insurance or employers can self-fund plans. Many employers offer choice of plans. -Around 83 million people in plans sponsored by firms with more than 50 employees.	When health plans are self-funded, state laws are preempted from applying. When health plans include traditional insurance products, those products would be subject to all state laws that apply to the business of insurance.

Source: CRS.

- a. Unpublished data from the Medical Expenditure Panel Survey Household Component, at the time of first interview in 2005. Includes civilian, noninstitutionalized individuals under age 65.
- b. From Georgetown Health Policy Institute, at [<http://www.statehealthfacts.org/>], and Council for Affordable Health Insurance, at [[http://www.cahi.org/cahi\\_contents/resources/pdf/HealthInsuranceMandates2008.pdf](http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf)].

## Self-Insured Plans Offered by Large Employers Are Exempt From State Laws

Sometimes, large employers choose to forego purchasing traditional health insurance for their employees. Instead the employer collects the premium contributions from all employees, combines those collections with its own contributions, and from those funds, pays for health care for workers. Under such a “self-funded” plan, provider networks may be organized by in-house health benefits administrators, or more likely, employers will engage in an “administrative services-only” (ASO) contract with a traditional insurance

<sup>1</sup> The employer group market, sometimes just called the “group market,” is composed of health plans generally offered by an employer to workers as part of a package of employment-related benefits (along with such other things as retirement benefits, vacation days, sick leave, etc.)

<sup>2</sup> The Employee Retirement Income Security Act of 1974 (ERISA) preempts state laws from applying to self-funded health plans. For more information about how this preemption applies, see CRS Report RS20315, *ERISA Regulation of Health Plans: Fact Sheet*, by Hinda Chaikind.

carrier or HMO. The major difference between traditional health plans purchased from indemnity insurance companies and the self-funded coverage offered by large employers, besides the preemption of state law, is that under self-funded plans, the employer retains the risk that one or more of its workers will be in need of costly medical care. Under traditional health plans, that risk is transferred to the insurance carrier or the HMO. Very large employers are able to self-insure their employees because the group for which premiums are being collected is sufficiently large to make the risk of having to pay for a few expensive people relatively small. In addition, because these firms tend to be large, they have the more considerable assets of the firm to fall back upon should the health plan costs exceed premiums collected. Small employers rarely self-insure because they do not have the large number of employees across which to collect premiums and spread risk; nor do they have considerable assets to back up the premium collections.

## **The Goals of “Harmonization”**

Advocates of bills intended to rationalize the body of insurance laws applying across state lines cite self-funded plans as examples of the way the small or individual markets for insurance could flourish if regulatory authority of the states were reduced. Large self-funded employer plans tend to have comprehensive and generous benefit offerings, offer a choice of plans, and employees tend to be happy with these plans.

By reducing the states’ laws that apply to multi-state plans, advocates hope that more plan choices would become available to small employers and individuals. Bills that would allow insurers to forego all or all but one “primary” state’s laws could eliminate some state benefit mandates, potentially allowing for less costly, limited benefit plans to be offered. In addition, if a primary state is one without rate regulations — laws that require premium rates to be averaged across both healthy and less healthy populations — lower-priced plans for healthier subscribers could become available. Finally, advocates hope that by making these changes in the individual market for insurance, new covered lives will be drawn into it — encouraging new options and higher enrollment — and thus improve the overall functioning of the individual market for insurance.

## **The Health Care Choice Act of 2007 (H.R. 4460)**

One approach to reducing the number of state laws and regulations that apply to insurance products sold across state lines is advanced in H.R. 4460, the Health Care Choice Act of 2007. The stated purpose of the bill, when referred to the Committee on Energy and Commerce on December 12, 2007, is to provide for cooperative governing of individual health insurance coverage offered in interstate commerce. The bill would allow insurance carriers and other issuers of health insurance sold to individuals (H.R. 4460 would not apply to health plans bought or sold in the employer group market for insurance) to designate a state — in which it is licensed and qualified to sell health insurance — as its “primary” state. The laws of the primary state would govern the sale of individual health insurance policies in that state as well as in any other “secondary” state. This would allow the issuer to sell its products in one or more secondary states without complying with most of the insurance laws of those secondary states, thereby simplifying the business of offering health plans across state lines. A primary state would have the sole jurisdiction to enforce its laws in its state as well as in any secondary states.

Under H.R. 4460, the only provisions of a secondary state that would be retained would be those laws, rules, regulations, or agreements governing the use of care or cost management techniques, provider contracting, network access or adequacy, health care data collection, or quality assurance. Secondary states, however, could require issuers to

- pay premium and other taxes such as high risk pool assessments;
- register with the secondary state’s insurance commissioner;
- submit to examinations of their financial condition if the primary state’s insurance commissioner has not already done so;
- comply with a lawful order issued in a delinquency proceeding or an injunction if they have been found to be financially impaired;
- participate in any insurance insolvency guaranty association; and
- comply with certain state laws regarding fraud and abuse, unfair claims settlement practices, and independent review.

Health insurance issuers would be required to give notice in any coverage offered (and at renewal) that identifies which state is its primary state and explains that the policy is not subject to the laws and regulations of the (secondary) state in which the policy is being issued. In addition, the bill includes a provision that would require any policy sold in a secondary state to also be offered for sale in a primary state — a provision that appears to be intended to establish that all plans be subject to the enforcement authority of regulators of a primary state.

Finally, the bill establishes a federal floor for coverage offered in secondary states in order for those plans to qualify for the exemption of state insurance laws. The floor consists of requirements related to plan solvency: for states to become secondary states, they must use a risk-based capital formula for determining capital and surplus requirements; and an external review requirement. For a state to be designated as either a primary or a secondary state, it must provide for independent external review.

## Issues Raised by the Harmonization Provisions of H.R. 4460

H.R. 4460 addresses insurance “harmonization” on a considerably smaller scale than other proposals because it focuses only on those plans offered for sale in the individual market for insurance. In the individual market, there are relatively few states that regulate plan pricing (see **Table 1**). In addition, under current law, sometimes benefit mandates do not apply to plans sold in the individual market. For example, requirements that plans cover prenatal care and newborn deliveries often are not applicable in the individual market for insurance.<sup>3</sup> Nonetheless, some consumer advocates and state insurance commissioners raise concerns about the potential negative consequences of removing all but one state’s authority over such plans.

Opponents raise the concern that insurance issuers will be motivated to designate those states that do little to exercise their regulatory authority as primary states, effectively eliminating all or much of the regulation over the business of insurance. Specifically, the loss of some of the state’s required benefits and many of the consumer protections is

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<sup>3</sup> Personal communication with Mila Kofman, Health Policy Institute at Georgetown University, June 29, 2006.

raised as a concern. Even though H.R. 4460 does not preempt the laws of *all* states from applying to these plans, there are some states that impose very few requirements on insurers selling policies. The bill's supporters, on the other hand, see this as a measure of the bill's success — minimizing the intrusion of state governments in the market for individual health insurance.

Advocates of the bill hope that the removal of states' benefit mandates and rating rules will allow for more and better-priced plans for the majority of the population that is relatively healthy. This approach, however, may result in loss of coverage for some individuals who are less healthy or who are struck by an unexpected illness. Without rating rules, insurers can reduce prices for healthy people — encouraging more coverage — but raise rates for those who are not, potentially resulting in a loss of coverage for those most in need of it.

Enforcement of a primary state's laws in a secondary state is seen as a potential problem with this bill. Under H.R. 4460, if a secondary state resident finds that the laws of the primary state are being misapplied, he or she would be required to seek the assistance of the insurance commissioner of the primary state for correction of this situation. Concerns have been raised by the National Association of Insurance Commissioners that “State regulators would be unable to assist their own constituents ... in the real world of tight state budgets it will be virtually impossible to assist a nonresident consumer in a distant state.”<sup>4</sup> Enforcement can become more challenging because of the incentive for insurers to migrate to the one or two states that have the least regulatory body, framework, and staff — potentially increasing the opportunities for fraud and abuse.

A goal of the bill is to create a level playing field with respect to state laws for insurers offering coverage across state lines. The bill does not, however, create a level playing field between insurers or among consumers or providers within a state. By harmonizing the laws for multi-state carriers, smaller local carriers could be put at a disadvantage. Their plans would continue to be subject to state mandates, rate regulation, and patient protections in each state, potentially making those products more appealing to those in poorer health. Consumers in one state could find their plans are regulated by another state, making it confusing and possibly difficult to seek enforcement of rights described by a geographically distant primary state. Finally, providers could be required to meet multiple different procedural laws for the multiple primary states that are designated by the carriers with which the providers contract.

## Other Approaches to Harmonizing Health Insurance Regulation

In addition to H.R. 4460, a number of legislative proposals have been introduced in recent sessions whose common purpose is to promote uniformity of insurance rules across state lines. The approaches typically involve either exempting insurers from state health insurance laws or federalizing such laws, at least in part. The expectation is that these

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<sup>4</sup> U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Health, *The Health Care Choice Act*, hearing on H.R. 2335 [sic], 109<sup>th</sup> Cong., 1<sup>st</sup> sess., June 28, 2005 (Washington GPO, 2005).

approaches, either separately or collectively, would reduce insurers' regulatory burden, which, in turn, would lead to lower health insurance costs.<sup>5</sup>

Broadly, the federal approach redesignates all or part of state insurance regulation as under federal jurisdiction. For example, S. 334, the Healthy Americans Act, specifies benefit standards that would apply to the new plans established under this bill. In addition, S. 334 would impose new rating rules. Both the benefit standards and rating rules would supercede existing state laws in these regulatory areas. Similarly, S. 1783, the Ten Steps to Transform Health Care in America Act, would, among other reforms, establish new federal rating rules in the small group market and new federal benefit standards in *both* the individual and group markets. Under S. 1783, insurers in the small group health insurance market and individual states would have the choice of complying with current state rating laws or the new federal rating rules. Similarly, all insurers would have the choice of providing benefits in accordance with current state law or the new federal standards. The bill would authorize the HHS Secretary to establish a board for the purpose of developing recommendations to harmonize inconsistent state laws in four insurance oversight areas: form and rate filing rules, market conduct, prompt payment of claims, and internal review of disputed claims.

Proposals that attempt to federalize all health insurance regulation typically have the goal of universal coverage. Often such bills propose to establish a new federal health insurance program. An example of such proposals is H.R. 2034, the Medicare For All Act. This act would establish a new federal program to provide health benefits to everyone who is currently not eligible for benefits under Medicare. Modeled after the Medicare program, the federal government would contract with private health insurance carriers to offer health benefits under the new program. However, the federal government would specify the rules and standards relating to the operation of the new program, including benefits, cost-sharing requirements, and payments to health care providers. Moreover, the federal government would establish a trust fund, financed by personal income and employer taxes, to pay for program costs.

Under the exemption approach, the obverse of the federal approach, insurers would not be required to comply with specified insurance rules. Often, exemption is targeted to new entities that pool individuals or groups together. A bill that incorporates features of both exemption and federal approaches is H.R. 241, the Small Business Health Fairness Act of 2007. Business or trade associations would be certified to offer health benefits in the small group market through association health plans (AHPs). AHPs would be exempt from a large body of state health insurance law, including benefits, consumer protections, grievance and appeals procedures, premium taxation, prohibitions on discrimination, and fair marketing practices. The bill does, however, maintain state regulatory authority regarding solvency standards and prompt payment laws. The bill would place enforcement authority (with respect to AHPs) with the federal government, in consultation with the states.

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<sup>5</sup> For a comprehensive discussion about general approaches to health insurance reform and relevant bills introduced in the 110<sup>th</sup> Congress, see CRS Report RL34389, *Health Insurance Reform and the 110<sup>th</sup> Congress*, by Jean Hearne.