

## **Appendix F**

State Regulation of Health Insurance:  
Implications for Health Care Access

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# State Regulation of Health Insurance: Implications for Health Care Access

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### Introduction

This paper, prepared for the Task Force on Access to Health Care, examines the role of state regulation of health insurance in improving access to affordable and adequate coverage.

This analysis begins by summarizing those characteristics of uninsured Texans that would be of particular relevance to an assessment of the potential role of state insurance regulation to improve access to coverage. The analysis then discusses the role of states in health insurance regulation and reviews their powers as well as the limits on those powers. This discussion is limited to the regulation of licensed health insurance products. It is important to note that numerous types of insurance products can finance health care (on either a defined benefit or defined contribution<sup>1</sup> basis); examples would be automobile insurance, workers compensation, accidental death and dismemberment, or disability insurance. The paper concludes with a discussion of the prospects for increased access through insurance reform.

### Key Characteristics of Texas' Uninsured Population

A recent study prepared for the Robert Wood Johnson Foundation<sup>2</sup> reported that Texas leads the nation in the proportion of uninsured working age adults; even when actual employment status is taken into account, this study shows that Texas leads the nation in the proportion of individuals without coverage. In 2003, 30.7% of all working age adults in Texas were uninsured, compared to less than 10% in Minnesota, the state with the lowest proportion. This report indicates that Texas' outlier status where uninsured adults are concerned persists regardless of state ranking criteria, including race and ethnicity, by the presence in the household of children, and actual 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

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<sup>1</sup> A defined benefit product enumerates specific classes of health care benefits and services whose coverage is guaranteed in whole or in part for members during their term of enrollment. Defined benefit products can be subject to numerous limits and exclusions, discussed below. A defined contribution product offers a cash payment toward health care rather than coverage for defined services and essentially operates as a cash indemnification for medical care. The cash payment (e.g., \$150 per day) also may be limited or constrained by numerous limitations and exclusions (e.g., no payment if the condition is the result of legal intoxication).

<sup>2</sup> Robert Wood Johnson Foundation, Characteristics of the Uninsured: A View from the States (University of Minnesota, State Health Access Data Assistance Center, April, 2005) ([www.shadac.org](http://www.shadac.org)) Figure 1 (Accessed April 29, 2005)

to health insurance: voluntary employer-sponsored benefits; individually purchased coverage; and coverage through a public program.<sup>3</sup> Statistics on health insurance by coverage source<sup>4</sup> suggests that in Texas relative to other states, it is the employer market that is particularly weak and that neither the individual market nor public insurance are sufficiently vigorous to overcome this deficit. Were Texas' employer-sponsored health insurance coverage rates equal to the U.S. average, 2003 coverage rates would have been a full six percentage points higher (54% versus 48%). A "back-of-the-envelope" effort to translate these percentage figures into actual people covered suggests that, were employer coverage available to 54 percent rather than 48 percent of the state's 19.6 million non-elderly residents, some 1 million additional residents would have had employer coverage in 2003.<sup>5</sup>

Data prepared by the Texas Department of Insurance (TDI) under a HRSA planning grant<sup>6</sup> offer important insight into the characteristics of uninsured Texans. The uninsured span all ages, but persons ages 18-44 appear to be at particular risk for lack of coverage in relation to other age groups.<sup>7</sup> Unemployment exponentially increases the risk of insurance among working age adults, but as noted, the uninsured rate even for employed adults is significantly elevated.<sup>8</sup> Immigration status affects coverage rates, but the lack of coverage among native and naturalized citizens also is notable according to the TDI data.<sup>9</sup>

Certain Texas industries also are associated with reduced health insurance coverage: construction, personal services, entertainment and recreation, agriculture, wholesale and retail trade, and health care and social services.<sup>10</sup> Notably, public employment is a strong predictor of coverage, a key factor in assessing the power of state regulation to provide some level of meaningful intervention. Industries associated with low coverage rates typically are characterized by part time and seasonal employment, cyclical work patterns with frequent layoffs, and relatively low cash wages and limited non-cash compensation (including even basic non-cash compensation such as sick leave).<sup>11</sup>

These employment characteristics are recognized predictors of reduced access to employer-sponsored coverage.<sup>12</sup> 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.<sup>13</sup> Smaller and lower wage firms face particular challenges in finding affordable coverage and subsidizing the

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<sup>3</sup> Institute of Medicine, *Insuring America's Health* (Washington D.C., 2004)

<sup>4</sup> Kaiser Family Foundation, *State Health Facts* (<http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Health+Coverage+%26+Uninsured&subcategory=Insurance+Status&topic=Distribution+by+Insurance+Status>) (Accessed April 30, 2005)

<sup>5</sup> The state resident population figure of 19.6 million non-elderly persons comes from the Kaiser Family Foundation *State Health Facts* website. <http://www.kff.org/statepolicy/index.cfm> (Accessed May 1, 2005).

<sup>6</sup> Texas Department of Insurance, *Texas State Planning Grant: Final Report to the Secretary, U. S. Department of Health and Human Services* (March 2003)

<sup>7</sup> *Id.*, Table 1.5

<sup>8</sup> *Id.*, Table 1.7

<sup>9</sup> *Id.*, Table 1.9

<sup>10</sup> *Id.* Table 2.3.

<sup>11</sup> Employer-sponsored benefit plans, particularly when subsidized, are a critical source of overall compensation.

<sup>12</sup> Institute of Medicine, *Insuring America's Health: Principles and Recommendations* (Washington D.C. 2004)

<sup>13</sup> C. Hoffman, D. Rowland, And A. Carbaugh, *Holes in the Health Insurance System: Who Lacks Coverage and Why?*, *National Health Reform and America's Uninsured* (S. Rosenbaum, ed.) *Journal of Law, Med. & Ethics* 32:3 (Fall, 2004) 390-407; *Insuring America's Health*, note 11, *supra*.

coverage they offer.<sup>14</sup> By 2004 only 63 percent of small firms surveyed nationally in one major study offered coverage, down from 68 percent in 2001.<sup>15</sup> These numbers also are reflected in the TDI data. To the extent that declining employee take-up rates in fact is a growing issue, cost again appears to be the driver. One widely reported study has 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.<sup>16</sup>

As both the TDI and national data show, working-age adults who are not in the labor market face especially challenging health insurance access problems because the individual insurance market is both 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 such regulatory interventions in the insurance market as guaranteed issue and high-risk pools, both of which are features of Texas law,<sup>17</sup> as well as the insurance laws of virtually all states.

Taken together, these statistics suggest a weak employer insurance market in the state, compounded by inadequate alternatives to employer-sponsored coverage. This weakness is significantly attributable to the cost of coverage in relation to employee compensation and family income. The TDI study cites health insurance cost figures that are comparable to national data showing that in 2004, the total average monthly cost of employer-sponsored family coverage exceeded \$800 while the cost of single coverage hovered at the \$300 mark.<sup>18</sup> 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, a central question thus becomes the extent to which regulatory intervention alone can open up a market and/or make it more affordable. Even the most energetic proponents of a market driven approach to health insurance reform that emphasizes individual coverage rather than employee benefits assume subsidization through tax credits.<sup>19</sup> In the absence of a subsidy program, expectations from regulation alone may be modest, and a more appropriate way of thinking about the issue might be to consider *which* regulatory interventions, in combination with subsidies, might do the most to aid the market.

In this regard, two basic types of regulatory interventions are relevant. The first is interventions aimed at creating more affordable and attractive employer-sponsored benefits. The second is interventions aimed at strengthening the individual coverage market. A matter to bear in mind in assessing the relative value of interventions into the individual and group markets is the underlying drivers of insurance costs. Other than for the elderly and workers with

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<sup>14</sup> Insuring America's Health , note 11, *supra*.

<sup>15</sup> J. Gabel, G. Claxton, I. Gil, J. Pickreign, H. Whitmore, E. Holve, B. Finder, S. Hawkins, and D. Rowland, "Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take their Toll on Coverage," *Health Affairs* 23:5 (Sept. /Oct. 2004) pp. 200-209.

<sup>16</sup> David Cutler, Employee Costs and the Decline in Health Insurance Coverage (Harvard/NBER, 2002).

<sup>17</sup> Texas State Planning Grant, note 6, *supra*.

<sup>18</sup> Kaiser Family Foundation and Health Research Educational Trust, *Trends and Indicators in the Changing Health Care Marketplace* (2004 ed.) <http://www.kff.org/insurance/index.cfm> (Accessed May 1, 2005).

<sup>19</sup> See, e.g., M. Pauley, Conflict and Compromise over Tradeoffs in Universal Health Insurance Plans, *Journal of Law, Medicine and Ethics*, note 12, *supra*. 465-473. Laura Trueman, Health Tax Credits for the Uninsured (Brief Analysis #498) National Center for Policy Analysis (2005) <http://www.ncpa.org/pub/ba/ba498/>

severe disabilities, the U.S. depends on a voluntary coverage system.<sup>20</sup> In such a system, the cost of coverage can be expected to be inherently higher as a result of adverse selection.<sup>21</sup> Employer coverage somewhat mitigates this likelihood because of who works, constraints on the timing of enrollment, and the incentivization of healthy workers through the employer contribution. Thus, regulatory models that aim to build on the individual system either will have only limited impact without heavy subsidies or must aim to replicate the market characteristics of voluntary group products.

## **The Role of States in the Regulation of Health Insurance**

### *Some Preliminary Considerations*

In assessing state regulatory powers in the health insurance market, it is valuable to consider the two fundamental factors that underlie the basic architecture of the market: pooling and design.

- *The insurance pool:* 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, although costs for young and healthy enrollees could be expected to be higher because of the characteristics of the group. Many aspects of insurance products are designed to keep bad risks out of insurance pools, with the notion of bad risks encompassing not only people who attempt to enroll at the point of services (adverse selection) but also persons whose characteristics and health status place them at higher risk for use of services.
- *Coverage design:* Health insurance coverage design considerations are complex and intricate, and highly relevant to a discussion of regulatory intervention. It is well understood that 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, the concept of design encompasses many other considerations: the classes and categories of benefits covered and the 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 to insurers to make final and binding coverage determinations and with broad discretion to construe the terms of the agreement.<sup>22</sup>

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 within -- insurance pools, costs in turn may rise for persons who are already adequately covered members of the insurance pool. For example, efforts to open up an insurance pool for older persons in fair to

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<sup>20</sup> Medicare of course is compulsory and universal. As noted, to some extent, other types of insurance products (such as automobile insurance, workers compensation, or homeowners’ insurance) may cover certain health care costs and may in fact be compulsory under state or federal law (e.g., state laws related to driver qualifications, state workers compensation laws, federal banking laws regulating mortgage insurance). The health care coverage offered under these arrangements is, as noted, beyond the purview of this paper, which examines state regulation of health insurance products.

<sup>21</sup> Mark Merlis, *Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform* (National Health Policy Forum, Washington D.C., April, 2005)

<sup>22</sup> Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, 1997; 2001-2002 Supplement) Ch. 2.

poor health may make coverage more accessible and affordable for them, while commensurately increasing costs for younger and healthier persons. Efforts to provide for more adequate coverage for persons who already are members of a pool, by limiting diagnostic-specific exclusions or strict annual payouts on claims may improve coverage for members of the pool with health conditions while elevating premiums for those without such conditions. These concepts of using regulatory powers to broaden and strengthen insurance pools are sometimes referred to as *risk solidarity*, and 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 the regulation of health insurance.<sup>23</sup> For state governments however, this hardly feels like an accurate statement. A host of federal laws have a limiting and pre-emptive effect on state insurance regulatory powers. The Employee Retirement Act of 1974 (ERISA),<sup>24</sup> which governs virtually all benefit plans offered by private employers, may be the best known federal law in this regard; while ERISA pre-emption principles “save” state laws that regulate insurance, self insured employer-sponsored health plans are not considered “insurance.”<sup>25</sup> As the Texas Insurance Department reports in its health insurance study, of the 11.4 million Texas residents with some form of private coverage, 5 million are members of self insured plans.<sup>26</sup>

Other federal laws have a similar pre-emptive effect. Depending on the labor patterns within the state, their cumulative limiting impact on state power to affect insurance through regulation may be considerable. 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. Medicare standards for insurance products sold to beneficiaries offers another relevant example of pre-emptive law.

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.<sup>27</sup> HIPAA itself does not regulate the rates that can be charged for these products, although many states regulate rates in the small group market.<sup>28</sup>

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.<sup>29</sup> Persons

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<sup>23</sup> *Law and the American Health Care System*, n. 22, *supra*. Ch. 2 The federal law delegating this power to states is the McCarrn-Ferguson Act of 1945, 15 U.S.C. §§1011 et. seq.

<sup>24</sup> 29 U.S. C. §1001 et. seq.

<sup>25</sup> Federal law however, does regulate certain coverage practices by ERISA plans, even in the case of self insured health benefit plans. For example, federal law requires most plans to offer continuation coverage, mandates certain benefits (e.g., maternity and newborn care), and prohibits variations based on health status among similarly situated individuals covered through employer plans. GAO, Private Health Insurance, Federal and State Requirements Affecting Coverage Offered by Small Businesses (GAO-03-1133, Sept. 2003)

<sup>26</sup> Texas Department of Insurance, n. 6, *supra*, p. 13.

<sup>27</sup> G. Claxton, How Private Insurance Works: A Primer (Kaiser Family Foundation, Washington D.C., April 2002).

<sup>28</sup> *Id.*

<sup>29</sup> *Id.*

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.<sup>30</sup> In many states, coverage is available through risk pools rather than through individual product.<sup>31</sup>

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.<sup>32</sup> Finally, HIPAA prohibits discrimination based on health related factors in rates charged to members of an employee group.<sup>33</sup>

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. To the extent that state residents are enrolled in plans exempt from state insurance law through pre-emption, their coverage is “off limits” to state regulations. Even where state regulators can reach employer plans, as is the case with products sold to fully insured plans by licensed health insurers, insurers may strongly resist regulation so as to avoid what they perceive as changes that will affect both their insured and self insured markets.

It is critical to bear in mind that there is one sizable group of insured residents who are members of a pool that is fully accessible 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. In Texas this group would be of considerable size and range.<sup>34</sup> Were state regulators to use this large pool of relatively healthy workers and their families as the basis for a broader restructuring for the group and individual markets, the impact might be substantial. Where reforms built on public employees are concerned, the constraints may be more operational and political than legal.

#### *An Inventory of State Insurance Regulatory Powers*

State insurance laws essentially are designed to accomplish three basic goals: (1) ensuring financial standards for licensure that guarantee the stability and solvency of insurance products; (2) to ensure appropriate market conduct and guard against marketing fraud or unfair business practices; and (3) and to regulate the accessibility, affordability, structure and content of licensed products. It is the third power of state regulators that is most relevant to this analysis. All states have laws falling into all three categories; beyond this threshold fact however, state laws vary enormously in their scope, range and the specifics of their 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 in only limited regulatory practices.<sup>35</sup> Whether these differences in regulation

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<sup>30</sup> Id.

<sup>31</sup> Id.

<sup>32</sup> Id.

<sup>33</sup> GAO, Private Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses(GAO, 03-1133, Washington D.C. 2003).

<sup>34</sup> It is worth noting that the very low percentage of individuals engaged in public employment who appear to be uninsured suggests that, in Texas as nationally, the problem is not the lack of willingness to participate in employer coverage, but the lack of affordable coverage to begin with.

<sup>35</sup> See, e.g.,Federal and State Requirements, n. 33, *supra*.

account for most, or even much, of the state-to-state variation in the cost of health insurance is not known. As noted, numerous factors (such as the underlying cost of medical care, the insurance markets present in particular states, the nature of the industry operating in any particular state, and even the unique health care culture of the state in which coverage is offered)<sup>36</sup> play important roles in determining the cost of coverage. It is perhaps worth noting again that the TDI insurance cost figures cited in its 2003 report parallel national norms; thus, 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.

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 rather than licensed insurers); and health maintenance organizations (HMOs).<sup>37</sup> State regulatory activities may be aimed at one, two or all three license holders, who in turn may sell in both the group and individual market. Regardless of their licensure category, all three classes of insurer would 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, trade associations) and by product type (e.g., different products made available to specific markets). Certain common factors are used to segment the market: age, occupation, gender, health status and geographic location.<sup>38</sup>

Insurers also may use underwriting in order to keep pools stable; underwriting is the process by which insurers will accept applicants for coverage and set the terms and price of coverage. Even where state laws require an insurer to accept applicants in the small group and individual market, they may give companies broad discretion where post-enrollment underwriting is concerned in order to set the coverage terms for enrollees. These terms, part of the product design itself, offer insurers additional safeguards against adverse selection.

States typically exercise various types of regulatory powers over health insurance products; these powers have been chronicled in a particularly understandable manner by Gary Claxton, an expert in health insurance regulation, who also notes that the exercise of these powers varies considerably by insurance product and by state:<sup>39</sup>

- *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% of the lowest rate for the same product). Thus, for example, a state insurance agency might specify that rates charged to small group purchasers be no more than 150% greater than the rate charged to very large groups such as a teachers’ union. Premium regulation also can consist of community rating standards which can be strict or modified to permit some variation in the rates at which different enrollees are charged for the same product. 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.

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<sup>36</sup> Localities vary enormously in how much and what type of health care they use. Utilization of course affects the cost of coverage.

<sup>37</sup> *How Private Insurance Works* n. 26, supra.

<sup>38</sup> Id.

<sup>39</sup> Id.



- *Medical underwriting:* Regulators also may regulate the extent to which insurers can engage in medical underwriting either at the point of application or subsequent to enrollment as a means of limiting adverse selection in terms of coverage use. 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”, that is, offers without a host of riders and exclusions that limit the terms of coverage.<sup>40</sup> Similar to premium banding, the regulation of medical underwriting practices would be distinct from the 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, at the end of a coverage term, an individual or small group purchaser is not denied contract renewal. Guaranteed issue is designed to ensure initial access to the market. HIPAA regulates guaranteed issue for transitioning individuals who are HIPAA-eligible, as well as small employers. But neither renewability nor guaranteed issue alone ensures affordable rates, since HIPAA does not regulate rates.
- *Coverage continuation:* As is the case 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, with coverage of specified benefits required. A 2001 GAO study found that Texas fell into the group of states with the highest number of mandates, although the study did not appear to group mandate by anticipated cost and grouped all forms of mandates (small group, large group, and individual market) together.<sup>41</sup>
- *Review and appeals:* An insurer’s discretion to make final and non-reviewable decisions typically is the subject of state regulation, with all states permitting at least 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 from group to group and for persons transitioning between the group and individual markets, HIPAA requires guaranteed issue for persons who are “HIPAA-eligible”, that is, who *previously had group coverage and 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 here is that HIPAA protects only persons transitioning from the group to the individual market, not individuals attempting to initially secure individual coverage. 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 as a person protected for purposes of guaranteed issue, 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.

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<sup>40</sup> *Fundamentals of Underwriting*, n. 23, *supra*; K. Pollitz, R. Sorian and K. Thomas, *How Accessible is Individual Health Insurance for Consumers in Less than Perfect Health?* (Georgetown Institute for Health Policy Studies for the Kaiser Family Foundation, Washington D.C. , 2001)

<sup>41</sup> Federal and State Requirements Affecting Coverage Offered by Small Businesses, n. 33, *supra*. Figure 1.

*More active state intervention in the individual market.* Over the past 20 years, states have begun to more actively regulate the small group market (employers between 2 and 50 persons; in some states, the self-employed are treated as a small group).<sup>42</sup> As one expert notes, 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.<sup>43</sup>

Table 1 summarizes the status of state regulation in the non-group market as of April, 2004. In some states, the level of regulatory protection exceeds minimum HIPAA requirements. As Table 1 shows, Texas has opted for few of these added protections.

One important “HIPAA +” protection would be a “guaranteed issue” rule that protects all applicants, HIPAA-eligible or otherwise. Table 1 shows that as of 2004, this protection was rare (5 states only). Another 12 states provided at least a limited additional level of guaranteed issue protection for certain classes of non-HIPAA qualified persons. Texas does not offer limited protections.

Some states have elected to make guaranteed issue a rule for self-employed persons as well as small groups. As table 1 shows, Texas did not extend this protection to self employed persons as of 2004.

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 would require 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 as Table 1 indicates, Texas 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 because they employ fewer than 20 persons on a full-time basis.

With respect to regulation of exclusionary provisions and premiums, Table 1 also shows that Texas has not elected to pursue options used in some states in the nongroup market. About one third of all states either totally or partially restrict the use of post-enrollment exclusion riders based on underwriting. Texas does not do so. 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 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 an affordability context. For example, a requirement that a premium not be more than 50% higher or lower than the standard rate might drop an \$11,000 premium to \$7,800 for a high risk person.<sup>44</sup> As Mark Merlis notes in his

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<sup>42</sup> Id.

<sup>43</sup> Id.

<sup>44</sup> Id.

excellent review of underwriting, rating restrictions could send products into a death spiral, as the lowest risks abandon the pool because of the rate increase.<sup>45</sup> Merlis notes that compulsory membership with tax subsidies might avert this result.

States, including Texas, have established high risk pools; as of 2003, 31 states had such pools, as Table 1 shows. Because these pools cover very high risk persons, even exceedingly high individual premium payments must be supplemented (typically by an assessment on insurers) to meet the costs of coverage. Even this assessment (typically 1 percent) may not be enough to make coverage affordable. In order to avoid outright rate regulation of these rates, states supplement their assessments on non-group insurers 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. Alternative approaches to structuring such a supplemental assessment on self insuring employers might pass muster. One possible alternative that avoids a direct assessment on an ERISA benefit plan was used in recent Maryland legislation, where the state legislature placed the assessment on large employers whose health expenditures for workers fall below a certain threshold. (This approach was dubbed the “Walmart Tax” because Walmart was the only large employer that, evidence suggested, could not satisfy the threshold expenditure requirements).

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. In this regard, 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, such an intervention is beyond the limits of state insurance regulatory powers in the traditional sense and would require a fundamental rethinking of the relationship between small groups and individuals on the one hand, and public employees on the other.

One approach that is highly dependent on federal law is reforms in the small group market. 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 preemption 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 through such techniques as premium and rate regulation, curbs on post-enrollment underwriting, and guaranteed issue.<sup>46</sup>

*More active state intervention in the small group market:* Tables 2-4 are taken from Appendices III-V of a 2003 GAO report that examines state regulation of the small group market. Table 2 (GAO Appendix III) shows that Texas was among the 47 states that in 2003 maintained at least some restrictions on the setting of rates in the small group market. Texas uses a rating band approach, which allows for variation within limits in premiums among types of small business based on factors such as age, group size and industry. Twelve states use either pure or modified community rating, which prohibit the use of health status to set premiums, thereby ensuring greater affordability for small firms with sicker employees, while potentially elevating rates charged firms with healthy employees during a particular contract year.

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<sup>45</sup> Id.

<sup>46</sup> Id.

Table 3 (GAO Appendix IV) shows which states exceed federal requirements in two respects in terms of how they approach small group plans. Texas was one of 40 states that required insurers to offer continuation coverage to former members of employer groups of fewer than 20 full-time employees (state COBRA). On the other hand, 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; Texas has not elected this option.

*Efforts to open the group insurance market to new products.* Individual coverage typically is subject to high deductibles, so the attention in recent years given to hybrid insurance products offering health savings accounts coupled with high-deductible plans may be most relevant to coverage access 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 as costs continue to escalate, employer interest may increase.<sup>47</sup> Whether a state would want to take aggressive steps to encourage a more robust market for this type of hybrid product is an issue for careful consideration. This is because introduction of such a product into the group market could have further segmentation effects on existing coverage arrangements, with elevated premiums for higher risk individuals. Without a companion initiative to stabilize premium rates for small groups with higher risk individuals, the risk carried by these hybrid products is their ultimate impact on affordability of coverage for the highest risk state residents.<sup>48</sup> 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 that they cannot afford even lower rates of incremental compensation associated with offering subsidized high deductible health products.

## **Discussion and Implications**

The evidence presented in this paper supports several conclusions. First, 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 paper. Even were the state to pursue Medicaid expansions and encourage a far more dynamic individual market (and national estimates of individual coverage suggest that at best this market is quite limited), the coverage shortfall produced by a weak employer market is so great that the road to reform in Texas is particularly steep. Reforms that stimulate greater employer participation appears to be a critical part of the puzzle.

Second, stimulating greater employer participation appears to be a function of the extent to which employers view coverage as affordable. Putting aside direct financial subsidies to employers and employees, there are regulatory interventions that might be worth considering. One such intervention is more active 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" that might give small employers the benefit of a far larger group membership, more choices, and better rates. Enlarging the group also might make use of a modified community rating system

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<sup>47</sup> B. Fuchs and J. James, Health Savings Accounts: The Fundamentals (National Health Policy Forum, Washington D.C., 2005)

<sup>48</sup> M. Kofman, State Coverage Initiatives Issue Brief V:3: Health Savings Accounts: Issues and Implementation Decisions for States (AcademyHealth, Washington D.C., 2004)

more conceptually feasible. Whether this approach is operationally and politically feasible remains an important question for consideration by the Task Force.

Third, this analysis also suggests that the state 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 appears not to have extended certain basic protections to self-employed individuals that are in use in other states. Nor does Texas provide basic conversion protection or other bridging arrangements for persons losing group coverage, who do not qualify for HIPAA protections. Finally, of course, the evidence suggests that the state does not offer the premium controls and cross subsidies available in other states.

Whether more aggressive approach to regulation and pooling reform would significantly alter the insurance picture in the absence of considerable subsidization cannot be known for sure. This is because states that show radically different insurance patterns experience these differences for many reasons that go well beyond their willingness to regulate the market. At the same time, the information presented here suggests that 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.