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Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change*

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April 2006

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Health insurance serves several public policy goals: it enables consumers to spread the risk of health care expenses and provides them access to medical services, which they might otherwise not be able to obtain. Because of the importance of health insurance to the general public welfare, states have been regulating private health insurance companies and products since the late 19th century. State insurance regulation has sought to promote several policy objectives, such as assuring the financial solvency of insurance companies, promoting risk spreading, protecting consumers against fraud, and ensuring that consumers are paid the benefits that they are promised.

The federal government has historically respected the state's role in regulating insurance. In 1944, the U.S. Congress explicitly recognized this role in the McCarran-Ferguson Act, which said "the business of insurance … shall be subject to the laws of the several States …."[1] Since the early 1970s, however, the federal government has taken a more active role in areas of insurance regulation that traditionally had been reserved to the states. In 1974, the federal government became the primary regulator of health benefits provided by employers. And in the 1980s and 90s, Congress established minimum national standards for group health insurance.

This paper provides an overview of current regulation of health insurance, including a discussion of state and federal standards, regulation, and oversight.[2] It then reviews three Congressional proposals to change health insurance regulation, largely by altering the current balance of federal and state regulatory roles.

I. HEALTH INSURANCE REGULATION TODAY

States remain the primary regulators of insurance companies and insurance products. There are, however, a few federal standards that apply to job-based medical benefits. Part A discusses state regulation of insurance. Part B focuses on federal standards, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which for the first time established a national minimum standard for certain health insurance products.[3]

A. State Regulation: Types of Standards For Health Insurance Coverage

Every state has adopted certain basic standards for health insurance that apply to all types of health insurance products. For example, all states require insurers to be financially solvent and capable of paying claims. States also require prompt payment of claims and other fair claims handling practices.

Other aspects of health insurance regulation, however, vary by state and by the type of coverage purchased. Although most states have passed "patient protections" like access to emergency services and specialists, the standards vary.[4] For instance, 42 states and the District of Columbia had external review laws in 2001. These various appeals programs established different standards concerning the types of disputes eligible for review, fees for the review, deadlines for filing appeals, and the selection and qualification of external reviewers.[5]

Other types of state health insurance regulations that vary by state can be grouped as follows: access to health insurance, rating, and covered benefits.

Access

State policy makers have sought to improve access to health insurance for small businesses and individuals using several regulatory approaches. Absent legislative interventions, in a private health insurance market, insurers adopt practices that seek to minimize their risk in order to avoid losses, including denial of coverage for applicants who have health conditions or a history of health problems.

An estimated 10% of individuals account for about 70% of health care spending.[6] Avoiding even a small number of high-cost individuals can substantially reduce an insurer's losses.[7]

Guaranteed issue: "Guaranteed issue" laws prohibit insurers from denying coverage to applicants based on health status. In the small group market today, all health insurance policies must be sold on a guaranteed-issue basis. Historically, this was not the case; generally states allowed commercial insurers not to sell to groups with medical needs. In many states, however, Blue Cross/Blue Shield plans offered coverage on a guaranteed-issue basis. In the 1980s, the market became more fragmented, however, and commercial carriers became more selective in who they would cover.[8] Among several responses (see guaranteed renewability below), State policymakers enact guaranteed-issue laws requiring all insurers to offer at least two health insurance policies to small businesses regardless of the medical conditions of the employees or their dependents. By the mid-1990's, 36 states had such requirements.[9] In 1996, this requirement became a federal law. The U.S. Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) and required all insurers to sell all their small group policies on a guaranteed-issue basis.

In the individual health insurance market, five states require insurers to sell coverage on a guaranteed-issue basis.[10] Other states have limited guaranteed access requirements (for example, only for HIPAA-eligible individuals or others with prior continuous coverage[11]). A handful of states require open enrollment periods during which insurers may not deny coverage due to a medical condition.[12]

Guaranteed renewability: Guaranteed renewability laws prohibit insurers from canceling coverage on the basis of medical claims or diagnosis of an illness.[13] By the mid-1990's 46 states had such requirements in the small group market.[14] Following HIPAA, all group and individual health insurance policies must be guaranteed renewable. Although HIPAA does not prohibit insurers from canceling all their policies and leaving the market, there is a penalty on market reentry of 5 years.

Unfair marketing practices requirements: States also have developed standards to prevent insurers from circumventing guaranteed issue and renewability requirements. For example, state marketing standards require insurers to actively market policies to all small businesses, not just the ones with a healthy workforce. Federal law does not provide for these kinds of fair marketing requirements.

Guaranteed access for special populations: States have also passed laws to improve access to health coverage for "special populations." For instance, most states prohibit insurers from canceling insurance for dependent adult handicapped children who were covered by their parents' policies as minors. In all states, newborns are automatically covered under their parents' policy for 30 days provided that the policy covers dependents.[15]

State continuation laws: State policymakers have also enacted coverage continuation laws similar to federal COBRA. These apply to policies purchased by small businesses not subject to federal COBRA. Thirty-eight states have such laws; some offer shorter periods of continuation coverage, while others are more generous than COBRA.[16]

Rating

Most states have enacted rating reforms in the small group market, prohibiting or restricting the ability of insurers to charge higher premiums based on health status or the risk of having future medical claims. Some states have enacted similar laws for the individual market. Generally there are two types of restrictions on insurers – rate bands and community/adjusted community rating.

Rate bands: Rate bands limit how much insurers can vary premiums for each policyholder based on health and claims of the policyholder. These limits force insurers to spread some risk more broadly across all policyholders.[17]

The extent to which premiums can vary under rate bands depends on the size of the rate band permitted and what factors are constrained by the band. For example, a model rating law for the small group market adopted by the National Association of Insurance Commissioners (NAIC) in the early 1990's (and since replaced) provided for rate bands that permit premium variation up to 200 percent based on health status. Also, the model act allowed further variation based on age, gender, industry, small business group size, geography, and family composition. Rates based on adjustments for these factors had to be actuarially justified but were not limited except for industry, which was limited to a 15% variation.

The old NAIC model act permitted a wide variation in rates, allowing for a price difference of 26 to 1, or more.[18] This means that for the same policy an insurer could charge a business or a person $100 per month or $2600 per month depending on risk and other factors. Higher rates under the model would be permitted as long as there was actuarial evidence to support wider variations.

Thirty-seven states have enacted rate bands for coverage sold to small businesses (See Attachment A). Of these, four states follow the original NAIC model act's restrictions on health-based rating and industry. The rest have modified their approach, applying different limits on insurers' ability to charge rates based on medical needs, industry, employer's size, age, gender, and/or other factors. A few allow broader variations in premiums based on medical needs. For example,

- 11 states limit or prohibit insurers from varying rates for small businesses based on the employer's size;
- 12 states limit or prohibit insurers from varying rates for small businesses based on the gender of members of the small group; and
- 8 states limit variations based on age of workers in small businesses.

At renewal, rate bands also limit how much insurers can surcharge a group or individual based on claims made in the prior year or other factors, such as the length of time (duration) since the policy was first purchased. The renewal surcharge permitted by the rate band, typically 15%, is applied in addition to any increase that would otherwise apply to all policyholders due to the cost of medical care (called "trend").

Community rating: Community rating means that insurers must set prices for policies based on the collective claims experience of everyone with such policy (and in theory, the price reflects the value of benefits and not the risk factors of people who purchase the policy).[19] Insurers are not allowed to vary rates based on health or claims of a business or a person. Under adjusted or modified community rating, premiums may be adjusted based on the geographic location and sometimes for a person's age; adjustments for gender are generally not allowed. At renewal, premiums are based on the claims experience of all people with that policy. In other words, businesses and individuals who had claims are not charged higher rates than others with the same policy.

Shortly after adopting its original model with rate bands, the NAIC replaced it with a model law for small groups that requires adjusted community rating, prohibiting premium surcharges based on health or other risk characteristics. The current NAIC model act limits premium surcharges based on age to 2:1; it prohibits insurers from varying small group premiums based on gender of people in the group or an employer's size.[20]

Today 12 states follow the current NAIC model act. Ten states require all insurers to use community rating or adjusted community rating for all small group policies. Two others, Michigan and Pennsylvania, require Blue Cross Blue Shield plans (their largest insurers) and HMOs to use adjusted community rating.

Rate regulation that spreads risk is, by nature, redistributive, and so not without controversy. Critics of rate regulation argue it raises premiums for healthy individuals and groups higher than they otherwise would pay in the absence of regulation. Advocates of tighter rate regulation note these rules protect consumers from dramatic premium increases when they are sick, or at renewal after they become sick. There is evidence in support of both points of view. For example, one study found that *average* health insurance premiums are somewhat higher in community rated markets, reflecting the relatively greater ability of older and sicker people to afford coverage.[21] Another study of rating practices in unregulated markets found rate variation of more than nine-fold (monthly premiums of $183 vs. $1,765) for the same policy based on age and health status.[22]

The variety in rating rules across states reflects the challenges policy makers have faced in balancing these tradeoffs. States also change rating practices over time in response to changing market and political circumstances. For example, New Hampshire recently restored adjusted community rating in its small group market, having previously repealed it. Legislators responded to dramatic premium increases that many small businesses with older and sicker workers experienced after rate-bands were put in place. Legislators reinstated adjusted community rating to spread the cost of any one small employer group's health experience more broadly.[23]

Covered Benefits

States have a wide range of standards that govern the types of conditions and treatments a policy is required to cover (called mandated benefits). For example, in 46 states health insurers are required to either cover (or offer to cover) benefits for diabetes supplies and education.[24] Twenty-seven states require insurers to cover cervical cancer screening.[25] Fifty states require coverage for mammograms and 32 require coverage for well-baby care (childhood immunizations and visits to pediatricians).[26] Mandated benefits also include requirements on insurers to reimburse certain types of medical providers, such as nurse practitioners. The term "mandated benefits" is also used to describe state laws requiring coverage for special populations, e.g., adult handicapped children.

One way to spread the cost of a medical condition or treatment among a broad population, making it less expensive for the group of people who need such coverage, is through a benefit mandate. It is also a way to encourage people to seek certain care, e.g., preventive services, that otherwise may not be received. In the absence of mandates, adding optional benefits to a policy can distort premiums if coverage is selected by people who need that benefit. As a way of example, in the 1990s Washington State required insurers to sell comprehensive policies covering all mandated benefits, but also allowed the sale of policies that did not cover certain benefits, like maternity and mental health care. All policies, regardless of covered benefits, had to be sold on a guaranteed issue basis and were subject to community rating. By 1998, premiums for policies that covered maternity and mental health benefits were anywhere from 30 to 100 percent more expensive than policies that excluded those two benefits. The choice in benefit design led consumers to self-segregate based on their health care needs, with adverse selection fueling the disparity in premiums for the products (See Attachment B).[27]

Policymakers make tradeoffs, balancing higher premiums with the need to help finance certain illnesses. How mandated benefits add to the cost of health insurance has been an issue of longstanding controversy. The answer depends in large degree on the extent to which mandates spread the cost of a particular health care service over a large number of policyholders. A recent study found that exemptions from mandates would lower premiums by five percent.[28]

Interaction of state regulation and other programs to expand health coverage

In addition to market rules, some states subsidize private health insurance. State programs have been developed to help expand access to private health insurance by addressing affordability problems. These

programs include tax credits and premium assistance, purchasing alliances, and reinsurance mechanisms. In 2002, for example, nine states had premium assistance or direct coverage programs, most for moderate and low income people.[29] A program, established in 2005 in Montana, offers tax credits and premium assistance to small businesses and workers. Arizona, California, Montana, New Mexico, and New York City have purchasing alliances for small businesses to negotiate favorable rates and coverage with private insurance companies on behalf of participating businesses.[30] Reinsurance programs have been tried in 21 states; reinsurance is used to subsidize the cost of big claims.[31] One of the largest programs is Healthy New York, covering approximately 100,000 people in New York state; it uses public funding to subsidize a portion of high-cost claims.[32]

While these state coverage expansion efforts vary, they share a common need for market stability. The cost to states of subsidizing private coverage can quickly become prohibitive if insurers can avoid or shed the most expensive risks or steer them to the subsidized coverage. States have adopted various mechanisms, including rating rules and standardized benefit packages, to limit adverse selection against these coverage expansion programs.[33]

B. State Oversight and Enforcement Tools

Insurance regulators use a number of tools to protect consumers of insurance and to oversee and enforce market rules. Some are designed to prevent problems from arising in the first place. For example, states have requirements for who can establish and manage an insurance company (including background checks and a prohibition on convicted felons). Other tools help regulators detect and correct non-compliance with market rules.

Form and rate filing: State requirements to file policies (called form filings) with the insurance department are designed to prevent insurers from selling non-compliant products. Filed policies are reviewed to ensure they cover required benefits, provide for appropriate appeals and grievance procedures, and meet other state requirements. Rate filings help regulators monitor prices to ensure that premiums are set in accordance with state law and to try to prevent significant rate increases by ensuring that initial rates are adequate to fund future claims.

Market conduct and financial examinations: Through market conduct exams (periodic or targeted audits of insurers designed to look at a specific practice or suspected problem), states can identify operational problems (such as failure to pay claims fairly or promptly) and other noncompliance with state law. Regulators also conduct periodic or targeted financial exams for signs of financial problems to prevent or mitigate insolvency.

Corrective actions: Tools available to state insurance regulators to ensure corrective action by insurers include fines, administrative "cease and desist" orders, and revocation of licenses that authorize insurers to operate in the state. Administrative authority of state regulators allows for quick resolution of problems by avoiding the need to go to court. Licensing is both the ultimate enforcement mechanism as well as a deterrent for insurers to refrain from repeatedly violating the state's consumer protection laws. In every state, a company must be authorized to engage in the insurance business and thus the loss of that authority means the insurers cannot do business in that state.

On the financial side, regulators can order an insurer to cease new enrollment. Insurance departments can also initiate receiverships or conservator actions, which means the insurance department takes over the company and either tries to cure its financial problems or shuts it down. States have established safety-nets designed to protect consumers in case of insurers' insolvency. State guaranty funds, financed by insurers in the market, pay unpaid medical bills. All states have such funds.[34] In case of HMO insolvencies, some states require HMOs to have "hold harmless" clauses with their providers, meaning that providers are not allowed to bill patients for HMOs' bills in cases of insolvency.

General prohibition on unfair practices: State insurance departments' consumer services divisions seek to help consumers who are having problems with their insurance. Through broad authority that regulators have under "unfair claims settlement" and "unfair trade practices" laws, regulators can investigate and require corrective action by insurers engaged in inappropriate practices even when such actions are not explicitly prohibited in state law.

C. Federal Legislative Interventions: ERISA, COBRA, and HIPAA

As a result of a 1974 federal law called the Employee Retirement Income Security Act (ERISA), health benefits offered by private employers are not regulated by states. ERISA does allow states to regulate health insurance policies that employers may purchase. However, employers that self-insure are not subject to state regulation. The types of state consumer protections discussed above do not apply to self-insured job-based health coverage.[35]

Congress has adopted some substantive standards for employer-sponsored group health plans. Most of these have been incorporated in ERISA and the federal tax code.

The most significant were added by COBRA in 1986 and by HIPAA in 1996. COBRA applies to employers with 20 or more employees and gives workers and their dependents a right to continue job-based coverage under certain circumstances. The continued coverage can last 18 to 36 months depending on the qualifying event.

In 1996, the U.S. Congress passed HIPAA to improve access to health insurance and to prohibit discrimination against people with medical needs. Generally, HIPAA set a minimum federal floor of consumer protections to apply to all private health insurance (with exceptions for state and local government employers). Congress allowed more protective state laws to continue to apply.[36]

Many provisions were based on state insurance reforms. HIPAA established national standards for health insurance sold to employers, prohibiting insurers from denying coverage to small businesses, limiting use of preexisting condition exclusions from coverage, prohibiting discrimination based on health, and requiring guaranteed renewability. HIPAA standards apply to group health plans (including those that self-insure, which are exempt from state insurance laws) as well as to insurers. HIPAA also established rights for people leaving job-based coverage, ensuring qualifying people access to individual coverage regardless of existing medical conditions. For both group and individual market coverage, HIPAA left it up to the states to decide whether and to what degree to regulate premiums insurers might charge groups with high medical needs.

Enforcement of HIPAA and related standards involves both states and the federal government. States had an opportunity to enact laws that provide at least the protections that are in federal law, and most have done so. Congress relied on states to adopt and enforce national insurance standards in part because the federal government does not have personnel or administrative capacity to regulate insurance on a broad scale.[37] However, the U.S. Department of Health and Human Services (HHS) was given authority to enforce federal standards in states that chose not to enact these and in those that are not substantially enforcing similar protections.[38] In other words, HHS became a back-up enforcer to the states. In the early implementation of HIPAA, HHS had to devote federal enforcement resources in states that did not adopt and enforce HIPAA standards.

The U.S. Department of Labor (DOL) continues to have authority over ERISA covered employers providing benefits, and the U.S. Department of Treasury has enforcement authority over employers through their tax qualified group health plans.[39]

II. FEDERAL PROPOSALS: H.R. 525, H.R. 2355, S. 1955

Three bills pending in the 109th Congress propose approaches to health insurance regulation that would depart from current law and change the role of states and the federal government. The three bills are:

- H.R. 525, the "Small Business Health Fairness Act of 2005" introduced by Representative Sam Johnson, would federalize regulation of association health plans. It passed the U.S. House of Representatives in July 2005; a companion bill S. 406 was introduced in the Senate by Senator Snowe, the chair of the Senate Small Business Committee.
- H.R. 2355, the "Health Care Choice Act of 2005" introduced by Representative Shadegg in 2005 would allow insurers to sell policies regulated by one state across state lines. A companion bill was introduced in the Senate by Senator DeMint (S. 1015).
- S. 1955, the "Health Care Marketplace Modernization and Affordability Act" was introduced in 2005 by Senator Enzi, the new chair of the Senate Health, Education, Labor, and Pensions (HELP) Committee. S. 1955 would federalize regulation of fully insured association health plans. It would also create new federal standards for all other health insurance and establish new parameters within which states would be allowed to regulate health insurance products and companies. The bill was approved by the HELP committee on March 15, 2006.

Under all three bills, Congress would limit state regulatory authority, although each bill adopts a somewhat different approach and the scope of affected health insurance also varies.

A. "Small Business Health Fairness Act of 2005" (H.R. 525)

H.R. 525 would federalize regulation of health coverage sold through associations and preempt state laws from applying to association health plans (AHPs).[40] This would change current law, which requires association health plans to comply with state laws and in some cases with ERISA.[41]

The bill seeks to make health insurance more affordable for small businesses by allowing them to band together, through associations, to negotiate for better options with insurers and to achieve cost savings through exemptions from state insurance laws.[42]

To qualify, health coverage must be sponsored by a trade, an industry, or a professional association like a chamber of commerce, and must meet specified standards in the bill. AHPs would be allowed to offer fully insured and self-insured health benefits. Fully-insured AHPs buy health insurance from state-licensed insurance companies; insurers are responsible for paying the medical bills. Self-insured plans collect contributions from enrollees into a fund, paying medical claims out of the fund. Self-insured AHPs would have to meet federally established solvency requirements in the bill.[43] Federal standards would be lower than current state-based requirements applicable to self-insured multiple employer arrangements.[44]

The U.S. Department of Labor (DOL) would be responsible for oversight. Once certified by DOL, an AHP would be authorized to operate nationwide, exempt from state insurance laws. State coverage requirements like well-baby care, preventive services, and mammograms would not apply to AHP policies.[45] In the area of rating, an AHP would have flexibility to set premiums not subject to state rating laws. Each employer group within an AHP could have premiums based on its own claims. The bill has conflicting provisions relating to an employer member's access to the association's health coverage.[46] Also enrolled businesses would not be guaranteed renewal of their coverage. Instead, an AHP could offer an employer different coverage at renewal.

Adverse selection effects from AHPs could impact state-regulated products. Through broad preemption of state guaranteed-issue, rating, marketing, product design, and guaranteed-renewability requirements, H.R. 525 would allow AHPs and their insurers to target healthy employers and avoid covering businesses once their employees develop medical needs. This could lead to market segmentation, with healthy

people leaving state-regulated market for AHP coverage and sick people leaving AHPs for state-regulated coverage. Several studies have concluded that premiums for state-regulated policies would increase as a result.[47] For example, the Congressional Budget Office (CBO) estimated that a similar bill would cause approximately 10,000 people to lose coverage because of higher premiums caused by the bill in the state-regulated market. CBO also estimated a 13% drop in price for AHP coverage, with a cost savings from exemptions from state mandates and covering groups with lower medical costs. Several studies have concluded that the overall affect on the uninsured problem would be minimal (CBO estimated 550,000 people would be newly covered).[48]

Also, federalizing regulation of AHPs can increase fraud and abuse.[49] There has been a long history of insolvency and fraud among association health plans. For example, between 2001 and 2003, four self-insured associations left 66,000 people with over $48 million in unpaid medical bills that should have been paid by the AHPs.[50] Although coverage would be less expensive as a result of lower reserve requirements, participating businesses would be exposed to a higher risk of AHP insolvency. Also, in the recent past, the most prevalent way to sell phony health insurance has been through associations. For instance, according to the GAO, between 2000 and 2002, phony health plans left over 200,000 policyholders with over $252 million in unpaid medical bills.[51] Because H.R. 525 would not give DOL new regulatory staffing resources or the type of authority that state insurance regulators currently have and use – including cease and desist authority that allows quick administrative action without going to court – to find and quickly shut down phony health plans, the bill could lead to increased health insurance fraud.[52]

B. "Health Care Choice Act of 2005" (H.R. 2355)

The "Health Care Choice Act of 2005" (H.R. 2355) would apply to coverage sold in the individual market. It would allow health insurers licensed in one state to do business in other states without complying with other states' insurance laws.

The legislation seeks to make health insurance more affordable by eliminating the need for insurers to comply with laws in 51 jurisdictions. It also seeks to give consumers more choices of products and companies in the individual market.

Under the bill, a company could choose a "primary" state among those states with solvency standards called "risk-based capital" (RBC) for health insurance issuers.[53] Once licensed in its primary state, a health insurer would be allowed to do business in all other states (called "secondary" states) without meeting solvency and licensing requirements of the states in which it does business.[54] An insurer would not be required to do business in the primary state. All other secondary state standards would be preempted, including guaranteed issue requirements, benefit mandates, rating laws, standards for reviewing denied claims (external appeals), and rules governing marketing practices.[55] This would be a significant departure from current law. Insurers today must be licensed in and comply with the laws of every state where they conduct insurance business.

H.R. 2355 would also restrict the general authority of insurance regulators in primary and secondary states in the following areas: solvency regulation and oversight activities, fraud and abuse, and payment of claims (limiting use of state unfair claims settlement laws).[56] As a way of example in the area of solvency, under current law a state may examine an insurer's financial condition. The bill would change that by allowing a secondary state to conduct financial exams only if the primary state has not conducted one in the recommended time period and only if the exam is coordinated with other states to avoid multiple exams.[57] Such restrictions on secondary states' authority could raise the risk of insolvency.

H.R. 2355 would also limit state authority in the area of fraud and abuse by defining what constitutes fraud and abuse narrowly and by restricting states' administrative authority. Under the bill, the secondary

state would be required to go to court in a fraud case, whereas now, states can shut down a phony insurance company through an administrative process -- a much quicker way to prevent an illegal entity from spreading.[58]

A concern is that H.R. 2355 would create asymmetry in health insurance markets in most states. A high degree of market de-stabilization could result. For example, in New York, health insurers are required to sell policies on a guaranteed issue basis, cover standardized benefits, and set premiums using community rating. These rules would not apply to companies licensed in a different primary state with different rules. Insurers licensed under New York's laws would be at a significant competitive disadvantage. Healthy people could self-select less expensive out-of-state coverage; without a guaranteed-issue requirement, out-of-state insurers would not have to sell coverage to sick people. New York companies could not remain in business covering only sick people. Consequently, this could adversely impact New York's consumers who need comprehensive, guaranteed health insurance, leaving such people with fewer choices or no options at all.

Provisions in the Health Care Choice Act also raise constitutional and practical questions about enforcement. H.R. 2355 seeks to give state insurance departments authority to enforce the new federal standards. However, under the U.S. Constitution, Congressional authority over state insurance departments is limited, meaning Congress cannot require states to do what H.R. 2355 sets out.[59] Unless the legislature in the primary state enacts a law to adopt these federal standards and to expand the authority of its insurance department to enforce these extraterritorially, consumers living in secondary states will not be protected by the primary state's laws. The bill would prohibit secondary states from enforcing their own laws and because of jurisdictional constrains under state constitutions, generally states are not authorized to enforce laws of other states.[60]

As a practical matter, even if a primary state were to pass a law extending its regulatory authority to insurance sold in secondary states (the authority of states to do this may have to be litigated), a primary state's resources would be stretched. For example, consumers in California (population 36 million) who bought a policy licensed in Delaware (population 840,000) would not be protected by California law. Instead, California consumers with insurance problems would have to seek assistance from a regulator some 3,000 miles away and staffed to regulate insurance markets on a much smaller population scale.

In addition, H.R. 2355 could also impact employer sponsored health insurance if cheaper out-of-state policies attract healthy people currently in job-based coverage. The CBO estimates that 1 million people would lose job-based coverage as a result of H.R. 2355 as healthy people leave job-based coverage, causing prices to increase for sicker and older workers and forcing some employers to drop coverage altogether.[61] Additionally, CBO estimates Medicaid spending would increase by $1 billion (2007-2015) in part as a result of lost job-based coverage among low-wage workers prompted by H.R. 2355.[62]

C. "Health Insurance Marketplace Modernization and Affordability Act of 2005" (S. 1955)

The "Health Insurance Marketplace Modernization and Affordability Act of 2005" was introduced in the U.S. Senate in the fall 2005; a revised version was considered and voted out of the Senate HELP Committee in March 2006 (S. 1955). The bill's sponsors cited a need to "modernize the health insurance marketplace" in order to expand health care access and to reduce costs.[63] Similar to H.R. 525, S. 1955 seeks to help small businesses afford coverage by allowing them to band together, through associations. It also seeks to offer more choices of products by allowing insurers to design products that are not subject to state mandated benefit laws and by establishing a national standard for premium rates for small businesses. The bill also seeks to make health insurance more affordable by trying to streamline how insurance companies are regulated.

Federal Regulation of Association Health Plans

S. 1955 would establish federal certification for fully insured association health plans, called "Small Business Health Plans" (SBHPs) and exempt these plans from state regulation.[64] Standards for SBHPs are almost identical to those for association health plans in H.R. 525, with a few key exceptions. Self-insured SBHPs are not authorized under S. 1955.

Also, different from H.R. 525, S. 1955 includes deeming provisions. If DOL does not act on an application within 90 days, SBHP would be deemed federally certified.[65] Because the bill provides no additional administrative resources to DOL, it is difficult to assess the thoroughness of review to which SBHP certification applications might be subject. The bill would preempt state ability to close down SBHPs. No exceptions, (for example, for suspected fraud) are provided under the bill.

One concern is that this bill would increase potential for fraud. For instance, unscrupulous individuals may falsely claim to have bought insurance, in the same way some have done in the recent past, defrauding small businesses. Once deemed federally certified, states would be prohibited from taking action. By the time the federal government investigates, it would be too late as these types of scams proliferate quickly.[66]

Similar to H.R. 525, coverage sold through SBHPs would be exempt from state insurance standards like benefit mandates. Generally, SBHPs would be allowed to offer mandate free policies. Insurers selling through SBHPs would be regulated by states for solvency.

Similar to H.R. 525, each association would have its own premium rate based on the claims experience of the association group and that base rate could vary for specific member employers of the association to reflect the claims of each employer group.[67] However, S. 1955 would limit this variation to no more than 2:1; that is, premiums for sick groups could be 200% of those for healthy groups participating in the SBHP.[68] The legislation would allow insurers to further vary rates without limits for each enrolled small business based on other factors like group size, age, gender, geography, family composition, and wellness.[69] An SBHP's claims experience would not be linked to the rest of the small group market.

Similar to H.R. 525, a concern with S. 1955 is that it would further fragment the small group market by exempting SBHPs from state standards that seek to prevent market segmentation including marketing practices, coverage design, rating and renewability, and by allowing SBHPs to have rates that are not linked to the rest of the small group market. If insurers are successful in attracting healthy groups to buy coverage through SBHPs, premiums for coverage outside the SBHP will be much higher, as healthy groups stop buying such coverage.

Federal Standards for All Health Insurance

S. 1955 would establish a new optional national standard that insurers could choose to follow. Under the new standard, state benefit laws would no longer apply to individual, small group, and large group health insurance. State rating laws in the small group market would also be preempted. The bill would preclude higher and different state laws when insurers choose to operate under the national standard, establishing a ceiling of protections. The bill would also restrict state oversight of health insurance policies and companies.

With respect to mandated benefits, S. 1955 allows health insurers to sell policies exempt from all state benefit mandates in the individual, small group, and large group market as long as the insurer also offers a policy with benefits and services covered under any plan option offered to state employees in one of the five largest states (Texas, California, New York, Florida, and Illinois).[70] For example, an insurer might

choose a high-deductible policy, similar to one option offered to Florida state government employees with an annual deductible of $2,500 for family coverage, leaving employers and individuals in all states a choice of a mandate-free policy or a high-deductible one.[71]

In addition to fewer choices, this could invite adverse selection raising prices for comprehensive coverage. S. 1955, would allow self-selection, sorting people with serious illness into the relatively more comprehensive plans, and raising the cost of such coverage substantially compared to mandate-free policies.[72] Overtime it would be difficult for insurers to continue to offer comprehensive policies if only people with medical needs bought them. Consequently, comprehensive coverage could disappear from the market.

With respect to rating, S. 1955 would establish an optional national standard for small group premiums, which insurers may choose to follow. The new federal standard is based on the old NAIC model act.[73] S. 1955 would allow insurers to charge a small business with sick workers twice as much as a business with healthy workers when first purchasing a policy. The bill would restrict surcharges based on an employer's industry to 15% (on top of the base rate). Additional premium variation without limits could be applied based on other factors including age, gender, geography, family composition, wellness programs, and small business group size. Different from the model, however, the bill excludes coverage sold through SBHPs and is unclear whether other associations would be allowed their own price not tied to the rest of the market (called "class of business" in the bill).[74] Although under the old NAIC model, price differences were 26 to 1 for the same coverage, S.1955 could create greater variations between coverage sold through associations and in the small group market.[75]

At renewal insurers would also be allowed to increase a small employer's premium by up to 15% based on claims of employees and dependents. The 15% increase for a specific group would be in addition to whatever renewal increase applied to all policyholders.[76]

The bill would preempt existing state rate standards. Although there are thirty-seven states with rate bands, only four follow the old NAIC model act's restrictions on health-based rating and industry. None of the four, however, allow the type of class structure contemplated in the bill – that is associations having their own class not tied to prices for small group market. The twelve states that follow the current NAIC model act that provides for adjusted community rating would be preempted also. In these states, the impact would be most dramatic as insurers would be able to raise prices significantly for sicker workers and older people. Only two jurisdictions have not enacted any small group rate reforms – Hawaii and the District of Columbia. Because the rating standards in the bill are optional, insurers in those two jurisdictions would not have to comply with new national rating standards.

Other: Regulation of Insurance Companies

S. 1955 would establish other new regulatory national standards and would limit authority of states in overseeing how insurance companies operate. A private board of insurance industry representatives and state officials would develop national standards in four areas: rate and form filings, market conduct exams, internal claim denial appeals, and prompt payment of claims requirements. These would replace current state standards.

S. 1955 provides specific guidelines for the private board to follow. For example, new national rate and form filing requirements would allow for self-certification by insurers. Market conduct examinations would be restricted and fines would be limited for certain violations.[77]

This oversight approach is different than the one states use now. Currently, by scrutinizing policies and rates, in other words not allowing self-certification, many state regulators identify and prevent problems before they occur. Likewise, broad state authority over market conduct has enabled states to detect

problems and to require corrective action. Limiting oversight authority could have significant adverse implications for insurance consumers.

Enforcement of New Federal Standards for Individual and Group Health Insurance

HHS would have authority to issue regulations providing guidance and the federal courts would have the exclusive right to interpret the standards for individual and group health insurance in S. 1955.[78] However, the bill would not authorize the federal government to enforce nor would it authorize injured consumers to go to federal court to enforce these national standards.[79] For enforcement, S. 1955 looks to states.

Constitutional limitations prevent Congress from requiring states to enact the national standards. Therefore, S. 1955 would give states an option of doing so. However, effective enforcement may be difficult. In particular, if a state were to enact the new standards, an insurer can challenge a state's interpretation in federal court. Some state officials have argued that this could have a chilling effect on state enforcement if a state is sued, forced to litigate its enforcement actions in federal court.[80]

S. 1955 is self-implementing. If a state chooses not to adopt the new national standard, S.1955 would authorize insurers to offer policies under the new national standard. If a state were to apply its old laws or prohibit an insurer from selling national coverage, S. 1955 would authorize the insurer to sue the state in the federal court of appeals on expedited review.[81]

In summary, the enforcement under S. 1955 represents a new approach to regulating health insurance, with four key departures from current law. The bill:

- would authorize a regulated industry to sue its primary regulator, a state, in federal court on expedited review (without an initial trial in district court, which is a typical process for law suits);
- would not create a fallback federal agency to enforce national standards if states choose not to;
- would authorize insurers to offer insurance products that are not subject to state or federal regulator oversight; and
- would not create a federal cause of action for injured consumers to enforce the new federal standards in federal court.

The new regulatory framework would largely rely on self-regulation by insurers and could result in insurance consumers relying on the insurance industry to operate appropriately and to not break the law. However, absent oversight and accountability, S. 1955 would create incentives for insurers to do just the opposite.

CONCLUSION

The Small Business Health Fairness Act of 2005 (H.R. 525), the Health Care Choice Act of 2005 (H.R. 2355), and Health Insurance Marketplace Modernization and Affordability Act of 2005 (S. 1955) if enacted would fundamentally change the way health insurance is regulated in the United States. In this context, the future of health insurance regulation is not entirely clear.

Congressional sponsors appear to depart from traditional reliance on states as laboratories for innovation and as primary regulators of health insurance. In the past, federal legislation established a floor of national standards. The three proposals would do the opposite. Also, while in the past Congress heavily relied on states to implement federal standards, the bills pending in Congress would substantially restrict state ability to regulate health insurance. All three bills would also have the effect of reducing the overall level of health insurance regulation by any level of government. While they would restrict authority of states to regulate risk selection, to limit unfair market practices, and to engage in oversight, none of the

proposals would invest substantial new regulatory authority or capacity with the federal government. In this respect, the three bills could be viewed as de-regulating health insurance to varying degrees.

The three bills intend to make markets more competitive by making it easier for insurance companies and associations to operate – not having to do business within the constraints of 51 different sets of regulators and rules. An unintended consequence, however, may be to allow new ways to segregate health insurance markets by risk. Consequently, to the extent that current insurance regulations have reached a balance in promoting competition while ensuring an equitable spreading of risk – through rating, covered benefits, and other rules that protect access to coverage by healthy and sick alike – the segmented market could destabilize premiums and coverage. Ironically, this may lead to a reduction in protection from medical expenses that health insurance offers individuals, families, and employers. It may lead to no private health insurance options for consumers with medical needs and fewer choices for others. It remains to be seen what direction for health insurance regulation the Congress may set, and what changes in private coverage may result.

Attachment A: State Small Group Standards

State	Group Size	Type of Rating Restriction: Small Group Market	Comments/ Exceptions
AL	2-50	Rate Bands Allowed: health (+/-25%), age (4:1), group size (+/-15%), gender, family composition, geography Prohibited: industry Renewal: same (1/12 months increase)	
AK	2-50	Rate Bands Allowed: health (+/-35%), industry (15%) Renewal: trend plus 15% for claims, health & duration	
AZ	2-50	Rate Bands Allowed: health (60%) Renewal: trend plus 15% for claims, health & duration	
AR	2-50	Rate Bands Allowed: health (+/-25% per class) Renewal: trend plus 15% for claims, health & duration	
CA	2-50	Rate Bands Allowed: health (+/-10%), age, geography, and family composition Renewal same	
CO	1-50	Rate Bands Allowed: health (+ 10%/-25% including industry), smoking (15%) Prohibited: gender and group size Renewal: trend plus 15% for claims, health & duration	
CT	1-50	Adjusted Community Rating Allowed: group size (1.25 : 1), industry (15%), gender, age and geography (defined) Renewal: same	
DE	1-50	Rate Bands Allowed: health (+/-35% per class), gender and geography, industry (15%) Prohibited: group size Renewal: trend plus 15% for claims, health & duration	
DC	2-50	No rating restrictions	
FL	1-50	Rate Bands Allowed: health (+/-15%), geography and family composition defined Prohibited: industry Renewal: trend plus 10% for claims, health & duration (1/12months)	
GA	2-50	Rate Bands Allowed: health (+/-25%), group size (+/-15%), age, gender, industry, geography Renewal: trend plus 15% (1/12 months)	
HI	2-50	No rating restrictions	largest plans may voluntarily community rate
ID	2-50	Rate Bands Allowed: health (+/-50% per class), age defined Renewal: trend plus 15% for claims, health & duration	
IL	2-50	Rate Bands Allowed: health (+/-25% per class) Renewal: trend plus 15% for claims, health & duration	
IN	2-50	Rate Bands Health +/-35% Renewal: trend plus 15% for claims, health & duration	

State	Group Size	Type of Rating Restriction: Small Group Market	Comments/ Exceptions
IA	2-50	Rate Bands Allowed: health (+/-25% per class), group size (1.2), age, gender (must be a blended rate) Prohibited: industry Renewal: trend plus 15% for claims, health & duration	
KS	2-50	Rate Bands Allowed: health (+/-25% per class), industry (15%) Renewal: trend plus 15% for claims, health & duration	
KY	2-50	Rate Bands Allowed: health (+/-50% per class), age (5:1), gender, industry, geography Renewal: trend plus 20% for claims, health & duration	
LA	2-50	Rate Bands Allowed: health (+/-33% per class) Renewal: trend plus 20% for claims, health & duration	Rate bands for (3-35). No restrictions for groups of 2 or 36-50.
ME	1-50	Adjusted Community Rating Allowed: 1:5 band for age, geography & industry; additional adjustment for family composition, smoking, wellness programs, and group size Prohibited: gender, health status and claims experience Renewal: same	
MD	2-50	Adjusted Community Rating Allowed: 40% for age and geography Prohibited: industry, gender, and group size Renewal: same	
MA	1-50	Adjusted Community Rating Allowed: 2:1 bands for: age, size (+/-5%), industry, and participation rate. Geography (+/-20%), up to 5% wellness discount Prohibited: gender Renewal: same	
MI	2-50	Rate Bands Commercial carriers: Allowed: +/-45% for health, industry, age, group size Adjusted community rating for BC/BS and HMOs Allowed: +/-35% for industry and age (HMOs are also allowed to use group size in this overall band) Renewal: trend plus 15% for changes in case characteristics but must stay within band above**	Insurers that offer coverage to groups of one may increase premiums by 25%. BCBS: g-issue to sole proprietors
MN	2-50	Rate Bands Allowed: +/-25% for health, claims, duration and industry; age (+/-50%); 20% b/w geographic areas Prohibited: gender Renewal: trend plus 15% for claims, health & duration	
MS	1-50	Rate Bands Allowed: health (+/-25% per class for health) Renewal: trend plus 15% for claims, health & duration	
MO	2-50	Rate Bands Allowed: health (+/-25% per class), industry (10%) Renewal: trend plus 15% for claims, health & duration	Rating restrictions applicable to certain groups (sized 3-25). Otherwise no restrictions.
MT	2-50	Rate Bands	Gender rating is prohibited by human

State	Group Size	Type of Rating Restriction: Small Group Market	Comments/ Exceptions
		Allowed: health (+/-25% per class), industry (15%) Prohibited: gender Renewal: trend plus 15% for claims, health & duration	rights laws
NE	2-50	Rate Bands Allowed: health (+/-25% per class), industry (15%) Renewal: trend plus 15% for claims, health & duration	
NV	2-50	Rate Bands Allowed: health (+/-30% per class), industry (20%) Renewal: trend plus 15% for claims, health & duration	
NH	1-50	Adjusted Community Rating Allowed: 3.5:1 for age, groups size, and industry; family composition Prohibited: health, claims, duration, gender, and geography Renewal: trend plus 20% transitional for 2006; afterwards same as at offer	REPEALED old adjusted community rating and replaced w/rate bands (+/-15% for health; 4:1 age, 15% for area, 20% for group size, 20% industry, no gender – these were repealed in 2005 after small groups experienced huge rate hikes
NJ	2-50	Adjusted Community Rating Allowed: 200% for age, gender, and geography Prohibited: health, group size, industry, claims, and duration Renewal same rules	
NM	2-50	Rate Bands Allowed: health (+/-20% per class); 250% band for: age, gender, geography, industry, and smoking Prohibited: group size Renewal: trend plus 10% for claims, health & duration	
NY	2-50	Community Rating Allowed: geography and family composition Prohibited: health, group size, industry, claims, age, gender, & duration Renewal: same	
NC	1-50	Rate Bands Allowed: +/-20% for age, gender, family composition, geography, claims experience and administrative costs Renewal: trend plus 15% for claims, health & duration	
ND	2-50	Rate Bands Allowed: health (+/-20% per class), industry (15%), age (4:1) Prohibited: gender Renewal: trend plus 15% for claims, health & duration	Rating restrictions apply only to groups sized 2-25.
OH	2-50	Rate Bands Allowed: health (+/-35%); industry (+/-15%) Renewal: trend plus 15% for claims, health & duration	
OK	2-50	Rate Bands Allowed: health (+/-25% per class); industry (15%) Renewal: trend plus 15% for claims, health & duration	An HMO may fix rates of payment under either a system of community rating, community rating by class, adjusted community rating or under all three systems.
OR	2-50	Adjusted Community Rating Allowed: age (43% of average area rate), geography defined Prohibited: health, group size, industry, claims, gender, and duration Renewal: same (1/12 months)	Rating restrictions apply only to groups sized 2-25.
PA	2-50	No rating restrictions	

State	Group Size	Type of Rating Restriction: Small Group Market	Comments/ Exceptions
		Adjusted community rating for BCBS and HMOs Allowed: +/-15% variation allowed based on all factors	
RI	1-50	Rate Bands Allowed: health (+/-10%); age, gender and family composition Prohibited: all other factors (group size and industry) Renewal: same (1/12 months)	Adjustment for health allowed only for carriers that used health status prior to June 1, 2000. "Adjusted community rating" (with adjustments for age, gender, and family composition) applies to all others
SC	2-50	Rate Bands Allowed: health (+/-25% per class), group size (20%) Renewal: trend plus 15% for claims, health & duration	
SD	2-50	Rate Bands Allowed: health (+/-25% per class), industry (15%), age (3:1) Renewal: trend plus 15% for claims, health & duration	
TN	2-50	Rate Bands Allowed: health (+/-35% per class), industry (15%) Renewal: trend plus 15% for claims, health & duration	Rating restrictions apply only to groups sized 3-25.
TX	2-50	Rate Bands Allowed: health (+/-25% per class), industry (15%), group size (20%) Renewal: trend plus 15% for claims, health & duration (1/12 months)	
UT	2-50	Rate Bands Allowed: health (+/-30% per class), industry (15%), group size (20%) Renewal: trend plus 15% for claims, health & duration	
VT	1-50	Pure Community Rating Allowed: family composition Prohibited: health, group size, industry, claims, age, gender, geography and duration Renewal same	
VA	2-50	No rating restrictions	Standard and essential products: Health +/-20%; industry and group size prohibited; Renewal same as initial
WA	2-50	Adjusted Community Rating Allowed: age (375%), wellness, family composition, and geography Prohibited: health, claims, duration, gender, group size, and industry Renewal: same (may adjust by +/-4%; greater variations subject to approval of commissioner). Increase 1/12 months	
WV	2-50	Rate Bands Allowed: health (+/-30% per class), industry (15%) Renewal: trend plus 15% for claims, health & duration	
WI	2-50	Rate Bands Allowed: health (+/-30% per class) Renewal: trend plus 15% for claims, health & duration	
WY	2-50	Rate Bands Allowed: health (+/-35% per class), industry (15%) Renewal: trend plus 15% for claims, health & duration	

Source: Georgetown University Health Policy Institute 2006

Notes: The terms "adjusted community rating" and "community rating" mean that insurers are prohibited from adjusting rates for each employer group based on the group's claims or other health-factors. Some state laws refer to "adjusted community rating" but allow adjustments based on claims and/or health. This chart calls these laws "rate bands." Also, unless otherwise indicated in the chart, states with rate bands allow adjustments that are actuarially sound for age, gender, industry, geography, and group size. Adjusted community rating generally prohibits these unless otherwise noted in the chart.

Attachment B

Washington State Premiums for Selected Individual Products, by Product Type and Subscriber Age, 1998

	Monthly Rate		
Product	**Age 25**	**Age 45**	**Age 60**
Blue Cross comprehensive	$174	$222	$390
Blue Cross (excludes maternity, mental health)	$ 89	$159	$296
Difference	2:1	1.4:1	1.3:1

Source: Kirk, Adele, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts," *Journal of Health Policy, Politics and Law*, Vol. 25, No. 1, 2000.

[*] The authors would like to thank Gary Claxton, Beth Fuchs, Mary Beth Senkewics, state insurance regulators and other experts for their suggestions and feedback on this paper. We would also like to thank our colleagues Kevin Lucia and Eliza Bangit for assistance. The views presented here are those of the authors and should not be attributed to the reviewers.

[1] 15 U.S.C. section 1012. For a history of insurance regulation, see Robert Jerry, II, Understanding Insurance Law, 2nd Edition (1996).

[2] For a discussion of different types of companies, managed care, and other aspects of regulation of insurance, see Claxton, Gary, "How Private Insurance Works: A Primer," Prepared for the Kaiser Family Foundation, April 2002 available at http://www.kff.org/insurance/2255-index.cfm (hereinafter Claxton Report).

[3] Public Law 104-191.

[4] Other patient protections include "network adequacy" requirements. For example, if a policy promises to cover cancer but there is no oncologist in the plan's network, then the promise to cover cancer is illusory. State network adequacy laws address this by requiring an appropriate specialist to be in the network. Some states also require that such specialist be located in close proximity to a person's home or work (to prevent the problem of having to drive long distances, for example 200 miles, to see a specialist).

[5]Pollitz, Karen, et al, "Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation," Prepared for the Kaiser Family Foundation, May 2002 available at http://www.kff.org/insurance/externalreviewpart2rev.pdf.

[6] Berk, Marc and Alan Monheit, "The Concentration of Health Care Expenditures, Revisited," *Health Affairs*, (March/April 2001): 145-149.

[7] The private health insurance market is largely a "for profit" market, with some of the largest companies publicly traded on Wall Street. These companies have an obligation to their shareholders to operate in ways that maximize profits, which means avoid the risk of loss. Not-for-profit insurers must also minimize losses. To stay solvent not-for-profit companies cannot insure only sick people absent government subsidies. In addition, not-for-profit companies must compete with for-profit companies for "good" risks.

[8] See Kofman, Mila and Karl Polzer, "What Would Association Health Plan Mean for California: Full Report?" California HealthCare Foundation, January 2004 available at http://www.chcf.org/documents/insurance/AHPFullReport.pdf (hereinafter California AHP Report).

[9] BCBSA, *State Legislative Health Care and Insurance Issues: 2005 Survey of Plans,* December 2005, page 57 (hereinafter BCBSA Report).

[10] Lucia, Kevin and Karen Pollitz, "Summary of Key Protections in Individual Health Insurance Markets (2004)" Health Policy Institute, Georgetown University, available at www.healthinsuranceinfo.net. Guaranteed-issue laws have varied widely among states resulting in consumers in some states having more protections than in others. In many states, however, people with medical needs (even minor ones) find that no insurer would sell them coverage in the individual market even when they can afford the premiums.

[11] HIPAA has a limited requirement that provides access to individual coverage to certain qualified individuals. The coverage may be through a state high-risk pool or through a private health insurance company. To qualify, an individual must have had 18 months of continuous coverage (without a 63 day break), the most recent coverage must be through a group health plan (job-based insurance), may not be eligible for other coverage, Medicare, or Medicaid, and must take and exhaust COBRA if eligible for it.

[12]In addition, states have implemented other programs. Thirty-three states have high-risk pools for people with medical conditions. In 2004, these pools covered approximately 180,000 people. Communicating for Agriculture and the Self-Employed, *Comprehensive Health Insurance for High-Risk Individuals*, 19th ed. Fergus Falls, Minnesota (2005).

[13] For individual policies, many states prohibit a practice called "reunderwriting" meaning that insurers may not target sick people for rate hikes at renewal, requiring premium increases to be spread among all insured people.

[14] BCBSA Report page 57.

[15] Pollitz, Karen and Kevin Lucia, "Health Insurance Resource Guide," Prepared for the March of Dimes, August 2002. Insurers are required to enroll newborns and renew that policy except for non-payment.

[16] KFF State Continuation Coverage for Small Firm Employees (COBRA Expansions) available at www.statehealthfacts.kff.org.

[17] Absent rate restrictions, insurers "experience rate" without limitations. That is, each person is charged a premium that reflects one's claims and medical needs, without spreading those costs among a broader group of people.

[18] NAIC Small Employer Health Insurance Availability Model Act adopted in 1990. For information on rate variations permissible under the model, see NAIC Guidance Manual in the Evaluation of Rating Manuals and Filings Concerning Small Employer and Individual Health Insurance.
[19] The community rate may be different for different insurance companies. That is, the community rate is based on claims experience (plus administrative cots, profits, etc) of people enrolled with that insurance company (rates adjusted for covered benefits).
[20] "Small Employer Health Insurance Availability Model Act" NAIC, Model #118, *Model Laws, Regulations, and Guidelines*, 118-13 (2001).
[21] See, Monheit, Alan C. and Joel C. Cantor, eds. State Health Insurance Market Reform: Toward Inclusive and Sustainable Health Insurance Markets. New York: 2004. See also, Buchmueller, Thomas C. and John DiNardo. 1999. "Did Community Rating Induce an Adverse Selection Death Spiral? Evidence from New York, Pennsylvania, and Connecticut." National Bureau of Economic Research Working Paper No. 6872, 5-6; Fuchs, Beth, "*Expanding the Individual Health Insurance Market: Lessons from the State Reforms of the 1990s*," The Robert Wood Johnson Foundation, Research Synthesis Report No. 4, June 2004 available at http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no4_synthesisreport.pdf.
[22] Pollitz, Karen, et al, "How Accessible is Individual Health Insurance for Consumers in Less than Perfect Health?" Kaiser Family Foundation, June 2001, available at www.kff.org (hereinafter Pollitz 2001 Report).
[23] See Bailey, Kathleen D., "Health Insurance Reform Clears Hurdle," *Seacoast Newspapers* 30 Nov. 2005; Senate Republican Communications, "Wonderling Hosts New Hampshire Lawmakers Sharing Solutions for Small Group Health Insurance Reform," *Pennsylvania Senate Republican News* 26 Oct. 2005 available at http://www.pasenategop.com/news/archived/2005/1005/wonderling-102605-nh.htm; Saunders, Anne, "N.H. Lawmakers Approve Gov. Lynch's Small Group Insurance Reforms," *Insurance Journal* 10 June 2005 available at http://www.insurancejournal.com/news/east/2005/06/10/55865.htm; New Hampshire Hospital Association, "2005 Legislative Report," Sept. 2005 available at http://www.nhha.org/nhha/state_law/Final%20Update%202005.pdf; New Hampshire Citizens Alliance, "SB 110: Bad Health Insurance Policy for New Hampshire," 5 Oct. 2004 available at http://www.nhcaaction.org/NHCA%20SB%20110%20Fact%20Sheet.pdf.
[24] See, American Diabetes Association, *State Diabetes Health Insurance Coverage Manual*, July 2003.
[25] BCBSA Report page 74.
[26] Id.
[27] Kirk, Adele, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts," Journal of Health Policy, Politics and Law Vol. 25, No. 1, 2000.
[28]See Bender, Karen and Beth Fritchen, "*Health Insurance Marketplace Modernization and Affordability Act of 2006,"* Mercer Report, March 2006, page 4 (available from authors).
[29] Lewis, Stephanie, "Expanding Coverage to the Uninsured: Lessons From the States," Prepared for the Congressional Research Service, November 2002, page 7.
[30] For information about Arizona, New Mexico, and California's programs see Kofman, Mila, *Issue Brief: Group Purchasing Arrangements: Issues for States,* State Coverage Initiatives, April 2003 available at http://www.statecoverage.net/pdf/issuebrief403.pdf. Maine also has a program similar to a purchasing pool, called Dirigo. Among its many features, is it helps pay for the cost of private health insurance for moderate income wage earners insured through the program. The coverage is through a private insurer. Funding for the program partly comes through Medicaid.
[31] Chollet, Deborah, *The Role of Reinsurance in State Efforts to Expand Coverage*, State Coverage Initiatives, October 2004, page 2 ; see also, Chollet, Deborah and Carolyn Watts, *Pooling and Reinsurance in Washington State Insurance Markets*, 24 Journal of Insurance Regulation 81 (Winter 2005) (hereinafter Chollet 2005); Swartz, Katherine, "Reinsurance: How States Can Make Health Coverage More Affordable For Employers and Workers," Commonwealth Fund, July 2005 (hereinafter Swartz 2005).
[32] Swartz page 5-8.
[33] Chollet, Deborah, Testimony before the Senate Finance Committee, "State Regulation and Initiatives to Expand Small Group Coverage," April 6, 2006.
[34] "Life and Health Insurance Guaranty Association Model Act" NAIC *Model Laws, Regulations, and Guidelines*, 520-47 to 520-80 (1999).
[35] For a detailed discussion of ERISA and interaction with state insurance law, see Butler, Patricia "ERISA Preemption Manual for State Health Policy Makers," State Coverage Initiatives (2000) available at http://www.statecoverage.net/pdf/erisa2000.pdf.
[36] For the most part, there are no federal benefit mandates. There are standards, however, that apply when plans provide coverage for mental health, maternity, or mastectomies. See Mental Health Parity Act (MHPA), Newborns' and Mothers Health Protection Act (NMHPA), and Women's Health and Cancer Rights Act (WHCRA).

[37] See Pollitz, K, Nicole Tapay, Elizabeth Hadley, and Jalena Specht, "Early Experience with 'New Federalism' In Health Insurance Regulation," *Health Affairs* 7-22 (July/August 2000).
[38] Public Law 104-191 adding sections 2721, 2722, and 2723 to PHSA.
[39] For more information about DOL's enforcement tools, see Kofman, Mila, Kevin Lucia, and Eliza Bangit, 2003, Proliferation of Phony Health Insurance: States and the Federal Government Respond, Washington, DC: BNA Plus (hereinafter Health Insurance Scams Report).
[40] States would continue to regulate health insurance sold through traditional small group markets.
[41] Any arrangement that is a "multiple employer welfare arrangement" may have obligations under ERISA.
[42] For more details, see California AHP Report.
[43] Id.
[44] Kofman, Mila and Jennifer Libster, *Turbulent Past, Uncertain Future: Is it Time to Reevaluate Regulation of Self-insured Multiple Employer Arrangements?* 23 Journal of Insurance Regulation 17 (Spring 2005) (hereinafter Self-Insured Arrangements Report).
[45] The state where an AHP is located may prohibit policies from excluding certain diseases. Such prohibitions would apply to AHP coverage. The federal standard for hospital stays for childbirth, mental health parity, and reconstructive surgery would apply to AHP coverage.
[46] See California AHP Report.
[47] For a discussion of studies looking at the potential impact of AHPs, see California AHP Report.
[48] *Increasing Small-Firm Health Insurance Coverage through Association Health Plans and Healthmarts*, CONGRESSIONAL BUDGET OFFICE (Jan. 2000). Downloaded from CBO website 04/03/2003. (www.cbo.gov).See Congressional Budget Office, letter to the Honorable George Miller, Senior Democratic Member, Committee on Education and the Workforce, U.S. House of Representatives, June 18, 2003, downloaded from CBO's web site Aug. 8, 2003 www.cbo.gov/showdoc.cfm?index=4352&sequence=0 , and Congressional Budget Office Cost Estimate: H.R. 660: Small Business Health Fairness Act of 2003 (as passed by the House on June 19, 2003), July 11, 2003, downloaded from CBO's web site Aug. 6, 2003 www.cbo.gov/showdoc.cfm?index=4413&sequence=0 .
[49] For more information, see Kofman, Mila, "Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud," Georgetown University Health Policy Institute, July 2005, available at http://hpi.georgetown.edu/ahp.html (hereinafter AHPs Fraud Report) Kofman, Mila, Eliza Bangit, and Kevin Lucia, *Multiple Employer Arrangements: Another Piece of a Puzzle, Analysis of Form M-1 Filings*, 23 Journal of Insurance Regulation 63 (December 2004); Kofman, Mila, Eliza Bangit and Kevin Lucia, "MEWAs: The Threat of Plan Insolvency and Other Challenges," Prepared for the Commonwealth Fund, March 2004; California AHP Report.
[50] Self-Insured Arrangements Report page 21.
[51] U.S. General Accounting Office, Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities Selling Coverage, GAO-04-312 (Feb. 2004).
[52] AHPs Fraud Report.
[53] While all states have adopted RBC for life and health insurers, only 21 states adopted RBC requirements for HMOs and other managed care plans. These states include: Arizona, Arkansas, Colorado, Connecticut, Georgia, Illinois, Iowa, Kansans, Kentucky, Maine, Maryland, Nebraska, New Hampshire, North Carolina, North Dakota, Pennsylvania, Rhode Island, Texas, Utah, Virginia, and Washington. See NAIC Model Regulation Service July 2002. The primary state must also have external review unless an insurer provides such review. An insurer's review must be "functionally equivalent" to the NAIC Health Carrier External Review Model Act. See H.R. 2355 Bill Sec. 4 adding new section 2797 to the Public Health Service Act (PHSA).
[54] See H.R. 2355 Bill Sec. 4 adding new section 2796 to PHSA.
[55] See definition of "covered laws" in H.R. 2355 Bill Sec. 4 adding new section 2795(7) to PHSA. See also new section 2796. The bill does not require companies to file copies of the policies they intend to sell. A company must provide a "summary" and self-certify that the coverage complies with the primary state's requirements. H.R. 2355 Bill Sec. 4 adding new section 2796(g) to PHSA. The bill seems to prohibit a state from asking for a copy of the full policy. This is a departure from current regulation, reviewing policies and rates to identify problems before they occur. The bill would also set standards for rates at renewal. H.R. 2355 Bill Sec. 4 adding new section 2796(d) to PHSA. It is unclear whether rating standards in the primary state would apply (it appears likely that the bill would preempt both rating standards in the primary and secondary states based on this new federal standard). The bill would also allow insurers to increase rates retroactively. H.R. 2355 Bill Sec. 4 adding new section 2796(d) to PHSA.
[56] See H.R. 2355 Bill Sec. 4 adding new section 2795 (6), (9), (10) and section 2796 to PHSA.
[57] See H.R. 2355 Bill Sec. 4 adding new section 2796(b)(1)(C), (D), and (E) and 2795 to PHSA.
[58] See H.R. 2355 Bill Sec. 4 adding new section 2796 (b)(1)(G) and section 2795(10) to PHSA. For a discussion of how states investigate and shut-down phony arrangements, Health Insurance Scams Report; see also, Kofman, Mila,

Kevin Lucia, and Eliza Bangit, *Issue Brief: Health Insurance Scams: How Government Is Responding and What Further Steps Are Necessary* (Commonwealth Fund Aug. 2003) available at www.cmwf.org.

[59] U.S. Const. amend. X and XI. For a discussion of federalism, see Thomas, Kenneth, "Federalism, State Sovereignty and the Constitution: Basis and Limits of Congressional Power, CRS Report for Congress, Updated June 17, 2005.

[60] Another question for courts is whether Congress could delegate authority to the legislature of one state to prescribe and enforce the law to be applied in another state.

[61] Congressional Budget Office Cost Estimate: HR 2355 Health Care Choice Act of 2005, Sept 12, 2005, page 5.

[62] Id. at 6.

[63] Preamble S. 1955.

[64] S.1955 Bill Title I Sec. 101 adding new Part 8 to ERISA Title I.

[65] S.1955 Bill Title I Sec. 101 adding new Part 8 sec. 802(d) to ERISA Title I.

[66] A challenge by a state or later removal of certification by DOL would not help people who became victims during the entity's operation. Fraudulent operations spread quickly. Employers Mutual LLC, an illegal entity, collected over $15 million in premiums in just 10 months. See Health Insurance Scams Report.

[67] A separate class of business will adversely impact the rest of the market. By their very nature, associations can attract healthy members (e.g., aerobics instructors). Through marketing, benefit design, and rating associations and their insurers can cherry-pick healthy businesses out of the market, leaving sicker ones in the small group market. This will make coverage more expensive in the small group market.

[68] S.1955 Bill Title I Sec. 101 adding new Part 8 sec. 805(a)(2)(B) to ERISA Title I.

[69] Id.

[70] S. 1955 Bill Title II Sec. 201 adding new section 2922 to PHSA.

[71] Health Investor PPO, Department of Management Services, Florida (available at http://dms.myflorida.com/dms/workforce/state_group_insurance).

[72] For a discussion of adverse selection, see Claxton Report page 4. This problem is also discussed in an industry letter on S. 1955. See Ignani, Karen, President and CEO, America's Health Insurance Plans, Letter to Senator Michael Enzi, March 7, 2006 (copy available from authors).

[73] S. 1955 Bill Title II Sec. 201 adding new section 2911 (b) to PHSA.

[74] Some regulators believe that rate restrictions in the small group market would be undermined if insurers are allowed to separate their association business from the rest of the small group market.

[75] See NAIC Guidance Manual in the Evaluation of Rating Manuals and Filings Concerning Small Employer and Individual Health Insurance.

[76] S. 1955 Bill Title II Sec. 201 adding new section 2911 (b) to PHSA.

[77] S. 1955 Bill Title III Sec. 301 adding new section 2931 et al to PHSA. Some regulators raise the additional concern that "market harmonization" requires states to write into state law procedural rights for insurers that would result in decreased consumer protection. They argue that "no federal financial regulator is subject to, or grants, these types of rights to the industry they regulate." Gomez, Jorge. Insurance Commissioner, Wisconsin Insurance Department, Letter to Senator Michael Enzi. 14 March 2006 (copy available from authors).

[78] S. 1955 Bill Title II Sec. 201 adding new section 2912(a), 2914(a), 2924, 2932 (authority of HHS), and 2934 to PHSA.

[79] S. 1955 Bill Title II Sec. 201 adding new section 2913(b)(3) and (4) to PHSA.

[80] See memo from Alex Feldvebel, Deputy Insurance Commissioner of New Hampshire, to NAIC, March 13, 2006. See also NCOIL Letter March 2006 to Sen. Enzi, page 2 (copy available from authors).

[81] S. 1955 Bill Title II Sec. 201 adding new section 2914 to PHSA.