Testimony of

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On

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Introduction

Mr. Chairman, distinguished members of the Subcommittee, I am Donald A. Young, MD, President of the Health Insurance Association of America (HIAA). HIAA is the nation's most prominent trade association representing the private health care system. Its nearly 300 members provide the full array of health insurance products, including medical expense, long-term care, dental, disability, and supplemental coverage to more than 100 million Americans.

HIAA has represented the private health insurance industry since 1956. During that time, we have consistently supported the state regulation of insurance. There are, however, issues that need to be addressed. Among them is "speed to market" – the need to make it easier to bring health insurance products to consumers; avoiding the adverse consequences so often associated with even the best-intentioned efforts to regulate the market; and rationalizing the relationship between state regulations and the growing number of federal requirements being placed on health insurers. In particular, inconsistency between state and federal rules governing the same area is a rapidly growing problem. One suggested solution for these problems, which has been receiving increased attention by the insurance industry, policymakers and others, is the possibility of allowing insurers to choose to be regulated at the federal level rather than the state level.

Current Proposals

Several concrete proposals have been made that would grant insurers the option of seeking a federal charter rather than a state license. Federally chartered insurers would then be allowed to do business in all 50 states without seeking state-by-state licensure, and would primarily be regulated at the federal level. HIAA has not taken a position on any of these proposals. We would, however, make a few observations.

First, current proposals only address a few of the areas in which states regulate health insurance. They are largely focused on licensure, oversight, corporate governance, and financial issues such as solvency and guarantee funds. Typically, they include very little

product specific language – to the extent specific insurance products are addressed, most of the authority is delegated to federal regulators through the rule-making process.

Second, the current proposals are structured around the regulation of specific product lines, with federally chartered insurers being licensed to sell one or more products. The breadth of these product lines, and the definitions established for them, would be critical. For instance, would a "health" insurance license include authorization to sell both Medicare Supplement coverage and PPO coverage? Would it include authorization to sell dental coverage? As we have found with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), definitions are critically important. Regulatory requirements intended for comprehensive medical expense insurance are problematic when applied to other forms of coverage, but requiring individual licenses for each product an insurer markets could rapidly become a significant burden without providing any additional protection to consumers.

Third, as currently drafted, optional federal charter proposals would essentially defer most health insurance issues to regulation. This suggests to us that the proponents of these proposals were simply not yet prepared to recommend a proper statutory framework for regulating health insurers at the federal level. The sweeping nature of the authority granted raises the concern that significant public policy issues could be decided by federal regulators, without adequate congressional guidance.

Health Has Unique Issues

While health insurance is a financial instrument, like any other form of insurance, the regulation of health insurance is unique. Most forms of life and property and casualty insurance tend to have relatively few claims; many forms of health insurance, such as medical expense and dental insurance, tend to have very high claim volumes. Most life and annuity claims are for fixed amounts; health insurance claims tend to be much more complex due to the intimate relationship of health insurance coverage to health care delivery and public health policy. Many everyday health insurance functions have no counterparts for most forms of life or property and casualty insurance. Examples are

easy to find: utilization review; determining when a treatment is no longer experimental; deciding whether or not clinical trials should be covered; and determining how network providers should be credentialed. (Some forms of property and casualty insurance, such as homeowners, automobile and workers' compensation insurance, do cover some medical losses, and raise some similar issues. However, the focus is on insuring the policyholder's legal liability for an injured individual's medical care. The extent of this liability determines the coverage that is bought; the amount of coverage or type of policy purchased doesn't determine what the policyholder owes the injured party.)

In the public realm, this distinction can be seen between the Social Security and the Medicare programs. Managing the Social Security program can present some very real challenges – but the fundamental issues are all financial; who will receive how much money, and where it will come from. In contrast, the Medicare program has, in addition to questions of eligibility and funding, all of the complexity associated with the management of a health plan. While serving beneficiaries, the Medicare program also has many complex rules and regulations that apply to determining which services will be covered, what's medically necessary, and what payment rates apply. Ensuring that quality health coverage is provided to enrollees inevitably involves questions of ensuring access to affordable health care, combating health care fraud, and ensuring appropriate utilization of medical care, and requires that policymakers make difficult trade-offs between spending on different kinds of services.

It is not surprising that proposals focusing on the financial aspects of insurance would not fully address health insurance issues. However, to be viable for health insurance, any regulatory structure will ultimately have to deal with these questions. In many cases, this may have to be done by statute, rather than by regulation.

Dual Regulation

Perhaps the primary reason an insurer would be interested in a federal charter would be to obtain regulatory "one-stop shopping" – which, for an insurer operating nationwide, could potentially be a significant advantage over dealing with over fifty separate local

jurisdictions. An increasingly significant issue, however, is the interaction between state and federal laws and regulations. Health insurance may already be subject to more federal regulation than any other form of private insurance, except perhaps for investment-based life and annuity products that are subject to federal securities regulations as well as state insurance laws. Proposals currently before Congress, such as the "Patients' Bill of Rights," would dramatically expand the federal role.

On the one hand, state regulation has some clear strengths. On the other hand, some health insurers see significant potential advantages in federal regulation if it can simplify the process of operating in multiple jurisdictions. What is incontrovertible, however, is that laying an additional, inconsistent set of federal rules on top of the existing state rules is the worst of both worlds. Privacy is a good example of this.

The Congress has now twice adopted laws relating to the privacy of health information, the Gramm-Leach-Bliley Act (GLBA) and the Health Insurance Portability and Accountability Act (HIPAA). The former is being implemented through state laws, not all of which are uniform. The latter is being implemented through federal regulations that are still in some flux. In addition, HIPAA does not fully preempt state privacy laws, but instead allows state laws more restrictive than federal requirements to continue to apply. This forces insurers and other covered entities to determine whether state laws are or are not more protective than the federal requirements, not always an easy thing to determine, and then to implement a compliance plan, which by definition will involve greater complexity than would be true if only a single uniform privacy law applied.

This state of affairs caused HIAA, in conjunction with other collaborating associations, to engage outside legal experts to conduct a state-by-state assessment of privacy laws and provide advice about which of them would still apply under the kind of federal preemption provided by HIPAA. This initiative was extremely expensive. And since states continue to pass privacy legislation and/or adopt privacy regulations, this will not be a one-time endeavor, but must be regularly updated. The lack of uniformity in the area of privacy regulation explains why HIAA continues to believe that federal

preemption of all state privacy laws is essential if we are to minimize the administrative burden on insurers and other covered entities. It goes without saying, of course, that increased administrative burden translates into higher insurance premiums, and these premiums are already being pressured by the ever-rising costs of health care services.

The problem of dual regulation extends beyond the question of whether or not an optional federal charter should be available. Whenever Congress decides to step into an area already regulated by the states, it is critical that it do so in a way that does not add to an already significant regulatory burden. With privacy, there was an opportunity to make the regulation of health insurance simpler and more consistent – that opportunity was missed. In that case, preempting the patchwork quilt of inconsistent state regulations with a single federal standard would have been far superior. Other alternatives may be appropriate in different situations. For example, HIPAA set federal standards for group-to-individual "portability," but allowed each state to determine the most appropriate local mechanism for meeting those standards, successfully avoiding the problems of dual regulation.

Market Fragmentation

One challenge that state policymakers continually struggle with is the need to avoid fragmenting the various health insurance markets. Or, from the point of view of insurers, the need to maintain a level playing field between different market participants. When different organizations offering coverage to the same set of consumers, such as small employers, are subject to different market rules opportunities are created to divide insurance pools, undermining the effectiveness of the insurance mechanism.

Perhaps the best example of this is the division between state-regulated insured health plans and federally regulated self-insured programs that was created by the Employee Retirement Income Security Act of 1974 (ERISA). Among other things, ERISA was intended to make it easier for employers, especially those with employees in multiple states, to manage their employee benefit programs. ERISA deferred to the state in the

regulation of the business of insurance, but preempted all other state efforts to regulate employee benefit plans.

Thus, the health plans of those employers, generally small, who provide benefits through an insurance contract are subject to state insurance law. On the other hand, the health plans of those employers who self-insure their benefit plans are exempt from state insurance law.

ERISA has been of significant benefit to large employers, allowing them to provide health benefits to their employees more efficiently and at lower cost, and protecting them from the unanticipated adverse consequences of many state regulatory initiatives. It has also created some public policy challenges. Much of the impetus for federal intrusion into the regulation of health insurance has come from the realization that roughly half of all employees with employer-sponsored health benefits are in plans that are exempt from state regulation.[1] While most of the federal initiatives deal with issues that states are already actively addressing for insured programs, such as the regulation of managed care and minimum requirements for mental health coverage, they invariably include insured plans as well as self-insured ones – thus expanding the problem of dual regulation.

The division created by ERISA between state-regulated insured health plans and federally regulated self-insured plans has created some market fragmentation. Perhaps the best example is the small group market. Most states have enacted comprehensive small group reform laws. Small employers willing to self-insure have been able to use ERISA pre-emption to opt-out of these reforms, however, limiting states' ability to restructure the market. While on the one hand it has allowed some employers to escape state requirements that unnecessarily increase the cost of coverage, on the other hand it has distorted the market by applying significantly different rules to different market participants. (It has also reduced the assessment base available to states for such health-related initiatives as high-risk pools.) A fundamental difference between banking and

[1] *Employer Health Benefits: 2002*, The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, September 2001, p. 130.

insurance is that insurance is based on the pooling of risks. Whenever the development of an alternative insurance regulatory mechanism is considered, a key challenge is ensuring that markets are not divided in a way that undermines their ability to effectively pool risks.

Particularly damaging have been the fraudulent health plans that have periodically sprung up, outside the state regulatory structure, often claiming some sort of federal authority. Insurance regulators all over the country are deluged with complaints, long after the fact, about unpaid claims – by which time the operators have long since moved on. Prime examples have been self-insured Multiple Employer Welfare Arrangements (MEWAs) or Multiple Employer Trusts (METs) that offer very small employers self-insured "coverage." Since these programs were self-insured, they claimed exemption from state insurance law by ERISA; but since ERISA was never intended to regulate organizations operating as quasi-insurers, it provided inadequate protections against insolvency and fraud. Fundamentally, these abuses have been the result of individuals attempting to exploit perceived cracks and ambiguities in the regulation of health plans. These are some of the fundamental considerations behind our opposition to proposals that would authorize the establishment of HealthMarts or Association Health Plans (along with research showing that purchasing alliances are not in fact effective in reducing the cost of coverage[2]).

What it Would Take

Establishing an optional federal insurance charter that encompassed the full range of insurance products would require a very careful review of existing state regulatory and other oversight roles and responsibilities, decisions about which of these need to be replicated in a federal regulatory structure, and then a determination, in each instance, of the specific regulatory policy that will apply to federally regulated insurers. In this

[2] U.S. General Accounting Office, *Private Health Insurance: Cooperatives Offer Small Employers Plan Choices and Market Prices*, March 2000, GAO/HEHS-00-49;
Elliot K. Wicks, Mark A. Hall and Jack A. Meyer, *Barriers to Small-Group Purchasing Cooperatives, Economic and Social Research Institute*, March 2000;
Stephen H. Long and M. Susan Marquis, "Pooled Purchasing: Who Are the Players?" *Health Affairs*, July/August 1999, p. 105-111.

regard, it needs to be understood that there is now a fair amount of variability in state insurance regulations, and a federal regulatory structure would presumably involve either picking and choosing from among the current range of state requirements to find the most appropriate one for application to federally regulated insurers, or creating some new federal policy not currently found in any state. This is a significant challenge. A simple review of the model acts and regulations that have been promulgated by the National Association of Insurance Commissioners (NAIC) would quickly illustrate the magnitude of this challenge. Moreover, a federal charter option would also require building an entirely new federal bureaucracy performing functions and handling issues that have never before been addressed at the federal level.

State insurance regulators play a number of key roles, including protecting the solvency of insurers (and thus ensuring that they are able to keep the promises they make to policyholders), protecting the interests of consumers, and limiting the effects of financial failing in the industry. This means that they must:

- Regulate Insurers' Financial Statements;
- Regulate Insurers' Investments (Permissible and Non-Permissible);
- Perform Financial Examinations;
- Oversee Mergers and Acquisitions (very specific rules);
- Review and Approve Premium Rates and Policy Forms;
- Regulate Form and Substance of Disclosures;
- Regulate Discontinuance and Replacement of Policies;
- Investigate Consumer Complaints and Respond to Inquiries;
- Perform Market Conduct Examinations;
- Investigate and Prosecute Insurance Fraud;
- License and Regulate Insurance Agents;
- Regulate Trade and Claim Payment Practices; and
- Supervise Receiverships, Insolvencies and Liquidations (the focus is on the protection of policyholders – not creditors).

State insurance law is generally well established, having been developed over a period of decades. Most statutory changes represent fine-tuning of existing regulatory structures, rather than the wholesale development of new law. As a result, such changes as are made are generally implemented fairly quickly, and states typically have an excellent track record of promptly publishing rules interpreting new statutes.

Unanticipated Consequences

As this committee considers the future of insurance regulation, HIAA believes it is important to understand that health insurance regulatory initiatives can have adverse consequences unanticipated by their proponents.

Benefit mandates provide an excellent example. Mandates are often seen as a way for legislators to provide a social good, such as cancer screening or smoking cessation programs, with little or no impact on government spending. But however well intentioned, mandates ultimately harm consumers by raising the cost of health insurance, placing it beyond the financial reach of even more individuals and small employers. The primary reason almost 40 million Americans are uninsured[3] is the high cost of health care and health care coverage.[4]

I'm happy to report that an ever-increasing number of states are recognizing this problem, and taking steps to address it. For example, some states are creating special commissions to examine the impact of benefit and other state mandates and to provide advice to legislators about future legislation in this area. On the other hand, I also need to acknowledge that mandates are not uniquely a state invention. Unfortunately, a number of bills currently before this Congress, including those relating to colon cancer screening, mental health parity, and patients' bill of rights, would impose a dizzying array of additional mandates on health insurers, thereby driving up the cost of coverage.

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[3] Mills, Robert J., *Health Insurance Coverage: 2000*, U.S. Census Bureau, September 2001.
[4] Custer, William S. and Ketsche, Patricia, *The Changing Sources of Health Insurance*, HIAA, December 2000.

Individual health insurance market guaranteed issue and community-rating requirements are another good example of how well intentioned reform efforts can have serious adverse consequences. Guaranteed issue and community rating requirements attempt to subsidize high-risk individuals by asking low-risk individuals to pay more. However, coverage is then no longer equally financially attractive for all consumers. From the standpoint of the low-risk individual, the additional cost does not bring additional value. As a consequence, many individuals will simply choose to forgo coverage.

State experience with guaranteed issue and community-rating requirements confirms this – they tend to increase average premiums and decrease, rather than increase, the number of individuals covered by health insurance.[5] Kentucky and Washington State provide good examples. Overly restrictive individual health insurance market reform efforts destroyed the ability of insurers to offer affordable coverage to individuals in those states, forcing them to exit the market. As a result, many consumers were left with few if any coverage alternatives.

I should note that other states have found ways to ensure access to affordable coverage without resorting to guaranteed issue and community rating requirements that undermine the market. State high-risk pools have proven effective mechanisms to guarantee access, because they incorporate a significant subsidy from outside the pool. The purpose of these pools is not to "share" costs between pool enrollees, which would be ineffective, but rather to transfer some of the cost of covering these high-cost individuals to a broader revenue base.

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[5] L. Nichols, "State Regulation: What Have We Learned So Far?" *Journal of Health Politics, Policy and Law* (February 2000): 175-196;
W. Custer, *Health Insurance Coverage and the Uninsured* (Washington, D.C.: HIAA, December 1999), 13-14;
F. Sloan and C. Conover, "Effects of State Reforms on Health Insurance Coverage of Adults," *Inquiry* (Fall 1998): 280-293;
M. Schriver and G. Arnett, *Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations* (Washington, D.C.: The Heritage Foundation, August 20, 1998), 1-2;
J. Marsteller et al., *Variations in the Uninsured: State and County Level Analyses* (Washington, D.C.: The Urban Institute, June 11, 1998), ii;
For a perspective from the front lines, see the report developed by the staff of the Maine Bureau of Insurance – *White Paper: Maine's Individual Health Insurance Market* (Augusta, Maine: Maine Bureau of Insurance, January 11, 2000), 7-8.

Any significant restructuring of the way in which health insurance is regulated must be done very carefully to avoid adverse effects. In a broader context, HIAA strongly recommends that costs associated with benefit mandates be carefully weighed, and that guaranteed issue or community rating requirements not be placed on the individual health insurance market. Rather, access to coverage should be guaranteed to individuals with serious health conditions through broadly funded high-risk pools.

Finally, in speaking of unintended consequences, one key difference between federal and state policy making should be kept in mind. If an individual state adopts a mandate or regulation that ends up having serious negative consequences for the health insurance sector, the damage is obviously more narrowly contained than would be the case if the same policy had been adopted at the federal level.

Other Initiatives

It is also important to note that the states, through the NAIC, are making serious efforts to streamline the insurance regulatory process. The NAIC has long played an important role in encouraging consistency among the states, and improving speed-to-market is currently a priority at the NAIC. We are aware that the NAIC is also now exploring the possible use of interstate compacts as a way to improve consistency and reduce the regulatory burden. Such compacts raise a host of structural, process and policy issues, and we anticipate working very closely with state insurance regulators and other interested parties to help assess these matters.

Conclusion

In conclusion, I must emphasize that HIAA has taken no position on the optional federal charter issue. While we have long supported the state regulation of health insurance, we remain concerned about a number of aspects of the current regulatory environment. For example, there is a very real need to streamline the regulation of health insurance and make it more consistent across jurisdictions. To ensure a competitive market, we must make it quicker and easier for insurers to bring new products to consumers – this is

particularly important for health insurance, as we strive to bring affordable coverage within the financial reach of more Americans. Inconsistent and overlapping federal and state requirements are a growing problem that must be addressed. Above all, whether in a state or federal context, we urge policy makers to carefully consider the cost consequences of their actions, since even the most well-intentioned regulations or mandates can end up making it more difficult to provide and obtain affordable health insurance coverage.

Mr. Chairman, I hope that my testimony today helps elucidate some of the many unique issues associated with the regulation of health insurance. HIAA would welcome the opportunity to work further with you and your committee as you continue to examine these issues.