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Regulation of Health Insurers and Health Maintenance Organizations*

This chapter describes the basic structure of state regulation of health insurance, through the regulation of health insurers and health maintenance organizations (HMOs). This chapter also describes some of the significant changes to health insurance set forth in the Patient Protection and Affordable Care Act of 2010 (ACA). [Pub. L. No. 111-148. *See* Q 23.2.]

* Revisions by Vanessa Scott and Christopher D. Jones.

Licensing and Regulation

Q 13.1 How are health insurance companies organized and licensed?

Health insurance companies are organized and licensed in much the same way as life and annuity insurers and property and casualty insurers. Like these other types of insurers, health insurance companies must be formed under the laws of a particular state, called the domiciliary state. The domiciliary state must license the insurer to transact the kind of insurance that authorizes the transaction of health insurance. In most states, this means a license to transact "accident and health insurance" or "accident and sickness insurance." [*See, e.g.*, Cal. Ins. Code § 106; Conn. Gen. Stat. § 38a-469; N.Y. Ins. Law § 1113(a)(3); Mass. Gen. Laws ch. 175 § 47.] As with other types of insurers, health insurers, once licensed in their state of domicile, may seek licensing in the other states in which they seek to transact insurance.

Q 13.2 Can a life insurer or a property and casualty insurer be licensed to transact health insurance?

Yes. Interestingly, health insurance is one area of insurance that both life insurers and property and casualty insurers may be licensed

to transact. Health insurers are sometimes authorized to transact solely health lines, but often health authority is held by life insurers and, alternatively, health authority can be held by property and casualty insurers. [*See, e.g.*, Fla. Stat. § 624.406; Md. Code Ann., Ins. § 4-111.]

Q 13.3 Do health insurance policies have to be filed with the Insurance Commissioner?

Yes. Typically, health insurance policies, like other forms of insurance policies, must be filed with and often must be approved by the Insurance Commissioner. [*See, e.g.*, Fla. Stat. § 624.4412; N.H. Rev. Stat. Ann. § 415:1.]

Q 13.4 Are rates of health insurers filed with the Insurance Commissioner?

Typically, yes, for some categories of policyholders. Health insurance rates for individual and small group (that is, groups of less than 50 or 100 lives, as discussed below) coverage are generally subject to regulation [*See, e.g.*, Fla. Stat. § 627.410(6)(a); N.H. Rev. Stat. Ann. § 415:1.], although large group health insurance rates generally are not. In addition, some of the changes to health insurance set forth in the ACA will affect rates that health insurers may charge, although even the "excessive rate" disclosure requirements therein do not apply to large group rates. [*See* discussion below regarding large groups.]

Since the passage of the ACA, many states have passed legislation or regulations that require prior approval of health insurance premium rates. In addition, the Department of Health and Human Services (HHS) has set aside over $250 million in grants to improve the process for state health insurance rate reviews. HHS has also deemed certain states' rate review processes inadequate and will undertake its own rate review when rate proposals are 10% or more. HHS has the authority to publicize excessive rates, but cannot prevent health insurers from implementing these rate increases.

Group and Individual Products

Q 13.5 What kinds of products do health insurers provide?

There are many ways to categorize the types of products health insurers provide. One broad category of product is whether the health insurance product is provided to a group or whether it is provided to an individual. Each state has detailed rules governing the types of products that may be issued to a group and the types of products that may be issued to an individual.

Q 13.6 What are some of these rules for products issued to a group?

First and foremost, perhaps, is the definition of what constitutes a "group" and the regulation of how group products may be issued. The most common type of group health insurance product would be a health insurance policy issued to an employer on behalf of all of the employer's employees. Thus, the employees comprise the "group" and the employer is the policyholder—the entity to which the policy is technically issued—which contracts for and holds the policy on behalf of all of its employees. Typically, the health insurer must be licensed in the state in which the employer is located and receives the policy. The employees receive "certificates" or "evidences of coverage" rather than an actual policy, although the certificate or other documentation evidencing coverage provides all of the information regarding coverage, benefits, terms and conditions. States often differentiate between "large groups" and "small groups" for purposes of the permitted or required terms or conditions for group coverage. For example, in Illinois, the small group market or large group markets refer to the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small or large employer. A "small employer" is defined as "an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of

the plan year," and a "large employer" as "an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year." [215 Ill. Comp. Stat. § 97/5. *See also* Del. Code Ann. tit. 18, §§ 3572(6), 7202(34).] A group health benefit plan generally may not establish rules for eligibility for individuals to enroll under the plan, or charge a higher premium based on any health status related factors in relation to the individual or any dependent of the individual. In addition, denial of coverage based on certain preexisting conditions is generally limited. [*See, e.g.*, Del. Code Ann. tit. 18, §§ 3573, 3575; Kan. Stat. Ann. § 40-2209f.]

Q 13.6.1 Does a group have to consist of an employer/employee group?

Different states have different rules, but most states recognize other legitimate forms of groups for purposes of health insurance. For example, states may variously recognize labor unions [*See, e.g.*, Ga. Code Ann. § 33-30-1.], some types of associations [*See, e.g.*, Del. Code Ann. tit. 18, § 3506.], and even holders of credit cards [*See, e.g.*, N.J. Stat. Ann. § 17B:27-68(g).] as legitimate groups for purposes of issuing health insurance. The general principle underlying the definitions of group coverage in the various states is that a group should be formed for a legitimate purpose and should not exist merely for the purpose of obtaining group insurance for members that otherwise would not be affiliated with each other.

Under federal health insurance law (which has obviously become more important with the enactment of the ACA), only "employer" groups (or groups formed by employers or unions) are considered to be "group health insurance." All other types of insurance, including policies covering organizations that are considered to be legitimate forms of groups under state law (for example, associations), are considered to be individual insurance under federal law. Increasingly, it appears that some states are adopting this approach. [*See* Bulletin from Gary Cohen, Acting Director, Office of Oversight, CMS, September 1, 2011.]

Q 13.7 What is individual insurance?

As its name implies, individual insurance is issued to a single person, sometimes on behalf of himself or herself and dependent children (but see discussion below regarding the ACA). The individual is the policyholder.

Q 13.8 Are there advantages to being insured under a group versus an individual health insurance policy?

As a general rule, the major advantage of being insured as a member of a group is better rates. Even where employees are required to contribute all or a portion of the premium for a group policy, health insurance is generally less expensive if purchased on a group basis rather than on an individual basis. This is basically because with a group, the insurer is able to estimate, based upon the numbers of insureds involved, the likely claims experience of the group members, and is often able to charge rates commensurate with the likely group experience. It is typically more difficult to estimate likely claims payout with an individual. Even where the insurer asks detailed questions, it is difficult to foresee—in the absence of claims information about members of a group—how the individual's claims experience will develop. As a result, insurers seek to charge higher rates for individual health insurance.

Other Categories of Health Insurance

Q 13.9 What other categories define health insurance offerings in the United States?

In addition to the group/individual distinction, there are other distinctions to the types of health insurance offered in the United States. For example, most Americans are familiar with "major medical" insurance. Typically defined as an accident and sickness insurance policy which provides hospital, medical, and surgical expense coverage, up to a certain aggregate maximum, major medical insurance provides reimbursement, subject to applicable deductibles and

co-payment requirements, for hospitalizations and other significant health treatments. Some health insurance plans offer comprehensive coverage, providing reimbursement, again subject to terms and conditions, for doctor visits, laboratory tests, x-rays, and similar services. [*See, e.g.*, N.Y. Comp. Codes R. & Regs. tit. 11, § 52.7; 18-1300-1304 Del. Admin. Code § 7.6.]

Q 13.10 What about less comprehensive health insurance products?

In addition to the comprehensive and major medical types of products that most consumers are familiar with, there are certain specialty products or limited benefit products that may be issued by health insurers. For example, some insurers provide what are called specified disease insurance. Such policies pay specified amounts if the insured is diagnosed with a specific disease or illness. Other policies are designed to pay the insured if the insured is hospitalized at all, or is confined to intensive care. Still other policies, sometimes called "medigap" policies, are designed to fill in gaps in other coverage—for example, to pay the deductible amount under a major medical policy. "Med-supp" policies are designed to supplement benefits provided under Medicare. Travel accident insurance is intended to provide coverage if an insured is injured while traveling.

Q 13.11 What are HMOs and how are they regulated?

HMOs are a type of health coverage called "managed care" plans. Essentially, HMOs enroll physicians, hospitals and other health care providers to provide services to covered persons through the specific list of professionals and facilities that have agreed to participate in the HMO. In addition to being licensed by State Insurance Departments or by the Managed Care Sections of State Departments of Health [*See, e.g.*, Ala. Ins. Code § 27-21A-3; Mich. Ins. Code § 500.3505.], the federal Health Maintenance Organization Act of 1973 [Pub. L. No. 93-222.] authorizes federal certification of certain HMOs.

ACA Provisions

Q 13.12 How has the ACA affected the state regulation of health care insurance?

ACA includes numerous provisions that apply to health insurers. In most instances, these provisions do not preempt state laws, but they do require cooperation and certain changes in the state-based system of regulating health insurers. [*See* Q 23.2.]

Q 13.13 What are some of these changes affecting health care insurance?

One fundamental and far-reaching provision of the ACA became effective January 1, 2014. This provision states that "group health plans and health insurance issuers offering group or individual 'health insurance coverage'" must provide "essential health benefits." [ACA § 1201, which amends § 2707 of the Public Health Services Act, 42 U.S.C. § 300gg *et seq.* (the "PHSA").]

"Essential Health Benefits"

Q 13.14 What does "essential health benefits" mean?

The ACA created a mandatory package of ten "essential health benefits." The scope of essential health benefits must be equal to the scope of "benefits provided under a typical employer plan," and certain enumerated benefits must be included in the definition of "essential health benefits" including, but not limited to, emergency services, hospitalization, newborn care, mental health and substance use disorder services, prescription drugs, laboratory services, and preventive care and wellness services. [ACA § 1302.] In February 2013, HHS issued final regulations that provide states with greater flexibility by allowing them to create health plan standards that include all ten federally required categories of benefits, and to benchmark them against the leading health insurance plans offered in that state. [*See* 45 C.F.R. § 156.100.]

Q 13.15 Are there any other requirements that these "essential health benefits" must provide?

Yes. Cost-sharing, including deductibles, for such coverage is limited by the statute [ACA § 1302(c)(1-2).] and certain levels of coverage must be offered. These levels of coverage are described in the statute generally as Bronze, Silver, Gold, and Platinum and prescribe percentages of coverage (60, 70, 80, and 90, respectively) of the "full actuarial value of the benefits provided under the plan." [ACA § 1302(d).] HHS requires the use of an actuarial value (AV) calculator by most health insurance policies to determine actuarial value. The current AV calculator can be found at www.cms.gov/CCIIO.

Q 13.16 Which insurance companies are required to provide these "essential health benefits"?

As noted, all insurers that issue non-grandfathered "group or individual 'health insurance coverage'" in the small or individual group market are required to comply with this provision. The only exceptions are insurers whose only health insurance business is an "excepted benefit" as defined under federal law. Plans in the insured large group market and employer-sponsored self-insured plans are not required to offer essential health benefits.

Q 13.17 How does the ACA use the terms "group" coverage and "individual" coverage for these purposes? Do the terms mean the same things as they do under state rules relating to group and individual health insurance coverage?

"Group" coverage as conceptualized in the ACA and in the related federal health laws to which the ACA refers, means an employer group. [ACA § 1304(a)(1).] As noted above in this chapter, state insurance laws often allow health insurance coverage to be issued to other types of groups, for example, groups consisting of certain types of associations. However, when the ACA and related federal health laws use the term "group" coverage, they are referring solely to employer groups. When the ACA and related federal health laws use the term "individual" coverage, that term is understood to mean all other types

of health insurance issued, whether such coverage is considered "individual" or "group" coverage under state law. In effect, therefore, a group health policy issued to an association "group" under state insurance law, for example, for the benefit of the members of the association would be considered and is referred to under the ACA as "individual" coverage.

Q 13.18 What other insurance market reforms are currently required by the ACA?

Some of the key insurance reforms required by the ACA include:

- *Fair Health Insurance Premiums*. Premiums in certain markets may vary only by certain prescribed factors, such as family structure, geography or region, actuarial value of the benefit, age, and tobacco use. [ACA § 1201, which amends § 2701 of the PHSA.]
- *Elimination of Annual Limits*. Insurers may not impose annual limits or lifetime limits on coverage for essential health benefits. However, annual and lifetime limits may be allowed on specific covered benefits that are not essential health benefits. [ACA § 1101, which amends § 2711 of the PHSA.]
- *Individual Mandate*. Each individual is required to obtain "minimum essential coverage" or be subject to a tax penalty. [ACA § 1501.]

NOTE: "Minimum essential coverage" is not the same as "essential health benefits." [ACA § 1501(b); *cf.* ACA § 1302(b).]

- *Guaranteed Availability of Coverage and Guaranteed Renewability of Coverage*. Insurers in the individual health market must make available and renew policies, except in cases of nonpayment, for which the issuer can terminate the plan in accordance with state law [ACA § 1201, which amends §§ 2702 and 2703 of the PHSA].

- *Prohibition of Pre-existing Condition Exclusions or Other Discrimination Based on Health Status*. Insurers in the group and individual market cannot deny individuals based on pre-existing health conditions or health status [ACA § 1201, which amends §§ 2704 and 2705 of the PHSA].
- *Prohibition of Excessive Waiting Periods*. Waiting periods to participate in coverage generally cannot exceed ninety days [ACA § 1201, which amends § 2708 of the PHSA].

Q 13.18.1 What does "minimum essential coverage" mean for purposes of satisfying the individual mandate?

To satisfy the individual mandate to obtain "minimum essential coverage," an individual must obtain one of the following types of coverage:

(A) Coverage under a government-sponsored program (such as Medicare, Medicaid, etc.);

(B) Coverage under an eligible employer-sponsored plan;

(C) Coverage under a plan in the individual health market;

(D) Coverage under a "grandfathered health plan" (generally, a plan in effect on March 23, 2010, that has not been substantially amended since that date); or

(E) Other coverage, as determined by the Secretary of HHS.

[ACA § 1501(b), amending Title D of the Internal Revenue Code (by adding section 5000A; *see* section 5000A(f)).]

The individual mandate to obtain "minimum essential coverage" is not satisfied by obtaining coverage under an "excepted benefits" type of coverage. [ACA § 1501(b), amending Title D of the Internal Revenue Code (by adding section 5000A; *see* section 5000A(f)(3)). *See* the explanation below of what constitutes "excepted benefits."]

In August 2011, the Eleventh Circuit held that Congress had exceeded its constitutional power under the Commerce Clause when the Patient Protection and Affordable Care Act of 2010 required individuals to purchase a health insurance policy with prescribed benefits

or be subject to a monetary penalty. [Florida v. United States HHS, 648 F.3d 1235 (11th Cir. 2011).] This is commonly known as the "individual mandate." The Supreme Court agreed to review the constitutionality of the individual mandate and heard arguments in March 2012. On June 28, 2012, the Supreme Court upheld the individual mandate in a 5-4 decision finding that, although Congress does not have authority under the Commerce Clause to require individuals to purchase a health insurance policy with prescribed benefits, Congress does have authority to use its taxation powers to impose a monetary penalty for failing to purchase such insurance. [National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012).]

Provisions Effective Shortly After the Implementation of the ACA

Q 13.19 What types of reforms were insurers required to comply with by September 23, 2010?

The following is a list of some of the key requirements that were effective September 23, 2010:

- *Pre-existing condition exclusions for children prohibited.* [ACA § 10103(e), which amends § 1253 (which was renumbered to § 1255) to clarify that the prohibition on pre-existing condition exclusions with respect to children pursuant to section 1201 (amending § 2704 of the PHSA) is six months after enactment.]
- *Rescissions prohibited except for fraud or misrepresentation.* [ACA § 1001, which amends § 2712 of the PHSA.]
- *Lifetime dollar limits prohibited.* [ACA § 10101, which amends section 1001 (which amends § 2711 of the PHSA). *See also* Reconciliation Bill § 2301.]
- *Use of unreasonable annual dollar limits prohibited (annual limits prohibited in 2014).* [ACA § 10101, which amends section 1001 (which amends § 2711 of the PHSA). *See also* Reconciliation Bill § 2301.]

- *Preventive health services coverage must be provided at first dollar*. [ACA § 1001, which amends §§ 2713 and 2717 of the PHSA.]
- *Coverage for young adults required*. [ACA § 1001, which amends § 2714 of the PHSA. *See also* Reconciliation Bill § 2301 (which applies the requirements to grandfathered plans).]
- *Consumer assistance required through implementation of an effective appeals process*. [ACA § 10101, which amends § 1001 (which amends § 2719 of the PHSA).]
- *Patient protections required, such as selection of primary care provider and prohibition of prior authorization for emergency care*. [ACA § 10101, which amends § 1001 (by adding § 2719A to the PHSA).]

Provisions Effective January 1, 2011

Q 13.20 What types of provisions are required effective January 1, 2011?

Perhaps among the most far-reaching reforms under the ACA, the use of "medical loss ratios" or MLRs, became effective on January 1, 2011. Issuers of group and individual health insurance coverage (see explanation above for the way in which the ACA uses these terms) are required to issue rebates to enrollees if the minimum percentage of total premium revenues spent on clinical services and activities that improve health care are less than 85% for large groups (more than 100 enrollees) and 80% for small groups and individual market plans. [ACA § 10101, which amends section 1001 (which amends § 2718 of the PHSA).] This requirement, which is supported by another requirement for health insurance issuers to submit this percentage data, promises to have widespread market impact on issuers of health insurance coverage. Insurers will be required to report in 2012 their medical loss ratios for 2011 and pay rebates beginning in 2012. The ACA also directs the NAIC to establish uniform definitions and standardized methodologies for determining what services constitute clinical services, activities that improve health care quality and other non-claims costs for carrying out this provision. [ACA § 10101, which amends § 1001 (which amends § 2718 of the PHSA; *see* § 2718(c)).]

Despite the NAIC's recommendation to include agent and broker commissions as a permitted health expense to be excluded in calculating Minimal Loss Ratios, the HHS still issued final MLR regulations that disregarded the NAIC recommendation. Broker fees are therefore counted as "overhead" for purposes of the MLR.

HHS regulations allowed for transitional gradually stepped-up percentages for mini-med policies and student plans to meet MLR-required percentages of 85% or 80% until 2014. HHS also recognized the unique purpose of expatriate plans and their higher administrative costs and allowed permanent reduction in such plans' minimum loss ratios.

"Excepted Benefits"

Q 13.21 What is the definition of "excepted benefits" that fall outside the scope of the various reforms contained in ACA?

The term "excepted benefits" is the same as defined in 42 U.S.C.S. § 300gg-91 (PHSA). Plans and policies that are "excepted benefits" are not subject to the ACA's insurance market reform provisions; however, they may be subject to other provisions of the ACA. To be an "excepted benefit," the coverage must fit into one or more of four statutorily prescribed categories, as follows:

Category #1: "Miscellaneous types of benefits"

(A) coverage only for accident, or disability income insurance, or any combination thereof;

(B) coverage issued as a supplement to liability insurance;

(C) liability insurance, including general liability insurance and automobile liability insurance;

(D) workers' compensation or similar insurance;

(E) automobile medical payment insurance;

(F) credit-only insurance;

(G) coverage for on-site medical clinics; and

(H) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. (Regulations have not been promulgated as of this writing.)

Category #2: "(Limited Excepted) Benefits [that] must be offered separately"

(A) limited scope dental or vision benefits;

(B) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(C) such other similar, limited benefits as are specified in regulations. Insurers that offer excepted benefits must carefully analyze their product to ensure that they meet excepted benefits requirements both in form and in substance. Incorrect classification of excepted benefits could lead to steep penalties for ACA purposes.

Category #3: "[Benefits that] [m]ust be offered as independent and non-coordinated benefits"

(A) coverage only for a specified disease or illness; and

(B) hospital indemnity or other fixed indemnity insurance.

Category #4: "Benefits [that] must be offered as separate insurance policy"

(A) Medicare supplemental health insurance;

(B) coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (10 U.S.C.S. § 1071 *et seq.*) (TRICARE); and

(C) similar supplemental coverage provided to coverage under a group health plan. (The term "similar supplemental coverage" has been generally described in Department of Labor (DOL) and HHS guidance.)

Regulations have been issued that add certain employee assistance plans (EAPs) and limited benefits that "wrap around" and fill gaps in certain other types of coverage to this list.

Powers of the States

Q 13.22 How will the ACA affect the cost of health insurance?

It is not possible to predict how the ACA will affect the cost of health insurance in the long term. It is possible to identify specific sections of the ACA that relate explicitly to premiums and the cost of health insurance. For example, the Fair Health Insurance Premiums provisions noted above will affect rates. Moreover, the use of MLRs and mandated rebates, also noted above, will also affect rates. States were granted $51 million to study and review their authority to regulate rates. [*See* www.hhs.gov/news/press/2010pres/07/20100729a.html.] States have also developed health insurance exchanges which may eventually lead to innovations in how insurance is priced and purchased. [ACA § 1311(b)(1).] These explicit provisions of the ACA are all likely to have direct effects on the cost of health insurance. However, due to the complexity of the statute, its long-term impact on the delivery of health insurance throughout the country is impossible to quantify or predict.

Q 13.23 Will the state Insurance Departments continue to be involved in the regulation of health insurance and health insurers?

Yes. For example, the organization and licensing and solvency regulation of health insurers will remain in the hands of the state Insurance Departments. In addition, the ACA expressly requires the cooperation of the states in working with the federal government in developing key aspects of the law—for example, importantly, in determining definitions and methodologies for calculating MLRs. So state insurance regulators remain very involved in the regulation of health insurance, albeit with a newly expansive partner in the regulation of this insurance product. Nevertheless, the overlay of these sweeping federal reforms on the existing state systems for regulating health insurance and the interplay between the federal and state rules are likely to raise numerous implementation and compliance questions for insurers that will take some time to resolve.