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Health Insurance Regulations in the United States: Lessons for India

Governments face major policy challenges in designing an appropriate regulatory framework to promote an equitable and efficient health insurance market. The United States has a sophisticated and market oriented health care system, relying on a combination of market strategies and regulations. This paper surveys health insurance regulations in the United States, and draws potential lessons for India. A brief history of health insurance, and evolution of insurance regulations in the United States is also presented. Legislative and regulatory processes relating to health insurance are described to understand the policy process. Regulations are analyzed to understand how these ensure financial solvency and market conduct of insurers, and problems faced in implementation and enforcement.

Regulation of the health care system is crucial to ensure efficient and equitable delivery of health care services. Governments face major policy challenges in designing appropriate regulatory frameworks to make affordable health care services available to its populations. But the characteristics of health care markets such as asymmetry of information (between consumer and health care provider, and between consumer and health insurer) besides highly unpredictable health care costs, contribute to market failure.

Therefore, health insurance regulations emerge from the need to correct market failures. The main goals of health insurance regulations are designed to protect the interests of insurance consumers, assure financial solvency of insurers and ensure that insurance premiums are either inadequate, in excess, or unfairly discriminatory. Health policies used as regulatory tools call upon governments to control health care markets by monitoring players such as insurance carriers and health care providers.

Though the regulation of the health sector primarily involves controlling health care settings and health insurance businesses, there are many stakeholders involved in the process – insurance intermediaries, employers and employees in group health plans, individual purchasers in individual health insurance markets, etc. Any set of regulations without addressing the
concerns of these stakeholders will not be successful. Therefore, regulation of the health insurance industry requires careful analysis of markets and issues raised by the stakeholders.

Despite spending 14 percent of the GDP on health care, the highest among developed economies, the United States still cannot provide universal health insurance cover to all its citizens. More than 40 million Americans do not have any health insurance coverage. In fact, the size of the uninsured population has been steadily increasing. Efforts of federal, state, and local governments to reduce uninsured pools could not achieve the desired momentum due to a variety of factors – increasing health care costs, sliding economy resulting in many people losing jobs, and small business employees and the self-employed unable to afford expensive health insurance premiums.

Health insurance is one of the most heavily regulated industries in the United States today. Public interest debates about it abound, legislation is on the increase, and litigation is rampant. In typical health insurance contracts, technical documents covering rights, duties and obligations of the parties are complicated and the promise to pay benefits when specific events occur is not without its problems. In the context of recent privatization initiatives of the insurance sector in India in which regulations for health insurance are being developed, it is important to understand the regulatory framework and draw possible policy lessons from the United States.

**Evolution of Health Insurance in the United States**

The United States has historically followed different patterns in financing health care. The practice of pooling resources for health services started in 1789, when Congress established the Marine Hospital Service for seamen by imposing the collection of compulsory contributions from their wages. In the mid-nineteenth century, the Massachusetts Health Insurance Company of Boston became the first insurer to offer sickness insurance.

Modern health insurance emerged in 1929 when the Baylor Hospital in Texas offered specific health services for a group of schoolteachers for a predetermined monthly premium. Employer-sponsored health insurance traces its roots back to 1933 when Kaisers introduced a prepaid health plan for construction workers in Southern California (EBRI, 1997, 1999).

In the late 1930s and early 1940s, there was a high demand for skilled workforce. As a result, wages increased rapidly. The government imposed
wage controls to restrict the rise of wages. The Internal Revenue Service passed a law in 1943 allowing employers to offer tax-exempt fringe benefits for workers that were tax deductible for employers. During World War II, wage controls prevented employee unions from negotiating wages, but were allowed to negotiate for fringe benefits. As a result, fringe benefits like pensions, health, life, and disability insurance flourished. Since then, the number of persons provided with employer-based group health benefit plans increased consistently.

From the early 1950s, commercial insurance companies started offering health insurance by pricing indemnity policies on the basis of case experiences. By the late 1950s, the federal government started offering health benefit plans to its workers. In the 1960s, increasing number of medium and large employers voluntarily came forward to offer health benefits for their workers. To provide insurance coverage for long hospital stays, commercial insurers and Blue Cross and Blue Shield offered health plans to cover catastrophic cases (OECD, 2001).

In the mid 1960s, Congress initiated two major government-sponsored health insurance programs – Medicare for the elderly and Medicaid for the indigent people. Medicare is fully funded by the federal government; Medicaid receives funding from federal and state governments. In 1972, the federal government extended the benefits of Medicare to people afflicted with end-stage renal diseases and to those with disabilities. With increased participation of federal and state governments in the financing of health care, the health insurance business experienced tremendous growth. Indemnity insurance was the most prevalent form of insurance till the early 1970s.

However, there was no incentive for physicians and insurance consumers to provide for, and avail rational health services. As a result, health care costs kept increasing at a fast pace. With the enactment of Health Maintenance Organizations (HMO) Act in 1972, the Congress initiated efforts to reduce spiraling health care costs. The HMO Act facilitated organizing provider networks besides integrating the financing and delivery of medical care. Under the Act, the federal government provided grants to boost the growth of HMOs and required employers to offer an HMO option to their employees.

In the 1980s, the federal government designed programs to provide HMO services to Medicaid and Medicare enrollees. While HMOs succeeded in reducing health care costs, enrollees and providers expressed concerns that centered on undue emphasis on cost minimization at the cost of quality health
Several forms of Managed Care Organizations (MCOs) like Preferred Provider Organizations, Point of Service, Physician Hospital Organization, among others, emerged. In 2001, about 73 percent of insured persons availed health insurance through their employers and managed care became the dominant form of insurance (CPS, 2002).

Though medium and large employers could successfully reap the benefits of managed care, not many insurers or MCOs offered insurance products for small employers and businesses, as their risk-spreading capacity happened to be limited. Individual health insurance is very expensive compared to group health plans. Adverse selection was a major cause for non-development of individual health insurance. Therefore, affordable health insurance is still a distant dream for many employees working with small employers, the self-employed, and individuals who do not have jobs. As a result, nearly 15 percent of the population is uninsured (CPS, 2002). This poses a great challenge to the health care system in the United States.

Analysis of Health Insurance Regulations

The United States has a long and varied history of regulating the insurance industry. The Constitution, the Bill of Rights (the first 10 amendments to the Constitution) and the Supreme Court have the authority to determine which level of government regulates insurance. Up to the 1860s, the federal government was given the authority to regulate interstate commerce. In 1868, the Supreme Court ruled that the business of insurance was not interstate commerce and hence states can regulate insurance (Sage, 1996).

With the advent of managed care health plans, the focus of regulation has changed. While traditional fee-for-service indemnity insurance focused on financial solvency of health plans, market conduct, and health plan benefits, regulation of managed care plans address access to services, quality assurance process, provider contracts, grievance and appeals, and medical necessity determinations in addition to solvency of insurers.

Though it is hard to answer whether a free market would provide better results as opposed to regulated health insurance market, well designed regulations will no doubt help in improving availability of health insurance and health care services to both sick as well as young and healthy persons. Regulatory provisions are intended to protect insurance consumers as well as promote healthy practices, and competition among insurers.

To ensure this, several federal and state regulations were developed to oversee
the insurance business depending on the type and coverage of various health plans. Several departments at the federal level enforce a host of laws and regulations. The McCarran-Ferguson Act of 1945 delegated the exclusive right of regulating health insurance to the states except in situations where federal law preempts state law. All the states were given the authority to develop their own regulatory mechanisms. Usually, the Department of Insurance (DOI) oversees financial solvency of insurers and benefits offered and the Department of Health (DOH) regulates quality of health care services.

DOI is the primary regulator of health insurance plans in 41 states and most of the rest are regulated by the DOH. The states regulated by the DOH lack the capacity and expertise to oversee financial and actuarial matters, and often depend on the DOI for technical guidance. Since the Employee Retirement Income Security Act (ERISA) preempted states from regulating self-insured health insurance plans, their regulatory reach has been confined to fully insured health plans, including managed care.

Greater diversity exists among states in terms of the regulating health insurance markets. Regulation of health insurance rates, mandated health insurance benefits, etc., vary from state to state. Health insurance regulations at the state level are intended to protect consumers by overseeing financial solvency of health plans, monitoring market conduct of insurers to prevent fraud and abuse, and ensuring coverage for certain services.

As the United States health insurance sector has been consumer-driven and highly market oriented, it is important to study the impact of insurance regulations on functioning of health care markets. Unfortunately, few formal evaluations were undertaken and results were mixed. As there are various types of health plans and multiplicity of state and federal regulations, collecting information on health insurance regulations and developing suitable models to analyze the data is quite difficult (Rogal & Stenger, 2001). In this paper, health insurance regulations were divided into four broad categories so that these could be analyzed in a meaningful way.

(a) Financial regulations: Regulators have primary responsibility to ensure organizational soundness and financial stability of existing insurers, and new organizations seeking licensure for undertaking health insurance business. The hard earned money of workers and individuals, paid as premiums, should be protected properly in order to meet their future health care costs. States use a variety of methods to monitor the health insurer’s financial solvency, including but not restricted to minimum capital and surplus levels, investment restrictions, and financial reviews.
The basic components of solvency regulation include regulatory requirements, asset valuation reserve or interest maintenance reserve, solvency monitoring, financial reporting, and solvency screening (OECD, 2002). Any organization seeking a license to become an insurer is required to submit documents pertaining to its internal operations. Since health insurance is a capital-intensive industry, laws and regulations require organizations to provide sufficient evidence that they possess sound and consistent organizational structure, and financial position.

To ensure this, organizations are required to submit copies of all applicable organizational documents such as articles of incorporation, articles of association, etc. If the organization has any partnership with other organization/s, documents pertaining to partnership agreements need to be submitted. Organizations are also obligated to provide information on organizational structure, including members of policymaking bodies, their names, principal occupation, employment details (if any), and their functions and responsibilities in the areas of administration and financial matters.

To ensure financial soundness and stability, insurers applying for renewal and new organizations applying for licenses to do insurance business are required to submit audited financial reports for at least the past three financial years and financial statements (such as balance sheet, statement of income and expense, and statement of changes in financial position, cash flow, capital expenditure and repayment schedule for existing or anticipated loans or alternative financing arrangements, projecting quarterly and annual results of operations for the next three years).

Insurers are also prohibited from investing in certain risky businesses. Carriers are also required to establish and maintain reserves or other funds as determined necessary to cover projected risks not otherwise assumed by another entity, carrier, or reinsurer. In addition, insurers are required to submit a detailed statement of current and projected reserve establishment calculations, amounts, purpose, and use of reserve. Usually, insurers domiciled in the state are given permanent licenses, and insurers from other states and non-United States companies are issued licenses on a yearly renewal basis.²

The National Association of Insurance Commissioners (NAIC) coordinates efforts of the states in the area of financial solvency in various ways.³ Responding to the need for standardized rules for financial regulation of insurers in 1989, NAIC developed the Financial Regulation Standards and
Accreditation Program. All the states except New York are accredited under this program. Risk-based capital adequacy standards have been applicable since 1992 for life, and since 1993 for non-life insurance. The objective of risk-based capital standard is ‘to incorporate several factors of risks such as technical risks (involving inadequate pricing or technical provisioning, liquidation, etc.), investment risks (interest rate risk, credit risk, risk of depreciation, etc.), and other risks (commercial risk, management risk, etc.) – confronting an insurer’ (Leflaive, 2001).

Basing on the type and amount of risk the insurers assume, insurers are required to comply with minimum levels under model risk-based capital standards. These standards enable regulators to ensure that insurers maintain adequate financial reserves to protect against a wide range of risks to the insurer’s financial condition.

(b) Market conduct regulations: These are intended to monitor activities such as marketing, advertising, underwriting, rating, and claims practices of health insurers and producers. Market conduct examinations are conducted to document alleged violations of law for possible enforcement actions, and work with insurers to implement corrective measures. Examinations are both corrective and preventive.

Insurance consumers receive restitution when corrective actions are implemented by an insurer as a result of deficiencies or violations identified during examination of claims. The guidelines and procedures for corrective actions to be taken by the health plans are developed to protect future claimants from fraudulent practices.

All MCOs are required to get accreditation in order to provide, or arrange for the provision of health services to consumers. Generally, accreditation granted to MCOs remains in force for 12 months unless revoked or suspended by the Commissioner of Insurance. Insurance agents play a critical role in the sale of health insurance, but their role is often unnoticed while formulating market reforms.

Agents sell most of the small group and individual health insurance plans. Any person or organization applying for an agent’s license should possess necessary qualifications and use appropriate application forms as determined by the state insurance department. Upon screening, if the information furnished is found satisfactory, the Commissioner of Insurance issues the license.
The Commissioner of Insurance may examine, audit, and inspect any and all books and records maintained by the two kinds of agents – those who work for specific health insurers (captive agents) and those who work for more than one insurer (independent agents). Independent agents are mostly paid on commission basis. Commissions vary from insurer to insurer. Health insurers often use varied rates of commission to identify and segregate good and bad risks. Insurers pay lower commissions for certain non-favored businesses such as guaranteed issue policies, or smaller groups with two to five members.\(^4\)

The type and amount of market conduct regulations vary from state to state. States require health plans, insurance agents, and/or brokers not to discourage employers from filing an application for health insurance policies because of the health status, and claims experience of their employees, industry, occupation, or geographic location of the employer. Regulations are also passed requiring health insurers not to direct an employer to seek health insurance benefits from another insurer because of the health status, claims experience, industry, occupation, or geographic location of the employer.

The chief regulating agency conducts field examinations of insurers and agent activities, and reviews their financial transactions and business practices to ensure they are in compliance with state insurance laws and regulations. In the process of market conduct examinations, regulators review business practices of health insurers, and assess how they fulfill their contractual obligations to consumers and claimants such as health care providers.

Underwriting and rating practices of insurers are reviewed for compliance with policy forms. State laws also require insurers to provide adequate information to consumers and advise them of their rights related to internal and external appeal processes. Therefore, while undertaking market conduct examinations, regulators assess whether insurers have taken steps to make updated information available to consumers on time.

As health insurance policy documents are complex and require careful scrutiny, it is necessary to regulate the content of policy documents, and rates of health insurance products. To ensure that health insurance premium rates are commensurate with benefits, health plans are given appropriate guidelines for submission and filing of insurance rates.

Health plans have to submit initial rate filings for approval of new health insurance products. If existing insurance policies need to be modified, then the health plan is required to submit rate adjustment filings. DOI reviews
rate and form filings for compliance with statutory and regulatory requirements.

In the 1990s, a vast majority of states passed legislation regulating the health insurance business, content, and pricing of private group health insurance plans. The main purpose of legislation was to reduce the number of uninsured persons, and to ensure appropriate care for those who are sick. Among the uninsured, a large number was employed persons (Kaestner & Simon, 2002).

Insurers, while advertising about their insurance products, provide information about their respective company’s financial position, and coverage statistics. States have passed laws requiring pre-approval of advertisements and sales material prepared by insurers. In states where there is no such mechanism, insurance regulations emphasize that advertisements and sales material should contain information that is correct, and should not mislead consumers with respect to assets, financial position, and other relevant facts.

With the predominance of managed care plans that have contracts with health care organizations, diagnostic centers, and other medical supply organizations, concerns were raised regarding delay in paying claim bills. Regulators in many states have responded quickly to these concerns and passed laws to minimize the delay in payments to providers and other agencies. For instance, New York passed the Prompt Pay Law, which requires all health plans to process claims for payment within 45 days. If organizations fail to do so, the law requires insurers to include interest with late payments.

To assess the quality of services provided, health plans are required to have mechanisms such as customer satisfaction surveys (to be conducted every year) to monitor and analyze quality of health services. Health plans are also required to assess satisfaction of enrollees with health care providers. Survey results should be discussed with providers to take remedial measures, and improve the quality of services provided.

NAIC model laws require all health plans to annually submit methods used for quality assessment and progress in meeting internal goals, and external standards. If the health plan is using services of any external agency to carry out quality assessment, the plan is responsible for monitoring the activities of the agency contracted.

All insurers are required to be examined once every five years to assess financial soundness. However, if the regulator finds any insurer experiencing financial difficulty, such an insurer will be examined as and when necessary.
The scope and content of examination will depend on the characteristics of the company to be examined (NAIC, 1997).

The Commissioner of Insurance, or any competent person designated by him/her can carry out the examinations. The Commissioner, while performing duties, may share examination reports, documents, and other materials with state, federal, or international regulatory and enforcement agencies, and with the NAIC provided that the recipient agrees to maintain confidentiality.

(c) Regulations protecting consumers: Consumers can make sound purchasing decisions if they are given reliable information. As part of the regulation of insurance business, insurance laws require health insurance plans to clearly specify rules, eligibility standards for each type health insurance policy, the process or admission to membership, and the rights and privileges of each membership class. The laws also specify that the insured shall have the right to vote on the management of the insurer. Membership rights are personal to the member and are not assignable.

To provide protection for the insured/members, insurers are also required to provide mechanisms for grievance or complaint procedures for members. Consumer advocacy agencies and interest groups argue that managed care puts profits before consumers. They strongly emphasize the need for proper grievance and appeals procedures for consumers to deal with large entities such as health insurers.

The volume of consumer complaints received by the insurance department indicates the level of consumer protection in the state. Every health plan is required to establish grievance and appeals procedures for the insured in case the insurer denies coverage for services that the insured and/or the physician believe are medically necessary. There are two types of appeal procedures called internal review process and external review process.

In an internal review process, providers of health plan and/or experts hired by the plan, review disputes and grievances of members. Many states require health plans to have a panel of reviewers composed of plan members and providers, besides specific timeframes within which the review process should be completed. If the internal review process fails to resolve a dispute, the insured member should have the option to appeal the case with an external agency.

Consumer protection acts or patients’ bills of rights respond to fears that some managed care practices too often mistreat enrollees (Blendon et al.,
Since it is hard to get any professional consensus between health plans and providers regarding medical necessity, health plans try to position themselves on the fiscally conservative side of clinical controversy by placing the burden on providers.

By the end of 2001, 42 states had passed laws requiring health plans to establish external review process, independent of health plan, for reviewing disputes between health plans, and consumers. The claimant is to exhaust all of the health plan’s internal grievance procedures before going for the external review process. The decisions made in the external review process are binding on health plans.\(^5\)

However, the extent of grievance redressal in procedures depends on whether the health plan is a self-insured employer plan or a fully insured plan. Consumers in self-insured plans have inadequate provisions for grievance and appeal. If the coverage dispute or grievance is not resolved at the plan sponsor level, DOL may advise consumers of their legal options, or refer them to legal aid organizations.

Under ERISA, individuals in self-insured health benefit plans can enforce their contract rights in a federal court (Jacobson & Pomfret, 1998). ERISA plan beneficiaries, however, cannot recover consequential personal injury or punitive damages in such suits. The ability to seek damages or injunctive relief under state law has been curtailed by ERISA’s preemption of state laws that relate to such plans. State insurance regulators are pessimistic about DOL initiatives to provide adequate protection for consumers in self-insured plans.

With the emergence of managed care as a dominant form of health insurance, plan members often express their concerns about the adequacy of provider network and direct access to specialists. Members have restricted choice of providers who are empanelled in the managed care plan. Plans often use provider networks with limited number of specialists as a means to contain costs. Plan members who need specialist services, have to wait for a long time to get care.

Members desire adequate access to providers, especially specialists. States have passed legislation or established regulations to ensure that adequate provider networks are maintained, and patients have adequate access to specialists through referrals. Network adequacy is measured by the number of providers and the type of provider specialty available. In some states, health plans are required to allow a referral to an out-of-network provider if
the plan has limited number of a particular type of specialists in its network. States have used a variety of strategies to demonstrate adequacy of network. Some states set guidelines that require plans to have hospitals and primary care physicians within 30 minutes or 15 miles from a member’s home or workplace; others require plans to ensure that services are accessible in terms of geography, hours of operation, and generally accepted standards for staffing patterns. States have passed laws that require health plans/insurers to allow patients to visit a non-primary care physician without a referral from a gatekeeper primary care physician for certain health services.

Most states have passed direct access laws for obstetrics/gynecology services and some states have passed laws allowing patients with chronic health conditions such as asthma or diabetes to seek specialty care directly from specialists. In some states, health insurers are required to offer a plan that allows members to choose providers outside of the plan’s network with higher cost-sharing. To ensure access to timely services, state laws prevent limitation on coverage of emergency services by requiring that emergency services be included if emergency care was warranted based on the determination of a prudent layperson. States have also passed laws regulating the minimum length of a hospital stay for childbirth, and mastectomy.

Regulations pertaining to disclosure of plan information to consumers were widely adopted in many states. The health insurance policy form is a complex and lengthy document that requires a great deal of effort to understand various provisions. Therefore, states have passed laws that require health plans to prepare policy documents in simple and easy to understand form, printed legibly, conforming to predefined standard. Disclosure of covered and excluded benefits, and a member’s financial obligations have long been the requirements.

States are now requiring plans to disclose information about provider financial incentives, referral process, grievance procedures, and the plan’s utilization review process. States are also requiring plans to disclose a broad description of their payment methodologies. Some states require plans to disclose the particular method by which a specific provider is compensated when requested by the member.

Utilization review is used to determine the medical necessity, cost-effectiveness, and quality of proposed and delivered services. Plans often use proprietary information in making medical necessity decisions. The utilization guidelines used by plans can be developed in-house or purchased.
from independent contractors. Respecting proprietary information, states are requiring plans to release specific clinical criteria used in a decision when requested by a member, instead of wholesale disclosure.

Managed care health plans have been the target of liability suits as these have been influencing the decision-making process regarding the treatment of patients. Legislation permitting enrollees to sue their health plans were enacted in some states, and many states have proposed such laws. Legislation generally permits enrollees to sue health plans under state law for damages resulting from actions or decisions of health plans. Health plans oppose such laws and legislation, arguing that this will drive up costs. Health plans are legally accountable for their role in the decision-making process of patient care. Therefore, states have passed legislation assuming that if managed care plans face a greater potential for lawsuits, decisions would be taken in the best interest of their members.

However, employer-sponsored self-insured health plans have been protected from state lawsuits as ERISA preempts state laws, including liability laws. Therefore, beneficiaries of self-insured health plans cannot sue health plans under state law for damages resulting from the plan’s involvement in denying or delaying coverage. Enrollees can go to federal courts, but damages are limited to the cost of plan benefits, and costs of litigation. Recovery of punitive damages is not allowed. ERISA rules pertaining to lawsuits are more restrictive compared to state laws. Although ERISA preemption of state regulations has been challenged in courts, most disputes regarding self-insured plan benefits and administration continue to be resolved under federal rules.

Managed care health plans contract with health care providers (both physicians and hospitals) to form networks. In the event the health plan terminates the provider from participating in the plan, or the provider chooses to leave the network, members with chronic health problems are allowed to receive ongoing treatment with their existing providers for a certain period. Similar protection is available for persons who enroll in a new plan in which the provider does not participate.

As providers disaffiliate from plan networks (at either the plan’s or the provider’s initiative), regulations require plans to allow members to stay with those providers for a certain period in order to make the transition to a new provider in a clinically appropriate manner. The non-network provider typically is required to accept the plan’s compensation arrangement, and
comply with other plan requirements, such as data reporting.

(d) Regulations protecting providers: Managed care health plans would like to retain the power to terminate any physician and/or specialist from the panel of providers if the plan does not need their services, or the doctors do not conform to the standards laid down by the plan. To maintain meaningful working relationship between insurers and providers, states have passed laws requiring health plans to give minimum time between notice of termination of providers, and its effective date.

Health plans are required to inform its members of provider disaffiliation in 15-30 days, while in some states plans and providers must give each other 60-90 days prior to termination. If the termination of the provider causes damage to the health plan members or to the provider’s future practice, health plans are prevented to exercise their powers.

Provider credentialing and profiling are recent trends in legislation to make MCOs work better. Health insurers are required to establish a comprehensive health care provider credentialing verification program to ensure that its participating health providers meet minimum standards of professional qualifications such as license to practice, history of licensure, board certification, and practice history.

If health insurers have contracts with the health care providers for more than three years, subsequent re-credentialing process is to be completed every three years. Provider profiling is used to analyze referral patterns, costs, utilization, profitability, and resource consumption of individual providers or groups within a network. This process allows for comparisons of performance by providers. It helps identifying inappropriate and unnecessary patient care. Health plans are required to share performance data with all participating providers and seek suggestions for improving the delivery of health care services.

Initiatives to Promote Health Insurance Coverage

The number of people who are either not getting comprehensive health insurance benefits or losing coverage has been increasing. It was felt that it is important to initiate mechanisms to expand health insurance coverage to maximum number of employees in small businesses, and uninsured individuals. Among major initiatives to promote health insurance coverage are the following:
(a) Health insurance purchasing coalitions: Small businesses employ more than half of the workforce in the private sector, but many of their employees remain underinsured, or uninsured due to the high cost of health insurance. Small businesses face several disadvantages due to their limited risk spreading ability among groups, lack of bargaining power, and high administrative costs of health plans. To address these issues, small businesses have been advised to come together to form health insurance purchasing cooperatives. Collective entities with strong bargaining power can gain administrative economies of scale.

The United States experience reveals that business firms, and employers participating in such purchasing coalitions were able to offer better information about the health plans, and choice of health plans to the covered employees. This helps in not only reducing premiums and administrative costs, but also enabling them to offer a choice of health plans for the employees.

(b) Subsidies to small businesses: Some recent innovations such as Small Business Health Insurance demonstration project initiated by the New York City Mayor’s Office of Health Services offered useful insights into how a subsidized health plan can be extended to employees of small businesses using underutilized public health facilities. This pilot project was launched in 1997. Though the project achieved limited success in terms enrollment, the program was relatively successful. The project targeted most of the small businesses that had not offered health insurance in the past, and employees who were previously uninsured (Rosenberg, 2002).

(c) Regulation to expand access to individual insurance: Individual health insurance markets suffer from various problems such as limited number of insurers willing to offer health plans, high premium and administrative costs, adverse selection, etc. In the absence of adequate regulation, persons working in small groups and businesses, self-employed, and individuals often pay high premiums to buy less comprehensive health benefit packages.

Policymakers, therefore, are interested in regulations that would help expand access to these consumers. New Jersey initiated the Individual Health Coverage Program in 1993 and used regulation to expand access to insurance coverage, and to limit segmentation of the individual insurance market. The program demonstrated that a viable insurance market could be created by establishing a mechanism for subsidizing loss making insurers (Swartz & Garnick, 2000).
**Implementation Issues**

Taxation policies in the United States provide incentives for businesses to provide health insurance, despite the fact that a person stays with an employer on an average only four years. Lack of tax benefits for individually paid premiums is one of the significant factors contributing to a decline in the number of people insured through individual health insurance markets. Since tax benefits are not allowed to individuals, employers often offer expensive, low-deductible, high-premium health insurance policies instead of paying higher wages.

Tax policies also trigger excess spending, especially on small claims. Low deductibles, and small co-payments induce people to use insurance for routine health care. The use-it-or-lose-it system combined with low deductibles, induces employees to use insurance for everything possible, making them less careful about where and how they spend that money. Much of the rising cost of health care is attributed to the increase in demand for health services that most insured persons might not otherwise pay for, and all of the administrative costs that go with it.

It is also being criticized that tax policies make people push up costs aggressively. That accounts for much of the high rates of growth in health care costs, which, in turn, drives up health insurance costs. Rising health care costs quite often lead to shifting of more costs of health insurance from employers to employees. This results in some employees buying less health insurance, and sometimes tempting them and their dependents to remain uninsured. Employees who do not get health insurance from their employers, and unemployed people are left without health insurance.

As health insurance is tied to employment, any employee who loses his/her job would face difficulty in getting continued coverage. The Consolidated Omni-Budget Reconciliation Act (COBRA) and state laws require employers to continue ex-employees and their dependents in the group insurance plans. An ex-employee has to pay 102 percent of group premium from out of pocket. The premiums are too expensive for someone whose income has just been cut off. It is difficult to select a higher deductible in order to lower premium payments because the plan is a group plan instead of an individual plan, and it is not permitted to change the deductible. It takes time to find and shift to a new individual or short-term policy. High premiums make it difficult to afford coverage during that search period.
Lessons for India

Policymakers and the Insurance Regulatory and Development Authority (IRDA), while designing regulations to strengthen health insurance sector and develop sound regulatory mechanisms, have to make judicious decisions pertaining to regulation and promoting market competition. The United States experience with regulating health insurance markets provides significant lessons for Indian policymakers seeking to increase access to health insurance by developing suitable regulations:

(a) **Dissimilar levels of consumer protection:** Fully insured health plans are subject to state regulations with stringent consumer protection, while self-insured plans governed by ERISA provide minimal safeguards for enrollees. State regulations are extensive and effectively protect consumers by creating adequate grievance and appeals processes, while employer-sponsored self-insured health benefit plans are not required to institute any comparable processes to protect consumers. Though enrollees in self-insured health plans offered by large employers have reasonable protection, their counterparts in small and medium businesses do not have the same level of protection. This indicates that there is a strong need for extending the same level of consumer protection for all enrollees irrespective of type of health benefit plan.

(b) **Jurisdictional overlaps:** Between multiple agencies lead to lack of coordination in enforcing regulations. Three federal agencies – DOL, DOH, and the Department of Treasury have jurisdictions to interpret and enforce core provisions of the Health Insurance Portability and Accountability Act (HIPAA). This requires joint promulgation of regulations by the departments. Coordinating implementation efforts and sharing of information among three departments creates difficulties and leads to delay in enforcing standards (GAO, 2001).

(c) **Regulations should change over time:** To meet changing conditions. With the ERISA preemption of state regulations on self-insured health plans, many private employers have incentives to switch to self-insured plans. Medium and large employers have incentives such that they need not pay premium taxes, be accountable to or follow state laws, provide mandated benefits, contribute to state high risk pools, etc. Absence of ERISA standards on minimum health benefits, financial reserve requirements, self-insured health benefit plans offered particularly by small employers (with less than 20 employees) often provide inadequate health care benefits, and undermine consumer choices and preferences. As ERISA failed to ensure continuity and portability of coverage, non-discrimination in health benefits, HIPAA
and other federal laws passed in the late 1990s attempted to address the shortcomings.

(d) Striking a balance: It is difficult to strike a balance between competing goals of public policy. ERISA preempts state regulations on employer sponsored self-insured health plans assuming that availability of coverage would be improved. Has the coverage really improved?

(e) Creating high-risk pools: Though there are regulations to minimize the segmentation of good and bad risks, insurers have been trying to underwrite policies for good risks by designing appropriate benefit packages such that young and healthy as well as old, poor, and sick people are sorted out accordingly. This leaves sick and poor people with no choice but to opt for high cost health plans with limited, and less generous benefits. In order to ensure affordable health insurance premiums for people with health problems, alternative financing mechanisms such as high-risk pools need to be established by levying taxes on insurers.

(f) Capacity to monitor and enforce regulations: Implementing and enforcing health insurance regulations demand adequate skilled human and financial resources. Financial examiners and actuaries need to be trained to update their skills in advanced methods of financial examination, and actuarial projections. Federal agencies assumed the responsibility of enforcing HIPAA standards in states that did not have adequate laws and regulations.

Lack of sufficient manpower and finances to discharge responsibilities fully caused some delay in monitoring and enforcing HIPAA standards by federal agencies. Initiatives such as regular interaction, and transparent communication have contributed to create a conducive working relationship between insurers and regulators in reporting of financial data, agent licensing and continuing education, and the approval process for rate and policy forms.

(g) Continuity of insurance coverage: COBRA does provide access to continued group coverage of health plans for ex-employees (of firms with a minimum of 20 people), retirees, their spouses, and dependent children for a limited time. But COBRA provisions do not provide continued coverage for federal employees, and members of health plans offered by religious organizations such as churches.

As India has been aggressively moving towards economic liberalization and privatization, policymakers, while developing insurance laws similar to COBRA, need to carefully analyze whether to extend continued access to
group health plans for retirees and voluntarily retired persons of government, quasi-government, and private sector organizations.

(h) Community-based health insurance: It is not feasible to involve commercial insurers, as the administrative costs would be higher. Community based insurance would be a viable option, though the financial risk protection is limited. Absence of adequate market conduct regulations for monitoring health insurers and minimal requirements to assess the quality of health care organizations including health providers and drug dispensaries, protecting the interests of insured populations, and providing better access to needed health services are major challenges for policymakers in India.

Notes:
1. The United States Congress passed ERISA in 1974 to protect employee pension funds and other benefit plans including health benefits offered by employers. ERISA preempts states’ authority to regulate the self-insured, employer sponsored health plans, and any managed care plans under contract with self-insured health plans. The preemption was viewed as a means of streamlining the administration of self-insured plans, and reducing their costs for multi-state employers and unions, that would have otherwise to deal with differing requirements in different states.
2. State laws require insurers to maintain a minimum level of capital or surplus to become licensed. The minimum level of capital surplus ranges between $ 200,000 and $ 5 million in the United States, while the Insurance Regulatory Development Authority in India requires insurers to maintain a minimum capital of Rs. 1 billion, which is much higher than the requirement in the United States (IRDA 2000; NAIC, 1997).
3. Such as maintaining databases on insurer finances, the financial assets they hold and relevant regulatory measures, drafting model legislation, and coordinating regulatory policy on important issues.
4. For instance, agents in the state of Florida were paid 1-3 percent of premiums, which is much lower compared to eligible premiums of 5-8 percent for small groups under four (Hall, 2000).
5. Interviews with state insurance regulators revealed that nearly one-half of the denials reviewed in the external review process were overturned in favor of complainants.
6. Such as information on the basic method of provider reimbursement (e.g., fee-for-service, salary, capitation), and whether financial incentives (e.g., withholds, bonuses) are used.
7. Some states allow members to stay with a provider for up to 60-120 days (Cornell, 2000).
8. COBRA of 1985 was aimed to address the problem of losing health insurance benefits in situations where the covered employee loses his/her job. Under COBRA, group health insurance plans sponsored by employers with 20 or more employees are required to offer continuation of coverage for the ex-employee, and his/her dependents for a period of 18 months. Under the same law, the worker’s family has the right to continued coverage for up to three years, following an employee’s death or divorce. In both the cases, the insured has to pay 102 percent of group health premium. Though it is expensive
for an employee who lost his/her job, the group premium is much lower than the premium for an individual health plan, if he/she chooses one.

9. HIPAA was introduced in 1996 to provide rights and protections for beneficiaries of group health plans. HIPAA amended ERISA of 1974 to expand the availability of health insurance for various types of individuals in the small and large group insurance market, and in the individual market. The Act also prohibits group health plans and group health insurance issuers from discriminating against individuals based on health factors. HIPAA requirements apply to both state-regulated insurers and employer-sponsored health plans. The HIPAA enactment had opened a new era of sharing the regulatory powers between federal and state governments.

References:


The term health insurance is commonly used in the United States to describe any program that helps pay for medical expenses, whether through privately purchased insurance, social insurance or a non-insurance social welfare program funded by the government. Accident insurance was first offered in the United States by the Franklin Health Assurance Company of Massachusetts. This firm, founded in 1850, offered insurance against injuries arising from railroad and steamboat accidents. Sixty organizations were offering accident insurance in the US by 1866, but the industry consolidated rapidly soon thereafter. Health insurance is also mandatory for all international students in the United States, so you will not be able to start studying without it. Note that with very few exceptions, there is no system of free healthcare or subsidized health insurance schemes in the U.S., so you will probably have to take out private insurance. These insurance policies are very expensive, so it often better to extend your national health insurance for a stay in the U.S. Note that without such an extension, your national insurance will probably not cover the astronomical medical cost in the U.S. as they will probably have to take out private insurance. Synonyms for this usage include "health coverage", "health care coverage", and "health benefits". In a more technical sense, the term "health insurance" is used to describe any form of insurance providing protection against the costs of medical services. This usage includes private insurance and