HOW PRIVATE HEALTH COVERAGE WORKS: A PRIMER 2008 UPDATE

APRIL 2008

THE HENRY J. KAISER FAMILY FOUNDATION

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This primer provides a basic overview of private coverage for health care. It begins by describing what we mean by private health coverage, and continues with discussions of the types of organizations that provide it, its key attributes, and how it is regulated. The paper addresses private health coverage purchased by individuals and employers; it does not address public benefit programs such as Medicare and Medicaid.

1. What is Private Health Coverage?

Private health coverage is a mechanism for people to (1) protect themselves from the potentially extreme financial costs of medical care if they become severely ill, and (2) ensure that they have access to health care when they need it.

Health care can be quite costly, and only the richest among us can afford to pay the costs of treating a serious illness should it arise. Private health coverage products pool the risk of high health care costs across a large number of people, permitting them (or employers on their behalf) to pay a premium based on the average cost of medical care for the group of people. This risk-spreading function helps make the cost of health care reasonably affordable for most people.

In addition, having an "insurance card" enables patients to receive care in a timely way by providing evidence to health care providers that the patient can afford treatment. Providers generally know that when they treat people with health coverage, they are likely to be paid for their services within a reasonable time.

Health coverage is provided by a wide array of public and private sources. Public sources include Medicare, Medicaid, the State Children's Health Insurance Program, federal and state employee health plans, the military, and the Veterans Administration.

Private health coverage is provided primarily through benefit plans sponsored by employers – about 158 million nonelderly people were insured through employer-sponsored health insurance in 2006.[i] People without access to employer-sponsored insurance may obtain health insurance on their own, usually through the individual health insurance market, although in some instances health insurance may be available to individuals through professional associations or similar arrangements. About 14 million nonelderly people bought health insurance directly in 2006.[ii]

> ***Policy**: This is the contract between the health insuring organization and the policyholder. The policyholder may be an individual or an organization, like an employer.*

2. How is Private Health Coverage Delivered?

Types of Organizations That Provide Private Health Coverage

Private health coverage is provided primarily by two different types of entities: state-licensed health insuring organizations and self-funded employee health benefit plans.

State-Licensed Health Insuring Organizations

State-licensed health insuring organizations, as the name implies, are organized and regulated under state law, although federal law adds additional standards and in some cases supersedes state authority. There are three primary types of state-licensed health insuring organizations:

Commercial health insurers. Commercial health insurers (sometimes called indemnity insurers) are generally organized as stock companies (owned by stockholders) or as mutual insurance companies (owned by their policyholders). A prominent example is Aetna, a stock company.

Blue Cross and Blue Shield Plans. Historically, many of these plans were organized as not-for-profit organizations under special state laws by state hospital (Blue Cross) and state medical (Blue Shield) associations. These laws differed significantly across states, sometimes imposing special obligations or regulatory requirements on Blue Cross and Blue Shield plans (e.g., to insure all applicants) and sometimes providing financial advantages such as favorable tax status. Today, some Blue Cross and Blue Shield plans continue to operate under special state laws; others are organized as commercial health insurers. Blue Cross and Blue Shield plans operate and are regulated in a similar manner to commercial insurers, although in a few states Blue Cross and Blue Shield plans continue to have special requirements to accept applicants for health insurance on a more lenient basis than is applied to other types of insurers.

Health Maintenance Organizations (HMOs). HMOs usually are licensed under special state laws that recognize that they tightly integrate health insurance with the provision of health care. HMOs operate as insurers (meaning they spread health care costs across the people enrolled in the HMO) and as health care providers (meaning they directly provide or arrange for the necessary health care for their enrollees). In many states, HMO regulation is shared by agencies that oversee insurance and agencies that oversee heath care providers.[iii] Prominent examples of state-licensed HMOs include Kaiser Permanente and Harvard Pilgrim.

Although states tend to separately license each of these types of entities, it is quite common for several different health insuring organizations to operate together under a common corporate identity. For example, an HMO may have one or more

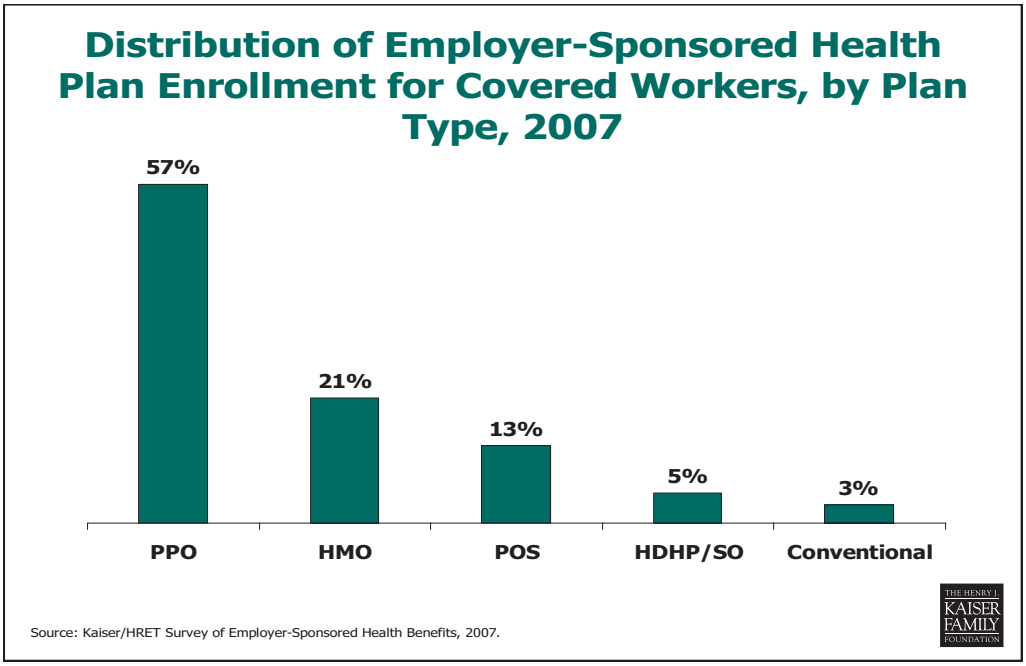
subsidiaries that are separately licensed as commercial health insurers, and may offer its group customers coverage packages that permit members to choose between the different types of coverage.

Self-Funded Employee Health Benefit Plans

Self-funded employee health benefit plans operate under federal law and are health benefit arrangements sponsored by employers, employee organizations, or a combination of the two. Under a self-funded arrangement, the plan sponsor assumes the risk of providing covered services to plan enrollees by paying directly for health care services of the plan's participants. In most cases, the sponsors of self-funded health plans contract with one or more third parties to administer the plans. These contracts are sometimes with entities that specialize in administering benefit plans, called third-party administrators. In other cases, sponsors contract with health insurers or HMOs for administrative services. The administering entity usually will manage the health benefits in the same way as a health insurer or HMO, but will pay for the cost of medical care with funds provided by the sponsor (i.e., no premium is paid).

Types of Private Health Plans

Private health plans include HMOs, Preferred Provider Organizations (PPOs), Point-of-Service Plans (POS), High Deductible Health Plans combined with Health Savings Accounts (HAS) or Health Reimbursement Accounts (HRA), and conventional health plans. For employer-sponsored health plans in 2007, enrollment is highest in PPOs (57%), followed by HMOs (21%), POS plans (13%), Health Savings Accounts/Health Reimbursement Accounts (or HDHP/SOs, 5%), and conventional plans (3%):



How Does Managed Care Fit In?

Formerly, conventional (or, indemnity) health plans were the most common type of health plan. These plans do not use provider networks and require the same cost sharing no matter which physician or hospital the patient goes to. Over the past 20 years, health coverage providers sought to influence the treatment decisions of health care providers and contain costs through a variety of techniques known as "managed care," including financial incentives, development of treatment protocols, prior authorization of certain services, and dissemination of information on provider practice relative to norms or best practices.

As managed care has become increasingly prevalent, the distinctions between different types of heath coverage providers have been shrinking. Commercial health insurers now offer coverage through networks of providers and may establish financial incentives similar to those traditionally used by HMOs. At the same time, HMOs have developed products, called point-of-service products, which permit covered people to elect to receive care outside of the HMO network, typically with higher cost sharing. Although it remains true that HMOs generally are the most tightly managed arrangements and most tightly integrate insurance and the delivery of care, virtually all private health coverage now involves some aspect of managed care.

What is a Preferred Provider Organization?

It is common for people to believe that they are covered by a preferred provider organization (PPO), but these entities generally do not actually provide health coverage. Rather, PPOs are networks composed of physicians and other health care providers that agree to provide services at discounted rates and/or pursuant to certain utilization protocols to people enrolled in health coverage offered by a health coverage provider. Typically enrollees in such an arrangement are given financial incentives – such as lower copayments -- to use network providers.

In some cases, PPOs are freestanding networks of health care providers that contract with a number of different health coverage providers to act as the health coverage provider's network in a particular area. In other cases, a health coverage provider may establish its own PPO network of health care providers in a particular area. Although some states have raised concerns about the level of insurance risk assumed by PPOs under some of their arrangements with health coverage entities, PPOs generally are not treated as health coverage providers in most states.

What are Health Savings Accounts and Health Reimbursement Accounts?

Changes in federal law in recent years have permitted the establishment of new types of savings arrangements for health care. The most common are Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs), which are tax-exempt accounts that can be used to pay for current or future qualified medical expenses. Employers may make HSAs available to their employees, and if the employer

contributes to the HSA the contributions are excluded from employee gross income. Individuals can also purchase HSAs from most financial institutions (banks, credit unions, insurance companies, etc.). In order to open an HSA, an individual must have health coverage under an HSA-qualified high deductible health plan (HDHP), which can be provided by the employer or purchased from any company that sells health insurance in a state.[1]

HRAs are employer-established benefit plans funded solely by employer contributions which are excluded from employee gross income, with no limits on the amount an employer can contribute. HRAs are often paired with HDHPs, but are not required to do so.

Risk Pooling, Underwriting, and Health Coverage

As discussed above, health coverage providers pool the health care risks of a group of people in order to make the individual costs predictable and manageable. For health coverage arrangements to perform well, the risk pooling should result in expected costs for the pool that are reasonably predictable for the insurer and relatively stable over time (i.e., the average level of health risk in the pool should not vary dramatically from time to time, although costs will rise with overall changes in price and utilization).

To accomplish this, health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Said another way, health coverage providers take steps to avoid attracting a disproportionate share of people in poor health into their risk pools, which often is referred to as "adverse selection." For obvious reasons, people who know that they are in poor health will be more likely to seek health insurance than people who are healthier. If a risk pool attracts a disproportionate share of people in poor health, the average cost of people in the pool will rise, and people in better health will be less willing to join the pool (or will leave and seek out a pool that has a lower average cost). A pool that is subject to significant adverse selection will continue to lose its healthier risks, causing its average costs to continually rise. This is referred to as a "death spiral."

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[1] HSAs and HDHPs are subject to certain federal requirements. The maximum contribution allowed from both employer and employee to an HSA in 2008 is $2,900 for self-only coverage and $5,800 for family coverage. In 2008, HDHPs must have a minimum deductible of $1,100 (self-only) and $2,200 (family); the maximum out-of-pocket limit is $5,600 (self-only) and $11,200 (family).

In practice, health coverage providers often have multiple risk pooling arrangements. They may establish separate arrangements for different markets (e.g., individuals who buy insurance on their own, small businesses, and trade associations) and for different benefit plans within markets (e.g., plans with different levels of deductible). In part, this product differentiation protects the health coverage provider because problems in one risk pooling arrangement will not have a direct effect on people participating in another pooling arrangement.

> ***Adverse selection**: People with a higher than average risk of needing health care are more likely than healthier people to seek health insurance. Adverse selection results when these less healthy people disproportionately enroll in a risk pool.*

Health coverage providers use underwriting to maintain a predictable and stable level of risk within their risk pools and to set terms of coverage for people of different risks within a risk pool. Underwriting is the process of determining whether or not to accept an applicant for coverage and determining what the terms of coverage will be, including the premium. As discussed below, both state and federal laws circumscribe the ability of health coverage providers to reject some applicants for coverage or to vary the terms of coverage.

A primary underwriting decision involves whether or not the health coverage provider will accept an applicant for coverage. In the individual insurance market (where people buy insurance on their own), health coverage providers typically underwrite each person seeking to purchase coverage reviewing the person's health status and claims history. If an applicant is in poor health, a health coverage provider (subject to state and federal law) may decide not to offer coverage. However, in most states, a health coverage provider also may choose to accept the applicant but vary the terms of coverage -- they may offer coverage at a higher than average premium (called a "substandard rate"), exclude benefits for certain health conditions or body parts (called an "exclusionary rider"), or do both. As discussed below, state and federal laws generally require health coverage providers to accept small employers applying for coverage, so the underwriting decisions are more limited to determining the premium and other terms of coverage (though these actions are also limited by law in many states).

To maintain the attractiveness of the risk pool to different segments of the population with different expected costs, health coverage providers typically vary premiums based on factors associated with differences in expected health care costs, such as age, gender, health status, occupation, and geographic location. For example, on average the expected health costs of people over age 50 are more than twice as much as the expected health costs of people under age 20. In cases where the individual is paying the full premium for coverage, health coverage providers will want to charge a higher premium to people who are older to recognize the higher expected costs. If premiums are not varied to account for the differences in expected costs, the pool may attract a disproportionate share of older, more expensive people, raising the average cost in the pool and making coverage in the pool less attractive to younger

people (who would have to pay a premium that exceeded their expected average health care costs). This is another form of adverse selection and would lead to a breakdown of the risk pooling. Other examples of underwriting include health coverage providers charging different premiums to small employers based on the industry of the employer or on the employer's prior health claims.

The most efficient and effective underwriting mechanism for avoiding adverse selection is to provide coverage to already formed large groups of people, such as the employees of a large employer. In such cases, the health coverage provider knows that the individual members of the group did not join it primarily to get insurance, so there is a much lower chance that the group is composed disproportionately of people in poor health. In these cases, the underwriting focuses on the group – its claims history, age distribution, industry, and geographic location – not on individual members of the group. Even in group underwriting situations, however, health coverage providers need to assure that they are not getting only those members of the group who are in poor health. To avoid adverse selection within the group, health coverage providers often limit the opportunity for employees to enroll in the plan (typically through an annual "open enrollment period"), require a minimum percentage of employees to participate in the coverage, and/or require the employer to contribute a minimum percentage of the premium on behalf of workers (to encourage participation).

The advantages of group underwriting break down in certain situations. For example, when a very small employer group (e.g., 2 to 5 employees) seeks coverage, there is a possibility that the need for health care by one member of the group (e.g., a family member of the owner) is the reason that the group is seeking coverage. A health coverage provider in such a case may (if permitted by state law) charge a higher premium based on the higher risk associated with smaller groups (called a "group size factor") or review the health status of each of the members of the group in order to vary the premium for the group. The higher inherent risk in providing coverage to small employers explains in part why a risk pool with 1000 five-employee groups will be less stable (and more expensive to cover) than one employer with 5000 employees.

Health coverage providers also take steps to protect themselves from adverse selection that may not be uncovered in the underwriting process by excluding benefits for a defined period of time for the treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage. For example, if a person seeks benefits for a chronic condition within a few months of enrolling for coverage, the health coverage provider may investigate to determine if the condition was diagnosed (or apparent) within a defined period prior to enrollment. If the health coverage provider determines that the condition was diagnosed (or apparent), it may exclude coverage of the preexisting medical condition for a defined period of time. Treatments for other medical conditions would not be affected by the

> ***Preexisting medical condition**: This is an illness or medical condition for which a person received a diagnosis or treatment within a specified period of time prior to becoming insured under a policy.*

exclusion. As discussed below, state and federal law substantially circumscribes the applicability of preexisting condition exclusions.

3. Regulation of Private Health Coverage

This section describes the basic regulatory framework for private health coverage under state and federal laws.

Understanding how private health coverage is regulated is complicated by the overlapping state and federal requirements for health coverage arrangements. States generally regulate the business of insurance, including health insurance. States license entities that offer private health coverage and have established laws that control the legal structure of insurers, their finances, and their obligations to the people that they insure. At the same time, a number of federal laws also regulate private health coverage. The most important of these laws, the Employee Retirement Income Security Act of 1974 (ERISA), establishes standards for employee benefit plans (including benefit plans providing medical care) established or maintained by an employer or an employee organization (i.e., a union). Since the vast majority of Americans with private health coverage receive it through employee benefit plans, understanding the interaction between federal and state laws is essential to understanding how private health coverage operates.

Unfortunately, this interaction is messy. In some cases, ERISA requirements coexist with state law and, in other cases, ERISA requirements preempt state law. And, precisely when ERISA preempts state laws is still the matter of much litigation, even though ERISA was passed over 30 years ago. Important interactions between state and federal law also occur under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This section begins with a general description of how states regulate health insurance and continues with a general description of the applicable provisions of ERISA and HIPAA and their interaction with state law and state oversight of state-licensed health insuring organizations.

State Regulation of Health Insurance

The regulation of insurance has traditionally been a state responsibility. In 1945, Congress enacted the McCarran-Ferguson Act,[iv] which clarified federal intent that states have the primary role in regulating the business of insurance.[2]

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[2] The McCarran-Ferguson Act was enacted in response to the U.S. Supreme Court's decision in *United States* v. *South-Eastern Underwriters Assn*., 322 U.S. 533 (1944), which held that insurers that conducted a substantial part of their business across state lines were engaged in interstate commerce and thereby were subject to federal antitrust laws. State and industry concern over the effect of the decision on state authority over insurance lead Congress to pass the McCarran-Ferguson Act to restore the primary role of states in regulating the business of insurance. See *United States Department of Treasury v. Fabe*, 508 U.S. 491, 499 (1993).

State regulation of health and other insurance starts with the licensing of entities that sell insurance within the state. The licensing process reviews the finances, management, and business practices of the insuring entity to evaluate whether it can provide the coverage that is promised to policyholders. States establish requirements for state-licensed health insuring organizations in a number of areas to protect the people that they cover. States also license the insurance producers (e.g., agents, brokers) who sell health insurance within the state.

***Minimum capital requirements**: These are requirements of state law that set a minimum amount of net worth that an insuring organization must have in order to operate. This minimum amount must be unencumbered – i.e., it must be available to pay for claims. The amount varies with the type of insurance that is being sold by the insurer (e.g., life, health, auto, workers compensation). Relatively recent state laws establishing "risk-based" capital requirements relate minimum capital requirements to insurers' risk exposure and business practices. For example, an HMO may have lower minimum capital requirements than an indemnity health insurer because the HMO has additional tools to manage risk.*

The discussion below describes the types of insurance laws that states have typically enacted, though the content and extent of regulation in these areas varies among the states, sometimes significantly.

Financial Standards

State financial standards include requirements for minimum capital, investment practices, and the establishment of claims and other reserves. States require state-licensed health insuring organizations to submit quarterly and annual financial statements, and also perform periodic on-site financial examinations to ensure that state-licensed health insuring organizations remain financially viable.

Market Conduct

State market conduct standards include requirements relating to claims practices, underwriting practices, advertising, marketing (including licensing of insurance producers), rescissions of coverage, and timely payment of claims. States generally have laws giving them authority to address unfair trade and unfair claims practices, and perform periodic market conduct examinations of state-licensed health insuring organizations to review business practices.

***Guaranty fund**: This is a funding mechanism established under state law to pay the claims of insurers that become insolvent. The funds to pay claims generally are provided by assessing other insurers that provide coverage in the state.*

Policy Forms

Policy forms are the pieces of paper that establish the contractual relationship between the health insuring organization and the purchaser. State standards for policy forms address the content of the form -- including required and prohibited contract provisions and standard definitions and terminology -- as well as how they are issued to purchasers. In some cases, states review or approve policy forms, although these practices vary by type of purchaser and by state.[v] States most often review or approve policies that are offered directly to consumers or to small employers; larger purchasers are presumed to be sophisticated buyers that need less protection.

> ***Policy form**: This is a representative contract of the policies that health insuring organizations offer to policyholders. Health insuring organizations will have different policy forms representing different configurations of benefits and different types of customers (e.g., individuals or small groups). In some states, health insuring organizations have to file the policy forms that they offer to certain types of customers with the insurance department.*

Access to Coverage and Required Benefits

State standards relating to access address when, and on what terms, state-licensed health insuring organizations must accept an applicant for coverage. Most states have laws that require state-licensed health insuring organizations to provide coverage to small employers that want it, with some limitation on the rates that can be charged (e.g., restrictions on how premiums can vary based on age and health status). Fewer states apply these types of rules to the individual insurance market, where people buy coverage on their own rather than through an employer. Federal law also includes requirements for access to coverage, as discussed under HIPAA below.

> ***Guaranteed issue or guaranteed availability of coverage**: This is a requirement that insurers accept specified applicants for coverage, generally without regard to their health status or previous claims experience. For example, health insuring organizations generally are required by state and federal law to issue coverage to small employers that apply. Separate provisions of law generally address the extent to which health insuring organizations can vary premiums based on health status, claims experience, or other factors.*

All states also have laws that require state-licensed health insuring organizations selling health coverage to offer or include coverage for certain benefits or services (known as “mandated benefits”), including items such as mental health services, substance abuse treatment, and breast reconstruction following mastectomy. The number and type of these mandates varies considerably across states. Federal law also includes certain mandated benefits, as discussed under HIPAA below.

State standards also address the ability of state-licensed health insuring organizations to offer restricted coverage to people with preexisting health problems. As discussed above, health coverage providers generally exclude benefits for a defined period of time for treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage. States set standards for how these limitations can be structured, and generally limit the application of such exclusions under group policies when people are switching from one health coverage to another (often called "portability" protection). Federal law also ensures this type of portability, as discussed under HIPAA below.

Premiums

State standards for premiums address the cost of insurance to consumers, both initially and when coverage is renewed. The degree of regulation varies by type of purchaser and by state. For health coverage offered directly to individuals, many states establish minimum loss ratios (the percentage of premium that must be paid out in claims rather than for administrative costs or profits) and also reserve the right to review or approve the rates submitted by state-licensed health insuring organizations.[vi] State standards generally require that rate variations (e.g., variations due to age, gender, location) be actuarially fair (meaning that they are based on true variations in health costs). Some states further limit the rights of insurers to vary premiums for individual policyholders by age or health status (often referred to as "rate band" or "community rating"). Health coverage sold to small employers also is regulated, but the regulation tends to focus more on limiting the extent to which the rates offered to a small employer can reflect the claims experience or health status of workers in the group.

***Loss ratio**: This is the ratio of benefits paid to premiums. Loss ratios can be calculated for a particular policy form, for a line of business (e.g., small group health insurance), or a health insuring organization's overall business. Minimum loss ratios for established by law or regulation typically apply to a policy form.*

***Rate bands**: These are laws that restrict the difference between the lowest and highest premium that a health insuring organization may charge for the same coverage. For example, a rate band may specify that the highest rate a health insuring organization may charge for a policy may be not more than 150 percent of the lowest rate charged for the same policy. The rate bands may limit all factors by which rates vary (e.g., age, gender), or may apply only to specified factors, such as health status or claims experience.*

***Community rating**: This is a rating method under which all policyholders are charged the same premium for the same coverage. "Modified community rating" generally refers to a rating method under which health insuring organizations are permitted to vary premiums for coverage based on specified demographic characteristics (e.g., age, gender, location) but cannot vary premiums based on the health status or claims history of policyholders.*

Renewability

Health coverage is generally provided for a limited period (typically one year), and state requirements address the extent to which a purchaser has a right to renew the policy for another year without being reevaluated for coverage. Federal law also is important in this area, and is discussed under HIPAA, below.

> ***Guaranteed renewability**: This is a provision of an insurance policy or law which guarantees a policyholder the right to renew their policy when the term of coverage expires. The health insuring organization generally is permitted to change the premium rates at renewal.*

State standards also address the ability of individuals covered under group policies to continue coverage if the group policyholder cancels the coverage or the person is no longer part of the group. Standards in some states permit these people to continue coverage or to convert to individual insurance in some instances. The requirements for terms of coverage and rates vary substantially across states. Federal law (often referred to as "COBRA" continuation) provides similar protection to individuals with employer-sponsored coverage, as discussed under ERISA, below.

HMOs, Managed Care, and Network Arrangements

States for many years have had separate standards for HMOs, recognizing their dual roles as providers and insurers of health care. State HMO standards, in addition to addressing typical insurance topics such as finances, claims administration, policy forms, and minimum benefits, also establish standards that affect HMOs as entities that directly deliver health care and closely manage the health care use of those they insure. Such state standards include requirements relating to the establishment of utilization review and quality assurance programs, the establishment of enrollee grievance processes, and the contents of contracts with participating health care providers.

As the use of managed care has proliferated among non-HMO state-licensed health insuring organizations (e.g., insurers offering PPO-type coverage), and as managed care practices have become more controversial with the general public, states have extended HMO-type standards to other entities offering managed care and have generally increased their regulatory scrutiny in this area. Standards relating to network adequacy (e.g., the number, location, and types of physicians), utilization review practices, credentialing of participating health care providers, and quality assessment and improvement have recently been adopted in a number of states.

Complaints, Remedies, and Appeals

States also have laws and regulations that assist people who do not receive the benefits that they believe are covered under their health plans. States receive consumer complaints, and in some cases are able to act as intermediaries to resolve specific conflicts between consumers and health coverage providers. The receipt of a

large number of complaints about a particular health coverage provider also may alert regulators to more pervasive market conduct abuses and trigger a broader review of marketing or claims practices.

State law also generally permits people who feel aggrieved by a state-licensed health coverage provider to seek redress through a lawsuit. Such suits may be brought under the contract for coverage, tort, or in some cases under special state insurance laws (such as unfair claims practices laws). For example, HMOs and other managed care arrangements may be sued under state medical malpractice laws if their delivery of health care does not meet ordinary standards of care. Under state law, a person covered by a health insurance policy also generally can sue the insurer if benefits are not delivered as promised and the failure to deliver the benefits was negligent and the proximate cause of the person's injury. In some cases where the aggrieved person is covered under an employee benefit plan, however, ERISA preempts the person's right to bring certain types of lawsuits. This interaction between state and federal law is discussed in more detail under ERISA, below.

In the last few years, most states have adopted standards that provide for an independent, external party to review certain benefit decisions made by state-licensed health coverage providers. For example, these states permit a covered person to appeal a decision by a health coverage provider that denies a benefit because it was not medically necessary or because it was experimental. The types of claims that are subject to review, who the reviewers are, and the procedures for requesting a review vary substantially across the states. There also is a question as to whether ERISA preempts state external appeal laws as they apply to benefit decisions for people covered under an employee benefit plan (as discussed under ERISA, below).

Federal Laws Governing Health Insurance

Although the business of insurance is primarily regulated by the states, a number of federal laws contain requirements that apply to private health coverage, including ERISA, HIPAA, the Americans with Disabilities Act, the Internal Revenue Code, the Civil Rights Act, the Social Security Act (relating to private coverage that supplements Medicare), and the Gramm-Leach-Bliley Act (relating to financial services and bank holding companies). The discussion below focuses on two of these laws, ERISA and HIPAA, because of the significant impact that they have on the structure of private health coverage. Other Federal laws that affect private health coverage are then discussed.

ERISA (Employee Retirement Income Security Act)

ERISA[vii] was enacted in 1974 to protect workers from the loss of benefits provided through the workplace. The requirements of ERISA apply to most private employee benefit plans established or maintained by an employer, an employee organization (such as a labor union), or both (referred to here generally as "plan

sponsors"). Employee benefit plans that provide medical benefits (and other non-pension benefits) are referred to as "employee welfare benefit plans."

ERISA does not require employers or other plan sponsors to establish any type of employee benefit plan, but contains requirements applicable to the administration of the plan when a plan is established. Thus, employers remain essentially free to decide if they want to offer health benefits at all and, if so, what level of benefits and the amount of coverage they will provide.

The important requirements for employee welfare benefit plans include:

Written document. ERISA requires that an employee benefit plan be plan be established and maintained pursuant to a written document, which must provide for at least one "named fiduciary" who has authority to manage and administer the plan.

> ***Fiduciary**: This generally refers to a person who manages funds or benefits for another. A fiduciary acts in a position of trust and generally is required to act in the best interests of the beneficiary. Under ERISA, a fiduciary is a person who exercises discretion or control in the management of an employee benefit plan or in the management or disposition of the assets of an employee benefit plan.*

Disclosure requirements. ERISA requires the administrator of an employee welfare benefit plan to provide a summary plan description (SPD) to people covered under the plan (called participants and beneficiaries). The SPD must clearly inform participants and beneficiaries of their benefits and obligations under the plan and of their rights under ERISA. The SPD must include information about how to file a claim for benefits and how a denial of a claim can be appealed.

Reporting requirements. ERISA requires administrators of certain employee benefit plans to file annual reports describing the operations of the plan. Reports are filed with the Internal Revenue Service, which forwards the information to the Department of Labor. Certain types of employee welfare benefits plans (e.g., those with fewer than 100 participants and are self-funded, fully insured, or both) are not required to file a report.

Fiduciary requirements. ERISA establishes standards of fair dealing for "fiduciaries" who exercise discretion or control in the management of an employee benefit plan or in the management or disposition of the assets of an employee benefit plan. ERISA fiduciaries may be corporate entities or individuals and may include, for example, plan trustees, plan administrators, or members of a plan's investment committee. ERISA requires that employee benefit plans have at least one "named fiduciary" who is responsible for

administration and operation of the plan. The plan documents may designate additional fiduciaries.

ERISA requires plan fiduciaries to carry out their responsibilities "solely in the interest of (plan) participants and beneficiaries and for the exclusive purpose of providing benefits . . . and defraying reasonable expenses of administering the plan."[viii] ERISA also requires plan fiduciaries to act with the same skill, care, prudence, and diligence that a prudent person would use in like circumstances, and to carry out their responsibilities in accord with the lawful provisions of the plan documents.

Claims for benefits. ERISA requires employee benefit plans to maintain procedures for claiming benefits under the plan and to inform participants and beneficiaries of the procedures. Employee benefit plans must also have a procedure permitting participants and beneficiaries to appeal a denial of benefits to a fiduciary. Department of Labor regulations made substantial changes to requirements for these procedures, including minimum standards for claims procedures, processes for appeal of denied claims, timeframes for plans to make decisions on claims for benefits and on appeals of denials of claims, and greater disclosure of information by insurers to claimants, effective for plan years after July 2002.[ix]

Remedies and enforcement. ERISA contains civil enforcement provisions that permit participants and beneficiaries to bring actions to obtain benefits due to them under an employee benefit plan, for redress of fiduciary breaches, to stop practices that violate ERISA or the provisions of the employee benefit plan, or for other appropriate equitable relief. Courts may award reasonable costs and attorney fees to participants and beneficiaries who prevail. ERISA does not, however, provide a remedy to recover economic or non-economic (e.g., pain and suffering) damages that may result from improper claims denials, fiduciary breaches, or other improper acts. ERISA also contains other civil and criminal penalties for violations of its provisions.

Continuation coverage. As amended by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), ERISA requires plan sponsors that employ 20 or more employees to offer continuation coverage to qualified beneficiaries (including dependents) who lose health coverage under an employee benefit plan for certain specified reasons (e.g., death of an employee, termination of employment, divorce, or legal separation). ERISA requires the plan sponsor to notify individuals of their right to continuation coverage and addresses the benefits that must be offered, the period that qualifying individuals are eligible for continuation coverage, and premium that they must pay.

ERISA Interaction With State Law

How ERISA interacts with state law is quite complex and has generated numerous court cases which, in the absence of clarifying federal legislation, have determined whether federal or state law pertains to employee benefit plans. As a general matter, ERISA preempts state laws that would regulate the operation of employee benefit plans, affecting several aspects of the regulation of these plans.

ERISA contains an express provision that preempts state laws that "relate to" an employee benefit plan.[x] In applying the term "relates to," courts have looked to whether the state law in question has a "connection with or reference to" an employee benefit plan.[xi] [3] For example, state laws that prohibited garnishment of benefits provided under an employee benefit plan or that required employers to maintain existing health coverage for employees who are eligible for workers compensation benefits have been found to be preempted by ERISA.[xii] State laws of general applicability, however, are not preempted merely because they impose some burdens on an ERISA plan. For example, a state law that imposes a surcharge on hospitals bills was found not to be preempted as applied to hospitals owned by an employee benefit plan.[xiii]

The ERISA preemption provision has an exception that saves from preemption those state laws that regulate insurance. This "saving" provision permits states to continue to apply their insurance laws to insurers, including state-licensed health insuring organizations, even when they provide coverage to or under an employee benefit plan. State insurance laws can be saved because, in the case of plans that buy insurance as opposed to self funding, the state laws regulate the insurance products sold to the ERISA plans, rather than the plans themselves.

The saving clause thus allows states to set standards for ERISA-governed employer-sponsored health benefits in those situations in which employers buy health insurance rather than buying just the administrative services of a health benefits services company for their self-funded plans. For example, state laws that mandate the inclusion of certain benefits in health insurance contracts are saved from preemption, even though application of the law affects the benefits provided under an employee benefit plan.[xiv] Similarly, a state insurance law that prohibits insurers from automatically denying a claim for benefits because it is not filed in a timely manner is saved from preemption because the law regulates insurance, even though the application of the law affects the administration of an employee benefit plan.[xv] A state law requiring managed care plans to permit all willing providers to participate in their networks is saved from preemption by applying the standards of whether the state law is specifically directed toward the insurance industry and whether is substantially affect the risk-pooling

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[3] The U.S. Supreme Court expressed concern about the unhelpful nature of the preemption language in ERISA, and has stated that in looking at whether a state law is preempted it "must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurer. Co.,* 514 U.S. 645, 656 (1995).

arrangement between the insurer and the insured.[xvi] State laws that simply apply to insurers, however, but which do not primarily regulate the business of insurance, are not saved from preemption.

Although the ERISA preemption provision saves state laws that regulate insurance, ERISA prohibits states from "deeming" employee benefit plans to be insurers. This provision prohibits states from treating employee benefit plans (i.e., self-funded employee plans) as insurers and attempting to regulate them directly under their insurance laws.[xvii]

As a practical matter under ERISA, states can continue to regulate the insurance activities of state-licensed health insuring organizations that provide health coverage to an employee benefit plan established by an employer or other plan sponsor. States generally cannot, however, regulate the content or activities of self-funded employee benefit plans. States also cannot indirectly regulate the practices of employee benefit plans by trying to regulate how third parties, including state-licensed health insuring organizations, provide administrative services to self-funded employee benefit plans. As an example, states can require insurance companies and HMOs to include coverage for specified benefits (e.g., mental health services) in the policies they sell. Any employer or individual purchasing insurance coverage would therefore have to purchase a policy that included those benefits. States cannot, however, require self-funded employer plans to offer any specified benefits.

Another area of ERISA preemption involves the civil remedies available to participants and beneficiaries relating to a claim for benefits. As discussed above, ERISA provides a limited set of civil remedies to participants and beneficiaries. The courts have determined that these remedies are the exclusive remedies available to participants and beneficiaries to contest a denial of benefits under an employee benefit plan. State laws that provide for causes of action against the administrator or another fiduciary of an employee benefit plan (e.g., for breach of contract or tort) are preempted if they could have been brought under the civil enforcement provisions of ERISA.[xviii] The Supreme Court has determined that "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted."[xix] [xx]

HIPAA (Health Insurance Portability and Accountability Act)

A second federal law that established important regulatory requirements for private health coverage is HIPAA, enacted in 1996. HIPAA was motivated by concern that people face lapses in coverage when they change or lose their jobs. As discussed above, health coverage providers often exclude benefits for preexisting health conditions for new enrollees. HIPAA also addressed other concerns of federal policymakers about private health coverage.

HIPAA and related standards address several areas, including: portability, access to coverage, renewability, nondiscrimination, and mandated benefits. The standards established by HIPAA vary by market segment (e.g., large group, small group, or individual coverage) and by type of coverage provider. HIPAA creates separate but similar standards for state-licensed health insuring organizations and employee welfare benefit (i.e., ERISA) plans. Generally, the provisions applicable to employee welfare benefit plans and plan sponsors are incorporated into ERISA and into the Internal Revenue Code, and the provisions applicable to state-licensed health insuring organizations are incorporated into the Public Health Service Act. In addition, the HIPAA standards that create individual rights (e.g., portability) and that are applicable to state-licensed health insuring organizations providing health coverage to employee benefit plans also are incorporated into ERISA and the Internal Revenue Code. Three federal agencies – the U.S. Departments of Labor, Health and Human Services, and Treasury -- coordinate rulemaking under HIPAA.[xxi]

Preexisting condition exclusions and portability. As discussed above, some private health coverage excludes benefits for treatment of preexisting medical conditions for defined period of time after initial enrollment. HIPAA requires state-licensed health insuring organizations providing group coverage and employee welfare benefit plans providing health benefits to limit preexisting condition exclusion periods to no more than 12 months (18 months for late enrollees unless they enroll under special circumstances). The preexisting condition exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before the enrollment date. For eligible individuals leaving group coverage for another group plan, any preexisting condition exclusion period must be reduced by the number of days that a newly enrolling person was previously covered by public or private health coverage; the time between lapse of the previous coverage and enrollment in the new coverage must be shorter than 63 days.

Access to coverage. HIPAA requires state-licensed health insuring organizations to make all of their small group products available to any qualifying small employer that applies, regardless of their claims experience or of the health status of their employees. Under HIPAA, a small employer is defined as having 2 to 50 employees. HIPAA does not have standards for the premium that can be charged to small employers seeking coverage, although, as discussed above, most states have laws that limit rate variation in the small group market.

HIPAA also requires state-licensed health insuring organizations to accept certain people leaving group health coverage for coverage in the individual market regardless of their health status and without any exclusion period for preexisting medical conditions. To be eligible, the person must not be eligible for other public or private health coverage, must have been previously covered for a period of at least 18 months, must apply for the individual coverage within 63 days of leaving the group coverage, and must have exhausted any federal or state continuation rights under their group policy. States are provided substantial

flexibility in determining the mechanism for making coverage available to eligible people. For example, in most states, eligible people are guaranteed access to coverage in the state's high-risk pool; private insurers are not required to sell coverage to them. HIPAA generally does not regulate the premiums that people can be charged for the coverage that is offered under HIPAA.[xxii]

Renewability. HIPAA requires state-licensed health insuring organizations and certain employee benefit plans that provide benefits to multiple employers to guarantee that the coverage can be renewed at the end of the period of coverage. This protection generally means that group (either small or large) or individual coverage cannot be terminated by the health coverage provider except in cases such as nonpayment of premium and fraud. HIPAA, however, does not have standards for the premiums that may be charged at renewal.

Nondiscrimination. HIPAA prohibits state-licensed health insuring organizations providing group coverage and employee welfare benefit plans providing health benefits from considering the health status of a member of the group in determining the member's eligibility for coverage, premium contribution, or cost-sharing requirements. Final 2006 rules clarified the exception for wellness programs (programs of health promotion or disease prevention), specifying the circumstances under which wellness programs can discriminate based on health status-related factors.[xxiii] A more recent clarification provided that supplemental coverage (including benefits under a wellness program, such as a reduced premium for nonsmokers) cannot discriminate on the basis of health factors unless specified criteria are met.[xxiv]

HIPAA was structured in a way that reasonably clearly delineates the state and federal roles in enforcing its standards. As described above, HIPAA standards applicable to employee welfare benefit plans and plan sponsors are incorporated into ERISA and the Internal Revenue Code, and are enforced by the U.S. Departments of Labor and Treasury. Standards applicable to state-licensed health insuring organizations generally are incorporated into the Public Health Services Act, and are under the jurisdiction of the U.S. Department of Health and Human Services (DHHS).[4] HIPAA provides however, that if a state's law establishes standards for state-licensed health insuring organizations that are at least as stringent as the HIPAA standard, the state is the primary enforcer of the standard, with DHHS having authority to enforce the standard if the state does not. Where a state's laws do not contain a standard at least as stringent as the HIPAA standard, enforcement falls to DHHS.

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[4] As discussed above, standards for some HIPAA provisions applicable to state-licensed health insuring organizations providing coverage to employee benefit plans also are incorporated in ERISA, and individuals may bring actions under ERISA to enforce those standards.

Although HIPAA establishes generally clear federal and state enforcement responsibilities, in practice there have been some difficulties. The test for when a state assumes enforcement responsibility is conducted separately for each different standard under HIPAA, which can lead to a patchwork of federal and state enforcement responsibilities.[xxv] This is most problematic for federally-mandated benefits.

Other Federal Laws That Affect Private Health Coverage

Other federal laws require health coverage providers to cover certain benefits as part of their benefit arrangements. Although enacted separately from HIPAA, the following benefit requirements are incorporated into the same legal framework as the HIPAA standards, and include the following: (1) the Women's Health and Cancer Rights Act requires group health coverage providers that provide coverage for mastectomies to also cover breast reconstruction surgery following a mastectomy;[xxvi] (2) the Newborns' and Mothers' Health Protection Act prohibits group health coverage providers from restricting hospital stays following childbirth to less than 48 hours (or 96 hours following delivery by cesarean section),[xxvii] and (3) the Mental Health Parity Act restricts the ability of group health plans sponsored by employers with more than 50 employees to impose annual and lifetime dollar limits for mental health benefits that are more stringent than for medical and surgical benefits.[xxviii] The Pregnancy Discrimination Act amends the Civil Rights Act to require that any health insurance an employer provides must cover expenses for pregnancy-related conditions on the same basis as costs for other medical conditions.[xxix] The Americans with Disabilities Act also amends the Civil Rights Act to prohibit discrimination solely on the basis of disability; employers are prohibited from such discrimination in many job-related aspects including employee compensation; however, the Act's requirements for insurers and their insurance products are less clear, allowing insurers to classify, underwrite, or administer health risks based on sound actuarial principles or experience.[xxx]

4. Conclusion

Health coverage is subject to significant requirements at both the state and federal level. While new laws and regulations have created important protections for consumers, they have also produced overlapping and sometimes duplicative or conflicting state and federal rules.

Continued interest by policymakers in expanding access to health care and to health care coverage may lead policymakers to revisit current regulatory standards. For example, proposals to provide federal tax credits for people purchasing individual health insurance are likely to prompt discussion of how to permit people in poorer health to have access to private individual coverage so that they can make use of the tax credit. As some state policymakers have discovered in addressing this issue, it will be a challenge to find ways to expand access to those in poorer health without undermining the stability of risk pools in this market.

As federal policy issues increasingly focus on regulation or expanded use of the private health insurance market, there will be greater need for policymakers to understand how this market functions and how state and federal rules interact.

This primer was written by Gary Claxton and updated by Janet Lundy of the Kaiser Family Foundation's Health Care Marketplace Project.

Endnotes

[i] Kaiser Family Foundation, *The Uninsured—A Primer*, October 2007, Table 3, p. 32, http://www.kff.org/uninsured/upload/7451-03.pdf.
[ii] Ibid.
[iii] National Association of Insurance Commissioners, "Departmental Regulation of HMOs" in *Compendium of State Laws on Insurance Topics*, 2000.
[iv] 15 U.S.C. 1011-1015.
[v] National Association of Insurance Commissioners, "Filing Requirements Health Insurance Laws Forms and Rates" in *Compendium of State Laws on Insurance Topics*, 2000.
[vi] Ibid.
[vii] 29 U.S.C. 1001 *et seq.*
[viii] 29 U.S.C. 1104(a).
[ix] 29 C.F.R. 2560.503-1 (also see *Federal Register*, Vol. 65, No. 225, November 21, 2000, pp. 70246-70271, and *Federal Register*, Vol. 66, No. 131, July 9, 2001, pp. 35886-35888).
[x] 29 U.S.C. 1144.
[xi] Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983).
[xii] District of Columbia v. Greater Washington Bd. of Trade, 506 U.S. 125 (1992).
[xiii] De Buono v. NYSA-ILA Medical and Clinical Services Fund, 520 U.S. 806 (1997).
[xiv] Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985).
[xv] Unum Life Insurer. Co. of Am. V. Ward, 526 U.S. 358 (1999).
[xvi] Kentucky Assn. of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003).
[xvii] Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1984).
[xviii] Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987).
[xix] Cicio v. Does, 385 F.3d 156 (2004), at 158, quoting Aetna Health Inc. v. Davila, 542 U.S. 200 (2004).
[xx] The Supreme Court has determined that state insurance laws that allow participants in insured plans to appeal to external review bodies to get an independent opinion regarding a claim that was denied are considered not to create additional remedies beyond those allowed by ERISA and therefore are not preempted by ERISA (Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002). Participants seeking such independent reviews would still have rely on the remedies under ERISA if a plan did not comply with a reviewer's external review determination.
[xxi] The HIPAA provisions incorporated into ERISA may be found at 29 U.S.C. 1181 et seq.; the provisions incorporated into the Internal Revenue Code may be found at 26 U.S.C. 9801 et seq.; the provisions incorporated into the Public Health Service (PHS) Act may be found at 42 U.S.C. 300gg et seq. Regulations issued by the Departments of Labor, the Treasury, and Health and Human Services on group market provisions are contained in 29 C.F.R Part 2590, 26 C.F.R Part 54, and 45 C.F.R Parts 144 and 146; reforms provided in the PHS Act for the individual market are contained in 45 C.F.R Parts 144 and 148. For the most recent regulations on portability, see *Federal Register*, Vol. 69, No. 250 (December 30, 2004), 78720-78799, http://www.dol.gov/ebsa/regs/fedreg/final/2004028112.pdf ; for the most recent rules on nondiscrimination and wellness programs, see *Federal Register*, Vol. 71, No. 239 (December 13, 2006), 75014-75055, http://www.dol.gov/ebsa/regs/fedreg/final/2006009557.pdf.
[xxii] General Accounting Office, *Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, and Regulators,* GAO/HEHS-98-67 (February 1998) and *Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards* (GAO/HEHS-99-100 (May 1999)10-16.
[xxiii] *Federal Register*, Vol. 71, No. 239 (December 13, 2006), 75014-75055, http://www.dol.gov/ebsa/regs/fedreg/final/2006009557.pdf.
[xxiv] U.S. Department of Labor, Employee Benefits Security Administration, Field Assistance Bulletin No. 2007-04, "Supplemental Health Insurance Coverage as Excepted Benefits Under HIPAA and Related Legislation," (December 7, 2007), http://www.dol.gov/ebsa/pdf/fab2007-4.pdf.
[xxv] *See* General Accounting Office, *Implementation of HIPAA: Progress Slow in Enforcing Federal Standards in Nonconforming States,* GAO/HEHS-00-85 (March 2000) and *Private Health Insurance: Federal Role in Enforcing New Standards Continues to Evolve*, GAO-01-652R (May 7, 2001.
[xxvi] The Women's Health and Cancer Rights Act of 1998 (Title IX of P.L. 105-277).
[xxvii] The Newborns' and Mothers' Health Protection Act of 1996 (Title VI of P.L. 104-204).
[xxviii] The Mental Health Parity Act of 1996 (Title VII of P.L. 104-204, most recently extended by P.L. 109-432).
[xxix] The Pregnancy Discrimination Act of 1978 (P.L. 95-555).
[xxx] The Americans with Disabilities Act of 1990 (P.L. 101-336). See J. Mathis, Bazelon Center for Mental Health Law, "The ADA's Application to Insurance Coverage," June 2004, http://uacf4hope.org/index2.php?option=com_content&do_pdf=1&id=257.

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