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OUT-OF-STATE TRUSTS AND THE POTENTIAL DEMISE OF THE INDIVIDUAL INSURANCE MARKET

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Abstract: Group and individual health insurance coverage differ. Group coverage is federally regulated and involves large groups of healthy individuals whose insurance is typically provided through an employer. Individual insurance is more costly, is regulated, often quite strictly, by each state and involves a diverse and fluid set of individuals, including many who are unhealthy. By domiciling in states with relatively little regulation, while operating in states with strict regulation of insurers domiciled within the state, organizations such as out-of-state-trusts can avoid consumer protection mandates and compete unfairly with in-state individual insurers. New public policy models are needed to correct this threat to the individual health insurance market.

Introduction

In an era of increasing health insurance premiums, regulatory requirements, and benefit mandates, insurers are searching for opportunities to become more affordable and competitive in an uncertain healthcare marketplace.[1,2] While this is true in the health insurance market in general, it is especially true within the weak, and somewhat volatile, individual market.

Contributing to this volatility is the fact that the individual market is relatively small compared to that of group health insurance, with over 65% of Americans under age 65 having employer-sponsored insurance and less than 10% percent relying on private, individual health insurance.[3] Although this may appear to be a fairly small segment of the market, individuals with this latter type of coverage are typically not eligible for other forms of health insurance such as group coverage, Medicaid or Medicare; so individual health insurance fills an important niche in the health coverage market.

The individual market typically covers a fluid and quite diverse set of persons while group coverage is typically offered to employers with a relatively homogenous, healthy workforce. Some persons seeking individual coverage may work for an employer that does not offer health insurance, while others may be early retirees, unem-

ployed, or dependants of those with group coverage. Others may have lost group coverage due to a change in their employment status. Individual purchasers are also characteristically a much more heterogeneous group compared to those covered by large group plans, resulting in premiums for some to be higher relative to those associated with group coverage.

While the heterogeneity characteristic of the individual market presents many challenges to the affordability of health insurance, business practices can also contribute to the volatility and affordability of premiums. States implement rules and regulations in an attempt to provide stability to this market. Each state regulates the individual market in different ways, with some, more than others, opting for regulation of eligibility, premiums and benefit mandates.

One of the most problematic aspects of this market stems from the practice of certain health insurers to avoid state regulation and mandates. They achieve this by domiciling in one state, and then marketing and offering coverage to individuals in a more regulated state.[4] This allows these insurers to gain a competitive advantage over the domiciliary insurers by freely entering and exiting a particular state's marketplace. We call these insurers "out-of-state trusts" (OSTs), and will show how the growth of OSTs can potentially harm consumers in some states and lead to the collapse of their individual health insurance market.

Background

Comparison of Individual with Group Health Insurance - We define individual health insurance as insurance plans that are not attached to a business or sponsored by an employer or other group, and are issued directly to the policyholder. Alternatively, group insurance is a health services contract or insurance policy that covers a group of persons, usually employees of a business or other entity. The majority of Americans obtain their health coverage through an employment-based group.[5] This coverage may also include an employee's family members within one contract with which the policyholder's employer provides or sponsors.

Within a group arrangement, health insurance is usually much more affordable than that purchased by the individual because employers receive a federal tax benefit if they fund all or part of their employees' health insurance. Plus, in most cases, the value of the full premium can be excluded from an employee's taxable income. Individual health insurance purchasers do not receive this same type of employer subsidy. Also unlike participants in group markets, individuals must pay the full cost of their health insurance premium and, under current federal tax law, can claim an itemized tax deduction only if premiums and out-of-pocket expenses exceed 7.5% of adjusted gross income.[6] Therefore, those who are not self-employed typically pay individual health insurance with after-tax dollars.

When employers purchase group health insurance for their healthy employees, they are, in effect, cross-subsidizing those employees that are considered to be sicker or "higher-risk" since premiums are determined by the risks associated with the group of beneficiaries as a whole. Unlike individual coverage, most group insurance is issued without a medical examination or other evidence of individual insurability. The insurer understands that as groups become larger it can insure enough individuals to balance those in poor health against those in good health. Thus, the group purchase of health insurance by larger employers generally makes the coverage more affordable to higher risk employees.

Individual insurance purchasers typically pay a premium that more closely represents their current and projected healthcare experience--they generally pay premiums that are based on their individual health status and risk characteristics. Individual coverage is medically underwritten, meaning that the insurance company gathers health information on the proposed insured and determines the individual's insurability and base premiums on these data. This information can be obtained from questionnaires, doctor and hospital records, and/or medical examinations. The risk of individual health insurance is not spread over a large group of individuals, resulting in individual purchasers often experiencing higher and more volatile premiums for either the same or even less generous benefits than those obtained by large employer group purchasers.

As a result, the decision making process is different for a person who is purchasing coverage within the individual market compared to an employer-based purchase. Relative to those participating in employer-sponsored coverage, individual purchasers compare the cost of coverage with the value of the benefits that are offered and often make economic decisions that benefit their personal financial performance.[7] As a result,

they may choose the least costly policy offered, often trading fewer benefits for lower cost.

Regulation of Individual and Group Health Insurance - Both group and individual health insurance coverage are regulated, albeit in different ways. Because of the federal McCarran-Ferguson Act of 1945 (P.L. 79-15), almost all health insurance is regulated at the state level, except for employer-sponsored group insurance coverage, which is federally regulated.[8] Individual health insurance coverage is subject to different regulations and mandates than insurance that is sponsored by employers, and is typically and almost exclusively, regulated at the state level.[9] Regulation for individual coverage often includes benefit mandates that require insurers to design their products in a particular way. Federal regulation of large group coverage, on the other hand, tends to have far fewer benefit mandates and requirements.

Since 1983, state governments have passed over 800 mandates designed to correct perceived or actual inadequacies within the health insurance market. Such mandates are requirements that an insurance company offer specified benefits within its insurance plan. Some states have proposed and implemented significantly fewer mandates than others. States such as Delaware, Connecticut, Idaho, and Wyoming, have enacted far fewer mandates on health insurers relative to other states such as California, Maryland, Florida, and New York.[10] While Massachusetts enacted the first health insurance mandate in 1956, it does not rank first in total number of mandates. Maryland and Florida respectively rank first and second in the number of mandated health insurance benefits. While there are a number of reasons why state governments seek these types of interventions, the following four reasons appear to be the most prevalent:

First, consumers may have mistakenly undervalued their need for some types of health benefits. Mandates may then cause these benefits to be offered, thus informing the public and increasing the demand for these previously undervalued benefits.

Second, there may be selection of certain types of expensive, relatively rarely used health coverage options, such as maternity or infertility treatment. A mandate may be employed to improve the affordability of coverage for these options by spreading their cost over a larger population including individuals who will not need or use such options.

Third, mandates may serve the political interests of state legislators, regulators and policy makers. For example, mandates enable them to broaden the protection of society and meet the needs of certain constituents or interest groups without directly raising taxes.

Fourth, mandates may also serve to shift the cost of state-funded health care services, such as mental health care, to the private sector. State funding is then available to spend on politically popular agenda items.

While an individual's personal health care experience influences the premium he or she will ultimately pay, there are also other factors that affect a person's premium. Health insurance mandates tend to cause the cost of health insurance to rise, with a number of studies indicating that mandated benefits raise the price that individuals and employers pay for health insurance.[11] For example, one study by the National Center for Policy Analysis (NCPA) indicates that mandates are increasing the cost of health insurance by as much as 30 percent.[12] Another study found that the total cost of the state of Maryland's mandates is about 14% of premium, which was 2.1% of Maryland's average annual wage.[13]

Health insurers experience the actual cost of coverage mandates in addition to the administrative cost of complying with each mandate. These costs are passed on to the consumer through higher premiums.[14] Therefore, if an insurer can avoid some or a majority of a state's coverage mandates, they can avoid the cost of complying with and implementing these mandates. As a result, insurers who avoid mandates may either lower their premiums relative to their competition or may reinvest the resulting savings back into their organizations.[15]

A concern about the inclusion of benefit mandates on health insurance is that they do not apply to all insurers, and therefore do not consistently and equitably affect coverage or costs for all insured people.[16] Insurers of most concern in this regard involve the out-of-state trusts (OSTs). Such OSTs have emerged as an alternative business model within the individual health insurance market. As noted earlier, the typical OST is a corporation, or association, which has its principal office in another state and is authorized to act as executor or administrator

of health care benefits offered in states in which it is not domiciled.

Many states allow insurers to establish OST arrangements. These arrangements typically mimic large-group plans but are actually vehicles to sell health benefits to individuals. The arrangements involve an insurer creating a legal entity, an OST, which issues a single master group policy in a similar way that employees sign up for health insurance under an employer plan. The OST then issues certificates of coverage to individuals who are enrolled in the trust group.[17] Sometimes the trust is described as a group or association that individuals join in order to obtain insurance. Sometimes these trusts have membership qualifications that are broad enough so that anyone may join. From one perspective they appear to be group coverage, but unlike group coverage the OST, like individual insurers, can underwrite individual premiums and exclude anyone from the group.

Out of State Trusts and Regulation - Insurers selling coverage to individuals have sought to avoid regulation as individual insurance by the use of group trust arrangements.[18] These trusts mimic self-funded groups but are typically exempt from individual state health insurance mandates. The opportunity to mimic self-funded plans presents a potential for OSTs to avoid the costs that are associated with mandates for which in-state insurers must comply.

> *"Specifically, 1) OSTs do not have to file and seek approval of policy forms in every state where the OSTs do business; 2) they can avoid prior rate approval by issuing the group policy in a state where this is not required; 3) they can avoid certain coverage mandates; and, 4) they pay lower premium taxes relative to instate insurers."*[19]

While state regulators have the authority to enforce their state's rules and regulations on their domiciled insurers who sell individual coverage, they may not have authority to similarly regulate OSTs. Therefore, OSTs avoid the more traditional regulatory burdens such as rate regulation, premium taxes and other health coverage mandates that apply to in-state insurers who offer individual health insurance.[20]

An insurer who seeks to develop an OST typically chooses to domicile in states with the most favorable regulatory environment since the large "group" involved can avoid regulation, except in the state where the trust is formed. As a result, OSTs tend to be domiciled in states with the least amount of state health insurance mandates, such as Wisconsin, Alabama, Delaware, Illinois, and choose to sell their insurance products in other states that require their state-domiciled insurers to comply with relatively more mandates.

These trusts then provide coverage to individuals in states with relatively more health coverage rules and regulations, but are only subject to the rules and regulations of the state in which they are domiciled. Since OSTs typically claim to be exempt from state law because they believe they fall under the same federal rules that allow employers to self-insure, they typically do not have to meet fiscal oversight and other requirements imposed by states. Therefore, OSTs believe they are subject to far fewer regulatory rules and regulations than in-state insurers.[21]These factors can create unfair competition between in-state insurers and OSTs.

Consumer Protection Implications - Since OSTs may not be regulated by the state in which they sell their products; there is greater potential for the consumer to experience unfair business practices. One such practice in which out-of-state trusts may engage is the so-called "death spiraling". Death spiraling begins when an insurer sells a certain number of policies and then closes that particular insurance pool to new members. The next group of buyers goes into a different pool. With no new individuals coming in, the first pool begins to age and average claims costs and premiums increase. As premiums increase, the healthier members switch to a cheaper policy. The individuals remaining in the first pool are sicker, so average claims costs go even higher and premiums rise again. Eventually, the sick will drop their coverage leaving only healthy or 'good risk' individuals in the OST's coverage pool.

For example, a class-action lawsuit was recently brought in Palm Beach County Circuit Court on behalf of hundreds of Florida customers accusing one OST of violating a 1997 state law that delineates the rights to new coverage for canceled policyholders. Allegedly, the OST began canceling an entire policy line and offering new health coverage to many of its Florida customers at higher rates as a means to separate healthy customers from sicker ones who posed a bigger claims risk.[22] As a result of such business practices, the sick or 'high risk' individuals will join

the pool of the state's uninsured or will seek coverage from in-state insurers under 'guaranteed issue' requirements laid out in state and federal law.

State Regulation of OSTs - In states where OSTs are 'loosely' regulated, they may be used as a vehicle to disrupt a state's health insurance market. Since the business practices, rates and forms of OSTs are not typically filed (or regulated) in the state in which they sell their products, OSTs can move more easily into and out of a state's health insurance market without having to re-file with a state's Department of Insurance (DOI) for approval each time. OSTs may also operate through various names and organizations, creating confusion for the consumer and the provider on who is ultimately responsible for paying claims.

This flexibility in movement and structure can create an ideal way for OSTs to disrupt a state's individual market by transferring the OSTs' high-risk members to in-state insurers. The market for in-state insurers then becomes increasingly smaller and less profitable as they risk insolvency without a pool of healthy individuals to balance the rising costs of an increasingly expensive high-risk pool. The OSTs then end up with the very healthiest of individuals, otherwise known as "cream skimming." This practice can be especially evident if an OST can avoid a state specific guaranteed issue requirement.

State Specific Examples – Florida - Due to the practices of some OSTs, the Florida Office of Insurance Regulation (OIR) has launched educational campaigns warning individuals not to buy insurance from health insurers that are not licensed within the state.[23] From 2001 to first quarter 2002, the OIR had tried to take action against four OST entities that attracted as many as 15,000 Floridians into plans, then stopped paying claims and went out of business when the incoming premiums were no longer enough to cover costs.[24]

Furthermore, an OST called Employers Mutual, L.L.C., was an unlicensed insurance company that was based in Nevada and sold health insurance in Florida. Employers Mutual presented itself as an OST that was not subject to state insurance regulations. It sold insurance to 22,000 people who paid Employer's Mutual $14 million in premiums. Of this amount, it only paid $3 million in claims. Similarly, T.R.G. Marketing group had been selling health insurance and marketed itself as an OST that was exempt from Florida regulation. T.R.G. left the state of Florida in 2001 leaving thousands of Floridians with unpaid claims.

Since OSTs may choose to offer a lower priced health insurance product by not having to comply with all of a state's mandates, individuals will find these lower premiums attractive and more affordable compared to in-state insurers. However, the rates may not be actuarially sound and the OST may not be required to set aside funds for reserves to cover the claims of OSTs. According to the Florida DOI, OSTs do not participate in a state guaranty fund, a fund that covers unpaid claims in the event of bankruptcy, and a fund to which state licensed companies must contribute. Policyholders in unlicensed trusts are usually left with the responsibility for unpaid claims when the trust leaves the market or becomes insolvent.[25] Between 2001 and 2002, the Florida DOI estimates that the loosely regulated practices of OSTs, as well as practices of unlicensed insurance companies, affected more than 30,000 Floridians with over $6 million in unpaid claims. It is estimated that, in addition to the cost of complying with state mandates, the practices of the 'loosely' regulated OSTs and unregulated insurance companies added as much as $1,400 a year to the premium costs of a Florida family who purchased its health insurance from in-state insurers.[26]

The regulatory advantages of an OST are significant in states, such as Florida, with guaranteed issue requirements within their individual market. Guaranteed-issue laws typically forbid insurance companies from rejecting applicants based on the condition of their health. Other states have elected to implement a "community rating" system, which requires insurers to charge everyone the same rates, regardless of health, or otherwise limits the insurers' ability to raise premiums. OSTs can typically avoid a state's guaranteed issue laws and community rating requirements while in-state insurers must comply with these requirements. In Florida, for instance, OSTs can avoid issuing guaranteed issue products by having the flexibility to raise rates on these products by as much as 500% to 1000% over their standard rates. Florida's in-state insurers are limited in their pricing practices for guaranteed issue products with a cap of 200% over their standard rates. This disparity in rates encourages high-risk individuals disproportionately to seek guaranteed issue products from in-state insurers.

Other State Examples - Similar to Florida, Kentucky, Hawaii, Indiana, and Louisiana have experienced OSTs that disrupted their individual coverage markets. Regulators of these states claim they lack the regulatory authority to enforce a system of "checks and balances" on OSTs.[27] Such OSTs have diverted millions of dollars in premiums from other state initiatives and then exited the state once their "members" experienced claims. These OSTs had promoted themselves as self-funded insurance plans for individuals at greatly discounted premiums, with benefits resembling standard health insurance and provider networks, then withdrew, leaving their sickest members with unpaid medical bills.[28]

The impact that OSTs have on the regulation of insurance depends on the provisions of each state's insurance law. If these laws apply to individual policies sold, rather than to certificates issued, OSTs avoid regulation as individual insurers because the policy is issued to the trust on a group basis, and coverage is sold to individuals as certificates for members, rather than as individual policies.[29]

Federal Regulation of OSTs - The federal government has traditionally done a weak job of regulating the health care industry. One can clearly see this with the ERISA (Employee Retirement Income Security Act of 1974) law that regulates employer-sponsored insurance plans. This law provides employers with a tremendous amount of leeway in designing group health care benefits and has few strict standards.[30]

This weakness at the federal level was also apparent when the government was charged with regulating Multiple Employer Welfare Arrangements (MEWAs). These MEWAs were a means for small employers and other groups to band together to purchase health care coverage and be regulated by the federal government rather than individual states. Unfortunately, the federal government was unable to adequately regulate these MEWAs. Resulting fiscal insolvency, fraud and mismanagement caused scores of people to lose their health care coverage. Today, MEWAs are regulated by the states, although there is push at the federal level to regain regulatory authority.

More recently, the US Congress has begun considering another public policy involving Association Health Plans (AHPs), which would be similar to MEWAs. Like MEWAs, AHPs would be a mechanism for small employers and purchasers, without the benefit of larger purchasing power, to form larger groups in order to gain leverage in health care purchasing decisions. A number of trade groups and national associations, including the Blue Cross and Blue Shield Association, National Governor's Association and National Association of Insurance Commissioners have lobbied against AHPs[31] because they would place heavily state regulated insurers at a particular disadvantage compared to these less stringently, federally regulated health plans. These lobbying groups note the disastrous federal regulation of MEWAs in advocating against AHPs. Under the current proposed legislation, it appears that OSTs would be allowed to operate as AHPs and therefore gain federal sanction for their business practices.

Overall, federal regulation of health insurance typically provides freedom over more stringent state regulation. Current proposals in the US Congress would only exacerbate this and result in tacit, if not explicit, federal promotion of OSTs and their business practices.

Public Policy Options - The insurance market in almost every instance operates at a regional or state level, with competition among insurers occurring in particular geographic areas. Therefore, regulation of the industry is best designed and implemented at that level, rather than at the national level. As was noted earlier, the federal McCarran-Ferguson Act of 1945 (P.L. 79-15) specified just that - that health insurance be regulated at the state level. But how can a state-regulated health plan be expected to compete fairly and equitable with a national health plan that could legally operate without many of the costly mandates required by most states? Clearly, state public policy options must be developed to ensure that a fair market continues to work.

State regulation allows individual states to craft regulation to protect their own citizens and to enable legislation that meets their own particular needs. All insurers participating in a particular state market ought to be required to abide by the same regulations. Aligning the regulation of in-state and out-of-state insurers would provide for strong consumer protections, promote fair corporate competition, and encourage economic efficiency.

One option to promote fairness would consist of banning the practice of what is termed "re-underwriting". This practice allows OSTs to discriminate against individual consumers based on

their actual or perceived health status.In addition, OSTs ought to have to abide by the same portability requirements and rating practices, along with the same rate filing and benefit coverage mandates, as in-state insurers. This will ensure that individuals with OST coverage have the same coverage options should they lose coverage, as do all other individuals with plans that are regulated by the state. These requirements ensure that policies offered by OSTs provide a minimum level of benefits and benefit offerings and act to prevent OSTs from gaining a competitive advantage over in-state insurers.

Recent Developments - One recent example of public policy that attempts to regulate OSTs is provided by Florida. n July 2003, new state legislation (SB 2264) was signed into law that now protects thousands of Floridians and in-state insurers by helping to mitigate some of the practices of 'loosely' regulated OSTs.This law now requires OSTs to disclose, in bold type, that their insurance plans may result in premium hikes at renewal that would not be permitted under a Florida-approved policy. It also defines the "death spiral" as a rate escalation caused by segregating healthy and unhealthy groups of insured people. The bill declares that this practice, engaged in by some OSTs, amounts to "predatory pricing" and is now illegal under an unfair discrimination provision.[32]

CONCLUSION

With the proliferation of out-of-state trusts, some states are experiencing a bifurcated individual health care coverage market characterized by in-state and out-of-state insurers. This divided system contributes to the instability of a state's individual insurance market and raises some significant public policy concerns. The ability for out-of-state groups to freely enter and exit a state's individual coverage market creates an environment that can harm a state's most vulnerable individuals.

Ironically, as OSTs proliferate, those persons most in need of coverage are those least likely to afford and acquire that coverage. Such proliferation can potentially contribute to the pool of uninsured individuals through 'death spiraling' and can also impact negatively the financial stability of in-state insurers who are subject to a state's guaranteed issue mandate and must accept a disproportionate number of high-risk individuals. It is essential, therefore, that as with Florida's new legislation (SB 2264), public policy be developed to protect consumers and attempt to guarantee that all insurers have the ability to function under the similar rules and meet similar standards.📖

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