United States General Accounting Office

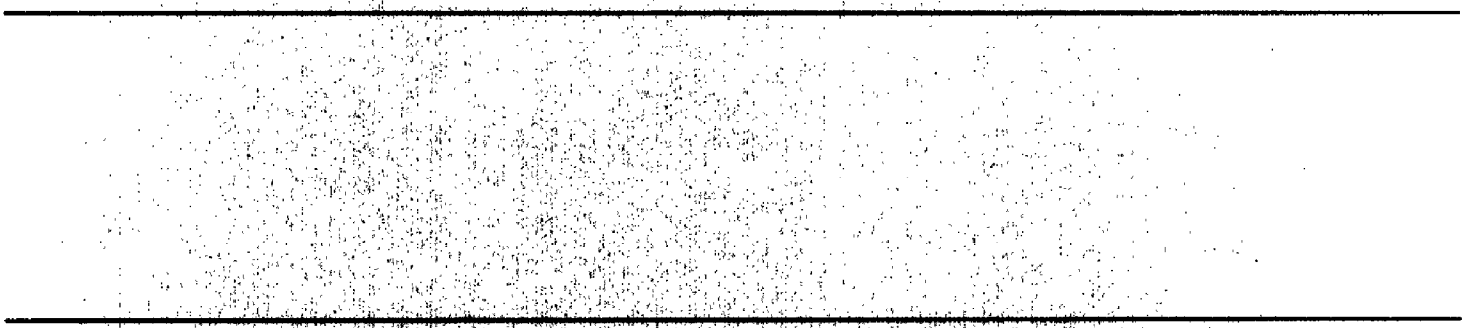
GAO

Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives

December 1993

HEALTH INSURANCE REGULATION

Wide Variation in States' Authority, Oversight, and Resources



GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-249867

December 27, 1993

The Honorable Fortney H. (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

The rapidly rising cost of health insurance and the growing number of uninsured have pushed the debate over health care reform to the forefront. State insurance departments have played an important role in previous state efforts to address problems with the cost and availability of health insurance. Because most health care reform proposals include provisions that could impose new requirements on health insurers, states and their insurance departments could play a large role in enforcing new requirements should any of these proposals be adopted.

Health care reform may also fundamentally change the health insurance marketplace and strain insurer finances as they attempt to respond to increased competitive pressures that many believe will result in a significant reduction in the number of health insurers. As the Congress prepares to consider various reform initiatives, questions have been raised about the states' capacity to adequately regulate the health insurance industry. In some cases, state insurance department efforts to regulate health insurers have not protected consumers from the adverse consequences of insurer failures. The consequences of an insurance company failure can be catastrophic for policyholders who may be left with millions of dollars in unpaid claims and without health insurance, and health care providers who may not be reimbursed for their services.

To facilitate the congressional debate over various health care reform proposals, you asked us to collect information on how states currently regulate health insurance. Specifically, you asked us to determine

- the role of state insurance departments in regulating health insurance and factors limiting their role;
- the standards state insurance departments follow and the extent of their regulatory responsibilities;
- the budget and staff resources state insurance departments commit to regulating health insurance; and
- the key activities they perform, including monitoring solvency, conducting rate and policy reviews, and responding to consumer complaints.

At your request, we also identified the conflict of interest standards that apply to state insurance department personnel, and examined questions about the propriety of certain insurance company-funded activities at National Association of Insurance Commissioners (NAIC) meetings. This information is contained in appendix I.[1]

To determine how states regulate health insurance, we conducted a questionnaire survey of the insurance departments of all 50 states and the District of Columbia, (app. II contains a summary of our survey results), and visited insurance departments in seven states—California, Colorado, Illinois, New York, Texas, Vermont, and Virginia.[2] We reviewed model laws, regulations, and guidelines for health insurance regulation developed by NAIC, and interviewed representatives of NAIC and the Health Insurance Association of America. We also reviewed previous GAO reports on states' efforts to monitor the financial solvency of insurance companies.[3]

Because there are no standards for evaluating the performance of state insurance departments, except in the area of financial solvency, we did not assess states' performance in regulating health insurance.

We conducted our study from May 1992 to May 1993 in accordance with generally accepted government auditing standards.

Results in Brief

Although state insurance departments are responsible for overseeing health insurers and protecting consumers, their authority extends over only part of the market and varies widely among states. Moreover, since the passage of the Employee Retirement Income Security Act of 1974 (ERISA), and the Supreme Court's interpretation of its preemption provision, more and more firms have elected to self-insure their health plans under ERISA, thereby avoiding state regulation. Currently, about 24 percent of health care is paid for by private health insurance that is regulated by state insurance departments.

Each state insurance department's role in regulating health insurance is affected by its legal framework and regulatory philosophy. Although NAIC

[1]NAIC is a voluntary association consisting of the heads of the insurance departments of the 50 states, the District of Columbia, and four U.S. territories.

[2]We selected these states because they included both large and small insurance departments in different geographic regions, and included states that had undertaken state health insurance reform.

[3]A list of related GAO products appears at the end of this report.

has developed many model laws and regulations to help establish a national system of uniform insurance regulation, it has no authority to require states to adopt or implement its model policies. This responsibility falls to state legislatures.

The resources state legislatures allocate to their insurance departments and the proportion the departments dedicate to regulating health insurance also vary widely among states. However, it is often difficult for states to estimate the number of staff that oversee a particular line of insurance because state insurance departments are typically organized by regulatory activity—not line of business.

State insurance departments' perform a variety of regulatory activities to protect consumers from insurer failures, unfair policy provisions, excessive premiums, and unscrupulous insurer business practices. Any one of these problems could be financially devastating to policyholders. Our current survey of states' regulatory activities found wide variations in the practices and procedures used to monitor insurer solvency, approve health insurance premium rates and policy forms, and respond to consumer complaints. In previous studies, we identified problems in state insurance departments' efforts to monitor insurer solvency, their most important consumer protection activity (see related GAO products).

Although it is not clear what form health care reform may take, it could involve fundamental changes in the health insurance industry that increase competitive pressures and strain insurer finances. As the Congress analyzes various reform proposals, it needs to consider what role, if any, state insurance departments will play in enforcing new requirements that may be imposed on health insurers.

Background

In 1945, the McCarran-Ferguson Act reaffirmed the states' primary responsibility for regulating the insurance industry. In general, state legislatures establish the rules under which insurance companies must operate, and state insurance departments enforce these rules.

The major responsibilities of state insurance departments typically include

- licensing insurance companies and the agents who sell insurance to ensure that companies are financially sound and reputable, and that agents are qualified;

- setting standards for and monitoring the financial operations of insurers to determine whether they have adequate reserves to pay policyholders' claims;
- reviewing and approving rates to ensure that they are both reasonable for consumers and sufficient to maintain the solvency of insurance companies;
- reviewing and approving insurance policies to make sure that they are not vague or misleading and to ensure that they meet state requirements, such as mandatory benefit provisions; and
- monitoring insurers' actions to make sure that they are not engaging in unfair business practices or otherwise taking advantage of consumers, and assisting consumers by investigating their complaints, answering questions, and conducting educational programs.

To promote effective insurance regulation and encourage uniformity in state approaches to regulation, the state insurance regulators established NAIC to help coordinate their activities. NAIC develops and adopts model laws and regulations that state insurance commissioners collectively believe are needed to regulate the insurance business. Many states adopt NAIC's models in whole or in part, but NAIC has no authority to require individual states to adopt them.[4]

Recent congressional staff reports have raised questions about the adequacy of insurance department efforts to monitor insurer financial solvency. For example, lapses in regulatory oversight contributed to the failure of West Virginia Blue Cross in 1990. Although West Virginia insurance regulators were aware of the troubled financial condition of West Virginia Blue Cross, they took little action against the plan because of a lack of resources and regulatory authority. In another case, the Maryland insurance department had difficulty identifying financial problems of the Maryland Blue Cross plan because of weaknesses in its financial reporting requirements. More stringent financial reporting requirements have since been implemented in both states.

More recently, questions have been raised about the New York state insurance department's oversight of Empire Blue Cross and Blue Shield—the nation's largest nonprofit insurer. A Senate subcommittee staff report criticized the department for inadequate oversight of Empire that failed to detect "...gross mismanagement, wasteful expenditures, fraud and a history of inattentiveness and non-action by its board of directors..."

[4]Appendix III lists NAIC models relating to health insurance regulation and state actions to adopt them.

that left Empire with underwriting losses of about $444 million in the last 2 years.[5]

Insurance Departments' Role in Regulating Health Insurance Is Limited

State insurance departments' oversight of health insurance coverage is limited to a portion of the health care expenditures in each state. This limitation is due, in part, to ERISA's preemption provision, which has constrained states' ability to regulate employer-sponsored health funds that choose to self-insure. Although ERISA was designed to correct serious problems with the solvency of employer-funded pension funds, the act also covers all employee welfare benefit plans, which include health and other employee benefits.

While ERISA's preemption provision confirmed the states' authority to regulate insurance companies, the Supreme Court has said that the provision prohibits states from regulating self-insured health plans. As a result, employee benefit plans can serve employees in many jurisdictions without becoming subject to conflicting and inconsistent laws of the various state and local governments. The ERISA exemption, as interpreted by the Supreme Court, has produced a divided system for regulating health benefits in each state such that the federal government has authority to regulate self-insured employee health plans, but not health policies sold by insurance companies. Conversely, states can regulate insurance companies and their policies, but not employee health benefit plans provided by employers who self-insure.

About 34 percent of the nation's health expenditures is paid for out-of-pocket by individuals or through self-insured employer health plans. The self-insured plans cover over half of all U.S. workers. About 42 percent of health care is funded and regulated by the federal government through programs such as Medicare, and jointly by federal and state agencies for programs such as Medicaid. The remaining 24 percent of health care is paid for by private health insurance that is regulated by state insurance departments.

[5]Staff Statement, Permanent Subcommittee on Investigations, Committee on Governmental Affairs, U.S. Senate, Hearings on Oversight of the Insurance Industry Blue Cross & Blue Shield: Empire Plan (NY), June 25, 1993.

States' Adoption of NAIC Models for Regulating Health Insurance Varies

Each state maintains its own legal framework for regulating insurance, in which the insurance department's roles and responsibilities may differ. Over the years, NAIC has developed about 200 model laws, regulations, and guidelines setting out the legal and regulatory authorities NAIC believes are necessary to effectively regulate insurance.[6] In some cases, state legislatures have not adopted NAIC's models; in others, they may have adopted their own law addressing the same issue as the NAIC model.

As of April 1993, many states had not adopted NAIC models addressing health insurance regulation even though this guidance had been in existence for at least 5 years. For example, 19 states had not adopted NAIC's model regulation that sets authority and standards for identifying insurers whose hazardous financial condition threatens the public or policyholders. Further, NAIC's model on minimum reserve standards for health insurance contracts, which establishes how health insurance companies must determine cash reserves for paying future claims, had not been adopted by 16 states.

NAIC's model on HMO investments, which sets limitations on what HMOs may invest in so that solvency problems from bad investments can be minimized, had not been adopted by 44 states. Finally, 28 states had not adopted NAIC's model minimum standard for individual accident and health insurance. This standard is designed to eliminate provisions in health insurance policies that are misleading or confusing, and provide reasonable standardization to facilitate public understanding and comparison.

Resources Committed to Health Insurance Regulation Vary Widely

State insurance departments are responsible for regulating many different types of insurance. In addition to health insurance, they also regulate life, auto, homeowners and other property and casualty insurance. Thus, their resources are spread over a wide range of insurance products. Because of the variation among the states in business climates, regulatory philosophies, and number of health insurance consumers, there is no agreed-upon level of resources needed to regulate health insurance. Our study found that, on average, state insurance departments devoted about 24 percent of their 1991 resources to regulating health insurance.

[6]NAIC believes that some models are not appropriate for certain states. For example, the NAIC High Risk Pool Model may not be needed in a state in which a Blue Cross Blue Shield Plan or health maintenance organization (HMO) still takes all applicants.

However, estimates of individual resource commitments varied widely, ranging from 4 to 57 percent of their budgets.[7]

It is difficult for states to estimate the number of staff who oversee a particular line of insurance because state insurance departments are typically organized by regulatory activity—not line of business. However, 28 states estimated that the number of full-time staff expended on regulating health insurance ranged from 1 to 153, with the median number being 18 staff members. Nine of the 28 states estimated that they had fewer than 10 full-time staff involved in regulating health insurance, and 22 departments said they were unable to estimate the number of full-time staff involved in regulating health insurance.[8]

Actuaries are particularly important employees of insurance departments because of the role they play in estimating future claims payments. Based on these estimates, they determine whether insurers have adequate reserves to cover expected losses. They can also review premium rate increases to determine whether they are sufficient to cover an insurer's expected losses. Our survey found that 21 states have 1 or more associate or fellow actuaries on staff to work on health insurance matters, and 11 others have an actuary under contract. However, 14 states did not have an actuary either on staff or under contract to work on health insurance.[9]

Two states we visited, Colorado and New York, reported that new responsibilities resulting from health insurance reforms placed an increasing strain on their resources. Almost all the states have implemented reforms designed to improve access to affordable health insurance for small firms and their employees. Typically, these reforms address practices that have made obtaining and keeping health insurance difficult or impossible for some people. Implementing these reforms has increased the workloads of state insurance departments in several areas, including preparing new regulations and ensuring compliance with new policy and rate provisions.

[7]Appendix IV lists state insurance department budgets and the percentage devoted to health insurance regulation.

[8]The nine states are Delaware, Idaho, Louisiana, New Hampshire, New Mexico, Rhode Island, South Dakota, Vermont, and Wyoming.

[9]Appendix V lists the states' total department staff, full-time equivalent (FTE) staff, and number of actuaries working on health insurance regulation.

Key Health Insurance Regulatory Activities

State insurance departments' major responsibilities include protecting consumers from insurer failures, unfair policy provisions, excessive premiums, and unscrupulous insurer business practices. Any one of these problems could be financially devastating to policyholders.

States try to protect consumers through a variety of regulatory activities. Our survey of states' regulatory activities found wide variations in the practices and procedures used to monitor insurer financial solvency, approve premium rates and policies, and handle consumer complaints. Our previous studies have raised serious questions about NAIC's program to accredit state insurance department efforts to monitor insurer financial solvency.[10]

Monitoring Insurer Financial Solvency Is Principal Insurance Department Responsibility

The principal responsibility of state insurance departments is to protect consumers by monitoring the solvency of insurance companies. The importance of solvency monitoring was demonstrated by the failure of West Virginia Blue Cross/Blue Shield in 1990, where about 50,000 policyholders were left with nearly $40 million in unpaid claims. Blue Cross/Blue Shield of West Virginia did not pay hospitals and other health care providers for their services, and many providers held policyholders personally liable for these claims. The failure of West Virginia Blue Cross/Blue Shield; the failure of several large life insurance companies; and the recent disclosures of the financial condition of Empire Blue Cross/Blue Shield, the nation's largest Blue Cross plan, have focused attention on the ability of state insurance departments to protect consumers.

The number of health insurer failures has increased in recent years. In the mid-1980s, about 10 life and health insurers failed each year. State insurance departments responding to our survey reported that in 1991 they liquidated 46 companies that sold health insurance. Over 70 percent of the failures occurred in four states—Illinois, Louisiana, Pennsylvania and Texas.[11] While some of the companies were not issuing health insurance when liquidated, state officials told us that the 6 companies liquidated in Texas in 1991 had insured over 20,000 Texans. They did not know the number of policyholders who were unable to obtain replacement health

[10]Appendix VIII summarizes the results of past GAO studies of NAIC's efforts to improve financial solvency regulations through its Financial Regulation Standards and Accreditation Program.

[11]Five of the eight liquidated companies in Pennsylvania claimed ERISA exemptions and were unlicensed health carriers.

insurance due to preexisting conditions or an inability to afford the new premiums.

To try to prevent these types of failures, state insurance departments monitor insurers' financial solvency through two primary means—analyses of an insurance company's financial data and on-site examinations of insurers. Although insurance departments rely on these activities to identify troubled and failing insurance companies, we found that these reviews have significant limitations.

Insurance departments review insurance company finances by examining insurers' financial statements and key financial ratios. NAIC assists states by identifying companies whose financial condition appears vulnerable and by acting as a clearinghouse for states to share financial analysis software. Officials in the seven states we visited believe that because insurers' financial conditions can deteriorate rapidly, these reviews should be performed at least annually. However, officials in two of the seven departments told us that they did not have sufficient resources to complete annual reviews on all licensed health insurers in their states. In the states we visited, the amount of time spent on each review ranged from about 1 to 40 hours.

We have several concerns about these reviews. First, they are inherently limited because the financial data are not verified to detect errors or misrepresentation. Further, there are inadequate criteria for evaluating the wide variety of techniques states use to review insurer financial data. As a result, there is no basis for determining whether states' financial reviews are of an acceptable level.

State insurance regulators use on-site examinations to verify insurer-reported data and to detect weaknesses and financial problems that could cause an insurer to fail. In an on-site exam, insurance department examiners evaluate the insurers' finances by reviewing a variety of insurer accounts. We believe that these examinations are too infrequent—one every 3 to 5 years—for regulators to detect solvency problems in a timely manner. Our analysis of survey results showed that in 1991, departments performed on-site financial exams on about 20 percent of their health insurers.[12]

[12]Appendix VI shows the number of licensed health insurers in each state and the number of financial examinations in 1991.

To protect policyholders against losses that might otherwise occur after an insurer fails, each state has established a life/health guaranty association to pay benefits for policyholders of failed insurers and provide limited continuation of coverage. Life/health guaranty associations are established under state law and administered and financed, at least initially, by assessments to insurance companies licensed with the state.

In a previous GAO study, we found that although most policies are covered, gaps exist in the collective safety net for life and health policyholders.[13] When a multistate insurer fails, policyholders in some states can find themselves totally unprotected because of the differences in the funds' rules of coverage. In addition, 30 state life/health guaranty associations currently do not cover policyholders in Blue Cross and Blue Shield plans.

Reviewing Health Insurance Premium Rates

States face a particular challenge in balancing consumers' interests for affordable insurance with insurance companies' need to collect sufficient premiums to pay future claims. There is no consensus among insurance regulators about how best to manage these competing demands. As a result, NAIC has not taken a position on how states should regulate insurance premium rates.

States use different approaches to regulating health insurance premiums. These procedures may even vary between insurance products. For example, different approaches may be used depending on whether a rate filing is made by a commercial insurer, an HMO, or a Blue Cross Blue Shield plan; whether the rate applies to individual, small group, or group coverage; and whether it is a first-time rate filing or a rate increase.

In several states, the insurance departments require detailed rate submissions that are reviewed before approving or disapproving the requested rates. In six states, the insurance departments do not require insurers to file information on health insurance rates for first-time rate filings, and four of these six do not require the filing of rate changes. In several other states, insurers are required to submit rate information, but the insurance department does not have authority to regulate insurance premiums.

States that review insurance premium rates generally use one of several processes—"file and use," "deemer," or "prior approval." File and use

[13]Insurer Failures: Life/Health Insurer Insolvencies and Limitations of State Guaranty Funds (GAO/GGD 92-44, Mar. 19, 1992).

means that the insurer may begin charging a rate as soon as it is filed with the insurance department. Under a deemer process, rates are "deemed" approved after a specified waiting period, usually 30 to 60 days, during which the insurance department can reject the rate filing. Under a prior approval process, an insurer may not begin charging a premium until the insurance department notifies it that the rate has been approved.

Table 1 shows the number of states that use each of the different procedures for reviewing and approving the rates for small group health insurance.

Table 1: Number of States Using Different Review Processes for Small Group Health Insurance Rates

	Blue Cross/Blue Shield plans		Commercial insurers	
Review process	First-time rates	Rate changes	First-time rates	Rate changes
Rates not filed	18	20	23	26
File and use	8	9	6	7
Deemer	18	13	15	9
Prior approval	5	6	3	4
Other	1	1	2	2

Note: Columns do not always total to 50 because some states did not answer all questions.

In response to our survey, five state insurance departments told us that their rate regulatory authority was inadequate. For example, Texas officials explained that when a health insurance company increases its rates more than 50 percent, the department contacts the insurer to ask why such a large increase is justified and whether it should be reduced, but can do no more. On the other hand, officials in Illinois do not believe that regulating health insurance premiums is in the consumers' best interest. Rather, they believe that premiums are best controlled in the competitive market.

In addition to variations in state processes for reviewing rates, the type of review states perform also varies. For example, New York requires insurers to submit detailed rate filing information for small group and individual insurance policies. Each rate filing is reviewed by an actuary to determine whether the premium rate is justified based on expected claims by policyholders. In Michigan, on the other hand, the department reviews rates to determine if they are competitive, rather than whether the expected losses justify the premium.

Reviewing Health Insurance Policies

Insurance regulators review health insurance policy forms because they are often complex and difficult for consumers to understand. Policy forms are reviewed for compliance with state laws, which often include provisions such as readability, required coverages, prohibited exclusions, and a variety of administrative requirements. While NAIC has developed model policy provisions, it has not provided guidance to states on how to review policies.

We found that all states review health policy forms and use a variety of procedures. For example, Texas uses a detailed checklist and reads each policy form line by line. In contrast, insurance regulators in Colorado require only that the insurer certify that the form complies with all state laws and regulations. Although a copy of the form does not have to be submitted with the certification, Colorado holds the insurer responsible for checking policy forms for compliance with state law.

Table 2 shows the number of states that use each of the different procedures for reviewing and approving individual and small group health insurance policies.

Table 2: Number of States Using Different Policy Form Filing Requirements

	Blue Cross/Blue Shield plans		Commercial insurers	
Form filing requirements	Individual policies	Small group policies	Individual policies	Small group policies
Policies not filed	2	2	1	2
File and use	3	4	2	1
Deemer	33	33	37	36
Prior approval	7	6	4	4
Other	4	4	5	5

Note: Columns do not always total to 50 because some states did not answer all questions.

Investigating Consumer Complaints and Insurer Market Practices

Insurance consumers are vulnerable to unscrupulous practices by insurance companies, such as high pressure sales practices, improperly denied claims, unfair discrimination, and improper denial of coverage. To protect against these problems, insurance departments investigate consumers' complaints. Most states also perform market conduct exams to review the marketing, underwriting, rating, and claims payment practices of health insurers.

In 1991, health insurance complaints constituted about 37 percent of the approximately 344,000 consumer complaints received by 45 state insurance departments. The other five states could not distinguish health insurance complaints from other insurance complaints in their tracking system. Our survey found that 38 states believe that the number of health insurance complaints has increased in recent years.

The level of resources dedicated to investigating and resolving consumer complaints varies widely among states, often depending on the state's population and the number of insurers licensed to do business. As of 1993, Rhode Island and the District of Columbia did not have separate consumer complaint sections, while California had over 100 people available to receive and investigate consumer complaints. California's staff is multilingual, and the department maintains access to a language institute so that complaints can be taken from individuals who do not speak one of the languages known by department staff.

All the states we visited use consumer complaints of potentially improper insurer activities, in such areas as sales, advertising, and claims denials, to target insurers for examinations of business practices (known as "market conduct" exams). Some states also use consumer complaints to target solvency reviews, because complaints of slow claims payment can be an indication of financial difficulties. Our survey found that, in 1991, the number of market conduct exams performed by states ranged from 81 in Missouri to 0 in 9 states, with a median number of 7 market conduct examinations of health insurers performed by a state.

Considerations for Health Care Reform

Although it is not clear what form health care reform may take, it could involve fundamental changes in the health insurance industry that increase competitive pressures and strain insurer finances. As the Congress analyzes various reform proposals, it needs to consider what role, if any, state insurance departments will play in enforcing new requirements that may be imposed on health insurers. A reform plan should clearly specify what state insurance departments are expected to do to carry out these responsibilities. These expectations need to consider the wide variation in state insurance departments' existing legal authorities, the regulatory activities and resources, and the possible actions that need to be taken to ensure that the departments have the necessary tools to enforce new requirements on health insurers.

We obtained written comments from NAIC on a draft of this report. (Appendix IX contains NAIC's comments and our response.) NAIC expressed concern that the report relied on previous GAO work in the solvency area that they contend was based on flawed analysis and unsupported conclusions.

GAO has, from the outset, supported NAIC's efforts to improve the quality and effectiveness of state solvency regulation through its accreditation program. Although we recognize that no regulatory scheme or accreditation approach is going to be perfect, we have identified weaknesses in the structure and implementation of NAIC's accreditation program. Some of these weaknesses, such as NAIC's inherent lack of authority to require state cooperation, may not be susceptible to resolution by NAIC. However, other identified weaknesses could be addressed by NAIC, but have not been. We have reviewed NAIC's comments and made changes to this report as appropriate. Further, we have added a list of documents that contain NAIC testimony and comments on our analysis of their accreditation program (see app. X).

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At the time, we will send copies to NAIC, state insurance commissioners, and other interested parties. We will make copies available to other interested parties upon request.

Please call me on (202) 512-7123 if you or your staff have any questions about this report. Major contributors to this report are listed in appendix XI.

Sincerely yours,

Leslie G. Aronovitz
Associate Director,
Health Financing Issues

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Abbreviations

CPA	certified public accountant
ERISA	Employee Retirement Income Security Act
FTE	full-time equivalent
HMO	health maintenance organization
IRIS	Insurance Regulatory Information System
NAIC	National Association of Insurance Commissioners

State Insurance Department and National Association of Insurance Commissioners Conflict of Interest and Ethics Standards

This appendix provides information about questions raised by the Chairman, Subcommittee on Health, House Committee on Ways and Means, concerning the conflict of interest standards that apply to state insurance department employees, and insurance company funded activities at National Association of Insurance Commissioners' (NAIC) meetings.

State Conflict of Interest and Ethics Standards

Each state maintains its own conflict of interest and ethics standards that apply to state employees, including those who work for the insurance department. NAIC views this issue as a state responsibility and therefore has not promulgated any models or guidelines addressing conflict of interest issues for employees of state insurance departments.

In our survey of state insurance departments, we asked about the conflict of interest and ethics standards that applied to insurance department employees. The state's responses to these questions are summarized in table I.1. The states indicated that state conflict of interest or ethics laws or regulations provide standards for the gifts and gratuities state insurance department employees can receive. In most cases, state rules also restrict insurance department employees' investment holdings. However, in many states there are no rules restricting an insurance department employee from leaving the department and immediately going to work for an insurance company that the department regulates.

Table I.1: Issues Addressed by States' Conflict of Interest or Ethics Laws and Regulations

	Laws for policy-making officials		Laws for other professional staff	
Issues	**Yes**	**No**	**Yes**	**No**
Gifts and gratuities	48	0	48	0
Employee investment holdings	40	6	40	6
Future employment	26	19	22	22

Industry-Funded Activities at NAIC Meetings

NAIC's members meet quarterly at different locations around the country. According to NAIC officials, at past meetings the insurance commissioner of the state where the meeting is held formed a committee of representatives from insurance companies domiciled in the state to organize and fund activities during the quarterly meetings. This group, called the "industry host committee," traditionally paid for the commissioners' dinner and for entertainment and gifts for the

commissioners. Additionally, insurance industry groups have sponsored buffet-type breakfast and lunches open to insurance regulators at NAIC's meetings. These activities have raised concerns about the propriety of insurance department officials accepting meals and entertainment from the industry they regulate.

While NAIC feels strongly that the ethical standards of its members are sufficient, it has taken actions to restrict insurance industry activities at future meetings to protect against the perception of impropriety. NAIC has decided to pay for the commissioners' dinner and close it to industry representatives. However, NAIC cannot prevent the commissioner of the host state from forming an industry committee to finance other activities if the commissioner decides to do so.

NAIC officials told us they cannot prohibit insurance industry representatives from offering meals or other types of hospitality to insurance regulators. However, because NAIC reserves all hotel space for its meetings, insurers wishing to sponsor buffets or hospitality suites must have NAIC release the space for the function. NAIC officials told us they will no longer release hotel space to industry groups sponsoring buffets or other free meals for insurance regulators at meetings.

Summary of Responses to GAO's Questionnaire

U.S. GENERAL ACCOUNTING OFFICE

Survey of State Insurance Departments:
Activities to Regulate Health Insurance

INTRODUCTION

The Subcommittee on Health, House Ways and Means Committee, has asked the U.S. General Accounting Office (GAO) to gather information about the states' health insurance regulatory efforts. We are sending this questionnaire to your state insurance department as well as those in the other states.

The purpose of this questionnaire is to gather information about your state's resources, staffing, and activities involved in regulating health insurance. We have collected information from a number of sources, including the NAIC, but we need additional information that only your state insurance department can provide. You will find that most of the questions can be answered quickly and easily by checking boxes. A few questions, however, may require a little additional time to answer because you may need to consult your department records.

INSTRUCTIONS

This questionnaire should be completed by the person(s) most familiar with your state insurance department and its health insurance regulatory activities. Please identify one primary person we may call if additional information or clarification is needed.

Name of person to call:_____

Official title:_____

Telephone number: ( )_____

If you have any questions about this questionnaire, please call Paul Alcocer or Darrell Rasmussen collect at (303) 572-7306. Please return the completed questionnaire within 2 weeks of receipt. In the event the envelope is misplaced, please send your questionnaire to

Mr. Paul Alcocer
U.S. General Accounting Office
Suite 800
1244 Speer Boulevard
Denver, Colorado 80204-3581

Thank you for your help.

INSURANCE DEPARTMENT PROFILE

1. How is your insurance department organized? *(Check one)* ***(N=50)***

   1. ***23*** Independent commission/department that reports directly to the Governor/Secretary of State
   2. ***15*** Part of a state agency/department (such as regulatory affairs or financial services)
   3. ***12*** Other *(Please specify)*

      _____

      _____

2. For each state fiscal year listed below, enter your insurance department's total budget. *(Enter dollar amount)* ***(N=50)***

		Range	Median
a.	1991	$ 768,215 - 72,122,000	$ 4,450,539
b.	1992	$ 838,526 - 77,365,000	$ 5,024,092

3. In addition to being responsible for activities related to insurance, is your department responsible for other activities? *(Check one)* ***(N=50)***

   1. ***11*** Yes, responsible for other activities
   2. ***39*** No, only responsible for insurance activities ---> ***(Go to question 5)***

4. Approximately what percentage of your insurance department's total budget is spent for activities other than those related to insurance? *(Enter percentage)* ***(N=8)***

Range	Median[1]
3-48 %	*11.5*

[1]***Median is the value at which 50 percent of the responses fall above and 50 percent fall below.***

Note: This questionnaire was sent to the 50 state insurance departments and to the District of Columbia insurance department. All but one (50) returned the questionnaire. However, some did not respond to all the questions. The 'N' for each question is the number of respondents who answered that question.

5. How many full-time equivalent (FTE) insurance department staff were employed as of December 31, 1991? *(Enter number)* *(N=47)*

Range	*Median*	
20-1,187	*91.0*	FTE insurance department staff

6. During calendar year 1991, how many, if any, health insurance policies were reviewed by your insurance department, either for policy form reviews or policy rate filing reviews? *(If no reviews were conducted, check box "a" below; Enter number)* *(N=50)*

a. *0* Did not review health insurance policies ---> *(Go to question 8)*
(N=41)

Range	*Median*	
177-33,033	*4,115*	Health insurance policies reviewed

8 Information not available

7. For those health insurance policies your insurance department reviewed during calendar year 1991, enter the number of policy forms and policy rate filings reviewed? *(Enter number; If none, enter "0")*

		Number reviewed		
		Range	*Median*	
1. Policy forms	*(N=34)*	*148-33,033*	*5,137*	*13* Information not available
2. Policy rate filings	*(N=31)*	*0-3,901*	*1,052*	*16* Information not available

POLICIES THAT PROVIDE MEDICAL EXPENSE COVERAGE

In responding to the following questions, we would like you to consider your state's activities in regulating all health insurance policies that provide medical expense coverage: that is, hospital, medical, and surgical; Medicare supplement; long-term care; hospital indemnity; specified disease; limited benefit; and accident only policies. Please do not include policies, such as automobile, homeowner's, or life insurance policies, that may pay medical expenses in some circumstances but whose major purpose is not to cover medical expenses.

8. Listed below are various organizations that issue health insurance policies that provide medical expense coverage. Indicate whether or not your insurance department has the authority to regulate each organization. *(For each organization, check "yes" or "no")*

Organization	Yes	No
1. Multiple employer welfare arrangements/ Multiple employer trusts *(N=48)*	*38*	*10*
2. Health maintenance organizations *(N=48)*	*44*	*4*
3. Blue Cross-Blue Shield *(N=49)*	*49*	*0*
4. Indemnity health insurer *(N=49)*	*49*	*0*
5. Other (*Please specify*) *(N=18)* _____	*18*	
6. Other (*Please specify*) *(N=12)* _____	*12*	

9. Consider all the activities your insurance department performs to regulate health insurance, such as market conduct and financial exams, policy form and rate filing reviews, and managerial activities by your senior management.

Approximately what percentage of your insurance department's total budget for your state fiscal year 1991 was spent on activities to regulate health insurance to cover medical expenses? (*Please give your best estimate; Enter percentage*) *(N=44)*

Range	Median
4-57 %	23.5 %

10. Now consider insurance department staff, including financial and market conduct examiners, attorneys, actuaries, and any other staff either under contract or employed by other agencies that work on activities regulating issuers of health insurance. Complete:

PART A: For each type of staff listed below, enter the number of all full-time and part-time staff who worked on activities regulating issuers of health insurance as of December 31, 1991. (*Please give your best estimate; If none, enter "0"; If this information is not available, check the box*)

PART B: For the staff identified in **Part A**, enter the number of FTE staff. (*Please give your best estimate; If none, enter "0"; If information not available, check the box*)

PART C: For the staff identified in **Part A**, enter the number of who worked exclusively on activities regulating issuers of health insurance. (*Please give your best estimate; If none, enter "0"; If information not available, check the box*)

As of December 31, 1991 .....

Staff	PART A Number of all full-time and part-time staff who worked on activities regulating issuers of health insurance	PART B Number of FTE staff who worked on activities regulating issuers of health insurance	PART C Number of staff who worked exclusively on activities regulating issuers of health insurance
1. Insurance department	*(N=45)* Range: 3-934 Median: 41 [4] Not available	*(N=28)* Range: 1-153 Median: 17.75 [15] Not available	*(N=46)* Range: 0-108 Median: 5 [3] Not available
2. Under contract or employed by another state agency (For example, actuaries or attorneys)	*(N=41)* Range: 0-51 Median: 1 [5] Not available	*(N=34)* Range: 0-19 Median: 0 [11] Not available	*(N=39)* Range: 0-4 Median: 0 [5] Not available

11. Consider all your insurance department staff and staff under contract who did any actuarial work related to health insurance as of December 31, 1991.

PART A: Enter the number of insurance department staff and staff under contract who did actuarial work related to health insurance. *(If none, enter "0")*

PART B: For the staff identified in **PART A**, enter the number of associate or fellow actuaries who did work related to health insurance. *(If none, enter "0")*

As of December 31, 1991 .....

Staff	**PART A** Number of staff who did actuarial work related to health insurance	**PART B** Number of associate or fellow actuaries who did work related to health insurance
1. Insurance department	*(N=48)* Range: 0-12 Median: 1	*(N=48)* Range: 0-10 Median: 0
2. Under contract	*(N=42)* Range: 0-12 Median: 0	*(N=39)* Range: 0-12 Median: 0

12. Does your state have conflict-of-interest laws or regulations that apply to your insurance department (1) professionals--actuaries, attorneys, rate and form analysts, and financial and market conduct examiners or (2) officials with policy-making responsibilities? *(Check one)* *(N=47)*

1. *0* Yes, professionals only
2. *1* Yes, officials with policy-making responsibilities only
3. *46* Yes, both professionals and officials with policy-making responsibilities
4. *0* No, conflict-of-interest laws do not apply to either --> *(Go to question 14)*

13. For each topic listed below, indicate whether or not it is addressed in your state conflict-of-interest laws or regulations for professionals in Part A and policy-making officials in Part B. *(Check "Yes" or "No" for each topic)*

	PART A Insurance department professionals			**PART B** Insurance department officials with policy-making responsibilities	
	Yes	No		Yes	No
1. Employee investment holdings *(N=46)*	*40*	*6*	*(N=46)*	*40*	*6*
2. Gifts, gratuities, and honoraria received by employees *(N=48)*	*48*	*0*	*(N=48)*	*48*	*0*
3. Restrictions on future employment activities of insurance department employees (that is, revolving door policies) *(N=44)*	*22*	*22*	*(N=45)*	*26*	*19*

14. Now we would like you to think about any policy forms and policy rate filings for policies that provide medical expense coverage that were submitted to your insurance department for review during calendar year 1991.

First consider the policy forms submitted to your department. For each type of policy form listed below, indicate whether or not any were submitted to your insurance department for review during calendar year 1991, and if "yes", enter the total number of policy forms submitted? *(Check "Yes" or "No" for each type; Enter number; If none, enter "0")*

Type of policy form	Form submitted for review during 1991? Yes	No		Number submitted Range	Median	
1. Medicare supplement	*49*	*0*	*(If yes-->) N=26*	*10-1,169*	*202*	*21* Information not available
2. Long-term care	*49*	*0*	*(If yes-->) N=23*	*10-624*	*105*	*24* Information not available
3. Other medical expense (such as hospital indemnity, specified disease, limited benefit, and accident only)	*49*	*0*	*(If yes-->) N=20*	*117-14,256*	*1,074*	*27* Information not available

15. Now consider the policy rate filings submitted to your insurance department for review during calendar year 1991. For each type of policy rate filing listed below, indicate whether or not any were submitted to your insurance department for review, and if "yes", enter the total number of policy rate filings submitted? *(Check "Yes" or "No" for each row; Enter number; If one, enter "0")*

Type of policy rate filing	Policy rate filing submitted during 1991? Yes	No		Number submitted Range	Median	
1. Medicare supplement	*49*	*0*	*(If yes-->) N=19*	*15-955*	*173*	*27* Information not available
2. Long-term care	*48*	*0*	*(If yes-->) N=15*	*5-625*	*30*	*30* Information not available
3. Other medical expense (such as hospital indemnity, specified disease, limited benefit, and accident only)	*48*	*0*	*(If yes-->) N=15*	*100-4,811*	*500*	*30* Information not available

HOSPITAL, MEDICAL, AND SURGICAL POLICIES

16. For the next series of questions, we would like you to consider the procedures your insurance department follows for hospital, medical, and surgical policies only.

Does your insurance department review any hospital, medical, and surgical policy forms submitted by Blue Cross-Blue Shield and other issuers of health insurance policies that provide medical expense coverage? *(Check one)*

1. *0* Yes, policy forms submitted only by Blue Cross-Blue Shield
2. *0* Yes, policy forms submitted only by other issuers
3. *49* Yes, policy forms submitted by both Blue Cross-Blue Shield and other issuers
4. *1* No --> *(Go to question 23 on page 8)*

17. Consider what happens to individual, small group, and group policy forms for hospital, medical, and surgical policies once they are submitted to your insurance department by Blue Cross-Blue Shield and other issuers.

PART A: Indicate whether or not each type of policy form is submitted to your insurance department.
PART B: For the type of form that is submitted, indicate in what way, if at all, use of that policy form is restricted while it is under review.

Type of form	PART A (*Check one*) Is the policy form submitted? Yes	No		PART B (*Check one for each type of form*) Once a policy form is submitted, the issuer can begin using it immediately.	Once a policy form is submitted, there is a specified length of time within which the insurance department must respond; the policy form may be used after the specified length of time if the department has not responded (some may refer to this as a "deemer")	Once a policy form is submitted, the policy can be used only after the issuer hears from the insurance department and there is no specified length of time within which the department must respond.	Other (*Please specify*)
Blue Cross-Blue Shield *(N=48)* 1. Individual	47	1	*If yes-> (N= 47)*	3	33	7	4
2. Small group	47	1	*If yes-> (N=47)*	4	33	6	4
3. Group	47	1	*If yes-> (N=47)*	4	33	6	4
Other issuers *(N=48)* 1. Individual	48	0	*If yes-> (N=48)*	2	37	4	5
2. Small group	47	1	*If yes-> (N=46)*	1	36	4	5
3. Group	47	1	*If yes-> (N=47)*	2	36	4	5

18. Where a hospital, medical, and surgical policy form is submitted for review, does your insurance department have a specified length of time within which the department must respond? *(Check one)* ***(N=49)***

1. ***42*** Yes

2. ***7*** No --> ***(Go to question 20)***

19. For those policy forms with a specified length of time within which your insurance department must respond, is the length of time the same for all types of hospital, medical, and surgical policies? *(Check one)* ***(N=41)***

1. ***34*** Yes, the length of time is the same ----------> What is that length of time? *(Enter number)*

	Range	Median	
(N=35)	***5-90***	***30***	days

2. ***7*** No, the length of time is different -----> What is the length of time for each type of policy? *(Enter number; If no deadline, enter "0")*

		Range	Median	
A. Blue Cross-Blue Shield				
Individual	***(N=6)***	***0-60***	***15***	days
Small group	***(N=7)***	***0-60***	***0***	days
Group	***(N=7)***	***0-60***	***0***	days
B. Other issuers				
Individual	***(N=7)***	***30-60***	***30***	days
Small group	***(N=7)***	***0-60***	***30***	days
Group	***(N=7)***	***0-60***	***30***	days

20. What was the total number of hospital, medical, and surgical policy forms that were submitted to your insurance department for review during calendar year 1991? *(Enter number; If none, enter "0")* ***(N=24)***

Range	Median	
38-15,238	***1,328***	Policy forms submitted

24 Information not available

21. Of those hospital, medical, and surgical policy forms submitted for review during calendar year 1991, how many, if any, did your insurance department review? (*If no reviews were conducted, check box "a" below; Enter number*)

a. *0* Did not conduct any reviews during calendar year 1991 ---> (*Go to question 23*)

	Range	Median	
(N=23)	*30-11,463*	*1,337*	Policy forms reviewed

21 Information not available

22. Now consider the hospital, medical, and surgical policy forms submitted by Blue Cross-Blue Shield and other issuers during calendar year 1991. What was the length of time it took your insurance department to review a typical policy form submitted during calendar year 1991? That is, from the time the policy form was submitted until your insurance department (1) first notified the issuer of any problems with the policy form, or (2) notified the issuer that the department authorized the marketing of the policy form, or (3) completed the review if the issuer was not to be notified, whichever came first. (*Enter number; If none, enter "0"*)

	Range	Median	
(N=45)	*2-240*	*25*	Days to review a typical Blue Cross-Blue Shield hospital, medical, and surgical policy form
(N=44)	*5-120*	*30*	Days to review a typical other issuers' hospital, medical, and surgical policy form

23. Does your insurance department review any hospital, medical, and surgical first-time policy rate filings submitted by Blue Cross-Blue Shield and other issuers of health insurance policies that provide medical expense coverage? (*Check one*) *(N=50)*

1. *1* Yes, first-time policy rate filings submitted only by Blue Cross-Blue Shield
2. *0* Yes, first-time policy rate filings submitted only by other issuers
3. *43* Yes, first-time policy rate filings submitted by both Blue Cross-Blue Shield and other issuers
4. *6* No --> (*Go to question 30 on page 11*)

24. Consider what happens to individual, small group, and group first-time policy rate filings for hospital, medical, and surgical policies once they are submitted to your insurance department by Blue Cross-Blue Shield and other issuers.

PART A: Indicate whether or not each type of first-time policy rate filing is submitted to your insurance department.

PART B: For the type of rate filing that is submitted, indicate in what way, if at all, use of that rate filing is restricted while it is under review.

Type of rate filing	PART A (*Check one*) Is a first-time policy rate filing submitted? Yes	No		PART B (*Check one for each type of first-time policy rate filing*) Once a first-time policy rate filing is submitted, the issuer can begin using the rate immediately.	Once a first-time policy rate filing is submitted, there is a specified length of time within which the insurance department must respond; the rate may be used after the specified length of time if the department has not responded (some may refer to this as a "deemer").	Once a first-time policy rate filing is submitted, the rate can be used only after the issuer hears from the insurance department and there is no specified length of time within which the department must respond.	Other (*Please specify*)
Blue Cross-Blue Shield *(N=44)*							
1. Individual	44	0	*If yes-> (N=43)*	9	25	7	2
2. Small group	33	11	*If yes-> (N=32)*	8	18	5	1
3. Group	30	14	*If yes-> (N=29)*	7	16	5	1
Other issuers *(N=43)*							
1. Individual	43	0	*If yes-> (N=40)*	7	26	6	1
2. Small group	27	16	*If yes-> (N=26)*	6	15	3	2
3. Group	23	20	*If yes-> (N=22)*	5	12	3	2

25. Where a hospital, medical, and surgical first-time rate filing is submitted for review, does your insurance department have a specified length of time within which the department must respond? (*Check one*) ***(N=44)***

    1. ***34*** Yes

    2. ***10*** No –> (*Go to question 27*)

26. For those rate filings with a specified length of time within which your insurance department must respond, is the length of time the same for all types of hospital, medical, and surgical policies? (*Check one*) ***(N=33)***

    1. ***26*** Yes, the length of time is the same ----------> What is that length of time? (*Enter number*)

	Range	***Median***	
(N=27)	***30-90***	***30***	days

    2. ***7*** No, the length of time is different ----> What is the length of time for each type of policy? (*Enter number; If no deadline; enter "0"*)

		Range	***Median***	
A. Blue Cross-Blue Shield				
Individual	***(N=6)***	***0-90***	***15***	days
Small group	***(N=4)***	***0-60***	***15***	days
Group	***(N=4)***	***0-60***	***15***	days
B. Other issuers				
Individual	***(N=7)***	***30-60***	***30***	days
Small group	***(N=3)***	***30-60***	***60***	days
Group	***(N=3)***	***30-60***	***60***	days

27. What was the total number of hospital, medical, and surgical first-time policy rate filings that were submitted to your insurance department for review during calendar year 1991? (*Enter number; If none, enter "0"*) ***(N=9)***

Range	***Median***	
2-1,478	***234***	First-time policy rate filings submitted

    33 Information not available

28. Of those hospital, medical, and surgical first-time policy rate filings submitted for review during calendar year 1991, how many, if any, did your insurance department review? (*If no reviews were conducted, check box "a" below; Enter number*)

a. *0* Did not conduct any reviews during calendar year 1991 ---> (*Go to question 30*)

	Range	Median	
(N=9)	*2-1,478*	*54*	First-time policy rate filings reviewed

27 Information not available

29. Now consider the hospital, medical, and surgical first-time rate filings submitted by Blue Cross-Blue Shield and other issuers during calendar year 1991. What was the length of time it took your insurance department to review a typical first-time policy rate filing submitted during calendar year 1991? That is, from the time the rate filing was submitted until your insurance department (1) first notified the issuer of any problems with the rate filing, or (2) notified the issuer that the department authorized the use of the rate, or (3) completed the review if the issuer was not to be notified, whichever came first. (*Enter number; If none, enter "0"*) *(N=37)*

Range	Median	
0-240	*25*	Days to review a typical Blue Cross-Blue Shield hospital, medical, and surgical first-time policy rate filing
1-180	*30*	Days to review a typical other issuers' hospital, medical, and surgical first-time policy rate filing

30. Does your insurance department review any hospital, medical, and surgical policy rate changes (increases/decreases) submitted by Blue Cross-Blue Shield and other issuers of health insurance policies that provide medical expense coverage? *Check one*) *(N=50)*

1. *2* Yes, policy rate filings submitted only by Blue Cross-Blue Shield
2. *1* Yes, policy rate filings submitted only by other issuers
3. *42* Yes, policy rate filings submitted by both Blue Cross-Blue Shield and other issuers
4. *5* No --> (*Go to question 38 on page 14*)

31. Consider what happens to individual, small group, and group policy rate changes for hospital, medical, and surgical policies once they are submitted to your insurance department by Blue Cross-Blue Shield and other issuers.

PART A: Indicate whether or not each type of policy rate change is submitted to your insurance department.
PART B: For the type of rate change that is submitted, indicate in what way, if at all, use of that rate is restricted while it is under review.

Type of rate change	PART A (Check one) Is a policy rate change submitted? Yes	No		PART B (Check one for each type of policy rate change) Once a policy rate change is submitted, the issuer can begin using the new rate immediately.	Once a policy rate change is submitted, there is a specified length of time within which the insurance department must respond; the new rate may be used after the specified length of time if the department has not responded (some may refer to this as a "deemer").	Once a policy rate change is submitted, the new rate can be used only after the issuer hears from the insurance department and there is no specified length of time within which the department must respond.	Other (Please specify)
Blue Cross-Blue Shield *(N=45)*							
1. Individual	44	1	*If yes-> (N=44)*	9	25	8	2
2. Small group	31	14	*If yes-> (N=30)*	9	14	6	1
3. Group	26	19	*If yes-> (N=26)*	8	13	4	1
Other issuers *(N=44)*							
1. Individual	43	1	*If yes-> (N=41)*	7	25	7	2
2. Small group	24	20	*If yes-> (N=23)*	7	10	4	2
3. Group	17	27	*If yes-> (N=17)*	6	8	2	1

32. Where a hospital, medical, and surgical policy rate change is submitted for review, does your insurance department have a specified length of time within which the department must respond? *(Check one)* ***(N=45)***

1. *32* Yes

2. *13* No --> *(Go to question 34)*

33. For those rate changes with a specified length of time within which your insurance department must respond, is the length of time the same for all types of hospital, medical, and surgical policies? *(Check one)* ***(N=30)***

1. *23* Yes, the length of time is the same ----------> What is that length of time? *(Enter number)*

	Range	Median	
(N=24)	*30-90*	*34*	days

2. *7* No, the length of time is different ----> What is the length of time for each type of policy? *(Enter number; If no deadline, enter "0")*

		Range	Median	
A. Blue Cross-Blue Shield				
Individual	*(N=7)*	*0-90*	*30*	days
Small group	*(N=2)*	*0-30*	*15*	days
Group	*(N=2)*	*0-30*	*15*	days
B. Other issuers				
Individual	*(N=7)*	*30-60*	*30*	days
Small group	*(N=2)*	*0-60*	*30*	days
Group	*(N=2)*	*0-60*	*30*	days

34. What was the total number of hospital, medical, and surgical policy rate changes that were submitted to your insurance department for review during calendar year 1991? *(Enter number; If none, enter "0")* ***(N=16)***

Range	Median	
66-1,689	*537*	Policy rate changes submitted

26 Information not available

35. Of those hospital, medical, and surgical policy rate changes submitted for review during calendar year 1991, how many, if any, did your insurance department review? *(If no reviews were conducted, check box "a" below; Enter number; If none, enter "0")*

a. *0* Did not conduct any reviews during calendar year 1991 ---> *(Go to question 30)*

	Range	Median	
(N=16)	*66-1,689*	*479*	Policy rate changes reviewed

21 Information not available

36. Now consider the hospital, medical, and surgical policy rate changes submitted by Blue Cross-Blue Shield and other issuers during calendar year 1991. What was the length of time it took your insurance department to review a typical policy rate change submitted during calendar year 1991? That is, from the time the rate change was submitted until your insurance department (1) first notified the issuer of any problems with the rate change, or (2) notified the issuer that the department authorized the use of the new rate, or (3) completed the review if the issuer was not to be notified, whichever came first. (*Enter number; If none, enter "0"*)

(N=39)	Range	Median	
	5-150	24	Days to review a typical Blue Cross-Blue Shield hospital, medical, and surgical policy rate change

(N=40)	Range	Median	
	2-180	30	Days to review a typical other issuers' hospital, medical, and surgical policy rate change

37. Consider the procedures your insurance department follows when reviewing a hospital, medical, and surgical policy for first-time rates and rate changes. Is the review of rates for a first-time policy more or less extensive than the review conducted for a rate change? (*Check one*)

First-time review is .....*(N=45)*

1. *3* Much more extensive
2. *2* More extensive
3. *20* About the same
4. *15* Less extensive
5. *2* Much less extensive
6. *2* Not applicable -- Do not review first-time rates
7. *1* Not applicable -- Do not review rate changes

38. Does your insurance department review any advertising for hospital, medical, and surgical health insurance policies submitted by Blue Cross-Blue Shield and other issuers of health insurance policies that provide medical expense coverage? (*Check one*) *(N=49)*

1. *1* Yes, advertising submitted only by Blue Cross-Blue Shield
2. *3* Yes, advertising submitted only by other issuers
3. *22* Yes, advertising submitted by both Blue Cross-Blue Shield and other issuers
4. *23* No --> (*Go to question 40*)

39. Now we would like you to think about advertising for hospital, medical, and surgical policies. Consider what happens to advertising for individual, small group, and group policies once it is submitted to your insurance department by Blue Cross-Blue Shield and other issuers.

PART A: Indicate whether or not advertising is submitted to your insurance department for each type of policy.
PART B: For the type of policy that advertising is submitted, indicate in what way, if at all, use of the advertising is restricted while it is under review.

Advertising for type of policy	PART A (Check one) Is the advertising for a policy submitted? Yes	No		PART B (For each type of policy, check one) Once advertising is submitted, the issuer can begin using it immediately.	Once advertising is submitted, there is a specified length of time within which the insurance department must respond; the advertising may be used after the specified length of time if the department has not responded (some may refer to this as a "deemer").	Once advertising is submitted, it can be used only after the issuer hears from the insurance department and there is no specified length of time within which the department must respond.	Other (*Please specify*)
Blue Cross-Blue Shield							
1. Individual *(N=24)*	*16*	*8*	*If yes-> (N=16)*	*3*	*8*	*3*	*2*
2. Small group *(N=23)*	*15*	*8*	*If yes-> (N=15)*	*3*	*6*	*3*	*3*
3. Group *(N=23)*	*12*	*11*	*If yes-> (N=12)*	*2*	*6*	*2*	*2*
Other issuers							
1. Individual *(N=25)*	*20*	*5*	*If yes-> (N=20)*	*5*	*11*	*2*	*2*
2. Small group *(N=24)*	*17*	*7*	*If yes-> (N=17)*	*4*	*9*	*2*	*2*
3. Group *(N=24)*	*16*	*8*	*If yes-> (N=16)*	*3*	*9*	*2*	*2*

ACTIVITIES OF DOMESTIC AND FOREIGN ISSUERS

40. Now we would like you to think about issuers domiciled in your state (domestic issuers) and issuers domiciled in another state (foreign issuers) that are licensed by your state to sell policies that provide **medical expense coverage.**

Remember as we discussed earlier, policies providing medical expense coverage include the following: hospital, medical, and surgical; long-term care; Medicare supplement; hospital indemnity; specified disease; limited benefit; and accident only. Do not include policies, such as automobile, homeowner's, or life insurance policies, that may pay medical expenses in some circumstances but whose major purpose is not to cover medical expenses.

For each category listed below, enter the number of domestic and foreign issuers of health insurance. (*Enter number; If none, enter "0"*)

Issuers	Number of domestic issuers	Number of foreign issuers
1. As of December 31, 1991, issuers licensed to sell only health insurance	*(N=46)* Range: *0-56* Median: *5*	*(N=42)* Range: *0-676* Median: *8*
2. As of December 31, 1991, issuers licensed to sell health and other lines of insurance	*(N=46)* Range: *1-391* Median: *35*	*(N=43)* Range: *55-1,454* Median: *858*
3. Issuers first licensed during calendar year 1991	*(N=46)* Range: *0-7* Median: *1*	*(N=43)* Range: *0-46* Median: *14*

41. Consider the disciplinary actions your insurance department has taken against domestic and foreign issuers of health insurance. Enter the number of domestic and foreign issuers against which your insurance department took each action listed below during calendar year 1991? (*Enter number; If none, enter "0"; If not applicable, enter "NA"*)

	Insurance department action during calendar year 1991	
Type of action	Number of domestic issuers	Number of foreign issuers
1. Sent written notification to the issuer that it was in violation of the insurance code or regulations	*(N=29)* Range: *0-47* Median: *1*	*(N=30)* Range: *0-162* Median: *6*
2. Imposed sanctions on the issuer (that is, fines, temporary limitations on writing new policies, temporary suspensions, or other penalties)	*(N=38)* Range: *0-88* Median: *1*	*(N=38)* Range: *0-127* Median: *10*
3. Revoked license of issuer	*(N=40)* Range: *0-3* Median: *0*	*(N=39)* Range: *0-30* Median: *0*

42. Now consider other actions your insurance department might take concerning the solvency of domestic and foreign issuers of health insurance. Enter the number of domestic and foreign issuers against which your insurance department took each action listed below during calendar year 1991? *(Enter number; If none, enter "0"; If not applicable, enter "NA")*

Type of action	Insurance department action during calendar year 1991: Number of domestic issuers	Number of foreign issuers
1. Required more frequent financial filings	*(N=40)* Range: 0-138, Median: 1	*(N=39)* Range: 0-688, Median: 2
2. Called for immediate financial examination	*(N=45)* Range: 0-18, Median: 1	*(N=37)* Range: 0-2, Median: 0
3. Placed the issuer in: a. conservation/rehabilitation	*(N=45)* Range: 0-14, Median: 0	*(N=33)* Range: 0-14, Median: 0
b. liquidation	*(N=44)* Range: 0-11, Median: 0	*(N=33)* Range: 0-12, Median: 0

ON-SITE EXAMINATIONS

43. Now we would like you to think about on-site financial and market conduct examinations conducted by your insurance department. Did your insurance department conduct any on-site financial or on-site market conduct examinations for issuers of health insurance during calendar year 1991? *(Check one)* *(N=50)*

1. *47* Yes
2. *3* No --> *(Go to question 45)*

44. Of those on-site examinations completed during calendar year 1991, how many were for (1) financial status only, (2) issuer's market conduct only, (3) both financial status and issuer's market conduct? (*If none, enter "0"*)

On-site examinations for.....	Number of examinations	
	Range	*Median*
1. Financial status only *(N=44)*	*0-118*	*2*
2. Issuer's market conduct only *(N=44)*	*0-81*	*1*
3. Both financial status and issuer's market conduct *(N=42)*	*0-58*	*1*
TOTAL *(N=40)*	*1-138*	*14*

CONSUMER COMPLAINTS

45. Next consider any consumer complaints your insurance department received during calendar year 1991 concerning issuers of any type of insurance. Excluding consumer informational inquiries, how many consumer complaints, if any, did your insurance department receive during calendar year 1991? (*If none, check box "a" below; Enter number*)

a. *0* No consumer complaints --> (*Go to question 47*)

	Range	*Median*	
(N=40)	*415-52,657*	*6,225*	complaints

46. What proportion of these complaints were related to health insurance coverage? (*Enter percentage*) *(N=44)*

Range	*Median*	
8-57	*40 %*	related to health insurance coverage

FACTORS AFFECTING WORKLOAD

47. Listed below are various factors that might have an impact on your insurance department's health insurance regulatory workload.

PART A: For each factor, indicate if it increased, decreased, or didn't change from January 1, 1989, to the present. (*Check one for each*)

PART B: For each factor that you identified as having changed in Part A, indicate what effect, if any, that change had on your insurance department's workload. (*Check one for each*)

Factor	PART A: How factor changed--from Jan 1, 1989, to present						PART B: Effect of Change on your insurance department's workload				
	Greatly increased	Somewhat increased	No change	Somewhat decreased	Greatly decreased		Greatly increased	Somewhat increased	No effect	Somewhat decreased	Greatly decreased
1. Requirements of state regulations applying to health insurance (N=49)	26	22	1	0	0	*If change->* (N=47)	18	29	0	0	0
2. Requirements of federal regulations applying to health insurance (N=48)	21	25	2	0	0	If change-> (N=46)	19	26	1	0	0
3. Number of provider networks (e.g., Preferred Provider Organizations) (N=43)	7	23	12	0	1	*If change->* (N=36)	5	16	9	0	0
4. Use of medical underwriting by the issuers (N=47)	7	27	13	0	0	*If change->* (N=34)	3	20	11	0	0
5. Number of policy forms submitted (N=48)	12	28	5	2	1	*If change->* (N=42)	14	25	2	1	0
6. Number of policy rate filings (N=47)	10	25	12	0	0	*If change->* (N=34)	11	23	0	0	0
7. Number of health insurance inquiries (N=46)	23	19	4	0	0	*If change->* (N=42)	23	18	1	0	0
8. Number of health insurance complaints (N=45)	14	24	6	1	0	*If change->* (N=39)	15	24	0	0	0
9. Attention to issuer solvency by your insurance department (N=46)	23	18	5	0	0	*If change->* (N=39)	23	14	2	0	0
10. Other (*Please specify*) _____ (N=6)	4	2	0	0	0	*If change->* (N=6)	4	2	0	0	0

48. In your opinion, overall has your insurance department's health insurance workload increased, decreased, or remained the same since January 1, 1989? *(Check one)* ***(N=50)***

1. ***27*** Greatly increased
2. ***20*** Moderately increased
3. ***3*** Somewhat increased
4. ***0*** Has not changed
5. ***0*** Somewhat decreased
6. ***0*** Moderately decreased
7. ***0*** Greatly decreased

49. Consider your insurance department's regulatory responsibilities to enforce state insurance laws, ensure issuer solvency, and protect health insurance consumers. Overall, how adequate or inadequate is your insurance department's legal authority to regulate issuers of health insurance, given its responsibilities? *(Check one)* ***(N=48)***

1. ***2*** Much more than adequate
2. ***8*** More than adequate
3. ***23*** About adequate

> *(Go to question 51)*

4. ***13*** Less than adequate
5. ***2*** Much less than adequate

> *(Go to question 50)*

50. Please describe how your insurance department's authority is less than adequate.

15 respondents provided comments.

35 respondents did not provide comments.

51. Finally, what future challenges and obstacles, if any, do you think insurance regulators will need to meet or overcome to protect the health insurance consumers?

40 respondents provided comments.

10 respondents did not provide comments.

Thank you for your help!

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HRD/SLS/8-92
(101241)

States' Adoption of NAIC Model Laws, Regulations, and Guidelines Related to Health Insurance, as of April 1993

NAIC model (year adopted)	Number of states that have: Model or similar legislation	Related legislation or regulation	Model or regulation pending	Taken no action to date
Minimum reserve standards for individual and group health insurance contracts (1941)	14	17	4	16
Health maintenance organization (HMO) model act (1973)	28	21	0	2
HMO investment, long-term debt, expenditure, and cash management guidelines (1986, 1987)	2	5	0	44
Model regulation to implement rules regarding contracts and services of health maintenance organizations (1987)	4	20	1	26
HMO producer model regulation (1989)	0	9	0	42
Life and health insurance guaranty association model act (1971)	50	1	0	0
Life and health reinsurance agreements model regulation (1986)	27	1	1	22
Group health insurance definition and standard provisions (1983)	13	35	0	3
Accident and health policy regulatory law to require filing and prior approval of individual policies (1947)	10	40	0	1
Official guide for the filing and approval of accident and health insurance contracts (1946)	3	26	0	22
Availability of alcohol and other drug dependency coverage (1991)	5	35	0	11
Health examination benefits availability act (1987)	2	15	0	34
Individual accident and sickness insurance minimum standards act (1974)	15	8	0	28
Model regulation to implement the individual accident and sickness insurance minimum standards act (1975)	21	3	0	27
Uniform individual accident and sickness policy provision law (1950)	49	1	0	1
Long-term care insurance model act (1987)	44	5	1	1
Long-term care insurance model regulation (1988)	36	5	4	6
Medicare supplement insurance minimum standards model act (1980)	36	12	0	3
Model regulation to implement NAIC Medicare supplement insurance minimum standards model act (1980)	50	0	1	0
Premium rates and renewability of coverage for health insurance sold to small groups/small employer health insurance availability (1990, 1991)	19	11	5	16
Model regulation to implement small employer health insurance availability act (1993)	1	5	0	45
Guidelines for filing rates for individual health insurance forms (1980)	10	16	0	25

(continued)

NAIC model (year adopted)	Number of states that have: Model or similar legislation	Related legislation or regulation	Model or regulation pending	Taken no action to date
Mass-marketed life or health insurance (1978)	6	2	0	43
Rules governing advertisements of accident and sickness insurance (1956)	43	3	1	4
Regulation to eliminate unfair sex discrimination (1976)	19	9	0	23
Medical/lifestyle questions and underwriting guidelines (1987)	18	25	0	8
Group health insurance mandatory conversion privilege (1976)	19	18	0	14
Group coverage discontinuance and replacement (1972)	22	7	0	22
Group coordination of benefits regulation (1971)	40	4	2	5
Noncancelable and guaranteed renewable terminology (1960)	12	2	0	37
Administrative procedures relative to renewability and cancellation provisions (1953)	2	7	0	42
NAIC model rule governing advertisements of Medicare supplement insurance (1988)[a]	6	3	0	42
Unfair trade practices act (1947)	45	4	0	2
Regulation for complaint records to be maintained (1973)	10	3	0	38
Unfair discrimination in life and health insurance on the basis of physical or mental impairment (1979)	9	14	1	27
Unfair discrimination in life and health insurance on the basis of blindness (1978)	36	7	0	8
Unfair life, accident, and health claims settlement practices (1976)	19	9	1	22
Comprehensive health insurance and health care cost containment (1976)	1	7	0	43
Prepaid limited health service organization (1989)	2	2	0	47
Preferred provider arrangements (1987)	5	22	0	24
An act to provide for the incorporation and regulation of nonprofit hospital service plan corporations (1946)	2	37	0	12
Model health plan for uninsurable individuals act (1983)	14	13	0	24
Jurisdiction to determine jurisdiction of providers of health care benefits (1982)	22	8	0	21
Model regulation for certification of health plans or policies (1988)	1	0	0	50

[a]Nearly all states have addressed these issues through the Rules Governing Accident and Sickness Insurance model.

State Insurance Department Budgets and Percentages Expended on Health Insurance Regulation

State[a]	1991 insurance budget (in thousands)	Percent devoted to health
Alabama	$3,475	[b]
Alaska	3,064	[b]
Arizona	3,066	50
Arkansas	3,200	40
California	72,122	[b]
Colorado	4,683	50
Connecticut	6,939	22
Delaware	2,998	10
District of Columbia	2,423	8
Florida	40,674	[b]
Georgia	14,322	16
Hawaii	1,660	4
Idaho	3,552	30
Illinois	14,727	19
Indiana	4,108	33
Iowa	4,061	20
Kansas	5,531	10
Kentucky	7,107	33
Louisiana	6,368	10
Maine	3,244	40
Maryland	8,486	25
Massachusetts	4,900	11
Michigan	8,644	13
Minnesota	5,488	50
Missouri	3,530	30
Montana	966	57
Nebraska	3,698	10
Nevada	7,600	7
New Hampshire	2,400	[b]
New Jersey	14,299	20
New Mexico	2,700	13
New York	58,699	18
North Carolina	22,542	50
North Dakota	1,411	30
Ohio	12,437	40
Oklahoma	4,218	38

(continued)

State[a]	1991 insurance budget (in thousands)	Percent devoted to health
Oregon	5,366	[b]
Pennsylvania	13,488	40
Rhode Island	1,932	10
South Carolina	5,406	33
South Dakota	768	15
Tennessee	3,599	15
Texas	56,760	14
Utah	2,260	27
Vermont	1,857	10
Virginia	11,800	30
Washington	8,004	28
West Virginia	1,697	35
Wisconsin	5,460	40
Wyoming	2,317	8

[a]Mississippi did not respond to our survey.

[b]State was unable to estimate the percentage of its budget expended on health insurance regulation.

State Insurance Department Staffing in 1991

State[a]	Total department staff	FTEs spent on health	Number of health actuaries	
			Department	Contract
Alabama	[b]	[b]	[b]	[b]
Alaska	30	[b]	0	0
Arizona	84	[b]	1	2
Arkansas	73	[b]	1	0
California	1,038	[b]	1	0
Colorado	91	[b]	1	0
Connecticut	74	15	1	1
Delaware	46	5	0	[b]
District of Columbia	42	[b]	0	[b]
Florida	[b]	[b]	5	[b]
Georgia	[b]	36	1	2
Hawaii	33	[b]	0	0
Idaho	62	9	[b]	2
Illinois	288	34	1	0
Indiana	86	[b]	0	2
Iowa	91	[b]	0	0
Kansas	147	21	0	0
Kentucky	98	[b]	0	1
Louisiana	134	4	0	1
Maine	67	27	1	[b]
Maryland	162	[b]	1	0
Massachusetts	113	13	1	[b]
Michigan	141	18	1	1
Minnesota	100	[b]	0	0
Missouri	101	18	0	[b]
Montana	21	13	1	0
Nebraska	82	10	0	0
Nevada	46	[b]	1	1
New Hampshire	45	1	0	[b]
New Jersey	490	[b]	4	0
New Mexico	64	36	2	0
New York	797	[b]	10	0
North Carolina	310	[b]	1	[b]
North Dakota	39	18	0	1
Ohio	208	[b]	0	1
Oklahoma	99	38	0	0

(continued)

State[a]	Total department staff	FTEs spent on health	Number of health actuaries	
			Department	Contract
Oregon	92	[b]	1	0
Pennsylvania	243	80	0	0
Rhode Island	40	3	0	2
South Carolina	115	19	1	0
South Dakota	22	9	0	[b]
Tennessee	98	30	0	1
Texas	1,187	153	2	[b]
Utah	52	[b]	0	1
Vermont	31	3	0	1
Virginia	157	[b]	0	12
Washington	138	24	1	0
West Virginia	49	22	0	0
Wisconsin	116	24	0	0
Wyoming	20	3	0	0

[a]Mississippi did not respond to our survey.

[b]Information not available from state insurance departments.

Licensed Insurers and Exams Performed by States in 1991

State[a]	Domestic[b] health insurers	Foreign health insurers	On-site financial exams	Market conduct exams	Combined financial and market conduct
Alabama	[c]	[c]	[c]	[c]	[c]
Alaska	9	[c]	0	0	2
Arizona	115	898	33	31	0
Arkansas	59	1,157	0	15	16
California	204	1,140	6	0	26
Colorado	[c]	[c]	22	20	0
Connecticut	77	405	1	0	6
Delaware	148	1,358	0	0	2
District of Columbia	4	66	2	0	0
Florida	30	732	6	20	0
Georgia	97	1,379	57	6	0
Hawaii	14	489	0	0	2
Idaho	2	660	0	0	[c]
Illinois	259	939	63	14	0
Indiana	119	1,195	0	0	24
Iowa	71	1,096	0	0	19
Kansas	45	903	0	7	0
Kentucky	19	594	0	4	4
Louisiana	[c]	[c]	17	0	0
Maine	7	212	2	0	0
Maryland	55	1,034	18	23	0
Massachusetts	36	436	7	0	0
Michigan	[c]	[c]	[c]	0	0
Minnesota	72	850	0	2	9
Missouri	135	1,589	25	81	[c]
Montana	2	847	1	0	1
Nebraska	61	1,098	14	8	0
Nevada	14	864	[c]	[c]	[c]
New Hampshire	52	774	0	0	1
New Jersey	33	605	3	3	0
New Mexico	21	834	0	1	4
New York	235	357	0	5	58
North Carolina	137	547	7	11	7
North Dakota	23	[c]	1	6	3
Ohio	203	914	90	1	0
Oklahoma	49	733	[c]	[c]	[c]
Oregon	33	891	18	8	0

(continued)

State[a]	Domestic[b] health insurers	Foreign health insurers	On-site financial exams	Market conduct exams	Combined financial and market conduct
Pennsylvania	210	866	66	1	2
Rhode Island	9	1,001	1	0	0
South Carolina	29	878	0	0	13
South Dakota	17	1,007	[c]	[c]	[c]
Tennessee	53	1,419	1	0	6
Texas	391	1,468	118	10	10
Utah	59	1,129	12	4	0
Vermont	8	351	2	2	0
Virginia	24	848	[c]	[c]	9
Washington	60	[c]	1	[c]	23
West Virginia	192	424	6	0	6
Wisconsin	4	400	18	4	5
Wyoming	2	548	[c]	[c]	[c]

[a]Mississippi did not respond to our survey.

[b]Domestic insurers are domiciled in the state shown; foreign insurers are domiciled in another state.

[c]Information not available from state insurance departments.

States' Adoption of NAIC Model Laws, Regulations, and Guidelines Related to Accreditation, as of May 1993

NAIC model (year adopted)	Number of states that have: Model or similar legislation	Related legislation or regulation	Model or regulation pending	No current legislation or regulation
Examination authority (1991)	26	25	6	0
Regulation to define standards and commisioner's authority for companies in hazardous financial condition (1985)	28	3	3	20
Holding company act (1969)	49	2	0	0
Holding company regulation (1971)	38	7	1	6
Credit for reinsurance Act (1984)	39	9	2	3
Credit for reinsurance regulation (1991)	5	4	4	42
Regulation for life and health reinsurance agreements (1986)	29	1	3	21
Standard valuation law (1943)	51	0	0	0
Actuarial opinion and memorandum regulation (1991)	6	3	4	42
CPA audit regulation (1980)	29	8	0	14
Rehabilitation and liquidation model act (1978)	29	22	2	0
IRIS model act (1985)	35	6	3	10
Risk retention act (1983)	45	2	2	4
Business transacted with producer controlled property/casualty insurer act (1991)	37	0	7	14
Managing general agent act (1989)	44	1	5	6
Reinsurance intermediaries act (1990)	37	1	9	13
Life and health insurance guaranty association act (1971)	50	1	0	0
Post-assessment property and liability insurance guaranty association act (1970)	44	7	0	0

Past GAO Studies of NAIC's Program to Accredit State Insurance Departments' Financial Solvency Regulation Efforts

To encourage states to enact model policies and provide sufficient regulatory resources, in 1989 NAIC adopted a set of minimum financial regulation standards that it believes are necessary for effective solvency regulation. In 1990, NAIC adopted an accreditation program to encourage individual state insurance departments to comply with NAIC's minimum standards for insurer solvency regulation. As of June 1993, NAIC had accredited 18 states.

Past GAO studies have identified three principal problems with NAIC's accreditation program.[1] First, the program's standards are general and have been interpreted permissively by the accreditation review teams. Second, the program focuses on a state's legal authority, rather than on how well the department acts on this authority.[2] Finally, accreditation decisions were inconsistent with problems identified by the review team. As a result, the NAIC accreditation program allows state insurance departments to become accredited without demonstrating that they are effectively regulating insurance company solvency. Growing resistance by some regulators, state legislatures, and industry representatives to the demands of the accreditation program raises questions about the long-term viability of the program.

[1]Insurance Regulation: The National Association of Insurance Commissioners' Accreditation Program Continues to Exhibit Fundamental Problems (GAO/T-GGD-93-26, June 9, 1993), Insurance Regulation: The Financial Regulation Standards and Accreditation Program of the National Association of Insurance Commissioners (GAO/T-GGD-92-27, Apr. 9, 1992), and Insurance Regulation: Assessment of the National Association of Insurance Commissioners (GAO/T-GGD-91-61, July 29, 1991).

[2]Appendix VII shows the status of states' adoption of NAIC models required for accreditation.

Comments From NAIC

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

NAIC

120 West 12th Street
Suite 1100
Kansas City, Missouri 64105-1925
816-842-3600

816-471-7004 Main Fax
816-842-9185 Financial Services & Research Fax

National
Association
of Insurance
Commissioners

September 17, 1993

Ms. Sarah F. Jaggar
Director, Health Financing and Policy Issues
U.S. General Accounting Office
Washington, D.C. 20548

Dear Ms. Jaggar:

Thank you for the opportunity to review and comment on your draft report Private Health Insurance: Wide Variation in State Insurance Departments' Regulatory Authority, Oversight and Resources. The report reflects a great deal of effort by GAO staff in attempting to quantify state regulatory procedures and resources in health insurance. Understandably, you have not drawn conclusions in this report about the states' ability to deal with health insurance reform.

We are pleased that you have pointed out the egregious deficiencies in ERISA. You may be interested in knowing that we are developing a white paper which identifies the deficiencies in plan regulation, the lack of consumer protections under ERISA and the inability of ERISA to accommodate state reform.

We note with interest, however, the absence of discussion in the report about how states have demonstrated the ability to handle reform for Medicare supplement insurance. As you are aware, states successfully carried out national reform in 1988, 1989 and 1990. Another area which was not fully addressed is department resources. The report does not enumerate the variety of additional functions that departments perform, such as the operation of medical databases, implementation of state health reform measures, or engaging in consumer education efforts like senior citizen counseling. Also not enumerated are the number of insurance departments that have shared primary or total regulation of health maintenance organizations and related entities like utilization review organizations, preferred provider organizations and exclusive provider organizations.

What is most disturbing, though, is that the report's central theme appears to be based primarily on previous work conducted by the GAO in the solvency area. Listed below are specific comments about statements which are either incorrect or misleading, along with some technical corrections.

See comment 1.
Now on p. 1.

Specific Comments

Page 2, Paragraph continuing from Page 1: The report states that "In some cases, State insurance department efforts to monitor the financial solvency of insurers have not protected consumers from insurer failures." It is not the goal of any financial regulatory system (whether for insurance companies or other financial institutions) to eliminate totally insolvency. It is to minimize the incidence and cost of insolvencies and to protect consumers from adverse consequences. Realistically, for the market to function in an insurance environment there has to be a mechanism to handle failure. If the standard is so stringent that failures are not allowed, the supply of insurance would be restricted because of the attendant cost. The report does not articulate what the appropriate standard should be.

See comment 2.
Now on p. 10.

Most policyholders are covered by state guaranty funds which ensure that coverage is continued. This should be pointed out in the text of the report. Research indicates that most claimants and the amount of claims are effectively covered. Some of the Blue Cross Plans (those formed as hospital, medical, dental service or indemnity corporations (HMDIs)) are handled differently in many states because of the unique regulatory status conferred on them by the legislatures. Hold harmless agreements and other measures are used to protect Blues policyholders. It is reasonable to ask whether these measures are adequate but that is a question that requires considerable analysis that was apparently beyond the scope of this report.

See comment 3.
Now on p. 3.

Page 6, 1st Paragraph: Previous GAO studies of state solvency regulation, as pointed out by the NAIC, contain serious flaws and their conclusions are unsupported. Many of the GAO's conclusions with respect to state solvency regulation have been presented in the form of testimony to Congress and have not been subject to prior review and comments by the NAIC or other experts. This report should alert the reader to the fact that previous GAO findings are in dispute. Copies of NAIC comments on GAO reports and testimony are attached.

See comment 4.
Now on p. 4.

Page 9: In discussing Blue Cross Plans (Blues Plans), the report does not point out that United States Congress explicitly granted a federal charter to Blue Cross and Blue Shield of the National Capital Area, organized as Group Hospitalization and Medical Services, Inc. (GHMSI), which provided a partial exemption from the insurance laws of the District. Legislation was finally introduced which established the District of Columbia as the legal domicile for GHMSI, required the corporation to be licensed in and covered by the laws and regulations of the District, and temporarily removed GHMSI's exemption from the District's laws and regulations. This legislation only covered one year; the 103rd Congress will need to enact permanent legislation.

In addition, the report states that insurance departments have difficulty in identifying financial problems because of weaknesses in the reporting requirements. The report does not mention that strict financial standards and reporting requirements were enacted in both Virginia and Maryland.

See comment 5.
Now on p. 6.

Page 12: The report implies that failure to adopt NAIC models results in ineffective regulation of health insurance. It should be pointed out that some models are not appropriate for certain states. For example, the NAIC High Risk Pool Model may not be needed in a state in which a Blues Plan or health maintenance organization (HMO) still takes all comers, or where the small

group guaranteed issue law may go down to one life. This is only one instance in which it would be illogical to blindly adhere to model legislation as the basis for effective regulation.

See comment 6.
Now on p. 8.

Page 17, Paragraph continuing from Page 16: As indicated above, the GAO "studies" cited are flawed and their conclusions are disputed.

See comment 7.
Now on p. 9.

Pages 17 - 20: The report asserts that GAO evaluators found that state financial review of insurers have significant limitations, but the support offered for this finding appears to be grossly inadequate. On Page 19, the report states that such reviews are inherently limited because the financial data is not verified to detect errors or misrepresentation. This statement is clearly erroneous as a number of measures are employed to check the veracity of data. This error and other errors in this section raise questions about the thoroughness of the GAO's evaluation. What steps did GAO take to assess state financial reviews?

The report fails to discuss the significance of a number of important measures used in monitoring multi-state insurers. These measures include mandated annual CPA audits, actuarial opinions, NAIC Insurance Regulatory Information System (IRIS) and Financial Analysis Solvency and Tracking (FAST) system and peer review activity through the Financial Analysis Working Group. The relative roles of domiciliary and non-domiciliary states in monitoring solvency also should be discussed. This section of the report should be eliminated given the cursory analysis that was performed.

See comment 8.
Now on p. 8.

Page 18, 1st Paragraph: The figures presented in the second and third sentences appear to be inconsistent and not comparable. The first figure is the number of life/health insurers that "failed" during the mid-1980s. The second figure is the number of insurers that sold health insurance that were "liquidated" in 1991. Some life insurers do not sell health insurance and some property/casualty insurers do sell health insurance. According to an A.M. Best study, for insurers that sold accident and health insurance as their principal line of business, there were 13 failures in 1991 compared with an annual average of 5.6 failures over the period 1983-1986.

See comment 9.
Now on p. 8.

The amount of accident and health business in the nine companies liquidated or placed in conservation in Illinois during 1991 was very small. At least two of the companies reported as liquidations had accident and health authority, but had no accident and health business. To say those are accident and health insolvencies is incorrect. The questionnaire asked about insolvencies for companies who held accident and health authority, not companies who wrote accident and health business.

See comment 10.
Now on p. 8.

Five out of the eight Pennsylvania companies reported as failures by the GAO in the report in fact claimed ERISA exemption and were unlicensed health carriers.

See comment 11.
Now on p. 9.

Page 19, 1st Paragraph: There is some confusion about the states' answers to questions about on-site examinations. States typically perform an annual desk audit of all domestic insurers and a prioritized review of licensed foreign insurers. On-site examinations are performed roughly every 3 to 5 years, but more frequently if necessary as indicated by desk audits or other information. The second and third complete sentences on Page 19 should be revised as follows to accurately reflect the states' responses: "Officials in the seven states we visited believe that

because insurers' financial conditions can deteriorate rapidly, these reviews should be performed at least annually on domestic companies. However, officials in two of the seven departments told us that they did not have sufficient resources to complete annual reviews on all licensed health insurers in their states." It should be reiterated that the NAIC does now require annual CPA audits verifying the accuracy of the filed statements.

See comment 12.
Now on p. 9.

Page 20, 1st Paragraph: The report states that state on-site examinations are too infrequent. What is the basis for this conclusion? What level of frequency does the GAO believe is adequate? The report makes no mention of the need to prioritize examinations based on insurer characteristics and the use of targeted examinations to pin-point problems on an as-needed basis. These are important regulatory concepts which are ignored by this report. Again, this type of statement in the report suggests that only a very superficial review was performed by GAO evaluators which would be inadequate to draw any valid conclusions about the adequacy of states' comprehensive solvency monitoring system including on-site examinations.

See comment 13.
Now on p. 10.

Page 21, 1st Paragraph: In addition to above comments on the report's statements with respect to guaranty funds, this report's reference to the 1992 GAO report on life/health guaranty funds is inappropriate. That report's findings with respect to gaps in guaranty fund coverage pertained primarily to life insurance and annuities. All states' guaranty funds cover accident and health insurance sold by licensed insurers. There is no evidence of significant gaps in guaranty fund coverage of health insurance.

See comment 14.

Now appendix III.

Page 62: Appendix IV indicates that 42 states have not adopted the NAIC Model Rule Governing Advertisements of Medicare Supplement Insurance. Nearly all states have in fact addressed that issue through the Rules Governing Advertisements of Accident and Sickness Insurance. In 1987 the Medicare Supplement aspects of the original rules were severed and placed into a separate rule, entitled Model Rules Governing Advertisements of Medicare Supplement Insurance.

We hope that these comments are of assistance in finalizing your report. Please contact us if we can be of further assistance.

Very truly yours,

Steven T. Foster
President

David Walsh
Vice President

Attachments: The attachments referred to above are of two types:

See comment 15.

1. Previous NAIC comments and testimony contained in GAO/T-GGD-93-26, June 9, 1993; GAO/T-GGD-92-43, Sept. 9, 1992; and GAO/T-GGD-92-27, April 9, 1992; and

2. Previous comments and testimony which are attached.

The following are GAO's comments on NAIC's letter dated September 17, 1993.

GAO Comments

1. We did not intend to imply that state insurance regulators should prevent all insolvencies as NAIC suggests. The goal of financial solvency monitoring of insurers is to identify troubled insurers; put failing insurers under state supervision; and, in cases of irreversible insolvency, place the company in liquidation, thereby minimizing the costs of the failure and protecting consumers from its adverse consequences. Past GAO studies have identified weaknesses in state solvency regulation that contributed to insurer failures.

2. We changed the text to indicate that most policyholders are covered by state guaranty associations. Nevertheless, significant gaps continue to exist in the protection of health insurance policyholders. State guaranty associations differ in whom they protect, what policies they cover, and how much the association will pay. These gaps were illustrated by the failure of West Virginia Blue Cross/Blue Shield, which left 50,000 policyholders with nearly $40 million in unpaid claims.

3. We added a statement to the text concerning NAIC's disagreements with the results of our prior studies of state solvency regulation and included a list of documents that discuss NAIC's previous comments. However, GAO has always discussed the results of its previous studies of state solvency regulation with NAIC before the studies were issued. In some cases, we obtained written comments from NAIC on drafts of our reports.

4. We have modified the text to indicate that stricter reporting requirements have since been implemented in Virginia and Maryland. According to NAIC, the partial exemption to District of Columbia insurance laws granted to Blue Cross and Blue Shield of the National Capital Area was removed by Public Law 103-127 in October 1993.

5. We footnoted the text to indicate that some models may not be appropriate for all states.

6. See comment 3.

7. NAIC contends that our statement that the financial reviews of insurers performed by state insurance departments are significantly limited is inaccurate. We disagree. None of the state insurance departments we

visited verified the data insurers submitted during annual financial reviews. These data are only verified during the on-site financial exams states conduct every 3 to 5 years. Further, NAIC standards for how state regulators should perform these financial analyses do not provide criteria specific enough to establish a minimum performance level.

None of the measures NAIC identifies as checks on the accuracy of insurer data ensure that state insurance departments have verified insurer information for annual financial reviews. For example:

- The certified public accountant (CPA) audits cited by NAIC are not a substitute for regulators' verification of the data because they are done after the financial data are submitted to insurance regulators. Further, states are not required to reconcile the data submitted to the regulators with the CPA audits.
- Actuarial opinions do not verify the accuracy of the financial information submitted by insurers and, in some cases, are prepared by actuaries employed by the insurance company rather than the insurance department.
- While NAIC's Insurance Regulatory Information System (IRIS) and Financial Analysis Solvency and Tracking system analyze insurer financial data and check it for consistency, they do not verify the accuracy of the data. GAO reported on weaknesses in the IRIS system in 1990.[1]
- Peer review activities, while useful in helping insurance departments improve the quality of their financial analysis, do not verify the data being analyzed.

8. We agree that the numbers are not directly comparable, and therefore have not made a direct comparison. Data directly comparable to those from our survey are not available for an earlier time period.

9. We have modified the text to clearly reflect that some of the companies reported by the states were not active in the health insurance market at the time of liquidation.

10. We have footnoted the report to reflect this information.

11. We have modified the text to clarify that the two states we cited were referring to all licensed insurers in their states, not just domestic insurers. However, we disagree with NAIC's inference that annual CPA audits

[1]Insurance Regulation: The Insurance Regulatory Information System Needs Improvement (GAO/GGD-91-20, Nov. 21, 1990).

compensate for some states' lack of sufficient resources to complete annual reviews for all insurers. The CPA's role is only to verify that financial statements fairly reflect an insurer's financial condition. Regulators are responsible for identifying troubled insurers and assessing whether an insurer's financial condition warrants regulatory interventions.

12. In our study of the failure of life insurers, we found that regulators' reliance on infrequent field examinations to verify financial data reported by insurers significantly impaired the regulators' ability to evaluate the insurer's financial condition and act on adverse findings.[2] Many observers believe that health care reform will significantly change the health insurance marketplace in ways that will strain many insurers' finances and increase the risk of insolvency. In our view, states will need to consider whether field examinations should be conducted more frequently than every 3 to 5 years in order to more quickly detect troubled insurers.

13. See comment 2.

14. We footnoted the table to add the information provided by NAIC.

15. The attachments to NAIC's letter are listed in appendix X.

[2]Insurer Failures: Regulators Failed to Respond in Timely and Forceful Manner in Four Large Life Insurer Failures (GAO/T-GGD-92-43, Sept. 9, 1992).

List of Documents Containing NAIC's Comments on Past GAO Reports

NAIC testimony before the Subcommittee on Commerce, Consumer Protection, and Competitiveness of the Committee on Energy and Commerce of the U. S. House of Representatives on H.R. 1290, The Federal Insurance Solvency Act of 1993, Apr. 28, 1993.

Report to the California Department of Insurance on Executive Life Insurance Company, by R.L. Clements & Associates, Sept. 9, 1992.

Testimony of Salvatore R. Curiale, Superintendent of Insurance, State of New York, submitted to U.S. House of Representatives, Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, Sept. 9, 1992.

NAIC testimony before the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce of the U. S. House of Representatives on The Adequacy of Insurance Regulation and Financial Reporting by Insurance Companies, Apr. 9, 1992.

NAIC letter to The Honorable Cardiss Collins, Chairwoman; Subcommittee on Commerce, Consumer Protection, and Competitiveness; House Committee on Energy and Commerce; Aug. 8, 1991.

Major Contributors to This Report

Human Resources Division, Washington, D.C.	John C. Hansen, Assistant Director, (202) 512-7114 Rolfe A. Forland, Evaluator Susan L. Sullivan, Senior Social Science Analyst Leonard J. Hamilton, Computer Specialist (Programer Analyst)
Denver Regional Office	Paul D. Alcocer, Evaluator-in-Charge Darrell J. Rasmussen, Evaluator

Related GAO Products

Insurance Regulation: The National Association of Insurance Commissioners' Accreditation Program Continues to Exhibit Fundamental Problems (GAO/T-GGD-93-26, June 9, 1993).

Insurance Regulation: Weak Oversight Allowed Executive Life to Report Inflated Bond Values (GAO/GGD-93-35, Dec. 9, 1992).

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (GAO/HRD-92-125, Sept. 22, 1992).

Insurer Failures: Regulators Failed to Respond in Timely and Forceful Manner in Four Large Life Insurer Failures (GAO/T-GGD-92-43, Sept. 9, 1992).

Access to Health Care: States Respond to Growing Crisis (GAO/HRD-92-70, June 16, 1992).

Access to Health Insurance: State Efforts to Assist Small Businesses (GAO/HRD-92-90, May 14, 1992).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992).

Insurance Regulation: The Financial Regulation Standards and Accreditation Program of the National Association of Insurance Commissioners (GAO/T-GGD-92-27, Apr. 9, 1992).

Long-Term Care Insurance: Better Controls Needed in Sales to People With Limited Financial Resources (GAO/HRD-92-66, Mar. 27, 1992).

Insurer Failures: Life/Health Insurer Insolvencies and Limitations of State Guaranty Funds (GAO/GGD-92-44, Mar. 19, 1992).

Small Group Market Reforms: Assessment of Proposals to Make Health Insurance More Readily Available to Small Businesses (GAO/HRD-92-27R, Mar. 12, 1992).

Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements (GAO/HRD-92-40, Mar. 10, 1992).

Medigap Insurance: Insurers Whose Loss Ratios Did Not Meet Federal Minimum Standards in 1988-89 (GAO/HRD-92-54, Feb. 28, 1992).

Insurance Regulation: The Failures of Four Large Life Insurers (GAO/T-GGD-92-13, Feb. 18, 1992).

Long-Term Care Insurance: Risks to Consumers Should Be Reduced (GAO/HRD-92-14, Dec. 26, 1991).

Private Health Insurance: Problems Caused by a Segmented Market (GAO/HRD-91-114, July 2, 1991).

Insurance Regulation: State Handling of Financially Troubled Property/Casualty Insurers (GAO/GGD-91-92, May 21, 1991).

Employee Benefits: Effect of Bankruptcy on Retiree Health Benefits (GAO/GGD-91-115, Aug. 30, 1991).

Medigap Insurance: Better Consumer Protection Should Result From 1990 Changes to Baucus Amendment (GAO/HRD-91-49, Mar. 5, 1991).

Insurance Regulation: The Insurance Regulatory Information System Needs Improvement (GAO/GGD-91-20, Nov. 21, 1990).

Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting (GAO/HRD-90-68, May 22, 1990).

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