

# Consumerism, Market Choice and Orientation, Market Segmentation, Advertisement Regulator's View

European Health Care Systems:  
Need for Substantial Change

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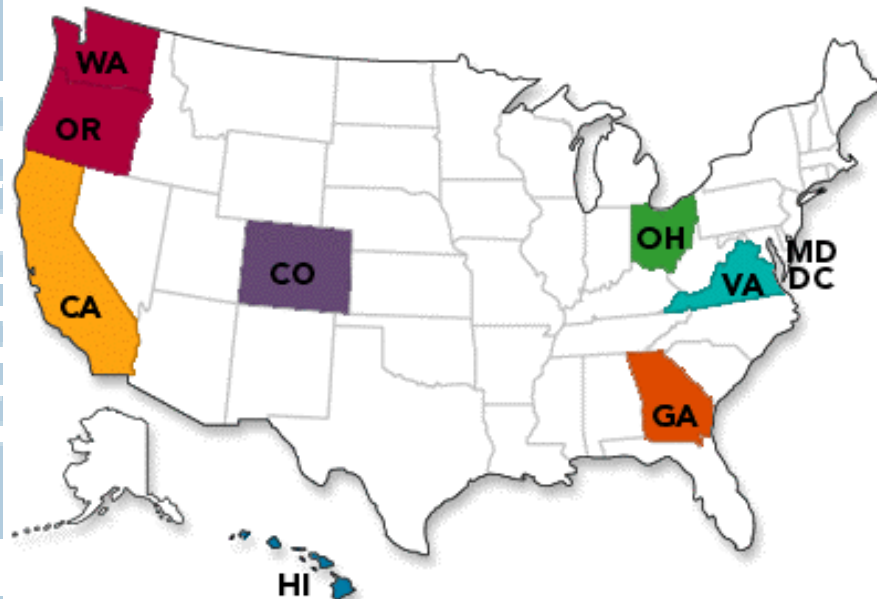
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Kaiser Permanente

# Kaiser Permanente

- Community-based Medical Care Program; providing comprehensive medical, surgical, hospital and ambulatory care, and pharmaceutical services to its members.
- Integrated financing and delivery scheme.
- Three separate organizations (Health Plan, Hospitals, Medical Group), bound together in both partnership and mutually exclusive contractual relationships.

# America's Largest Non-profit Health Care Program



**Integrated health care  
delivery system  
8.4 million members  
11,900+ physicians  
134,000 employees  
8 regions serving 9 states  
and D.C.**

**30 hospitals and medical  
centers  
431 medical offices  
450,000 surgeries  
85,000 deliveries  
\$28 billion annual revenue**

# Health Care Regulation In The US

- Regulated by each of the 50 states.
- Except for Financial Review, no uniform standard.
- Most large employers provide health benefits without any meaningful state or federal regulation.

# US Healthcare is Generally Purchased by Employers

Employers purchase coverage 3 ways:

- Self insure
- Indemnity Insurers
- Health Maintenance Organizations

# US Healthcare is Generally Purchased by Employers

## Self Insurance

- Employers set aside a sum of money to cover health care costs.
- Hire a third-party administrator (generally an indemnity insurer) to administer the benefit.
- Employer defines benefit and cost-sharing by employees.
- No state regulation and minimal federal regulation.

# US Healthcare is Generally Purchased by Employers

## Indemnity Insurance

- Pay providers on a fee-for-service basis.
- Preferred Provider Organizations are a form of indemnity insurance.
  - PPOs arrange for providers to accept a discounted rate for enrollees.

## Dual Choice for Employees

- To help HMOs grow, federal government required that employers offer HMO together with indemnity coverage.
- Allowed employees to have “choice”.
- No longer the law.

## Most Large Employers “Self-Insure”

- The federal government requires that they have sufficient financial resources to pay for the benefit provided to their employees.
- Consumer protections to employees in a self-insured health plan are limited.
- Most state regulation applies to employees of 200 persons or less and individuals who purchase coverage directly.

# Each State Has Same Type of Protections

- Financial requirements to assure HMO or Insurer can pay for or provide the contracted care.
- Governance standards.
- Mandated benefits that all HMOs and Insurers must cover.
- Grievance procedures for individuals to appeal denial of care.
- Market conduct requirements and oversight.
- For HMOs, Access Standards and Provider Network requirements.

# Financial Requirements

## Financial Solvency is the Greatest Consumer Protection

- National Association of Insurance Commissioners (NAIC) is the “trade association” for insurance regulators in the U.S.
- NAIC’s greatest influence is in financial oversight.
- NAIC has adopted model statutory and regulatory guidelines to assure insurers and HMOs are financially stable.
- NAIC mandates that all states review HMO and Insurer financial status using a tool called “risk-based capital” to assure that the entity is financially able to conduct business.

# NAIC Financial Requirements

National Association of Insurance Commissioners  
Solvency Requirements address:

- Financial reserves.
- Deposits in the event of financial challenge or insolvency.
- Hold Harmless provisions for covered persons in the event of insolvency.
- Annual and quarterly filing of financials.
- Standard Statutory Account Procedures.
- Regular Audits by Regulator.
- Significant change in any of the above or in its operations be immediately reported to the regulator.

# NAIC Financial Requirements

## Risk-Based Capital

- HMOs and Insurers must report financial information quarterly and annually.
- Measures the minimum amount of capital that an insurer or HMO needs to support overall business operations.
- Used to set capital requirements for healthy operations considering the size and degree of risk taken.

# Risk-Based Capital

## Four Major Categories of Risk Measured

- **Asset Risk** – measure of an asset’s default of principal or interest or fluctuation in market value as a result of changes in the market.
- **Credit Risk** – measure of the default risk on amounts that are due from policyholders, creditors or reinsurers.
- **Underwriting Risk** – measure of the risk that arises from underestimating the liabilities from business already written or inadequately pricing current or prospective business.
- **Off-Balance Sheet Risk** – measure of the risk due to excessive rates of growth, contingent liabilities or other items not reflected on the balance sheet.

# Governance Standards

Prior to receiving a license, the Insurer or HMO must file with the regulator a copy of all organizational documents such as:

- Articles of incorporation and bylaws.
- Names, addresses and biographical information for all members of the board of directors and senior officers.
- Disclosure of any person having the right to own or acquire 5% of the voting securities or subordinated debt of the organization.
- Description of business plan.
- Description of provider network.
- Other relevant information.

After license is received, any change in the filed information must be sent to the regulator.

# Grievance Procedures

## Internal Grievance Procedure:

- Mandated series of steps an individual can take inside the HMO or Insurer.
- Strict time frames for when HMO or Insurer must respond to complaint and in what manner, generally in writing.
- HMO or Insurer must report to the regulator the number of grievances every year and how they were resolved.

# Grievance Procedures

## External Grievance Procedure:

- Available after internal grievance procedure has been fully used.
- External review does not interpret contract.
- Generally operated by an entity chosen by the regulator to administer the grievances.
- Can be a single administrative judge or a panel of experts in the disputed area.
- Strict time frames.
- Paid for by the Insurer or HMO.
- In some states, the decision of the external review body is binding; some have it be a recommendation to the regulator who makes the final decision.

## Market Conduct Reviews

Regulators regularly review the manner in which the carrier advertises and operates in the market.

# Market Conduct Reviews

Regulator reviews all marketing material

- Advertising.
- All documents given to employer, purchasers and individual enrollees.
- Reviews marketing practices, including rating and underwriting, to see if there is inappropriate discrimination based on race or neighborhood.

# Market Conduct Reviews

## Advertising

No advertisement or other consumer information can be untrue, misleading or deceptive.

- Must be easily readable.
- Must be “true” in context as well as in the specific detail.
- Regulator has a great deal of discretion in approving or disapproving advertisements.

# Market Conduct Reviews

## Marketing Materials

The regulator reviews marketing materials to assure that all important information about the coverage is included:

- Benefits fully listed.
- Rate and cost sharing accurately stated.
- Provider network properly described.
- Providers properly listed.
- Enrollee's rights to appeal clearly explained.
- Right to renew clearly stated.
- Most state, even dictate, size of type (e.g., text in 10-point block type; headings in 12-point bold face type).

# Market Conduct Reviews

Regulator reviews whether Insurer or HMO is in compliance with state license requirements.

- Access
- Provider network
- Grievance procedures
- Other