America's
Health
Insurance
Plans

GUARANTEEING ACCESS
TO COVERAGE FOR ALL AMERICANS

Our Commitment

The members of America's Health Insurance Plans (AHIP) believe that all Americans—regardless of health status or income—should have access to affordable health care coverage. We also believe that it is our responsibility to offer solutions to help the nation meet its health care challenges.

Last year, AHIP's Board of Directors unveiled an ambitious—yet practical and fiscally responsible—proposal to provide health care coverage to all Americans. We also have put forth a comprehensive plan to improve the safety and quality of care nationwide, and continue to advance strategies to make health care more affordable.

Health insurance plans stand ready to work with policymakers to guarantee access to health insurance to all who seek coverage in the individual market. At the same time, we are recommending a series of reforms to give consumers peace of mind, including limiting the use of pre-existing condition exclusions, restricting rescission actions, and establishing a new third-party review process for pre-existing conditions and rescission decisions.

The members of AHIP offer these solutions to help the nation meet its health care challenges and stand ready to work with other stakeholders and policy leaders to make sure all Americans have access to affordable health care coverage.

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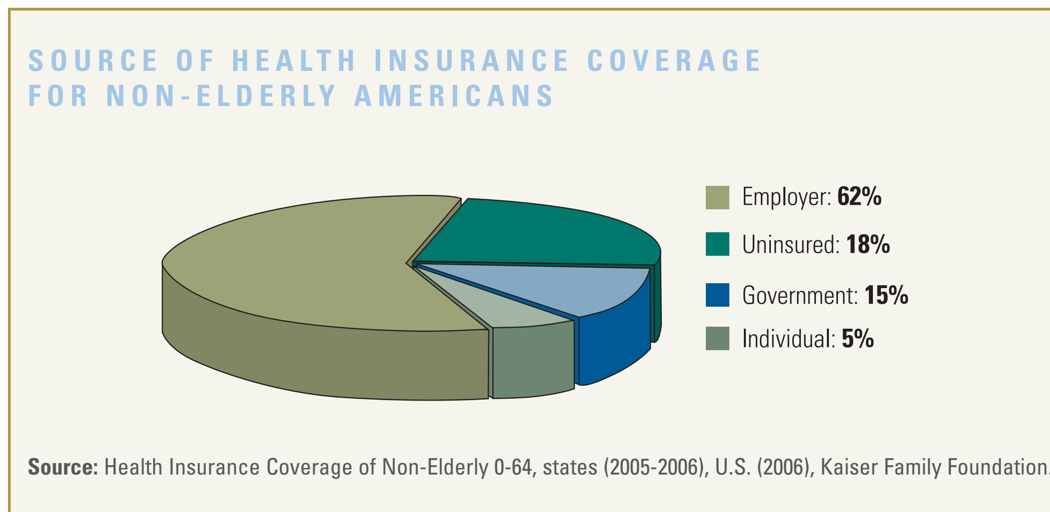
Background on the Individual Health Insurance Market

More than 230 million Americans currently access health care coverage through their employers or through a government programs such as Medicare or Medicaid. For those who do not have access to employer-sponsored health insurance and are not eligible for public programs, the private individual insurance market is a critical source for quality, affordable health care coverage. This market currently provides coverage to approximately 18 million people, and 89 percent of applicants who go through the application process are offered coverage.

At the same time, some individuals are unable to purchase individual health insurance coverage in the private market because of their health status. One approach taken by states to address this issue has been the enactment of guarantee issue and community rating legislation for the individual health insurance market. Unfortunately, these well-intentioned reforms have often resulted in major unintended consequences, including higher costs for those who are currently insured and a significant contraction of choices in the market.[1] Many states also have created high-risk pools that provide subsidized coverage to individuals who have very high health care costs.

AHIP has carefully analyzed this experience and is proposing a new strategy built on shared responsibility between the public and private sectors.

SOURCE OF HEALTH INSURANCE COVERAGE FOR NON-ELDERLY AMERICANS



Source: Health Insurance Coverage of Non-Elderly 0-64, states (2005-2006), U.S. (2006), Kaiser Family Foundation.

1 *The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets*, Milliman, Inc. (August 2007).

Guarantee Access to Health Care Coverage

Highlights of Our Proposal:

- States should create Guarantee Access Plans to provide coverage for uninsured individuals with the highest expected medical costs
- Health plans will guarantee coverage to all applicants who are not eligible for the Guarantee Access Plan
- Health plans should limit any rescission actions to those based only on information that should have been included in a complete and accurate response to questions asked in a clear and understandable application
- States should provide consumers with access to a third-party review process to resolve disputes involving medical issues related to pre-existing condition exclusions and rescission decisions

Establish Guarantee Access Plans

Guarantee Access Plans can ensure that everyone—including individuals with pre-existing medical conditions—has access to health care coverage. Uninsured individuals with the highest expected medical costs would be eligible to enroll in the new plans. Health insurance plans would guarantee coverage to all applicants who are not eligible for the Guarantee Access Plan with premiums capped at one-and-one-half times standard market rates.

Guarantee Access Plans are loosely modeled on state high-risk pools, but include a number of important enhancements to ensure that those with the highest health care costs can access coverage without making coverage unaffordable for others.

HOW GUARANTEE ACCESS PLANS WILL ENSURE ACCESS TO AFFORDABLE COVERAGE

Individuals would be eligible for coverage through the Guarantee Access Plan if their health care claims costs—based on objective, independent underwriting criteria—are expected to be more than twice the statewide average. Premium rates for Guarantee Access Plan coverage would be limited to one-and-one-half times standard market rates.

HOW HEALTH INSURANCE PLANS WILL PROVIDE A COVERAGE SAFETY NET

Health plans would guarantee coverage to individuals who are not eligible for coverage through the Guarantee Access Plan. Each health insurance plan would guarantee issue policies to these individuals up to a predetermined level of participation (for example, 0.5 percent of the health plan's insured population in the individual market). This cap would need to be reset if all health plans reach that level. Health plans would limit the premium for these guarantee issue policies to one-and-one-half times standard market rates.

STREAMLINING THE GUARANTEE ACCESS PLAN APPLICATION PROCESS

Health plans would provide assistance with the Guarantee Access Plan enrollment process, including informing individuals about the availability of coverage under the Guarantee Access Plan and, at their request, transferring information to the Guarantee Access Plan application.

LIMITING THE USE OF PRE-EXISTING CONDITION EXCLUSIONS

Pre-existing condition exclusions would not be imposed by health plans or the Guarantee Access Plan if the individual maintains continuous coverage. When a Guarantee Access Plan is established, there would be a one-time open enrollment for uninsured individuals to obtain coverage with no pre-existing condition exclusions.

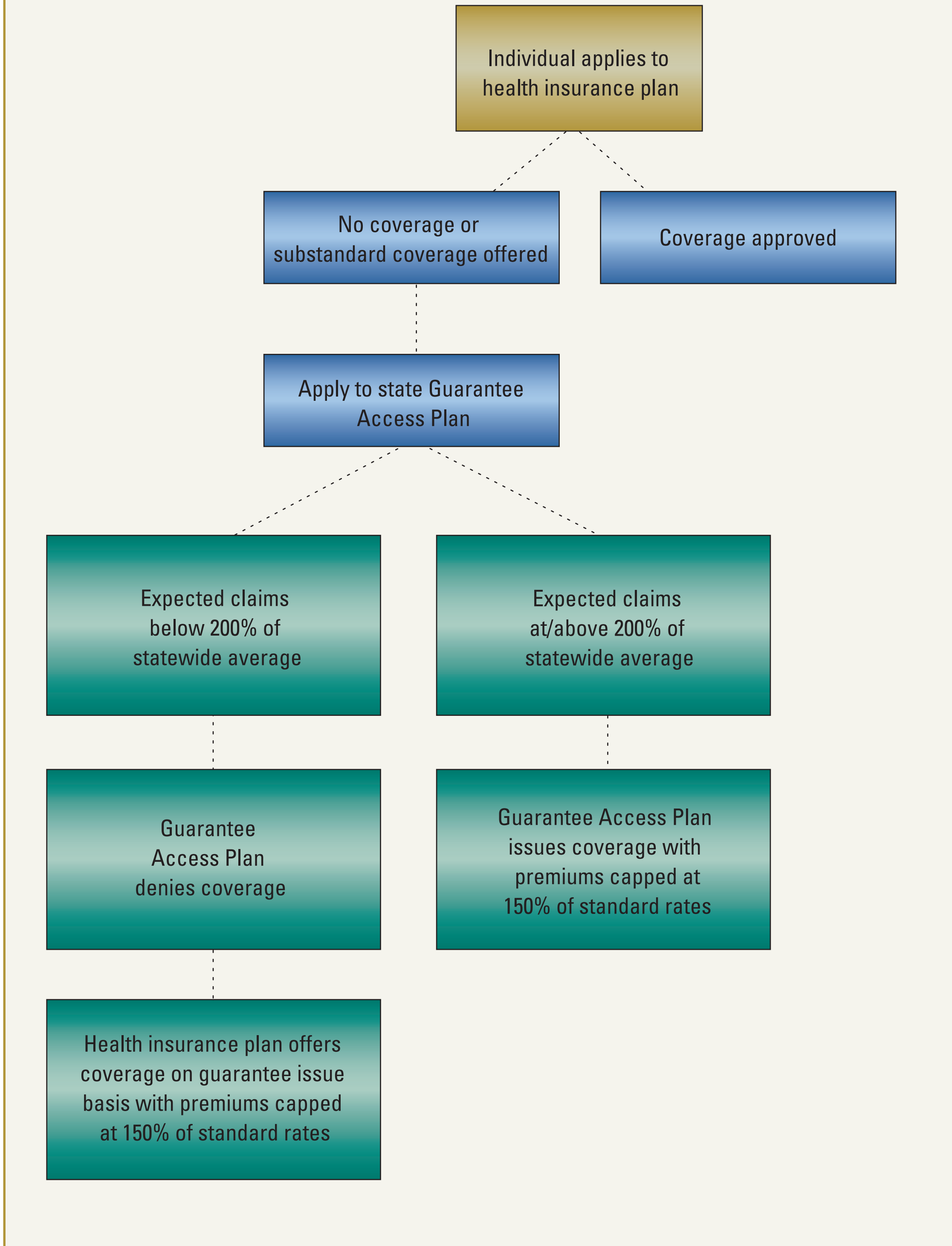
COVERAGE OPTIONS THAT MEET CONSUMERS' NEEDS

The Guarantee Access Plan would offer coverage options with a range of premiums, resulting from different levels of policyholder cost-sharing amounts, and would reflect benefit packages available in the private market.

MAINTAINING AFFORDABILITY

As part of their efforts to keep coverage as affordable as possible, states will need to:

- Allow health plans to offer features such as:
  - Pharmacy programs that promote both value and safety;
  - Disease management, preventive, and care coordination programs that bring evidence-based care into everyday practice; and
  - New benefit design and payment incentives that reward quality and value.
- Create a sliding-scale premium subsidy program with additional assistance for those with high health care costs.
- Fund the Guarantee Access Plans from a broad base of sources, so that coverage remains affordable for those who are currently insured.


HOW THE GUARANTEE ACCESS PLAN WOULD WORK
Individual applies to health insurance plan
No coverage or substandard coverage offered
Coverage approved
Apply to state Guarantee Access Plan
Expected claims below 200% of statewide average
Expected claims at/above 200% of statewide average
Guarantee Access Plan denies coverage
Guarantee Access Plan issues coverage with premiums capped at 150% of standard rates
Health insurance plan offers coverage on guarantee issue basis with premiums capped at 150% of standard rates

Peace of Mind for Consumers

AHIP's Board of Directors is also recommending important initiatives to enhance the peace of mind of those purchasing coverage in the individual health insurance market.

- States should provide consumers with access to a third-party review process to resolve disputes involving medical issues related to pre-existing condition exclusions and rescission decisions.
- Health plans should limit any rescission actions to those based only on information that should have been included in a complete and accurate response to questions asked in a clear and understandable application. If a health plan does not conduct a review of unclear or incomplete information on the application, then the health plan should not use any subsequently-acquired information as a basis for rescinding coverage.
- Health plans should ensure that all communications are clear so consumers understand their rights and responsibilities, as well as those of the health plans, with respect to the application process, rescissions, and pre-existing condition clauses.
- Health plans should waive the application of pre-existing condition exclusions for medical conditions that are disclosed by the applicant (unless subject to a rider).
- Consumers should have knowledge of their medical information and provide complete and accurate responses on coverage applications. Coverage applicants should also be prepared to respond promptly to inquiries regarding their medical and personal information.

BENCHMARK DATA ON NUMBER OF RESCISSIONS IN THE INDIVIDUAL MARKET

Comprehensive Health Insurance Policy Rescissions in the Individual Market Reported by AHIP Member Companies, 2007 Survey

	2005	2006
POLICIES IN SURVEY	1,161,398	1,215,383
RESCISSIONS	2,688	1,842
RESCISSION RATE	0.23%	0.15%

A rescission is the process of voiding an insurance contract due to a misrepresentation or omission on an insurance application that would have resulted in a different underwriting decision by the health insurance plan. As the data show, rescissions are very rare. They are only used as a last resort when it is clear that an applicant has omitted information or provided inaccurate information on his or her application.

Requirements for Universal Participation

The Guarantee Access Plan and operations initiatives outlined above can ensure universal access to affordable coverage and further enhance the market for individual health insurance. Some states, however, may seek to achieve universal participation by requiring that every citizen in the state has health care coverage.

Given that few states have experimented with universal participation, there is little data available on the effectiveness of these initiatives. While AHIP is not advocating an individual mandate, we have explored this issue and have identified five critical steps that states would have to follow to achieve universal participation:

- Develop an insurance coverage verification system;
- Enforce the requirement to purchase and maintain coverage;
- Establish an automatic enrollment process and be prepared to provide backstop funding if individuals do not fulfill their responsibility to purchase coverage;
- Create a premium subsidy program for moderate- and low-income individuals and families, as well as provide additional assistance for those with high health care costs; and
- Fund coverage initiatives from a broad base of sources.

A new partnership between health insurance plans and states along with a renewed emphasis on personal responsibility could enable health insurance plans to guarantee coverage to all applicants without regard to pre-existing medical conditions.

The establishment of a universal participation program that is proven to be effective could avoid the unintended consequences that have hampered many well-intentioned efforts by states to assist those pursuing coverage in the individual health insurance market. Experience shows the absence of a universal participation requirement serves as a powerful incentive for healthy individuals to defer coverage until they have health problems, which causes health insurance to become significantly more expensive for those who have it.

Previous State Reform Efforts Had Unintended Consequences

As states considered proposals during the 2007 legislative sessions to expand access to coverage, AHIP commissioned a new report to assess the impact of prior reform efforts across the country. The study, conducted by Milliman, Inc., documents the impact of guarantee issue and community rating rules on the individual market in eight states that implemented such requirements.

Guarantee issue requires insurers to sell an individual health insurance policy without regard to a person's health, and community rating requires that all consumers pay the same or similar premiums without regard to health status. According to the report, these initiatives have the potential to cause individuals to wait until they have health problems to buy insurance. This could cause premiums to increase for all policyholders, increasing the likelihood that lower-risk individuals leave the market, which could lead to further rate increases. If this continues, the pool or market could essentially collapse or shrink to include only the high-risk population.

Overall, the report found that states that implemented guarantee issue and community rating saw a rise in insurance premiums, a reduction of individual insurance enrollment, and an exodus of health insurers from the individual insurance market. In addition, the report found no significant decrease in the uninsured population in states that implemented these initiatives, often a stated goal of legislators.

Consequently, several states that initially implemented guarantee issue and community rating have since repealed or modified their laws with the intent of stabilizing the insurance marketplace and providing consumers more choice and access to coverage.

Additional Information on Individual Health Care Coverage

New AHIP Survey Examines Premiums, Availability, and Benefits in Individual Health Insurance Market

A survey by AHIP shows that individually purchased health care coverage is more affordable and accessible than may be widely known. The report, which is a follow-up to several previous AHIP surveys of the individual market, represents the most extensive health plan survey of individual coverage to date. A wide variety of AHIP member companies responded to the survey, including large and small multi-state plans, single-state plans, and local or regional plans.

AVERAGE ANNUAL PREMIUMS FOR INDIVIDUAL HEALTH CARE COVERAGE, 2006-2007

Type of Coverage	Average Annual Premium
SINGLE	$2,613
FAMILY	$5,799

Source: Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits, AHIP (December 2007)

Premiums varied by state, reflecting a variety of factors, including premium rating and underwriting rules, differences in health care costs, demographics, and consumer benefit preferences.

MOST WHO APPLY ARE OFFERED COVERAGE

Approximately 89 percent of applicants undergoing medical underwriting were offered coverage. Offer rates varied from a high of 96 percent for applicants under age 18 to 71 percent for applicants aged 60-64. Forty (40) percent of offers in the survey were at standard premium rates; 49 percent were offered at lower (preferred) rates; 11 percent were offered at higher-than-standard rates. Standard or preferred rates were available in all age brackets. Among adults age 60 to 64 who were offered coverage, nearly three-quarters (74 percent) of offers were at standard or lower (preferred) rates.

The most commonly purchased products were preferred provider organization (PPO) or point-of-service (POS) coverage, representing 78 percent of single policies and 66 percent of family policies in force. Ten (10) percent of single policies and 23 percent of family policies chosen provided coverage in conjunction with health savings accounts (HSAs).

INDIVIDUAL MARKET OFFERS WIDE RANGE OF BENEFITS AND OUT-OF-POCKET COST PROTECTION

Consumers in the individual market were offered a wide range of benefits, including behavioral health, prescription drug, preventive, and maternity benefits. Inpatient and outpatient behavioral health and substance abuse benefits were included in approximately 85 percent of policies purchased in the survey.

Most of the policies chosen had annual out-of-pocket limits under $5,000, and the average lifetime maximum benefit (among plans with a maximum) was nearly $4 million.

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