HEALTH AFFAIRS | Robert Wood Johnson Foundation

Health Policy Brief

October 21, 2009

Health Insurance Reforms: Should there be a new federal law and regulations to broaden coverage and make the market work better for individuals and small businesses?

What's the issue?

Major health reform proposals in Congress include provisions that would revamp the private health insurance market to dramatically broaden insurance coverage. The goal is to provide affordable private health insurance to people who now have difficulty getting it, either because they must purchase it on their own or because they work for a small, lower-wage business. The changes would broaden federal regulation over private health insurance, a sector that has primarily been regulated at the state level. There is substantial bipartisan support for these reforms as well as broad backing, with some conditions, from private health insurance companies.

Many of the proposed changes are designed to end health insurance discrimination against individuals and business groups based on their health. Rather than excluding applicants in the individual market who might incur large medical claims, insurers would have to sell them comprehensive coverage. They could not exclude coverage for pre-existing health conditions or cancel coverage once it was in effect. In general, premiums charged to policy holders would be roughly the same in any given geographic area, and could only vary within limited ranges based on policy holders' ages, the size of their families, where they live, or the type of insurance product they purchased. Premium increases for "small group" coverage purchased for workers in small businesses would also be limited, since insurers could no longer use workers' underlying health conditions as a factor in deciding what to charge them.

Pro and con: For supporters, these changes are essential to achieving universal coverage. A basic principle of insurance is that it is most affordable — and the market works best — when the costs of the relatively few people who become sick are spread across the far larger group of people who are relatively healthy. That means it's important to get as many people as possible into the insurance "pool." In effect, healthy beneficiaries would subsidize care of the sick, and everybody would be protected in the case of sudden or unexpected illness.

Opposition to, or concern about, these proposals comes from different camps. Some are leery of vastly increased federal regulation over health insurance. And recently, insurers have raised concerns that some aspects of the reforms may not be

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effective at getting everybody into the health insurance pool. They point, for example, to relatively low penalties for individuals who don't comply with a mandate that everyone be covered. Unless Congress toughens measures to make certain that healthy people buy coverage, insurers contend, the reforms simply won't work and could make matters worse.

What's the background?

Private health insurance in the U.S. has long been segmented into several very different markets. Employment-based coverage, especially in large firms, generally covers all full-time workers employed at a company. In these large, employer-based pools, the risk that some workers will become ill is spread broadly across the entire group of relatively healthy people. Employers heavily subsidize coverage, generally contributing the same amount toward each worker's coverage; employees each contribute the same amount, too, with adjustments if they are also buying coverage for their dependents. A sick worker doesn't pay higher premiums than anyone else; the group as a whole bears the costs. What's more, most very large employers do not even buy health insurance policies; rather, they "self-insure," or pay employees' medical expenses directly. They can do this because the pool of workers covered is large enough for employers to take on — and spread — the risks that a few will become very ill.

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Spreading risk: Health insurance traditionally is sold to individuals, small employers with 2–50 employees, and larger employer groups with 51 or more employees that choose not to self-insure. Spreading risks in these "voluntary" markets, when people or firms can buy coverage but don't have to, can be difficult. Insurers worry about a phenomenon called "adverse selection," which is when individuals or groups decide to buy coverage because they expect to make claims. At the same time, consumers are vulnerable to "risk selection" by insurers. Because about 10 percent of Americans account for roughly two-thirds of the nation's health care spending, insurers need only to avoid some of the sickest patients in order to avoid significant losses. Insurers use various methods to avoid high risks, depending on what market they are in and what state and federal laws allow.

For example, in the small-group market, federal law requires that all policies be sold on a guaranteed-issue basis. That is, no small-group applicant can be turned down because somebody in the group is sick. However, in most states, if insurers can determine that an employee of a small business is sick or may become sick, they may charge extremely high premium rates to protect themselves in the event they have to pay out large claims. Once firms grow to employ more than 50 workers, federal guaranteed-issue protections end. In addition, no state laws require insurers to sell coverage to firms with 51 or more employees, nor do any state rating protections apply to groups of this size.

In the individual insurance market, insurers can also risk-select, or segment the risk. Insurers in all but five states — Maine, Massachusetts, New Jersey, New York, and Vermont — can legally engage in "medical underwriting." This allows them to review an applicant's extensive medical history and then price a policy or limit coverage based on their best estimate of how likely the applicant is to incur medical claims in the future. Applicants with serious health conditions such as diabetes or cancer can be denied coverage. Often less serious health conditions, even acne, can also trigger a denial of coverage, a special surcharge on top of the premium, or a limitation of what the plan will pay for.

In addition to underwriting based on health status, insurers also vary premiums based on demographic characteristics, especially gender and age. Under age rating, for example, a 64-year-old may be charged a premium as much as seven times greater than that charged a 19-year-old, according to the major association representing health insurers, America's Health Insurance Plans (AHIP).

Private health insurance is regulated very differently across different aspects of the market. For the very large employers who frequently "self-insure" their medical claims — in effect, paying them directly out of company revenues — only certain federal laws and regulations apply. For the individual and small-group markets, by contrast, regulation exists, with a few exceptions, primarily at the state level.

Much state regulation governs the ways insurers can or cannot price insurance for different groups of people. Some states, for example, forbid insurers from charging different premiums to male and female applicants with comparable health status. In the individual insurance market, two states require a type of pricing known as

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"community rating," which means that everyone in the same geographical area must be charged the same amount in premiums. Five states require "adjusted community rating," which means that premiums cannot vary based on the health of a person applying for coverage but may vary based on other key risk factors, such as age. Another 11 states have "rate bands," which limit how much premiums can vary.

Some federal regulations apply to the individual and small-group health insurance markets as well. For example, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 has a number of provisions intended to protect people who must move from employment-based coverage to individual coverage — for example, because of a job loss. Federal law (the Genetic Information Nondiscrimination Act, or GINA) also bars health insurers from denying coverage or charging higher premiums to people who may have a genetic predisposition to developing a disease in the future.

Patchwork: The upshot of this patchwork of state and federal regulation is that individuals and small groups purchasing coverage in different states have different protections when buying private health insurance. Similarly situated consumers in different states may have to pay very different premiums for coverage — in some instances, because of differences in underlying health costs, use of health care services, and regulations. A number of individuals are simply priced out of the market and end up uninsured. Also, a large group of Americans are considered to be "underinsured" for several reasons, including the existence in their health insurance policies of high deductibles, heavy cost-sharing requirements, or low lifetime caps on the amount that insurers will pay out in claims. One study has estimated that as of 2007, 25 million insured people ages 19–64 in the United States were underinsured — a 60 percent increase since 2003.

There are also widely perceived inequities in what different groups of people have to pay to obtain health insurance in the individual market relative to other groups. For example, in most states, insurers can charge higher premiums based on gender. A 2008 survey by the National Women's Law Center found that in nearly all states and the District of Columbia, insurers charged 40-year-old women 4–48 percent more than 40-year-old men for the same coverage in the individual market. This is because women of that age use more health care services than men do, according to actuaries. By contrast, insurers charge men ages 55–64 more than women for the same reason: They use more services than women of that age.

Another unpopular health insurance practice in the individual market is the so-called rescission of health insurance: the retroactive withdrawal of coverage after individuals have filed claims for medical treatment. For example, in February 2009, California's largest for-profit health insurer, Anthem Blue Cross, agreed to pay a $1 million fine and restore coverage to 2,330 people it dropped after they submitted bills for expensive medical care. Insurance executives say that these coverage rescissions occur because beneficiaries sometimes misrepresent their medical histories at the time they apply for coverage.

In the early 1990s, the Clinton administration's proposed national health reform plan included a number of market reforms and consumer protection measures similar to those being discussed today. At the time, the health insurance industry fought many of the measures and led a campaign that contributed to the plan's eventual defeat. Since then, a number of states have instituted reforms to address many of these concerns and to make their insurance markets function better for individuals and small groups. And in general, health insurers today see their future business as helping manage the costs and quality of care for all Americans now broadly covered within a broad insurance "pool" or pools.

What's proposed?

Similarities: All major bills making their way through Congress contain similar provisions for insurance market reforms. As of the publication date of this brief, a new bill being crafted by the Democratic leadership in the House of Representatives is likely to incorporate many measures in the America's Affordable Health Choices Act of 2009 (HR 3200), a bill passed in slightly different versions by three House committees during the summer of 2009. Similarly, the Senate Democratic leadership is crafting new legislation based on a blend of two bills: the America's Healthy Future Act of 2009, voted out of the Senate Finance Committee on October 13, 2009, and the Affordable Health Choices Act (S 1679), passed by the Health,

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Education, Labor, and Pensions (HELP) Committee in July 2009.

All of the bills passed by congressional committees share a number of features. All would create new health insurance "exchanges" or "gateways" at the state or federal level, or both. These would enable individuals who don't have employment-based coverage, and who don't qualify for various forms of public coverage such as Medicaid and Medicare, to purchase private health policies through more highly organized health insurance markets. In an exchange, all health insurance policies would have standardized benefits. Consumers would still have choices, but policies would vary mostly based on the level of cost sharing (e.g., deductibles and copays) that would apply to covered benefits. Federal subsidies would be available to help low- and moderate-income people pay for coverage. And under all bills, a new individual mandate would compel most people to have coverage or pay penalties (see Health Policy Brief, "Individual Responsibility," September 29, 2009).

All bills would also impose new federal requirements on all health insurance coverage, whether offered through the exchanges or not. These would include the following:

- Coverage would have to be sold to anybody who applied for it, regardless of health status. This is the provision known as guaranteed issue.
- Renewability of coverage would have to be guaranteed, which means that policies that are sold to individual policy holders or to a small business would have to be renewed from one year to the next.
- Coverage could not exclude payment of claims for treatments involving an individual's pre-existing medical conditions. For example, an insurer could not sell a policy to a person with hypertension that explicitly did not cover claims related to his or her high blood pressure.
- Premiums charged to individuals buying coverage through a particular exchange could not vary based on an applicant's gender, employment, or health status. This is called community rating.
- There would be limits on how much companies could vary the premiums charged to different policy holders based on age, family, or place of residence. The Senate Finance Committee bill would allow insurers to vary premiums by as much as four to one based on age; this means that a 64-year-old enrollee could be charged four times as much as a 19-year-old. Under the House and HELP Committee bills, premiums could vary by as much as two to one based on age.
- Both Senate bills would also allow companies to vary premiums based on whether an applicant used tobacco products.
- No cost sharing could be imposed for preventive care under the House and Senate Finance bills, including (under the House bill) those services recommended by a Task Force on Clinical Care and vaccines recommended by the Centers for Disease Control and Prevention. The HELP Committee bill would permit only nominal fees for preventive care and relies on the U.S. Preventive Services Task Force to specify what preventive care services should be provided.
- Insurers would not be able to set annual or lifetime limits on the amount of claims they will pay in a policy holder's behalf.
- Policy holders would see their annual out-of-pocket expenses for health care capped at specific levels. For example, the Senate Finance bill would adopt the same limit set for health savings accounts ($5,950 for individuals and $11,900 for families in 2010). The Senate HELP bill also adopts that same limit, but varies it depending on the plan type. The House bill's out-of-pocket limit is $5,000 for individuals and $10,000 for families (with annual increases based on the Consumer Price Index).
- Insurers would be required to report their "medical loss" ratios — the percentage of overall premium dollars that they pay out annually in medical claims. Some versions of legislation would also require the secretary of health and human services to set a minimum medical loss ratio; this would be enforced by compelling insurers to make rebates to policy holders if the ratio wasn't met. One version of the House legislation passed by the Education and Labor Committee required a minimum medical loss ratio of 85 percent.
- "Risk adjustment" payments or assessments would be made to or collected from insurers, based on the health status of enrollees. This way, insurers wouldn't lose money simply because they had enrolled more sick individuals than other insurers had.
- Health insurers would be required to provide enrolled individuals with coverage for emergency room services at any hospital without the need for prior authorization. Enrollees could not be charged copayments or cost sharing for emergency room services furnished out-of-network that are higher than in-network rates.

"Insurers would have varying ability to engage in risk selection by steering risks among various groups in health insurance markets."

Differences: For all the areas of agreement among various bills, they also take different approaches in some key areas, as follows:

Oversight: The bills differ on how new laws and regulations would be enforced at the state or federal level, or both. For example, the House bill would create a new federal insurance department that would engage directly in oversight and enforcement of new federal standards. States would continue to enforce their laws, provided that these statutes are at least as strong as federal minimum standards; if they are not, the federal standards would prevail. The Senate Finance and HELP bills, by contrast, would have states enact legislation incorporating the new federal requirements. The federal government would only enforce the laws as a last resort, if states fail to do so. Two of the bills (House and Finance) would create a new federal ombudsman's office to handle consumer complaints about health insurance, but with varying degrees of authority and oversight responsibility.

Which insurance markets would be affected: There are also some differences in what portions of the health insurance market would be subject to these changes. The Senate Finance rules would apply to the individual health insurance market and to the small-group market for small businesses with 50 or fewer employees. The Finance bill would also allow states to merge these two markets, thus spreading the risk over a larger pool. The House and Senate HELP legislation would apply reforms to all private insurance markets for individuals and all sizes of businesses.

Where people can buy insurance: The bills differ as to whether or not individuals must buy policies only through newly created health insurance exchanges, or whether they can buy coverage outside of exchanges in traditional individual markets. The House bill requires all people buying individual coverage to buy through a single new national Exchange, creating one large pool. The Senate Finance bill would permit individuals to purchase coverage in or out of a national or state exchanges, although insurers all would have to adhere to the same rules and sell the same policies at the same prices in both markets. Under the Senate HELP bill, individuals could choose to buy in or out of the state "gateways," but insurers could sell different products in and out of the gateways at different prices. Under these three approaches, insurers would have varying ability to engage in risk selection by steering risks among these markets.

Unique features: The bills also have some unique features, as follows.

The Senate Finance Committee bill would:

- provide immediate transition assistance by creating a temporary high-risk pool with subsidized premiums for people who have had no insurance for at least six months and were denied coverage because of a pre-existing condition. The high-risk pool would exist until 2013.
- require all new policies offered through or outside the exchange (except stand-alone dental, vision, and long-term care insurance plans) to conform to one of four benefit packages — each with different levels of coverage. Health plans in the individual and small-group markets would at least have to offer coverage in the second and third ("silver" and "gold") categories. (These benefit structures would apply to existing individual and employer-sponsored plans.)
- permit sale of a "young invincible" plan for individuals age 25 and younger, with limited catastrophic coverage and the exclusion of preventive care benefits from the deductible.
- establish an interim reinsurance program funded by mandatory payments from health insurers to help stabilize premiums and minimize any adverse selection during the first three years of the exchanges.
- allow states to form "health care choice compacts" and allow insurers to sell policies in any state participating in the compact. Only the rules and regulations of the state where the policy originates would govern the policy. This is a highly controversial provision, because it could allow insurers in states with weak regulation to sell their products into other states; it may be dropped from the final Senate bill.

The Senate HELP bill would:

- encourage better quality of care by requiring insurers to offer financial rewards to health care providers who improve care coordination and chronic disease management and reduce medical errors, among other steps.
- allow dependent children up to age 26 to be covered under parents' individual and group policies.

The House legislation would:

- impose tighter consumer protections, including uniform marketing standards and fair grievance and appeals procedures.

- set standards to simplify financial and administrative transactions.
- create a Health Choices Administration, which would establish the new national Exchange and the qualifying health benefits standards, administer the affordability credits, and enforce requirements for insurance policies offered in and outside the Exchange.

What's the argument?

In support: Supporters say market reforms would remove barriers that prevent some of the sickest individuals from getting and keeping needed health coverage. At present, access to affordable nongroup health insurance is nearly impossible for those who are not in perfect health.

For those with pre-existing medical conditions, older people, and others subject to the insurance industry's discriminatory practices, opponents say that coverage is unaffordable, woefully inadequate, or both. For the first time in the health care reform battle, there is near-universal agreement that such practices should end, with support coming from provider and consumer groups, state insurance commissioners, and the industry itself.

Insurers are among the strongest advocates for change — a "drastic departure from where our industry was the last time we attempted comprehensive health care reform," says Robert Zirkelbach, an AHIP spokesman. Instead of trying to insure some people and avoid others, the idea is to insure everyone and help manage everybody's costs — from those least likely to become seriously ill to those already sick or likely to become sick. Insurers stand to collect premiums from tens of millions more customers, many of whom haven't purchased insurance in the past because they were relatively healthy. However, insurers stress that the reforms would need to be enacted in a package that included an individual mandate with tough penalties for noncompliance. For reasons described below, they say the system will only work if everybody is in the pool and insurers can truly spread risks across the entire population.

Against: Opposition to insurance market reforms takes several forms. Some say that the changes wouldn't go far enough to provide universal and affordable coverage. Some question whether private companies should be in the business of providing health coverage and would prefer to see the government do that through a so-called single-payer system. Others think that private companies should be allowed to offer coverage only if they operate as highly regulated nonprofits, without the duty to pay out a portion of any profits to private shareholders.

Still others who like the proposed changes say that they will work only if other features of health reform legislation are also put in place. For example, insurers say reforms won't work without an individual mandate and stiff penalties if people don't comply. The industry advanced its arguments through two reports released in October 2009 — one by PricewaterhouseCoopers, commissioned by AHIP, and another by Oliver Wyman for the Blue Cross Blue Shield Association. The studies assert that the Finance Committee's package, with relatively low penalties for people who don't buy health insurance, would produce the opposite of what lawmakers intended: higher premiums that would keep coverage out of reach for millions of people. Critics of the reports noted that they failed to take into account other aspects of the legislation that could help keep premiums affordable. These include the proposed income-based subsidies to encourage the previously uninsured to buy coverage, as well as a number of other measures designed to stabilize the health insurance market.

Generosity of benefits: There is also widespread concern about whether the tax credits in legislation would be generous enough to help low- and moderate-income people afford coverage, even in a reformed individual or small-group health insurance market. And still others worry about the interactive effects of many of the insurance reforms. In one example, Blue Cross Blue Shield Association executives cited another Oliver Wyman report in a recent letter to members of Congress, warning that limits on how much premiums could vary according to age — two to one under the House bill — would result in a 69 percent increase in premiums for young, healthy individuals in the first year of health reform. Price shock would create a strong incentive for young people to avoid getting health insurance, triggering a cascade of events that could undermine the system. Young people's premiums are crucial to offsetting the cost of older, less healthy people and keeping premiums affordable for everyone, according to Blue Cross Blue Shield.

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On the other hand, permitting a wider variation in age-rated premiums could adversely affect older beneficiaries. Researchers at the Urban Institute modeled the effects of different age rating limits in an October 2009 study. They found that allowing insurers to vary premiums by as much as five to one — as originally envisioned in the Finance Committee bill — would mean that premiums could consume as much as 26.5 percent of income, for a single person age 55–64 with an income of 400–500 percent of the federal poverty level. "The larger the variation permitted in the premiums based on age, the less broadly risk is shared, as health care expenditures tend to increase with age," they wrote. For young adults, by contrast, the Urban Institute study found that the benefits of age rating would be much smaller. More than 90 percent of young adults enrolling in coverage through an exchange would be eligible for subsidies. These subsidies would help greatly in making coverage affordable for young people, even if no rating differences based on age were allowed.

Wellness provisions: There are also concerns about legislative provisions that would allow insurers to reward or penalize beneficiaries based on whether they successfully completed "wellness" programs geared to reducing obesity, smoking, or other unhealthy conditions or behavior. Provisions in the Senate HELP and Finance bills would allow rewards or penalties in the form of adjustments to premiums or copayments equal to as much as 50 percent of the price of the health plan. The Finance bill would allow such programs in employer-sponsored policies, and would permit wellness adjustments in the individual market on a pilot basis in ten states. Critics of these provisions are concerned that they are a back-door way of varying premiums based on health status. For example, people could be charged higher premiums or cost sharing if they have health conditions that are linked to lifestyle choices, such as hypertension or obesity. But because the differences are characterized as incentives, and therefore part of a wellness program, they would be permitted.

The prospect of limits on companies' medical loss ratios has also raised concerns. Limits on those ratios could require insurers to reduce such nonmedical expenses as administrative costs or profits paid out to shareholders. Eroding profits would make the industry less attractive to investors; this could drive up insurers' costs of attracting capital — an expense that might well be passed along to policy holders in the form of higher premiums. A tight limit on medical loss ratios could also penalize insurers that spent money on certain types of administrative programs designed to rein in health spending. For example, in testimony before a House committee in September 2009, a WellPoint official noted that the company's chronic care management programs for asthma, heart disease, and diabetes are classified as administrative expenses and could be constrained under a requirement for a low medical loss ratio, even if they helped control health costs. On the other hand, minimum loss ratios might also prompt insurers to reduce commissions to agents and brokers, which today can be 10 percent of the first-year premium, or higher, in some markets.

Finally, there is concern that oversight and enforcement will be inadequate to oversee these sweeping market reforms and consumer protection measures. To date, overburdened state insurance regulators have focused mainly on licensing health insurance plans and ensuring their solvency. They have only limited resources for dealing with consumer complaints or protections, such as investigating rescissions. Because the Senate bills would continue to rely on states as the primary regulators, there are concerns that oversight would be inadequate. What's more, none of the congressional reform bills provides new appropriations to expand regulatory capacity at either the federal or the state level.

What's next?

As this brief is being published, Senate and House Democratic leaders are finalizing the bills that will eventually go to the floor of each chamber for a vote. In the Senate, the bill could be further modified through amendments. If the House and Senate bills pass their respective chambers, they will likely go to a House-Senate conference committee. Differences between the bills would be reconciled there and a final "conference report" prepared. At any of these points along the way, provisions of the bills discussed in this brief could be altered.

Resources

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Health Policy Briefs are produced by *Health Affairs* with the support of a grant from the Robert Wood Johnson Foundation.

Cite as:
Susan Jaffe, "Health Policy Brief: Health Insurance Reforms," *Health Affairs*, October 21, 2009.