



GEORGETOWN UNIVERSITY

HEALTH POLICY INSTITUTE

“Private Health Insurance Market Regulation”

Statement of
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before the
Senate Finance Committee
Health Reform Summit

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Good morning Senator Rockefeller, Senator Hatch, Members of the Committee.

Thank you for hosting this Health Reform Summit and for inviting my remarks on the regulation of private health insurance. My name is Karen Pollitz. I am a Research Professor at Georgetown University's Health Policy Institute, where I have directed research on private health insurance regulation for twelve years.

Much can be said about the regulation of private health insurance. It is a topic of significant complexity and controversy. In my brief time today, I offer a few simple statements that, I hope, can garner broad agreement, and perhaps steer a course for the discussion this morning.

We buy health insurance in case we get sick. Therefore, how private health insurance works for us *when* we are sick is of the utmost concern. Health insurance is our ticket to health care. In order for the promised protection of health insurance to be meaningful, it must satisfy four tests.

Availability

First, health insurance must be available. That means we must be eligible to enroll. Today, eligibility for health coverage is largely derived from other factors – our work status, family status, age, income, where we live, and so on. Most non-elderly Americans are covered by job-based group health plans because they are eligible for employment health benefits in their own right or as the spouse or dependent of an employee. The majority of uninsured Americans also work, but they are not offered health benefits or are not eligible to participate in the employer health plan.

Safety net public programs – primarily Medicaid and S-CHIP – offer coverage for millions of low-income persons. Yet, coverage is not available to most uninsured low-income adults because they do not meet program categorical and income eligibility rules.

People who are not eligible for job-based coverage or Medicaid – that is, most of the uninsured – can seek coverage in the individual health insurance market. However, medically underwritten coverage in this market conditions eligibility on health status, and so tends not to be available to applicants who are sick. Dozens of health conditions – from cancer, to diabetes, to pregnancy – render people “uninsurable” in most states. People also may be unable to buy individual coverage if they have a history of health problems. Even minor health conditions, such as hay fever or acne, can trigger a denial by some insurers.¹

Only a relatively small proportion of the non-elderly are covered by individual health insurance at any point in time. (See Figure 1) However, over a three-year period, one-in-four adults seek coverage in this market, most without success.² That makes individual health insurance the weak link in the health coverage chain. Two million Americans lose or change health insurance each month. Those who need individual policies when they are sick or after they’ve been sick may not find coverage available to them.

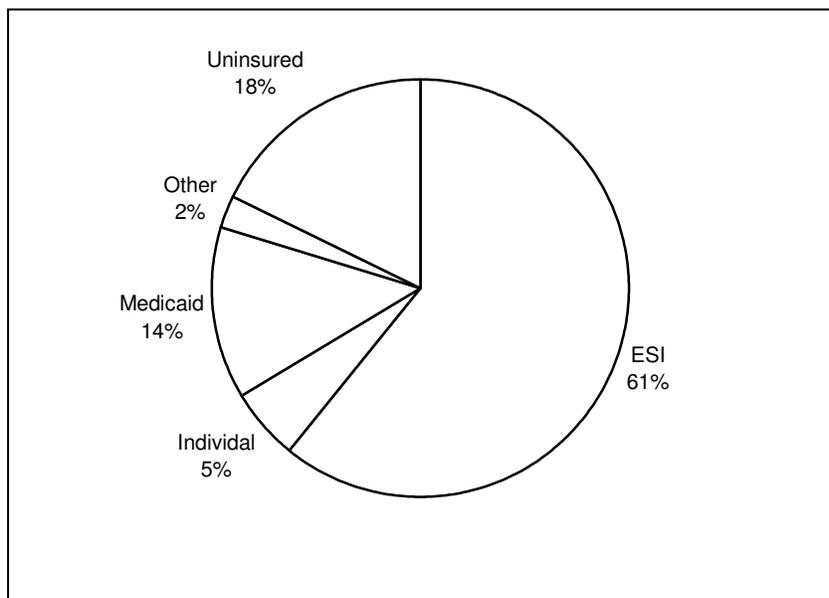
Improving the availability of private health insurance can be and has been addressed through regulation. Some states require individual health insurance to be sold on a “guaranteed issue” basis. That means applicants cannot be turned down because of health status. Federal law

¹ See, for example, K. Pollitz, R. Sorian and K. Thomas, “How accessible is Individual Health Insurance for Consumers in Less than Perfect Health?” Henry J. Kaiser Family Foundation, June 2001. See also D. Grady, “After Caesareans Some See Higher Insurance Cost,” *New York Times*, June 1, 2008.

² L. Duchon, et. al., “Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk,” The Commonwealth Fund, December 2001. See also J. Hadley and J. Reschovsky, “Health and the Cost of Nongroup Insurance,” *Inquiry*, Volume 40, Number 3. Fall 2003.

(HIPAA) requires individual health insurance to be sold on a guaranteed issue basis to certain eligible individuals when they leave job-based group coverage. That same federal law requires that all policies sold to small employers must be offered on a guaranteed issue basis.

Figure 1. Sources of Health Coverage, Non-Elderly



Source: Urban Institute estimates of March 2006 Current Population Survey, U.S. Census Bureau

Adequacy

Health insurance coverage must also be adequate. Adequacy must be measured against the health needs of people who are sick, pregnant, or in need of other expensive care or treatment. Adequate health insurance must ensure that people can obtain needed care without owing more than a manageable level of costs out-of-pocket. One recent study suggested that people may be underinsured if out-of-pocket medical expenses reach ten percent of income or higher (five percent for persons with incomes below 200 percent of the poverty level), or if deductibles

constitute five percent of income or more.³ Evidence suggests the problem of underinsurance is serious; medical debt and medical bankruptcy are primarily problems of the insured.⁴ Coverage adequacy problems tend to be worse in the individual market, where policies are less comprehensive compared to job-based health plans.⁵

Numerous health plan features can affect adequacy of coverage:

- Pre-ex exclusions and riders – Most private health insurance policies will temporarily exclude coverage for a new enrollee’s pre-existing condition. In the individual market, insurers in most states can also amend policies with riders that permanently exclude coverage for an applicant’s health condition, or for the body part or system it affects.
- Covered and excluded benefits – Insurers in most states have broad flexibility to design policies to cover or exclude specific benefits. Especially in the individual market, it is possible to find many policies that do not cover, or that strictly limit coverage for, key health services such as medical office visits, chemotherapy, mental health care, maternity care, and prescription drugs.
- Cost sharing – Typically patients must pay at least a portion of the cost of covered services through deductibles, co-pays and coinsurance. Most policies provide for an annual out-of-pocket maximum, but this cap may be porous; for example, the annual deductible or prescription co-pays may not count toward the limit. Cost sharing limits typically apply for a calendar year; however because 75 percent of health care spending is due to chronic conditions, it is important to consider patient cost burdens over the entire

³ C. Schoen et. al., “How Many Are Underinsured? Trends Among US Adults, 2003-2007,” *Health Affairs*, Web Exclusive, June 10, 2008.

⁴ D. Himmelstein, E. Warren, et. al., “Illness and Injury as Contributors to Bankruptcy,” *Health Affairs*, Web Exclusive, February 2, 2005. See also J. May and P. Cunningham, “Tough Trade-offs: Medical Bills, Family Finances and Access to Care,” Center for Studying Health System Change, June 2004. See also, H. Tu, “Rising Health Costs, Medical Debt, and Chronic Conditions,” Issue Brief No. 88, Center for Studying Health System Change, September 2004.

⁵ J. Gabel, et. al., “Individual Health Insurance: How Much Protection Does it Provide?” *Health Affairs*, Web Exclusive, April 17, 2002.

course of care.⁶ Even modest co-pays can mount relentlessly when people are sick. For example, over 18 months of active treatment, a breast cancer patient might have as many as 140 doctor and other treatment visits and require up to 40 prescriptions and refills.⁷ If a co-pay of \$25 applied for each, her expenses due to co-pays alone would be \$4,500.

- Other coverage restrictions – Additional features that may be less obvious and less easy for patients to investigate can also limit what is covered. Tiered provider networks mean patients may pay more, or all, of expenses for covered services depending on where care is rendered, with higher cost sharing applied to more specialized services. Tiered formularies vary cost sharing depending on the cost of drugs. These policy features exist for cost containment purposes, but also can have the effect of shifting cost burdens to the sickest patients. Further, their impact may not be obvious to consumers until they get sick and experience firsthand how their coverage works.

Adequacy of health insurance can also be addressed through regulation. State laws mandating coverage of single benefits are one traditional approach, though these laws are incremental and do not always specify cost sharing standards. Some states have gone beyond discreet benefit mandates to define more broadly the covered benefits and cost sharing limits that licensed insurers must provide.⁸ By contrast, federal law provides very little guidance on coverage adequacy, defining health insurance as “benefits consisting of medical care...under any hospital or medical service policy or certificate...offered by a health insurance issuer.”⁹ A more

⁶ For example, most nine-month pregnancies will span two years. A recent study of out-of-pocket spending for maternity care under consumer driven health plans found patients might be liable for as much as 80 percent of the cost of their care when pregnancy is covered under two different plan years. See K. Pollitz, M. Kofman, A. Salganicoff, and U. Ranji, “Maternity Care and Consumer-Driven Health Plans,” Henry J. Kaiser Family Foundation, June 2007.

⁷ Georgetown University Health Policy Institute, estimated costs of care for various serious and chronic health conditions, unpublished.

⁸ Massachusetts, New York, New Jersey, Maine, and Vermont are examples of states that have adopted such standards.

⁹ Section 2791 (b), Public Health Service Act.

comprehensive definition of health insurance is needed. Coverage that is inadequate should not be called health insurance.

Affordability

Health insurance premiums must also be affordable. Premiums for private coverage vary widely today, driven largely by differences in the availability and adequacy of policies. Policies that exclude sick people or coverage for key health benefits will have lower premiums relative to policies that are available and adequate; but we must not be distracted by this comparison of unlike products. Rather, we must accept the fact that health insurance, which covers people and their needed health care, will be expensive. Per capita health care spending in the U.S. reached almost \$7,000 in 2006.¹⁰ By contrast, the median income of Americans in 2006 was \$45,000.¹¹ Therefore, significant subsidies will be needed in order for coverage to be simultaneously affordable, adequate and available.

In addition to subsidies, insurance market regulation is needed to prevent insurers from varying premiums based on health status, age, gender, and other factors. The experience of the Health Coverage Tax Credit (HCTC) is instructive. Congress provided for a variety of possible qualified coverage arrangements but no rating standards. In a number of states, HCTC-qualified coverage includes individual market policies that are not subject to rating limits. For example, in North Carolina, individual policy premiums for a 55-year-old with serious health conditions were found to be as high as \$3,926 per month.¹² Even with a 65 percent HCTC subsidy, this policy was unaffordable.

¹⁰ Center for Medicare and Medicaid Services, National Health Expenditure Accounts, 2006.

¹¹ U. S. Bureau of the Census.

¹² S. Dorn, T. Alteras, and J. Meyer, "Early Implementation of the Health Coverage Tax Credit in Maryland, Michigan, and North Carolina: A Case Study Summary," The Commonwealth Fund, April 1, 2005.

Always

Finally, health insurance must be available, affordable, and adequate all of the time. Nearly 40 percent of non-elderly Americans experience a spell of uninsurance over a three-year period.¹³ If we are to continue with our current, pluralistic coverage system, we will have to provide mechanisms to make continuous coverage possible even as people move from plan to plan.

Regulation must also address private insurance company practices that make it difficult for people to remain enrolled in coverage once they get sick. These practices have been described as “lemon dropping” (in contrast to “cherry picking,” which refers to practices that deter initial enrollment.) Several renewal rating practices fall into this category. “Experience rating” increases premiums at renewal for policyholders who have made claims. More common in the individual market, “durational rating” increases premiums for all policyholders over time and prompts those who remain healthy to resubmit to medical underwriting in order to escape renewal rate increases. Many insurers also engage in a practice known as “closing a block” of business. This means the insurer ceases to actively market a policy to new enrollees. Without an influx of newly underwritten healthy enrollees, the average cost experience of in-force policyholders increases dramatically until premiums reach prohibitive levels. Current federal law requirements of guaranteed renewability laws dictate that policyholders must be allowed to remain eligible for coverage, but not that coverage remain affordable over time.¹⁴

“Post-claims underwriting” triggers another category of practices that can threaten the availability, affordability, and adequacy of coverage over time. Policyholders who make claims

¹³ P. Short, D. Graefe, and C. Schoen, “Churn, Churn, Churn: How Instability of Health Insurance Shapes America’s Uninsured Problem,” The Commonwealth Fund, November 2003.

¹⁴ “On their Own: Far from a remedy, individual health insurance is a world of pain,” *Consumer Reports*, January 2008

for expensive health conditions after they enroll may be subject to investigation to determine when the condition first appeared and whether it was disclosed. Insurers may exclude coverage for conditions determined to be pre-existing, in some cases even if they were disclosed during the underwriting process. Post-claims underwriting may also result in the retroactive imposition of exclusion riders or premium surcharges; or coverage may be cancelled or rescinded. Post-claims investigations are defended as necessary to deter consumer fraud, but abusive insurer practices have also been documented, including recent reports that one carrier paid staff bonuses based in part on how many individual policyholders were dropped and how much money was saved.¹⁵

Future Health Reform Agenda

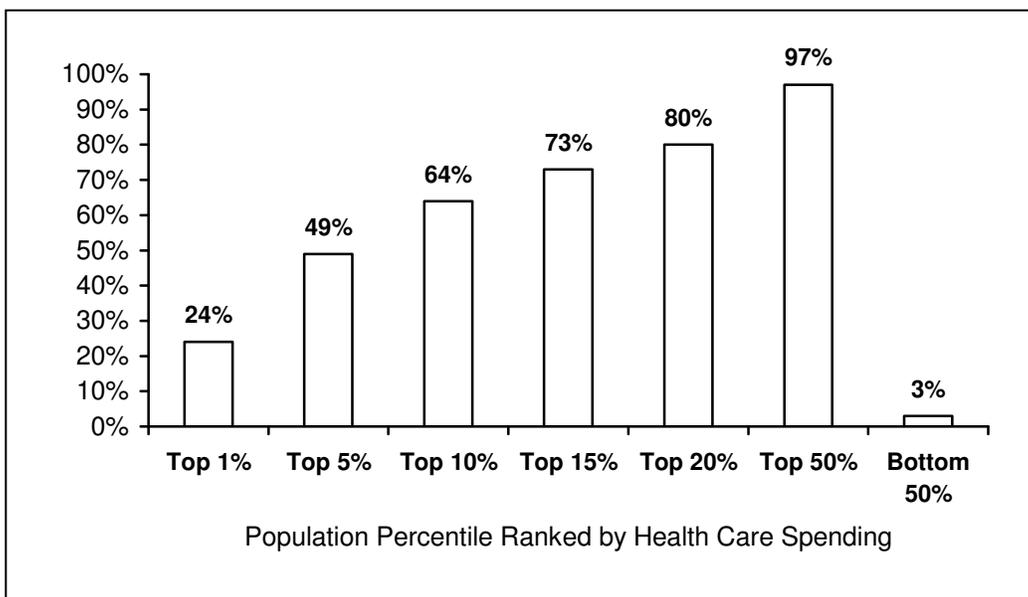
As you contemplate the next round of health reform, one key question policymakers must answer is whether it makes sense to continue a role for a competitive, private health insurance market. If we agree that health coverage must always be available, affordable, and adequate for everyone, then we must ask whether the private health insurance industry is up to this task. Over the years it has been argued that private insurance companies must engage in the practices just described if they are to remain viable and offer coverage for affordable premiums. Yet too often, these practices result in private coverage failing people just when they need health insurance the most.

Continued reliance on private health insurance will require much tighter regulation. Even under health reform that provides for mandatory universal coverage and generous subsidies, the incentive to “cherry pick” and “lemon drop” will persist. The distribution of health expenses across the population makes this inevitable. It will always be more profitable for private insurers

¹⁵ L. Girion, “Health insurer tied bonuses to dropping sick policyholders,” *Los Angeles Times*, November 9, 2007.

in a competitive market to avoid that small proportion of the population who account for the lion's share of health care spending. (See Figure 2)

Figure 2. Concentration of Health Spending in the U.S. Population



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2003.

Whatever you decide, I urge you to move forward swiftly and with resolution. Efforts to achieve universal health coverage have stalled since Theodore Roosevelt first ran on this platform back in 1912. We're approaching a century of stalemate. A nation as great as ours must do better.