Center for American Progress Action Fund

Conservative Health Reform Proposals

Severe Consequences for People with Pre-Existing Health Conditions

Stephanie Lewis, JD, LLM

July, 2008

www.americanprogressaction.org

CONSERVATIVE HEALTH REFORM PROPOSALS

Severe Consequences for People with Pre-Existing Health Conditions

Stephanie Lewis, JD, LLM
Center for American Progress Action Fund

July 2008

Introduction and Summary

Most nonelderly Americans with private health insurance—nearly 162 million in 2006—get their insurance from an employer.[1] A significant number of these Americans—56 million—have one of 12 pre-existing health conditions, including asthma, cancer, depression, diabetes, and hypertension, which put them at greater risk of facing financial difficulty, and even bankruptcy, because of medical bills.[2]

Some conservative health reform proposals seek to change how most Americans get their health insurance. These proposals could ultimately place many of these 56 million Americans in danger of not getting the care that they need because of a lack of access to adequate health insurance.

Some of the most prominent conservative proposals include:

- Providing a financial incentive for people to get health insurance coverage from a variety of other sources—namely, individual health insurers but also professional associations and religious organizations

- Eliminating the income tax exclusion for contributions to job-based health insurance and substituting a tax credit or tax deduction, regardless of the source of health insurance

- Allowing individual health insurers to operate across state lines without complying with the laws in the states in which they operate and without proposing a set of national standards with which they must comply[3]

These conservative proposals do not include provisions that help people who have a pre-existing health condition access health insurance, afford those choices that are available to them, or ensure that their health insurance adequately covers their condition. Instead, the proposals methodically undermine existing provisions that help them do so. This paper discusses the implications of these proposed insurance reforms for people with conditions such as cancer, depression, diabetes, and heart disease.

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, created a federal floor of protections in the dominant segment of the private health insurance market—the group, or employer-based, market—against certain forms of medical underwriting. Through medical underwriting, insurers determine how much of a risk an applicant poses by evaluating their medical history, current medical conditions, age, and other factors. As a result people with a medical condition or a medical history may

be prevented from getting the insurance they need. Insurers engage in medical underwriting principally because they are concerned about consumers waiting until they are sick to buy insurance (called adverse selection) and the health care costs associated with high users of health care.

Given that 10 percent of health care spenders represent 70 percent of health care spending,[4] insurers seek to avoid insuring those who fall or are likely to fall into that category. As a result of medical underwriting, to the extent the law allows, an insurer will decide if it should decline to offer insurance, exclude coverage for certain medical conditions, or charge a premium that is higher than the standard rate.[5] HIPAA blunted many of the harsh effects of medical underwriting, reflecting a national ethos that the role of private health insurance is not only to insure against a risk of loss but to facilitate access to health care.

This floor breaks down, however, under conservative proposals that focus on individual coverage and make significant changes to insurance market regulation. Ostensibly, employer-sponsored health plans will still be held to the HIPAA standard. Employees will still benefit from these protections, unless they buy insurance through an individual health insurer, a professional association, or a church. The latter choices—encouraged by these proposals to replace employer-based coverage as the dominant players in the private health insurance market—will not have an obligation to insure any of the greater number of people that will come to them with federal tax credit in hand for health insurance coverage. Instead, they could be subject to even fewer restrictions than apply to them now.

This prospect would put people with existing conditions in serious jeopardy. By removing the practical ability of states to enact laws that temper the sharp edge of medical underwriting, individual health insurers and professional associations will be able to limit their risks to younger and healthier persons. Some older, less healthy people will be left out.

Those who can obtain coverage in the individual health insurance market may find themselves with insurance that does not adequately cover their health care needs and places them in a precarious financial position. Plans sponsored by employers will be at a competitive disadvantage resulting in the loss of job-based coverage for Americans whose employers drop coverage. And states, which have been struggling with this issue for decades, will be left with an even tougher challenge than currently exists. Their efforts to cover the uninsured will be hampered by restrictions on the regulatory tools they will have available to them. The resulting uninsured population is likely to consist of more people who are sicker, and therefore will likely be even more expensive to cover than it is presently.[6] As a result, the states' means to cover the low-income and the uninsurable, namely Medicaid and high-risk pools, will be further burdened. A lack of sufficient funding to address these issues only means a more substantial financial burden for those who require the most health care services.

Implications of conservative proposals for people with pre-existing conditions

The private health insurance market consists of two distinct sources of coverage: group coverage and individual coverage. In 2006, 62 percent of Americans under the age of 65 had group coverage from an employer, either as an employee or as a dependent of an employee.[7] It is by far the most valued benefit offered by employers. In 2004, 60 percent of nonelderly workers reported in a survey that health insurance coverage was the most important benefit they received from their employer.[8] Employers, while the dominant source of private health insurance coverage, are not the only source. In 2006, nearly 7 percent of Americans had health insurance coverage that they purchased on their own from an individual insurer.[9]

The incentives to buy individual health insurance voluntarily or because of the loss of job-based coverage could have severe consequences for those who have pre-existing conditions because the laws that apply to job-based and individual health insurance differ considerably. To understand how conservative health proposals would undermine the existing protections for Americans with pre-existing conditions, we must first examine the differences between employer-based group insurance and the individual insurance market.

Job-based group health insurance

Through a combination of federal and state law, job-based group health insurance provides greater protections from the medical underwriting process for people with pre-existing conditions than individual health insurance.

At the federal level, the Health Insurance Portability and Accountability Act of 1996 prohibits the use of some of these medical underwriting practices. It protects employees and their dependents who have pre-existing conditions in part by prohibiting health plans sponsored by employers from:

- Making people with pre-existing conditions ineligible for coverage because of their health conditions.
- Extending a pre-existing condition exclusion period for longer than one year (18 months for late enrollees) and extending the period during which the health plan looks back to see if a pre-existing condition existed to more than six months.
- Charging unhealthy employees a higher premium than healthy employees.[10]

These and other federal protections apply across the employment-based group health insurance market.

In addition, legal protections under state law may apply to employment-based coverage depending on the nature of the employer's plan. The Employee Retirement Income Security Act of 1974, or ERISA, bars states from regulating employer-sponsored health plans. As a result of this federal law, coverage provided by employers that self-fund (i.e., pay for their share of employee health care costs out of their own general assets) is not subject to any additional insurance regulation by the states.

But because the states regulate health insurance companies, any policies purchased from a health insurer, even those purchased by an employer-sponsored health plan, must be in compliance with state insurance law, including laws that guarantee access, limit premiums, or define the scope of coverage. In the group market, state laws generally reach small employers with less than 50 employees since they less effectively pool risks among their employees on their own.

In general, state laws are more comprehensive than federal laws, and thus workers whose coverage is fully insured often have broader legal protections that temper the effects of medical underwriting. Almost all states, for instance, provide limits on the amount by which all small group health insurers in the state can vary the premiums among small employer groups for the same coverage.[11] In at least 10 of these states, insurers cannot consider health status at all in setting a small employer group's premiums (called community rating).[12] In addition, many states require insurers to cover certain conditions or providers. States may also enact other laws such as those that require insurers to permit physicians to make standing referrals and to have adequate provider networks.

Individual health insurance

Protections that reduce discrimination against people with pre-existing conditions in the group health insurance market often do not exist in the individual market.

Access

As previously stated, federal law requires that all employer plans that offer health coverage make it available to all eligible employees regardless of health status.

STATE INSURANCE REFORMS FOR GROUP AND INDIVIDUAL MARKETS, 2007

PROVISION	GROUP MARKET REFORMS	INDIVIDUAL MARKET REFORMS
All Products Guaranteed Issue	51 (applied to small group policies only)	5
Prohibit Elimination Riders	51	13
12-Month or Less Limit on Pre-Existing Condition Exclusion Period	51	28
6-month or Less Limit on Pre-Existing Condition Lookback Period	51	16
Pre-Existing Condition Exclusion Period Reduced by Credit for Prior Coverage	51	26
Rating Restrictions	47 (applied to small group policies only)	18
Guaranteed Renewability	51	51

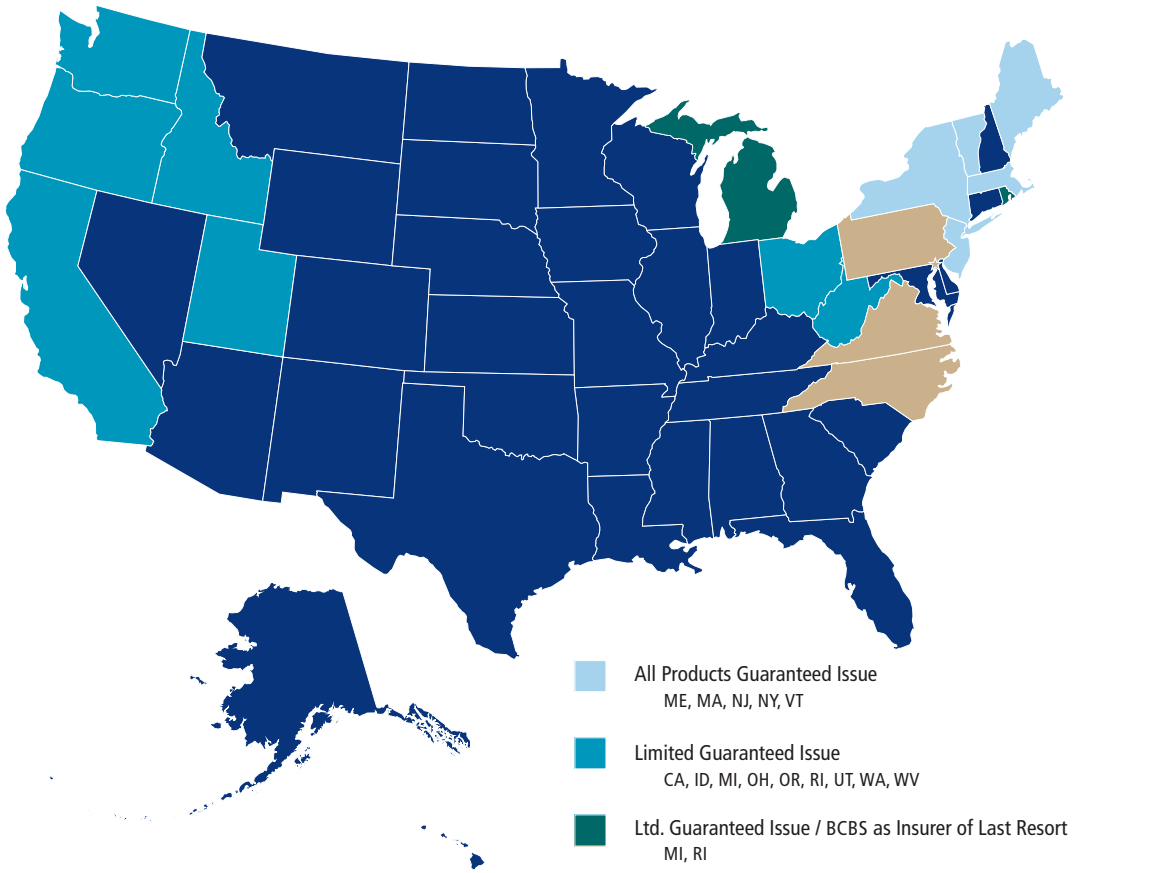
Source: Kaiser Family Foundation, www.statehealthfacts.org, 2007. Figures include research results on 50 states and the District of Columbia.

With respect to the non-group health insurance market, HIPAA only requires that the states identify a mechanism for obtaining non-group coverage, such as the individual health insurance market or high-risk pools, for those who have lost coverage held continuously for at least 18 months; exhausted continuation coverage (if applicable); and meet other requirements, provided they do seek insurance within 63 days of loss of coverage.[13] This population, called HIPAA-eligibles, is very small. Further, the federal law does not limit how much can be charged for this coverage.

Beyond the federal requirement that HIPAA-eligibles have access to non-group coverage on a guaranteed-issue basis, states may require stronger protections and a few have done so. In five states—Maine, Massachusettes, New Jersey, New York and Vermont—all individual health insurers must make coverage available to any individual who applies (called all products guaranteed issue).[14]

There are 15 states that have access requirements, but they are more limited, and in many cases far more limited, than

STATE GUARANTEED ISSUE RULES IN THE INDIVIDUAL HEALTH INSURANCE MARKET, 2007



these five states. They may, for example, require individual health insurers to issue coverage to a narrowly defined group of applicants or issue coverage to a limited number of applicants during an open enrollment period once per year. In a few states, Blue Cross Blue Shield plans in that state must serve as an insurer of last resort.[15] In most states, people who leave or lose job-based coverage and have a pre-existing health condition may find that the individual health insurance market does not offer them meaningful or affordable coverage options.

Coverage adequacy

For those who are offered individual health insurance, coverage under the policy may not be adequate for a number of reasons. First, in many states, coverage for pre-existing conditions can be excluded altogether. In 37 states and the District of Columbia, individual health insurers can exclude coverage for an applicant's existing or suspected medical conditions permanently or for an extended period (called an elimination rider).[17]

Some states do not allow individual health insurers to impose elimination riders. In those 13 states, an insurer cannot, for example, amend the policy of a person with asthma or cancer to exclude coverage for her asthma or cancer treatment, supplies, and medications.[19]

Insurers can also impose lengthy pre-existing condition exclusion periods during which they can exclude coverage for a certain medical condition that existed for a specified period of time prior to the insurer issuing coverage (called a look-

Health Insurance Glossary

Elimination rider: A condition that amends the insurance policy to exclude coverage for a specific medical condition, body part, or system either permanently or for an extended period.

Exclusion Period: Time during which an insurer can exclude coverage for a certain medical condition that existed for a specified period of time prior to the insurer issuing coverage.

Guaranteed Issue Laws: Laws that prohibit insurers from rejecting otherwise eligible applicants based on health status.

Lookback Period: The time period prior to the issuance of coverage in which the insurer can examine if the individual had and/or was treated for a specific health condition.

Medical Underwriting: Process by which insurers determine how much of a risk an applicant poses by evaluating their medical history, current medical conditions, age, and other factors.

Rating Restrictions: There are two categories of rating restriction laws that apply: community rating laws and rate band laws.

Rate band laws limit the extent to which insurers can vary premiums based on health and other factors (such as age and gender).

Pure Community rating laws prohibit insurers from varying premium rates for the same policy.

Adjusted community rating laws prohibit insurers from considering individual health and claims experience when setting premium rates but may permit insurers to vary the premium based on other factors such as age and gender.

Denial Due to Pre-Existing Condition

Pamela (62) and her husband retired early. They live in Ohio. Pamela is a four-year cancer survivor and the ordeal made them realize how important it is to slow down and enjoy their lives together. They elected COBRA and it is about to run out, at which point they will be HIPAA-eligible. In Ohio, that means Pamela must be eligible for certain policies without regard to her health status. Unfortunately, insurers can charge a great deal for these HIPAA policies. One offered her a policy for $1,900 per month, just for Pamela. Another quoted a premium of $800 for a policy with a $5,000 deductible (also single coverage). By contrast, the COBRA premium for the couple is currently $650 per month. Pamela asked the insurer that provides her COBRA coverage if any cheaper options are available. The insurer said Pamela would be turned down for those policies until she has been cancer free for 10 years. Pamela thinks she should be applauded for surviving cancer, not penalized.[16]

back period). In almost half of the states, individual health insurers can impose a pre-existing condition exclusion period that lasts for more than one year. In more than one-half of the states, individual health insurers can look back more than six months before the date coverage was issued to identify pre-existing conditions.[20]

In Texas, for instance, if an insurer issues coverage to an applicant who suffered from a condition like depression in the five years prior to applying for insurance, it can exclude coverage for that condition for up to two years.[21] Notably, there are states in which there is no legal definition of what constitutes a pre-existing condition and no limit on how far back into an applicant's medical history an insurer can look or how far into the future it can exclude coverage for a pre-existing condition.[22]

Group health plans are required to reduce the length of the pre-existing condition exclusion period by the number of months a person covered under the plan had continuous coverage within 63 days before joining the group. About one-half of the states apply this same rule to individual health insurers as well. This is a meaningful protection because many people who seek individual health insurance coverage are doing so because they have recently become uninsured due to the loss of a job, divorce, or loss of dependent status. It is also an important protection because pre-existing condition exclusion periods of any length of time can adversely affect health care access for a person with pre-existing conditions.

To the extent a pre-existing condition period applies, though, policyholders can be subject to ongoing underwriting under a process called post-claims underwriting. If a policyholder files a claim for a health condition in the year or two after buying the policy, the insurer may investigate if the condition existed or had been treated during the look-back period before the policy was issued. If so, the exclusion period applies and claims related to that condition will be rejected.[23]

Apart from specific coverage limitations imposed on individuals' pre-existing conditions, it is generally true that individual health insurance policies offer significantly less coverage compared to job-based group health plans. Policies in the individual market are more likely to not cover or to cap coverage for certain types of services (such as maternity care, mental health care, and prescription drugs). For those who want or need coverage for these services, a rider, if available, would need to be purchased at additional cost.

STATE PORTABILITY RULES IN THE INDIVIDUAL HEALTH INSURANCE MARKET, 2007

PROVISION	# OF STATES	STATES
Limits Pre-Existing Condition Exclusion Period to 12 Months or Less and Look-Back Period to Six-Months or Less	14	ID, KY, MA, MI, NH, NJ, NM, NY, ND, OH, UT, VT, WA, WY
Prohibits Elimination Riders	13	CA, ID, IN, KY, ME, MA, MI, MN, NJ, NY, OR, VT, WA
Credits Prior Coverage	26	CA, CO, CT, FL, ID, KY, LA, ME, MA, MN, MT, NH, NJ, NM, NY, NC, ND, OH, OR, SD, TX, UT, VT, VA, WA, WY

Source: Kaiser Family Foundation, www.statehealthfacts.org 2007. Figures include research results on 50 states and the District of Columbia.

Moreover, individual policies tend to impose much higher deductibles and other cost-sharing for services that are covered.[24] One study found that actuarially, individual insurance covered only 63 percent of the average policyholders' medical bills, while group insurance covered 75 percent. Among sicker-than-average policyholders, the discrepancy was even greater. For those whose medical expenses ranked in the top 25th percentile of the population, individual policies covered 66 percent of expenses while group insurance covered 85 percent. Similarly, for the healthiest policyholders, individual policy coverage also did not compare well. For those whose expenses ranked in the bottom 25th percentile, individual health insurance only covered 30 percent of expenses while group insurance covered 67 percent.[25]

Affordability of premiums

In the individual health insurance market, even those with pre-existing conditions who find an insurer willing to issue coverage for their condition may find it unaffordable. Insurers consider a range of factors, to the extent permitted by state law, when setting premiums. In addition to health status, age also has a significant bearing on premiums, since health care use rises as people age. Premiums for a policy that covers a 60-year-old can be two to four times the premium for a policy that covers a 25-year-old.[26]

Insurers consider other factors, such as geography and occupation, when setting the premium as well. There are 18 states that impose some form of rating restriction in the individual market, limiting the

Exclusion of Pre-Existing Condition

Andy (59) just changed jobs and moved to Georgia. His former job, in North Carolina, provided health benefits and Andy was eligible for COBRA, but no doctors where he lives now are in the former plan's network so COBRA didn't seem worthwhile. His new job doesn't offer benefits, so Andy must buy a policy on his own. In 2001, he was diagnosed with non-Hodgkin's lymphoma and treated successfully. He's been in remission ever since. Even so, he's finding this history makes it extremely difficult to buy health coverage. The first insurer he approached turned him down. A second offered him a policy, but with a rider (amendment) that would exclude coverage for any type of cancer for 10 years.[18]

STATE RATING RULES IN THE INDIVIDUAL HEALTH INSURANCE MARKET, 2007

PROVISION	NO. OF STATES/DC	STATES
Community Rating Prohibited	7	ME, MA, NJ, NY, OR, VT , WA
Rate Bands	11	ID, IA, KY, LA, MN, NV, NH, NM, ND, SD, UT
No Rating Limits	33	AL, AK, AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, KS, MD, MI, MS, MO, MT, NE, NC, OH, OK, PA, RI, SC, TN, TX, VA, WV, WI, WY

Source: Kaiser Family Foundation, www.statehealthfacts.org, 2007. Figures include research results on 50 states and the District of Columbia.

extent to which the insurer can consider health status, age, gender, occupation, or geographic location in setting premiums. Of the 18 states, seven prohibit insurers from making any adjustments to premiums based on health status (called adjusted community rating). One of these seven states (New York) also prohibits insurers from adjusting premiums by age, gender, and other factors (called pure community rating). The remaining 11 states impose what are called rate bands. Rate bands limit the extent to which insurers can vary premiums among policyholders based on health, age, gender, or other factors.[27]

The remainder of the states and the District of Columbia impose no parameters on what factors insurers can consider in setting premium rates. As a result, the coverage that can be obtained is too expensive to buy for many individuals in poor health.

Access, affordability, and adequacy over time

Once an individual insurer issues coverage, federal law does require that it renew that coverage, unless the person does not pay the premium, commits fraud, fails to comply with plan terms, or the plan no longer operates in that geographic area.[29] This rule is designed to prevent insurers from dropping policyholders after they become sick. There are no federal limits, however, on how much the insurer can increase premiums upon renewal, although there are some at the state level. State laws governing renewal rating vary.

Those who become older or sick after obtaining health insurance may find their coverage increasingly unaffordable over time. In many states premiums can increase as a policyholder ages. In addition, while premiums may be affordable at the outset, additional renewal

Premium Surcharges

Chuck, a 22-year old Virginian, sought individual coverage when he was laid off by a small employer. While the state does not require individual insurers as a whole to issue coverage to all comers, Blue Cross and Blue Shield in Virginia serves as an "insurer of last resort" in that state for those who otherwise could not obtain coverage. The premiums they charge for applicants with a medical condition (diabetes, in this case) are higher, however, and the $900 per month they required of him for coverage was more than he could afford.[28]

Inadequate and unaffordable coverage over time

Martha, a self-employed woman who lived with her family in Alabama, learned about the pitfalls of individual health insurance policies over time. After holding an individual health insurance policy for a number of years, she was diagnosed with diabetes. She increased the deductible and cost-sharing amounts on her existing policy to fend off significant premium increases. But, the combination of premium ($3,600 per year) and cost-sharing amounts—$2,500 in deductible and $1,500 in other cost-sharing—was now reaching unaffordable levels. Her current insurer was obligated under federal law to renew her policy but no other insurer was obligated to issue her coverage. There was little possibility that she could get a more affordable policy with another insurer.[31]

rate increases may be imposed based on the length of time a policy has been in force (called "durational rating"). Further, insurers in the individual health insurance market may simply stop actively marketing a given policy to new applicants after that policy has been for sale for just a few years (to the extent permitted under state law). This is known as "closing a block of business."

After the block is closed, insurers will begin actively marketing a new policy to new applicants. Policyholders covered under the closed policy may also buy the new policy if they are sufficiently healthy to resubmit to medical underwriting. Policyholders who have become sick will be stranded in the closed block. Without an influx of new enrollees to moderate the average cost of all policyholders, the premium for the closed policy can skyrocket at renewal after several years.[30] Policyholders may try to moderate renewal premium increases by reducing coverage under their policy by, for instance, increasing their deductible and copayments. Over time, however, the combined effect of rising premiums and declining coverage can put people at risk for large out-of-pocket expenses if they get sick.

The Conservative Proposals

Some conservative proposals would fundamentally change where many individuals get health insurance coverage and the legal protections that exist for people with existing health conditions. The following are three of these proposals, and how they would alter coverage for those with pre-existing conditions.

Substitution of tax credits for job-based health insurance tax exclusion

Currently, the value of private health insurance obtained from an employer is excluded from taxable income. The tax exclusion is one important reason why employers have been the primary source of health insurance coverage for the nonelderly.

Conservative proposals would repeal this income tax exclusion. As a result, employees would pay income tax on the health coverage provided by their employer. In the Universal Health Care Choice and Access Act (S. 1019), Senator Tom Coburn (R-OK) would partly repeal the income tax exclusion for job-based coverage and provide a tax credit of up to $2,000 for individuals and $5,000 for families.[32] Under this proposal, the amount of tax an individual owes to the federal government would be reduced by the amount of the tax credit. A person could, however, arrange to have the government send the amount of the tax credit directly to an insurer.[33] President Bush has also proposed repealing the income tax exclusion, and substituting a standard tax deduction of $7,500 for individuals and $15,000 for families, which could be claimed by anyone who holds at least a high-deductible insurance policy.[34]

Many others have explored alternative approaches to tax subsidies, including tax credits, because the tax exclusion only benefits those with private insurance who have job-based coverage, and it provides the greatest tax advantage to those with higher incomes.[35]

With job-based coverage neutralized from a tax standpoint under these proposals, employees will have a new incentive to consider whether it is the best source of coverage for them or if competing individual health insurers can offer adequate coverage for better value. There are reasons which will lead some employees to remain with their job-based coverage, despite price, such as scope of coverage, convenience, and trust that the employer would have better information on which to base a coverage decision and/or serve as a more successful advocate than the employee would on his or her own.[36] But the average total premium for single coverage offered by an employer in 2007 was $4,479.[37] This is compared to the average premium, according to one industry study, of $2,613 for single coverage in the individual market in 2006-2007.[38]

AVERAGE ANNUAL PREMIUMS		
	SINGLE	FAMILY
Job-Based Coverage (2007)	$4,479	$12,106
Individual Coverage (2006-2007)	$2,613	$5,799

Source: Kaiser Family Foundation/Health Research and Educational Trust Employer Health Benefits Survey 2007 and America's Health Insurance Plans, 2007.

The lower price of not necessarily comparable policies available on the individual market may entice many employees who are young and/or have limited to no pre-existing medical conditions to forgo employer coverage. As a result, employers will find themselves with a pool of older and sicker employees and fewer younger and healthier employees across which to spread the risk. Absent another viable and affordable alternative, employees who had previously declined to elect job-based coverage in favor of individual coverage will enroll in the employer plan once they become ill.

At its worst, this scenario could lead to a "death spiral" as the increased health care costs force the employer to raise premiums and cost-sharing amounts and/or lower the scope of coverage to such an extent that the plan no longer delivers value and employers stop offering health insurance. At its best, this scenario would lead to even higher cost-sharing amounts and scaled back benefit packages. This problem would be particularly acute among small employers.[39]

Permitting sale of health insurance across state lines

Additional conservative insurance reforms include initiatives that will make the barriers to health insurance even steeper for people with pre-existing conditions. Health insurers are licensed in each state in which they operate and are subject to the insurance laws of those states, including laws regarding access to coverage, premiums, and scope of coverage. As noted above, state laws on private health insurance vary considerably. Nonetheless, these approaches would allow individual health insurers to operate across state lines without adhering to the standards that would otherwise apply to them in each state, giving insurers virtually unfettered discretion in their medical underwriting practices.

One of the leading exemplars of this approach is the Health Care Choice Act of 2007 introduced by Representative John Shadegg (R-AZ) in the U.S. House of Representatives in December 2007. (A companion bill was reintroduced in the Senate by Senator Jim DeMint (R-SC).[40] Under the bill, an individual health insurer would only be subject to the laws of the state in which it is licensed even if it issues individual health insurance coverage in other states. In other words, an insurer could decide to obtain a license in and comply with the laws of a state that lacks key consumer protections in the individual health insurance market, such as Alaska, Arizona, Nebraska, and Oklahoma. It could then proceed to operate in contravention of the laws of states that seek to limit the use of certain medical underwriting practices in the individual market.

Allowing insurers to operate under one set of rules could reduce administrative costs and complexity. This proposed approach, however, would mean that

each insurer operating in a state could be subject to dramatically different standards. This will further fragment the health insurance market and eviscerate the viability of markets that guarantee access, restrict premiums, limit coverage exclusions, and/or mandate benefits, especially in states such as Maine, Massachusettes, New Jersey, New York, and Vermont, which have the most comprehensive protections. It will likewise undermine the laws of other states that have some protections and effectively foreclose these and other states from strengthening any protections.

Arizona and New York illustrate this dynamic well as they have dramatically different rules regulating medical underwriting practices in the individual market. While Arizona has no reforms, New York has the most stringent reforms in the country.

An insurer who is licensed by the state of Arizona could offer individual health insurance policies to residents of the state of New York without obtaining a New York insurance license. The insurer would not be subject to New York's guaranteed issue or community rating laws when it issues policies to New York residents. Instead, it would be permitted to deny coverage based on health status and charge higher premiums. Nor would it ever have to cover any pre-existing conditions (as that term is defined by the Arizona-licensed insurer). It could even permanently exclude coverage for any pre-existing conditions. Competitors licensed in New York, however, would have to sell coverage to all applicants at community rates.

The Arizona-licensed individual health insurer could therefore choose to insure only the healthiest of applicants from the state of New York, leaving it to New York-licensed insurers to cover those with no other options.

A 2001 study of hypothetical applicants in various state individual health insurance markets illustrates the potential effect of the market segmentation that would result from this approach. A hypothetical 24-year-old woman with hayfever, but otherwise healthy, submitted an application to nine individual health insurers in Tucson, Arizona. She received offers from eight of the nine insurers and the average annual premium quoted was just under $1,500 for the year. However, the eight Arizona insurers restricted the benefits she would receive under the policy for her pre-existing condition. Insurers

COMPARISON OF INDIVIDUAL HEALTH INSURANCE MARKET PROVISIONS: ARIZONA AND NEW YORK, 2007

	ARIZONA	NEW YORK
Guaranteed Issue	No products	All products
Rating Restrictions	No rating limits	Pure community rating
Maximum Pre-Existing Condition Exclusion Period	Unlimited	12 months
Maximum Look-Back Period	Unlimited	6 months
Standard Used to Determine If Condition Pre-Existing	No legal definition	Objective standard: Conditions for which medical diagnosis and treatment were received during look-back period
Elimination Rider	Permitted	Prohibited

Source: Kaiser Family Foundation, www.statehealthfacts.org 2007. Figures include research results on 50 states and the District of Columbia.

used different forms of benefit restrictions from eliminating coverage for allergies and drugs to increasing deductible levels. One insurer offered coverage with an exclusion rider eliminating coverage for her entire respiratory system. A second hypothetical applicant, a 62-year-old man in poor health, also made nine applications in Tucson. He was denied coverage by six insurers. The average annual premium quoted by the three insurers who offered coverage was $10,584.[41]

Both hypothetical applicants also applied for coverage under 10 policies in Albany, New York, where policies must be sold on a guaranteed issue basis and priced using community rating. Each applicant was accepted under all 10 policies. The average annual premium quoted was identical for both: $4,104. No insurer could apply an exclusion rider.[42]

The comprehensiveness of the laws in states like New York (not to mention its overall higher cost of living) has contributed to the higher cost of insurance in that state compared to others. There is evidence that younger and healthier New York residents are less likely to purchase health insurance in the New York market because of its cost.[43] But it has been difficult to parse out the extent to which costs have been most affected by insurance reforms or other factors.[44] Research suggests that factors other than New York's comprehensive reforms have contributed to this problem since states in the same region with no reforms or moderate reforms have experienced a similar trend.[45] The barrier to coverage for the young and healthy because of cost is a problem Rep. Shadegg and Sen. DeMint seek to address. In seeking to do so, however, their approach may create other severe consequences.

It is unlikely that insurers in New York and other states that have attempted to limit medical underwriting by insurers would be able to remain competitive under this proposal. More likely, this proposal would trigger a "race to the bottom" with insurers seeking licensure in states with the most permissive laws. States may have no other recourse but to eliminate rules that protect those who most need health insurance coverage in order to keep these insurance companies in the market. As the young and healthy move to cheaper coverage options (so long as they remain young and healthy), locally based insurers will be left with a pool of older and unhealthy, higher cost enrollees potentially leading to the same type of "death spiral" described for employer plans earlier in this discussion.

In addition, the Congressional Budget Office estimated that this bill as introduced in the prior legislative session would result in loss of coverage for about 1 million employees and their dependents.[46] As a result, if the Shadegg-DeMint approach prevails, a person who lives in the state that does guarantee access to coverage, limit premiums, or require limitations on pre-existing condition exclusion periods and compliance with benefit mandates could lose those protections.

Encouraging the use of other sources of insurance

A third prong of conservative health reforms would encourage individuals and small employers to purchase coverage from professional associations, churches, and other similar entities. For many years, however, the U.S. Congress has considered legislation that would encourage small employers to band together to promote

the sale of health insurance through entities that would be called association health plans. There is a significant amount of commentary on these proposals.[47]

One strong concern voiced about these proposals is that they would enable health plans offered by professional associations and others to override state laws that mandate coverage for the treatment of certain conditions, providers, or populations. As of July 2004, for instance, 47 states required health insurers to cover diabetes self-management education, 50 states required them to cover mammograms, 21 states required them to cover colorectal cancer screenings, and 37 states required them to cover off-label drug use for certain conditions like cancer.[48] These consumer protection standards would not apply to individuals covered under these health plans.

These bills would also give association health plans a competitive advantage over other groups because they would preempt, and not replace, other critical state laws as well in both the small group and individual health insurance markets that require that insurers guarantee access to coverage, and/or set premiums below certain levels. These proposals, like the other proposals discussed in this paper, seek to address important concerns but could further segment the health insurance market. As a result, premiums would increase for those still subject to state insurance laws and those most in need of health care insurance would be left with few, if any, affordable options.[49]

Supplemental efforts to make coverage available

Researchers have concluded that tax credits which are not adjusted for health and age will be of far less benefit to those who are older and sicker than they will be to those who are young and healthy.[50] The individual health insurance (or other unregulated) market will not be a viable option for them even with some adjustment if insurers are not required to issue coverage to people with pre-existing conditions or cover their pre-existing conditions.

To address these concerns, some conservative proponents have turned to existing models, such as high-risk pools, to provide a coverage option for high-risk people. In S. 1019, Senator Coburn, for example, would require all states to establish a high-risk pool or an "alternative mechanism" to provide a coverage option for "medically uninsurable" individuals.[51] Similarly, Representative Jeff Fortenberry (R-NE) has proposed expanded federal funding for high-risk pools in his health reform legislation.[52]

High-risk pools, which exist in 33 states, serve as the only available source of coverage for many who do not have job-based coverage and are rejected by individual health insurers as a result of their underwriting practices.[53] As of December 31, 2006, however, the total number enrolled in those 33 pools was 190,361, with about 60 percent of nationwide enrollment from only six states (Illinois, Maryland, Minnesota, Oregon, Texas, and Wisconsin).[54] For the most part, high-risk pools have not been a viable alternative for the medically uninsurable largely because of high premiums—an expected consequence of a pool consisting almost entirely of people with high-cost health care needs—and inadequate funding to subsidize the full cost of providing insurance to a high-cost population.[55]

Given that high-risk pool premiums are between 125 percent and 200 percent of standard premiums in the individual health insurance market, it is not surprising that the premium burden is even more pronounced for older Americans. In some states those who are 50 to 64 years old are subject to monthly premiums in excess of $1,000 per month for a policy with a $1,000 deductible.[56] The federal government has made initial efforts to provide financial support to high-risk pools. It authorized $75 million per year for operational and bonus grants for the next several years and $15 million per year for seed grants to support the efforts of states who want to establish a high-risk pool.[57]

Health care spending for high-risk pools is, however, steep—about $1.6 billion for the approximately 190,000 people currently covered.[58] The extent to which premiums cover high-risk pool costs varies among the states considerably. In no state, however,

do premiums cover the full medical claims and administrative costs of the high-risk pool. Consequently, states rely on other sources of funding in addition to premiums, most frequently from assessments on insurers but also through general state revenues and other sources.

States have been actively grappling with this issue—how to increase the number of people with health insurance while maintaining adequate and affordable coverage for those with medical conditions—for decades, with varying degrees of success. Massachusettes is implementing the most far-reaching of state efforts thus far to achieve universal coverage. Maine and Vermont have also enacted reform plans designed toward this end. As of January 2008, there were 33 other states that had proposed universal coverage plans.[59] A few states have experience trying to address this issue through non-Medicaid related coverage expansion programs. But getting and maintaining the funding for these programs has been a very significant challenge.[60]

Conclusion

The conservative proposals discussed in this paper would restructure the health insurance marketplace without seeking to ensure that all Americans can get adequate health coverage. Instead, the restructuring process would redistribute the haves and the have-nots. Some who currently have health insurance will lose that coverage while some who do not have health insurance will gain coverage. Those who lose their coverage will not necessarily be able to replace it, or may not even be able to get health insurance that is adequate or affordable.

Similarly, not everyone who is currently uninsured will be able to take advantage of the financial incentives provided in some of these proposals to buy health insurance. And those who voluntarily change coverage may find their new insurance inadequate once they become ill. Older and less healthy Americans would experience the most dramatic and adverse fallout of all from this disruption.

To better serve Americans when their health makes them the most vulnerable, proposals for reform will need to be carefully designed to move the nation's health coverage system toward universal access to adequate and affordable coverage.

Endnotes

1 Paul Fronstein, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey" (Washington: Employee Benefit Research Institute, October 2007, Issue Brief No. 310) p. 4.

2 Jeanne Lambrew, "McCain's Health Plan Puts At Least 56 Million People with Chronic Disease at Risk of Losing Health Coverage" (Washington: Center for American Progress Action Fund, April 29, 2008).

3 Office of Management and Budget, "Overview of the President's 2008 Budget." (Department of Health and Human Services, 2008) available at http://www.whitehouse.gov/omb/budget/fy2008/hhs.html; Universal Health Care Choice and Access Act, S. 1019; Health Care Choice Act, H.R. 4460; Health Care Choice Act of 2007, H.R. 4460 and S. 2477; Small Business Health Plans Act of 2008, S. 2818; Small Business Health Fairness Act of 2007, H.R. 241.

4 Linda J. Blumberg and others, "Lowering Financial Burdens and Increasing Health Insurance Coverage For Those with High Medical Costs" (Washington: The Urban Institute, December 2005) Health Policy Briefs, p. 1, citing Berk, Marc and Alan Monheit, "The Concentration of Health Expenditures, Revisited," Health Affairs (March/April 2001): 145-149.

5 Mark Merlis, "Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform" (Washington: National Health Policy Forum, April 13, 2005).

6 Lambrew, "McCain's Health Plan Puts At Least 56 Million People with Chronic Disease at Risk of Losing Health Coverage," p. 20.

7 Fronstein, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey," p. 4.

8 Ruth Helman and others, "Public Attitudes on the U.S. Health Care System: Findings from the Health Confidence Survey" (Washington: Employee Benefit Research Institute, Issue Brief No. 275, November 2004).

9 Fronstein, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey," p. 4.

10 29 U.S.C. section 1181-1183; 26 U.S.C. section 9801-9802; 42 U.S.C. section 300gg-41-44.

11 "Small Group Health Insurance Market Rate Restrictions," available at http://www.statehealthfacts.org (last accessed July 2008).

12 Ibid.

13 42 U.S.C. 300gg-41

14 "Individual Market Guaranteed Issue (Not Applicable to HIPAA Eligible Individuals)," 2007, available at http://www.statehealthfacts.org.

15 Ibid.

16 Composite story based on actual experiences of people with health insurance problems who contacted the American Cancer Society's Health Insurance Assistance Service.

17 "Individual Market Portability Rules (Not Applicable to HIPAA Eligible Individuals)," 2007, available at http://www.statehealthfacts.org (last accessed July 2008).

18 Composite story based on actual experiences of people with health insurance problems who contacted the American Cancer Society's Health Insurance Assistance Service

19 "Individual Market Portability Rules (Not Applicable to HIPAA Eligible Individuals)," 2007, available at http://www.statehealthfacts.org (last accessed July 2008).

20 Ibid.

21 Ibid.

22 Ibid.

23 Merlis, "Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform," p. 10.

24 Jon Gabel and others, "Individual Insurance: How Much Financial Protection Does it Provide?" Health Affairs, April 17, 2002: W177.

25 Ibid., W176.

26 Elisabeth Simantov and others, "Market Failure? Individual Insurance Markets for Older Americans," Health Affairs 20:4 (July/August 2001), p. 139; Deborah Chollet, "Understanding Health Insurance Markets: Structure, Practices and Products in Ten States" (Washington: Kaiser Family Foundation, March 1998).

27 "Individual Market Portability Rules (Not Applicable to HIPAA Eligible Individuals)," 2007,available at http://www.statehealthfacts.org (last accessed July 2008).

28 Pollitz and others, "Falling Through the Cracks: Stories of How Health Insurance Can Fail People with Diabetes," (Washington: Georgetown University Health Policy Institute and American Diabetes Association, February 8, 2005) , p. 10.

29 42 U.S.C. 300gg-42(b).

30 Government Accountability Office, "Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverge Trade-offs," (Washington: GAO/HEHS-97-8, November 1996), p. 50, and "The Individual Health Insurance Market: A Building Block for Health Care Reform? Insights from HCFO Research Results" (Washington: AcademyHealth, May 2008).

31 Pollitz, "Falling Through the Cracks: Stories of How Health Insurance Can Fail People with Diabetes," , p. 11.

32 Universal Health Care Choice and Access Act, S. 1019.

33 Ibid.

34 Office of Management and Budget, "Overview of the President's 2008 Budget." ,

35 Leonard E. Burman and Jonathan Gruber, "Tax Credits for Health Insurance" (Washington: Urban-Brookings Tax Policy Center, June 2005); Mark Pauly and Bradley Herring, "Expanding Coverage Via Tax Credits: Trade-Offs and Outcomes," Health Affairs (January/February 2001): 9-26.

36 Paul Fronstein and Dallas Salisbury, "Health Insurance and Taxes: Can Changing the Tax Treatment of Health Insurance Fix Our Health Care System?" (Washington: Employee Benefit Research Institute, Issue Brief No. 309, September 2007) p. 12.

37 KFF/HRET Employer Health Benefit Survey, 2007.

38 "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits" (Washington: America's Health Insurance Plans Center for Policy and Research, December 2007), p. 7.

39 See Kaiser Family Foundation, "Coverage and Cost Impacts of the President's Health Insurance Tax Credit and Tax Deduction Proposals" (2004), discussing results of model by Jon Gruber of impact of President Bush's tax deduction and tax credit proposals.

40 Health Care Choice Act of 2007, H.R. 4460 and S. 2477.

41 Karen Pollitz and others, "How Accessible Is Individual Health Insurance for Consumers in Less Than Perfect Health?" (Washington: Kaiser Family Foundation, June 2001).

42 Ibid.

43 Beth C. Fuchs, "Expanding the Individual Health Insurance Market: Lessons from the States Reforms of the 1990s" (Princeton: Robert Wood Johnson Foundation, Policy Brief No. 4, June 2004).

44 Merlis, "Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform."

45 Thomas Buchmueller, "Consumer Demand for Health Insurance" (Washington: National Bureau of Economic Research, Summer 2006).

46 Congressional Budget Office Cost Estimate, "H.R. 2355 Health Care Choice Act of 2005" (Washington, D.C., September 12, 2005), p. 5.

47 *Small Business Health Plans Act of 2008*, S. 2818, introduced by Senator Michael B. Enzi (R-WY) April 3, 2008 and *Small Business Health Fairness Act of 2007*, H.R. 241, introduced by Congressman Sam Johnson (R-TX), January 5, 2007. For a more detailed discussion of earlier versions of each of these bills see, Kofman, Mila, and Karen Pollitz, "Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change" (Washington, D.C: Georgetown University Health Policy Institute, April 2006).

48 Victoria Craig Bunce and JP Wieske, "Health Insurance Mandates in the States 2004" (Washington: Council for Affordable Health Insurance, July 2004).

49 Mila Kofman and Karen Pollitz, "Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change" (Washington: Georgetown University Health Policy Institute, April 2006), p. 8.

50 James D. Reschovsky and Jack Hadley, "The Effect of Tax Credits For Nongroup Insurance on Health Spending by the Uninsured," *Health Affairs* – Web Exclusive, February 25, 2004: p. W4-114.

51 *Universal Health Care Choice and Access Act,* S. 1019.

52 *America's Affordable Health Care Act of 2008*, H.R. 6280..

53 "State High-Risk Health Insurance Pools," available at http://www.statehealthfacts.org (December 31, 2004, last accessed July 2008). Florida, which has a high-risk pool, has not been included in this count because its pool has been closed since 1991.

54 "State High Risk Pool Programs and Enrollment, 2007," available at http://www.statehealthfacts.org (last accessed July 2008).

55 S. Lewis and others, "Expanding Health Care Coverage for the Uninsured: Lessons From the States A CRS Report for Congress" (Washington, D.C., May 17, 2004), pp. 19-20.

56 Author review of state high risk pool websites. For more detailed information on state high risk pools, see, "Comprehensive Health Insurance for the High-Risk Individuals – A State by State Analysis 2005/2006" Nineteenth Edition (Communicating for Agriculture and the Self-Employed).

57 P.L. 109-172, State High Risk Pool Funding Extension Act of 2006, enacted February 10, 2006.

58 Center for American Progress Action Fund, "Analysis of McCain's Health Care Announcement" (April 29, 2008).

59 The Kaiser Commission on Medicaid and the Uninsured, "States Moving Toward Comprehensive Health Care Reform" (Washington: Kaiser Family Foundation, January 29, 2008).

60 Lewis, "Expanding Health Care Coverage for the Uninsured: Lessons From the States A CRS Report for Congress," p. 20

About the Author

Stephanie Lewis, JD, LLM is an attorney and independent policy consultant with expertise in health insurance regulation and employee benefits law. She has a Master of Health Services Administration from the University of Michigan as well as a Juris Doctor and Master of Law in Taxation from Georgetown University Law Center.

The author would like to thank Karen Pollitz, MPP, of the Georgetown University Health Policy Institute for her helpful input and feedback on this paper.

ABOUT THE CENTER FOR AMERICAN PROGRESS ACTION FUND

The Center for American Progress Action Fund transforms progressive ideas into policy through rapid response communications, legislative action, grassroots organizing and advocacy, and partnerships with other progressive leaders throughout the country and the world. The Action Fund is also the home of the Progress Report and ThinkProgress.

Center for American Progress Action Fund
1333 H Street, NW, 10th Floor
Washington, DC 20005
Tel: 202.682.1611 • Fax: 202.682.1867
www.americanprogressaction.org