

**Private Health Insurance Reform:  
Good, but – Without Public Insurance Option – Not Good  
Enough**

**Timothy Stoltzfus Jost**

**Executive Summary**

Our country is in the midst of a great debate about how to reform our health care system. Nearly fifty million Americans are uninsured, and millions more are inadequately insured. Many Americans cannot buy health insurance at any price, others not at an affordable price, others are insured but find out that when in fact they need health care, their insurance still leaves them without access to necessary care or with massive financial obligations. While the insurance market reforms under discussion currently in Congress will address many of these issues, the inclusion of a public health insurance option, as in the House legislation (HR 3200) and legislation reported from the Senate Health, Education, Labor, and Pensions (HELP) Committee, provides the cost and quality benchmarks and health security critical to ensuring accountability from the private health plans.

**Where Does the Legislation Fall Short?**

The legislation currently being considered by Congress—in particular the House bill, would dramatically improve the availability of insurance to lower- and middle-income Americans. It would also effectively address many of the worst health insurance abuses that Americans now endure. It would end insurer discrimination on the basis of health status, prohibit pre-existing condition exclusion clauses, limiting cost-sharing, and guarantee essential benefits and consumer protections. It does not, however, solve all of the problems attributable to private health insurance.

Neither the House bill nor the HELP bill does enough to control private health insurance premiums. An amendment passed by the House Energy and Commerce Committee would limit premium increases. The exchange is also intended to constrain premium growth by encouraging price competition among plans and the House bill's limits on administrative costs may moderate some of the most wasteful expense of insurers. In the end, however, without a public plan option, the legislation may not do enough to effectively control continued premium increases.

Other insurance abuses may also continue. Although the House legislation would extend grievance and appeal procedures to all insureds, the legislation still will not stop rationing of care by insurers. The Senate HELP bill permits levels of cost-sharing, particularly under employment-related plans that will remain unaffordable for many

Americans. The HELP Committee bill does not provide for internal appeals for all plans and does not even address external appeals, and no bill currently under consideration repeals the federal law that shields employer plans from liability in state courts when their decisions or delays result in injury or death. The HELP bill leaves the responsibility to enforce its insurance protections largely with the states, many of which have poor track records in protecting insured Americans.

### **Why is the Public Health Insurance Option Critical?**

The public health insurance option offers the potential for much more effective cost control than is otherwise possible. It also promises the chance of a less expensive alternative to private insurance. If the public health insurance plan is allowed access to the Medicare network of providers and permitted to pay something close to Medicare prices, it should be able to get control over provider costs. The public option should also be able to avoid some of the administrative costs that burden private insurers. The public option should, therefore, offer a less expensive alternative to those for whom saving money is a paramount concern. It is also to be expected that private plans will respond to competition from the public plan by reducing their own prices, especially in some of the most concentrated markets where there is little or no competition today. Private plans could tighten their belts administratively (perhaps lowering executive salaries a little), and drive harder bargains with providers. This would help all purchasers in the market, and lower costs for individuals, businesses, and taxpayers.

Further, a public health insurance option could also lead to a more transparent market. As long as insurers conceal provider prices, price competition in provider markets is unlikely. As long as coverage protocols and utilization data are concealed, quality competition among plans is unlikely. The coverage protocols and provider payment rates of the public option, on the other hand, would be open to the public. And data on the utilization of health care services under the public plan would be available for expert analysis and reporting, just as Medicare data are now.

Finally, the public option is necessary as a backstop against risk selection. It takes more than simply prohibiting risk selection to stop it. Even with risk adjustment and strong non-discrimination rules, private insurers are likely to find a way to dodge people whose costs are expected to be high in order to protect profitability. The job of the public option, on the other hand, is to accept, not to avoid, risks and to be accountable to the public, not shareholders.

# Private health insurance reformed: Better, but without public plan choice, not good enough

Timothy Stoltzfus Jost\*

Our country is in the midst of a great debate about how to reform our health care system. Nearly fifty million Americans are uninsured, and millions more are inadequately insured.<sup>1</sup> Many Americans are unable to purchase health insurance at any price, others not at an affordable price, others have health insurance but find out that when in fact they incur medical expenses that their insurance leaves them with uncovered services and massive medical debt.<sup>2</sup> Health reform legislation pending in Congress would fix some of these problems but not others.

This paper begins by describing the problems that Americans face with getting, keeping, and using health insurance through the use of stories that illustrate common situations in which Americans experience difficulties with insurance coverage. The next section describes broadly the approach that reform legislation takes to extending health insurance coverage to Americans. The third section of the paper discusses the regulation of health insurance under health reform and how it addresses current problems. The paper then returns to the stories with which it began, considering how each of these stories would end once health reform is implemented. Some problems are solved, some remain. Finally, the paper concludes by asking what public plan choice adds to the insurance reforms already explored. An appendix explores how health insurance is currently regulated in the United States.

## Today's Health Insurance Horror Stories<sup>3</sup>

**Insurer refusal to cover pre-existing conditions:** Mary just graduated from college and is working at a restaurant as a waitress as she looks for a more permanent job. She has been trying to find an insurance policy in the nongroup market that will cover her until she can find a job with health benefits. Mary has asthma, however, and most insurers to which she has applied have rejected her. One insurer offered her a policy but at a very high rate and with a pre-existing conditions exclusion clause that excludes coverage for any medical treatment related to her asthma or, in fact, for her entire respiratory system.

**Insurer rescission of health insurance policies:** Joe was recently diagnosed with cancer. He had purchased insurance earlier in the year, months before he began to experience any symptoms or to suspect he had a problem, and has been paying his premiums faithfully. When his surgeon filed for preapproval for Joe's cancer surgery, his insurance company cancelled his coverage. It turns out that Joe had had a scan last year that had found gallstones, a condition completely unrelated to his cancer. Joe had not been told about the gallstones and did not mention them on his insurance application.

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The insurer went over all of Joe's medical reports when the cancer approval claim was filed and rescinded his policy retroactively because of the nondisclosed gallstones.

**Insurer annual and lifetime policy limit:** Rosa has been insured with the same insurer for years. She has been hospitalized for three months because she has required multiple surgeries for a serious but rare disease. She has also been receiving very expensive medications for several years. She has just received notice that she has reached the \$1,000,000 lifetime limit on her policy, and will no longer be covered.

**Lack of affordable coverage in individual market:** Sam lost his job when his employer went out of business earlier this year. He had a good health insurance plan through his job, but it was cancelled thirty days after his job ended. He is sixty-two years old and has chronic high blood pressure, and cannot afford any plans that will insure him in the nongroup market. The least expensive policy he's been offered would cost more than \$275 per month with a \$10,000 annual deductible, and the policy doesn't cover office visits or prescription drugs. His premium is high because of his age (the policy charges 62-years-olds more than five times the premium that would be offered to 22-year-olds) plus he faces a 50 percent surcharge due to his blood pressure. For a policy with a \$1,000 deductible that covers office visits and prescription medications, Sam would have to pay over \$800 per month. He is not eligible for COBRA coverage because his employer is no longer offering health insurance to anyone.

**Job-lock in order to maintain good health insurance coverage:** Elaine has been dreaming for years of quitting her dead-end clerical job and launching her own business. She has decent health coverage at work and can't afford to give it up and lose coverage for herself and her three children.

**Insurer coverage limits:** Mario had a compound fracture of his wrist when he fell trimming a tree in his yard earlier this year. His doctor was able to repair the wrist, but Mario had to be casted for two months, and when the cast was removed his hand was useless. His doctor prescribed physical and occupational therapy (three sessions per week for two months) to restore the use of the hand. Mario's insurance policy, however, only covers six sessions of therapy, so Mario was uncovered after two weeks of therapy. Now he faces a dreadful dilemma. At \$94 per hour for the therapy, Mario can't afford the treatment, but neither can he afford to be without use of his hand.

**Lack of good information comparing health insurers:** Jacob is also self-employed, working as a web design consultant. He makes a pretty good income and is young and in good health. He found several nongroup policies online that he could afford. Each seems to have different benefits and cost-sharing structures, and he is having a hard time figuring out which is the best deal. He also cannot figure out which doctors in his community are in-network for which plans and what his costs might be for out-of-network services. Finally, he has heard that administrative costs for nongroup plans are very high, but he can find no information as to which plans actually spend the highest proportion of their premiums on medical care.

**No financial security if out-of-network care needed:** The Miller’s baby was born last month with a congenital heart problem. They have been advised by their pediatrician that the infant must be operated on at a specialty children’s hospital. The children’s hospital is out of their plan’s network, however, and therefore their normal 80 percent coverage with 20 percent coinsurance does not apply. Rather, they must pay a coinsurance rate of 40 percent, as well as any charges of the hospital and the doctors who will be treating their child there above what their plan is willing to cover for out-of-network providers.

**Repeated insurer regulatory violations:** Vic had a minor surgery earlier recommended by his doctor. His insurance company denied coverage for the \$5,000 bill and upheld the denial on an internal appeal. Vic appealed the decision to his state’s external reviewer, which reversed the insurer’s decision, holding that the surgery was clearly medically necessary and covered. He complained to his state’s Insurance Commissioner. The investigator who interviewed Vic about the complaint said that the insurer has a track record of denied claims for covered services and for having those denials overturned. The Insurance Commissioner has fined the insurer several times for improper claims denials, but the company has apparently concluded that this practice is profitable. Many policyholders don’t end up pursuing formal appeals or filing formal complaints – for every claim-plus-fine the insurer pays, it saves more in other denied claims that never get paid.

## **The Health Reform Solution**

The health insurance reform provisions of the legislation-- the provisions that would actually expand health insurance coverage and help to control health care costs—are organized around six quite simple concepts. While at this point there is no single health reform bill and there is unlikely to be one for some time, there are currently two major vehicles that have been reported out by four of the five Committees involved in the debate. In the House, H. R. 3200 has been marked up by the House Committees on Ways and Means, Energy and Commerce, and Education and Labor. Slightly different amendments were adopted in each committee, but the legislation is likely to be re-combined into a single bill in the next month.<sup>4</sup> In the Senate, the Health, Education, Labor and Pensions (HELP) bill went through an extensive mark-up earlier in the summer<sup>5</sup> These two bills each embrace each of the six basic concepts described below, often in very similar ways. These bills:

**1. End insurer discrimination on basis of health status and other practices that limit coverage:** Currently, insurers who sell policies to individuals and small groups pursue a basic strategy of risk avoidance—they select the best risks to insure at favorable rates (“cherry picking”), they refuse to insure or charge very high premiums to people who are actually sick or at high risk of becoming ill; and they attempt to dump persons who actually become ill where they are able to do so (“lemon dropping”). Reform provisions would end discrimination on the basis of health status, requiring insurers to take all applicants and to charge them premiums that could not vary based on health status. Reform will also limit the sale of poor quality insurance policies, requiring all new policies to cover minimum benefits, limiting

cost-sharing obligations, and ending annual and lifetime coverage limits. Finally, insurers will have to disclose the percentage of their premiums that they actually spend on health care. Under the House bill, insurers would also be required to limit their administrative costs.

**2. Create an insurance “exchange” where consumers can choose from comparable insurance policies that meets their needs:** The exchange will be a better organized health insurance marketplace than individuals and small employers use today. A choice of health plans will be offered to everybody who buys health coverage through the exchange. The exchange will also provide consumers with better comparative information about the plans for sale – with detail about what the plans cover and what they cost in a format that makes it easier for people to select a plan that will better serve their needs. In the exchange, subsidies will also be offered to people on a sliding scale basis so premiums will be more affordable (see below). The exchange will also monitor insurers’ market behavior and have the authority to exclude insurers that don’t follow the rules.

**3. Require all Americans to have health coverage.** All Americans will have to be insured. Whether people are offered coverage at work or are eligible for Medicare or Medicaid or buy policies on their own, people will be responsible for having health insurance coverage.

**4. Provide sliding scale subsidies for low- and moderate-income uninsured Americans and their families to make health insurance affordable.** Subsidies that decline as income rises will probably be available to American households with incomes up to 400 percent of the poverty level, well above the median income, recognizing that health insurance has become unaffordable to ordinary Americans. Cost-sharing obligations will also be limited for lower-income households.

**5. Contain an employer obligation or mandate.** Most Americans currently get health insurance through their jobs, but some employers currently refuse to provide health insurance, leaving their employees uninsured.<sup>6</sup> Employers have also in recent years been shifting an ever greater portion of the cost of employment-related insurance to their employees through higher employee premiums and cost-sharing, making insurance less affordable to their employees and of less value if they or their families actually become ill. While the legislation is still evolving in the House and Senate, the House bill requires employers to contribute to or offer coverage to employees or dependents; those that offer will be required to meet minimum standards, including providing protection against excessive cost-sharing. These minimum standards would currently be met by most firms that offer health insurance, and their primary intent is to discourage further erosion of benefits rather than to impose onerous new requirements on employers. Firms with lower total payroll will be exempt from these requirements, though the precise threshold that determines exemption is still under consideration. Certain small employers will also be eligible for tax credits if they opt to provide coverage, irrespective of whether they are required to do so.

**6. Offer a public health insurance alternative to private health insurance to increase consumer choice and the competitiveness of insurance markets.** The public option has been discussed extensively in other papers and will be discussed here only in the context of what it adds to the other reforms.

The House bill also expands Medicaid coverage to those with incomes below 133 percent of the poverty level, improves Medicare coverage and the efficiency of the Medicare program, and strengthens the nation's public health infrastructure and health care workforce. The Senate HELP bill assumes a Medicaid expansion to 150 percent of the poverty level and strengthens the nation's public health infrastructure and health care workforce but was unable to address Medicare provisions because of jurisdictional constraints. These provisions will not be discussed in this paper, although the expansion of Medicaid to cover all Americans below 133 or 150 percent of the poverty level (that is, most American families dependent on a minimum wage job) will be a vital adjunct to the insurance reform provisions of the legislation. These new Medicaid recipients will no longer be dependent on the private insurance market.

This paper instead discusses how the reform legislation in fact operationalizes the basic building blocks listed above, focusing particularly on the insurance reform provisions of the legislation pending in each chamber.

## **What Changes Would Pending Health Reform Legislation Bring About?**

### **The New Configuration of the Health Insurance Market**

New legislation would mean that the federal government would take on much more responsibility for regulating health insurance. Consequently, new protections would be extended to individuals in all states and some protections now available to them in only some states would become available in all. Under the House bill, a newly created federal Commissioner of Health Insurance Choices would, together with the states, enforce these protections.<sup>7</sup> Under the Senate HELP bill, the states would retain primary responsibility for enforcing the new federal laws, but the federal government would have “fall back” authority to enforce federal standards in states that fail to enforce the laws.<sup>8</sup> Under both versions, states would retain the authority to regulate insurance where their own laws do not conflict with federal law.

Under the reform legislation, nongroup and group policies will in general be subject to the same regulations (although, particularly under the HELP bill, policies sold within the exchange are subject to different requirements than policies sold outside the exchange). Self-insured employer plans would also be subject to the same federal requirements except for laws that only make sense to apply to actual insurers (for example, underwriting or guaranteed issue requirements) and requirements that apply only within the exchange.<sup>9</sup> Four distinct categories of insurance will be recognized for regulatory purposes.

- **Grandfathered policies.** The mantra remains, “If you like what you have you can keep it,” as long as the plan complies with current pre-reform state and current federal laws. This is true for current nongroup policies under both the House and HELP bills and for employment-related policies under the HELP bill

and for the first five years under the House bill. Coverage would lose its grandfathered status, however, if its terms changed.<sup>10</sup>

- **Insurance offered through a health insurance exchange (called “gateways” in the HELP bill).** Insurance would be available through a national exchange under the House bill or state-based gateways under the Senate bill to individuals not otherwise insured, to small groups, and possibly in time to larger groups.<sup>11</sup> Insurance sold through an exchange must comply with all of the general insurance reform requirements, described below, but also must comply with additional requirements imposed through the exchange.<sup>12</sup> Public premium subsidies will only be available to purchase exchange policies.<sup>13</sup> The creation of an exchange as a new, organized marketplace for insurance is a key reform, but, as noted below, not all insurance will be sold within the exchange. The exchange offers added resources and supports for individuals that will help them purchase insurance plans. The exchange can also be somewhat selective about the insurers who can sell insurance. The House version gives the exchange the power to negotiate; the HELP bill gives the gateways discretion over which plans they allow to participate. In a more organized market, it should be easier for people to compare products and make informed choices. Plans sold through the exchange will continue to be regulated by the states insofar as state laws are not inconsistent with federal law,<sup>14</sup> although benefits offered under state mandates beyond those required by federal requirements will not be funded by the federal premium subsidies and will have to be funded by the state or repealed.<sup>15</sup> The public plan will be subject to the same requirements as exchange-based plans and probably additional requirements as well.
- **Insurance sold outside of the exchange.** Insurance plans would continue to be available outside of the exchange to employment-related groups, and under the HELP bill, to individuals as well.<sup>16</sup> These policies would need to comply with the basic insurance reforms but not with the additional exchange requirements. They would also be subject to state regulations not inconsistent with federal law. There is a real danger, particularly under the Senate HELP bill, that these plans will offer substandard plans with little value and also be used to cherry-pick good risks away from the exchange, destabilizing the market.
- **Self-insured employer plans will be subject to most of the new insurance requirements,** but not requirements imposed by the exchange or state law.

### Limits on Risk Selection

To regulate these different categories of insurance, the legislation imposes new rules intended to end risk selection and premium discrimination. These rules will apply to all insurance plans, group and nongroup, in and outside of the exchange, except grandfathered policies. They include:

- A requirement that plans **guarantee issue** to any applicant (subject to certain limitations).<sup>17</sup>
- A **prohibition against discrimination in coverage on the basis of health status.**<sup>18</sup> Discrimination is also prohibited in premiums on the basis of health status (although the HELP bill permits plans to offer substantially more favorable

rates to group members who participate in wellness activities *and who achieve certain health targets* – which could have the effect of causing sick people to pay more for health insurance). Variance in premiums is only permitted based on geography, the number of people covered under a policy, and under the HELP bill, actuarial benefit value and tobacco use. Up to 2:1 premium variance based on age is also permitted.<sup>19</sup>

- A total **prohibition against pre-existing condition exclusion clauses.**<sup>20</sup>
- A requirement that plans **guarantee renewal of coverage. Rescission is prohibited** except for fraud.<sup>21</sup>

In addition, the HELP bill prohibits discrimination by group plans based on salary (except that lower premiums can be offered low-income employees) and requires coverage for dependents up to age 26.<sup>22</sup>

### **Required Benefits**

The legislation would also require plans to cover “essential benefits.” Here the House and HELP bills diverge somewhat. The House bill imposes coverage requirements on all plans.<sup>23</sup> The HELP bill only imposes most of these requirements on “qualified health benefit plans” sold through the exchanges (i.e. those eligible for federal premium subsidies)<sup>24</sup> and allows “qualifying coverage,” (i.e. employee or individual coverage that meets the employer or individual mandates but does not qualify for subsidies) to meet lesser requirements.<sup>25</sup>

The House and HELP bills’ lists of essential benefits are quite similar, including hospital and physician care, prescription drugs, maternity care, rehabilitation, and mental health care. The House bill prohibits and the HELP bill limits cost-sharing on preventive benefits. Both bills limit annual out-of-pocket expenditures. Under the House bill, this limit would be around \$5,000 for individuals per year, \$10,000 for families, adjusted annually for inflation.<sup>26</sup> The Senate bill has higher limits (nearly \$6,000 per individual, \$12,000 per family) in the first year.<sup>27</sup>

The House bill explicitly and the HELP bill implicitly, however, only limit patient out-of-pocket spending to services that are received in network. Neither bill requires a cap on patient cost-sharing for care received from out-of-network providers, although the House bill does require plans to cover out-of-network specialists at in-network rates if the network doesn’t have an appropriate provider in its network.<sup>28</sup> The House bill bars limits on benefits unrelated to clinical appropriateness.<sup>29</sup> Both bills prohibit lifetime or annual dollar limits.<sup>30</sup> The House bill requires plans to meet standards of network adequacy.<sup>31</sup>

Critically, however, the HELP bill only requires plans sold through the gateways to provide essential benefits. Plans can be sold outside of the gateways or provided by employers that provide only “minimum qualifying coverage.” Minimum coverage must not cover an unreasonably limited set of diseases or conditions, cannot impose cost-sharing obligations above those allowed by health savings account-related high deductible health plans, and must otherwise meet minimum requirements defined by HHS.<sup>32</sup>

## **Consumer Protection Provisions**

Both bills also contain provisions to protect Americans with health insurance. Both provide for the promulgation and enforcement of fair marketing standards, grievance and appeal requirements, and standards for disclosure of plan terms.<sup>33</sup> These provisions only apply within the exchange under the HELP bill, and only outside the exchange if specified by the Commissioner under the House bill.

Both bills provide for three different “tiers” of benefit plans offered within the exchange to facilitate the availability of plans with a variety of cost-sharing levels.<sup>34</sup> The House bill also permits a fourth level of benefits beyond those in the essential benefits package. Both bills also provide for risk equalization among plans.<sup>35</sup> The House bill provides only for risk pooling within the exchange, but the HELP bill seems to apply risk pooling to all plans, inside and outside the gateways, other than grandfathered or self-insured plans.

Both bills require the exchange to require plans to make available information on their benefits, premiums, cost-sharing, grievance and appeal procedures, and networks to members and potential members, and to present information in a simple and comparable form.<sup>36</sup> Additionally, the HELP bill requires disclosure of information about the use of preventive services within plans and the House bill requires information on claims payment policies and practices, data on enrollment and disenrollment, periodic financial disclosure, data on the number of claims denials, and information on cost-sharing and payments for out-of-network coverage.<sup>37</sup> Finally, the House bill requires plans to disclose their medical loss ratios (and to meet minimum ratios) and the HELP bill requires disclosure of the percentage of revenues spent respectively on clinical services, improving the quality of care, and administrative costs.<sup>38</sup>

The HELP bill requires plans to use provider payment structures that create incentives for meeting a variety of quality goals. The House bill imposes requirements for timely payment of providers and for the use of standardized forms. The House bill also establishes a health insurance ombudsman – a federal agency (within the new Health Choices Administration) that will provide information and assistance to Americans, help them navigate choices, and accept and help resolve questions and complaints.

## **Other Provisions to Encourage Insurance Availability**

The House and Senate bills provide for subsidies (“affordability credits”) so uninsured individuals earning up to 400% of poverty can afford to buy insurance within the exchange, although the approaches of the different bills to providing assistance is quite different.<sup>39</sup> Both bills impose an individual mandate, although the HELP bill provides for waiver if a plan is not affordable. The House bill permits a waiver in cases of “hardship.”<sup>40</sup> Both provide for an employer mandate and require the employer to cover at least a minimum percentage of the premium of employee policies (72.5 % for individuals and 65% for families in the House bill, 60% for both in the HELP bill).<sup>41</sup>

Under the House bill, the employer must make a contribution for exchange coverage if an employee cannot afford employer coverage and rather seeks coverage through the exchange. Both bills exclude from the employer mandate the smallest employers, and both provide some subsidies for the purchase of health insurance by small employers. Tax penalties on both individuals and employers that do not comply with the mandate are modest under the HELP bill and more substantial under the House bill.

In sum, both bills offer a comprehensive federal law framework for limiting discrimination on the part of insurers against people in ill health. Both the House and HELP bills require insurance plans to offer a solid benefit package, but the HELP bill permits less comprehensive coverage for employees outside of the exchange. Both bills offer consumer protections, but under the HELP bill these protections might not apply outside of the exchange.

### **What does the Legislation fail to do?**

Although the legislation addresses many of the worst health insurance abuses that consumers now endure, it does little or nothing to address others. First, it does not control private health insurance premiums. It is expected that the exchange will encourage price competition among plans and the House bill's limits on administrative costs may moderate some of the most wasteful expense of insurers. An amendment passed by the Energy and Commerce Committee will cap annual premium increases. But neither of the reform bills limits premiums as such.

The legislation permits levels of cost-sharing, particularly under non-subsidized employment-related plans, that will remain unaffordable for many Americans. The HELP bill does not provide for internal appeals for non-exchange plans and does not even address external appeals, and neither bill guarantees judicial review for insurance plan denials. Other than recognizing a right to appeal, already available in most states, the legislation does little to discourage insurance company denials, delays in providing care, and rationing of care. The HELP bill leaves the responsibility to enforce its insurance protection with the states, many of which have poor track records in protecting insured Americans with insurance.

### **The Stories Revisited**

The best way to understand what the bills fix and what they do not is to return to the stories with which we began this memorandum. The bills:

- **Require insurers to cover pre-existing conditions.** Under both the House and HELP bills, preexisting conditions clauses are eliminated. Mary would be able to get coverage without regard to her preexisting condition. Under both the House and HELP bills, Mary could not be refused coverage because of her health problems. Indeed, she could not even be charged higher premiums. Depending on how risk pooling is designed, she may even be attractive to some insurers. This does not guarantee, however, that her insurance would fully cover all of her health

needs. That will depend on how essential benefits are defined. She may also still face substantial cost-sharing that may discourage adequate care, although the extent of the cost-sharing she faces will depend on her income, and could be quite manageable if her income is low. Finally, if risk adjustment does not adequately compensate insurers for taking on higher risk, she may face more subtle forms of risk selection, like selective marketing or benefit design, or poor service intended to encourage her to switch coverage.

- **Ban insurer rescissions of health insurance policies.** The House bill bars insurers from rescinding contracts except where there is clear and convincing evidence of fraud, so Joe would most likely be protected from rescission.
- **Prohibit annual and lifetime caps.** Both bills eliminate annual and lifetime limits, assuring true catastrophic coverage. Rosa's problem would be solved.
- **Guarantee affordable coverage for people without employer coverage.** With both bills, loss of employment will no longer mean loss of insurance. If after his job loss Sam's household income fell below 133% of the poverty level (possibly 150% under the Senate bill), he would be eligible for Medicaid. If loss of employment left Sam between 133% and 400% of the poverty level, Sam could purchase insurance through the exchange and receive a premium subsidy, with some limits on cost-sharing. The bill's limits on out-of-pocket expenditures and prohibition of annual or lifetime limits offer substantially more protection than is available to many Americans today, particularly in the nongroup and small group markets. Under the HELP bill, the **individual mandate to buy coverage would be waived for Sam on affordability grounds** if his *premium* cost exceeds 12.5% of his adjusted gross income. However, the additional amounts Sam might owe for cost-sharing are not considered in calculating the affordability waiver of the individual mandate.
- **Free people from job-lock.** Job-lock should become much less of a problem. Elaine can leave her job and start up her own business, and receive premium subsidies as long as her income remains below 400 % of poverty.
- **Impose some constraints on insurers limiting coverage.** Under the reform legislation, plans will still be able to limit their coverage. In particular, plans outside of the exchange may under the HELP bill be able to provide very limited coverage. The House legislation, on the other hand, prohibits limits on coverage "unrelated to clinical appropriateness." Mario will be able to appeal the coverage denial to the plan, and, under the House bill, obtain external review. The House bill also preserves access to judicial review under state law if not inconsistent with ERISA. If the insurance contract in fact limits the number of physical therapy visits as it may, an appeal will be of little use.
- **Provide better information comparing plans.** If Jacob purchases insurance through the exchange, he should be able to obtain much more information on plans than he can now in many states. The information should be in comparable form allowing him to actually compare coverage. He should be able also to obtain general information on how much plans actually spend on medical care. He will not be able to see rates that the plans he is considering have actually negotiated with providers or what they will pay for out-of-network care. Nor will he be able to see much if any reliable outcomes data.

- **Cap cost-sharing, but at very high levels.** Although both bills limit cost-sharing for individuals who purchase insurance through the exchange with the assistance of premium subsidies, outside of the exchange (including most employment-related policies) an insured's total exposure for in-network, covered services would be limited under both bills to about \$5,000-\$6,000 if she is covered as an individual, \$10,000-\$12,000 if she has family coverage. But these levels of cost-sharing are not sustainable for many lower and middle-income Americans.<sup>42</sup> By contrast, the average annual deductible for an individual employment-related PPO policy with a deductible in 2008 was \$560, \$1344 for a family policy.<sup>43</sup> Lower and middle-income Americans who purchase their policies through the exchange receive much greater protection.
- Compounding this problem, **cost-sharing limits under both bills only apply to covered services from in-network providers** (unless, under the House bill, the network is determined to be inadequate). The problem of out-of-network costs is only addressed in part by the reform legislation. Both the House and HELP bills contemplate the continued existence of networks. The HELP bill requires exchange-certified health plans to have adequate networks and to disclose the differential costs of using out-of-network providers (although, without knowing actual out-of-network charges, this information may not be very useful). The House bill goes further and prohibits cost-sharing differentials if network providers are not adequate. But neither bill bans or limits out-of-network cost-sharing requirements. The Miller family's problems, therefore, might not be addressed.
- **Government oversight and enforcement may remain limited.** It must be expected that some insurers will continue to violate their contractual and legal obligations after the reform legislation goes into effect. The House bill permits the Commissioner to exact substantial civil penalties against insurers that violate the law, as well as to suspend enrollments in an insurer's plans or payment to the insurer, and even to terminate qualified-plan status. The HELP legislation depends on the states to enforce the law, and it must be expected that this enforcement will continue to be as uneven as it is today.

### **What Does Public Plan Choice add?**

Once the private market is reformed, will the choice of a public health insurance plan ("public plan choice") still be needed? If private plans must take all applicants, cannot refuse to cover preexisting conditions, and cannot charge the sick more than the healthy, impose annual or lifetime limits on care, or exceed statutory out-of-pocket limits for cost-sharing, why do we need a public option?

The most compelling answer to this question is that the public health insurance option guarantees a choice and offers the potential for cost control and delivery system innovation that is otherwise unlikely. A second, closely related answer is that the public health insurance option offers the chance of a less expensive alternative to private insurance.

Although other parts of the reform legislation such as comparative effectiveness research or Medicare payment reform hold out the promise of moderating health care cost-growth as well as improving the quality and appropriateness of care, the insurance reform portions of the legislation directly address the cost of health care or of health insurance only to a limited extent. The HELP bill exhorts exchange-certified health plans to pursue payment strategies that might control costs and requires health insurers to disclose how much of their premiums are spent on administrative costs. The House bill goes further, requiring plans to achieve minimal medical loss ratios or pay refunds to their members. Annual insurance premium increases would be capped under an amendments to HR 3200 from the Energy and Commerce Committee. Savings will also accrue as market reforms and the greater availability of comparative information about plans through the exchange leads to better informed purchasing by individuals and businesses. But direct cost control measures are very limited.

If the public health insurance option is allowed access to the Medicare network of providers and permitted to pay something close to Medicare prices, it should be able to get control over provider costs. The public option should also be able to avoid some of the administrative costs that burden private insurers. It would not need to make a profit, for example, and would likely spend less on marketing (including brokerage commissions, which can consume from two to six percent or more of the premiums of group plans and a much higher percentage of premiums in the nongroup market).<sup>44</sup> The HELP bill prohibits its public plan from covering anything other than the required essential health services, while the House bill requires the public plan to offer all three of the standard tiers of coverage – basic, standard and enhanced. The public option should, therefore offer a less expensive alternative to those for whom saving money is a paramount concern.

It is also to be expected that private plans would respond to competition from the public option by reducing their own prices. Private plans could tighten their belts administratively (perhaps lowering executive salaries a little), and drive harder bargains with providers. This would help all purchasers in the market.

Further, a public option could also lead to a more transparent market. Both the HELP and House bills require disclosure of medical loss ratios, but coverage protocols, and claims payment practices, as well as provider reimbursement rates would presumably remain trade secrets. As long as provider prices are concealed, price competition in provider markets is unlikely. As long as coverage protocols and utilization data (like the data available under the Medicare program) are concealed, quality competition among plans is unlikely. The coverage protocols and provider payment rates of the public plan, on the other hand, would be open to the public. And, insurer claims-payment practices and utilization data would be available for expert analysis and reporting. If private plans are going to make the argument that costs are being shifted to them from the public plan and that they provide better quality care, they will need to be more forthcoming with their data.

Finally, the public option is necessary as a backstop against risk selection. It takes more than simply prohibiting risk selection to stop it. Despite the best efforts of regulators, some people with serious medical problems will find it problematic to get good service from private plans. The job of the public option is to accept, not to avoid, risks. It is probably to be expected that the public option will have a worse risk pool than private plans just as traditional Medicare does now compared to Medicare Advantage, although the House bill and HELP bills require risk adjustment payments to exchange plans to reflect any possible selection. But in the end, the public health insurance plan will undoubtedly be more hospitable to those who need health insurance most.

## **Appendix: Current Insurance Markets and How They are Regulated**

Health insurance in the United States today is regulated very differently depending on the market in which it is sold.<sup>45</sup> The fundamental distinction is between the nongroup and individual and group markets. Group policies are almost inevitably employment-related, although in a few states groups may be constituted by trade associations or other non-employer groups. Group policies are further divided between small and large group policies, with the cut-off point usually being about 50 members. Finally, a sharp distinction is drawn between insured and self-insured employment-related groups. In the former, the employer purchases an insurance policy from an insurer and the insurer bears the risk (although policies are usually experience-rated so that if an employment-related group experiences high costs its premiums are likely to rise dramatically the next year, and thus ultimately the risk is borne by the group). With self-insured policies, the risk is borne by the employer (although employees usually pay a part of the cost and most economists believe that the entire cost is ultimately passed on to the employees in the form of lower wages). Self-insured plans are often administered by insurers and are usually reinsured, so that there is often in fact little difference between insured and self-insured plans, although the legal difference is very significant.

Employee benefit plans, including health plans, are regulated by the federal government under the Employee Retirement Income Security Act of 1974, or ERISA.<sup>46</sup> ERISA imposes few obligations on plans. ERISA plans may not discriminate on the basis of health status in either providing coverage or in the premiums charged. Plans must follow certain federal rules when they deny claims governing timing, explanation of decisions, and appeal rights. Plans must also provide their members with specific information concerning benefit coverage and meet fiduciary obligation requirements. Federal law imposes a handful of benefit mandates on employee benefits plans—minimum stay coverage for maternity benefits, breast reconstruction benefits if the plan covers mastectomies, and mental health parity. Finally, ERISA provides judicial review of benefit denials in federal court, although a beneficiary denied coverage can only recover the benefit denied, not damages for injuries that result from benefit denials. Courts also usually defer to the discretionary coverage decisions of insurers. Self-insured plans are regulated exclusively by ERISA (which is to say, they cannot be regulated by the states and are largely unregulated); insurers who sell insured plans to employers, however, are also regulated by the states.

A few other federal laws also apply to health insurance. The Health Insurance Portability and Accountability Act (HIPAA) limits but does not outlaw preexisting conditions clauses in group policies and requires, subject to certain exceptions, insurers to issue policies to any applicants in the group market and to renew existing policies in the group and nongroup markets.<sup>47</sup> Provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides extended coverage of employees and

their dependents whose coverage is terminated for certain specific reasons, but only if the employee pays the full premium.<sup>48</sup> The civil rights laws occasionally affect coverage. The gender discrimination prohibition, for example, prohibits discrimination in coverage for pregnancy related services.

Federal law, however, does not require employers to offer coverage and with very few exceptions allows employers complete discretion to define the benefits covered and cost-sharing obligations imposed by employment-related coverage. Federal law does not limit insurance premiums in any way. It does not prohibit insurers from charging much higher premiums to riskier groups or raising premiums dramatically from year to year. Finally, federal law has virtually no provisions governing the nongroup market.

The states have plenary authority to regulate insurance other than self-insured employee plans. Indeed, the federal McCarran-Ferguson law recognizes the exclusive authority of the states to regulate insurance except in situations where the federal government specifically steps in to regulate insurance itself.<sup>49</sup> The scope and effectiveness of state insurance regulation varies dramatically from state to state. Some states have comprehensive regulatory schemes, others impose minimal regulatory obligations.<sup>50</sup> States also vary dramatically in their commitment to enforcing their regulations and their effectiveness in doing so.<sup>51</sup>

State laws applying to all insurers address basic issues such as licensure, solvency and reserves, marketing, and claims practices. States have imposed a wide variety of coverage mandates on health insurers, requiring health insurers to offer certain benefits (mammography screening, alcoholism treatment), cover services offered by particular providers (chiropractors, psychologists), or cover specific persons (adopted children). During the 1990s, most states adopted statutes and regulations governing certain managed care practices. State managed care laws, for example, provide for internal and external review of utilization review decisions, impose provider network adequacy requirements, and require plans to provide direct access to certain specialists. State contract and tort law, and sometimes specific statutes, permits persons denied benefits by insurance plans not covered by ERISA to sue in state court to recover benefits denied, and in some egregious cases for additional damages.

State regulation of insurance underwriting and rating practices varies dramatically depending on the state and the market. Most states do not regulate underwriting and claims practices in the large group market, concluding that large employers have enough bargaining clout and purchasing expertise to look after themselves. States are more likely to regulate insurer practices in the nongroup market, with virtually all states requiring guaranteed renewal, many states limiting preexisting conditions clauses, and a number of states requiring insurers to offer policies to individual applicants. Only a minority of states regulate underwriting or premiums in the nongroup market. Two thirds of the states have high risk pools for individuals who cannot obtain affordable insurance otherwise, but high risk policies are usually quite expensive and are not widely purchased. States are most aggressive in their regulation of the small group market,

where virtually all states limit the disparity of insurance rates and a number require community rating—that is, charging the same rate regardless of health status.

To summarize the current regulatory landscape for insurance:

- Although most Americans, 160 million, receive health insurance through their employment, **employers are not required to provide health insurance.** Employers who provide health insurance are largely unconstrained as to the benefits they provide and the cost-sharing obligations and employee premium contributions they impose. Self-insured employers are not subject to state regulation, therefore an employer who does not wish to comply with state insurance requirements merely needs to self-insure (and, if it contracts with an insurer to administer its claims and reinsure its risk, can continue to operate much as it did before it self-insured).
- The **nongroup (individual) market, which insures 13 million Americans, is regulated only by the states, and regulation varies from state to state.** Insurers may turn down applicants if they are unhealthy and in most states can vary premium rates significantly on the basis of health status. Pre-existing conditions clauses are unregulated in about two fifths of the states, and limited in their extent but permitted in most others. All states require plans to renew existing policies, but insurers may raise rates when they offer renewal. In general, states do not regulate the premiums charged by insurers in the nongroup market. Most states do not regulate the deductibles, copayments, or coinsurance charged in the nongroup market, and most do not define the essential benefits plans must cover, except with respect to specific products and services covered by mandates.
- The **small group insurance market is regulated by the states and, if groups are employment-related, by ERISA.** Although states require insurers to guarantee issue and renewal in the small group market and most states limit underwriting to a greater or lesser degree, the size of premiums and the cost-sharing requirements and benefits of small group plans are largely unregulated.

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## Endnotes

(Please note that where a citation refers to HR 3200, the House bill, or in the HELP bill, the section citation is to either the section of the legislation or to the section number of a section it adds to or amends in existing legislation, usually the Public Health Services Act, whichever is more specific).

<sup>1</sup> Although the most recently available census data as of this writing found the number of uninsured to be 45.7 million in 2007, [http://www.census.gov/Press-Release/www/releases/archives/income\\_wealth/012528.html](http://www.census.gov/Press-Release/www/releases/archives/income_wealth/012528.html), far more are uninsured today because of the massive job loss during the economic downturn.

<sup>2</sup> See <http://www.coveramericatour.org/> for real life stories of Americans suffering these experiences. See also, Kaiser Family Foundation, Health Care and the Middle Class: More Costs and Less Coverage (July 2009); <http://www.kff.org/healthreform/upload/7951.pdf>.

<sup>3</sup> Although these stories are fictional, all are possible under today's insurance system and some are based on the experiences of actual victims of insurance abuses.

<sup>4</sup> [http://energycommerce.house.gov/Press\\_111/20090714/aahca.pdf](http://energycommerce.house.gov/Press_111/20090714/aahca.pdf).

<sup>5</sup> An earlier, and still basically relevant, version of this bill is found at [http://help.senate.gov/BAI09A84\\_xml.pdf](http://help.senate.gov/BAI09A84_xml.pdf).

<sup>6</sup> See Kaiser Family Foundation/ Health Research and Education Trust, 2008, "Employee Health Benefits Annual Survey." <http://ehbs.kff.org/>.

<sup>7</sup> Sec. 141.

<sup>8</sup> Sec. 3104.

<sup>9</sup> HELP bill, sec. 9185(b).

<sup>10</sup> HELP bill, sec. 131; HR 3200 sec. 102.

<sup>11</sup> HR 3200, sec. 202; HELP bill sec. 3101(b).

<sup>12</sup> HELP bill, sec. 3103.

<sup>13</sup> HR 3200, sec. 241; HELP bill, sec. 3111(b).

<sup>14</sup> HELP bill, sec. 3101(n); HR 3200, sec. 151(a)(1).

<sup>15</sup> HELP bill, sec. 3101(c) (3); HR 3200, sec. 203(d).

<sup>16</sup> HELP sec. 3101(b); HR 3200, secs. 102, 202.

<sup>17</sup> HR 3200, sec. 112; HELP bill, sec. 2702. Note however that both bills also provide for 'open enrollment' periods, suggesting that there may be times during the year when people might not be able to enroll in health coverage.

<sup>18</sup> HR 3200 sec. 113; HELP bill, sec. 2701.

<sup>19</sup> How this will interface with the law prohibiting age discrimination in employment for employers who insure their members through the exchange remains to be seen.

<sup>20</sup> HR 3200, sec. 111; HELP bill, sec. 2705.

<sup>21</sup> HR 3200, sec. 112; HELP bill, sec. 2703.

<sup>22</sup> HELP bill, secs. 2709, 2719.

<sup>23</sup> HR 1320, sec. 121.

<sup>24</sup> HELP bill, sec. 3103(a).

<sup>25</sup> HELP bill, sec. 3103(b)(2); 3116(a)(5)(B).

<sup>26</sup> HELP bill, sec. 3111(a), HR 3200 sec. 122(c). The Senate HELP bill defines out-of-pocket limits in terms of the limits placed on high-deductible health plans by the health savings account provisions of the Tax Code (section 223).

<sup>27</sup> ). HELP bill sec. 3111(a), The Senate HELP bill defines out-of-pocket limits in terms of the limits placed on high-deductible health plans by the health savings account provisions of the Tax Code (section 223). In addition, under the Senate bill, cost sharing limits for families would apply on a per-policy basis. Even if only one family member is sick, that person would have to satisfy the entire family-level limit on cost sharing before the plan would pay 100% of covered claims for the rest of the year.

<sup>28</sup> HR 3200 sec 1(c)(4).

<sup>29</sup> HR 3200 sec. 121(c).

<sup>30</sup> HELP bill, sec. 2710; HR 3200 sec. 122(a)(3).

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- <sup>31</sup> HR 3200 sec. 115.
- <sup>32</sup> HELP bill, sec. 3103(a)(1)(B).
- <sup>33</sup> HR 3200, secs. 131, 132, 133; HELP bill, sec. 3101(l).
- <sup>34</sup> HELP bill, sec. 203; HR 3200, sec. 3111(a).
- <sup>35</sup> HELP bill, sec. 206(b); HR 3200, sec. 3101(b)(6).
- <sup>36</sup> HELP bill, sec. 3101 (l); HR 3200, sec. 205(c).
- <sup>37</sup> HR 3200, sec. 133.
- <sup>38</sup> HELP bill, sec. 2704.
- <sup>39</sup> HELP bill, sec. 3111; HR 3200, secs. 241-246.
- <sup>40</sup> HELP bill, sec. 301; HR 3200 secs. 161, 59B(b).
- <sup>41</sup> HELP bill, sec. 163; HR 3200, secs. 311-324.
- <sup>42</sup> See Paul Jacobs and Gary Claxton, “Comparing the Assets of Uninsured Households to Cost Sharing Under High-Deductible Health Plans,” Health Affairs Web Exclusive (April 15, 2008), w-214.
- <sup>43</sup> KFF/HRET Survey, *supra* note 3.
- <sup>44</sup> See, Leslie Jackson Conwell, “The Role of Health Insurance Brokers,” Center for Studying Health Systems Change, 2002. <http://www.hschange.com/CONTENT/480/>.
- <sup>45</sup> For a more complete description of health insurance regulation in the United States, see Timothy Stoltzfus Jost, “The Regulation of Private Health Insurance,” National Academy of Social Insurance/National Academy of Public Administration, 2009. [http://www.nasi.org/usr\\_doc/The\\_Regulation\\_of\\_Private\\_Health\\_Insurance.pdf](http://www.nasi.org/usr_doc/The_Regulation_of_Private_Health_Insurance.pdf); See also Mark A. Hall, “The Geography of Health Insurance Regulation,” Health Aff. 19(2), 173 (2000).
- <sup>46</sup> 29 USC 1001, et seq.
- <sup>47</sup> Parts of HIPAA are found in ERISA, title XXVII of the Public Health Act, and in the Internal Revenue Code. The group and nongroup market provisions are found at 42 USC 300gg et seq.
- <sup>48</sup> The American Reinvestment and Recovery Act of 2009 subsidizes 65% of this cost for laid off persons for up to nine months between February 17 and December 31, 2009. <http://www.dol.gov/ebsa/cobra.html>.
- <sup>49</sup> 15 USC 1011.
- <sup>50</sup> See Susan Laudicina et al., “State Legislative Health Care and Insurance Issues, 2008 Survey of Plans,” BlueCross BlueShield Assn 2008.
- <sup>51</sup> See Families USA, “Failing Grades,” <http://www.familiesusa.org/resources/publications/reports/failing-grades.html>, and Insurance Company Rules, Where is the Referee, [http://www.insurancecompanyrules.org/learn\\_more/where\\_is\\_referee](http://www.insurancecompanyrules.org/learn_more/where_is_referee).