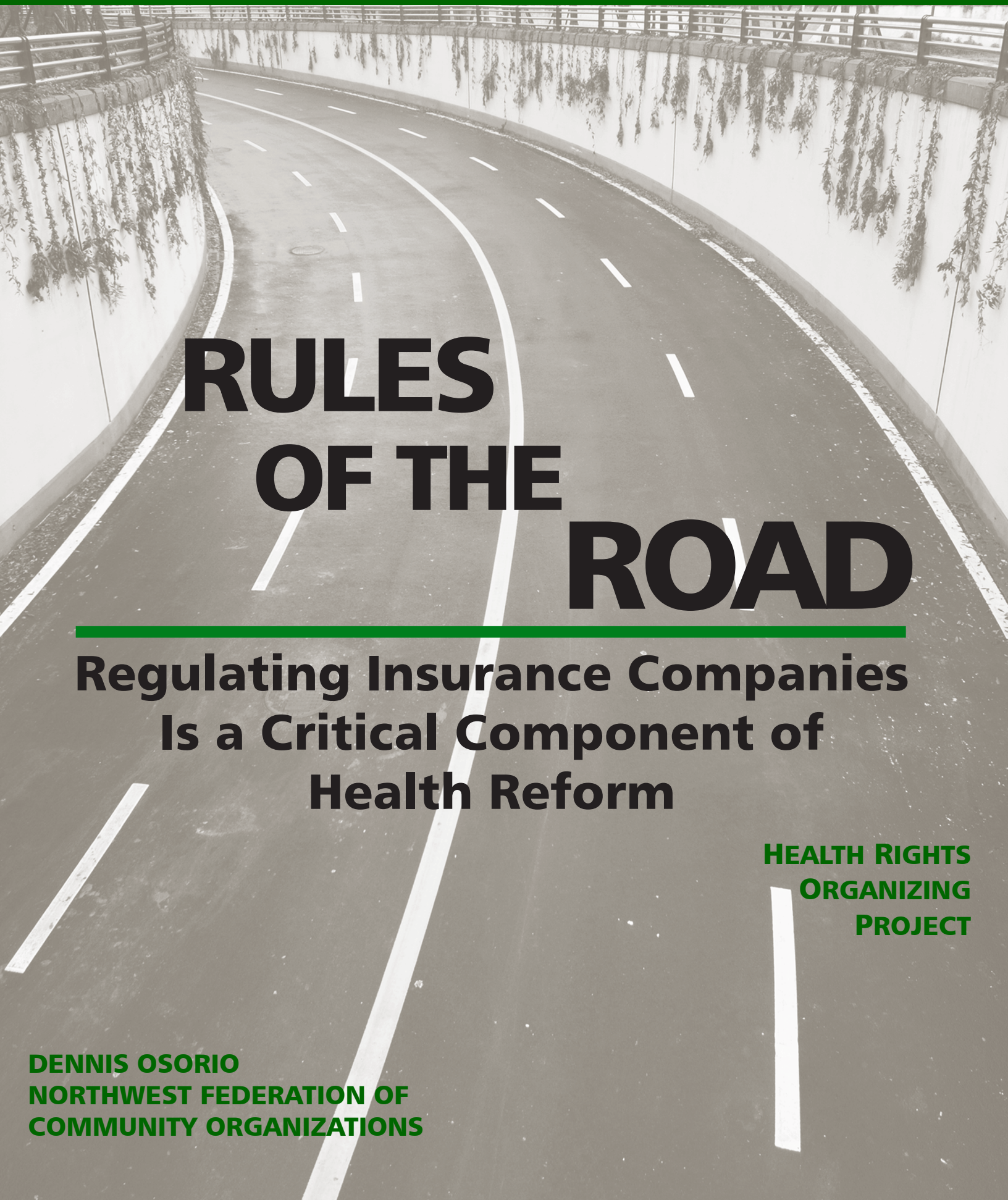

RULES OF THE ROAD

Regulating Insurance Companies Is a Critical Component of Health Reform

HEALTH RIGHTS ORGANIZING PROJECT

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INTRODUCTION

On March 23, 2010, President Obama signed historic health reform legislation.[1] The Patient Protection and Affordable Care Act (PPACA) aims to increase the quality and accessibility of health insurance in the United States. This overhaul includes significant changes to public oversight of health insurance and creates state-based insurance Exchanges to assist with the purchase of insurance. These reforms are meant to promote the affordability of health insurance, facilitate access to health care, and protect patients against practices of the health insurance industry that have undermined access to quality care.

Much remains to be decided about the operation of the Exchanges and the requirements health insurers will have to meet both inside and outside the Exchanges. Ultimately, the success of health reform depends on these decisions. Accordingly, elected officials and policymakers on both the state and federal level should promote quality coverage and ensure the strongest possible oversight of the health insurance industry, thereby protecting the health and financial wellbeing of consumers.

This report discusses and makes recommendations in five key areas:

- Review of health insurance rates;
- The portion of premiums insurers will be required to spend on health care;
- Oversight of grandfathered plans that remain main exempt from many requirements under reform
- Benefit standards; and,
- Operation of the Exchanges.

BACKGROUND

The Patient Protection and Affordable Care Act introduces important changes in the way consumers purchase insurance and in the protections they can expect from private health insurers.

One of these changes is the creation of state-based insurance Exchanges, entities that will facilitate the purchase of insurance by individuals and employers. The federal Department of Health and Human Services (the Department) will develop rules for the implementation of these Exchanges, which will begin making insurance available in 2014. Generally, the Exchanges will create marketplaces for individuals and small groups to purchase health insurance, offering a variety of plans and operating under a set of common rules.

In addition to establishing the Exchanges, PPACA introduces important new measures for the oversight of insurers. Health insurance companies will be required, among other things, to cover people with preexisting conditions, offer a basic package of essential benefits, and stop dropping policyholders after they become sick. They will also be required to spend a minimum portion of each premium dollar on health care. Additionally, rate increases proposed by insurers will become subject to new oversight measures. Both the Department and state regulators will be responsible for enforcement of these new provisions.

PROTECTION AGAINST UNREASONABLE RATE INCREASES

For more than twenty years, health insurers have been steadily raising their rates, which consistently have grown faster than both inflation and workers' earnings.[2] Although the 10 largest insurance companies saw their profits increase by 250 percent between 2000 and 2009 – 10 times faster than inflation[3] – these insurers have implemented sharp rate hikes. A recent survey found that over 75 percent of individuals who buy their own in surance had seen their insurers raise premiums by an average of 20 percent in the past year.[4] This, in turn, has led many policyholders to switch to cheaper, less comprehensive plans.[5] These trends highlight the need for vigorous review of rates.

Historically, the regulation of health insurance rates has been a state matter, and oversight varies greatly across the country. Some states, such as Maine and Rhode Island, require regulatory approval through an open public process,[6] while in other states, such as Montana, regulators lack the authority to review rates and deny unreasonable increases.[7]

PPACA creates a pathway through which all states can strengthen their rate review, directing the Department to work with states to establish a process for reviewing unreasonable premium increases. Insurance companies are, in turn, required to file justifications for such increases before they are implemented.[8] The rate review process will be open to the public.[9] However, PPACA leaves a number of questions unanswered with regard to rate review. Among these unanswered questions are the following:

- What is the threshold at which a proposed premium increase triggers a rate review?
- How will "unreasonableness" be defined - or, what will constitute an "unreasonable" rate increase?
- What is the process by which rates will be deemed reasonable or unreasonable?
- Although much rate information will be made available to the public, will there be sufficient advance notice of proposed increases for significant public input? Will affected policy holders have the right to public hearings?
- What will the consequences be for health insurers that implement unreasonable rate increases?

In 2010, the Department will establish new regulations related to rate review. With input from the states, the Department will establish the process for annual review of premium increases,[10] and health insurers will be required to file justifications of proposed unreasonable rate increases.[11] In addition, states seeking federal grants to support rate review will start reporting on trends in premium increases.[12] They also will begin making recommendations on whether insurers that have implemented excessive or unjustified rate increases should be excluded from state-based health insurance marketplaces (the Exchanges).[13]

To strengthen the rate review process, states and the Department should:

- Place the burden of proof on the health insurer to demonstrate that a proposed premium increase is not "unreasonable";
- Define as unreasonable all premium increases that are unnecessary;
- Ensure that the process is transparent and that justifications and other documentation related to proposed increases be made publicly available;
- Foster public participation in the rate review process by ensuring that adequate advance notice of proposed rate increases be provided, that policyholders impacted by rate increases be given the right to public hearings, and that proposed increases be published on the Department's new web portal;
- Factor insurer profits, surplus levels, executive compensation and lobbying expenses across lines of business in the course of determining whether premium increases are "unreasonable"; and,
- When unreasonable rate increases do occur, insurance companies should be held accountable by having their health plans excluded from the Exchanges.

ENSURING PREMIUM DOLLARS ARE SPENT ON HEALTH CARE

Medical loss ratio (MLR) is a measure that quantifies the portion of each premium dollar a health insurer "loses" to health care expenses compared to profit and administrative costs. Low medical loss ratios indicate that a health insurer has diverted a high portion of premiums on profits, administrative costs, or a combination of both.

This problem is particularly acute in the individual and small group markets. In some cases, insurers in the individual market sell plans with medical loss ratios of only 60 percent, keeping 40 percent of premium dollars for administration, marketing, and profits.[14] Medical underwriting – the use of medical or health status information to determine whether, and at what price, insurance is offered – can represent 20-25 percent of premiums in the individual market and 10-15 percent in the small group market.[15] Furthermore, administrative costs account for almost 30 percent of premiums for policies purchased by small firms with fewer than 25 employees and individuals.[16]

PPACA sets minimum standards and reporting requirements related to MLRs. Starting in 2010, insurers must provide annual reports on MLRs for the health plans they sell.[17] Effective January 1, 2011, if MLRs do not meet minimum standards, insurance companies will be required to rebate excess premiums to policyholders.[18] The minimum standards established by PPACA are as follows:

- Eighty-five percent for large group policies (or higher, if established by a given state);[19]
- Eighty percent for small group or individual policies (or higher, if established by a given state).[20]

However, PPACA does not specify which expenses will represent health care expenses for MLR purposes, establishing only that costs for both clinical services and for quality improvement will qualify toward the minimum standard.[21] The Department, together with the NAIC, has been tasked with adopting regulations that specify these qualified expenditures, including what count as activities related to health care quality. These definitions are to be established no later than December 31, 2010. [23]

Health insurers have an incentive to include administrative expenses (including initiatives that help increase insurer profits) as qualified expenditures. The insurers are now engaged in an effort to claim as qualified expenditures a host of costs that appear administrative. Examples include: quality initiatives without proven benefit to patients; provider network development; new technologies; and, unproven wellness programs.[24] As noted by the NAIC, "the medical loss ratio and rebate program could be rendered useless if the definitions and calculations are too broad." [25]

Among critical health services that should not be overlooked, however, are language services. In the U.S., almost 20 percent of people speak a language other than English at home,[26] and many are considered to have limited English proficiency (LEP). To communicate symptoms and treatment instructions effectively in a medical setting, competent health care language services are vital. Failure to overcome language barriers can have severe health consequences for LEP patients, including misdiagnosis and sub-standard or inappropriate medical care.[27]

To make the MLR requirements truly effective, the Department should:

- Define qualified expenditures as only those costs that can be shown to improve the health of patients;

- Prevent companies from reclassifying other business activities so that they qualify under the Act;

- Ensure that programs not related to direct clinical services for a company's policyholders, but that may contribute to policyholders' health, be periodically reviewed, with companies establishing that health outcomes have improved; [28] and,

- Classify health care-related language access costs as qualified expenditures.

GRANDFATHERED HEALTH PLANS

A large exception exists to many of the new oversight powers and consumer protections created under PPACA. The legislation allows individual consumers and employers to continue to use and renew insurance plans currently in place.[29] These plans will be "grandfathered," meaning that they will be exempt from a number of new reforms, such as:

- Improved internal and external appeals processes;
- Restrictions that protect individuals against annual dollar limits for health benefits;
- Review of rate increases;
- Essential health benefits package;
- Direct access to OB/GYNs; and,
- Modified community rating, which prohibits insurers from setting premiums based on health status, but allows consideration of some factors such as age, tobacco use, and geography.[30]

The grandfather provision provides health insurance companies (and employers) the opportunity to maximize profits at the expense of policyholders not covered by the consumer protections provided under PPACA. The Department has issued interim final regulations that set out the triggers for loss of grandfather status.[31] These rules – and the final rules eventually adopted by the Department – are a floor, not a ceiling; state regulators can issue regulations that exceed federal requirements so that policyholders of grandfathered plans benefit from consumer protections found in non-exempt plans.

To ensure that the grandfather plan provisions are not exploited by insurance companies, and to maximize the number of people protected by new consumer protections, the Department and states should:

- Establish a registry of all grandfathered plans;
- Maintain consumer-oriented information detailing what federal-based and state-based consumer protections are available or those with grandfathered plans;
- Where states have regulatory authority over insurance plans, adopt consumer protections from which the plans may be exempt under the federal law (such as direct access to OB/GYNs and coverage of essential health benefits);
- Require insurance companies and employers to notify policyholders if their coverage is grandfathered with an explanation of what health reform benefits do not apply because of the plan's grandfathered status; and,
- Establish clear criteria for determining when changes to health plans are significant enough to terminate grandfather status.

EXCHANGES

PPACA created a new means for buying health insurance called Health Benefit Exchanges. The Exchanges are state-based entities that will offer a choice of insurance plans and establish rules regarding the marketing and pricing of insurance. As of 2014, Exchanges will be available in each state for the purchase of insurance by individuals and small groups.[32] In 2017, states will have the option of opening Exchanges to larger employers.[33]

The Congressional Budget Office has estimated that approximately 29 million people will acquire health insurance through the Exchanges in 2019.[34]

Purpose and Function of the Exchanges

The creation of the Exchanges is meant to address the difficulty individuals, small businesses, and small groups have finding affordable and adequate health insurance.[35] The Exchanges will create very large "pools" of customers of different ages and health statuses, spreading risk widely and making costs more affordable and predictable.[36] This is a reversal of traditional insurance practices of risk selection, where competition is strong for young, healthy enrollees on whom insurers can spend very little, while avoiding those who are older or less healthy.[37]

To qualify to sell coverage in an Exchange, plans must demonstrate that they meet the following requirements, among others: those with significant health needs are not discouraged from signing up; consumers are given an adequate choice of health care providers; essential community providers which serve low-income people are included; and, pre-existing conditions are covered. [38]

Other functions the Exchanges will perform are:

- Certifying health plans to ensure they are qualified to be included in Exchanges;
- Developing a standard enrollment form and presenting health plan information in a standardized format to assist with the purchase of insurance;
- Informing people about potential eligibility for Medicaid, the Children's Health Insurance Program, and other public coverage programs and facilitating enrollment in those programs;
- Creating a "navigator" program that awards grants for public education about and enrollment in the exchanges; and,
- Certifying exemptions from the individual responsibility requirement established under PPACA.[39]

Structure of the Exchanges

Considerable flexibility is given to states for setting up the Exchanges. States are free to establish separate Exchanges to serve individuals, small business groups, and distinct geographic areas.[40] The Exchanges will have to create application and documentation procedures.

Funding to create Exchanges will be available to states from 2011 until January 1, 2015, at which point Exchanges are to be self-sustaining. States must allow Exchanges to charge assessments or user fees to participating insurance companies or to generate funding through other means. If a state does not set up an Exchange by 2014, the Department will establish and run an Exchange in that state, either directly or through a nonprofit. States can restrict Exchanges to businesses with fifty or fewer workers until 2016, when businesses with up to a hundred employees can join. In 2017, states may choose to allow businesses with over a hundred employees to purchase coverage from an Exchange.[41]

Access to the Exchanges

Transparency is an important feature of the Exchanges so that consumers can compare plans' features, such as claims payment policies, denied claims, information on cost-sharing for out-of-network coverage, and other standardized information. Subsidies for the purchase of insurance will be available for consumers with incomes from 133 percent to 400 percent of the federal poverty level.[43]

Regardless of how Exchanges are ultimately configured, they will have a duty to assist individuals looking for health coverage and to streamline the enrollment process. It is important that Exchanges address language barriers that may prevent people of limited literacy or limited English proficiency from receiving essential health care. A 2002 study of children's Medicaid participation found that "English language proficiency has a significant effect on patterns of enrollment and perceived barriers to Medicaid enrollment."[44] Similar challenges exist with regard to literacy.[45]

Under PPACA, insurers participating in the state Exchanges must disclose certain pieces of information, such as the insurer's claims payment policies, rating practices, and cost-sharing for out-of-network care. Insurers must provide this information in accessible, readily understood "plain language," taking into account readers of limited English proficiency. Additionally, insurers are required to provide information about their appeals processes in a linguistically and culturally appropriate manner.[47]

The success of PPACA depends on whether those seeking health care understand insurance offerings and health care providers. This will require clear information, enrollment support, and interpreting and translation[48] at all levels of engagement.

Recommendations

Governors, insurance regulators, and legislators are forming committees and work groups to begin the development of Exchanges. While some states are considering letting the Department operate the Exchange, others are discussing state and multi-state Exchanges.

To ensure that the Exchanges foster the availability of health coverage for individuals and small businesses, the Department and states should:

- Not establish multiple Exchanges in each state, thereby separating individuals from small businesses or by geography. Such separation would undercut the Exchange's pooling advantage and exacerbate disparities (such as urban versus rural, wealthy versus low-income, and communities of color versus white communities);

- Establish "active purchaser" Exchanges whose goals would be to keep costs down, improve health care outcomes, and increase enrollment. "Passive purchaser" Exchange by contrast, would simply accept any qualifying health plan put forth by insurance companies;

- Not add unnecessary documentation requirements in a misguided attempt to exclude undocumented immigrants. Such documentation requirements would result in substantial costs to small businesses and governments. They also would create hurdles for many (immigrant and non-immigrant alike), including people born outside of hospitals, those who have lost documents in disasters like fires or hurricanes, and the homeless;

- Commit to providing information and communicating in a manner that is linguistically and culturally appropriate and accessible to people of limited literacy. This includes making sure that translation and interpretation is available for those who need it. Such a commitment would ensure that all individuals being served by the Exchanges understand various health insurance offerings and are able to enroll.

ESSENTIAL BENEFIT REQUIREMENTS

Having quality coverage and comprehensive benefits makes a big difference when it comes to health care access. By 2007, an estimated 25 million adults in the U.S. were underinsured, a 60 percent increase from 2003.[49] The underinsured are disproportionately low-income – in 2003 almost 75 percent had annual incomes below 200 percent of poverty.[50]

PPACA requires the Department to develop a package of essential health benefits,[51] the requirements of which will apply to health plans offered by insurers both inside and outside the Exchanges.[52] These essential benefits will include a broad set of items and services, such as hospitalization, maternity care, preventive services, and management for chronic diseases.[53] This benefit package must match the scope of benefits found in a typical employer health plan, based on surveys conducted by the Department of Labor.[54]

Furthermore, in developing the package the Department must consider the health needs of diverse populations (including women, people with disabilities, children, and others),[55] as well as report whether policyholders experience problems accessing needed services.[56] The Department will periodically review the package of essential benefits and report on gaps in access and services, the need to update or modify the package, and other issues.[57]

As of 2014, health insurers will be required to meet this minimum threshold for all their plans except grandfathered plans.[58] (Insurers may also offer more comprehensive policies.) Additionally, cost-sharing will be limited for these services.[59] Moreover, beginning in September 2010, health plans can not impose lifetime dollar limits on essential benefits, and annual dollar limits are restricted.[60]

Although the creation of essential health benefits offers many protections to consumers, some loopholes exist:

- Before annual limits on essential health benefits are completely eliminated in 2014, insurers may have an incentive to adopt new annual limits on these benefits to compensate for the elimination of lifetime limits on those same services.[61]

- Self-insured employer-based plans are regulated by the U.S. Department of Labor, rather than the Department of Health and Human Services. This may lead to uneven oversight of the annual and lifetime limit provisions in these plans.[62]

- Although annual and lifetime limits for essential health benefits will be subject to regulation starting September 23, 2010, the Department is not required to define those benefits by this date.[63]

- Even though PPACA regulates monetary lifetime and annual limits, insurers may still establish non-monetary limits, such as the number of allowed doctor visits or hospital days. Such limits would leave many consumers, particularly those with chronic diseases such as cancer, heart disease, and diabetes, disastrously under-insured.

To ensure that essential health benefits protect the health and financial wellbeing of policyholders, the Department and states should:

- Before annual limits on essential health benefits are eliminated altogether in 2014, ensure that annual limits meet the needs of low-income patients and those with chronic diseases;

- Ensure that the Department of Labor is adequately staffed to provide the necessary oversight to confirm that self-insured plans follow the annual and lifetime limit regulations related to essential health benefits;

- Vigilantly track trends in all markets related to non-monetary benefit limits imposed by insurance companies. This information should be publicly available;

- Ensure that health services that are vital to low-in come communities and populations experiencing health disparities are included as part of the essential health benefits package. Examples include treatment for diabetes, hypertension, STI's, HIV/AIDS, contraceptive services, and prenatal care; and,

- Include language services as part of any definition of essential health benefits. This would be consistent with the research linking interpretation to health outcomes and would go a long way toward protecting the health and civil rights of LEP patients.[64]

CONCLUSION

The Patient Protection and Affordable Care Act makes considerable changes to how health insurance in the U.S. is regulated and purchased. Although many decisions and regulations have yet to be made regarding the Exchanges and the oversight of health insurers, it is important that the central goals of health reform be advanced. Elected officials and policymakers, at both the federal and state levels, should develop effective rules, standards, and policies that promote access to quality health coverage and strong oversight of the insurance industry. Anything less will undermine the health and financial well-being of millions in the United States.

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