National Association of Benefits and Insurance Professionals
NABIP
Shaping the *future* of healthcare

INDIVIDUAL HEALTH INSURANCE CHALLENGES AND SOLUTIONS

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BACKGROUND

Health insurance can mean the difference between receiving needed healthcare and not having access to care at all. For many years, the individual health insurance market was considered dysfunctional in that it did not allow access to all who wished to obtain coverage there. If a person had a pre-existing condition, he or she was unlikely to be accepted for traditional private coverage in most states.

From a cost perspective, during those times individual-market coverage was one of the more economical health insurance options, assuming a person could pass medical underwriting requirements. There were no consistent rules on underwriting from state to state, or on the benefits that had to be included. Medical underwriting allowed insurance carriers to mitigate a risk that is especially common in the individual market where there is no employer contribution toward coverage. This risk is adverse selection. Asking health questions as a part of applying for coverage in the individual market meant that a person couldn't wait until he or she was sick to apply for coverage, avoiding adverse selection. Underwriting kept the pool of insured individuals fairly “clean” and this kept the rates that could be offered for coverage relatively low. Insurance carriers also didn’t usually include coverage for things like pregnancy that were difficult to predict through the underwriting process.

The result was that if a person was healthy, he or she could obtain individual health insurance that was fairly affordable, even though plans that included coverage of benefits such as maternity were often not available or were offered as limited benefit riders. If a person was in less-than-perfect health, his or her application for coverage was likely to be denied, issued at an increased rate or issued with an exclusion rider in most states. If he or she lived in a state where there was a high-risk pool, coverage might have been available at up to two times the normal cost of coverage. However, in some states there was no option for health coverage at all for a person with a preexisting condition who didn’t have access to employer-sponsored coverage.

The Affordable Care Act (ACA) brought significant changes to the individual health insurance market. The notion of people being denied health insurance coverage because of an existing health condition was rejected as being morally indefensible. However, to ensure affordability of coverage, it was accepted that there had to be rules about applying for coverage. To prevent people waiting until they were sick to apply for coverage, the law began with the idea that everyone needed to be covered continuously. Fines would be imposed for those who remained without health insurance coverage.

If a person was not permitted to wait to obtain coverage, the theory was that there should be a mix of healthy and less-healthy risks in the pool of insured individuals. This would allow coverage to be issued without asking health questions and without putting limits on preexisting conditions. If combined with limited enrollment periods, it should, in theory, prevent adverse selection, keep coverage affordable and allow access to coverage for everyone.

After addressing these primary concerns, the authors of the Affordable Care Act looked further into the issues faced when a person is seeking health insurance coverage. The first issue they chose to address was to ensure that health insurance carriers would be required to issue coverage without regard to health status and without limitations on preexisting conditions. After considerable debate, a list of essential health benefits was created that would be required in all policies in the individual and small-employer market. Limits were established for cost-sharing to ensure that individuals would have access to health insurance coverage at adequate levels of coverage.

The other primary requirement for coverage was affordability. This was addressed in two ways. The first was aimed at reducing the wide differences in the cost of coverage for people of different ages, genders and geographic areas. A modified community rating system was created that eliminated differentiation by gender, limited geographic differences within a state and allowed age differentials to differ by no more than three to one for the oldest person that might be offered coverage to the youngest. This was significantly different from prior rating models, which averaged a seven-to-one spread in rates. In some states, there had been no prior limits at all on the spread between rates for the youngest versus the oldest of enrollees. The result of the new rating system was that rates in general were higher for the youngest people to be insured and lower than they otherwise would have been for older enrollees.

Additionally, given that some people might not be able to meet the requirement to maintain coverage due to income limitations, the ACA expanded the availability of Medicaid. This expansion was made optional for states. The ACA also created a system of premium tax credits to help people pay for their coverage based on income. These credits were not available to those eligible for Medicaid or Medicare. It was also not available to those who were offered affordable employer-sponsored coverage that met minimum-value affordable requirements.

THE INDIVIDUAL MARKET TODAY

Did the market reforms imposed by the ACA work? From the perspective of barriers to coverage, the primary barrier today is not the inability to find coverage if you are sick but rather the ability to pay for coverage regardless of your health status. ACA reforms included a broader set of essential health benefits than were provided in the individual market before; therefore, the cost of paying for the increased level of covered care has increased. The ACA rating mechanism discouraged younger enrollees, who generally are healthier than older enrollees, by making coverage more expensive for them. As the penalties for not enrolling were small in the early years, expected enrollment has been less than anticipated. Those who enrolled tend to be those who were older or who had existing health conditions.

Health insurance costs are directly related to the cost of healthcare. In fact, the ACA requires that they be related. There is a requirement that 80% of every health insurance premium dollar be allocated for payment of medical expenses. As covered medical expenses have increased, so has the cost of health insurance. The importance of this issue cannot be overstated: Health insurance costs continue to rise as the underlying cost of healthcare skyrockets. Healthcare spending in the United States reached $2.9 trillion in 2013 and accounted for 17.4 percent of gross domestic product (GDP). This is an increase from $2 trillion and 15.9 percent of GDP in 2006 and spending continues to rise, with costs projected to exceed $5.1 trillion and 19.3 percent by 2023. [1]

[1] U.S. Centers for Medicare and Medicaid Services

Studies have shown that price is the number-one reason Americans fail to purchase insurance. Seventy-one percent of the non-elderly uninsured and 97.5 percent of the elderly uninsured who go without coverage for more than one year indicate cost as the driving factor for their lack of coverage.[2] It is correctly feared that, even faced with noncompliance penalties, people will still not – or cannot – purchase insurance policies. The tax credits provided under the ACA provide substantial aid to a significant population, but actual enrollment in qualifying policies remains a fraction of those eligible. Eligibility determination, premium tax credit delivery, policy cost calculation and payment and educating consumers in this complex subject are all impediments to a transparent and effective market.

The increased cost of coverage has been coupled with increased cost-sharing. In an effort to control health plan rate increases, there has been a development of significantly higher deductibles on health plans and more narrow networks – all in an effort to control the cost of healthcare. In many states, PPO policies in the individual market are now non-existent. Although coverage is technically more broadly available, increased prices for health insurance and increased cost-sharing have resulted in fewer insured individuals than expected.

PROPOSED SOLUTION

The solution is a double-edged sword. If everyone is to have health insurance coverage it is essential that everyone be in the pool of insured individuals, yet barriers have been created by attempting to cover every feasible expense a person might have. This has led to pricing those that are needed the most in the pool of covered individuals out of coverage.

Getting young people into the insured pool means more than fining them if they don't have coverage. Many are in income brackets that render them exempt from the individual responsibility requirement and therefore not subject to fines. Even with premium tax credits, the cost of coverage has risen to a point where many individuals find that the reduced premiums are still beyond their means. There needs to be a significant increase in the number of low risk individuals in the insured pool. The most immediate change needed is to enroll more individuals who have lower claims risk into the insured pool. From an actuarial stand point, increased claim costs directly correlate with increases in age. For that reason, the first item to address to offset the high cost claimants and balance the risk would be to change the rating mechanism to encourage younger individuals who statistical have fewer claims to enroll. Changing the age bands to a more favorable ratio of at least five to one would provide significant assistance in enticing younger, healthier individuals to enroll in coverage. While this would still be a significantly smaller age spread than was present prior to the ACA, it should not impact rates for the older and statistically higher claim individuals; therefore, it should not create cost barriers for the older applicants. The Essential Health Benefits package also needs to be revised. What is really needed for good health, and does all of it need to be a mandatory part of every health insurance policy? Child dental health and vision are very important for our children to be able to learn and thrive, but is it really necessary to cover these services in our mandatory benefit package? Those benefits could be offered as optional coverages, just as they have been for many years in the private market.

[2] Congressional Budget Office. "How Many People Lack Health Insurance and for How Long?" May 2003. www.cbo.gov/showdoc.cfm?index=4210

The list of preventive benefits should also be revisited. Preventive care is essential. It should be covered with lower cost-sharing to prevent more serious conditions. The question is not whether preventive care is important but whether the current list of covered items and services considered preventive are the ones that should be included. The current list of preventive services is exhaustive. A number of the services included have been controversial and were never previously considered in the preventive category.

While these would provide some immediate relief, in the long run the underlying cost of delivering healthcare must be addressed. There must be a fundamental change to the way healthcare is paid for. This can be done by encouraging value-based purchasing and requiring transparency of healthcare costs so people can know what the cost of the services they are purchasing will be in advance.

The use of more and more services must be discouraged. Many of these services are duplicative or unnecessary. Incentivizing greater quantities of services because of the way they are paid for must be stopped. While some incentives in this area were included relative to Medicare in the ACA, there needs to be a move significantly beyond small demonstration projects to make innovative payment mechanisms the norm instead of the exception.

There needs to be a connection for all of the electronic medical records that have been created by our medical providers to ensure that they are interoperable so that any doctor can communicate electronically with any other doctor, hospital or ancillary medical provider. All of this does not have to be accomplished via government mandate. State and federal governments must lead by creating incentives for health plans and healthcare providers that make these types of efforts to control the cost of healthcare.

Solving these cost problems will require cooperation across many sectors of our economy. NABIP believes we can achieve the greatest positive impact by empowering the competitive forces inherent within the private-market system.

In summary, we are proposing:

1. Change the age banding ratio to five to one
2. Evaluate Essential Health Benefits to determine which are most critical to good health based on medical evidence
3. Evaluate preventative care benefits to determine which truly prevent future illness and ensure good health
4. Encourage value-based purchasing and transparency in the cost of healthcare
5. Make electronic medical records interoperable