



# The Council for Affordable Health Insurance's ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

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## Access to Coverage: Building on Current Protections

The health care reform debate has focused on how the federal government can ensure access to health coverage, completely ignoring the role of the states. In fact, both federal and state law provide a number of protections to help people with medical conditions keep or obtain coverage. But we can do better, and we must address the cost of coverage. With the right reforms we can build on the current system to ensure that everyone has access to affordable coverage in a way that is financially sustainable.

**The Role of Existing Legislation.** Thirteen years ago Congress passed and the states implemented one of the biggest health reform bills in history — the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

HIPAA built on both the state regulatory system and the federal Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, which required employers with 20 or more employees and who provided health coverage to allow a departing employee to stay on the company's health insurance plan for up to 18 months, as long as the employee paid 102 percent of premiums.

One goal of HIPAA, COBRA and the state-based reforms was to minimize "job lock," i.e., the fear that changing jobs will force employees to lose their employer-provided health coverage. While COBRA allowed workers to continue their employer's coverage, HIPAA promised permanent-replacement coverage in the individual market if COBRA didn't apply or when the 18-month period ran out.

**States as Laboratories of Democracy.** As happens so often in this country, it is the states that have led on health care issues, while the federal government followed. In a major step forward, both Minnesota and Connecticut passed legislation creating the first high risk pools in 1976. This incredibly simple idea — to cover individuals who have been denied coverage by creating a state-based subsidized health insurance pool — spread and by 2008 more than 30 states had a functioning high risk pool in conjunction with other reforms.

As always, there was an opposing vision. In this case it was exemplified by the eight states — Kentucky, Maine, Massachusetts, New Hampshire, New Jersey, New York, Vermont and Washington — that passed "health care reforms" requiring guaranteed issue (accepting all applicants for coverage) and modified community rating (a price control severely limiting insurers' ability to adjust rates based on the risk of the applicant).

Despite warnings from many health policy experts, including the Council for Affordable Health Insurance, these eight states went ahead with their vision. After numerous insurance company exits and exploding health insurance rates, the policy was considered enough of a disaster that three states (Kentucky, New

Hampshire and Washington) eventually abandoned the approach.

States also passed reforms affecting employer-based health insurance, especially small group coverage. By the time federal HIPAA legislation passed, most states had implemented reforms that:

- Limited pre-existing condition clauses and required "whole group coverage" (insurers could not reject one employee for poor health); and
- Required certain plans be issued to any employer who applied for coverage (guaranteed issue).

States also created their own versions of "mini-COBRA," which extended health insurance continuation rights when employees involuntarily lost their health insurance coverage.

**HIPAA Reforms.** Instead of building on state reforms, the Clinton health care reform effort looked to usurp the states, which created many problems for the bill. With the eventual defeat of the Clinton plan (and the subsequent Republican takeover of Congress), Congress appeared to have little appetite for major health reform.

But just a few years later, Democratic Sen. Edward Kennedy and Republican Sen. Nancy Kassebaum proposed HIPAA as a way to address both health insurance access and "portability" problems. Instead of repeating the Clinton mistake, they decided to build on state initiatives.

HIPAA established several requirements in an effort to ensure greater access to health insurance coverage, including:

- Guaranteed access to health insurance for small employers;
- Guaranteed permanent coverage to individuals leaving their employer coverage;
- Elimination of pre-existing condition exclusions for individuals with prior group coverage;
- Limited pre-existing condition exclusion time frames in the small group market;
- Requirements that all plans in the individual and small group markets renew policies at the option of the policyholder (i.e., guaranteed renewable); and
- Limits on reasons for cancellation of coverage to nonpayment of premium, misrepresentation or fraud.

To accomplish these goals, HIPAA set a federal floor and allowed states to implement their own standards. For example, for those wanting it states were required to provide guaranteed access to those who:

- Lost coverage involuntarily (i.e., not for fraud or nonpayment of premium);
- Had 18 months of prior coverage and whose most recent coverage was group (even for only one month);
- Are not eligible for any other coverage; and
- Exhausted their continuation options under COBRA or state mini-COBRA.

However, states implemented these standards in one of four different ways by:

- Requiring insurers to provide guaranteed issue and modified community rating for all applicants in the individual market (e.g., New York, New Jersey, Maine, etc.); or
- Creating a high risk pool to cover only individuals covered by HIPAA; or
- Creating a high risk pool to cover all applicants (most states); or
- Requiring insurers to meet “federal fallback” requirements (i.e., offer eligible individuals their two most popular plans or the actuarial equivalent).

While every state meets the minimum standards, what may be surprising is how many states actually exceed them. By our count, all but five states — Alabama, Arizona, Georgia, Hawaii and Nevada — guarantee coverage for any applicant regardless of their health history. While some states do this through the previously discussed costly mechanism of guaranteed issue and community rating, most states have done so through high risk health insurance plans.

**Lessons for Reform.** HIPAA provided a great model for reform — maintain an effective state-based regulatory system and allow states flexibility to meet minimum standards. The net result was that all but five states exceeded the federal standard. But that doesn’t mean the system is perfect.

The new federal mandates in HIPAA came without corresponding federal dollars, and guaranteed access always comes at a financial cost. States have decided to shift these costs to the private market both directly and indirectly.

States with high risk pools directly allocate these costs to insurers through assessments to help pay for the losses of the high risk pool — and these costs are very transparent.

On the other hand, states with guaranteed issue and modified community rating hide the costs with an unfunded mandate on insurers to provide coverage on a guaranteed issue and modified community rating basis. Then politicians blame insurers for the high cost of health insurance.

Though high risk pool coverage can be very expensive, it is clear that between the two approaches high risk pools have been more successful. Kentucky, New Hampshire and Washington all partially or fully repealed their guaranteed issue and modified community rating reforms as a result of rising premiums.

**A Better Solution.** We think a better approach to health reform is to consider revamping high risk pools into what we call “tri-share guaranteed access plans.” These new plans can be built off existing high risk pools, but with new federal minimum standards. We believe those standards should include:

- More affordable premiums than are currently available in many high risk pools;
- More coverage options, including plans with higher lifetime maximums and Health Savings Accounts;
- Premium-subsidy programs for low-income individuals;
- Disease management programs, wellness programs and other initiatives to better control costs of those programs;
- Incentives for carriers to participate in these programs and offer products that provide incentives to better manage chronic conditions;
- Other best practices already in place in existing programs.

The plans will be paid for by a three-way partnership — government (state and federal dollars), insurers (through assessments) and subscribers (through premiums).

**A Real Safety Net.** Though it isn’t perfect, most Americans have access to health insurance through their employers and in the individual market, or through existing government programs for children, seniors and the poor. State laws, as well as COBRA and HIPAA, have provided individuals with important protections to help them obtain or keep health coverage.

By expanding access through the tri-share guaranteed access approach, Congress would not only guarantee affordable health insurance access for all Americans, but would do so in a more sustainable and cost-effective manner.

We believe insurer assessments, premiums and limited funding from state and federal government can provide people with the hand-up they need. Most importantly, this proposal can address the issues of access and affordability without creating another expensive entitlement program.

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