

In the Spotlight: ACA Insurance Reforms

Making health insurance more accessible for Americans is among the Affordable Care Act's (ACA) primary aims. One way ACA sets out to achieve that goal is through implementation of several provisions collectively known as the law's insurance reforms - new rules which will change the way health insurers are allowed to operate, and dramatically alter the dynamics of today's voluntary insurance market.

Generally speaking, an underpinning of almost any sort of insurance today (health, auto, homeowners etc.) is the practice of 'pooling' individuals into a group, whereby each part cross-subsidizes the whole. When a given policy holder has high-cost claims, those costs are spread across the larger group. To illustrate why this is important for health insurance specifically, in North Carolina:

- It takes 3 people with no claims to cover the cost of one person's bariatric surgery
- It takes 13 people with no claims to cover the cost of one person's coronary artery bypass surgery, and
- It takes 36 people with no claims to cover the cost of one person's kidney transplant.¹

Effective pooling of risks (both good and bad) is why insurers can shelter individual consumers from a financial catastrophe while making costs for the whole group predictable, manageable and stable. That's why it's critical for health insurers to maintain a risk pool with a relative mix of healthy and unhealthy individuals.

The ACA's insurance reforms will greatly affect how insurers determine that relative mix. The resulting impact will be felt primarily by those who purchase insurance on their own (the Individual Market) and by small employer groups (1-50 employees in NC today, but required by ACA to change to 1-100 by 2016). The most significant of ACA's insurance reforms – Guarantee Issue, Community Rating and the Individual Mandate – are discussed at a high level below.

Guarantee Issue

Starting in 2014, the ACA requires insurance companies to provide coverage to every individual market applicant, regardless of health status. Also known as 'guarantee issue', this policy is a primary means by which the ACA will assure that all Americans have access to health insurance, including those with pre-existing medical conditions. Guarantee issue for children under the age of 19 went into effect in September of 2010, and will take effect for all adults on January 1, 2014.

Community Rating

Starting in 2014, insurers will be prohibited from considering the health of an individual (or the average health of a small group) in determining what premium to charge. Today, 'medical underwriting' is used in the individual market. Medical underwriting is the practice of assessing health status and assigning a rate based on a prediction of future claims. Medical underwriting is also utilized in the small group market within the requirements of Small Group Reform. Other Rating requirements include:

- Limiting the premium impact of a person's age to no more than a 3 to 1 ratio for adults
- Limiting the premium impact of a person's tobacco use to no more than a 1.5 to 1 ratio
- Prohibiting premiums from varying based on gender (permitted in North Carolina today, based on expected differences in medical utilization)

While Community Rating will change the specific rates charged for a particular individual, it doesn't impact the overall cost of health care. As a result of limitations on how much individuals can be charged, *some* people (generally those who are older and in poorer health) will see *lower* premiums - but those decreased costs will directly result in *higher* premiums for healthier, younger people whose individual risk is lower. It's not unlike what happens to the air inside a balloon when it is squeezed: one part shrinks as the other expands.

The Individual Mandate

The ACA's most controversial provision is its 'individual responsibility requirement' (better known as the individual mandate), which is a requirement that nearly all Americans carry a health insurance policy meeting defined minimum benefit levels, or pay a federal fine. From a policy perspective, the primary purpose for the individual mandate is to enable Guarantee Issue and Community Rating to work by creating a risk pool with a relative mix of healthy and unhealthy individuals. While many experts believe the existing individual mandate is weaker than it should be, it's still the glue that holds the ACA together. Should the individual mandate be stripped away – either through Congressional repeal or Supreme Court ruling – and absent significant other changes to the law, premiums are likely to rise even more dramatically.

If the mandate is removed while insurers continue to be required to accept everyone regardless of their health status (Guarantee Issue) and forbidden from using health history as a gauge for determining premiums (Community Rating), there would be little incentive for people to carry coverage at all times. Instead, people could:

- **avoid buying health insurance** (since they're guaranteed the ability to purchase coverage later)
- **purchase coverage when they're sick or injured** (since they'll be charged the same rate regardless)
- once they're covered, **immediately utilize health care services** to treat the sickness or injury (where their costs would be spread to everyone else who's already in the system), and then
- **quit their insurance plan** once they're healthy again.

This is an example of 'adverse selection' – the tendency for people to buy insurance when they know they will need it and avoid buying when they won't – and it drives up premiums for everyone in the insurance pool. It's no different than allowing a person to buy homeowners insurance after their house has caught on fire. More detail about the individual mandate – and state-level precedent for this type of 'gaming the system' – [can be found here](#).

BCBSNC Views

Blue Cross and Blue Shield of North Carolina has long supported a meaningful individual mandate as a solid means to achieve the improved access to insurance coverage of Guarantee Issue and Community Rating provisions, which change the dynamics of today's voluntary health insurance market. The impact of rating reforms will be greatly dependent on individuals being required to purchase coverage under a strongly enforced mandate. For insurance reforms like Guarantee Issue and Community Rating to work properly, everyone must be in the insurance pool. This allows risk (and costs) to be spread across the young and the old, the healthy and the sick. The ACA's weak mandate is likely to prevent the insurance reforms from working properly and is likely to result in significantly higher average claims cost per person in the insurance pool that remains.

For More Information

Kaiser Family Foundation: How Health Insurance Works:

<http://www.kff.org/insurance/upload/How-Private-Insurance-Works-A-Primer-Report.pdf>

Center for American Progress: "Health Care Reform is a Three-Legged Stool":

http://www.americanprogress.org/issues/2010/08/pdf/repealing_reform.pdf

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ⁱ BCBSNC Internal Data, 2011.