

## The Facts: Insurance Reform August 2009

HCSC has long supported comprehensive health reform to extend coverage to everyone, rein in costs and improve quality. HCSC supports the broad framework of the reform proposals being advocated by the President.

Last year – long before “insurance reform” became a popular phrase – HCSC, along with Blue Cross Blue Shield Association (BCBSA) and America’s Health Insurance Plans (AHIP) announced support of major *insurance market* reforms that ensure everyone has access to insurance, regardless of preexisting conditions and to discontinue the practice of varying premiums based on health and gender. To ensure these reforms result in affordable coverage for all, these changes must be accompanied by an individual responsibility requirement to obtain coverage and subsidies to help those with low and moderate incomes.

The insurance industry has set the bar in calling for changes in their own industry. Below are some basic facts about health insurance that must be considered when discussing insurance reform.

**Claim:** *Insurers are opposed to health care reform.*

**Fact:** HCSC strongly supports enactment of health care reform this year. We also support new federal rules to require insurers to offer coverage to everyone – regardless of pre-existing medical conditions – coupled with an individual responsibility requirement and federal subsidies to make health coverage affordable.

**Claim:** *Insurers can drop you whenever you get sick.*

**Fact:** Federal law (HIPAA, 1996) already prohibits insurers from dropping members when they get sick. Insurers are required by federal and state laws to issue coverage on a “guaranteed renewable” basis – meaning the decision to renew is made by the individual and not the insurer. These rules apply to all coverage sold to individuals, small employers and large employers.

**Claim:** *Insurers retroactively rescind individuals’ policies if they become sick.*

**Fact:** Under Federal and state laws, policies in the individual market can only be cancelled in cases of fraud or material misrepresentation (e.g., not being truthful on applications) and nonpayment of premiums. Rescissions are very rare. The National Association of Insurance Commissioners reports only 56 complaints nationwide regarding rescissions in 2007.

**Claim:** *Insurers raise premiums when someone becomes sick.*

**Fact:** Federal and state laws prevent employers or health insurers from charging an employee in a group health plan a higher premium based on their health or claims status. Premiums paid in the individual market are subject to significant state regulation. Individuals generally cannot be singled out for rate increases based on their health status once they obtain insurance. HCSC does not cancel policies or raise premiums for individual members because they get sick and file claims.

**Claim:** *People can't take their coverage when they leave a job.*

**Fact:** Federal law requires most employers (over 20) to allow people to “take” their coverage with them (for up to 18-36 months) when they leave by paying 102% of the premium (COBRA). Many states apply these same rules to smaller employers. In addition, Federal law (HIPAA) requires all states to assure that people who run out of COBRA coverage have permanent guaranteed coverage rights.

**Claim:** *Insurers routinely discriminate against individuals with pre-existing conditions.*

**Fact:** Insurers can exclude pre-existing conditions subject to federal and state law. This is necessary to ensure that people do not wait to buy coverage until they are sick, which raises premiums for everyone.

**Claim:** *Insurers need a government plan to keep them “honest.”*

**Fact:** Health insurance is one of the most heavily regulated industries today. This regulation occurs at the state level. Creating a new government-run program – which would have huge market advantages by underpaying providers and thorough exemptions to health plan requirements, such as new federal and state taxes – would be very costly and unnecessary to achieve reform objectives.

**Claim:** *There is inadequate competition in the insurance market and insurer profits are high.*

**Fact:** There is significant competition in local health insurance markets. There is a median of 27 carriers serving the small group market in each state, with a range varying from 4 insurers in Hawaii to over 300 in Indiana (GAO, 2009). Moreover, health plan profits are much lower than most other industries – averaging 2-3% per year. Health plan profits have declined in 2009.

**Claim:** *A high percentage of premium dollars go towards private plans' administrative costs.*

**Fact:** Private health plans' administrative expenses are much lower than commonly perceived. Based on 2007 data from Sherlock Co., administrative expenses represented 9% of premiums and costs for small employers and individual insurance were 11% and 16% of premiums respectively, amounts that are two to three times lower than commonly cited.

Additionally, according to a PriceWaterhouse Coopers report, the health care premium increases between 2004 and 2005 were driven by increased utilization (43%), general inflation (27%) and health care price increases in excess of inflation (30%). The last category was driven by increased costs of labor, higher-priced technologies, provider consolidation and movement among purchaser toward broader-access health plans. Administrative costs are not cited as a cost driver.