

The Washington Post

Largest health insurer to keep key parts of law regardless of court ruling

By N.C. Aizenman, Published: June 10

The nation's largest health insurer will keep in place several key consumer provisions mandated by the [2010 health-care law](#) regardless of whether the statute survives Supreme Court review.

Officials at UnitedHealthcare will announce Monday that whatever the outcome of the court decision — expected this month — the company will continue to provide customers preventive health-care services without co-payments or other out-of-pocket charges, allow parents to keep adult children up to age 26 on their plans, and maintain the more streamlined appeals process required by the law.

UnitedHealthcare would also continue to observe the law's prohibitions on putting lifetime limits on insurance payouts and rescinding coverage after a member becomes ill, except in cases where a member intentionally lied on an insurance application.

The provisions are part of a larger package in the law often referred to by supporters as “the Patients Bill of Rights” that took effect as plans renewed after Sept. 23, 2010. They are popular with consumers and relatively uncontroversial among insurers. And there had already been signals from industry insiders that some insurers were likely to leave them in place. UnitedHealthcare, a [UnitedHealth Group](#) company, is the first to publicly commit to the idea.

“The protections we are voluntarily extending are good for people's health, promote broader access to quality care and contribute to helping control rising health care costs,” Stephen J. Hemsley, president and chief executive of UnitedHealth Group, said in a statement. “These provisions are compatible with our mission and continue our operating practices.”

The court's options include upholding the law, overturning part or all of it, and delaying action until after the law takes full effect.

A spokesman at UnitedHealthcare said officials chose to announce their intentions now because “people in this uncertain time are worried about what might happen to their coverage and we think the time is right to let people know that these provisions will continue and they can count on us.”

The announcement applies to the roughly 9 million consumers in plans that they or their employer have purchased from UnitedHealthcare. An additional 27 million people are covered by plans that are administered by UnitedHealthcare but for which their employer has assumed

the financial risk, meaning that in effect their employer is their insurer. In these cases it would be up to the employer to decide which provisions to continue offering voluntarily.

While UnitedHealthcare would include birth control and sterilization among the preventive services it would continue to offer without co-payments, officials said they would honor requests from employers or individual customers wishing to remove such services from the list because of religious or other objections. By contrast, in implementing the health-care law's preventive-services requirements, the Obama administration has issued controversial restrictions on the types of employers that can refuse to offer birth control coverage on conscience grounds.

Officials at UnitedHealthcare said they did not have statistics on what, if any, impact the decision could have on premiums.

The Obama administration has estimated that on average the law's early consumer mandates would increase premiums by less than 2 percent. However, that figure has probably varied depending on whether a particular plan already included the new requirements — often the case with plans bought by large employers — or whether insurers had to incorporate the new rules — often the case with plans sold to individuals and small businesses.

Further complicating the picture, other forces, such as a drop in use of health care, have exerted a countervailing downward pressure on premiums in recent years.

The "Patients Bill of Rights" also includes several mandates that UnitedHealthcare did not pledge to continue complying with in the event the Supreme Court invalidates the law. These include the elimination of annual limits on insurance payouts, which are being phased out under the law, and that statute's ban on denying coverage to children with preexisting conditions.

The latter would be impossible to do unilaterally, said UnitedHealthcare officials, because the company's risk pool could be quickly skewed toward sick children. But in a statement they said the company is "committed to working with all other participants in the health care system to sustain that coverage."

Ronald Pollack, executive director of the consumer advocacy group Families USA and a supporter of the law, welcomed UnitedHealthcare's announcement.

"It would make a huge difference for a great number of people who would otherwise be left out in the cold in terms of getting coverage," he said. "And hopefully, given UnitedHealthcare's market share, this would have tremendous influence on other companies."

But even if the entire insurance industry followed suit, Pollack said, it would hardly make up for the loss of other provisions in the law that are set to take effect in 2014 — including the extension of Medicaid to cover a larger share of the poor, subsidies to help low-income Americans buy insurance and bans against insurers discriminating against adults with preexisting conditions.

This would be a “one-third of a loaf” substitute, Pollack said. “A very good step, but in no way altering the necessity of implementing the much larger protections included in the new law.”

State Refor(u)m.org

Can Active States Endure A Ground Shift? Implications Of The Supreme Court's Health Reform Decision

June 4, 2012 by [Sonya Schwartz](#)

"Can Active States Endure A Ground Shift? Implications Of The Supreme Court's Health Reform Decision" was originally published on the [Health Affairs Blog](#).

We do not know what the Supreme Court will decide about the Affordable Care Act, but we *do* know that changes to the ACA's coverage provisions would have a major impact on states already active in implementing the law. Would active states be able to overcome the loss of key provisions? That depends on the [Richter Scale](#) magnitude of the ground shift set off by the Court's decision.

For the purposes of this analysis, we have identified 14 states as actively implementing the health reform law: Alabama, Connecticut, California, District of Columbia, Hawaii, Kentucky, Maryland, Massachusetts, Nevada, New Mexico, New York, Oregon, Rhode Island, and Vermont. They are considered active because they have completed at least five of seven progress criteria based on exchange development, insurance reforms, the Medicaid expansion, and public sharing of implementation information. For more details about which states are active and why, see our [activity chart](#) on State Refor(u)m.

The Entire ACA Is Upheld: 2.0 On The Richter Scale

If the entire law is upheld, it would be like a micro quake, unlikely to be felt, but recorded in our history books. States that are already active in implementation would likely have renewed momentum and move even more confidently to implement reforms by 2014. They would continue to work to create health insurance exchanges, build eligibility systems, and make changes to private market rules prescribed by the ACA.

Individual Mandate Declared Unconstitutional, The Rest Of The ACA Upheld: 4.0 On The Richter Scale

Under a scenario where the individual mandate is stripped away, there would be some rattling and shaking, but significant damage would be unlikely if the active states were able to adapt and craft new policies to protect against adverse selection in the individual health insurance market. The [Congressional Budget Office](#) has suggested that without the individual mandate, individual market premiums would rise 15 to 20 percent, young and healthy individuals would be more likely to remain uninsured, and less healthy individuals would likely remain insured. Take-up rates in employer coverage and Medicaid are also projected to fall substantially without the individual mandate. Subsidies in the exchange and annual enrollment might mitigate this problem somewhat, but active states wanting to cover the largest share of the uninsured would likely look for other ways to prevent adverse selection.

Among the states we have identified as active, only Massachusetts has an individual mandate in place. A handful of the active states, like [California](#), might consider following these footsteps and passing an individual mandate, but this would not be easy to accomplish. Other options like setting up [auto-enrollment](#) mechanisms, late enrollment penalties, or using aggressive marketing strategies to inform individuals about the new federal subsidies and insurance options would also likely be on the table. At least [one estimate](#) predicts that these options would be unlikely to cover as many people as an individual mandate.

Individual Mandate And Market Reforms Stricken: 5.0 On The Richter Scale

If the remedy chosen by the Supreme Court includes striking the ACA's market reforms such as guaranteed issue and a prohibition on underwriting by health status, it is likely to damage insurance markets and have serious implications for the functionality of health insurance exchanges. Even among active states, [very few](#)—only Massachusetts, New York, and Rhode Island—currently have some type of guaranteed issue in place today in the individual market.

Without guaranteed issue and clear guidelines on premium prices based on rating rules, state exchanges would face real barriers to providing consumers an actual offer of coverage at a set price. Active states would be free to enact guaranteed issue and rating restrictions at the state level. But, in a world without an individual mandate, insurance plans would be likely to **vehemently oppose** guaranteed issue and a lack of underwriting by health status. Some of the **early insurance reforms** — such as prohibiting lifetime limits on health benefits, prohibiting preexisting-condition exclusions for children, and more — that **almost half** of the active states have put in place would likely stay on the books, particularly if they are now part of state law or in regulation. Even though states might not have enacted these early consumer protections without the impetus of the federal law, the protections might be popular enough for states to hang onto in the absence of federal requirements.

Medicaid Expansion, Individual Mandate And Market Reforms Invalidated: 7.0 On The Richter Scale

If the Medicaid expansion is declared unconstitutional in addition to the other elements, or if it is invalidated as part of the Court's remedy, it could cause serious damage to active states' efforts. Although some active states had programs in place to cover low-income uninsured adults before passage of the ACA, and might have political support to continue these programs, state budgets have only gotten tighter. These active states are unlikely to be able to continue offering coverage to these populations without federal funds.

States could decide to cover low-income parents even if the Medicaid expansion is unconstitutional, but they would cover them with existing federal financing levels (a match rate of 50 percent to 74 percent in FY 2012) and not with the enhanced match of 100 percent federal funds provided under the ACA. Also, because of the Medicaid program's pre-ACA structure, states would not be able to cover childless adults without a federal waiver.

Some of the active states, including **Vermont**, **Massachusetts** and **California**, already have Medicaid Section 1115 waivers in place that provide federal funds to cover all adult populations until 2014. These states might try to renegotiate these waivers and extend them beyond 2014. Other active states might try to supplement their limited state resources through this type of waiver as well. These waivers are required by law to be budget neutral during a five-year period, but states have in the past been able to find savings to offset the expansion to childless adults. Without filling in these gaps for the lowest income individuals, active states are likely to miss covering from **26 to 50 percent** of the uninsured who have incomes below 100 percent of FPL (the Federal Poverty Level).

In active states that do not currently provide coverage for the lowest-income populations without federal funds, and cannot come up with state matching funds to expand coverage to parents, or waivers to cover noncustodial adults, a major gap would exist. Individuals and families between 100 and 400 percent of the FPL would receive subsidies to purchase health insurance through the exchange with the premium tax credit, but the lowest-income adults (those with incomes below 100 percent of the FPL) would no longer be eligible for Medicaid and likely remain uninsured.

Title I Of The ACA Invalidated Or Entire Law Invalidated: 8.0 On The Richter Scale

Whether the court invalidates Title I of the ACA or the entire ACA, the implications for active states would be enormous, even massive, but not totally devastating.

If the Court invalidates the individual mandate, it might also choose to strike down the rest of Title I of the ACA, where the mandate, market reforms and subsidies are laid out and exchanges are funded. In this scenario, states that have made strides to establish and plan for an exchange might still have establishment legislation or executive orders on the books, but they would no longer have federal resources available to move forward. Many of these states would continue to progress, impeded by a lack of federal resources for planning but with some additional flexibility to do things "their own way" without a federal framework.

Federal subsidies to support individuals and small business in the exchange would also disappear. Lacking state funds to provide these subsidies, states' ability to entice the uninsured to enroll would be dramatically limited. As a result, take-up rates in the health insurance exchange would likely be much lower and the risk of adverse selection would increase. However, the Medicaid expansion provisions are included in Title II of the ACA, so active states would have generous federal resources to provide coverage to the lowest income adults.

If the entire ACA, beyond Title I, is invalidated, myriad other federal grant programs that active states are taking advantage of also disappear, leaving no new resources for states to move forward on delivery system and population health reforms. Active states would continue to look for other ways to meet some of their health reform goals with the limited resources they have through regulation of the markets, Medicaid waivers, and other available levers, but would have significantly fewer tools in the way of federal funding in their toolboxes.

If the Supreme Court invalidates components of the Affordable Care Act, active states will try to adapt to the shifting ground by designing new policies to mitigate adverse selection and cover the uninsured. However, their success in doing so will depend in part on how much the ground shifts. States can likely sustain a 2.0 or 4.0 on the Richter scale, but an impact much greater than that will be a seismic shift, causing the need for a major rebuilding of insurance markets or reconstruction of Medicaid program financing.

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More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges as of 2014

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Authors: Jon R. Gabel, M.A., Ryan Lore, M.P.P., Roland D. McDevitt, Ph.D., Jeremy D. Pickreign, M.S., Heidi Whitmore, M.P.P., Michael Slover, M.S., and Ethan Levy-Forsythe

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Contact: Jon R. Gabel, M.A., Senior Fellow, Health Care Research Department at NORC at the University of Chicago, Gabel-Jon@norc.org

Synopsis

More than half of Americans who have health coverage through the individual insurance market are in plans that would not meet the standards for "essential benefits" set by the Affordable Care Act. Most people enrolled in employer group plans, however, have more comprehensive coverage with less cost-sharing.

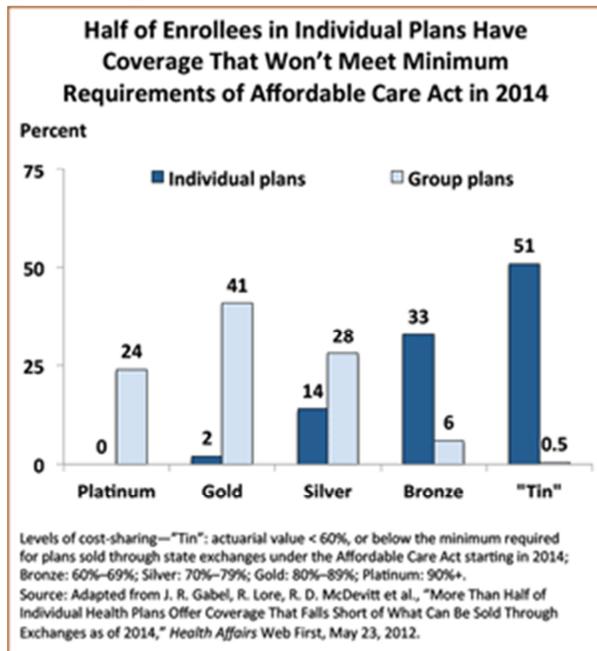
The Issue

Although Under the Affordable Care Act, beginning in 2014 individuals and small employers will be able to enroll in health coverage through state-based insurance exchanges, which will act as marketplaces where people can comparison-shop for health plans. All plans sold in the exchanges must offer a set of essential health benefits, which includes ambulatory and emergency care, maternity care, and other comprehensive health care services. In addition, the law sets up four tiers of cost-sharing based on actuarial value—a measure of the financial protection afforded by a plan, expressed as the estimated percentage of medical bills that it will pay. For instance, if a plan has an actuarial value of 75 percent, the insurer pays three-fourths of the bills and the insured person pay one-fourth out-of-pocket in deductibles, copayments, or other cost-sharing, on average, for a standardized population.

Under the Affordable Care Act, the exchanges will sell plans with the following actuarial values: platinum (90% or greater), gold (80%–89%), silver (70%–79%), and bronze (60%–69%). This Commonwealth Fund–supported paper, published in *Health Affairs*, uses data supplied by health plans to determine the financial protection they provided in

2010 in the individual and small- and large-group markets, and then compares that protection against the new 2014 standards.

Key Findings



- The average actuarial value of group plans in 2010 was 83 percent, compared with an average of 60 percent for individual plans.
 - Most people (65%) enrolled in group plans were in either the gold or platinum tier; about 28 percent were in the silver tier and 6 percent were in the bronze tier. Fewer than 1 percent were in plans with an actuarial value of less than 60 percent—dubbed “tin” plans by the authors.
 - In the individual market, 51 percent of enrollment was in tin plans. Another third of enrollees were in bronze plans, 14 percent were in silver plans, and 2 percent were in gold plans. In the individual market, there were no platinum plans.
 - Average out-of-pocket spending per household in the group plans was \$1,765. In the individual plans, average household out-of-pocket spending was \$4,127. The highest spenders in tin-tier individual insurance plans—including very sick people who incur huge medical bills—had more than \$27,000 in annual out-of-pocket spending..
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Address the Problem

The majority of Americans with individual insurance coverage today are enrolled in plans with actuarial values too low to qualify for the new insurance exchanges, say the authors. Under the Affordable Care Act, all insurance policies sold through the

exchanges and the individual and small-group markets in 2014 will have to offer consumers plans with minimum financial protections and benefits. "Together with a ban on medical underwriting, the individual market of the future will sharply contrast with the market of past decades," they conclude.

About the Study

The authors used data from the Kaiser Family Foundation/Health Research and Educational Trust 2010 Employer Health Benefit Survey, data from plans in the individual market in 2010 in five states (California, Florida, Michigan, Pennsylvania, and Utah), and the Thomson–Reuters MarketScan 2008 medical claims database to analyze individual and employer-based group plans on the market in 2010.

Bottom Line

More than half of Americans who had individual-market health insurance coverage in 2010 were enrolled in plans that would not meet the Affordable Care Act's minimum benefit standards for the new insurance exchanges.