Issue BRIEF

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Protecting Consumers from Unfair Rate Hikes: The Need for Regulation of Health Insurance Renewal Premium Increases

In April 1999, Bruce and Wanda Chambers—the owners of their own financial planning business—bought health insurance coverage for themselves and their daughter at a monthly premium of $388. In March of 2000, Mrs. Chambers was diagnosed with Type II diabetes. In less than a one-and-a-half-year period, the family received three notices of premium increases; the final monthly premium was $655 a month. The Chamberses could no longer afford to continue this coverage. They decided to search for a new insurance company that would offer affordable coverage. The Chamberses did not anticipate, however, the 18-month battle ahead. After a string of bad experiences with unauthorized plans, high out-of-pocket payments, and coverage denials from companies who refused to offer their family coverage because of Wanda's illness, the Chamberses finally obtained a policy with a reputable company. But this happy ending occurred only after Mrs. Chambers obtained a second job with a real estate company that offered her coverage with a group plan. If their original insurance company had not exorbitantly raised premium rates, the family could have avoided their saga altogether.

The Chamberses' story and others like it demonstrate the need for regulation of health insurance premium increases. State and federal laws prevent insurers from canceling health insurance coverage when people become sick and/or make medical claims—a practice that, if allowed, would defeat the very purpose of having health insurance as protection against unexpected illness. However, some insurers try to circumvent these laws by raising premiums so high that people drop their coverage. This problem can exist in both the individual and small group markets.

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Health Insurance Consumers Pay Now for Protection Later (Why We Buy Health Insurance)

People purchase health insurance to protect themselves from the financial consequences of possible future illness. Health insurance pools people who have lesser need for health care services with those who have greater need. An insurer then looks at the total pool and sets premiums for everyone in it based on the collective risk of claims. People who are currently healthy subsidize the medical care of people who are not currently healthy; if they become sick, they then will benefit from this cross-subsidization of costs.

There is only one reason why healthy consumers pay for insurance: they *expect* to have financial help if they are unlucky and get sick some time in the future. If health insurance could be canceled or premiums dramatically increased whenever people used their coverage, why would any of us buy health insurance?

Insurers Target Healthy People to Make Money

In order to increase their profits, health insurers try to maximize the number of people who will pay premiums but submit few claims and to minimize the number who will make substantial claims. That is, they want to "cherry pick" the healthiest people and avoid covering people who are sick. While insurers strive to bet on customers that will stay healthy, consumers purchase health insurance anticipating that they will need coverage at some time in the future.

Insurers play this betting game with very few rules. First, insurers may not have to bet at all—that is, they often do not have to offer insurance coverage to people they believe have a higher probability of needing health care in the future. Federal law only provides the right to buy insurance in the small group market,[1] and only a handful of states—Maine, Massachusetts, New Jersey, New York, and Vermont—have comprehensive "guaranteed issue" laws that protect their residents' rights to buy in the individual market. Even in the small group market and in states with guaranteed issue in the individual market, insurers use a number of strategies to avoid offering coverage to sick people, such as targeting their marketing in ways that only reach healthy people (for example health club members) or by designing benefit packages that appeal to healthy people and do not meet the needs of sick people. For example, a benefit package that has no copayments for preventive check-ups and screening tests but has high copayments for specialist follow-up visits, inpatient and outpatient hospital services, and prescription drugs will be purchased by young, healthy people and not by people with health problems.

Secondly, insurers control the size of the bet. Federal law does not regulate premium rates in the small group or individual market. While some states regulate the price of coverage (premium rates) to some degree in the small group market, only a handful of states regulate the price of coverage in the individual market. Thus, insurers can hedge their bets by charging very high premiums that will cover the cost of any future medical care; in some cases, the premiums are so high that the coverage is unaffordable.

Guaranteed Renewability Versus Re-Underwriting at Renewal

■ Guaranteed Renewability Laws: Intended to Stop Health Insurers from Dropping Sick People

When insurers decide to make the bet—that is, to provide a person or a small group with insurance coverage at a given price—they cannot renege on the deal by refusing to renew the sick person's coverage.

The federal Health Insurance Portability and Accountability Act (HIPAA) requires that all state-licensed health insurers in the individual and small group markets guarantee that coverage can be renewed at the end of the period of coverage.[2] In the individual market, HIPAA does not address the price that insurers can charge at renewal. Insurers can selectively impose high premium increases at renewal to people who have a change in health status and/or who have made medical claims.

In the small group market, HIPAA only prohibits insurers from charging one person in a small firm higher premiums than others in the same firm because of health status. HIPAA does not prevent insurers from raising premiums overall for the small firm or charging it higher rates than other small firms.

Thus, under current federal law, it is up to the states to regulate premium rate increases in both the individual and small group markets.

■ Re-Underwriting at Renewal: A Way to Drop People Who Become Sick

Guaranteed renewability does consumers little good if it is not coupled with protections on the cost of renewing health coverage. Some premium increases are reasonable. For example, premium increases may be appropriate to offset health services inflation or rising prescription drug costs. However, premium increases based on a change in health status or claims made in the past year—called medical re-underwriting—is an inappropriate way to circumvent the

federal HIPAA guarantee of renewability. Doubling or tripling premiums for individuals who have become ill (or for the small group to which the individual belongs) forces the insured person or group to drop the policy. The result is the same as when the insurance company refuses to renew or cancels coverage.

Insurance companies that support medical re-underwriting assert that they want to keep the costs down for healthy people in the insurance pool and only pass on higher costs to sick people. This justification is contrary to the very concept and core principle of what insurance is and how it works—pooling people and protecting people against *future* illness. Insurance companies also argue that health insurance should be allowed to increase rates "based on an individual's experience, just like auto or homeowners' insurance. If the risk changes, then the premium changes."

However, health insurance is different from these other forms of insurance for several reasons. First, while people have some control over how they choose to drive or how they protect their home, people cannot control the onset of the majority of illnesses. Our society's values and our laws generally do not support policies that penalize people on the basis of genetic make-up or other factors over which an individual has no control. Insurance companies already have the ability to raise premiums to deter some behaviors that are linked to health problems (e.g., smoking). Second, compared to auto or home insurance, health insurance addresses a more fundamental need and thus the state has a much higher stake in protecting people who purchase health insurance. Policy makers must consider whether or not they truly *want* health insurance to work like auto insurance. Third, when people are forced to go without health insurance coverage, the state is often left holding the bag: State costs for Medicaid and for public hospitals and clinics that provide care to the uninsured are likely to increase.

It is hard to pin down how many insurers use changes in medical status, claims history, or other factors in re-underwriting at renewal. The factors used by insurers in the underwriting process are reported to be closely guarded trade secrets. Some experts contend that the practice of medical re-underwriting is limited to only a few small, for-profit insurers and that recent media reports have brought undue attention to the issue. Other recent events suggest this might not be the case. At the annual meeting of the National Conference of State Legislators in July 2002, a workshop on re-underwriting at renewal briefed state legislators on the "resurrection of re-underwriting." The Health Insurance Association of America

has said it opposes high annual rate increases but *not* modest rate increases based on medical condition or claims history. The Wisconsin Physician Services Insurance Corporation, *a not-for-profit* insurer with more than 220,000 customers in the state, has publicly stated that it has begun to charge some policyholders more at renewal based on their claims in the prior 12 months. These examples suggest that medical re-underwriting at renewal is a growing trend.

States Need Clear Laws to Protect Consumers From Unfair Re-Underwriting At Renewal

States take different approaches to laws that limit premium rates. And each state may regulate the individual market differently from the small group/employer market (which, in 13 states, could include a group of one—a self-employed person). The individual market is generally less regulated than the small group/employer market. Most states do not prohibit insurers in the individual market from increasing premiums at renewal based on health status (which includes medical status, claims history, and other information used to predict possible future health care needs) or duration of coverage. A few states use community rating, which requires insurers to charge every policyholder in a plan the same premiums. Some additional states use modified community rating, which allows premiums to vary based on age but not other risk factors. Or they use rating bands that allow premiums to vary but only within a certain limited range. Currently, a number of states are trying to add power to limit increases in renewal premiums to their state insurance departments' existing authority to prohibit unfair trade practices. However, this approach may not withstand court challenges.

Current Efforts To Regulate Re-Underwriting At Renewal

■ **Federal Level Efforts**

At the federal level, Senators Bob Graham (D-Florida) and Peter Fitzgerald (R-Illinois) introduced a bill (S.3119), and Representative Earl Pomeroy (D-North Dakota) introduced a companion bill (H.R.5682), to limit the practice of medical reunderwriting at renewal. The same bills are expected to be reintroduced in the current 108th Congress. If passed, these bills would ban health insurance plans from raising members' premiums after they become ill or file claims. Building on the existing guaranteed renewability protections in the Health Insurance Portability and Accountability Act (HIPAA), the bill would add limits on insurers' ability to selectively target premium increases at renewal to individuals based on any "health-status-related factors."

■ State Level Efforts

The National Association of Insurance Commissioners (NAIC) recently repudiated the practice of medical re-underwriting at renewal at its national meeting in June 2002. Steven Larsen, Maryland Insurance Commissioner and head of the NAIC committee on health insurance and managed care, called re-underwriting "fundamentally unfair." The NAIC sent out a memo dated July 17, 2002 urging state insurance officials nationwide to "review your state laws in light of the suggestion that the practice may become more prevalent."

The basis for this repudiation was two longstanding model laws developed by NAIC addressing appropriate health insurance business practices in the individual and small group insurance markets. These model laws can guide state legislators who want to address the problem of re-underwriting at renewal. Both the NAIC Small Employer and Individual Health Insurance Availability Model Act (Model #35) and the Individual Health Insurance Portability Model Act (Model #37) prohibit insurers from increasing premiums based solely on health status or duration of the policy. These Model Acts also only allow limited, reasonable premium increases for age.

Under the various diverse state rating laws, regulations, and regulatory authority, not all state insurance departments have clear power to regulate re-underwriting. State legislators who want to protect consumers from unfair premium hikes may want to question their state insurance regulators about the situation in both the small group and individual markets in each state. In most states, legislators may want to consider legislation specifically addressing premium increases at renewal that will clarify authority as well as encourage regulators to exercise active oversight of premium increases.

This issue brief was written by Denise Harris and Kathleen Stoll.

For more information about this or other consumer perspectives on health care issues, contact Kathleen Stoll at Families USA (202-628-3030 or kstoll@familiesusa.org).

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[1] HIPAA defines the small group market as businesses with from 2 to 50 employees. As with other small group insurance, federal law requires that insurers provide coverage regardless of a person's current or past health status, and the policy must cover preexisting conditions. No such requirements apply to an individual health insurance policy. HIPAA does not regulate the premiums charged for coverage in either market.

[2] The guarantee of renewability does not apply in cases of nonpayment of premiums or fraud by the insured party.