United States Senate Committee on Commerce, Science, and Transportation,
Hearing on Mini-Medical Plans
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Statement of Timothy Stoltzfus Jost

My name is Timothy Stoltzfus Jost. I hold the Robert Willett Family Professorship at the Washington and Lee University School of Law. I have taught and written about health law, and in particular health insurance law, for thirty years. I am a consumer representative to the National Association of Insurance Commissioners and have been heavily involved in the implementation of the Affordable Care Act. Thank you for the opportunity to speak to you today about limited-benefit health insurance policies, also known as mini-medical plans.

Much has been made of the impact that the Affordable Care Act will have on the uninsured once it is fully implemented, and rightly so. The CBO estimates that the Affordable Care Act will reduce the number of uninsured Americans by 32 million.

But equally important is the assistance that that the legislation will provide to the underinsured. It is estimated that 25 million insured adults under age 65, 20 percent insured American adults, were underinsured in 2007.[1] Seventy-one percent of Americans who are among the top 25 percent of spenders on health care services and whose income is at or below 200 percent of poverty were underinsured.[2] Over half of underinsured Americans report problems gaining access to care, including over 40 percent who report not filling a prescription and 30 percent who report skipping a test or treatment or not following-up on a recommendation from a doctor because of the cost the care.[3] Forty-five percent of underinsured Americans report problems with medical bills.[4] Sixty-two percent of bankruptcies in 2007 had a medical cause, but almost 70 percent of those bankrupts were insured at the time of the bankruptcy.[5] Obviously, their insurance was not adequate to provide financial security. $2.6 billion of the debt involved in those bankruptcy proceedings was owed directly to health care providers, which in all likelihood lost billions more to unpaid bills owed by underinsured Americans who did not go bankrupt.[6]

Many of the underinsured have health insurance coverage with high cost-sharing obligations, including high deductibles. But over a million of the underinsured have limited benefit, or mini-med, policies. High cost-sharing policies expose lower-income Americans to immediate, sometimes unsustainable, costs when they seek medical care. Limited benefit policies, on the other hand, are more insidious, as the persons whom they cover often are not fully aware of how inadequate their coverage is compared to the medical costs they are likely to incur. An individual whose coverage excludes the first day of a hospital stay may not realize that most, often virtually all, of the costs of a hospital stay may be incurred during the fist day, when a surgery is most likely to occur. A family whose policy limits coverage to $250 a day for hospital care may not realize that this would not cover 10 percent of the average per diem cost of hospitalization in the United States.

When the Affordable Care Act is fully implemented in 2014, it should dramatically reduce the level of underinsurance in the United States. All health plans in the individual and small group market will be required to cover a federally-defined essential benefits package and caps will be placed on deductibles for small group plans and for out-of-pocket costs for all health policies.[7] Employees who are offered plans at work with an actuarial value below 60 percent of covered benefits or who are required to pay more than 9.5 percent of their income for the employee share of insurance premiums will be eligible for federal premium tax credits, and their employers will have to pay a penalty.[8] Annual dollar limits on health coverage will disappear.[9] Most importantly, premium tax credits and Medicaid expansions will make it possible for Americans with low income jobs to get access to real comprehensive insurance coverage.[10]

In the interim, however, significant protections are being put in place for plan years beginning after September 23, 2010 to shield insured Americans from financial disaster. For most Americans, these requirements go into place on January 1, 2011 when their new plan year will begin. First, lifetime limits on coverage are banned, and annual coverage limits will go up immediately to $750,000, increase further for 2012 and 2013, and then disappear by 2014.[11] Few insured persons ever encounter lifetime limits, but persons who do are very sick people who face financial devastation and the possibility of losing life-sustaining treatment. Annual limits are a more common problem. The law will ensure that annual limits are high enough to provide insured Americans with real protection. Insurers will also be barred from imposing higher cost-sharing on enrollees who have to go out-of-network to get emergency care.[12] The September 23 reforms also ensure that enrollees in non-grandfathered plans will have access to preventive services without cost sharing.[13]

Beginning next year, insurers in the individual and small group market will also need to spend 80 percent (and insurers in the large group market, 85 percent) of their premium revenue on health claims or expenses that improve quality of care.[14] Effective March, 2012, all health plans will need to disclose their plan benefits and limitations on coverage in a standard, easily-readable, format so that all enrollees will be able to clearly see the limits their coverage imposes.[15] Limited-benefit plans will no longer be able to hide their limitations.

Unfortunately, two of the most important September 23 reforms will not be applied immediately to limited benefit plans. Exercising authority granted by the Affordable Care Act to "ensure that access to needed services is made available with a minimal impact on premiums,"[16] HHS has, to date, waived the annual limits requirement for one year for 111 plans covering 1.175 million Americans.[17] Under a Guidance issued September 3, 2010[18] and a Supplemental Guidance issued November 5, 2010, plans can apply for and be granted a waiver if full compliance with the annual limit requirement, "would result in a 'significant decrease in access to benefits' or a 'significant increase in premiums.'"

HHS also announced in its medical loss ratio rule, released on November 22, that limited benefit plans with annual limits of $250,000 or less will be allowed to double the amount that

they spend on medical claims and quality improvement activities for calculating their medical loss ratios (effectively lowering the target percentage of their premium revenues that they must spend on medical care and quality improvement from 80 percent to 40 percent in the small group and individual market and to 42.5 percent in the large group market.).[19] This dispensation will only apply for 2011, and during 2011 limited benefit insurers are required to submit quarterly reports of their experience so that HHS can determine if further adjustments will be permitted. HHS took this step under the authority it has under the medical loss ratio provision to take into account the special circumstances of "different types" of plans in establishing the medical loss ratio calculation methodology.[20]

It is unfortunate that enrollees in limited benefit plans will not get immediate relief from the highly restricted annual dollar limits imposed by those plans. On the other hand, prior to 2014 when tax credits become available, there may be few affordable alternatives available for limited benefit plan enrollees. An important protection in the November 5 HHS Guidance is a requirement that enrollees in a limited benefit plan receive a notice:

> informing each participant or subscriber that the plan or policy does not meet the restricted annual limits for essential benefits set forth in the IFR because it has received a waiver of the requirement. The notice will be required to include the dollar amount of the annual limit along with a description of the plan benefits to which it applies, and will be required to be prominently displayed in clear, conspicuous 14-point bold type. In addition, the notice will be required to state that the waiver was granted for only one year. HHS will establish model notice language for issuers [which will be posted at the HHS website].

Disclosure that a plan does not comply with the requirements of the Affordable Care Act is very important because in some instances the premiums for limited benefit plans are not significantly different from those charged for more comprehensive plans (including higher deductible plans). An enrollee in or applicant for a limited benefit plan may be able to find alternative coverage. Alternative coverage may also be available through a high-risk pool or state assistance plan. Moreover, enrollees who receive limited benefit plans through their employers may be able to request more comprehensive coverage or find an employer that offers better coverage if they understand how limited their coverage is.

The annual waiver Guidance does not state when this notice should be given. This question is addressed by a model law recently approved by the health insurance committee of the National Association of Insurance Commissioners.[21] HHS should require notice to be given at the time the waiver is granted and to prospective applicants and enrollees during any open or special enrollment period. Notice should also be given to the state insurance commissioner in the state where the waiver is granted and be posted on the healthreform.gov web portal if any limited benefit plan is identified on the web portal. Notice should also when a waiver expires.

The HHS medical loss ratio rule does not require that plans give a special notice to enrollees that the plan is excused from the rebate requirement. HHS should also require notice to be given of loss ratio waivers. Presumably only plans that receive the annual limits waiver will qualify for the medical loss ratio waiver, and the notice of the loss ratio waiver should be given at the same time that an annual limit waiver notice is given. HHS should also carefully consider the quarterly data submitted by limited benefit plans this year and only extend the

medical loss ratio adjustment beyond 2011 if it becomes indisputably clear that an extension of the adjustment is necessary to assure continued availability of coverage. Even then, the required target should be raised to a level closer to the statutory requirement of 80 or 85 percent. While it may not be possible to eliminate limited benefit plans immediately, they should be required to operate as efficiently as possible.

Limited benefit plans leave Americans exposed to far too great a level of financial and health risk. They should disappear as soon as possible. As a practical matter, however, they may be the only coverage available to some Americans until the premium tax credit and Medicaid expansions take place in 2014. In the interim, it is essential that these plans comply with the requirements of the law to the maximum extent possible and that consumers be fully informed of any waivers or adjustments granted to these plans and of how limited their coverage under these plans truly is.

References

[1] Persons are underinsured if they must spend at least 10 percent of their income for out-of-pocket medical expenses, or at least 5 percent if their income is below 200 percent of the federal poverty level, or if their deductibles equal or exceed 5 percent of their income. Cathy Schoen, et al., How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007, Health Affairs, June 10, 2008, w298 to w309, w300.
[2] Jon R. Gable, et al., Trends in Underinsurance and the Affordability of Employer Coverage, 2004-2007, Health Affairs, June 2, 2009, W595- w606, w604.
[3] Schoen, et al., at w304.
[4] Ibid.
[5] David Himmelstein, et al., Medical Bankruptcy in the United States: Results of a National Study, The American Journal of Medicine, available at http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf.
[6] Melissa Jacoby & Mirya Holman, Medical Providers as Lenders: A National Study (working paper).
[7] Pub. L. No. 111-148, ' 1302(a)
[8] 26 U.S.C. ' 4980H(b), added by Pub. L. No. 111-148, ' 1513.
[9] 42 U.S.C. ' 2711(a)(1)(B), added by Pub. L. No. 111-148, ' 10101(a).
[10] Pub. L. No. 111-148, '' 1401, 1402, 2001.
[11] 42 U.S.C. ' 2711(a)(2), added by Pub.L.No. 111-148, ' 10101(a); 45 C.F.R. ' 147.126
[12] 42 U.S.C. ' 2719A(b), added by Pub. L. No. 111-148, ' 10101(h).
[13] 42 U.S.C. ' 2713, added by Pub. L. No. 111-148, ' 1001.
[14] 42 U.S.C. ' 2718, added by Pub. L. No. 111-148, ' 10101(f).
[15] 42 U.S.C. ' 2715, added by Pub. L. No. 111-148, ' 1001.
[16] 42 U.S.C. ' 2711(a)(2), added by Pub.L.No. 111-148, ' 10101(a);
[17] http://www.hhs.gov/ociio/regulations/approved_applications_for_waiver.html
[18] http://www.hhs.gov/ociio/regulations/patient/ociio_2010-1_20100903_508.pdf
[19] See Interim Final Rule, Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act, '' 158.120(d)(3), 158.221(b)(3). http://www.ofr.gov/OFRUpload/OFRData/2010-29596_PI.pdf
[20] 42 U.S.C. ' 2718(c), added by Pub. L. No. 111-148, ' 10101(f).

[21] The National Association of Insurance Commissioners' Proposed Model Law for Lifetime and Annual Limits requires:

> Sec. 4(C) (2) (a) At the time a health benefit plan receives a waiver from the U.S. Department of Health and Human Services, the health benefit plan shall notify prospective applicants and affected policyholders and the commissioner in each state where prospective applicants and any affected insured are known to reside.
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> (b) At the time the waiver expires or is otherwise no longer in effect, the health benefit plan shall notify affected policyholders and the commissioner in each state where any affected insured is known to reside.

Available at http://www.naic.org/documents/committees_b_101122_materials.pdf