

Impact of the Elimination of Medical Underwriting Under Health Care Reform

By Jeff Fluke

Guaranteed-issue health insurance coverage – which ensures that individuals are not denied coverage or forced to pay higher premiums because of pre-existing conditions or poor health status – is expected to be a key component of any final health reform bill. It is currently included in both the House and the Senate health reform bills and has bipartisan support. Implementing such a guarantee may, however, require the gradual elimination of medical underwriting due to the restrictions outlined in the bills on rating practices and the requirement that all individuals have access to coverage regardless of their health conditions.

This article examines the impact of potentially eliminating medical underwriting including:

- Mandates
- Potential for increased cost
- Impact to employer-sponsored plans
- Reduced market advantages
- Network and medical management strategies

Current Environment

Medical underwriting refers to the use of medical or health status information in the evaluation of an applicant for coverage. It is designed to protect the long-term viability of the insurance system by providing financial checks and balances (i.e., adding membership at the proper and adequate premium levels). Health information may be used in making two related decisions: whether to offer or deny coverage and what premium rates to set.

From the insurer's point of view, medical underwriting is necessary to prevent the uninsured from waiting to purchase insurance until they are sick or in need of medical care. Waiting to obtain health insurance until one *needs* coverage creates a pool of insureds who have high utilization; this increases the premiums insurance companies must charge in order to pay for claims incurred. The resulting increase in premiums would further discourage healthy people from obtaining coverage.

Proponents of medical underwriting argue it ensures that health insurance premiums are kept as low as possible by attracting healthy people into the insurance pool, while applying surcharges or denying coverage to those who are unhealthy. This is especially important in the individual health insurance market because these policies are guaranteed renewable in most states. In other words, once a policy has been issued and the required premiums are paid, the policyholder can keep it forever—regardless of medical condition.

The practice of medical underwriting is more important in the individual and small-group employer markets because they are more volatile than the large-group employer market. Those in the individual and small-group markets are more likely to come and go due to health status and insurance needs, while those in the large-group market are, by and large, not taking a job because they are sick and need to obtain health insurance.

As there is currently no federal requirement for individuals to have health insurance coverage, insurers use both incentives and penalties to attract and retain people in the individual market and create the most stable product for all. Excluding coverage for a pre-existing condition or charging higher premiums based on health status serve as incentives for individuals to purchase insurance while they are healthy. These also serve as deterrents for delaying purchase until an individual is sick and in need of medical care. Without these practices in place, premiums would be driven up by those who incur expensive medical bills, while the young and healthy wait until they are in need of medical care before obtaining health insurance. Implementing a mandate that requires health coverage for all should address this problem.

Mandates

The removal of medical underwriting requires strong incentives or penalties to ensure continuous participation by low-risk individuals and groups. These incentives and penalties may become rather complex,

and current proposals released to date are not likely adequate to meet the necessary requirements.

The individual mandate of coverage for all will need both a robust system to verify coverage and effective enforcement of the requirement. For guaranteed coverage to remain available and affordable, risk must be shared broadly across the population. Under a reformed market model, this is best achieved by means of an enforceable individual mandate to obtain coverage.

The small-group market demonstrates the importance of a mandate. Nearly every state has had a small-group guaranteed-issue provision in place for over 15 years, yet a very large proportion of the uninsured are employees of small groups. Why? Because the guaranteed-issue provisions are not coupled with a mandate. Thus, adverse selection occurs, driving up premiums and creating an affordability barrier. Similarly, the elimination of underwriting would mean high-cost individuals are eligible for coverage, making it critical for health plans to enroll the low-risk population in order to maintain the viability of the insurance pool.

We can look at other types of insurance as a model for a health insurance mandate. For example, states typically require proof of insurance in order to obtain or renew a driver's license. Correspondingly, lawmakers have hinted at using the tax code as an enforcement mechanism to require health coverage. Any tax deduction or penalty must be substantial enough that it becomes more cost effective to have health coverage than not.

Under any mandate, broadening the risk pool is essential because insurance spreads costs by covering the high costs of a few unhealthy people with premiums from the majority of the population (generally in good health). For instance, suppose an insurance pool includes a large number of healthy individuals who pay premiums. They may never get sick. But what if a member of this same pool had a heart bypass and now

needs four different kinds of daily medication? Without the premiums of the healthy individuals, the insurance pool would not have enough money to cover the ongoing medical expenses of the heart bypass beneficiary without charging him a very high, potentially unaffordable premium. Just as you would not wait until you have an accident to get automobile insurance, the health insurance system will not work if people wait until they are sick to obtain insurance.

Potential for Increased Cost

New policy requirements, new restrictions and new regulations related to medical underwriting will require that health plans be flexible and adaptable, and that they fully understand their current and possible future risk.

If an individual mandate is unable to reduce adverse selection, insurers would be forced to boost premiums in order to cover the risk. In addition, a federal guaranteed-issue requirement, coupled with some form of modified community rating, is likely to prompt health plans to increase rates for all members. Those most likely to see a rate increase would be low-risk, healthy individuals. If these individuals move to lower-cost coverage plans, or opt out completely, health plans will face adverse selection.

One way to soften the potential premium increase that would be passed along to consumers is to introduce legislation allowing individuals to use pretax dollars to pay their premiums. This would also help to get more people into the risk pool and mitigate the potential adverse selection issues.

As health plans work to attract new enrollees, it is important to fully understand the risk being taken. Actuaries will need to estimate the likely claims costs and adjust premiums to cover the cost of the previously uninsured, some of whom could be high-risk, high-cost, special needs individuals with chronic conditions. In addition, insurers would likely experience an initial spike

in medical services utilization due to pent-up demand from those previously uninsured.

Impact to Employer-Sponsored Plans

One of the specific reform proposals that could potentially have a cost impact for employers is the pay-or-play mandate; this would require companies to provide coverage to workers and their families or pay an assessed fee to the government. Many companies will need to ask themselves, “Should our company continue to play an active role in providing health coverage for employees or, given that our employees will be able to secure affordable health care coverage in a reformed individual market, should we exit health plan sponsorship and instead pay an assessment to the government?”

Regardless of the final details, health care reform seems destined to alter the medical underwriting environment for employer-sponsored health plans. Proposals are likely to reduce spending on employer-provided health insurance and could lead to a decline in the number of individuals covered under such plans. For example, some companies (especially in industries with high turnover, low wages and low margins) might consider dropping their health care plans if alternatives for other guaranteed coverage are available. Many companies will also take the opportunity to revisit their role in sponsoring health care coverage and will thoroughly consider dropping coverage and instead offering cafeteria or defined contribution plans that allow their employees to find coverage through other sources.

Reduced Market Advantages

Group carriers without individual experience and expertise will be challenged if a mandate is established requiring all carriers to serve *both* the group and individual markets. Individual carriers will also face many challenges, as most of the strategies at which they currently excel will be disallowed in a reform environment, including: medical underwriting to set the

appropriate price for each policy, administration of exclusion riders and pre-existing condition look-backs, and sales and marketing processes that support the current environment. In a reform environment, carriers will instead need to depend upon network discounts, low administrative costs, strong customer service and other unique value propositions in order to compete. This will change the playing field for those companies that have historically relied on strong medical underwriting to develop a high-quality, low-risk pool along with corresponding lower rates.

Network and Medical Management Strategies

Overall, network and medical management strategies may shift to attract different risks. A health reform law requiring plans to accept all applicants regardless of health status would likely force plans to compete on their own ability to control costs and provide effective medical care. Health plan actuaries would be required to establish, monitor and comply with the risk-adjustment mechanism likely to be in place. They would also need to certify compliance with new “actuarial equivalence” requirements across benefit plans. The more traditional actuarial roles (financial reporting, pricing, medical management evaluations and provider network evaluations) would still be required.

Conclusion

Health reform proposals remain uncertain. Many include significant changes in medical underwriting, including restrictions on rating practices and the requirement that all individuals have access to coverage regardless of their health conditions. What is clear is that any potential health reform legislation will require strong incentives or penalties to ensure continuous participation by low-risk individuals and groups. If adopted, these changes could have a significant effect on a health plan’s competitive and strategic positioning in a post-reform environment. Given the complexity of modeling that may be required to address the post-reform environment, health plans

should begin evaluating these proposals now to be better prepared for any reform proposals that may eventually become law.

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