The Inevitability of Disruption in Health Reform

Timely Analysis of Immediate Health Policy Issues

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Summary

The recent furor over policy cancellations in the individual health insurance market demonstrates a long-standing challenge to the enactment, let alone the implementation, of effective health reform. Disruption of the 84 percent of Americans who have health insurance creates a powerful impediment to the extension of insurance to the 16 percent of Americans without it. But despite claims to the contrary, it is not possible to reform our health insurance arrangements without somehow disrupting existing arrangements.

The ACA's disruption, though, is remarkably modest—it is far less disruptive than other coverage expansion strategies, such as single-payer proposals on the left and market-based proposals on the right. And its disruption improves the pooling of risk that is essential to effective insurance. This brief clarifies the realities and political risks of disruption and places the ACA in context relative to other reform proposals.

Disruption Is Inevitable in Any Health Reform[1]

Employer-sponsored insurance (ESI) composes the core of the American health insurance system. Many factors built and entrenched this core in the middle of the 20th century. In the 1940s and 1950s, insurers learned they could avoid appealing only to people needing care by marketing to employers, thus attracting a broad mix of risks. Employers found they could attract and keep workers by expanding fringe benefits. And policy-makers—first administratively and then legislatively—supported these employer-provided benefits with tax subsidies, the most important of which was the exclusion of employer-paid premiums from employee taxable income. ESI expanded rapidly for several decades, though since the 1980s it has reached a declining share of the population. Nevertheless, about six in 10 Americans under age 65 currently have insurance coverage through their jobs.[2]

From the 1950s on, public health insurance advocates saw the political advantage to building around, rather than disrupting, rapidly-growing ESI for the working population. In 1965, Medicare and Medicaid targeted public health insurance to people ESI obviously could not reach because they were not expected to work: Medicare for the elderly and Medicaid for recipients of cash assistance; that is, children of poor single mothers as well as poor adults who were elderly, blind or disabled. Both programs expanded—Medicare to the disabled as well as elderly recipients of Social Security; and Medicaid to broader categories of low-income people. But neither these public programs nor ESI effectively reached adults without dependent children who worked in low-wage, low-benefit jobs that did not (and still do not) offer health insurance. Today, almost two-thirds of people without health insurance are in families of full-time workers.[3]

For the last several decades, the primary political and policy challenge to health reform has been how to extend coverage to people who lack it without in some way disrupting the rest. As discussed in more detail below, some policies actually intend that disruption: advocates of a single-payer approach want to replace private with public insurance; advocates of market-based reform support ending the employer premium tax exclusion and replacing ESI with individual coverage. But past and current political reactions reveal the risk that displacement poses to policy reform.

Disruption in the ACA

President Obama's promise that people who liked their insurance policies could keep them intended to avoid a repeat of the failed health reform experience of the Clinton Administration in the early 1990s. Interestingly, the Clinton Health Security Act tried to avoid disruption by requiring employers to offer coverage—simultaneously extending coverage and locking existing sources of coverage in place, and guaranteeing benefits equivalent to those offered by the most generous employers. Also, new coverage was to be largely financed without new taxes. Instead, aggressive measures to slow health care cost growth were projected to reduce future Medicare and Medicaid spending and, by reducing projected ESI spending, to reduce future revenue losses because of tax preferences. The combination of lower-than-projected public expenditures and higher-than-expected tax revenues made room in the federal budget to finance the new subsidies that were essential to coverage expansion.[4]

But the Clinton Health Security Act also required that all but the largest employers (those with more than 1000 workers) give their employees a choice of plans in new marketplaces. It also regulated the benefits, operation and premium growth in those plans. Though the intent of the policy was to secure private coverage while adding an element of individual choice, the policy was attacked as big government interference with the ESI most people counted on and as cost containment that

would undermine and ration people's access to quality care. When the legislative effort came to an end, polls indicated that only about one in five Americans believed reform would make them better off—in general and in their quality of care. A far larger share, more than one in three, believed they would be worse off from enactment of the proposed reform.

The Affordable Care Act assiduously avoided a similar result by building around, rather than reforming, ESI. In stark contrast to the Clinton proposal, the ACA leaves health insurance operations fundamentally unchanged for large employers (defined as more than 50 workers through 2015, and as more than 100 workers thereafter). For the roughly 100 million people covered by large employers,[5] the ACA fulfills the President's commitment to letting them keep their plan. Indeed, unless they lack an offer of affordable coverage,[6] these workers are not eligible for subsidies in the ACA's new marketplaces, which are explicitly limited to people not offered coverage through their jobs. And, except for requirements that children's coverage extend until age 26, preventive benefits be available without cost-sharing and limited consumer protections,[7] the benefits and operation of these plans are not regulated by the law. Beginning in 2018, the ACA does impose an excise tax on health plans with especially high costs. Experts believe the tax would lead some employers to reduce their benefit offerings. Although rapid premium growth could increase the effect of this tax over time, at current growth rates it is expected to affect only 6 percent of the nation's health plans in 2018.[8]

Critics charge that the law's penalties on employers who do not offer affordable coverage are insufficient, and that this will lead them to stop offering coverage, given the new availability of insurance (subsidized for some) outside the workplace. But analyses by the Congressional Budget Office, Rand and the Urban Institute show little change in the long-standing advantage to the vast majority of workers of tax-favored ESI. Thus, they conclude that the ACA will have a negligible impact on ESI coverage and costs.[9] ESI remains the core of the American health insurance system.

The target of reform in the law—and the locus of disruption—is the insurance market outside large employers, both for small employers and for individuals buying insurance directly. Making these markets work to provide meaningful protection and spread risk requires fundamental transformation. For people who are in it and want to remain in it, that means disruption. To date, most attention has focused on disruption in the individual market, where reforms and subsidies in new marketplaces (also called exchanges) are at the heart of the ACA's strategy to expand health insurance coverage.

One might think that the nongroup or individual market is a safety net for people who do not get insurance through their job or who lose their job or want to work independently. Over the course of a year, almost a third of working-age Americans are without insurance for some period.[10] But the individual market may not assure affordable access to insurance protection. Not only can premiums exceed the means of many low and modest income people without ESI; people with pre-existing conditions are denied access; policies often offer limited benefits; and coverage can be rescinded—or rates hiked—when people make large claims.[11]

Policies in the ACA address these limitations of the individual market—requiring insurers to accept everyone, regardless of health status; prohibiting rate variation based on health status and gender and limiting rate variation based on age; requiring coverage of "minimum essential health benefits" defined to cover the range of services health professionals typically provide; and prohibiting annual and lifetime dollar benefit caps. To prevent adverse selection, these requirements on insurers are accompanied by requirements on individuals—to purchase coverage or pay a penalty. And to make that requirement feasible, subsidies are provided to limit premiums and cost-sharing as a share of income. By creating a broad risk pool, these policies enable people to contribute when they are healthy so they can receive benefits when they get sick.[12]

But by prohibiting the sale of policies that do not meet its requirements, the ACA necessarily disrupts people now holding individual policies who want to keep them. New policies will typically cover more services than pre-ACA policies; and new premiums independent of health status will produce premiums that are higher than pre-ACA premiums for young or healthy purchasers.

In theory, these changes could affect almost everyone now holding an individual policy, with the exception of people who purchased their policies before the enactment of the ACA (and whose policies were "grandfathered" by the law). In practice, however, the typical policyholder buys individual insurance to fill a gap in ESI that, for most people, lasts less than a year.[13] For others, insurer rate hikes or policy closures may bring coverage to an end, whether they want to keep it or not. For the rest, by foreclosing at least some policyholders' option to keep their policies, the ACA definitely disrupts their current coverage. Although many of them will be eligible for subsidies, they are nevertheless required to give up coverage they preferred to keep.[14]

Some small employers now holding coverage will find themselves in similar circumstances. Before the ACA, insurers in the small group market had been able to vary premiums for small employers based on health status, as was done with individuals. That makes insurance prohibitively expensive for employers with older or sicker workers, and produces significant rate hikes when employees—especially in a very small group—get sick. Such variation will be prohibited under the ACA, which applies the same benefit requirements and rating rules to the small group as to the individual market. Thus, small employers with healthy workers who have been benefiting, at least for a time, from low premiums, will see higher premiums under the ACA.

Although complaints about disruption will arise, the ACA will likely affect currently covered small employers less than currently covered individuals. First, the ACA's required benefits are, in many states, modeled on benefits small employers already provide, which tend to

be far more comprehensive than benefits in individual policies. Second, since 1996, federal law has prohibited insurers from denying coverage to small groups, regardless of health status, and many states have regulated how much premiums can be raised to reflect health status and how much other factors can raise premiums. Nevertheless, there is no doubt that some employers have benefited from their relatively low health risks and new rules may lead them to perceive themselves to be worse off, just as some individual purchasers do.

Now, as in the past, disruption is tough for policy-makers to take. In the flurry surrounding individual cancellation notices, the Obama administration has authorized states to extend by a year the period during which people who have individual policies can keep them and has allowed them a hardship exemption from the coverage requirement as well as access to catastrophic coverage. A Senate proposal would further extend the retention period for people who have policies, and the House has passed legislation that would simply undo individual market reforms—allowing insurers to enroll new purchasers in unregulated policies.

Though they vary by degree, all these measures are designed to reduce the disruption created by the ACA's market reforms. But reducing disruption simultaneously reduces the risk pooling the ACA aims to provide, enabling insurers to continue to cover the healthy and avoid the sick.[15] Average premiums will be somewhat higher for the less-healthy population participating in the new marketplace if healthier individuals retain their existing coverage. And that will raise per person subsidy costs for the federal government as well as out-of-pocket premiums paid by unsubsidized participants. Participation by the healthy will decline, insurers will become less willing to offer coverage, and uninsurance will rise. That is precisely what happened in the 1990s when a political backlash led state legislatures to repeal reforms that they had enacted.[16] The more reforms are weakened, the more the future market will resemble the unacceptable status quo.

Disruption by Alternatives to the ACA

Concern about even modest disruption regenerates the belief that "there's got to be a better way" to make insurance available, adequate and affordable. But a look at alternatives to the ACA suggests otherwise.

On the left, the oft-cited candidate for "another way" is a single-payer approach sometimes referred to as Medicare-for-all. As noted at the outset, that proposal embraces, rather than avoids, disruption in order to replace private with public insurance in a single risk pool. What people would actually get and at what cost would, of course, depend on policy specifics. But coverage would undoubtedly be less generous and more costly for some Americans and more generous and less costly for others. Such a shift would disrupt 170 million people who currently rely on ESI, along with the 11 million people in the individual market.

The same would be true for conservative proposals to replace the tax preference for ESI with a flat tax credit for the purchase of individual coverage in a market without ACA's regulatory structure. Senator McCain offered such a proposal as the Republican nominee for president in 2008. That proposal would disrupt tens of millions of workers and their families who depend on ESI, and—unlike single payer—would increase risk segmentation.[17]

That is because the current ESI tax preference, or subsidy, promotes natural risk pooling—by supporting coverage of all workers in a firm at the same premium, regardless of differences in age, health status or other factors. Eliminating the tax subsidy would increase the likelihood that healthy and young workers would seek a better deal in the individual market—where, were the ACA repealed, insurers would be free to vary premiums with health status and less healthy and older workers would face higher premiums and more frequent coverage denials. With healthier workers leaving ESI, average premiums for the less healthy and older workers remaining would increase, likely leading to a decline in the share of employers offering coverage.

Even proposals that limit but retain the ESI tax preference cannot avoid a disruptive effect. Senators Burr, Coburn, and Hatch recently announced a proposal to replace the ACA that would include a cap on the dollar amount of employer-paid premiums that could be excluded from an employee's taxable income, initially described as set at 65 percent of the average plan cost.[18] In contrast to the limited effect of the ACA's excise tax on high-cost plans, this cap (which was immediately revised)[19] would affect more than three-quarters of ESI covered employees based on 2012 premium distributions.[20] Employers could respond in many ways, depending on the income and preferences of their workers. Some employers might retain existing benefits, sharing or shifting the new tax obligation to employees; some might reduce benefits to avoid tax obligations; and some might drop coverage altogether, because its costs increased and its benefits became less attractive to workers. Any of these reactions would significantly disrupt current employee coverage arrangements.

Even more modest proposals offered as alternatives to the ACA cause disruption. Allowing insurers to sell policies across state lines, enhancing tax benefits for health savings accounts tied to high deductible insurance, and facilitating the establishment of association health plans are measures touted by their proponents as market-based alternatives to regulation that would promote competition. But absent the ACA's market reforms, the competition they promote would disrupt existing risk-pools and further segment health insurance markets.

Proposals to allow the sale of health insurance across state lines would enable insurers in states with less-regulated insurance markets to pick off the healthy from insurance markets in states that regulate to pool risk, driving up the premiums for those who stay. The regulatory "race to the bottom" that would ensue would disrupt coverage and raise premiums in individual markets in states that had previously tried to assure broadly accessible coverage.[21]

Tax preferred health savings accounts that are tied to high-deductible health plans disrupt the natural risk pools in ESI by

encouraging healthier, higher-income people to opt out of traditional insurance (inside or outside ESI).[22] The value of tax deductions for contributions to and interest earned on health savings accounts rises with income, and people who are better off, especially if relatively healthy, can better afford the risk of high-deductible plans than people with modest or low incomes, especially if they have health problems. Given that this tax-sheltered income is available not just for medical but for any expenses after age 65, the inducement to leave the traditional risk pool is potentially strong. If better-off, healthier people leave traditional insurance, the less-wealthy, less-healthy employees who remain will face higher costs.

Creation of unregulated association health plans similarly disrupts existing risk pools, especially for small businesses.[23] Proponents justify incentives for businesses to combine into associations as offering small businesses the efficiencies of large businesses in the purchase of insurance. But these incentives typically include federal exemptions from state insurance regulation. Their lower premiums come from restricting participation to employers of healthier workers. Premiums then increase for employers left in the traditional small group market, because of the age or other characteristics of their workers.

Whether modest or large-scale, proposals to enhance competition without reform of the health insurance market disrupt coverage that spreads health care risk. By segmenting the healthy from the sick, they produce lower premiums for people when they are healthy and raise premiums for people who get sick.

Disruption to Share Risks Makes Sense

ESI has always been the core of the American health insurance system. But, along with the Medicaid safety net, it fails to reach increasing numbers of Americans. And the unregulated individual market simply cannot fill the gap. No proposal aimed at fixing that hole in the current system can avoid disruption of some Americans who currently have insurance. Disruption can be large-scale and intentional—as in single-payer proposals or proposals to eliminate the tax preference for ESI. Even small-scale proposals aimed at the individual or small group market can lead to significant disruption—lowering premiums for the healthy at the expense of the less healthy.

The ACA's limited disruption takes the opposite approach—creating rules that make adequate coverage available to people, regardless of health status, and creating broad-based risk pools into which everyone contributes toward the cost of care. These rules disrupt some people who had coverage they liked—people who were benefiting, for a time, from the low premiums that came from medical underwriting and narrowly defined benefits. But eventually even these disrupted consumers could very well find that their coverage was inadequate or its costs had become unaffordable.

No one likes disruption. But some disruption is inherent in any approach that corrects the risk segmentation of unregulated markets. As is, the ACA's disruption is modest in scope, cushioned by subsidies and, over time, will benefit all participants.

Notes

1 This section draws on Feder J. "Crowd-out and the Politics of Health Reform," Journal of Law, Medicine and Ethics, 32(3): 461–64, 2004.

2 Urban Institute analysis, Health Insurance Insurance Policy Simulation Model, 2014.

3 Kaiser Family Foundation. "The Uninsured: A Primer," October 23, 2013. http://kff.org/report-section/the-uninsured-a-primer-2013-1-how-did-most-americans-obtain-health-insurance-in-2012/

4 Feder, 461–64.

5 Urban Institute analysis, Health Insurance Policy Simulation Model, 2014.

6 Employees of firms that offer coverage are only eligible for subsidized coverage in the exchange if the employee's share of the lowest-cost premium for individual coverage exceeds 9.5 percent of income or if, on average, the plan reimburses less than 60 percent of covered expenses.

7 Rules addressing dollar caps on annual and lifetime benefits, length of waiting periods prior to the initiation of coverage and rescissions of coverage already in place have been implemented without controversy (see Blumberg LJ, Buettgens M, Feder J, et al. "Implications of the Affordable Care Act for American Business." Washington, DC: Urban Institute, 2012. www.urban.org/UploadedPDF/412675-Implications-of-the-Affordable-Care-Act-for-American-Business.pdf).

8 Herring B and Lentz LK. "What Can We Expect from the Cadillac Tax in 2018 and Beyond?" Inquiry 48(4) (Winter): 322–37, 2011–2012. Although the authors highlighted their estimate that 15.5 percent of plans would be affected if premiums grew 6 percent, at 4 percent growth—closer to actual experience—their estimate is that only 6 percent of plans would be affected.

9 Blumberg L, Buettgens M, Feder J, et al. "Why Employers Will Continue to Provide Health Insurance: The Impact of the Affordable Care Act." Urban Institute, 2011. www.urban.org/UploadedPDF/412428-The-Impact-of-the-Affordable-Care-Act.pdf.

10 Statement of Sabrina Corlette, Georgetown University Health Policy Institute Center on Health Insurance Reforms, before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, November 14, 2013. http://docs.house.gov/meetings/IF/IF14/20131114/101481/HHRG-113-IF14-Wstate-CorletteS-20131114.pdf.

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16 Kirk A. "Riding the Bull." Journal of Health Policy, Politics and Law, 25: 133–73, 2000.

17 Blumberg L and Holahan J. "An Analysis of the McCain Health Care Proposal." Urban Institute, 2008. www.urban.org/UploadedPDF/411755_mccain_health_proposal.pdf.

18 "The Patient Choice, Affordability, Responsibility, and Empowerment Act." Legislative Proposal, January 2014. http://www.hatch.senate.gov/public/_cache/files/bf0c9823-29c7-4078-b8af-aa9a12213eca/The%20Patient%20CARE%20Act%20-%20LEGISLATIVE%20PROPOSAL.pdf.

19 See Note 1 in Antos J, Capretta JC. "A Senate GOP health reform proposal: the Burr-Coburn-Hatch plan." Health Affairs Blog, February 12, 2014. http://www.aei.org/article/health/healthcare-reform/a-senate-gop-health-reform-proposal-the-burr-coburn-hatch-plan/

20 Calculated from 2012 data in Tables X.C and X.D of Agency for Healthcare Research and Quality. "Medical Expenditure Panel Survey." U.S. Department of Health and Human Services, accessed February 4, 2014. http://meps.ahrq.gov/data_stats/quick_tables_results.jsp?component=2&subcomponent=2&year=-1&tableSeries=10&searchText=&SearchMethod=1&Action=Search.

21 Blumberg and Holahan, "McCain Health Care Proposal."

22 "Addressing Adverse Selection in Private Health Insurance Markets," statement by Linda Blumberg before the Joint Economic Committee of the U.S. Congress, September 22, 2004. http://www.urban.org/UploadedPDF/900752.pdf.

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