Private Insurance Limits and Responses

Elizabeth Weeks, JD, University of Georgia School of Law

SUMMARY. The COVID-19 pandemic exposed a number of existing flaws in the United States' patchwork approach to paying for and providing access to medical care. Shelter-in-place orders, social distancing, and other public health strategies employed to address the pandemic spawned a global recession, causing rapid and high unemployment rates in many countries. The U.S. unemployment rate peaked in April 2020 at 14.7%, higher than in any previous period since World War II. The United States has long hewed an anachronistic policy of relying heavily on private employers to provide health insurance to a substantial portion of the population. Those who are not eligible for employer-sponsored insurance (ESI) must fend for themselves in the non-group market, unless they qualify for government-sponsored insurance or safety net programs. Companion Chapters in this volume describe the COVID-related challenges for Medicaid and the uninsured, while this Chapter focuses on the private insurance market. The Patient Protection and Affordable Care Act of 2010 (ACA) dramatically overhauled health insurance in the United States. But those reforms have been under continuous threat of dilution or wholesale repeal, including a case currently pending before the U.S. Supreme Court that could strike down the entire Act. Thus, any evaluation of the benefits or demerits of the private insurance market must be read against the possibility that existing consumer protections could be eliminated with the stroke of a pen.

Introduction

The ACA enacted a comprehensive strategy to extend health insurance to more than 20 million previously uninsured individuals and families in the United States. Even at the time of enactment, many viewed the ACA as a fragile compromise and second-best solution to U.S. health care fragmentation. The COVID-19 pandemic casts in stark relief the limits of the ACA's initial design as well as its steady erosion through legal challenges, implementation hurdles, executive orders, and partisan politics. The United States' overreliance on ESI, limited public entitlements, and "Wild West" of an individual insurance market fail to serve the population's health care needs under normal circumstances, not to mention a global pandemic and economic recession.

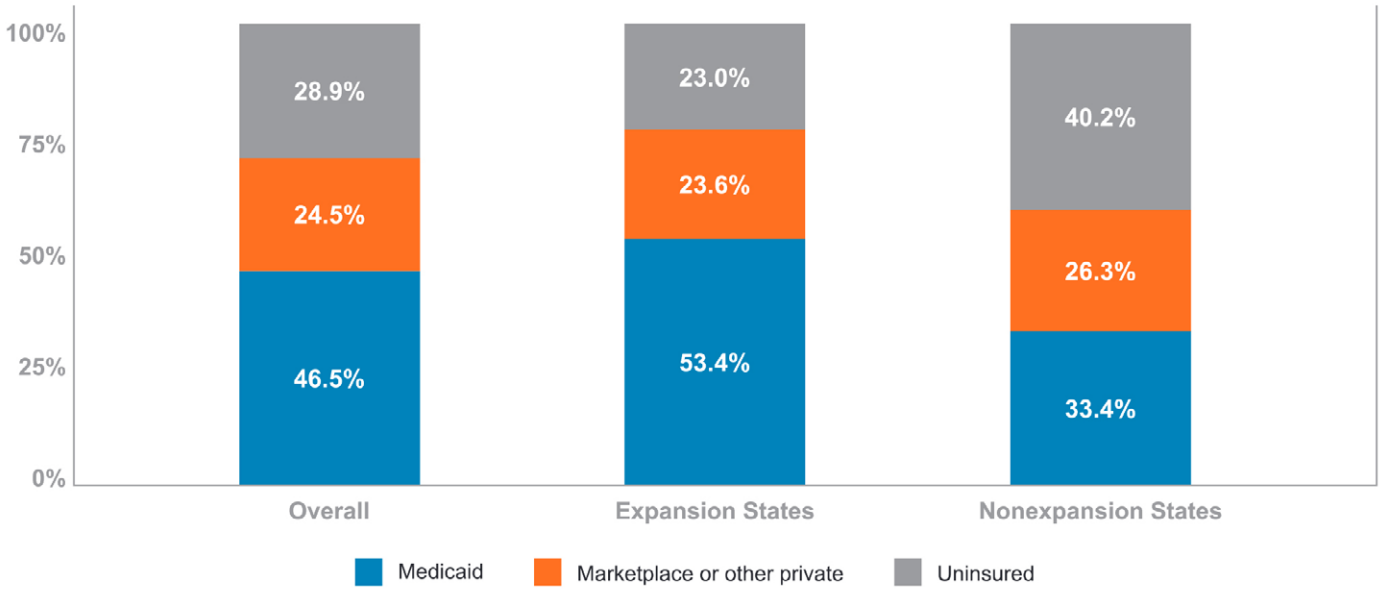
One component of the ACA's patchwork coverage strategy was expansion of public insurance, namely, Medicaid, to U.S. citizens and qualified non-citizens below 138% of the federal poverty level. But the U.S. Supreme Court later ruled that provision merely optional for states, resulting in 38 states (including Washington, D.C.) expanding Medicaid and 13 not expanding. Another strategy involved significant changes to the market for private health insurance, both ESI, the source of coverage for almost half of the country, and the individual and small-group insurance market, which historically has been fraught with limits, exclusions, and price distortions. The COVID-19 pandemic exposed key coverage gaps as well as long-standing inequities in health insurance and access to care. Those realities of the existing private insurance market presented numerous difficulties and considerable uncertainty for customers, including coverage for COVID testing and treatment, enrollment restrictions, and unexpected billing for out-of-pocket and out-of-network costs.

ACA Private Insurance Reforms

With respect to ESI, the ACA requires large employers (at least 50 full-time-equivalent employees) to offer affordable, minimum-value coverage to employees. Coverage is "affordable" if self-only coverage costs no more than roughly 10% of the employee's household income. Coverage is "minimum-value" if the plan pays, on average, at least 60% of the cost of covered services. If an employer fails to offer such coverage to a requisite portion of its eligible workforce, it may be subject to an ACA tax penalty called a "shared responsibility" penalty. The shared responsibility penalty is triggered when an employee receives federally subsidized coverage through the ACA's Health Insurance Marketplaces. Small employers are not subject to the shared responsibility penalty but may be eligible for tax subsidies or other assistance to extend coverage to their employees.

With respect to individual and small-group plans, the ACA dramatically overhauled both markets. Two of the key reforms include eliminating pre-existing condition exclusions and

Figure 12.1. Estimated Coverage Types of People Losing Employee-Sponsored Health Insurance



Sources: Urban Institute analysis based on 2017 and 2018 American Community Survey data and 2019 and 2020 monthly Current Population Survey data.
Notes: Medicaid coverage is inclusive of CHIP coverage for children. Coverage changes modeled for US population under age 65.

disallowing premium-rate variation based on individual risk factors, with limited exceptions. Premium-rate variation means insurers may charge different premium rates based on geography (where the plan is sold), plan type (individual or family), age (with a premium variance no greater than 3 to 1), and tobacco use (with a premium variance no greater than 1.5 to 1). Those provisions are significant for COVID-19 coverage because they would seem to allow individuals and families to obtain coverage, without price gouging, even after being diagnosed or for the purpose of being tested.

The Health Insurance Marketplaces are another critical component of the ACA's statutory design to create a more accessible market for private health insurance. Marketplaces operate in each state and facilitate comparison among policies, enrollment, and access to federal subsidies. They may be operated by the state or the federal government. Marketplace plan enrollment is limited to certain times of the year, absent an applicable exception, as described more fully below. Consumers purchasing Marketplace plans are eligible, depending on income level, for two different types of federal subsidies. First, premium-assistance tax credits, which lower monthly premiums, and second, cost-sharing reduction (CSR) payments, which lower out-of-pocket costs for deductibles, co-insurance, and co-payments.

Moreover, all non-group plans, both Marketplace and non-Marketplace, must comply with the ACA's broad coverage mandate, meaning that plans must offer a package of "essential health benefits" (EHB), defined by reference to state benchmark plans, which typically include acute inpatient care, urgent care, emergency room care, and outpatient care. The EHB requirement does not apply to ESI, but ESI plans are assumed to provide similar coverage, if not more. Indeed, the statute defines an EHB package by reference to benefits provided by a typical ESI plan.

Both Marketplace and ESI plans operate under annual Open Enrollment Periods, meaning they are available for enrollment only once a year, for a limited time period. Open Enrollment is subject to certain "life event" exceptions, such as losing health coverage, moving across state lines, getting married or divorced, having or adopting a child, becoming unemployed, or experiencing a death in the family. Those life events trigger Special Enrollment Periods (SEPs), which typically provide 60 days before or after the event to enroll. If the consumer misses the SEP window, she will have to wait until the next annual Open Enrollment Period to apply. These rules limit influx during the plan year, thereby helping insurers better predict costs and set premium rates. They have the effect, however, of preventing, or at least delaying, some consumers from accessing health insurance, even though they cannot be excluded based on preexisting conditions. In the COVID-19 context, that means that individuals without a qualifying life event, seeking insurance outside of the annual Open Enrollment period, would be out of luck.

Coverage Requirements and Out-of-Pocket Limits

Several ACA requirements apply to both ESI as well as individual and small-group plans. For one, plans must cover preventive care, such as screening, vaccinations, and well-child visits, without requiring co-payments, co-insurance, or deductibles, called "first-dollar" coverage. Also, plans may not impose lifetime or annual caps on EHB and are subject to annual out-of-pocket cost limits on covered EHB, meaning all benefits after the limit is hit must be provided without cost-sharing. For 2020, the out-of-pocket limit is $8,150 for individual coverage and $16,300 for family policies. Although ESI plans are not required to cover EHB specifically, the EHB definition is relevant for applying these caps.

States may impose additional coverage or other requirements on individual and small-group plans. Those additional requirements, however, do not apply to self-insured ESI plans because of sweeping federal preemption provisions in the Employee Retirement Income Security Act of 1974 (ERISA). About 60% of people who receive insurance through employers are in self-insured plans, meaning that most ESI-insured individuals are in plans not subject to state regulation. That means that even if states enact broader COVID-19 coverage provisions or other consumer protections, a considerable number of insured individuals would not benefit from those reforms. An employer "self-insures" when it bears the financial risk of the medical claims rather than purchasing a group health plan for its employees. Many large employers opt for self-insuring, as it is less costly to directly pay for employees' medical bills than to pay costly group premiums and underwrite state-mandated benefits. By contrast, under an "insured" ESI plan arrangement, the health insurer is the financial risk-bearer, and the employer pays premiums to the insurer on behalf of the entire group.

Off-Marketplace and Non-ACA-Compliant Plans

In addition to ESI and Marketplace plans, individual and small-group "off-Marketplace" plans are available. Off-Marketplace plans may be similarly comprehensive to other ESI but not eligible for federal premium-assistance or CSR subsidies. Effective with the 2019 plan year, the tax penalty attached to the ACA's individual health insurance mandate was zeroed out. That means there is no longer any penalty or sanction for failure to carry "minimum essential coverage" in the form of a comprehensive health plan. Accordingly, many people may choose not to purchase insurance at all or may opt for more loosely regulated, less comprehensive plans lacking the ACA's signature consumer protections and coverage terms. For example, "catastrophic" plans typically have especially high deductibles and cost-sharing obligations without the ACA's annual out-of-pocket limits, and short-term limited duration (STLD) plans may exclude coverage for pre-existing conditions and EHB, yet impose annual and lifetime limits. In the first quarter of 2019, an estimated 2.1 million individuals enrolled in off-Marketplace plans, and 1.1 individuals enrolled in non-ACA-compliant coverage. Although some states have responded with individual mandates, coverage mandates, or other measures to prevent proliferation of these substandard plans, individuals going into the COVID-19 pandemic with those sorts of plans may find themselves with very limited coverage and very steep out-of-pocket costs before coverage kicks in.

Insurance Coverage for COVID-19

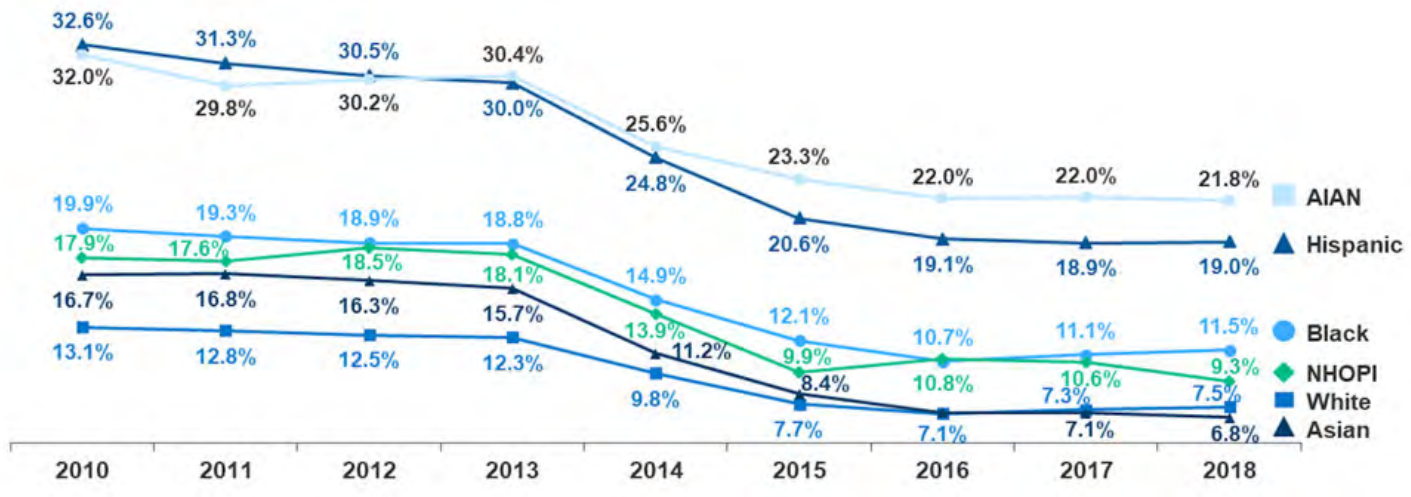
Against that landscape, the COVID-19 pandemic presents a number of challenges for private insurance customers and plans, including coverage for testing and treatment, consumers' exposure to out-of-pocket or out-of-network costs, and enrollment limitations.

Coverage for Testing

One of the first questions regarding health insurance coverage for the COVID-19 pandemic concerns testing for the virus. The ACA's "first-dollar" preventive care coverage requirement does not clearly encompass diagnostic testing, yet testing is essential for limiting disease spread by identifying infected individuals who should isolate themselves from healthy individuals. Private health plan cost-sharing requirements might deter individuals from getting tested, thereby undermining those public health strategies.

Congress acted quickly after the United States' COVID-19 outbreak in spring 2020 to enact two bills containing provisions related to health insurance coverage. The Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act require all ACA-compliant and other comprehensive group and non-group health insurance plans to cover testing for detection or diagnoses of COVID-19 and the administration of that testing. FFCRA covers testing for both the active coronavirus infection as well as serological tests for the COVID-19 antibody. The coverage requirement only applies

Figure 12.2: Uninsured Rates for the Nonelderly Population by Race and Ethnicity, 2010-2018. Source: Samantha Artiga & Kendal Orgera, Kaiser Family Foundation, 2020



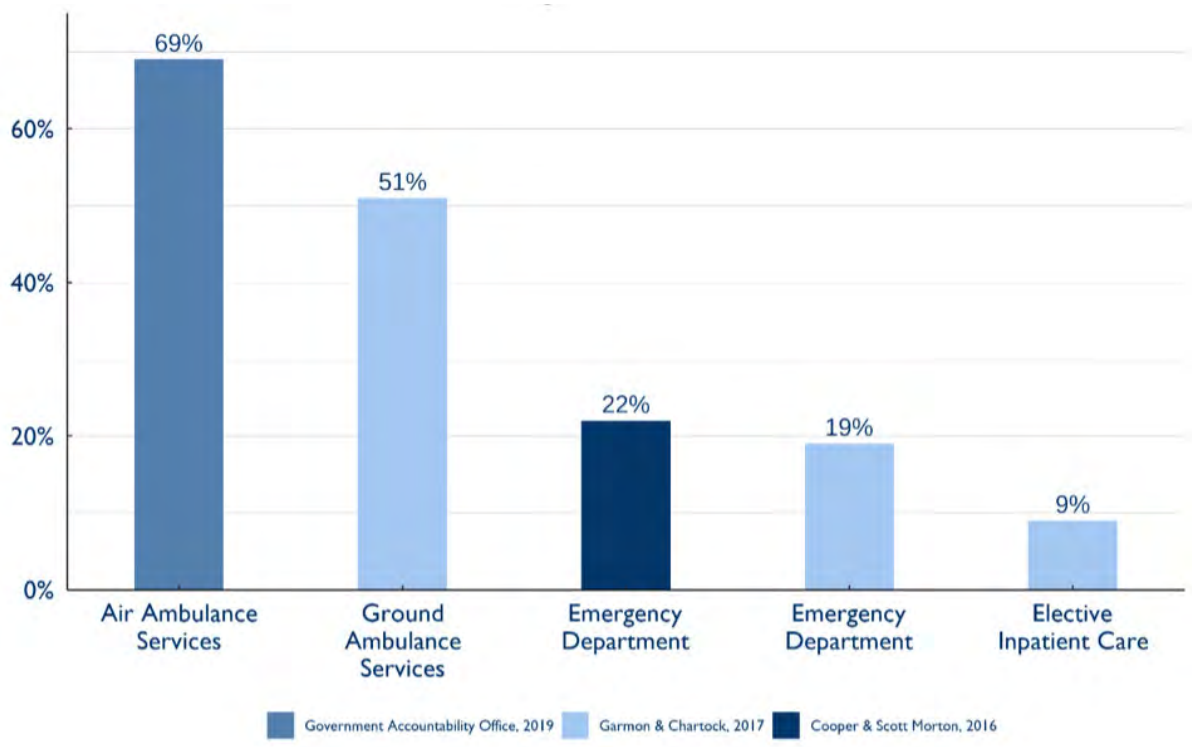


Figure 12.3: Percentage of Visits Leading to Surprise Out-of-Network Bills. Source: Christen Linke Young et al, USC-Brookings-Schaeffer on Health Policy, 2019.

during a federal public health emergency declaration, which HHS Secretary Alex M. Azar II initially declared January 27, 2020 and most recently renewed on April 26, 2020. The HHS Secretary may extend this public health emergency declaration for subsequent 90 day periods, for as long as the COVID-19 public health emergency persists).

Initially, coverage was limited under FFCRA to FDA-approved testing, but the CARES Act extends to (1) tests provided by clinical labs on an emergency basis (including public health labs); (2) state-developed labs; and (3) tests for which the manufacturer says it will seek approval. Coverage also extends to any services or items provided during a medical visit that result in COVID-19 testing or screening. For example, if a patient is screened for influenza to rule out other causes of respiratory illness before the COVID-19 test is administered, the influenza test would be covered (Keith, 2020a).

The laws also specify that COVID-19-related diagnostic testing must be covered like other preventive care under the ACA, that is, without regard to deductibles, co-payments, co-insurance, preapproval, or precertification (Keith, 2020a). Under the CARES Act, plans are required to cover COVID-19 vaccines and other preventive measures on a first-dollar basis, starting 15 business days after the measure is approved. This requirement extends to all types of group health plans, including insured and self-insured ESI plans. The Departments of Labor, Treasury, and Health and Human Services' guidance on FFCRA and CARES Act specifies that testing must be covered when furnished in traditional settings, including physicians' offices, urgent care centers, and emergency rooms, as well as non-traditional settings, such as parking lots, football fields, and other public spaces.

The CARES Act addresses provider reimbursement for COVID-19 diagnostic testing, requiring all comprehensive private health insurance plans to reimburse test providers based on the rate negotiated between the plan and the provider (i.e. the in-network rate). If there is no negotiated rate between the plan and provider (i.e. the provider is out-of-network), then the plan must fully reimburse the provider based on the provider's own, publicly available "cash price" (Keith, 2020a).

Coverage for Treatment

Once an individual is infected with COVID-19 and experiencing acute symptoms, the next concern is coverage for treatment. These questions generally are resolved under the terms of the plan. ACA-compliant plans both on and off the Marketplaces typically include such care under EHB. Likewise, comprehensive ESI plans typically cover treatment services. Since FFCRA and the CARES Act do not address COVID-19-related treatment costs, any applicable coverage limits and cost-sharing requirements would seem to apply (Pollitz, 2020).

Consumers' responsibility for treatment costs vary depending on their plans' cost-sharing configurations, coverage terms, and provider networks. The ACA's annual out-of-pocket limit provides some financial protection, but up until that point, consumers may face some unexpected out-of-pocket costs. While predictable out-of-pocket costs include deductibles and co-payments, unexpected costs could arise from "surprise" medical bills, typically for out-of-network care (Keith, 2020b). For example, if a hospital-employed anesthesiologist or an on-call emergency room doctor treats a patient even though that provider is not covered by the patient's

plan, the provider may later bill the patient directly for the services at out-of-network rates.

Surprise medical billing has been a focus of both state and federal legislative efforts since well before COVID-19. Analysis of emergency room visits covered by large employer plans found that 18% included at least one out-of-network charge. For non-emergency stays at in-network hospitals and facilities, 16% involved at least one out-of-network claim (Pollitz, 2020).

While not addressed in the CARES Act explicitly, federal guidance implementing the Provider Relief Fund portion of the law suggests intent to prohibit surprise billing. One of the terms and conditions attached by the HHS to those relief funds stipulates that for all possible or actual cases of COVID-19, the provider (hospital, clinic, or physician practice) cannot charge more for out-of-pocket care than if the provider were in-network or had contracted with the patient's insurance company (Keith, 2020b).

In addition to the above, rather obscure federal guidance, a handful of state insurance regulators have required or encouraged insurers to waive cost-sharing for COVID-19 testing and treatment (Norris, 2020). In terms of state responses, New Mexico, for example, requires health plans to waive cost-sharing for medical services related to COVID-19, pneumonia, and influenza. Massachusetts requires health plans to provide COVID-19 treatment with no cost-sharing, although the mandate is limited to care in a doctor's office, urgent care clinic, or emergency room, and not the more expensive inpatient care. Vermont requires state-regulated health plans to waive cost-sharing for COVID-19 treatment. Minnesota initially issued guidance suggesting that insurers fully cover the cost of testing and limit or eliminate the cost of treatment, then also called for further state legislative response. In all cases, state cost-sharing waivers do not apply to self-insured ESI plans due to ERISA preemption, as explained above.

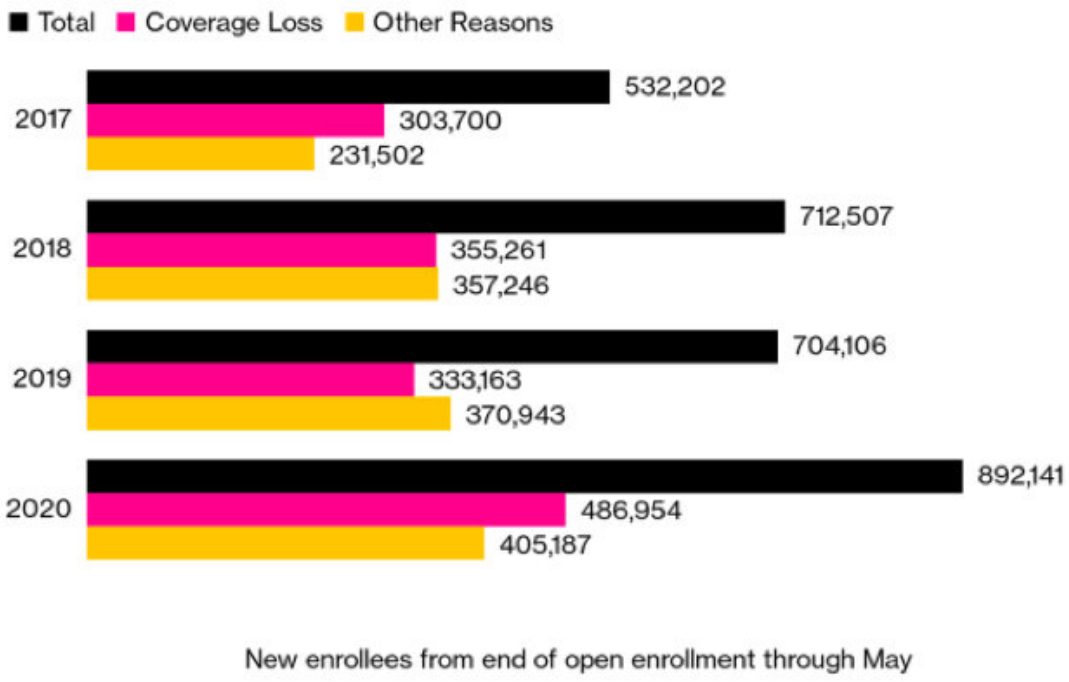
In states where cost-sharing waivers are not required, a few private insurers have voluntarily issued waivers with varying policies. For example, some of these voluntary waivers apply to both in-network and out-of-network treatment, while others waive cost-sharing for any in-network treatment but only out-of-network emergencies. Most commonly, cost-sharing is waived only for in-network treatment, and in some cases, the waivers have date cut-offs or do not extend to self-insured ESI plans (Konrad, 2020).

Open Enrollment Periods

Although the ACA's ban on preexisting condition exclusions would allow individuals who tested positive for COVID-19 to obtain coverage, open enrollment for Marketplace and most ESI plans had already concluded by the time COVID-19 became prevalent in the United States in spring 2020, and the federal government has not opened SEPs in response to the coronavirus pandemic (Norris, 2020). This means that uninsured individuals in states with federally-operated Marketplaces cannot enroll in coverage at this time unless they qualify for a standard SEP. Accordingly, many individuals who had not previously purchased health insurance have found themselves unable to obtain coverage during the pandemic.

U.S. Bureau of Labor Statistics data show that the unemployment rate jumped from 4.4% in March 2020 to a high of 14.7% (20.5 million people) in April 2020, which is around the time that most states issued stay-at-home orders to prevent the virus

Figure 12.4: Marketplace Special Enrollments Spiked Due to COVID-19. Source: Sara Hansard, Bloomberg Law, 2020.



from spreading. Broken down by gender and race/ethnicity, the unemployment rate in April 2020 was 12.8% for white men, 15.8% for white women, 16.4% for Black men, 16.9% for Black women, 16.7% for Latino men, and a whopping 20.2% for Latina women. As a result, the Department of Health and Human Services reported that 487,000 people signed up for Marketplace plans after losing ESI coverage between January and June 2020, which is a 46% increase from the same time period in 2019 (Hansard, 2020b). In April 2020 alone, Marketplace enrollment due to unemployment increased by 139% compared to April 2019.

By contrast, nearly all of the state-run health insurance Marketplaces opened SEPs – irrespective of qualifying life event – in response to the coronavirus pandemic. As of November 1, 2019, 13 states have been operating their own Marketplaces, and all of them except Idaho reopened their Marketplaces to allow uninsured individuals to enroll in ACA-compliant health plans (Norris, 2020). Still, SEP enrollment periods and effective coverage dates vary by state, and all except for Vermont (enroll by August 14, 2020) and the District of Columbia (enroll by September 15, 2020) have already closed.

SEPs triggered by the coronavirus pandemic are designed to let uninsured people gain coverage; they do not allow people with health insurance to switch to different plans. Some non-ACA-compliant health plans, such as STLD, farm-bureau-issued, or health care sharing ministry plans, are not required to cover COVID-19 testing, but enrollees in those plans would be deemed uninsured for purposes of obtaining access to SEPs or possibly Medicaid (Norris, 2020).

Another option for the recently unemployed may be to retain coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA is a long-standing option for former employees to maintain ESI coverage, allowing them to retain access to the same comprehensive plan, provider network, and negotiated group rate for up to 36 months. The downside is that COBRA requires former employees to pay not only their contribution, but also the employers' prior contribution toward the premium, plus a 2% administration fee. In 2019, the average cost of ESI in terms of annual premiums was $7,188 for single coverage and $20,576 for family coverage. While the individual was employed, the employer might have paid 80% of that premium for individual coverage and 70% for family coverage (Gangopadhyaya & Garret, 2020). As a result, COBRA coverage is unaffordable for many, especially after losing income from a job.

In prior economic emergencies, Congress authorized subsidies for employees to keep their job-based coverage after being laid off. According to the Treasury Department, COBRA subsidies from the 2009 stimulus package were "especially important for maintaining health insurance coverage for middle-class families during the recession" (Keith, 2020a). While laid-off workers will qualify for SEPs in both state- and federally-operated Marketplaces, potentially with subsidies, COBRA subsidies could help workers and their families maintain continued access to their providers and limit gaps in coverage.

Recommendations for Action

Federal government:

- HHS should open a Special Enrollment Period for all federally-facilitated Marketplaces as well as self-insured employer-sponsored insurance plans, irrespective of qualifying life events.
- Congress should pass legislation waiving cost-sharing obligations and prohibiting balance-billing for out-of-network charges to self-insured plans.
- HHS should clarify that federal coverage mandates and fee waivers are retroactive to the beginning of 2020 and will continue for the duration of the public health emergency.
- Congress should extend fee waivers for COVID-19 screening and provide that screening may be conducted by an out-of-network provider as long as the member makes a good faith effort to see an in-network provider.
- Congress should authorize COBRA subsidies to help workers and their families maintain continuous, comprehensive coverage.
- Congress should establish a federal vaccination fund, which would allow the federal government, rather than insurance companies or Medicaid programs, to negotiate prices with vaccine manufacturers in order to equitably distribute free virus and serological testing to all Americans as well as reimburse providers for administering these tests based on Medicare rates.

State governments:

- States should open a Special Enrollment Periods and extend their end-dates for state-operated Marketplaces in all states.
- States should enact individual health insurance mandates to stabilize risk pools and provide access to timely and appropriate preventive care and other treatment, rather than allowing individual to delay and seek care once conditions become acute, as originally intended under the ACA.
- In the event of wholesale repeal of the ACA states should enact comprehensive reforms, including prohibitions on health-status underwriting and ratemaking.
- States should enact legislation providing for a "public option," publicly funded health insurance, for those who do not qualify for Medicare, Medicaid, other government health care programs, or ESI, that would be included along with private plans offered on the ACA's state-based marketplaces.

About the Author

Elizabeth Weeks, JD, is Associate Provost for Faculty Affairs and Charles H. Kirbo Chair in Law at the University of Georgia. Her research focuses on health care financing and regulation, health care federalism, health care reform, and public health law. She is the author or co-author of two books, including a comprehensive health law casebook and Healthism: Health Status Discrimination and the Law, and nearly 40 articles in law reviews, journals, and other publications.

References

Corlette, S. (2020). I've Been Calling for Greater Private Insurance Coverage of COVID-19 Testing, I've Been Wrong. *Health Affairs Blog*. Retrieved July 9, 2020, from https://www.healthaffairs.org/do/10.1377/hblog20200513.267462/full/

Gangopadhyaya, A., & Garret, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Retrieved July 9, 2020, from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

Hansard, S. (2020a). Telehealth, Tested in COVID-19 Crucible, Expands in Health Plans. Retrieved July 9, 2020, from https://news.bloomberglaw.com/health-law-and-business/telehealth-tested-in-covid-19-crucible-expands-in-health-plans

Hansard, S. (2020b). Obamacare Coverage Spikes After Covid-Related Job Losses. *Bloomberg Law*. Retrieved July 9, 2020, from https://news.bloomberglaw.com/coronavirus/obamacare-coverage-spikes-after-covid-related-job-losses

Jost, T. (2020). Private Health Insurance Coverage in the COVID-19 Public Health Emergency. Retrieved July 9, 2020, from https://www.commonwealthfund.org/blog/2020/private-health-insurance-coverage-covid-19-public-health-emergency

Keith, K. (2020a). COVID-19 Package #3: The Coverage Provisions. *Health Affairs Blog*. Retrieved July 9, 2020, from https://www.healthaffairs.org/do/10.1377/hblog20200320.739699/full

Keith, K. (2020b). New Guidance to Implement Covid-19 Coverage Requirements and More. *Health Affairs Blog*. Retrieved July 9, 2020, from https://www.healthaffairs.org/do/10.1377/hblog20200413.78972/full

Kemp, E., St. Louis, M., Lincoln, T., & Tanglis, M. (2020). Insurers' Offers of Free Care for Coronavirus are Often Confusing and Limited. Retrieved July 9, 2020, from https://www.citizen.org/article/coronavirus-insurance-benefits/

Konrad, W. (2020). Does Your Health Insurance Cover You for COVID-19? *CBS News*. Retrieved July 9, 2020, from https://www.cbsnews.com/news/coronavirus-health-insurance-cover-covid-19-testing-treatment/

Norris, L. (2020). COVID-19: State and Federal Efforts to Improve Access to Testing, Treatment, and Health Coverage. Retrieved July 9, 2020, from https://www.healthinsurance.org/obamacare/state-and-federal-efforts-to-improve-access-to-covid-19-testing-treatment/

Pollitz, K. (2020). Private Health Coverage of COVID-19: Key Facts and Issues. Retrieved July 9, 2020, from https://www.kff.org/coronavirus-covid-19/issue-brief/private-health-coverage-of-covid-19-key-facts-and-issues/