Private Insurance Limits and Responses

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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. Notwithstanding the change in administration, 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 the “Wild West” of an individual insurance market fail to serve the population’s health care needs under normal circumstances, not to mention during a global pandemic and economic recession.

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. The working population is at risk of losing insurance coverage if they become unemployed. Those who are lucky enough to retain their jobs are also at risk, however: the underinsured population has steadily grown in recent years, and those who need medical treatment but are unable to pay expensive out-of-pocket costs may avoid treatment or incur crippling medical debt. The patchwork system of private health insurance is battered on two sides: first, by a global pandemic that has required costly treatment for millions who cannot afford it, and second, by an economic crisis that this fragile system is unable to withstand.

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. 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 disallowing premium-rate variation based on individual risk factors, with limited exceptions. Premium-rate variation means insurers may charge different premium rates based on where the plan is sold, plan type (individual or family), age, and tobacco use. 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, operated by states or the federal government, operate in each state and facilitate comparison among policies, enrollment, and access to federal subsidies. 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 either premium-assistance tax credits, which lower monthly premiums, or cost-sharing reduction (CSR) payments, which lower out-of-pocket costs for deductibles, co-insurance, and co-payments.

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.

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 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. These rules limit influx during the plan year, thereby helping insurers better predict costs and set premium rates. They have the effect, however, of 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. Plans must cover preventive care, such as vaccinations, 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 was $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. 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. 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.

Private insurance enrollment has declined drastically since the start of the pandemic. Although the reduction in ESI was offset in part by a corresponding rise in public insurance coverage, the number of uninsured adults still increased by roughly two million.
Those groups that saw the largest ESI losses, Hispanic adults, non-Hispanic Asian adults, men, adults without a college degree, and adults aged 18-39, also saw the largest increases in un-insurance.

The recession caused by the COVID-19 pandemic is the first to not only test the limits but also the positive impact of the ACA. Enrollment in Medicaid for low-income Americans and a tax credit program for low- and middle-income Americans who are buying their own health insurance through the ACA marketplace has increased since the beginning of the pandemic. Declines in ESI increased in states that did not expand Medicaid under the ACA. However, the rate of un-insurance during this recession is notably lower than those in past economic downturns.

Inadequate Coverage and the Rise of the Underinsured

Those who benefit from private insurance options like ESI or a marketplace plan are not necessarily protected from unaffordable health care costs. Many who have insurance are underinsured, which means they have disproportionately high out-of-pocket costs relative to their household income. Uninsured individuals are also much more likely to be unable to pay their medical bills, and thus are more likely to incur medical debt. Many who incur this debt find that they are unable to pay their bills while simultaneously paying for necessities such as food, heat, and housing.

Among those insured in private health plans, those 15 million who were enrolled in plans they purchased on the individual market were underinsured at the highest rates. In addition, 25% of the 122 million adults with ESI were underinsured. A study by the Commonwealth Fund found that growth in the underinsured population since 2010 has been mostly driven by increasingly inadequate coverage in employer health plans. Businesses have responded to rising health insurance prices by saddling employees with more out-of-pocket costs. Deductibles, for example, had more than tripled. This rise in costs could conceivably result in greater marketplace participation, although there are many who do not qualify for Medicaid but are still unable to afford marketplace coverage.

The Black population and other nonwhite minority groups are significantly more likely to be underinsured than the white population. The country’s reliance on tax-subsidized ESI and history of race-based employment discrimination means that nonwhite groups are particularly likely to experience underinsurance. People of color are also more likely to be infected with COVID-19 than white people. If they are forced to choose between feeding their families and paying for a doctor’s visit, it is not unlikely that they will avoid treatment. During a global pandemic, those who avoid treatment due to an inaccessible health care system will create a greater risk for themselves, their communities, and the rest of the country.

In order to reduce the underinsured population and encourage access to COVID-19 testing, treatment, and vaccines, the federal government must collaborate with states to decrease the price of premiums and other out-of-pocket costs by amending federal preemption and increasing regulation of ESI. Particularly during a public health crisis, relying on a piecemeal private insurance system to effectively and affordably cover millions of people without regulations to ensure fairness and equity will only exacerbate the spread of COVID-19 among un- and underinsured populations.

President Biden’s health care policy platform expands upon the existing marketplace infrastructure in order to address underinsurance. The platform includes plans to eliminate the 400% income cap on tax credit eligibility and to lower the limit on the cost of coverage from 9.86% of a household’s income to 8.5%.
Additionally, the president intends to increase the size of the tax credits themselves by amending the calculations to give more families the ability to afford coverage with lower deductibles and fewer out-of-pocket costs. For families that may still not be eligible for marketplace coverage, there would be a new premium-free public option that would provide insurance for those that have slipped through the cracks of the existing insurance system.

**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. In response, Congress has enacted legislation that would require insurance providers to cover testing. It has also appropriated money to go directly to states to cover the cost of testing.

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 during a federal public health emergency declaration, which HHS Secretary Alex M. Azar renewed on January 7, 2021. The HHS Secretary may extend this public health emergency declaration for subsequent 90-day periods, for as long as the emergency persists (Centers for Medicare & Medicaid Services, 2020).

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.

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,
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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. This requirement extends to all types of group health plans, including insured and self-insured ESI plans.

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. 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). The Consolidated Appropriations Act (CA Act), signed into law by President Trump on December 27, 2020, provides few additional details with regard to how states must administer and charge for COVID-19 tests, but it does appropriate an additional $22 billion to states for testing, tracing, and other COVID-19 mitigation programs. This includes $2.5 billion specifically for improving testing and tracing for underserved populations.

Coverage for Treatment

Once an individual is infected with COVID-19 and experiencing acute symptoms, the next concern is coverage for treatment. ACA-compliant plans both on and off the marketplaces typically include such care under EHB. Likewise, comprehensive ESI plans typically cover treatment services.

Consumers’ responsibility for treatment costs varies 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 consumers may still 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.

The federal government has required private insurers, ESI plans included, to waive cost-sharing for COVID-19 related treatment and testing establishing a baseline level of care throughout the country. States have taken a number of actions expanding the minimum federal requirements of private insurers ranging from requiring off-drug formulary coverage to premium payment relief. The additional requirements imposed upon insurers vary from state to state. For example, some states prohibit insurers from terminating insurance contracts due to nonpayment while others may merely recommend insurers refrain from coverage cancellations (O’Brien, 2021).

The CA Act includes measures to increase transparency and prevent surprise medical billing; beginning on January 1, 2022, patients will be protected from surprise medical bills that may arise...
from emergency care they receive from providers outside their networks. A patient may still be billed for out-of-network, non-emergency care, but the patient must provide informed consent, in writing, prior to receiving this care.

Although the surprise billing provision of the CA Act will not be implemented for another year, 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).

**Coverage for Vaccination**

The CA Act appropriates approximately $30 billion for the federal government to assist with the purchase and administration of the COVID-19 vaccine, as well as other COVID-19-related therapeutics. This includes $8.75 billion to the CDC to plan, prepare for, administer, monitor, and track coronavirus vaccines, and ensure broad distribution and access. Of this, $4.5 billion must be allocated to states, localities, and territories, and an additional $300 million must be allocated to high risk and underserved populations, including racial and ethnic minorities and those living in rural communities.

**Open Enrollment Periods**

For more information on open enrollment periods, please see the analysis in Chapter 12 in *Assessing Legal Responses to COVID-19: Volume I.*
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.
- President Biden should execute an executive order limiting renewals of short-term limited duration plans, thereby, reestablishing their role as stop-gap insurance rather than plans that would divert participants away from ACA-compliant plans.

State governments

- 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.
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The author would like to thank Somer Brown for her research assistance.

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