

An Advocate's Guide to the Private Health Insurance Market



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Alice in Insuranceland

"It's time for another adventure," said the white rabbit, glancing at his pocket watch.

"Would you care for hedgehog bowling, black ant counting or health insurance purchasing?"

"Oh, the last, by all means," said Alice, clapping her hands. "I'm so pleased to have a meaningful goal to accomplish. Everyone needs health insurance."

"Don't be so sure of that," said a deep voice from a tree overhead. On one of the branches lounged a large, frowning Cheshire cat. "How do you feel?"

"Quite fine, thank you," said Alice politely.

"So far so good," said the cat. "Any aches or pains?"

"I got a crick in my back last week reaching for the cocoa," said Alice.

The cat began to vanish, tail first. "Do you realize," it said sternly as its hind quarters disappeared, "how costly it is (there went its shoulders and neck) to treat a trick back?" By now, all that was left was its frown.

"I said 'crick,' not 'trick,'" said Alice, irritably. "I'm perfectly healthy in every respect."

"I'll be the judge of that," said the cat, reappearing. "Do you have any preexisting conditions?"

"How on earth am I supposed to know what conditions I had before I existed?" asked Alice.

"You should have asked," said the cat grumpily. "Are you now, or have you ever been a florist, a chef, a fisherman, or a taxi driver? We avoid insuring these."

"What do those occupations have to do with anything?" asked Alice.

"They have as much to do with anything in the insurance business as anything else," said the cat with dignity. "Next, you'll be telling me you don't have any marital problems. We don't insure people with marital problems."

"I don't have any marital problems because I'm not married," said Alice firmly.

The cat nodded. "That's a problem."

"It is not!" said Alice indignantly. "Someday, I shall marry some very nice man."

"Meanwhile, you're single, so you have single problems," said the cat. "Like no spouse to nag you about putting only one pat of butter on your scone." It began to vanish again. "Single people are grievous risks."

Alice stamped her foot. "Come back this very instant," she said. "I am obviously as healthy as a horse, so you have to sell me health insurance."

The cat slowly reappeared, frown first. "Well, as long as you're sure you're healthy enough so you won't use it," said the cat reluctantly. "How much do you want?"

"How much is it?" asked Alice. At that the cat brightened.

"If you have to ask, you can't afford it," it said. "And if you can't afford it, you can't buy it. Actually, if you were rich enough to afford it, you'd be rich enough to hire your own doctors, so you wouldn't need it anyway."

"Do you mean to say that you sell health insurance only to those healthy enough not to use it and rich enough not to need it?" demanded Alice. "What kind of business do you call that?"

"Excellent," said the cat. And this time when it disappeared, all it left behind was a large grin.

(Source: *The Grape Vine*, a newsletter published by the Central California AHU as printed in *Health Insurance Underwriter*, March 1991.)

As much as many of us would like to escape down a rabbit hole rather than talk about risk pooling, adverse selection, and experience rating, health insurance is an unavoidable part of the discussion about health care access and why some people do not have it. Everyone who advocates for improved access knows this, but some may not fully appreciate how the private insurance market works, why it behaves the way it does, and how it can be and has been changed to improve access.

This guide, then, provides a review of that information. Here is a synopsis of what follows.

PART 1: So, Just What Is Insurance? And What in the World Does It Have to Do with Health Care?

In the United States we have become used to talking about “health insurance” as the way most health care is paid for. Most of us do not often pause, however, to consider exactly what that means or how different aspects and expectations of our health care system do or do not lend themselves to a private insurance model of financing.

Part 1 of this guide begins with a basic definition of insurance and the necessary characteristics of an insurance market. Ideally, an insurance market provides a mechanism for members of a group to spread the costs of expensive, unpredictable events across the entire group. A well-functioning market presents individual buyers of insurance with a premium that they consider to be a reasonable price to *insure* against the probability of a much greater expense. It also gives sellers of insurance a large enough group to be able to predict the overall costs of expensive “insurable events” that may occur within the group.

We then explain some of the characteristics of our health care system that reflect the qualities of an ideal insurance market, and others that depart from them. Some of these imperfect qualities are:

- The voluntary nature of private health insurance;
- The advent of insurance for care—such as maternity care—that doesn’t meet the criteria of an “ideal insurable event”; and
- The growth in the practice of insurers setting premiums for every group they insure based on the specific health care experience and demographic characteristics of that group, thus dividing the insurance pool into smaller and smaller pieces.

Having introduced the concept of insurance and how it is applied to American health care, Part 1 concludes with a discussion of the advantages and disadvantages of using a voluntary, competitive insurance model for financing health care.

PART 2: A Typology of the Health Insurance Market

“Health insurance” is a generic term that does not nearly capture the complexity and multiplicity of products available to help pay for health care. In addition to medical plans, one may purchase dental insurance, long-term care insurance, and other products. Within the universe of medical coverage, it is possible to buy insurance that covers costs (such as Medicare copayments) that are not covered by other insurance. In addition, the medical insurance market actually consists of a few segmented markets—large group, small group, and individual or nongroup—that have their own rules and market dynamics. Those rules and dynamics, in turn, differ for each state in the country.

Part 2 also introduces what many consider to be the most confounding complexity of all: the Employment Retirement Income Security Act, or ERISA. ERISA is a federal law that has the effect of exempting certain types of health plans—those for which employers rather than insurance companies assume the financial risk—from state laws regulating health insurance. This is important because most laws governing health insurance are state laws. ERISA is confusing because to the casual observer plans that enjoy the ERISA exemption look similar to plans that do not, and because it is difficult to know exactly how many people ERISA provisions affect. It is complex because it essentially creates two parallel health insurance markets—one that is subject to state regulation and one that is not—which makes comprehensive insurance reform at the state level extremely difficult.

Part 2 includes an introduction, in relatively simple terms, to the provisions of ERISA. It discusses the implications of the ERISA preemption of state laws and recent federal government efforts to overcome the barriers ERISA creates by taking a role in insurance market oversight, which had previously been almost exclusively in the sphere of state governments. Readers may find this discussion enlightening or further confounding; such is the nature of ERISA.

PART 3: Health Insurance: The Major Players

Part 3 introduces the cast of characters in the drama of the American health insurance market—buyers, sellers, agents, providers, legislators, regulators, and (not least) the public. No one is a bystander. As the rest of the guide describes insurance reforms and reform strategies, Part 3 serves as a reminder of the intricate political calculus involved in creating significant change.

PART 4: Health Insurance Reform

Reform is what happens (or is attempted) when the market does not produce the most desirable results. Defining what is “desirable” is essentially a political exercise, and the various definitions—efficiency of the market, retaining insurers in the market, maximizing the number of people with insurance—are sometimes contradictory. Furthermore, since states make most insurance rules, choices concerning reform differ across the country.

Part 4 of this guide first presents the basic menu of reforms that states (and, in limited cases, the federal government) have enacted over the past decade or so. These reforms basically fall into three categories:

- *Benefits*: to guarantee that people who have insurance receive a minimum set of benefits;
- *Availability*: to increase the likelihood that insurance products are available to anyone who wants to purchase them; and
- *Affordability*: to manage the cost of insurance so that more of those who would like to have insurance can pay for it.

Following general descriptions of the various approaches within each category, Part 4 continues with a presentation of case studies of reforms in six states. Each state's effort was distinctive in terms of its goals, target population, features, and impacts. The six stories taken together comprise a broad survey of states' strategies to improve the health insurance market along at least one of the dimensions of benefits, availability, and affordability.

Part 5: Lessons for Advocates

Alice's adventure in Insuranceland notwithstanding, the American health insurance market is a reality, not a fantasy, and a complicated one at that. It is an imperfect way to finance health care, but it is not likely to disappear in the foreseeable future. With that as a starting point, Part 5 of the guide presents to community advocates thirteen important lessons garnered from the reform efforts of the past decade.

Lessons learned in the last campaign might be applied in the next. Insurance reform is not always the smoothest road to expanded access; in fact, the road might not go there at all. On the other hand, trying to tweak the insurance market is not always a dead end and might be, depending on circumstances, the most promising way to win access to health care for greater numbers of people. These lessons offer advocates some ideas for strategic consideration.

This guide only scratches the surface of insurance theory, the market, and the role of reform. Our intent is to ground readers in some basic concepts and policy approaches so that they may apply this context to their health advocacy work. For those who get hooked, however, the authors will be happy to recommend further reading!

INTRODUCTION

“Health insurance.” Two words that conjure up dread and even anger in the average U.S. consumer. We have a love–hate relationship with our health insurance, if we’re lucky enough to have it. On the one hand, health insurance is a vitally important type of financial protection and security for us. On the other hand, it’s complicated, confusing, ever-increasing in cost, and, particularly in these days of managed care, imposes considerable burdens on us in terms of approvals and paperwork. Plus, it often does not cover the care we need. As an industry, health insurers rank only slightly above tobacco companies in public opinion.

Many issues of health care access are intertwined with issues of health insurance. Health insurance matters. In fact, living without health insurance is a serious health risk.

People without insurance receive less care and have worse health outcomes. Compared with insured people, the uninsured:

- Are less likely to have a regular source of medical care and more likely to report delays in getting health care.
- Are much less likely to see a doctor or receive hospital services.
- Are far more likely to postpone seeking care because they cannot afford it.
- Are more likely to have conditions that can be detected and treated with regular primary care (e.g., hypertension, cervical cancer, and breast cancer) and less likely to survive the conditions.
- Are more likely to have avoidable hospitalization.

- Tend to be diagnosed at later stages of life-threatening illnesses.
- Suffer higher overall mortality rates.¹

But just what is health insurance? Why has it become central to the financing of health care in the United States? How did the private health insurance system get to be so complicated? What are the central characteristics of private health insurance markets? What are these markets good and not good at achieving? Are there ways to make the private health insurance system work better for consumers? Have recent efforts at health insurance reform been successful at making health insurance more accessible? More affordable? What should advocates know about health insurance markets in order to assess where and when changing them would be an effective strategy for improving access, and what should those changes be? Or is insurance reform doomed to failure, and should we instead focus our efforts on working to replace our private health insurance system with something better?

This guide attempts to answer these questions. It serves as a primer on health insurance and related public policy for the relatively uninitiated, with the intent of helping advocates realistically appreciate the challenges in changing the current system. Our goal is to help groups working to improve access determine whether health insurance reform is a realistic strategic option for meeting their goals.

¹ See, for example, J. Ayanian, et al., "The Relation Between Health Insurance Coverage and Clinical Outcomes among Women with Breast Cancer." *New England Journal of Medicine* 329:5, 326–331; J. Ayanian, et al., "Unmet Health Needs of Uninsured Adults in the United States." *Journal of the American Medical Association* 284:16, 2061–2069; P. Braveman, et al., "Adverse Outcomes and Lack of Health Insurance among Newborns in an Eight-County Area of California." *New England Journal of Medicine* 321, 508–512; E. Ford, et al., "Health Insurance and Cardiovascular Disease Risk Factors among 50–64 Year-Old Women: Findings from the Third National Health and Nutrition Examination Survey." *Journal of Women's Health* 7:8, 997–1006; J. Hadley, et al., "Comparison of Uninsured and Privately Insured Hospital Patients." *Journal of the American Medical Association*, 265:3, 374–379; C. Hoffman and A. Shlobohm, *Uninsured in America: A Chart Book*, The Kaiser Commission on Medicaid and the Uninsured, Second Edition (May 2000); P. Newacheck, et al., "Health Insurance and Access to Primary Care for Children." *New England Journal of Medicine* 338:8, 513–519; J. Weissman, et al., "Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland." *Journal of the American Medical Association* 268:17, 2388–2394.

So, Just What Is Insurance? And What in the World Does It Have to Do with Health Care?

Insurance as Organized Generosity

Although health insurers are often disparaged, it is important to remember that health insurance meets real social and economic needs: illness, the high costs of medical care, and an unequal distribution of income and wealth. Because of these problems, we have the need to share health care costs collectively in order to finance our health care system, reduce the financial vulnerability of all of us, and attain better health outcomes as a society. Whether we do this through public social insurance mechanisms, through private insurance, or both, insurance is a form of collective generosity by all of us. Just imagine what it would mean to have to pay for all of your medical expenses on an out-of-pocket basis!

What Is Insurance?

People buy insurance to guard against risk in the face of uncertainty. Insurance provides financial protection against the cost of an event: a car accident, a fire in your home, becoming disabled, needing hospital care. The type of event that is most appropriate for insurance is one that cannot be predicted and which average people could not afford to pay for out of their own pockets if it occurred. The unpredictability of the event makes it difficult to plan for these expenses, and the cost of the event makes it impossible to save for, even if it could be predicted.

In order to have a market for insurance, there need to be people who want to buy insurance and an entity—an insurer—that wants to sell it. From the buyer's perspective, consumers must be willing to sacrifice a certain premium to insure against the probability of a considerably larger loss. Insurance operates by risk pooling and the law of large numbers. In other words,

although the risk of an event occurring may be highly unpredictable for any one person, and financially costly if it does occur, if risks can be pooled across a large enough group of people, the cost becomes fairly predictable. And the cost for any one person becomes more affordable.

“The Ideal Insurable Event”

From the seller's perspective, an insurer would ideally like to sell coverage only for events that have certain characteristics:

- *Rare*: if an event is rare, it is harder to predict for any one individual, and it is easier and cheaper for an insurer to spread the expected cost of the event broadly across a group of insured people.
- *Very costly*: if the event is very costly when it occurs, it increases the willingness of people to buy insurance coverage.
- *Homogeneous*: this means that the event happens with a similar probability and at a similar cost to people with identifiable characteristics. This helps make the cost and expected return from purchasing insurance similar for some group of people. For example, it might be hard to sell earthquake insurance at the same cost to residents of San Francisco and New Orleans. Within the group of people living in New Orleans, some very risk-averse individuals may be willing to pay for earthquake insurance, even though they might not use it. But *among* different groups, people in New Orleans have no economic incentive to voluntarily pay premiums that subsidize people in San Francisco, who have a much higher probability of having an earthquake.
- *Unpredictable for the insured*: the more uncertain and fortuitous an event, particularly when it is extremely expensive, the more likely people will be interested in buying insurance protection. In addition, the unpredictability of the event makes it more likely that a range of people will buy coverage, not just people who think they are at risk of needing the coverage.
- *Predictable for the insurer*: predictability for the insurer ensures that adequate premiums can be charged to cover losses when they occur. Insurers do not need to know who, on an individual basis, will have claims (although they'd like to if this information could be collected!). But they need to be able to rely on the law of large numbers to ensure that their experience and costs for an entire insured population will be predictable.

Is Health Care an Ideal Insurable Event?

The simple answer is: yes and no. Certainly many types of medical care meet these criteria: emergency care, most hospitalization, many physician services. But many types of health care are predictable and relatively low cost: preventive care, many office visits, certain types of lab tests, routine dental visits. In addition, many individuals, because of their personal characteristics or behavior, are at much higher risk for certain types of medical problems (e.g., smokers, people who are overweight, white women for osteoporosis).

The fact that the need and use of medical care is often not an ideal insurable event gives rise to a number of important problems in health care insurance systems, particularly in the United States where the private health insurance system is largely a voluntary one (i.e., we do not require individuals or employers to buy health insurance).

- *Moral hazard*: This odd phrase refers to the fact that people will tend to use more of certain types of medical care when they are insured than when they don't have insurance. This is because the additional cost (or marginal cost in economic terms) of consuming more services decreases with insurance. For example, I am more likely to go to the doctor for a minor ailment if I am insured and have a relatively low out-of-pocket cost, than if I have to pay the full fee myself. Of course, moral hazard does not apply to all types of services. The fact that I have insurance, for example, does not make it more likely that I seek care when I am in a serious car accident (although it might alter the willingness of some hospitals to care for me and affect the type of care I receive). But, in general, people do consume more care as the care becomes less and less costly to them directly.
- *Provider-induced demand for services*: Insurance can also change the incentives of health care providers, leading them to provide more services to people who have insurance than to those who are uninsured. This problem arises, in part, from an asymmetry of information between consumers and providers. A person who needs health care may have little knowledge of what she or he needs or is buying at the time care is needed. A patient with chest pain is in a poor position to question the necessity or cost of services ordered by his physician. Even in a nonemergency situation, consumers often lack the expertise and experience to evaluate different treatment options (although the increase in question-asking by consumers is one of the greatest medical advances of our time). For these reasons, consumers rely upon providers of care to act as their agents, and to make decisions about the types and amount of medical care they receive. And the presence of insurance has been shown to influence providers in

many situations to provide more services, because the consumer (patient) is shielded from the cost of these services by insurance.

- *Adverse selection:* This refers to the problem of insurers attracting consumers who are sicker and more expensive than the general population (or at least the population the insurer assumed when setting premium rates). This problem occurs because of another asymmetry of information: A potential insured person knows more about her expected health expenditures in the next year than does the insurance company.

This means that consumers who know they will have the need for medical care are much more likely to buy insurance than people who do not anticipate the need for services. (They are also likely to select health plans with broader coverage.) Adverse selection—the tendency of people with greater needs at higher costs to buy insurance—in a voluntary system creates insurance pricing problems. Remember, risk is the primary reason for insurance. However, if lower risks are grouped with higher risks and all consumers pay the same premium, those at lower risk face an unfavorable rate compared to their expected experience and will tend to underinsure—either by foregoing insurance entirely or buying less comprehensive coverage. Conversely, those at higher risk will face a favorable premium and tend to overinsure.

Ways That Insurers Deal with These Issues

In order to stay in business in a voluntary health insurance system, health insurers have developed a variety of mechanisms to deal with these problems. These techniques are usually referred to as “underwriting.”

- *Group insurance:* Employment-based groups rather than individual policies help to deal with asymmetric information and adverse selection. Under group policies, employees usually have fewer choices and insurers have relatively good information about the predicted costs of the entire group, although the expenses for any member of the group are generally not nearly as predictable.
- *Minimum participation requirements:* Insurers impose requirements on employers, particularly small employers, that a certain proportion of the group must be covered by the insurance policy. This requirement can be as large as 100 percent participation in a very small group. Minimum participation rules protect against adverse selection, and a concern that only higher-risk and high-cost individuals might choose insurance if the choice is voluntary.
- *Minimum contribution policies:* It's common for insurers to require that an employer contribute a certain percentage of the premium—

usually at least 50 percent—toward the cost of group health insurance. This rule applies to both small and large employers. Again, the insurer is concerned about adverse selection. If employees must pay the entire premium, the tendency will be for those group members who need the insurance most to be the most willing to participate in the insurance plan.

- *Medical screening*: Insurers request information about a consumer's medical history in order to minimize adverse selection, as well as to use in developing premium rates that are homogeneous for people with similar risk characteristics. Ideally an insurer would like to be able to base its underwriting and rating practices on any factor that helps predict an individual or group's future health care costs. From an actuarial standpoint, many factors are predictive: age, gender, race, ethnicity, education level, geography, industry or occupation, health status, and medical history. In the past, insurers have been given broad discretion to use most of these factors in making underwriting and rating decisions.
- *Cost-sharing for consumers*: The use of deductibles, coinsurance, and copayments is designed to reduce moral hazard by requiring the insured person to bear at least some of the cost of the medical care he or she receives.
- *Benefit limitations/exclusions*: When health insurers are particularly worried about the possibility of adverse selection and/or moral hazard and/or provider-induced demand, they limit or exclude benefits for certain services. Some of these exclusions can be quite subtle in their purpose. For example, glucose testing supplies and many types of assistive equipment (e.g., wheelchairs) are often excluded in health insurance policies, although they are not particularly expensive. The intent of the insurer in many of these instances is not to avoid the cost of the excluded services themselves, but to provide protection against the cost of other medical care that might be required by individuals with diabetes or who use assistive equipment.
- *Waiting periods*: Some insurance policies impose waiting periods for coverage (e.g., care for nonemergency conditions is not covered for the first six months of the policy). These provisions protect the insurer, at least during the waiting period, from the cost of providing care for preexisting conditions, but are not as onerous to the consumer as outright exclusions.
- *Financial risk-sharing with providers*: Shifting risk from insurers to providers is a relatively new method of dealing with provider-induced demand. Under traditional fee-for-service payment methods, providers earned more money when they provided more services. Under financial risk-sharing payment methods, such as capitation, providers earn more money by providing fewer services. Although

there is a great deal of concern among advocates, providers, and the public about the potential negative effects of capitation on quality of care, when used wisely capitation can be one means of creating systems of care that are more patient-focused.

The Social Transformation of the Insurable Event

Health insurance has evolved over the years to reflect certain social, political, and economic trends. Insurance products have moved from covering rare, unpredictable events to, in many cases, covering most medical expenses. Sometimes these changes have occurred with the assent of the insurers; in other cases government has dictated them. Many of the insured services we take for granted today were in the past viewed as uninsurable by insurers. These include:

Maternity care: Pregnancy was regarded by insurers as a predictable, planned, and budgetable life event, one that was not appropriate to be covered by health insurance. Although many group purchasers began to include maternity care in their health plans in the 1950s and 1960s, it was not until the passage of federal and state laws in the 1970s and early 1980s that it became illegal to exclude maternity coverage in health insurance policies.

Dental care: Very little dental insurance was available until the 1980s. Insurers were slow to offer dental coverage because they believed dental services were relatively low cost and common and that only people with higher-than-average dental needs would be willing to purchase insurance. While employer interest in offering dental insurance as a fringe benefit overcame the concern of insurers about the appropriateness of using prepayment to finance dental care, the concern about adverse selection remains. As a result, it is impossible to purchase dental coverage on an individual basis and very difficult to find coverage for small employers.

We Want to Encourage Healthy Behavior, Right?

Insurance companies often consider weight, smoking, and age when assessing the health of potential policyholders and setting premium rates. But how much discretion should insurers, and group purchasers, have to consider other factors when making underwriting, rating, and payment decisions? Consider some examples of health insurance policies that have been adopted or proposed by some employers:

- Lower premiums for vegetarians
- Reduced coverage for substance abuse treatment when illegal drugs are involved
- Reducing maternity benefits for women who do not receive prenatal care in the first trimester of pregnancy and ineligibility of the baby for coverage in the first year of life
- Exclusion of coverage for people involved in accidents in which they were drunk, not wearing a seatbelt, or not wearing a bicycle or motorcycle helmet

The Historical Accident of the U.S. Health Insurance System: From Calamity Comes . . . More Calamity?

Most countries use insurance as a way to finance health care. But the United States is unusual in relying primarily on a voluntary, private health insurance system. In contrast, most other countries have mandatory social insurance systems that provide universal coverage and are financed by taxes and/or, in some cases, mandatory employer contributions.

The fact that we have an employment-based, private health insurance system in the United States is, in many ways, an historical accident. There are examples of health insurance in the United States that date back to the late 19th century. But the real impetus for the growth of coverage was the Depression of the 1930s, which created financial problems for many hospitals whose patients could not afford to pay their bills. In 1929, at Baylor University Hospital in Dallas, Texas, a hospital insurance plan was started for schoolteachers, at a premium rate of 50 cents per month for 21 days of hospitalization. For the hospital, the plan offered a mechanism for reducing bad debts and stabilizing cash flow. For Dallas schoolteachers, the plan provided a way to ease the financial strain that unexpected hospitalization (which was usually accompanied by a large bill as well as a period of unemployment) usually inflicted on the family pocketbook. The prepayment scheme caught on rapidly during the depression years as hospital associations in several states signed prepaid hospital care contracts with groups of employees. It wasn't long before physicians, who suffered from bad debts just as hospitals did, realized that prepayment could enhance their financial security as well. These early prepaid health plans became the prototype for the Blue Cross Blue Shield system.

The growth of our employment-based health insurance system was the product of another major calamity: World War II. During World War II, employers were subject to wage and price controls and were unable to compete for scarce workers by giving wage increases. But they were permitted to offer fringe benefits. Companies looking for workers began to offer health insurance to employees. After the war, unions continued this trend by negotiating for health insurance benefits. Federal tax policy also helped fuel the growth of employer-based health insurance in two ways: by treating employer premium payments as a tax-deductible business expense, and by not treating the health insurance fringe benefit as taxable income to the employee. This federal subsidy of employer-based health insurance is enormous, representing lost tax revenue of approximately \$100 billion per year.

The Halcyon Days of Health Insurance: The Demise of Community Rating

In the early days of health insurance, Blue Cross Blue Shield plans established premium rates using a method called “community rating.” This meant that Blue Cross charged the same premium to each policyholder, regardless of age, gender, health status, or any other characteristic. In the 1950s, commercial insurers (private, for-profit companies) began to offer health coverage to employers using a different rating technique, called “experience rating.” Under experience rating, the premium paid by an employer was based, at least in part, on the characteristics of the company (e.g., age and gender composition, industry), as well as the company's actual medical costs. The profound impact this change had on the health insurance market can be demonstrated by considering a simple example:

Blue Cross Blue Shield insures three groups:

- The Vitality Company, whose workers are young and healthy and have health care costs of \$50 per month.
- Modern Maturity Company, whose workers are older but healthy and have health care costs of \$160 per month.
- Ailing Asbestos, Inc., whose workers have high rates of asbestosis and other chronic health problems and health care costs of \$240 per month.

Blue Cross uses community rating and charges each group \$150 per month per employee, the simple average of the three companies' costs. This results not only in a subsidy of people who become ill by those who remain healthy, but also in a significant subsidy of the asbestos workers by the workers at Vitality Company.

Now the Frontier Insurance Company, which sets its rates based on the experience of each employer, comes to town. What happens?

First, Frontier offers a lower premium—anywhere between \$50 and \$150—to the Vitality Company. (How much lower the new premium is depends on whether Frontier faces other competition and how profitable it hopes to be.) If Vitality leaves Blue Cross, the premium rate for the two remaining groups increases to \$200 per month. This creates an opportunity for Frontier to lure Modern Maturity by offering a lower premium—anywhere between \$160 and \$199. If this happens, Ailing Asbestos, Inc. will have to pay \$240 per month, which could make it unaffordable for the company to continue to provide insurance.

This exact scenario occurred in the 1950s, as commercial insurers used experience rating to market to desirable employers, leaving Blue Cross Blue Shield plans with higher-cost, higher-risk patients. In response, Blue Cross plans across the country were forced to abandon community rating and switch to experience rating. This change made older and sicker groups, such as the elderly and those with chronic illnesses, and those with lower incomes, less and less able to afford health insurance, and was a major factor leading to the enactment of Medicare and Medicaid.

While experience rating works to the advantage of younger, healthier groups, it is far less redistributive than community rating. But community rating cannot work as a rating method unless *all* health insurers are required to use it. But the policy challenge is this: Any requirements imposed on insurers to switch from experience to community rating will decrease premiums for some but increase premiums for others—those whose demographic and cost characteristics give them advantageous premiums under experience rating. These groups will not eagerly or voluntarily give up the advantages of experience rating to subsidize groups of sicker people.

Advantages and Disadvantages of Using an Insurance Model for Financing Health Care

The health insurance program of a country reflects its cultural beliefs, political priorities and power, and medical imperatives. The voluntary, private health insurance system in the United States has been shaped by a number of cultural, political, and social factors, including:

- A deep belief in individual responsibility and control
- Distrust of government
- Faith in competition and the market
- Faith in technology
- The power and influence of interest groups (e.g., the AMA, insurance companies, employers)
- Professionalism and self-regulation of providers

Although our private, pluralistic health insurance system is consistent with many of our country's deeply held values, it's sometimes hard to figure out much else to recommend it! Certainly insurance offers many advantages compared with out-of-pocket payments, including risk pooling and, for most privately insured people, the advantages of group purchasing. Many proponents of private health plans contend that insurers are more innovative, and point in particular to some of the recent quality measurement and management initiatives adopted by managed care plans (e.g., the Healthplan Employer Data and Information Set²), as well as developments in information technology.

There are, however, a number of disadvantages of using a competitive, voluntary private insurance model as the major means of financing health services. Most of these problems arise not because health insurers are evil or individuals are irresponsible, but because there are certain rational and predictable responses to the incentives created by market forces. Insurers

² The Healthplan Employer Data and Information Set (HEDIS) is a set of performance measures developed by the National Committee for Quality Assurance (NCQA) and used by employers and other group purchasers to assess the performance of managed care plans. For more information about HEDIS, visit the NCQA website at www.ncqa.org.

need to make money to remain in business, and will act strategically to do so, even if the results run counter to social goals. Among the major problems that arise in competitive health insurance markets are:

- *Competition based on risk selection:* It is always easier for health plans to achieve lower costs and lower premiums by attempting to identify and avoid the relatively small proportion of the population that accounts for most medical expenses, rather than finding ways to improve the delivery of care.
- *Decisions not to insure:* In a voluntary insurance system, some individuals will make the decision to forego insurance. Sometimes, the decision is based on affordability—buying health insurance is simply too expensive. For others, health insurance is affordable, but the individual decides not to purchase it, choosing instead to rely on good health, luck, or the expectation that there will be other ways to finance services if needed (e.g., charity care, relatives). For many of the uninsured, the decision not to purchase coverage, while contrary to the collective interest, is rational from the standpoint of individual economic self-interest: the expected benefit from purchasing insurance is less than the cost of coverage. However, this choice drives up the cost of coverage for those who are insured and ultimately imposes at least some of the cost of care for the uninsured on those who are insured.
- *Different power, different premiums:* In a private market system, purchasers with greater bargaining power pay lower premiums. For example, health insurance rates are usually lower for larger groups than smaller groups, and highest of all for people who must buy coverage in the individual health insurance market. While some of these premium differences result from real differences in the cost of serving different market segments, often the powerless subsidize the powerful regardless of actual costs or ability to pay.
- *Administrative costs and complexity:* One byproduct of our private health insurance system is tremendously high administrative costs compared with those of health financing systems in other countries or even of the public payers in the United States, including Medicare and Medicaid. Depending on the health plan, somewhere between 10 percent and 30 percent of private health insurance premiums in the United States are used for administrative expenses, compared to less than 5 percent for the federal Medicare program. And this figure does not include the growing administrative expense being imposed on providers of health care by managed care plans. Some time close your eyes and imagine how much health care (or education, housing, or the health-enriching service of your choice) we could buy with the resources we spend on marketing, underwriting, rating, and otherwise administering the U.S. private health insurance system.

Shifting Responsibilities: MSAs and Defined Contribution Plans

MSAs: Medical Savings Accounts (MSAs) allow people to set aside tax-deductible savings to pay routine medical bills. Account holders purchase companion health insurance policies with very high deductibles, as protection against very expensive, catastrophic care, but these policies are much less expensive than more comprehensive health insurance coverage. Any money in the MSA that is not used for medical expenses can be rolled over and accumulate for retirement.

Depending on whom you talk to, MSAs are the solution to the problem of the uninsured or just another tax shelter for the wealthy. Proponents of MSAs believe that MSAs are a way to provide low-cost health coverage to millions of uninsured people. Opponents say the accounts merely siphon off the healthiest people from traditional health plans, making insurance less affordable for those who need it most.

In 1997, Congress allowed MSA contributions to be tax deductible for self-employed people and small businesses on a pilot basis in order to determine if this would encourage their growth. Although the federal law permitted up to 750,000 people to be enrolled in the pilot program, fewer than 45,000 people had MSAs as of year-end 1999. About one-fourth of those people were previously uninsured, according to the Internal Revenue Service. There is a debate in the Congress about whether the MSA pilot should be expanded by raising the amount of the contribution that is tax deductible (currently limited to about \$1,500 for an individual and \$3,400 for a family) or declared a failure and eliminated.

Defined Contribution Plans: With health insurance premiums continuing to rise, employers are always looking for ways to moderate their costs. One of the latest trends is for employers to change the nature of their contribution to health coverage from the current method of “defined benefit” to an approach called “defined contribution.” In a defined benefit approach, the employer offers employees the choice of one or more health plans and pays some or all of the cost of the plan selected. The employer’s cost of coverage may vary depending on the option chosen by an employee (e.g., if the employer contributes 80 percent of the cost of the plan selected, its contribution is higher for higher-priced plans). In a defined contribution approach, the employer sets an annual amount that it will contribute to health insurance coverage (e.g., \$2,500), which does not vary depending on the coverage chosen by the employee. Employees use the amount to purchase a health plan, from among the options offered by the employer. If employees want more comprehensive coverage than they can buy with the employer’s contribution, they pay the difference themselves. If they buy less comprehensive coverage, they can use the amount left over to purchase other benefits, like dental insurance or disability coverage. In the most extreme form of defined contribution, the employer does not even offer health coverage at all, but leaves it to the employees to find their own health plan, using the employer’s contribution to pay for at least some of the cost (the so-called “medical voucher” approach).

The advantage for the employer is that it can predict and limit its costs under a defined contribution approach much more easily than under the traditional defined benefit scheme. Although defined contribution is not common, many observers believe it will become the method used by most employers to finance health coverage over the next decade. But many advocates are concerned about this possibility, fearing it will simply become a way for employers to shift more of the costs of health insurance onto their employees, and leave consumers—particularly those with serious health problems—adrift in the confusing world of health coverage, with not nearly enough information or bargaining power to find affordable, quality health insurance.

A Typology of the Health Insurance Market

The Different Types of Health Insurance: One Size Does Not Fit All

There are a number of different types of health insurance coverage. These include:

- *Medical plans:* This coverage is the most common type of health insurance, providing protection for catastrophic expenses such as hospital and surgical care, ancillary services such as laboratory tests and radiology, and, increasingly, other types of care, such as office visits, immunizations, and well-child care.

Most types of group and individual medical plans now include at least some elements of “managed care.” Although there is no universal definition of managed care, and managed care plans vary dramatically (leading to the adage, “if you’ve seen one managed care plan, you’ve seen one managed care plan”), there are a number of features common to most types of managed care:

- “networks” of contracting, or participating, providers
 - financial incentives, or requirements, to use providers in the network for most medical care
 - medical management programs, including the use of primary care providers as “gatekeepers” who must approve referrals to specialists, preapproval of hospital admissions, and case management programs for patients with certain chronic and/or expensive conditions.
- *Medigap insurance:* This type of insurance supplements the federal Medicare program. Although Medicare covers a large portion of medical expenses, Medicare beneficiaries are still exposed to substantial out-of-pocket costs. Medicare itself has significant premiums, copayments, coinsurance, and deductibles. In addition, Medicare does not

cover certain important services, such as prescription drugs. Medigap protects individuals against some or most of these expenses. Medigap coverage is available from commercial insurers and Blue Cross Blue Shield plans, as well as from some managed care plans.

- *Dental insurance:* Insurance for dental expenses was not generally available until the 1970s, and is still offered only on a group basis. Most plans have three levels of benefits: comprehensive coverage for routine preventive services; coverage for restorative services after an annual deductible and with some patient coinsurance; and much more limited coverage for services such as crowns, inlays, and prosthetics. Unlike most medical plans, dental plans are also usually restrictive in terms of annual limits on benefits (e.g., a cap on coverage of \$1,000 per year).
- *Long-term care insurance:* Long-term care insurance is designed to pay for those services required due to a chronic illness or condition lasting a prolonged period of time. Long-term care services are typically provided in a nursing home or at home, although they may be provided in an assisted living facility or adult day care center. These services differ from traditional medical care because they help a person to maintain her or his level of functioning, as opposed to acute care services that are designed to rehabilitate or cure certain medical problems. Currently, private long-term care insurance pays for less than 5 percent of all long-term care expenses, but there is growing interest among employers and individuals in this type of coverage. Policymakers on the federal and state level are attempting to stimulate the purchase of long-term care insurance policies by permitting premiums to be tax deductible and by liberalizing eligibility for Medicaid for individuals who purchase long-term care coverage.

The Different Segments of the Private Health Insurance Market: Caviar for Some and for Others, Just Fish Eggs

- *Large group:* Most large employers (over 90 percent) provide health insurance to their workers. The majority of these companies (about 53 percent) still offer a choice of health plans, although almost all plans these days are some variation of managed care. It has become common for large employers to offer self-funded rather than insured plans, which means that the employer rather than an insurance company assumes the risk for medical costs. (As discussed below, the trend to self-funding has major implications for state-level health reform efforts.) It is unusual to have any type of individual medical underwriting or health screening in large group health plans because the size of the group itself provides health insurers with protection against adverse selection (although large groups vary significantly in terms of their

average health care costs—consider, for example, the difference in medical costs between a group of coal miners and a group of 20-something computer programmers).

- **Small group:** Almost half of small businesses do not offer health coverage to their workers. In fact, 40 percent of people who are uninsured work for firms with 25 or fewer employees, and more than 40 percent of workers in small businesses are uninsured. Employees of small businesses that do not offer insurance have a much higher proportion of low-wage workers than those that do offer coverage. Research consistently shows that the major barrier to small employers offering health insurance is cost.

In small companies that do offer health insurance, there is generally no choice of plan. Although managed care penetration among small businesses is lower than in the large employer market, the proportion of small firms offering managed care plans is increasing rapidly.

In the past, health insurers used a wide range of restrictive underwriting and rating practices in the small employer market. These practices were adopted by health insurers because of a number of potentially problematic characteristics of small employers compared to large employers, including:

- adverse selection (small businesses that buy health insurance are more likely to be in high-risk businesses and/or to have owners or workers with higher than average medical care costs)
- less ability to spread costs broadly because of the size of the group
- higher employer turnover (small businesses frequently move their coverage from one insurer to another in response to premium changes)
- higher administrative costs

Many of the health insurance reform initiatives that have been adopted at the state and federal level have focused on the small group market. As a result, the underwriting and rating rules with which health insurers must comply are radically different in most states than they were a decade ago. These reforms are discussed in more detail in Part 4.

- **Individual/nongroup:** Approximately 10 percent of insured people purchase their health coverage directly from a health insurance company rather than as a member of a group. The importance of this individual, or nongroup, market is growing as more and more people work for employers that do not provide coverage, or are not eligible for group plans because they work on a part-time or contract basis or are self-employed.

There are great problems with the availability and affordability of coverage in the individual market, although recent reforms on the federal level and in a number of states have limited somewhat the ability of health insurers to engage in some of the rating and underwriting practices that were common in the past. Still, medical underwriting is common in the individual market, as is the practice of basing premium rates on age. Although the growth of managed care products in some markets has increased the affordability of coverage, people who rely on individual health insurance often encounter significant barriers to access, generally have a limited choice of plan, may be unable to find comprehensive benefits, and almost always pay much higher premiums than group purchasers for comparable, or even less generous, coverage.

ERISA: An Afterthought That Has Become a Major Roadblock to Reform

The federal Employment Retirement Income Security Act (ERISA), enacted in 1974, was a law designed primarily to address abuses in the oversight of pension plans, not to regulate health insurance. However, in the last twenty-five years, ERISA has come to have a profound effect on the structure and regulation of health plans and has also become a major barrier to the ability of states to pursue certain strategies to reduce the number of people without health insurance.

- *What is ERISA?* ERISA is a federal law that applies to all private employee pension, health, and other benefit plans, and to benefit plans offered to federal employees.
- *Why is ERISA important?* ERISA exempts “self-insured” (also called “self-funded”) health plans from state laws, including state insurance laws. This means that there is a largely unregulated sector of group health coverage.
- *What is a self-insured plan?* A self-insured plan is one in which the financial risk for medical costs is assumed by the employer rather than an insurance company. Self-funded employers usually contract with an insurance company or other administrator for administrative services only.
- *How does ERISA work?* In legalese, ERISA has a “3-tier structure”:
 1. ERISA preempts “any and all state laws” that “relate to any employee benefit plan.” Health plans are an employee benefit plan.
 2. ERISA includes a “savings clause,” which protects state insurance laws from preemption. Because of this clause, states can regulate health insurance companies and the plans they sell.

3. Although self-funded plans function, for the consumer, in the same way as insured health plans, ERISA says specifically that self-funded plans *are not insurance* plans, and are, therefore, preempted from state insurance laws.

The effect of these ERISA provisions is that states can still regulate employer health plans as long as those plans are insured by an insurance company and are not self-funded.

- *What are the advantages of self-funding health coverage for employers?* There are a number of reasons why employers adopt self-funding, including:
 - avoidance of certain administrative charges paid to insurers
 - exemption from state premium taxes
 - avoidance of state-mandated benefit requirements
 - for multistate employers, the ability to have one uniform health plan regardless of the insurance laws of each state in which the employer operates
- *How many people are covered by ERISA plans?* About 75 percent of people who have health coverage are covered by plans that are subject to ERISA. These include private-sector employees in insured and self-funded plans, and federal employees. The major categories of health coverage that are not subject to ERISA are individual policies and the plans offered by state and local governments. *NOTE: Not all ERISA plans are self-insured, so the preemption of state laws does not affect all health plans regulated by ERISA.*
- *How many of these ERISA plans are self-insured?* No one knows exactly. It is estimated that between one-third and one-half of the 123 million people who have employer health coverage are in self-insured plans.
- *What are some of the implications of the ERISA preemption?*
 - *Mandated benefits:* Self-insured firms are not required to comply with the host of mandated insurance benefit provisions enacted by virtually every state legislature.
 - *State continuation-of-coverage protections:* Many states have adopted laws that give rights to continue eligibility for group health insurance coverage to certain classes of people who would otherwise be ineligible (e.g., laid-off workers, divorced spouses). These laws do not apply to self-funded health plans. Although federal law includes continuation requirements for self-funded plans, the protections available under state law that apply to insured plans are sometimes broader.
 - *State mandates on employers to provide and/or pay for health insurance:* ERISA makes it impossible for states to address the problem of the uninsured by requiring employers to offer or pay for health care

benefits to their employees. Such mandates would “relate to” employee benefit plans and, hence, be preempted by ERISA.

- *Assessments on employers to finance care for uninsured people:* Many states operate high-risk pools for uninsured people or have implemented methods to reimburse hospitals for the cost of providing uncompensated care. Most of these approaches are funded, at least in part, by taxes or assessments on health insurance companies. ERISA makes it impossible for states to impose these assessments on self-insured employers directly.
 - *The ability to sue health plans for negligence:* Over the past several decades, the courts have made sweeping interpretations of what laws “relate to” an employee benefit plan. Recently, many courts have found the medical decisions of most types of managed care plans to be decisions of what benefits are available under the plan. These decisions are thus exempted from state law. Unlike malpractice suits, where a successful plaintiff can be awarded punitive damages, including pain and suffering, the only remedy available to consumers under the ERISA law is the value of the benefits denied.
- *What is being done to address the problems created by the ERISA preemption?*
- Congress has become increasingly aware of the severe restrictions that ERISA imposes on the ability of states to regulate health plans in a consistent and equitable fashion. Since elimination of the preemption seems to be politically impossible because of strong opposition from self-funded employers, the federal government has instead become more involved in the oversight of health plans, an area of regulation that has historically been left almost entirely to the states. The most important federal laws that apply to insured and self-funded health plans are:
- The 1986 COBRA law, which grants continued eligibility for group health in the case of certain qualifying events (e.g., job loss, divorce, death of spouse)
 - The 1996 Health Insurance Portability and Accountability Act (HIPAA), which authorized a broad federal role in regulating insured and self-insured health plans, by imposing a variety of guaranteed issue, renewal, and portability requirements on group and individual plans
 - The 1996 and 1998 mental health parity laws
 - Laws prescribing minimum maternity hospital length of stay and breast reconstruction for post-mastectomy patients

Health Insurance: The Major Players

Insurers

Health insurance companies are one of the most powerful, and often reviled, players in the health financing scene. In most states, there are three basic types of insurers: Blue Cross Blue Shield plans; commercial insurance; and independent plans, such as health maintenance organizations (HMOs). (The distinctions among these types of insurers is fading, as Blue Cross Blue Shield plans and commercial insurance companies operate HMOs, and some Blue Cross Blue Shield plans have been acquired by larger, national organizations.) The number and relative importance of each type of insurer varies significantly from state to state. In general, commercial insurers have a dwindling share of the market, and many commercial companies have abandoned health insurance as a product in recent years, due at least in part to insurance market reforms and declining profitability. HMOs have captured a growing share of most markets, although commercial insurance companies now own many of the largest national HMOs. The performance of Blue Cross Blue Shield plans has varied, but these carriers continue to be a major, if not the dominant, insurer in most states.

Purchasers

The term “purchaser” is used to refer to those who buy health coverage. Purchasers include governmental programs like Medicaid and Medicare, self-funded employers (who generally contract with an insurance company or other intermediary to administer their health plan), employers that contract with health carriers on an insured basis, and individuals who purchase coverage directly from health plans. Not all employers are the same, and there are several distinct segments to the employer market in terms of health insurance: small employers (50 or fewer employees), medium-sized

companies (more than 50 but fewer than 300–500 employees), and large employers.

Agents and Brokers (Sometimes Called “Producers”)

Insurance agents and brokers are an extremely powerful, and often overlooked, force in the health insurance market. An agent is considered a representative of an insurance company. Some agents are “captive,” which means they represent only one insurer, while other agents sell for more than one insurance company. A broker is independent and is considered a representative of the insured. Agents and brokers (producers) play a particularly important role in the individual and small employer markets. (In contrast, larger employers often use benefit consultants, who do not sell insurance but provide technical assistance and advice to the employer.) Producers are generally paid on a commission basis, based on a proportion of the value of the premiums for the business they sell.

Providers

Since private health insurance is a major source of revenue for most health care providers, the practices and policies of health insurers have major implications for physicians, hospitals, and other providers, as do health insurance reforms.

Regulators

Health insurance has historically been regulated at the state level, which means there is a different regulatory agency in each state responsible for overseeing health insurers, using a unique set of state laws and regulations. However, as noted above, with the growth of self-insured plans the federal government is taking a more active role in regulating health coverage. The incursion of the federal government into health insurance has caused considerable tension with state regulators, who have a long history of independence.

Legislators

Health insurance is a public issue: almost everyone knows something about it and has an opinion on it. It is also a topic that receives considerable media attention. This means that it is on the radar screen of every legislator. However, health insurance is also very arcane and complicated,

particularly from a legislative perspective. So although most legislators care about health coverage, they often don't understand it well.

The Public

The general public has several beliefs about health insurance: it costs too much, it doesn't cover enough, too much money is spent on administrative costs, and like all insurance, it's complicated and boring. But while the public is wary of health insurance in general, studies show that most insured people are quite satisfied with their own health plans.

Health Insurance Reform

Health insurance in the United States has evolved essentially as a private market, with buyers (groups and individuals) and sellers (insurers) voluntarily entering transactions that are presumably advantageous to both parties. Though this evolution has moved away, for economic and social reasons, from what would be considered “pure” insurance, the fundamental character of the market remains.

Examples of Typical Problems Before State Health Insurance Reform

1. Sally, who is seven months pregnant, is covered by the health plan offered by her employer, a small business. She arrives at work one day to discover that her employer, in an effort to maintain insurance that is affordable, has decided to switch to a new insurance carrier at the end of the month. Under the new health plan, Sally’s pregnancy is a preexisting condition and will not be covered.
2. Miguel owns a company that employs twenty people. Six months ago, one of his workers, who is covered by the company’s health plan, had a serious illness, and his total medical bills were \$100,000. The renewal notice from the health plan arrived in today’s mail, and the company’s premium rates are going to increase by nearly 300 percent, from \$490 per month for a family policy to nearly \$2,000, because of “adverse claims experience.”
3. Doug has just started a new public relations and communications company located in a largely gay neighborhood. He has called a dozen insurance companies that operate in his state, looking for health coverage for himself and his three employees, but been told by all of the companies that they do not write business in his zip code.
4. Marian had a routine screening mammogram last year as part of her annual physical; the test results were normal. When she applied for individual health insurance, the company imposed a “preexisting condition” exclusion for “any conditions or diseases relating to her breasts.

The Purpose of Reform

As with most markets, the health insurance market does not always yield the most desirable results when left to its own devices. So, as with many markets, the government—usually the states, but increasingly the federal—has a role in regulating and, when it is perceived to be necessary, “reforming” the health insurance market.

The question of what are the “most desirable results” is slightly more complicated with health insurance than it would be with, say, a consumer product like a toaster. On one level, the government’s interest is the same in either market: to make needed information more available, to give more consumers access to the market, to ensure that sellers of a product all face the same requirements—for example, minimum safety or quality standards. On the other hand, the health insurance market’s commodity is something that many see as having an important societal aspect; health insurance is especially valuable because it is the key to receiving adequate health care, which should be available to all. As essential as a toaster may be, not many would argue as a matter of social policy that everyone should have one.

Insurance market reforms may be built around two general goals: improving the workings of the market, or promoting social equity by increasing the possibility that the uninsured will gain coverage (these goals are not always exclusive of one another). A well-functioning market does not necessarily lead to more people being covered, however. The choices reformers make depend on the perceived shortcomings of the market and the value they place on the two goals. Some reforms may address both of these goals, but most tend to lean more toward one or the other. This section reviews the various types of insurance market reforms that state and federal governments have instituted in the past decade or so. It also includes a number of stories of actual state reforms that illustrate the tension that exists between these two distinct goals and how successful the reforms have been at achieving each goal.

Types of Reforms

There have been many insurance market reforms, at both the state and federal levels, addressing one or both of the goals discussed above. Many of the state reforms in the 1990s focused on the small group (usually 50 members or fewer) and individual markets, where relatively unfettered market conditions led to more and more small employers and individuals unable to find or afford health insurance for their employees and themselves. These reforms, which have had varying levels of success, were intended to

increase the availability of coverage and improve the overall fairness and efficiency of the market.³

The specific provisions of reforms fall into three general categories: benefits, availability and affordability.

Benefits

Benefit mandates do not increase the availability or affordability of insurance for those who do not have it. Rather, they protect people who have coverage from being “underinsured,” as defined (depending on one’s point of view) either by underlying social values about what constitutes adequate access to care, or by the political strength of competing provider and patient groups. Some market-oriented reformers claim that benefit mandates result in higher premiums, which add to the ranks of the uninsured by making coverage unaffordable for some who would otherwise be able to purchase a more economical plan. Evidence of the extent of such an effect is mixed: while adding any benefit necessarily increases the cost of a given health plan, it is not certain that benefit mandates have increased uninsured rates.⁴

Most states require that health insurance policies include certain specified benefits, from the fairly common—breast cancer screening (48 states) and emergency care services (39)—to the rare—experimental treatments (7 states) and infertility treatments (13).⁵ Since insurance regulation has historically been the province of state governments, there are many fewer federal mandates. In the last few years, though, Congress has passed the Mental Health Parity Act of 1996, the Newborns’ and Mothers’ Health Protection Act of 1996 (mandating minimum maternity stays), and the Women’s Health and Cancer Rights Act of 1998 (requiring plans that cover mastectomy to cover reconstructive breast surgery as well).⁶

³ T. Riley and B. Yondorf, *The Flood Tide Forum. Access for the Uninsured: Lessons from 25 Years of State Initiatives*. National Academy for State Health Policy, January 2000.

⁴ One recent study (by Sloan and Conover) used statistical analysis to estimate that the probability of being uninsured rose by 0.4 percent for each state mandate added and extrapolates that finding to suggest that all mandates add 4 percentage points to the percentage of adults who are uninsured. A subsequent literature review (by Jensen and Morrisey) calls this finding “suggestive, not definitive.” F. A. Sloan and C. Conover, “Effects of State Reforms on Health Insurance Coverage of Adults.” *Inquiry* 35:3 (Fall 1998); G. A. Jensen and M. A. Morrisey, “Employer-Sponsored Health Insurance and Mandated Benefits Laws,” *Milbank Quarterly* 77:4 (December 1999).

⁵ Health Policy Tracking Service, *Major Health Care Policies: 50 State Profiles 1999*. National Conference of State Legislatures, 1999.

Benefit mandates have been the object of reforms attempting to make insurance more affordable by allowing insurers to offer “bare bones” products. This is discussed in the Affordability section below.

Availability

■ State reforms

Most of the small group and individual market reforms that states enacted in the 1990s included as their central elements features designed to increase the availability of insurance to willing purchasers.

- *Guaranteed issue*: These provisions require insurers to offer at least one of their products to small groups and individuals, regardless of health status or claims history.
- *Guaranteed renewal*: This requires that insurers renew existing policies regardless of an individual's or group's claims experience.
- *Limitations on preexisting condition exclusions*: These mandate a maximum period that insurers may exclude coverage to an individual for an existing medical condition.
- *Portability*: These provisions require insurers to credit individuals newly enrolled in a coverage plan for preexisting condition exclusion periods already met under other recent coverage.
- *High-risk pools*: Twenty-nine states have established high-risk insurance pools for individuals for whom regular market-based policies are not available.⁷ In practice, this refers to people whose medical conditions make market premiums unaffordable, or who are altogether uninsurable for medical reasons. These pools are used by a limited group of higher-income individuals because of the high premiums that are required. For the most part, state reforms have included either a high-risk pool or guaranteed issue in the individual market, but usually not both.⁸

For example, the Minnesota Comprehensive Health Association is one of the oldest and largest high-risk pools in the country. It was established in 1976 and has about 26,000 enrollees, less than 1 percent of the state's population. The fund offers coverage to anyone who does not have access to coverage in the individual market, for a variety of reasons: those denied due to preexisting conditions or who exhaust COBRA benefits, dependents of employees whose employers do not offer family coverage, or people waiting for employer coverage while fulfilling a probationary employment period, to name a few. Premiums for the fund are about 125 percent of the average premium

⁶ Riley and Yondorf.

⁷ Health Policy Tracking Service.

charged for an equivalent product in the private individual market. In fiscal year 2000, this translated into a monthly premium, for a plan with a \$1,000 deductible, ranging from \$81 for an individual age 15 to 29 up to \$241 for someone age 60 to 64. Medicare supplement plans are also available. Premiums at this level provide only about half of the funds needed to run the program; the remainder comes from an assessment on private insurers. ERISA plans are excluded from the assessment, however, so the funding base has been getting narrower over time. Currently, the fund's operating losses—the excess of claims costs over premiums—amount to about \$50 million per year, or roughly \$2,000 per enrollee.⁹

■ Federal reforms

In addition to these state initiatives, the federal government has also passed some important reforms.

- **HIPAA.** In 1996, Congress passed the Health Insurance Portability and Accountability Act. HIPAA enacted portability provisions and limitations on preexisting condition exclusions for all employer-sponsored health insurance. HIPAA also requires guaranteed issue and renewal for all small group policies and guaranteed renewal for individual policies. As a result, all states now have in place these availability reforms for the small group market which either meet or exceed HIPAA standards. In addition, thirteen states mandate guaranteed issue in the individual market, and thirty-one states have preexisting condition limitations for individuals.¹⁰
- **COBRA.** Prior to passing HIPAA, the federal government's major effort to expand the availability of health insurance coverage was a provision in the Consolidated Omnibus Budget Reconciliation Act ("COBRA") of 1986. COBRA allows for a person to continue group coverage that would otherwise end because of events such as leaving an employer, divorce, or death of a spouse. COBRA gives the former employee the option to keep the same health insurance plan by paying the full cost of the premium plus a 2 percent administration fee—still less, in most cases, than the cost of an equivalent plan in the individual market. COBRA effectively makes group coverage available during transitions in employment.

⁸ Health Policy Tracking Service.

⁹ Minnesota Comprehensive Health Association, *Annual Reports 1997/98 and 1998/99*, and accompanying letter from Lynn R. Gruber, President, dated February 15, 1999.

Affordability

The provisions we have just discussed, which include the most common types of reforms that states passed in the 1990s, seek to ensure that insurance coverage be available to people through the market. This, of course, is a necessary condition of maintaining and expanding coverage in a voluntary market: sellers must be willing to sell. These provisions by themselves, however, do not address what products should cost so that buyers are able to buy. One might even argue that, for these reforms to be viable and fair to insurers, high premiums are almost a necessary byproduct.

Some reforms explicitly address the cost of insurance. Some common approaches have been regulating how insurers set their rates, allowing products with less extensive benefits to be sold, encouraging the formation of large purchasing cooperatives, and providing public subsidies to some for the cost of premiums. These provisions are often part of more comprehensive reforms that also address availability, but they may stand on their own as well.

- ***Community rating.*** This is the requirement that an insurer charge the same rate for a given policy to everyone in the community, regardless of age, health status, or any other characteristic that might predict the use of health care services. Community rating brings an insurance market closer to the model of “organized generosity” as younger, healthier people effectively subsidize the care of their older, less healthy neighbors. Community rating is thus a reform that can make insurance more affordable for people at greater risk of needing health care. The danger is that, because participation in the insurance market is voluntary, people at lower risk may choose not to insure themselves at all rather than pay the relatively higher rates in a community-rated market.

Other rate restrictions include “adjusted” or “modified” community rating, which allows some variation in rates based on age or demographic characteristics, but not the health status or claims experience of an individual or group. “Rating bands” allow variation in rates based on certain characteristics that may include health status and claims experience, so that rates for a particular product could not vary by more than, for example, a ratio of two to one.

- ***Premium subsidies.*** The most direct way for a state government to increase the affordability of insurance is by subsidizing the purchaser of the coverage for some or all of the cost. High-risk pools, for those who cannot obtain coverage in the private market, are an example. A number of states have created other programs that subsidize low-income individuals and families who qualify for coverage but simply cannot afford it. These programs either provide coverage directly to those who

qualify, possibly charging a small premium (in Minnesota, Washington, and Oregon, for example), or assist with premium payments for employer-based coverage (as in Massachusetts). The Massachusetts program also promotes expanded availability of coverage by offering subsidies to small employers with low-income employees.

- *“Bare bones” plans.* These are policies that are exempt from some or all of a state’s benefit mandates, which insurers may therefore offer at lower rates. Many states experimented with allowing bare bones policies during the 1990s, but they were largely unsuccessful in expanding coverage. Relief from mandates did not substantially reduce premiums and plans were sold with very high copayments and deductibles, meaning additional costs for those purchasing the coverage.¹¹
- *Purchasing cooperatives.* These entities combine the purchasing power of their members—usually small employers—to realize the benefits of large group purchasers. Cooperatives, or alliances, are theoretically able to negotiate better rates, provide more choices of plans to employees, and reduce administrative costs. Twenty-eight states currently have laws authorizing cooperatives.¹²

¹⁰ Health Policy Tracking Service.

¹¹ Riley and Yondorf. *Also*, E. D. Kinney, et al., “Three Political Realities in Expanding Coverage for the Working Uninsured: One State’s Experience.” *Health Affairs* (July/August 1999).

HEALTH INSURANCE REFORM STRATEGIES

The preceding section describes the goals that states may have in undertaking insurance reform and some of the policies they might enact to meet those goals. The following case studies present stories of actual reforms in six states. They comprise a broad survey of states' strategies to improve the health insurance market along at least one of the dimensions of benefits, availability, and affordability.

Purchasing Alliances for Small Employers

CASE STUDY

The Health Insurance Plan of California/PAC Advantage

In 1993, California implemented a single, statewide publicly overseen voluntary health insurance purchasing alliance for small employers. This alliance, called The Health Insurance Plan of California (HIPC), was one element of a broader small-group insurance reform law enacted in 1992 that also included market rules on guaranteed issue, guaranteed renewal, limits on preexisting conditions, and rating restrictions.¹³ The goal of the HIPC is to make the advantages of large-group purchasing available to small employers, including offering a wider range of more affordable health plans.

Goal of Reform: To increase coverage among small employers by making coverage more affordable and expanding the choice of plans available.

Target Population: Employers with 2 to 50 employees are eligible to join the HIPC.

Features: The HIPC serves as an intermediary between participating health plans and employers with 2 to 50 employees. It was originally administered by a public agency, the Managed Risk Medical Insurance Board, but management of the HIPC, on behalf of the state, was transferred to the Pacific Business Group on Health, a nonprofit organization. The HIPC is now also referred to as Pacific Health Advantage, or PacAdvantage. One advantage of the HIPC is administrative simplicity for small businesses. The HIPC establishes the benefit package, negotiates with health plans, and collects premiums from participating employers.

¹² Riley and Yondorf.

¹³ The rating restrictions permit variations based on age, family status, and geographic area, as well as a ten percent variation to account for other cost factors not captured by the permissible rating factors (although the HIPC does not permit its participating plans to make the ten percent premium variation). Insurers are also limited in their ability to raise or lower premiums from year to year.

Any employer with 2 to 50 employees is eligible to join the HIPC, regardless of type of business, health of the group, or age of employees. Enrollment occurs directly through the HIPC or through independent insurance agents.¹⁴ Employers must contribute at least 50 percent of the lowest-cost, employee-only plan, and at least 70 percent of a firm's eligible employees must participate (100 percent of eligible employees must participate at firms of two or three employees).

Individual employees of small businesses that belong to the HIPC may select any participating health plan that serves their geographic area. There is an annual open enrollment period, during which individuals may change health plans. As of April 2000, PacAdvantage offered a choice of 15 HMO and 4 Point of Service (POS) products (the number of plans available to enrolled individuals or firms varies by geographic area). The organization also offers dental, vision, chiropractic, and acupuncture coverage. Because the choice of health plan occurs at the employee level, individuals covered by the HIPC often have a broader choice of plan options than do employees of most other small businesses (and of many medium-and large-sized businesses as well).

In order to attempt to minimize the adverse risk selection that could result from permitting individual choice of health plan, the HIPC has implemented a standardized benefit package, with four levels of cost-sharing. It also uses an innovative risk adjustment mechanism that attempts to assess and adjust premiums for risk differences among participating health plans. This risk adjustment process compares certain characteristics (gender, family size, and the types of diagnoses for which plan members received hospital care) of the enrollees in each participating plan to those in the HIPC as a whole. Health plans that have a membership with a significantly higher risk profile based on these factors receive additional funds; plans that have an enrolled population with lower than average risk make payments to a risk transfer pool, which is used to subsidize plans with higher-risk members.¹⁵

Impact: About 10,000 firms and 140,000 individuals were enrolled in the HIPC as of November 2000.

Although the HIPC has become a large intermediary, it appears to have had a modest impact on the number of uninsured individuals in California. Although enrollment has grown steadily since 1993, the HIPC's market share has remained constant at approximately 1 percent of the small group

¹⁴ Several sources indicate that one early barrier to HIPC enrollment growth was that, by paying lower commissions than other intermediaries, the plan failed to establish good relationships with insurance agents and brokers. However, these problems have apparently been rectified.

¹⁵ See S. Shewry, et al., "Risk Adjustment: The Missing Piece of Market Competition." *Health Affairs* (Spring 1996) 171–181, for details on the HIPC risk adjustment process.

market.¹⁶ Most of the firms enrolled in the HIPC were already insured at the time they joined. The premium rates available through the HIPC do not appear to be significantly different from those otherwise available to small employers. In addition, the guaranteed issue and other insurance market reforms enacted at the same time the HIPC was created have also made non-HIPC health plans more widely available. In particular, since these reforms were enacted more HMOs have entered the small group market in California, making a larger number of health plan options and more affordable premiums available to small employers.

One of the major lessons from the HIPC experience seems to be that voluntary small business alliances will not be successful at expanding health insurance coverage among small employers unless they are combined with significant premium subsidies that make coverage much more affordable for small businesses.

¹⁶ California Health Care Foundation, "Health Insurance Purchasing Alliance for Small Firms: Lessons from the California Experience," May 1998, and J. Yergin, et al., "The Health Insurance Plan of California: The First Five Years," *Health Affairs* (September/October 2000) 158+.

Linking the Small Group and Individual Markets

CASE STUDY

Individual Health Insurance Reform in Massachusetts

Massachusetts adopted a health insurance reform law in 1996 that required most health plans operating in the small group market to offer individual health insurance.

Goal of Reform: To increase the availability of health insurance for individual purchasers and reduce competition among insurers based on selective underwriting and marketing.

Target Population: People who purchase health insurance in the individual (or nongroup) market.

Features: Health insurers, including Blue Cross, HMOs, and commercial insurers, are required to offer coverage in the Massachusetts nongroup market if they had 5,000 or more covered lives in the state's small group (50 or fewer lives) market at the end of the prior calendar year. The state has adopted three types of nongroup health plans: medical, preferred provider, and managed care.¹⁷ Each type of plan has standard benefits and cost-sharing requirements, and the three plans are required to be actuarially equivalent. Products must be offered on a guaranteed issue and guaranteed renewable basis, and no medical underwriting or preexisting condition exclusions are permitted. The state has a two-month annual open period for individual insurance, although insurers are required to make coverage available at other times to people who meet certain criteria (e.g., recently moved to the state, lost eligibility for group coverage). Carriers are permitted to vary premium rates based on certain demographic factors (e.g., age, geography) but rate variations for any carrier's product are limited to no more than a 2 to 1 difference between the highest and lowest premium.

Impact: The goals of the law were to increase the number of individual products available, to make benefits more comparable among carriers, to reduce the dispersion in premium rates, and to create a "level playing field" for all nongroup plans. The impetus for the law was the lack of availability of coverage for people with preexisting medical conditions; waiting periods and restrictions on coverage; lack of choice for people with medical problems (prior to the law's passage only Blue Cross Blue Shield was required to offer coverage on a guaranteed issue basis, and it imposed waiting periods of up to three years for preexisting conditions); wide variations in premium rates,

¹⁷ Health insurers were permitted to maintain and renew individual plans that did not meet the standardized benefit plans for a period of no more than three years (so-called closed blocks of business), but could not market these products to new enrollees.

particularly by age; and a general unavailability of managed care products, which had come to dominate the group market.

The Massachusetts law has had mixed results in achieving its objectives. Although opponents of the law predicted a massive exodus of carriers from the small group market if the law were enacted, only a handful of carriers withdrew, with no discernable effect. A greater number of managed care options are being sold in the individual market, although enrollment has been heavily concentrated in just a handful of plans. As of the fall of 2000, there were twenty-one guaranteed issue plans available in the nongroup market, but two of the plans insured more than 90 percent of the individuals with guaranteed issue products, and almost half of the nongroup products had no members at all. Furthermore, enrollment in the individual market was much more concentrated than in the small group market. The two health plans with 90 percent of the individual market insured less than 50 percent of the small group market in Massachusetts, while the other carriers in the nongroup market—with a collective market share of 9 percent of lives covered by guaranteed issue individual plans—insured more than 40 percent of the total covered lives in the small group market.

The major reason for the concentration of individual enrollment is the wide variation in premium rates charged for the guaranteed issue health plans. Although the standard plans are actuarially equivalent, there are significant variations in the premiums being charged by different health plans for the same individual. Depending on age, family size, geographic location, and plan choice, there could be as much as a fivefold difference in the spread in the premium rates for the lowest and highest cost nongroup plans available to a consumer (i.e., the highest-cost plan is five times the cost of the lowest-cost plan).

Not surprisingly, the two health insurers with significant enrollment consistently have the lowest premium rates, while the plans with little or no enrollment have much higher premiums. The Massachusetts law requires regulators to review premiums only if they fall outside two standard deviations of the average rate. Given the great dispersion in rates, the two standard deviation test has proven to be completely ineffectual as a means of ensuring the reasonableness of rates. Instead, most of the health insurers required to participate in the individual market have been able to set premium rates at levels high enough to avoid attracting any significant number of individual policyholders.

In addition, although the reforms have improved the availability of coverage and range of choices available for some people, particularly those in poor health, it has also eliminated certain lower-cost products that previously were attractive to lower-risk individuals, including catastrophic health insurance policies. On balance, the Massachusetts law appears to have had little, if any, effect on the number of uninsured individuals in the state.

Community Rating

CASE STUDY

Small Group and Individual Market Reform in New York

New York has been the only state to include community rating as a component of its reforms of the small group and individual insurance markets. The state enacted its initial reform legislation in 1993, followed by another law in 1995. One of the factors in the passage of the 1993 law was the precarious financial condition of Empire Blue Cross, the largest insurer in the small group and individual health markets and the “insurer of last resort,” meaning Empire was obligated to make coverage available to any person or group that applied. Empire was also required to community rate its products. The company contended that it was disadvantaged in the market by these requirements, which did not apply to commercial carriers, and had experienced adverse selection and rapidly rising medical costs as a result. (Although HMOs were not required to offer products in the individual or small group markets, they were subject to community rating and open enrollment requirements if they voluntarily chose to serve these markets.)

Goal of Reform: To increase the availability of coverage in the individual and small group markets, reduce the variability in premium rates, and create a more equitable competitive environment for health insurers.

Target Populations: Health insurers, and people who purchase coverage in the individual and small group markets.

Features: The state’s initial reform law imposed a range of new requirements on all insurers that chose to sell coverage in the small group (defined originally as groups of 3 to 50 employees) and individual markets, including guarantee issue of any product they chose to sell, open enrollment periods, a mandatory risk-adjustment mechanism that attempts to spread risks evenly among all insurers, and “pure” community rating (i.e., premiums could vary only by family size, benefit design, and geography).

The effect of the 1993 reforms was a dramatic increase in premiums for products offered by commercial insurers and a significant decline in commercial enrollment in both the individual and small group markets. In addition, HMOs, which had offered more generous benefits than commercial insurers, reduced the scope of their benefit packages in an attempt to avoid adverse risk selection, particularly in the area of prescription drug coverage. Empire Blue Cross also decided to discontinue offering indemnity, or non-managed care products, in the individual market, leaving people in this market without any products that provided comprehensive benefits and freedom of choice of provider.

The 1995 amendment was primarily directed at changing the reforms that applied to the individual market, which was widely regarded as problematic. The law requires only HMOs to guarantee issue coverage in the individual market and eliminated commercial indemnity products. Only two standardized HMO and POS plans may be sold to nongroup members. HMOs were also required to sell individual plans if they wanted to do group business in New York.

Impact: Although the reforms may have improved the availability of coverage for individuals with medical problems, in general, the results of the New York experience seem to have been higher premiums, a reduction in the range of benefit packages available, and no reduction in the number of uninsured people. Since Blue Cross and HMO premiums were already community rated, the major initial impact of community rating in New York has been on the premiums of small groups and individuals insured by commercial carriers. For these policyholders, community rating has had varying effects, depending on the age of the group or individual policyholder and the carrier. In general, the cost of coverage for young people has increased significantly compared to rates available when age-rating was permitted, a trend that has been exacerbated by the adoption of standardized benefit packages with considerably less cost-sharing than individual products previously available in the New York market. On the other hand, more affordable coverage from a larger number of carriers is now available for high-risk and older individuals. On balance, however, community rating appears to have had little, if any, effect on reducing the number of uninsured people in New York, although it has also not had many of the dire effects critics of the reforms predicted.¹⁸

¹⁸ Several observers contend that some of the rate shock predicted did not materialize because the state initially kept premium rates in the individual market artificially suppressed by the use of the state's rate review process for HMOs and Blue Cross, which requires a public rate hearing for any proposed increases of more than 10 percent. However, others believe that regulation prevented insurers from using high premiums as a way to avoid enrolling individual members. In 1998, the state used surpluses in the risk-adjustment pool to offset premium increases requested by the two largest individual insurers, in order to avoid huge rate increases for nongroup members. For a discussion of these and other issues, see M. Hall, "An Evaluation of New York's Reform Law." *Journal of Health Politics, Policy and Law*, 25:1 (February 2000) 71–99.

Insurance Market Reform with Premium Subsidies

CASE STUDY

Washington's Basic Health Plan

The state of Washington began the Basic Health Plan (BHP) in 1987 as a pilot program, the first of many initiatives that would follow, to reform the state's insurance market and expand access to health care. In the late 1980s, Washington's Blue Cross Blue Shield was experiencing financial woes,¹⁹ so state policymakers in Washington responded by trying to draw more *buyers*—particularly the low-income, working uninsured—into the individual market.

Goal of Reform: To increase coverage by making insurance more affordable.

Target Population: The BHP offers subsidies to low-income individuals and families (up to 200 percent of the federal poverty level) to purchase private managed care coverage in the individual market. Employers can also offer BHP to their employees, though very few employers have enrolled thus far. An unsubsidized BHP is available to families with incomes over 200 percent of the poverty level.

Features: Insurers offer BHP enrollees a standard benefit package with set levels of coverage and copayments; the state negotiates premium levels, which vary by age, county, and insurer. Children who are in the BHP use Medicaid, if they are eligible, to cover services the BHP excludes.

The BHP subsidy is linked to family income. Everyone (except children eligible for Medicaid) pays a premium of at least \$10 per month (\$20 per family), plus copayments. The subsidy declines as income increases and disappears when income reaches 200 percent of the federal poverty level (about \$2,800 per month for a family of four). The maximum premium that someone age 19 to 39 would pay ranges from about \$54 to \$99 per month, varying by county and health plan. The range for 55- to 64-year-olds is \$118 to \$217.²⁰ Most subsidized BHP members are at the low end of the income spectrum: more than half (about 73,000 people) had family incomes below the poverty level, and nearly three-quarters were below 125 percent of the poverty level. Only about 10 percent of subsidized members had incomes over 150 percent of the poverty level.²¹ That everyone is expected to pay something, that the plans offered are commercial products with private enrollees, and that BHP enrollees include low-income working people from

¹⁹ Riley and Yondorf.

²⁰ Washington Health Care Authority, "How Much Will Basic Health Coverage Cost?" October 1999.

²¹ Washington Health Care Authority, unpublished table, April 2000.

across the political spectrum are all factors in the strong support that the subsidized program enjoys.²²

The level at which the subsidy is set has a clear impact on the number of participants. In 1996, state officials were concerned that enrollment was low and greatly reduced BHP premiums, leading to a near doubling of participation in the program.²³ While the existence of some cost-sharing boosts support for the program, potential participants are very sensitive to the amount they must pay.

Impact: The BHP has been popular since it began. As a pilot in 1987, enrollment was capped at 25,000, a level that was quickly reached. In 1993 the state legislature passed comprehensive reform in the Health Services Act (HSA), much of which was later repealed. The HSA did increase the enrollment cap for the BHP to 100,000, though, and added the unsubsidized component. With subsequent cap increases, enrollment in the subsidized BHP now stands at about 130,000. The program is budgeted to cost the state about \$481 million for subsidized benefits in the 2000-2001 biennium.²⁴

The BHP has not been without its challenges. Employer use of the BHP for purchasing coverage for employees is minimal. Employers have not been attracted to the plan because it is an individual rather than a group product, with different premiums and copayments for different income levels, which makes their participation complicated. The absence of employer contributions to the program has put added fiscal pressure on the state.

The other significant challenge has been in the unsubsidized BHP, which has suffered from extreme adverse selection resulting first in large premium increases and ultimately in most insurers either freezing enrollment in the plan or withdrawing from the individual market altogether. Provisions intended to make coverage more available, such as very short waiting periods that allow someone to enroll for a specific need and then drop out, have been one driver of spiraling costs. Apart from the subsidized BHP, the individual market in Washington has been unstable, and some counties now have no private insurers writing individual policies.

A new law enacted in March 2000 addresses this instability by, among other things, increasing the waiting period for preexisting conditions from three months to nine, and clarifying rules regarding the right to move from one plan to another. In addition, the law guarantees coverage through the state's high-risk pool for those denied private coverage, and expands

²² L. Nichols, L. Ku, S. Norton, and S. Wall, *Health Policy for Low-Income People in Washington*, Urban Institute, 1997.

²³ L. Ku and T. Coughlin, "Sliding Scale Premium Health Insurance Programs: Four States' Experiences." *Inquiry* 36:4 (Winter 1999-2000).

²⁴ Washington Health Care Authority, Annual Report 1999.

eligibility for the BHP up to 250 percent of the federal poverty level. In signing the bill, Governor Gary Locke acknowledged the adverse selection problems in the individual market:

. . . in order for our health insurance system to work, it must be allowed to operate like an insurance system. Our insurers must be allowed to have rules in place that encourage people to sign up for insurance before they need medical care, not after.²⁵

The subsidized BHP has been successful in making coverage more affordable to low-income uninsured individuals, thereby increasing the ranks of the insured. It is an example of a major financial commitment in the public sector to expand private coverage.

²⁵ Health Policy Tracking Service.

Buy-In to Public Program

CASE STUDY

MinnesotaCare

Goal of Reform: To increase the number of people with health insurance.

Target Population: Uninsured, low-income children, parents, and childless adults.

Features: MinnesotaCare uses a Section 1115 Medicaid waiver to extend state-sponsored coverage to families and individuals further up the income scale than would be eligible normally. The expanded coverage is funded by premiums that beneficiaries pay on a sliding scale according to income, and by a 2 percent tax on providers. In effect, MinnesotaCare offers lower income uninsured people the opportunity to “buy into” the state’s Medicaid program.

Children under 21 years old, their parents, and dependent siblings (up to age 25) are eligible for MinnesotaCare until family income reaches 275 percent of the federal poverty level (about \$46,000 for a family of four). Single adults and households without children are eligible up to 175 percent of the poverty level (about \$14,000 for a single adult and just under \$20,000 for a couple). As in Washington State, everyone in MinnesotaCare must pay something. The minimum premium is \$4 per month for children below 150 percent of the poverty level. Premiums for others increase as a portion of income as income rises; the range is from 1.5 percent to 8.8 percent of gross family income.

Expanding coverage is the goal, however, so even enrollees whose incomes rise above program eligibility levels may remain in the program, by paying the full (unsubsidized) premium, for an eighteen-month notice period. Beyond that period, if the cost of coverage through Minnesota’s high-risk pool²⁶ exceeds 10 percent of gross family income, the family may remain in MinnesotaCare, paying the full premium. This demonstrates a policy bias toward promoting affordability, though 10 percent of income is still, to many, a prohibitive cost for health insurance.

Some of MinnesotaCare’s eligibility provisions protect against erosion of the private, employer-based insurance market. Individuals (except low-income children) who have access to employer-sponsored coverage are not eligible

²⁶ The Minnesota Comprehensive Health Association offers coverage to Minnesotans who are unable to purchase insurance in the individual market. The cost is about 25 percent above the average premium for equivalent individual coverage. As an example for determining continuing MinnesotaCare eligibility, the relevant premium for a family of four with two children and parents age 35 to 39 is \$416 per month.

for MinnesotaCare, regardless of their income. In cases where employer coverage is not available because the employer dropped health insurance as a benefit, a person must be without access to coverage for eighteen months. In addition, individuals must be uninsured for at least four months before they can be eligible; again, low-income children are exempt. These provisions discourage employers and employees from dropping coverage in favor of the public program, a phenomenon known as crowd-out. Further, benefit limitations for adults act as a safeguard against adverse selection in MinnesotaCare. For example, inpatient hospital services for adults with incomes over 175 percent of the poverty level are limited to \$10,000 per year, with a 10 percent copayment.

Minnesota's program is insurance market reform only in the sense that it resulted in previously uninsured people becoming insured. It was not an attempt to correct market failures in the private market, either for buyers or sellers. While Minnesota did enact many of the same small and individual market reforms as other states during the 1990s, MinnesotaCare was the cornerstone of the state's efforts to expand coverage. The state's own literature on the program declares:

MinnesotaCare was established to provide health care coverage to low-income people who do not have access to health coverage. MinnesotaCare was not intended as a low-cost alternative for employer-subsidized insurance nor to compete with the private health insurance market.²⁷

Impact: MinnesotaCare is popular and relatively noncontroversial. As of April 2000, about 116,000 people were enrolled in the program. A 1997 study found that MinnesotaCare had been effective in reducing the number of uninsured children, though less effective in reaching single adults, indicating the need for more public awareness of the program.²⁸ In 1998-1999, 8.7 percent of Minnesotans were without health insurance.²⁹

²⁷ Minnesota Department of Human Services, "History of MinnesotaCare." <http://www.dhs.state.mn.us/hlthcare/AsstProg/mncare/history.htm>.

²⁸ K. T. Call, et al., "Who Is Still Uninsured in Minnesota? Lessons from State Reform Efforts." *Journal of the American Medical Association* 278:14 (October 8, 1997).

²⁹ R. J. Mills, "Health Insurance Coverage." U.S. Census Bureau, Publication P60-211, September 2000.

Stabilizing the Individual Market

CASE STUDY

New Jersey's Individual Health Coverage Program³⁰

The state of New Jersey began the Individual Health Coverage Program (IHCP) in 1993, as a response to a court decision that threatened the financing mechanism of the existing individual insurance market. Prior to 1993, Blue Cross Blue Shield of New Jersey wrote almost all of the individual insurance in the state. According to state law, Blue Cross was “insurer of last resort,” a special status that meant it had to offer coverage to anyone seeking it. State law also subsidized Blue Cross's losses in the individual market through hospital rate surcharges, paid by all other insurers in the state. In 1992, though, a federal court found that the surcharge violated ERISA, throwing the individual market into crisis.

The IHCP grew out of this crisis, and the coincident interests of key parties. Blue Cross, if it continued as insurer of last resort without the subsidy mechanism, was in danger of bankruptcy. The governor did not want to see the individual market collapse and 175,000 Blue Cross individual subscribers become uninsured. And the state's other insurers, some of whom suspected they were subsidizing Blue Cross's inefficiencies in addition to its operating losses, wanted to find a better way to spread the risks of the individual market over all carriers.

Goal of Reform: To create a competitive individual market and prevent a massive increase in the number of uninsured that would result from the market's collapse.

Target Populations: Insurers, individual market policy holders.

Features: The IHCP requires any insurer selling group health insurance in the state either to sell policies in the individual market or share in the losses of those that do; insurers must “play or pay.” The program creates a “level playing field” for competition by creating standardized benefit plans—four indemnity plans and one HMO. Insurers may compete on price and service but not on variations in the benefit package, and consumers have a clear basis for comparison. The IHCP also protects against risk selection by requiring guaranteed issue and renewal. In effect, all of New Jersey's insurers are now either insurers of last resort or help to subsidize those that are. Premiums in the individual market must be community rated. In exchange for this provision, the state agreed that insurers would be free to

³⁰ Much of the material in this case study is derived from K. Swartz and D. W. Garnick, “Hidden Assets: Health Insurance Reform in New Jersey.” *Health Affairs*, July/August 1999.

change premiums without prior approval from the Department of Banking and Insurance.

Impact: The IHCP created a broad market for individual insurance where there was only a limited one before. The state used its regulatory authority to compel insurers to participate in the individual market. As of July 2000, 17 carriers offered a range of standardized policies to individuals and families.³¹ The IHCP is considered one of the more successful individual market reforms. It has stabilized the market and increased the availability of insurance, though it has had little impact on expanding coverage overall. The feature of the IHCP that allows premium increases without state approval is a clue to why.

The architects of the reform focused on salvaging the market and ensuring the availability of individual coverage. This they did, creating a market that arguably is superior to the one it replaced and preventing a serious *contraction* in overall coverage. Less emphasis was placed on affordability, however. The community rating requirement puts premiums more in reach of older, less healthy individuals, but makes insurance more costly overall. Competition among the multiple carriers in the market has controlled premium increases, but there is no *public* policy in place to assure the availability of affordable products.

Still, premium increases have apparently been modest enough to maintain robust enrollment in the individual market. Total enrollment in the IHCP was at about 131,000 at the end of 1998, down from its peak of 220,000 three years earlier, but much of that decline may be a product of growing employment in the state and people formerly covered in the individual market moving into employer-based coverage. With no subsidies to help at least lower-income individuals afford coverage, though, it is unlikely that the IHCP, or any other individual market reform, will make much of a dent in the number of uninsured.

This reform, as with any that alters the distribution of health care resources, created “winners” and “losers” relative to circumstances prior to reform. While overall social welfare may be improved and some individuals now have coverage who did not before, others are no longer covered or are covered at greater expense. Similarly, there are winners and losers among insurers, hospitals, and others providers. Advocates for market reform must consider who will be harmed by overall improvements; it is the rare policy that benefits all.

³¹ “NJ Health Insurance Reform Information,” <http://www.naic.org/nj/reform.htm>.

Lessons for Advocates

For better or worse, the United States will continue to have a private health insurance system for the foreseeable future. Consequently, community advocates must continue to deal with this system and make decisions about when and how to become involved in health insurance reform. Here are some of our key lessons learned from the last decade of reform efforts.

Lesson#1: Health insurance market reform will not, by itself, reduce the number of uninsured people in any significant way.

The efforts of many states over the past decade to reform health insurance markets have had, in general, only a modest impact on reducing the ranks of the uninsured. Insurance market reforms have been attractive to states for many reasons, not the least of which is that they do not require any significant state expenditures. However, the most successful state initiatives have been those that have coupled insurance market reforms with state subsidies so that health insurance is both more available *and* affordable.

Lesson #2: Nevertheless, health insurance market reforms can help real people.

It is easy to abandon hope about the possibility of effective reform of private health insurance. Many advocates believe incremental changes in the private insurance market are not valuable or may even prop up the current system inappropriately, hindering the potential to make more fundamental and radical change. While this view certainly has merit, we think it's important not to lose sight of the fact that reforms that are minor in the big picture can help real people in significant ways, while we work for the revolution.

Lesson #3: Understand who will win and who will lose in any proposed reform. (Also remember that losers will almost always make more noise than winners.)

One of the challenges of changing the current health insurance system is that it produces different results for different groups. For example, people

who are young or healthy, or employers who are large, all do better in the current system than older people, individuals with health problems, or small employers. This means that reforms that benefit those disadvantaged under the current system will, generally, impose additional costs on the advantaged. Advocates need to recognize that there are losers in most reform efforts, attempt to minimize their losses where possible, create the most compelling reasons possible for how reforms advance the greater good, and mobilize those who will be helped to be vocal advocates of reform.

Lesson #4: Changes in rating practices are the hardest to achieve.

Since price and affordability are the key considerations of most people buying insurance, any changes that result in premium increases will be the most contentious. Any efforts to reduce the variability in premium rates will decrease rates for some and increase rates for others. Although there is no evidence that these types of rating changes have any negative effect on the number of uninsured, health plans will generally make exaggerated claims about how these changes will reduce the number of employers who provide coverage, disrupt the health insurance market, and escalate overall health care costs. It is particularly difficult to adopt community rating because it does make coverage much more costly for young individuals or groups, which raises the potential problem that they will drop coverage and, thus, raise the average cost of providing coverage for the population that remains insured.

Lesson #5: Beware of insurers crying “we will leave the state.” It’s often a bluff and remember that more insurers is not necessarily better.

The knee-jerk reaction of many insurers to any proposed changes they dislike is to threaten to withdraw from whatever state is contemplating the changes. While this exodus does sometimes happen if the reforms are enacted, it often does not. It should be noted, however, that this ability of insurers to divide and conquer the states is one of the challenges of state-based regulation of insurance. Sometimes reforms provide cover to companies to get out of states or lines of business that already are unprofitable. Advocates need to examine insurer threats carefully, and they must be able to make the case to policymakers that fewer companies is not always harmful from the standpoint of availability or affordability of coverage. In fact, it’s even possible that fewer insurers may create a more rational and manageable marketplace.

Lesson #6: Don’t ignore the distribution system.

Insurance agents and brokers are critical players in the health insurance market. As noted in the case studies of New Jersey and California (and in Aetna’s bare bones policy on page 50), any failure to include agents and

brokers in the marketing of health insurance after market reforms, or to pay them market commissions, can be a fatal error. Agents and brokers are a potent and vocal force in every state—there are lots of them, they are well organized, and they can be mobilized easily and quickly. While this sometimes means that they are a formidable foe in any efforts to change the status quo, it also means that they can be powerful allies if you can enlist their support of your reforms. While not always possible, never dismiss agents and brokers as just an expendable part of the administrative overhead of the private health insurance system. Agents and brokers are also almost always in a position to give you the best sense of where the current system is working poorly, and how reform initiatives are really working “on the ground.”

Lesson #7: Availability is not the same as affordability.

We cannot rely on insurance market reform to make health insurance more affordable overall. Reforms that reorganize and change the rules of the market have made coverage available to many who were locked out of previous systems, particularly those with preexisting health conditions and many in small groups. But there is little or no evidence that improving availability has made coverage more affordable, which studies consistently show is the primary reason people are uninsured. In fact, some reforms have eliminated lower-cost options that were available to healthy people.

Lesson #8: Outreach is crucial—availability is not the same as increased coverage.

Just as recent experience with the Children’s Health Insurance Program (CHIP) has shown, expanding eligibility for health coverage is not enough. Increased availability of coverage must be coupled with aggressive outreach. Insurance reform is just one step. It must be coupled with aggressive and sustained campaigns to make people aware of what reforms do, and do not do, in terms of making coverage more available.

Lesson #9: Reducing benefits does not appear to be an effective means to expand coverage.

Although many insurers and purchasers have long argued that reducing benefits (e.g., eliminating mandated benefits, permitting higher levels of cost-sharing) is one means to increase the number of people with insurance, results of these types of approaches suggest that this is, in fact, not very effective. Most states that have experimented with relaxing benefit standards have had little success: Few insurers have taken advantage of the opportunity to sell more stripped-down policies and few individuals have purchased the policies when they were offered.

Lesson #10: In order to be effective at expanding coverage, insurance market reform must be combined with approaches like premium subsidies.

The bad news of this lesson is that the levels of subsidy that are required to broaden coverage are enormous. While mechanisms like purchasing

Not Enough Meat on Aetna's Bare Bones Policy

In 1999, Aetna announced with great fanfare Affordable Health Choices, a new line of lower-cost, lower-benefit plans designed for employers with five or fewer workers. The plans had monthly premiums of \$156 to \$275 for a family and \$46 to \$91 for an individual, and fairly low fixed benefits for most types of medical care (e.g., \$50 payment for a doctor's visit, regardless of the doctor's fee; \$100 per day for hospital stays of longer than eight days). Although Aetna claimed the plans would help deal with the problem of the uninsured, almost no one enrolled. One problem was Aetna's decision to use insurance brokers to sell the plan but then to pay extremely low commissions to those brokers compared to what other health plans paid. But even without this problem, many observers thought the plans were a bad idea from the start. "We didn't think it offered much value, even for the low price," according to the National Federation of Independent Businesses. "The last thing employers want is to give their employees a health plan they can complain about."

alliances can be helpful in making lower-cost coverage available, they do not appear to reduce premium rates enough to bring many more people into the market.

Lesson #11: Don't settle for toothless reform: Regulatory resolve and enforcement are critical to making any reform successful.

Even the best reforms will not be optimally effective unless they are combined with sufficient resources for enforcement. Advocates of health insurance market reform need to advocate for resources to implement and monitor reforms once they are enacted. But money for more regulators is also not enough. Regulation requires regulatory resolve, frequently lacking without ongoing external scrutiny and pressure. It's important to set up explicit monitoring mechanisms as part of any health insurance reform initiative (e.g., external advisory boards, required annual reports, periodic legislative hearings).

Lesson #12: Data, data, data: Reforms need to be coupled with monitoring and evaluation.

Talk about data is not scintillating to everyone (although we love it), but advocates and policymakers must have current information about health coverage and costs in order to assess how reforms are working and where changes and new reforms are needed. In many states, it has been difficult to assess the impact of insurance market reforms due to a lack of baseline data on what the health insurance market looked like before reforms, and failure to make data collection and evaluation an integral part of the reform.

Lesson #13: Much, but not all, is lost under ERISA.

Although ERISA has made many health insurance reform efforts more difficult, it has not affected the ability of states to regulate health insurance. Interpretations of the ERISA law are also changing as more and more court decisions are issued, often narrowing the scope of ERISA's reach.

Glossary of Health Insurance Reform Terms

Adverse selection: A phenomenon that occurs when a particular health insurance plan has a disproportionate number of members with high health care costs compared to other health insurers.

Asymmetric information: A situation in which parties on opposite sides of a transaction have different amounts of relevant information. For example, encounters between patients and physicians are usually characterized by asymmetric information.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, a federal law that requires employers to give certain categories of people the right to continue their group health coverage when they otherwise would no longer be eligible for insurance.

Community rating: The practice of setting health insurance premiums based on the average costs of *all* members of a health plan. Rates do not vary for different groups or subgroups of members, based on factors such as age, gender, claims experience, or health status.

ERISA: Employment Retirement Income Security Act, a 1974 federal law that removes self-insured health plans from the reach of state insurance laws.

Experience rating: A method of setting premium rates for an individual group on the basis of the actual health care costs of the group.

Family status: The range of people covered under a health insurance policy. The most common types of policies are individual/self-only, two-adult, parent and child, and family.

Guaranteed issue: A requirement that health insurers offer coverage to any eligible individual or group that applies for coverage, regardless of the

health status of the applicant. Insurers usually retain the right to deny coverage for certain specified reasons, including failure to pay premiums, fraud, or misrepresentation.

Guaranteed renewal: A requirement that health insurers renew coverage for any insured individual or group, without regard to the cost or claims experience of the group. Insurers usually retain the right to deny coverage for certain specified reasons, including failure to pay premiums, fraud, or misrepresentation.

HEDIS (Health Plan Employer Data and Information Set): A set of 60+ performance measures developed by NCQA used by employers and other purchasers to evaluate managed care plans.

HIPAA (The Health Insurance Portability and Accountability Act): A federal law containing portability and preexisting condition provisions for all employer-sponsored health insurance, and further provisions to maintain the availability of small group and individual policies.

NCQA (National Committee for Quality Assurance): A private nonprofit organization that works to improve the quality of managed care plans. NCQA has two major activities: a voluntary accreditation program, which reviews managed care plans against a number of criteria and awards the managed care equivalent of the “good housekeeping” seal of approval; and the development of performance measures, referred to as HEDIS.

Open enrollment period: A period during which new members may elect to enroll in a health insurance plan. Open enrollment periods may be used in the sale of new policies to individuals or groups, or apply to the period during which already insured people can switch health plans. This period may be the only time during the year when insurance is made available.

Portability: A requirement that allows people who are changing health plans to have the waiting period or underwriting requirements of their new insurer reduced because of their previous health coverage.

Preexisting condition: An injury, disease, or condition that existed prior to the issuance of a health insurance policy. Usually the person must have received care or treatment for the condition before the insurer considers it “preexisting.”

Preexisting condition exclusion: A provision in a health insurance policy that excludes from coverage the costs of any care for a preexisting condition.

Self-insured (or self-funded) health plan: A health plan where the risk for medical costs is assumed by the employer rather than by an insurance company or managed care plan. Self-insured companies usually contract with insurance companies or third-party administrators to administer the

benefits. Self-insured plans are exempt under the federal ERISA law from state laws, such as insurance laws regarding mandated benefits.

Standardized benefit packages: Health products that must comply with specified benefits and cost-sharing requirements, generally with little or no variation.

Underwriting: The process used by an insurer to determine whether to offer coverage to an individual or group and, if coverage is offered, under what terms and conditions (e.g., premium rates, benefits, preexisting condition restrictions).

