Access to Affordable Insurance for Individuals and Small Businesses:

Barriers and Potential Solutions

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Acknowledgments

Community Catalyst is a national advocacy organization that builds consumer and community participation in the shaping of our health system to ensure quality, affordable health care for all.

We work to strengthen the voice of consumers and communities wherever decisions shaping the future of our health system are being made. We do this by assisting state and local consumer advocates in developing or expanding their capacity to participate in such discussions. The technical assistance we provide includes policy analysis, legal assistance, strategic planning, and community organizing support. Together we're building a network of organizations dedicated to creating a more just and responsive health system.

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Executive Summary

The high cost of health insurance in the U.S. is a serious issue for more and more of the population, but the impact falls especially hard on two groups: small business owners, and individuals who don't have coverage through a job. These two market segments generally pay more for their coverage than large employers, and they get less for their money. Not surprisingly, the high cost of coverage means that small businesses are less likely to offer insurance to their employees, and those that do are more likely to drop it during difficult economic times. Cost is also a barrier for individuals seeking coverage in the non-group market because they don't have the benefit of an employer contributing to the premium.

This paper is directed to health access advocates. Its goal is to provide enough information so that they can educate their constituencies – many of whom are small business owners or employees -- on why coverage costs are so high and availability so limited. It also addresses what's wrong – or right – with the approaches that have been proposed or tried to date to make coverage more affordable and accessible. Finally, it recommends a package of reforms that offer the best hope for providing relief without placing undue burden on those who are in less than perfect health. The pressure is building in all economic sectors as well as within all levels of government to address the crisis in health care cost and coverage. Consumers have a vital role to play in the policy debates. With so much at stake, it is critical that they be equipped with a level of knowledge that allows them to evaluate "solutions" and promote those that will result in meaningful improvements. This paper aims to contribute to that education process.

Background

The health insurance market is characterized by two competing orientations. One is that each individual or group should be charged according to its own risk profile. Thus, the person with cancer, or the group that has a lot of older workers, should pay a higher premium than someone who is healthy or a group with a lot of 22-year old employees. This is called "experience" rating. The other orientation is that risk should be pooled and spread, so that everyone pays approximately the same regardless of age, health status, or any other factor. This is called "community" rating. Under this approach, the 22-year old may pay more than his or her counterpart in an experience-rated product, but the 55-year old pays less. If the healthy 22-year old is in a serious motorcycle accident, his premium will skyrocket if it's based on experience rating, but it will remain unchanged in a community-rated product.

Blue Cross plans, which were the first health insurers of any size in the United States, were created by state laws that required them to use community rating and to offer coverage to anyone who came through the door regardless of health status. These plans had few competitors until after World War II, when commercial carriers saw an opportunity to enter the health insurance market and introduce the kinds of underwriting techniques associated with life insurance. They set premiums based on individual or group health status, and they refused coverage to people with pre-existing conditions. These commercial carriers soon had a competitive advantage over Blue Cross plans

because they could limit their bad risk and charge lower premiums. Small businesses and individuals generally were at a disadvantage. Large employers had risk pools that were big enough to offset the costs of sick employees with those who were healthier, but small groups had no such risk-balancing mechanisms. Thus while many large employers sought coverage from commercial carriers, small groups and individuals were forced to stay with carriers that used community rating. As the "good" risk left the community rated carriers' risk pools, the premiums increased for the individuals and groups who were left behind. Eventually though, even the community-rated Blue Cross plans were forced to adopt some of these practices or find themselves priced out of existence. The result, in many cases, was that some small groups, and many individuals, could not obtain coverage at any price.

Over the last 10-15 years, most states have responded to these market tactics by passing laws that limit the ability of insurers – including Blue Cross – to shut small businesses and individuals out of the market altogether. Typical reforms include requiring insurers to offer and renew coverage, and limiting variations in premium rates for the same type of coverage. While these measures have reduced absolute barriers to coverage, they have done nothing to reduce costs. Indeed, they may have resulted in higher costs for many small groups and individuals.

Health Care Costs

High insurance premiums are the most frequently cited barrier to purchasing or maintaining coverage for small businesses and individuals, but it's important to remember that premiums are primarily a reflection of the underlying cost of health care. There are many theories as to why the cost of health care is so high. Some say that it's because the factors necessary for effective market competition are lacking in health care. Shopping around for the best deal in coronary by-pass surgery is very different from shopping around for a new washing machine. Qualitative information is much harder to come by, and other factors such as the doctor-patient relationship impact the decision-making process. Others say that high costs are related to quality problems in health care. Unnecessary medical procedures and costs associated with medical errors are estimated to cost around $150 billion annually. Still others point at administrative inefficiencies in our health system, such as the costs associated with a system of multiple public and private insurers. The reality is that all these factors play a role, and the issue of how they should be addressed has prompted substantial debate across the political spectrum.

Potential Solutions

The principal difficulty in developing solutions that address access and affordability issues in the small business and non-group insurance markets is that many proposals improve conditions for some segments of the market but make them worse for others. A range of approaches have been proposed, and some have actually been tested. In general, they fall into one or more of three broad strategies: risk shifting, risk spreading, and reducing underlying costs. These approaches are not mutually exclusive, and there are a variety of ways of implementing each of them.

Risk shifting approaches generally reduce premiums by making the consumer responsible for more of his or her health care costs. Some examples of approaches that utilize risk shifting include "consumer driven health plans" (CDHPs), association health plans (AHPs), high risk pools, and "bare bones" health plans.

CDHPs are supposed to encourage more efficient health care spending by making consumers more cost conscious. CDHPs consist of health care spending accounts into which the individual and/or the employer deposits money that can be used for certain medical services. The account is paired with a lower-cost, high-deductible insurance plan. Once the account is depleted and the deductible amount is met, the insurance coverage is triggered. A difficulty with these plans is that they effectively penalize those who need more care -- individuals who are chronically ill or disabled. On the other hand, if the people who opt for CDHPs are generally low risk while high risk individuals choose more traditional plans with comprehensive coverage, the premiums for those traditional plans will quickly become unaffordable because the good risk has left the pool. This phenomenon is called "adverse selection."

AHPs represent a different approach. They are a form of group purchasing arrangement that is intended to allow small businesses to join together both to spread risk and exercise more clout in negotiating with insurers. AHPs are operated by private entities, and under most current state laws, they are subject to some – but not all – state insurance regulation. Pending federal legislation would free AHPs from state regulation altogether, including requirements that they offer coverage to everyone, limit premium variations, and include state-mandated benefits. AHPs also would be exempt from the state solvency requirements. The principal concern with AHPs is that they would have the same impact on the market as CDHPs. Because they could utilize medical underwriting in setting premiums, and because they could limit benefits, they would be attractive primarily to healthy individuals and groups. Sicker individuals, who would feel compelled to remain in more comprehensive state-regulated products, would see their premiums rise as the risk pool became increasingly unbalanced.

"Bare bones" insurance plans are plans that exclude certain types of coverage that ordinarily is mandated by state law, such as maternity and mental health coverage. As with CDHPs, the negative impact of reduced benefits falls disproportionately on those who are in poor health, who are most likely to need the benefits that have been eliminated. A more concrete concern, though, is that bare bones plans do not lead to substantial reductions in premiums unless the benefits are cut – or coinsurance amounts increased – dramatically.

Finally, high risk pools are state-run programs that provide coverage for people who are "uninsurable" in the non-group market. They are supposed to promote broader affordability by shifting high-risk people out of the risk pool, which theoretically results in reduced premiums in those pools. High risk pool costs are financed by pool participants' premiums along with assessments on private insurers or public financing. Despite their attraction as a policy solution, pool enrollment generally has remained low.

The premiums that enrollees pay are still high – higher than what they would pay in the private market -- and the pool subsidies are rarely sufficient to cover pool costs, so many state pools have capped pool enrollment. Thus, while high risk pools eliminate technical barriers to coverage for high risk individuals, they do not eliminate cost barriers.

Risk spreading approaches are those that promote the aggregation of risk rather than segmentation. Examples of approaches include purchasing pools, tax credits, premium assistance, and public reinsurance.

Purchasing pools, which differ from association health plans in that they are state-authorized and regulated, are cooperatives of small businesses that purchase health insurance for their members. In theory, premium savings will result from the joint purchasing because the pools will achieve administrative economies of scale, and because they will have clout in dealing with insurers. The problem is that while pools have expanded the number of coverage choices available to small business members, they have not lowered premiums. Reasons for this include failure to attract enough small businesses to exercise the necessary purchasing leverage, and failure to achieve the anticipated administrative savings.

Tax credits are intended to make non-group premiums more affordable for low-income individuals and families by spreading part of the risk to the public. In effect, the public covers part of the cost of coverage through a refundable federal tax credit. A significant problem with current tax credit proposals is that the amount of the credit is too limited to serve as an incentive to bring large number of moderate- and low-income individuals and families into coverage. A broader issue with tax credits, though, is how to establish a credit amount that is sufficient to bring currently uninsured people into the market (or ease the financial burden on some people who have insurance) while simultaneously preventing employers from dropping coverage because the credit would enable their employees to obtain coverage in the non-group market.

Premium assistance programs use public funds to subsidize Medicaid-eligible employees' contributions for private or employer-based insurance. These programs are intended to encourage workers to obtain health coverage in the private or non-group market by spreading a portion of their risk to the tax-paying public. The benefit to Medicaid programs is that they essentially cap what would otherwise be their liability for the cost of care for the individual or family. The principal concern with this approach from the small employer's perspective – assuming that it even offers coverage in the first place – is that it costs more unless the program includes an employer subsidy of some sort. Where before a low-income employee might have been enrolled in Medicaid, the premium assistance approach involves enrolling the employee in the group plan, and the employer now has to contribute to the premium for an additional enrollee.

Public reinsurance programs are based on the premise that the highest health care costs are attributable to a relatively small percentage of individuals. If a substantial portion of the expenses of these high cost cases can be removed from insurance premiums and spread across the general population, then the premiums will be reduced. The expenses

of high cost cases that exceed a certain level would be spread over the broadest possible base -- the tax-paying public. The cost of such a program would be substantial if it were applied to the entire private insurance market. If, however, it were limited to non-group enrollees and small businesses (i.e. below 25 employees), insurance costs for those sectors could be reduced by as much as 75 percent.

Approaches that focus on reducing underlying costs include regulation of health insurance premiums and provider rates, and strategies that address other cost drivers. Rate regulation of health insurance premiums and provider prices is promoted by some as a method for reducing costs where competition has failed to do the job. Many states had some type of provider rate regulation in the 1970s and 1980s, but with the exception of Maryland, they've all eliminated it. While policymakers show little inclination to return to regulation, it is important to note that both Medicare and Medicaid have been relatively successful in controlling costs through price setting. In addition, the surge of interest in drug reimportation from Canada, where prices are regulated, suggests that if cost pressures become great enough, there could be a groundswell of pressure to re-examine regulatory approaches.

Strategies to improve the quality of health care, and prevent illness and disease in the first place, could have a significant impact on the cost of health insurance. Unnecessary care and medical errors, for example, are estimated to cost more than $150 billion. Progress on these strategies is slow though, in part because our health system is so fragmented, and also because some improvements – such as better health information technology – will require major capital investments and system-wide cooperation.

Recommendation

There is no silver bullet for the access and affordability issues that pervade the small group and non-group insurance markets. It is possible, however, to envision a package of reforms that achieves the original purpose of insurance, which is to spread the financial risk and cost of illness broadly, and simultaneously keeps insurance available and affordable regardless of individual health status.

The first step would be to limit the potential for direct and indirect risk selection. There must be rules that prevent insurers from "cherry picking" the healthy and shutting the sick out of the market either through astronomical premiums or outright denial. Those rules include requiring all insurers to offer coverage to everyone, limiting waiting periods and pre-existing condition exclusions, and eliminating pricing based on actual or expected health costs. Avoiding risk selection might also require standardization of benefit packages so that there is no built-in incentive for health people to gravitate to one type of plan and sick people to another. These rules already apply to the small group market in a number of states, but they have not been extended to the non-group market.

Instituting and enforcing these rules is not enough though. Indeed, by themselves these rules are likely to raise rather than reduce premiums, especially in the non-group market. Additional steps are necessary to achieve premium reductions. Such steps could include

a combination of publicly financed reinsurance, which would broadly spread the expenses association with high-cost cases, and premium or cost-sharing assistance to further reduce the cost of coverage for low-wage workers. Premiums for these market segments could be reduced further if the public sector were to absorb some of higher administrative costs associated with small group and non-group coverage. This could be accomplished through creation of a publicly sponsored pool to handle some of the administrative tasks.

It is crystal clear that the plight of small businesses and individuals who need to purchase insurance directly cannot be addressed by bringing back the practices that led to insurance market reform in the first place. Approaches which do that indirectly by promoting products that disadvantage older and sicker people will only exacerbate the affordability issue and result in many more people who have no insurance at all. It is equally clear that meaningful improvements depend on public sector participation in risk sharing. While the current political environment is hostile to expenditure of public dollars for purposes like this, the pressure is building. And as it has in the past, the small business sector has the power to influence the outcome of the debate. That's why it is important for it to be armed with information that deconstructs the workings of the health insurance market and provides a critique of broad approaches and of specific proposals. We hope this paper, and the educational materials that will be derived from it, accomplish that purpose.

Part I—Introduction

As the price of health insurance climbs, an increasing number of people find themselves unable to afford coverage.[1] Two groups that have particular difficulties in obtaining coverage are small business owners and individuals who don't have access to coverage through an employer. Small business owners and their employees are particularly vulnerable because small businesses are less likely to offer health insurance and more likely to drop health insurance during difficult economic times.[2] The purpose of this paper is to summarize the major barriers faced by small businesses and individuals who try to obtain health insurance. First, it will look at how the market for health insurance evolved to create the current situation. Next, it will examine why health insurance is expensive and why the cost is increasing so rapidly. Finally, it will look at some of the ideas that are being considered in the public policy arena to make health insurance more accessible and affordable for small businesses and individuals, and it will identify those approaches that seem to hold the greatest promise of success.

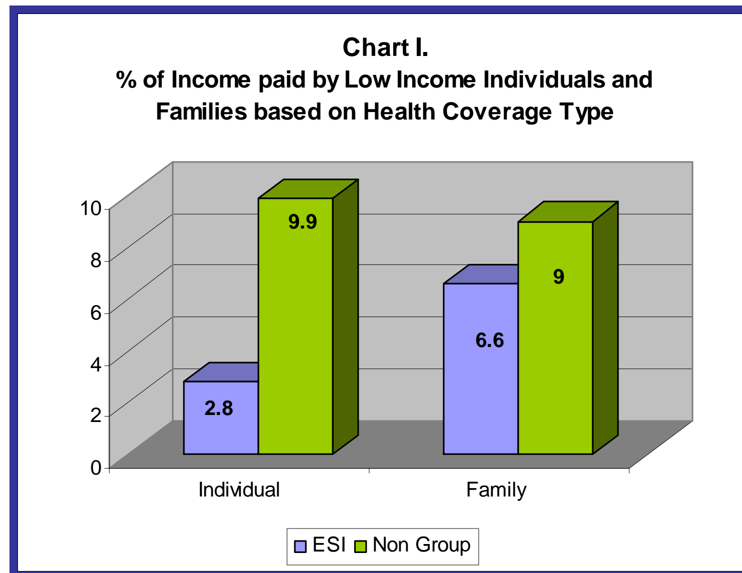
Part II—Current Problems

It used to be that many small employers and individuals could not obtain health insurance at any price. Insurance companies could refuse to issue or renew coverage if there were any sort of preexisting condition or other question about an individual's or group member's health status. As health care costs increased though, policy makers in most states realized several things. First, the costs of limiting access to coverage were considerable, and if people had no insurance coverage, then those costs had to be spread across public programs and private insurance. Big employers' insurance premiums started to reflect this, as did state-funded programs like Medicaid. Second, there was something inherently unfair about limiting access to coverage for those who had a chronic condition or were otherwise not in perfect health. Finally, as we became increasingly reliant on the marketplace to control health care costs and quality, policy makers realized that the system was flawed if certain populations were shut out of it altogether.

Most states addressed these issues by enacting insurance market reforms, which will be described in some detail in a subsequent section. The elimination of those absolute barriers to coverage means that today, some form of coverage generally is available to everyone. Nonetheless, significant and arguably growing problems remain. Three particular problems face those seeking to purchase small group or nongroup insurance: cost, value, and predictability.

By almost any measure, the cost of health insurance is high. Currently, the average annual premium for employer-sponsored group coverage is $3,383 for an individual and $9,068 for a family plan,[3] while the median income is $32,359 for an individual and $56,500 for a family.[4] This means that employer-sponsored health insurance adds 10–16 percent to the compensation of a median-income family. These high costs make it particularly difficult for lower-wage individuals to obtain coverage either through the workplace or on their own.

For individuals and families with incomes at 200 percent Federal Poverty Level (FPL), the cost of health insurance relative to annual income nearly doubles. In 2003, an income at 200 percent FPL was $17,964 for an individual and $36,804 for a family of four.[5] The cost of health insurance relative to income for this group ranged from 19–25 percent of income. With health insurance premiums equaling an average of 10–16 percent of the median wage and at 19–25 percent for the 200 percent FPL group, the current cost to employers providing benefits to lower-wage workers may be prohibitive. The high cost of health insurance relative to the wages of low-wage workers makes employers reluctant to provide health insurance. At the same time though, it is too costly for low-income families to purchase coverage on their own.



On average, an individual or family unit seeking to buy coverage on its own would have to pay $1,786 for an individual plan or $3,331 for family coverage.[6] While the cost for this nongroup coverage is less than the cost of employer-sponsored coverage, it is important to note that benefits are generally less comprehensive. Moreover, in many states, higher-risk individuals are excluded from the individual market and can only purchase coverage through costly high-risk pools. Even with lower premiums, individuals and families purchasing coverage in the nongroup market must pay the full premium cost themselves. In contrast, individuals and families who have access to job-based coverage usually split the premium cost with the employer. Indeed, the average employer contribution is $504 for individual coverage and $2,412 for a family plan.[7] In other words, low-income individuals and families purchasing in the nongroup market would have to pay 9.0–9.9 percent of their income to obtain coverage versus the 2.8–6.6 percent they would have to pay for employer-sponsored insurance.[8] (See Chart I.) It is no wonder that the ranks of the uninsured are largely made up of low-wage working people and their families, many of whom work for small businesses.[9]

Not only do small groups and individuals pay more for their coverage, but they also get less for their dollars. Administrative costs for small groups and individuals tend to be much higher than for large groups, and their health benefits are less comprehensive.[10] For example, employees in small firms paid an average annual deductible of $419 in 2003 for individual coverage through a PPO plan, using a preferred provider. In contrast, employees in large firms paid an average annual deductible of $209.[11] Those who purchase nongroup insurance have even higher cost sharing, with 68 percent facing deductibles of $1,000 or more. Individuals purchasing their own insurance are also more likely to opt for minimal-benefit packages to keep their costs down, while people with employer-based coverage often have comprehensive benefits.[12, 13]

A third serious problem is the unpredictability or instability of premium costs. Even if an individual or small employer can afford coverage today, the recent rapid increase in premiums has made many fear that they will be unable to afford such coverage in the

future. If employers fear having to discontinue health insurance as a benefit in the near future, they may hesitate to offer it in the first place—to avoid creating an expectation among their workers.

As a result of these problems, small employers are less likely to offer health coverage, are more likely to pass rising costs on to their employees (making them less likely to take up or maintain their coverage), and are more likely to cut back on benefits or eliminate coverage altogether.[14]

Among small business people, the self-employed have special problems. In some states such as Connecticut, a self-employed person can obtain insurance as a business whereas in other states, such as Rhode Island, a self-employed person is considered an individual. In either case, depending on the rules of the nongroup market, problems can occur.[15] If a self-employed individual is considered a business in a state that guarantees access to coverage for small employers regardless of their health status or that of their families (as most states do), and if there is no similar guarantee in the nongroup market, then healthy self-employed individuals will purchase nongroup insurance because it will cost less. Higher-cost individuals will have to remain in the small-group market, thereby driving up premium costs for all small businesses. If, on the other hand, a self-employed individual is not considered a business for the purpose of obtaining insurance, he or she may find that the only option for obtaining coverage is a state high-risk pool. These pools typically have much higher premiums and lower benefits than traditional policies.[16] (For more information, see "High-Risk Pools," below.)

Individuals who do not have access to employer-based coverage also face greater barriers to obtaining insurance than do others. In many states individuals can be charged a greater amount based on their health status, subjected to lengthy preexisting-condition exclusions, or denied regular coverage altogether and relegated to a high-risk pool.[17]

Part III—Historical Development

The health insurance market has long been characterized by two divergent philosophies. The first argues that each individual or group should be charged according to its specific risk profile. The second stresses the idea of pooling and spreading risk. The former view is similar to that which prevails in other sectors of the commercial insurance industry, such as individual life insurance. The latter incorporates some of the ethos of publicly sponsored social insurance.

These two competing orientations each have distinct advantages and disadvantages. The first approach, which we will call "every person for him or herself," has the advantage of making lower-cost insurance available to low-risk groups. The disadvantage of this approach is that higher-risk groups may be priced out of or excluded from coverage entirely. In contrast, the approach that stresses pooling and sharing risk, known as "community rating," has the advantage of making coverage available to all and ensuring that the financial burden of illness does not fall disproportionately on the sick. However, because this approach involves transferring income from the healthy to the sick, healthier individuals may decide that the cost is not worth the benefit, and they will opt to forgo insurance altogether.

An additional problem with a system that offers a community rate but does not require individuals to purchase coverage is that some people will not obtain coverage until they know they are going to need it. This is known as adverse selection. The danger of adverse selection is particularly acute in the nongroup market, where individuals can decide to seek coverage based on their own knowledge of their health status. Adverse selection is less severe, although still worrisome, in the small group market. (Adverse selection is not thought to be a problem for large groups, which generally are considered big enough to maintain a balanced risk profile.)

These two opposing philosophies of health insurance cannot coexist peacefully. An insurance company that practices community rating will be fatally undermined if its competitors are companies that can offer lower premiums to lower-risk groups. The practice of community rating depends on attracting more or less "average" risk. If the high-risk groups are in one pool and the low-risk groups are in another, the premiums in the high-risk pool will be unaffordable.

The evolution of health insurance law and regulation may be seen as a result of the struggle between these two divergent approaches. This struggle has played out in debates over laws and regulations relating to guaranteed issue and rating. It also is present in struggles over standardizing benefits. The issue in this regard is whether there should be multiple insurance options with varying levels of out-of-pocket costs and benefits, or whether there should be limited variations in coverage. With multiple options, healthier individuals are more likely to buy high-deductible plans, while sicker individuals are more likely to opt for the more comprehensive benefits. The comprehensive plans quickly become prohibitively expensive. If there are fewer types of health plans from which to choose, the risk of illness is spread more broadly, resulting in a smaller financial burden on the individual.

The initial Blue Cross plans were community rated and guaranteed issue. This obligation to take all comers often existed in the statutes which created the Blue Cross plans. Once commercial insurers entered the health insurance business, however, the dynamics changed substantially. Commercial insurers used a variety of strategies, including experience rating, preexisting-condition exclusions, and medical underwriting, to avoid sicker, more costly groups and individuals. The Blue Cross plans were forced to adopt similar practices or else find themselves priced out of existence.[18]

As the "every person for him or herself" paradigm came to dominate the insurance industry, small groups and individuals found themselves at particular risk. While large-employer groups had big enough risk pools to offset the cost of sick employees with those who were healthier, small groups and individuals had no such risk-balancing mechanism. As a result, they increasingly found that health insurance might not be available to them at any price (even if they "played by the rules" and maintained continuous coverage). Others found themselves subject to preexisting-condition exclusions or, perhaps worst of all, found that their premiums could be inflated dramatically if their risk profile changed, pricing them out of insurance just when they needed it most.[19]

In a real sense, the triumph of the "every person for him or herself" paradigm grew out of a voluntary system with multiple competing insurers. Since employers are free to offer or not offer coverage and workers are free to accept or decline the offer, adverse selection is virtually inevitable. No insurer wants to have a less healthy risk pool than its competitors. In fact, insurers can reap substantial economic rewards by attracting a healthier than average risk pool. These dynamics create a powerful incentive for insurers to find ways to avoid bad risks by establishing the sort of underwriting policies discussed above.[20] The incentive to avoid bad risk is so powerful that it persists even in "reformed" markets, where insurers may seek, via benefit design or marketing strategy, to attract healthier–than-average risk.[21]

At the same time that individuals and small groups found health insurance increasingly unavailable to them due to the structure of the insurance industry, Blue Cross plans found themselves at a growing competitive disadvantage relative to companies that were freer to discriminate in their pricing strategies. This created a community of interest among Blue Cross plans and many small businesses and consumer advocates. The result was a wave of state and federal insurance reform legislation in the 1980s and 1990s.

Typical state reforms of the small-group market included provisions requiring health insurers to offer coverage to all small businesses, and provisions limiting the risk factors that insurers could use to determine rates and the amount by which they could vary premiums for the same coverage.[22] Similar reforms were adopted for the nongroup market in some states, but most states established high-risk pools as a mechanism for providing coverage to individuals who were excluded from the regular health insurance market because of their health status.[23]

On the federal level the Health Insurance Portability and Accountability Act of 1996 (HIPAA) included important protections for an estimated 25 million Americans (approximately 1 in 10) who move from one job to another, who are self-employed, or who have preexisting medical conditions.[24] Some key provisions of the law affecting small businesses include:

- **Guaranteed Access for Small Business.** Small businesses (50 or fewer employees) are guaranteed access to health insurance. No insurer can exclude an employee or a family member from coverage based on health status.
- **Guaranteed Renewal of Insurance.** Once an insurer sells a policy to any individual or group, they are required to renew coverage regardless of the health status of any member of a group.
- **Guaranteed Access for Individuals.** People who lose their group coverage (for example, because of loss of employment or a change of job to a business that doesn't offer insurance) will be guaranteed access to coverage in the individual market, or states may develop alternative programs to assure that comparable coverage is available to these people. The coverage is available without regard to health status, and renewal is guaranteed.
- **Preexisting Conditions.** Workers covered by group insurance policies cannot be excluded from coverage for more than twelve months due to a preexisting medical condition. Such limits can only be placed on conditions treated or diagnosed within the six months prior to their enrollment in an insurance plan. Insurers cannot impose new preexisting condition exclusions for workers with previous coverage.
- **Self-employed Individuals.** The tax deduction for insurance costs of self-employed individuals was gradually increased from 30 percent in 1996 to the current 100 percent.

HIPAA was also limited in several important respects. It did not guarantee access to nongroup insurance unless a person was moving from a group plan, and, perhaps most importantly, it said nothing about the price of insurance or any factors that insurers could use to vary premiums (e.g. health status or age).

The reforms of the 1980s and 1990s were aimed at improving the availability of health insurance and reducing the variability of price based on health status. In this they were largely successful, however they did nothing to address the high overall cost of health insurance. Nor did they address the inherent tendency toward adverse selection built into a voluntary system. (Some have argued that by letting sicker people obtain insurance, these reforms caused prices to rise and the number of uninsured to climb. This argument is addressed in a subsequent section.)

Today the small and nongroup health insurance markets are subject to the high and rapidly increasing premiums noted earlier. In most states, only a handful of carriers offer coverage to these segments, and there are very few limits on what kinds of premiums they can charge.[25]

Recently there has been an effort in some states to enhance competition by weakening or repealing laws regulating access to insurance and rating factors. The idea is that without these laws, more carriers might enter the market and increase competitive pressures. Such actions, however, are likely to simply recreate the circumstances that gave rise to the reforms of the 1980s and 1990s in the first place. For example, New Hampshire recently rolled back its small group reforms and reintroduced experience rating into the small-group market. As a result, many employers saw their premiums skyrocket and were subjected to intrusive questioning about their own and their employees' health status for purposes of medical underwriting.[26]

Part IV—Health Care Costs

The solution to problems in the small-group and nongroup markets is not to return to the pre-reform era, but rather to institute additional reforms that make health insurance more affordable *and* more available. In order to develop these reforms, we must first understand why health insurance is so expensive. A related but somewhat different issue is why the cost is increasing so rapidly.

There is substantial debate over the reasons why health insurance is so expensive. Some popular explanations are that

- it is mainly a function of the underlying cost of health care;
- the administrative costs of health insurers are to blame;
- there is neither effective competition in, nor effective regulation of, the health insurance market; and
- mandates (such as the reforms relating to rating and offer rules) and mandated benefits are largely to blame.

We will look at each of these explanations in turn.

The Underlying Cost of Health Care

What is the cost of health care in the United States, and by what standard can we determine whether it costs a lot or a little? In 2001, the United States spent nearly $1.4 trillion—or 13.9 percent—of its gross domestic product (GDP) on health care. This translates to $4,887 per person. By comparison, other countries in the Organization of Economic Cooperation and Development (OECD) spent, on average, $1,930 per person. Switzerland, the country with the next highest spending, spent only 68 percent as much on health care per capita in 2001 (see Chart II). Over time, health care spending in the U.S. has risen by an average annual rate of 9.1 percent.[27] This rate of growth has tended to be very similar to the trend line in other countries, suggesting that perhaps all advanced health systems are facing some similar sources of cost pressure.[28]

Chart II: Health Spending In Select OECD Countries, 2001[29]

Country	*Total health spending per capita in PPP$*	*Health spending as percent of U.S. health spending*	*Health spending as percent of GDP*
United States	4,887	100	13.9
Switzerland	3,322	68	11.1
Germany	2,808	57	10.7
Canada	2,792	57	9.7
France	2,561	52	9.5
United Kingdom	1,992	41	7.6
Spain	1,600	33	7.5
OECD median*	2,161	44	8.1

*Includes all 30 OECD countries

But to say that health insurance is expensive because health care is expensive is, of course, to immediately invite the question of why health care is expensive. Again, there are multiple theories.

In part, health care is expensive because the normal laws of supply and demand do not seem to apply to health care (whether they can be made to apply, and whether it would be a good thing if they did are separate questions). Most of the factors that economists say are necessary for effective market competition are lacking in health care. There are "barriers to entry" for new actors (e.g. hospital bed limits or physician licensure statutes). Transactions in health care between physician and patient are not "arms length." Rather, the physician is acting as the fiduciary agent of the patient, protecting his or her welfare. There is certainly a cost in continuity and quality to changing provider relationships repeatedly. There is generally a gross imbalance of information between the seller (health care provider) and buyer (patient), and the cost of gaining information is substantial, though it may be somewhat reduced by the internet. Patients are often constrained in their ability to "shop" among providers or insurers. Even when they are free to do so, cost and quality information is not readily available. In some places particular providers exercise substantial market power that can lead to higher prices. Finally, most people are uncomfortable with rationing the quantity and quality of health services based on individual ability to pay, and that is what markets do.

Some economists have argued that health insurance itself, which insulates the patient from the true cost of care, has contributed to higher prices and overall costs. Interestingly, while Americans are more subject to cost sharing at the point of service and, as a result, actually have fewer physician visits and use fewer hospital days than their counterparts in other OECD countries, both price and total spending are lower in those countries that do not rely so heavily on cost sharing as a mechanism for cost containment.[30]

Another set of explanations focuses on quality problems in health care as a major culprit. Unnecessary medical procedures account for $122 billion in spending in the United States.[31] In February 2000, a report on medical errors by the federally appointed Quality Interagency Coordination Task Force estimated the cost of medical errors at approximately $37.6 billion each year.[32] Lack of access to early diagnosis and treatment also results in unnecessary hospital admissions and increased treatment costs.[33] Frequently, the cost of "defensive medicine," allegedly practiced by doctors to shield themselves from malpractice suits, is cited. However, a recent analysis by the Congressional Budget Office found that there was no persuasive evidence that defensive medicine contributed significantly to the cost of health care.[34]

Administrative Costs

Another factor in the high cost of health care is the substantial administrative cost of the system. One recent study estimated that between $0.22 and $0.42 of every premium dollar goes to provider administrative expenses.[35] High levels of a different but associated type of administrative cost—those associated with private health insurance plans—is another common explanation for the high overall cost of health insurance, particularly among those calling for a universal public insurance system. They point to studies showing that the administrative cost of the private insurance system is much higher than in public programs like Medicare or Medicaid, or in other countries that have universal public insurance.[36] They further argue that much of the provider administrative cost is related to the cost of dealing with multiple insurance plans. (It is important to note that not all administrative spending is "waste." Functions such as quality assurance and health education can also be classified as administrative costs.)

Lack of Effective Competition or Regulation

Regulation and increased competition have both been proposed as ways to limit costs, but to date, all efforts to impose regulation or inject more competition into health insurance markets have been unsuccessful in restraining costs. In fact, according to some analysts, nothing has worked for very long.[37]

Although the idea of injecting market forces into health care is very much in vogue, there is some reason to be skeptical about the likelihood of competition succeeding as a cure for high health care premiums. As noted above, most of the conditions for competitive markets in the underlying health care system are absent. Also, much health insurance regulation exists to prevent socially pernicious outcomes. For example, in the absence of regulation, we could expect to see more defaults and more consumer fraud by insurers.[38] We would also likely see a return of carriers attempting to reduce premiums by avoiding high-risk individuals and groups, with all the negative consequences discussed above. In addition, we are faced with the ironic situation in health care in which a competitive market among insurers means that each insurer is a weak purchaser relative to the providers. On the other hand, when insurance markets are concentrated, insurers may be stronger purchasers but feel less competitive pressure to lower premiums.

Finally, economic theory itself, particularly what is known as "the theory of second best," actually teaches us that the simplistic notion that competition will cure what ails the health care system is ill-founded, and that attempts to act on that idea may do more harm than good. The theory of second best says that in a system where multiple market failures exist, making part of the system more competitive will not necessarily produce a better outcome.[39]

It is for these reasons that the idea of managed competition gained favor for a while among health economists and political leaders. The idea of managed competition was to use regulation to structure the relationships among insurers and providers to correct for the market failures in the provider and insurance systems.[40] There was, however, no consensus on the likely effectiveness of managed competition as a cost containment approach.[41] In any event, since the defeat of the Clinton health plan in the early 1990s, no serious attempt to implement a managed competition program has been advanced, and the term "managed competition" is now used erroneously to describe unmanaged competition among managed care plans.

If competition among health insurers is unlikely to produce a cure for high premiums, what about regulation? Again, there is reason to be less than optimistic. The regulation of health insurance that currently exists, while extensive, mainly addresses issues such as solvency, claims payment, and underwriting rules. Comparatively little effort has been made to directly regulate premiums. In part this is because insurance regulators have had only limited authority to deny premium increases. In addition, serious and ongoing review of health insurance premiums would require a significant commitment of public resources that has largely been lacking. Finally, in some cases at least, there has been a lack of political will on the part of regulators to restrain premiums, even when they have the authority to do so.

Even with the best of intentions and adequate resources, direct regulation of premiums may not be a workable—or even sufficient—approach to bringing down health insurance premiums. Insurers are the middlemen in health care, standing between the users and the providers. They have only limited control over the cost and volume of services for which they pay. As will be discussed below, efforts by insurers to exercise more direct control over the price and quantity of care through managed care organizations provoked a significant backlash among both providers and patients. (For more information on the potential of premium regulation to reduce health care costs, see Part IV, "Potential Solutions," below.)

In assessing the reasons for the high cost of health insurance, the issue of mandates also needs to be considered. Mandates come in many forms. Some, as we have already discussed, relate to requirements to offer coverage regardless of health status. Analyses of these types of mandates in the small-group market have found that they do not appear to have had a significant effect on premiums in that market, though similar reforms did cause some net increase in nongroup premiums.[42] (Most large groups are exempt from state mandates.)

Another form of mandate is the kind that requires insurers to provide coverage for a particular type of service or class of providers. These mandates are commonly referred to as "mandated benefits." Mandated benefits vary from state to state, but common ones include maternity coverage and mental health services. Some analysts argue that the cost of mandated benefits is substantial and accounts for as much as 29 percent of the premium dollar.[43] Most studies, however, have found a much smaller effect, pegging the cost at around 5 percent or less.[44] The wide variation among the findings occurs because the studies concluding that mandates contribute significantly to the cost of premiums have looked at the total cost of mandates rather than the marginal cost. This means that these studies have ignored the fact that some employers would offer those benefits even without a mandate. The studies also have ignored the possibility that a policy failing to cover one service or class of provider might have higher expenditures for another service. Finally, the debate over mandates is really a debate over how much of the risk of illness should be spread across the whole group and how much should fall on the individual. Without the mandates, insurers would avoid covering certain services as a way of making coverage less attractive to sicker people and leaving them to foot the bill for their illnesses. Ultimately, the mandate question comes back to the insurance paradigm—whether we should spread risk or have each person or group pay for itself. While it is not "all or nothing," and while it may be the case that some mandates are appropriate while others are not, mandating benefits is about ensuring that the cost of illness is spread.

Rising Costs

Closely related to the question of why health insurance is so expensive is why health insurance premiums are rising so quickly. Again, there is not a single answer. Factors driving the rise in health insurance premiums include rising spending on hospital care, prescription drugs, and administration. With respect to both hospitals and drugs, technological innovation—the introduction of new procedures and drugs—is a significant factor in the rising cost of premiums.[45]

In recent years we've also seen premiums increase faster than underlying health care costs. In 2003, health insurance premiums rose 13.9 percent, compared to an 8.5 percent growth in health care costs.[46] In all probability, this is a routine part of what is known as the "underwriting cycle." At some points, insurers try to increase their market share by holding premiums down, often below the rate of cost growth. Eventually the insurers need to recoup their losses, and the result is premium growth in excess of the underlying growth in health-care costs. However, given the growing concentration of the health insurance industry, it is possible that current premium growth in excess of costs represents a decline of competitive pressure.[47] It is also possible that insurers have been seeking to offset losses to their reserves due to the recent large decline in stock prices.

Another factor contributing to the recent rise of health insurance premiums has been the exhaustion of the ability of managed care to slow premium growth. In the beginning, managed care was a revolutionary idea designed to correct certain weaknesses in the conventional health insurance system. Where conventional insurance paid for sickness only, managed care—which meant health maintenance organizations (HMOs)—would

emphasize preventative and primary care. Where the traditional system relied on patient cost sharing to manage utilization in a disorganized maze of providers, managed care would rely on good clinical management in an integrated network. In place of the incentives by clinicians to earn more fees by providing more services, managed care would substitute salaried clinicians with neutral incentives; and in place of an over-reliance on specialty care, managed care would elevate the role of primary care physicians and other clinical professionals such as nurse practitioners and physician assistants.[48]

As managed care became the norm, however, large established insurers found that they could expand more quickly by relying on strategies that emphasized manipulating financial and administrative incentives to providers rather than by directly reengineering clinical systems.[49] For example, many insurers found it easier to negotiate fee discounts with providers in exchange for a guaranteed flow of patients; or to place providers at greater risk for the care they provided, rather than substantively rethinking ways of delivering or administering care.

Ultimately, the savings to be derived from managed care appear to have been time-limited in nature.[50] In part, the premium advantage that managed care organizations enjoyed as a result of the younger and healthier population they initially insured began to wear off as more and more people switched into managed care. The savings derived from reducing the number and length of hospital days also seemed to reach a limit, with the cost of hospital care, particularly outpatient care, surging in recent years.[51]

For a number of years, managed care plans also were benefiting from a two-fold government subsidy. This was particularly true in the early- to mid-1990s, when managed care seemed to be enjoying unprecedented success in constraining employers' health insurance premiums. Medicare payments to both hospitals and HMOs were well in excess of costs in those years, making it possible for hospitals to accept lower reimbursement from managed care organizations and for the managed care organizations themselves to charge lower premiums.[52]

When Congress cut back on Medicare over-payments as part of the Balanced Budget Act of 1997, new pressure to raise prices and premiums emerged on the commercial insurance side of the system. At the same time, because managed care had wrung excess capacity out of the system and providers themselves had undertaken a host of mergers to enhance their market standing, providers were in a much stronger position to demand rate increases than they had been in the early days of managed care. Providers' negotiating leverage was enhanced by the backlash among patients who objected to the restrictions placed upon them by the limited networks of the managed care organizations.[53]

The result of all of these factors was managed care lost much of its ability to restrain health care costs. Since there was no alternative in place, the erosion of managed care as a cost-containment strategy helped fuel the recent spike in health insurance premiums.

Conclusion

The questions of why health insurance costs so much and why these costs are increasing have prompted substantial debate across the political spectrum. The reality is that a number of factors, including the nature of health care, the structure of our health care system, clinical waste, and administrative inefficiency all play a role in these cost trends. Mandates and regulations, including requirements relating to the provision and pricing of coverage to sicker people and requirements that insurance cover certain services, probably play a role as well. In the case of many such regulations, however, we must ask if the savings from their elimination is worth the cost, which invariably includes placing more of the economic burden of illness on those who already bear the burden of poor health.

Before leaving the discussion of health insurance costs, it would be useful to refocus on the underlying question: Is our real problem that we are spending too much on health care in an absolute sense, or is it that the health insurance and health care delivery systems are too inefficient and we are not receiving sufficient value for our spending? Different answers to that question will lead in very different policy directions. For example, if one believes that we are spending too much in an absolute sense, the inclination would be to wring savings out of the health care system and return them to individuals to spend elsewhere. If, on the other hand, one assumes the problem is that we are not getting enough value for our dollars, then the inclination would be to redirect some current spending to other purposes, such as covering the uninsured—the second-class citizens of our health care system—and to additional advances in care, but not attempt to reduce overall societal spending on health care.

To some extent the question, "Can we afford high and rising health spending?" depends on who this "we" is. As a society, we can afford to spend above the international norm on health care, and we can even afford—for awhile—to devote a growing portion of our GDP to health care in a growing economy. For example, if the difference between real per capita health spending and GDP growth averages 2 percent, non-health GDP per capita will continue to rise until about 2040. If we manage to control costs, keeping the growth rate differential to about 1 percent, non-health GDP per capita will continue to grow throughout the next seven decades.[54]

It is also important to remember that what is affordable for a society as a whole may not be affordable for each individual and employer. The question of how costs are distributed is just as important as the question of absolute levels of spending. In addition, the fact that we, as a society, can afford a given level of health care spending does not mean that we *should* afford it, particularly if the money is not being well spent.

Part V—Potential Solutions

Before we evaluate potential solutions, it is useful to identify several different conceptual approaches to reducing premiums. Strategies to reduce premiums fall into one of three broad categories. The first way premiums for small businesses and individuals can be lowered is by shifting more of the cost of illness out of the premium and into out-of-pocket spending at the point of service. A second strategy is to spread the risk of illness more broadly. A third approach is to reduce and control the cost of insurance either through direct regulation or through addressing the underlying cost of health care. These approaches are not mutually exclusive and there are a variety of ways of implementing each of them.

It also is important, at the outset, to determine what our goals are, and also, what constitutes a "solution." Is the goal of reform to make health insurance more stable and affordable for employers who already offer it, or is it to significantly increase the proportion of small employers who offer—and low-wage workers who elect—coverage? Different levels of intervention are needed to obtain different results.

We will begin by discussing a number of approaches (which are currently being debated and, in some cases, being tested) to making health insurance more affordable. We will conclude by trying to synthesize the most promising approaches into a sketch of a direction for a solution. The approaches listed in Chart III use one or more of the three broad strategies mentioned above to reform the nongroup or small group market or to create system-wide reform.

Chart III

Strategy	Individual Market	Small-Group Market	System-Wide Reform
Risk Shifting	High Risk Pool; Consumer Driven	Association Health Plans; Consumer Driven; Barebones; Tri-share	
Risk Spreading	Tax Credit; Premium Assistance; Reinsurance	Purchasing Pool; Premium Assistance; Tri-share; Reinsurance	Universal Coverage
Underlying Cost Reduction	Purchasing Pool; Consumer Driven; Medicaid Buy-in; Rate Regulation	Association Health Plans; Purchasing Pool; Consumer Driven; Medicaid Buy-in; Rate Regulation	Capital/Price Regulation; Universal Coverage; Quality / Efficiency Improvement

Purchasing Pools

Small-business purchasing pools, also called "alliances" or "cooperatives," were created during the 1990s as a way for small businesses to reduce their health insurance costs by jointly purchasing insurance. The theory behind purchasing pools was that forming a larger purchasing body would reduce costs for small businesses by spreading risk more broadly, reducing administrative costs, and giving them more purchasing power, which would allow them to exact pressure on insurers to hold costs down.

To date more than twenty states have passed laws authorizing or creating pools. Although some pools are initiated and run by private organizations, in most cases, the state itself administers the pool or sponsors a nonprofit entity that operates the pool. State-sponsored pools generally mandate a standard set of benefits and require employers to offer a choice of competing health plans. Health plan participation is voluntary, and the terms under which cooperatives can negotiate or choose between plans differ from state to state.[55]

While purchasing cooperatives have expanded the number of health plan choices available to participating small businesses, they have thus far failed to deliver on their primary stated goals: reducing insurance premiums and expanding coverage among small business employees. Studies to date have found no difference between premiums offered to firms participating in cooperatives and those in the wider small group market. The studies also have found that purchasing pools have not expanded coverage among the uninsured.[56]

According to a report by the federal Government Accounting Office (GAO), purchasing pools have failed to achieve premium reductions for three principal reasons. First, the pools have not attracted enough employers to gain the necessary purchasing leverage. Their share of the total group market, even in states with relatively successful cooperatives, is less than 5 percent. Second, administrative savings have not materialized since the need to market new plans and administer billing and benefits for many small firms replicates many of the costs cooperatives had hoped to avoid.[57] Third, many states have laws or regulations that prevent variations in premiums charged to groups for the same coverage in the small-group market. These regulations exist both to protect higher-risk consumers from paying steep premiums and to limit the possibility of adverse selection. If benefits, premiums, or pricing regulations available through the pool differ from those in the wider market, more high-risk groups may choose to enter the pool, driving costs up. This actually happened in Texas, where the regulations that governed the small-group market were altered for the pool so that premiums for high-risk individuals were lower than those available in the broader market, while those for healthy people were higher. As a result, a classic adverse selection "death spiral" ensued as large numbers of high-risk individuals joined the pool and many healthy people left. As a result, the Texas pool was forced to disband in 1999.[58]

The possibility of adverse or favorable selection is a serious problem confronting purchasing pools because they are voluntary. This leaves open the possibility that the pool as a whole will attract poor risks, individual health plans will attract poor risks because of their prices or benefits, and individual plans will compete on the basis of risk selection. In California, for instance, all of the participating preferred provider organizations (PPOs) dropped out of the pool due to adverse selection—poor health risks disproportionately selected the PPOs because they offered less restrictive benefits than participating HMOs.[59]

The perception among health plans that purchasing pools are an invitation for bad risks is the main reason that pools have had difficulty attracting plans interested in participating. Health plans have also been hesitant to participate for a number of other reasons, such as

their lack of interest in grouping their customers together so the customers can bargain with them for lower prices, their desire to sell directly to employers through the small-group market rather than “competing” with themselves by selling to the pool, and their preference for avoiding competition on price alone for a standardized set of benefits.[60]

The difficulty in attracting established health plans is closely related to the difficulty in attracting employers to take part in the pool. This is because pools need the clout and marketing capabilities of health insurers to attract employers. There is a negative feedback system at work here: health plans don’t feel compelled to participate because pools represent such a small segment of the total small-group market, and the size of the pool won’t increase significantly unless more health plans participate and attract additional employers.[61]

A similar problem is at work with respect to premium costs savings. Purchasing pools will not achieve administrative or premium cost savings until they have attracted enough employers to have a significant market share, but they can’t attract more employers until they demonstrate a cost advantage over the regular small-group market.[62] At present, small firms that do join the pools appear to be doing so because the pool offers increased choice and administrative assistance in selecting health plans.[63] Added choice alone, however, is not likely to attract enough firms to build the critical mass necessary to win cost savings that are, in turn, necessary to expand coverage to the previously uninsured.[64]

Purchasing pools alone do not seem capable of expanding affordable health coverage to small businesses and their employees. To be effective, they would have to work in combination with other policy changes, or as part of an effort that includes public subsidies. States, for example, could require that sellers of small-group insurance only sell to the pool, or that all insurance products offered in the small-group market must also be offered to the pool. Pairing the pool with a subsidy that lowers the cost of insurance for small businesses or low-income workers would go further toward stimulating demand, increasing market share, and lowering administrative costs.[65]

Association Health Plans

Association health plans (AHPs) are similar to purchasing pools in that they are a form of group purchasing arrangement that would, in theory, allow small businesses to join together in order to spread risk and better negotiate with insurers. Unlike purchasing pools, which are generally organized by a state government, AHPs are privately run and are not subject to many of the same rules. AHPs are composed of members of organizations who sponsor the plans, such as small-business trade groups or chambers of commerce.

AHPs already exist, but many in Congress as well as the current Administration support legislation that would change the rules governing them. While current AHPs are bound by state borders, the legislation under consideration would allow small businesses to unite across state lines. These new AHPs would be free from existing state regulation and would, instead, be licensed and regulated by the U.S. Department of Labor. AHPs, for

example, would be exempt from state requirements that insurance plans cover certain benefits such as diabetic supplies, and treatment for alcoholism. AHPs could also escape some of the state's premium-setting rules, and they would not be subject to state insurer solvency standards.[66]

AHPs might be able to offer lower premiums for some, but they will not help the overall problem of the uninsured, and they pose other significant problems. The major weaknesses that many, including the Congressional Budget Office (CBO), foresee stem from the AHPs' exemption from state regulations. Without state regulation of benefits, AHPs would be able to create less comprehensive benefit packages with lower premiums. According to a model constructed by the CBO, firms with AHPs would see their premiums reduced by about 13 percent. Of these savings, 5 percent would be due to the exemption from state benefit mandates. Most of the remaining premium reduction would come from favorable selection, while a negligible amount would stem from savings from group purchasing. Moreover, the CBO concludes that small businesses not currently offering insurance are unlikely to purchase AHPs to save money through group purchasing because group purchasing cooperatives already exist.[67]

The resulting reduced benefits packages would attract healthier firms, a tactic known as favorable selection or "cherry picking." In addition, AHPs would favor healthier firms by basing premiums on the expected health costs per enrolling employer. While this behavior is currently banned by most state premium-setting rules, the AHPs' exemption from these rules would allow them to charge high-risk clients more than low-risk ones.[68]

With mostly low-risk firms in their membership, AHPs could further reduce premiums because there would be fewer health expenses. Not only would this policy discriminate against the sick, but also has the potential to discriminate against women. State benefit mandates cover many health expenses particular to women, such as maternity care.[69] Most states currently ban this type of health care discrimination, but AHPs would be able to escape these regulations.

By attracting the healthiest firms and leaving the less healthy ones for state-regulated insurers, AHPs would force those state-regulated carriers to raise their premiums. Opponents, such as those from the National Small Business Association, fear that AHPs would create two small-business insurance markets: the association market and the state-regulated market.[70] Less healthy individuals would be forced into paying higher premiums in the state-regulated market. Opponents of AHPs also fear that lenient state regulations would increase the risk of plan insolvency and fraud. Because AHPs would be subject to more lenient federal solvency standards, they open the door to a greater risk of fraud, and AHP members would run a greater risk of paying for their own claims out of pocket if the AHP became insolvent.[71]

Additionally, and contrary to proponents' claims, the CBO states that AHPs would only insure 330,000 previously uninsured individuals. Furthermore, while AHPs would indeed reduce premiums for 4.6 million people, they also would result in increased premiums for

another 20 million. The increased premiums for firms with state-regulated insurance could cause many such firms to drop coverage.

While AHPs have a number of influential supporters within the small-business community, such as the National Federation of Independent Business (NFIB), a number of other entities, including small-business organizations such as the National Small Business Association (mentioned above), are opposed. Also opposed are the National Governors Association and the National Association of Insurance Commissioners

"Consumer-Driven" Health Plans

Consumer-driven health plans (CDHPs) are intended to cut health care costs by changing the existing insurance system that shields consumers from the true cost of health care. The proponents' theory is that by exposing consumers to the actual costs of medical care, CDHPs will encourage more efficient health care spending. The most common CDHPs combine a catastrophic insurance plan (a plan with a much higher deductible than is typically offered) with a health care spending account (HSA).

These plans provide employees with a fixed annual sum to be used for approved medical services. That sum can be replenished yearly by the employer, the employee, or both. Once this account is depleted, employees pay out-of-pocket for medical care that falls in the "employee gap" between the savings account and the high deductible. Once the deductible is met, the insurance plan starts covering expenses often with a certain coinsurance rate. Some plans include an out-of-pocket maximum after which the plan covers 100 percent of expenses; however, there may be no out-of-pocket maximum for services obtained out of network, or services that aren't covered, and those expenditures would not count toward the deductible.[72]

Proponents hope that providing consumers with their own health care accounts will encourage them to take more responsibility for how they purchase care. In many cases, unused funds from this account can "rollover" to the next year, and they can accumulate over time. This creates an additional financial incentive for members to watch their spending.

Consumer-driven health plans are based on the premise that discretionary choices by patients lead to a lot of unnecessary and costly care. According to Families USA however, there is little evidence to support this notion. Annually, about 50 percent of all health care services are used by only 5 percent of the population—those with chronic illness and disabilities who need extensive medical treatment.[73] The cost of care for these individuals would not be covered by health savings accounts but by the high-deductible plan, with the bulk of the cost of care far exceeding the deductible. As a result, the presence of the deductible would have minimal impact on spending. For the rest of the population, cost sharing could lead to a decline in obtaining necessary care. Opponents of CDHPs are particularly afraid that patients' heightened sense of financial responsibility will lead them to neglect important preventive care. To ensure that patients continue to seek this care, plans would have to include separate preventive care coverage that is not

deducted from the account, although no such requirement exists in current models.[74] Opponents also fear that patients will wait to obtain costly medical services until they have sufficient funds in their account, placing their health at risk.

Consumer-driven health plans pose many other problems. Adverse selection is a serious concern with CDHPs, because the healthiest members reap the greatest benefits. Employees who use health care services infrequently would benefit from this type of plan as their unused funds roll over to the following year and their accounts grow closer to the high deductible. Sicker members, on the other hand, generally pay more out of pocket with CDHPs than they would with traditional health plans. As a result, they will deplete the savings account quickly and be forced to use their own money to cover the high deductible. This disparity would have a significant destabilizing effect on the risk pool by causing healthier individuals to enroll in CDHPs while encouraging higher-risk people to remain in traditional plans. These traditional plans would, in turn have to charge higher premiums to cover the costs of their less healthy population.[75] The end result is this: the cost among the higher-risk and the healthy remain segmented, and the older and sicker population bears the burden of those higher medical costs.[76] (Again, heightened by the unprecedented tax advantages of HSAs, a number of health researchers including RAND, American Academy of Actuaries, Urban Institute, and others, predict that traditional plan premiums could more than double). CDHPs may also increase the uninsured population since employers might be inclined to drop coverage, citing the availability of tax advantaged HSAs in the individual market.[77]

HSAs also provide a tax benefit tilted toward upper-income households. Low-income families would not benefit from the tax deductions associated with this plan. With certain types of savings accounts, employees can deposit their own money. With some accounts, such as HSAs, this money could accumulate tax-free. After retirement, the investment can be withdrawn, included in the member’s gross income, and used for any purpose, including nonmedical purposes. Since this money will not be taxed, these funds can serve as a tax shelter. This feature would most benefit those with higher incomes because they are in a higher tax bracket.[78] For low- and moderate-income families however, the tax benefits are much less significant and do not offset the increased out-of-pocket expenses.[79] Also, many low-income households will not have enough disposable income to contribute to an HSA.

Lack of information is another serious problem with CDHPs. Simply entrusting consumers with a health spending account and increasing their responsibility for cost control does not make a plan truly “consumer directed.” Consumers need extensive information on health-care cost and quality in order to make truly informed purchasing decisions.[80] This information often is not available and, when it is, it typically is not presented in a readable, accessible form. Many health plans have their own websites and often include basic health information or recommendations, but they are less useful in addressing more complex situations such as determining the current best treatment for breast cancer or heart disease. Additionally, people must own—or otherwise have access to—a computer to obtain the online information.

Provider advertising, such as a hospital marketing its cardiac care services, is particularly worrisome because providers may present distorted information or manipulate rating systems in the competition for patients. For example, Hospital A could advertise a far better success rate for a certain procedure than Hospital B, but if Hospital A performs fewer and less complicated procedures, the rating does not necessarily reflect either hospital's true quality. Because there are no set definitions for health care quality, these ratings would be difficult to decipher.[81]

Finally, when people are left alone to purchase health care as individuals using their HSAs rather than being linked to group purchasing, such as through an HMO or PPO, they may find that the fees that they have to pay are higher. This is because they don't have an intermediary – such as an HMO or PPO – negotiating discounts on their behalf.

Ideal operating conditions for CDHPs include, among other things, the availability of lots of consumer information and support. Even if these ideal conditions were the norm, however, CDHPs still present serious problems. The savings-account–high-deductible combination inherently benefits the healthy, and this built-in favoritism could lead to adverse selection, more uninsured people, and the underutilization of needed health care services. Thus, while CDHP members may have more control and responsibility, CDHPs shift much of the cost and risk onto the sickest individuals.

"Barebones" Health Insurance

One way to bring down the price of health insurance is to reduce the scope of covered benefits. So-called barebones health insurance plans do this by eliminating minimum benefit mandates, reducing the scope of services that are covered, and making patients responsible for a much larger proportion of their health care costs. While this reduces their monthly premium, it exposes them to much greater financial risk. Barebones plans are essentially a risk-shifting strategy: less risk is pooled and more rests with the individual who gets sick. Stripped-down insurance policies have been around for a long time, and they have drawn criticism from some unlikely sources, including most major insurer associations.[82] The most telling critique has been that where these plans are available, they have attracted relatively little interest from employers and employees. Nonetheless, in the face of rising premiums, a number of states are again experimenting with barebones plans.[83]

One problem with barebones plans is that, as noted previously, the elimination of mandated benefits is unlikely to produce substantial savings. To achieve real savings, benefits must be cut dramatically. For example, the deductible in a plan would need to be raised from $200 to $1,300 in order to realize a 30 percent premium reduction.[84] While this is a very substantial increase in the deductible, it may be less burdensome than other options. Alternatives such as eliminating mental health and prescription-drug benefits would achieve comparable savings, but would also leave some of the very sickest people with tens of thousands of dollars in uncovered health claims.

For low-income people (the group least likely to have insurance today and thus most likely to be attracted by lower premiums), increasing cost sharing enough to make

premiums go down is likely to deter them from seeking needed medical care. It may also seem like a poor value, leading people to remain uninsured even if such a plan were available from their employer.[85] Furthermore, underinsurance could lead to serious financial problems, such as the inability to meet essential household costs or even bankruptcy.[86]

Another limitation of the barebones approach is that it invites risk selection. Because less-comprehensive policies are more likely to seem acceptable to healthy workers, low-risk individuals are more likely to buy them, while sicker individuals and groups will be more inclined to retain comprehensive coverage. The cost of comprehensive coverage inevitably will increase because of the sicker risk pool.

Tax Credits

Another approach to improving access to coverage would be to provide low-income individuals and families with refundable tax credits for purchasing policies in the nongroup market. There are a number of different tax credit proposals, each of which varies in the size of the tax credit provided and the income eligibility of the recipients. In general, the proposals would make the tax credits available to individuals and families below certain income levels who do not participate in employer-sponsored insurance (ESI) or public health-insurance programs. In theory, the tax credit would decrease the number of uninsured by making health insurance more affordable.

As part of its fiscal year 2005 budget, the current Administration has proposed a tax credit of up to $1,000 for individuals and up to $3,000 for families with children. The full credit would be available to individuals with incomes under $15,000 and to families with incomes under $25,000. The tax credit would be reduced for those with higher incomes and would disappear altogether when incomes reach $30,000 for individuals and $60,000 for a family of four.

Some key issues exist with tax credits as a solution to the problem of the uninsured. Two key ones are:

> The availability of the tax credit would encourage some employers to cease providing coverage for their employees because they would know that their workers could get a tax credit to purchase coverage in the nongroup market.[87] Jonathan Gruber of Massachusetts Institute of Technology estimates that employers would drop coverage for approximately 2.3 million workers.[88] An estimated 1.2 million of these currently insured persons would become uninsured because they would be unable to afford coverage in the nongroup market, even with a tax credit.[89] Overall, the employer-sponsored insurance system would be weakened by the increased number of people moving into nongroup plans.
>
> Having people buy into a largely unregulated nongroup market is not the most effective way to spend money in attempting to cover the uninsured. While the net movement of employees away from employer-sponsored insurance does not at

> first seem to be significant, the individual market does not have many of the HIPAA protections of the group insurance market. As a result, prices for a comprehensive health insurance plan are generally much higher for those in the nongroup market. In addition to price variation, employer-sponsored and nongroup insurance policies also offer differing levels of benefits. While employer-sponsored insurance policies tend to provide comprehensive benefits including maternity, mental health, and prescription drugs with relatively little variance between premiums, nongroup policies vary widely by benefits offered and the amount of premiums and out-of-pocket spending. A recent study estimates the average deductible for non-group insurance at of $1,550. The study also estimates that on average, these plans cover 63 percent of medical costs compared to 75 percent under employer-sponsored group plans."[90]

More fundamentally, the proposed tax credits are inadequate to make comprehensive health insurance affordable for many people. Older and sicker individuals are particularly at risk for being priced out of the nongroup market. In some states they also would have trouble finding coverage for their preexisting health conditions because of the lack of regulation of benefits and cost sharing.

In addition, health insurance would continue to be unaffordable for many low- and moderate-income families. The General Accounting Office estimated the mid-range premium for a comprehensive family plan in the individual market exceeded $7,300 in 1998.[91] Even without factoring in the increases in health insurance costs since 1998, a family of four with an income of $25,000 that received the full $3,000 tax credit would still have to spend more than 17 percent of its gross family income on premiums. There would also be additional out-of-pocket expenses in connection with deductibles and co-payments.

Because health insurance would remain unaffordable for many families, the number of people who would benefit from the tax credits is small relative to the growing number of uninsured Americans. Estimates of the impact of the Administration's tax-credit proposal have ranged from a reduction in the number of uninsured by as much as 4 million to as little as 1.8 million.[92] Even coverage of an additional 4 million people would leave more than 40 million people without health insurance. Moreover, the addition of 1.2 million previously insured people to the ranks of the uninsured also seems counterproductive to efforts to cover more of the uninsured.

Tri-Share Plans

Tri-share plans—in which premium costs are divided among employers, employees, and the public, with each paying roughly one third—are essentially a risk-spreading mechanism. In these plans, the general public—through the government—is taking on a share of the risk and cost of insurance for eligible small businesses and their employees. To the extent that only a limited benefits package is available, the tri-share approach also may involve some aspect of shifting risk onto insured individuals. Some programs have

sought to bring down overall cost even further by paying lower rates or relying on a limited provider network, or both.[93]

In general, these programs have tended to be local or "demonstration" in nature. None have been tried on a large scale to date. Constraints in philanthropic or public funding have prevented the programs from becoming widely adopted. These constraints also have limited plan enrollment.[94] In addition, although these programs may offer a substantially reduced premium, the employee's one third premium share, coupled with limited benefits, high cost-sharing, or both, may limit the number of eligible employees who choose to participate.[95]

Another barrier to the expansion of these types of programs is that providers and insurers may have concerns about their wide-spread adoption. A network of providers may be willing to offer reduced fees to a low-wage, previously uninsured population, but it might be reluctant to have those fees applied to a larger population. Similarly, insurers might not want to have their regular, unsubsidized offerings compete with the subsidized product. Insurers might also be concerned about adverse selection relative to more limited benefits plans. Limiting eligibility to low-wage employers who did not previously offer insurance could mitigate some of these concerns. It could, however, raise equity issues since similar employers who already offer insurance would not be eligible for the subsidized plan. Finally, even some of the successful demonstrations have recently run into administrative problems.[96]

Medicaid Premium Assistance

Premium assistance programs use public funds to subsidize the employee's contribution for private or employer-based insurance. These programs reduce the cost workers pay for individual or family coverage by spreading a portion of their risk to the tax-paying public. So far, twelve states have implemented premium assistance programs, nearly all funded through Medicaid or SCHIP (State Children's Health Insurance Program). Enrollment in these programs has been limited, both because the programs apply only to a small population (the low-income uninsured who have access to job-based insurance) and because they involve significant start-up costs and administrative challenges for states.[97]

Despite these obstacles, proponents of premium assistance claim the program has three main advantages:

- it is cost-efficient;
- it minimizes crowd-out, and;
- it encourages family coverage.

Proponents argue that premium assistance is more cost-efficient than traditional public programs because the state does not pay for the full cost of coverage. By subsidizing only the employee's portion of job-based premiums, the theory is that states can "capture" employer contributions, which cover the majority of the cost. This theory is built into federal rules, which require that premium assistance programs be more cost-efficient than

traditional public coverage in order for states to use Medicaid or SCHIP funding for that purpose.[98]

There is a disagreement about whether or not premium assistance actually saves states money, in part because there is no standard way to measure or compare cost savings. Some states report significant savings while others have elected not to pursue the strategy because of cost concerns.[99] It is clear, however, that potential cost-savings are at least partially offset by three main factors. First, commercial insurance is more expensive than coverage provided through public programs, and costs are rising more rapidly in the private sector. In 2002, the average premium for employer-sponsored family coverage was $7,954, and it had increased by an average of 7.1 percent since 1997. In contrast, the annual cost of covering a family of four through Medicaid was $7,107 and had increased only 4.8 percent over the same period.[100]

Second, premium assistance programs carry high start-up and administrative costs, while they have enrolled only small numbers of people—fewer than 5,000 in most states.[101] The strategy is administratively complex and presents a number of difficulties for states, which must design new information tracking systems. States must also take on much of the administrative work normally performed by insurers in order to ensure employer participation and protect employee privacy.[102] A feasibility study conducted in Colorado, for instance, found that the administrative cost of running a premium assistance program would be $1 million per year and would cover only 4,500 children.[103]

Finally, if measured in terms of cost per newly insured person, premium assistance may be more expensive than other public programs. In addition to the high administrative cost-to-enrollee ratio, many of the people who qualify for the program already have access to insurance. While the program may lower costs for these already-insured individuals, enrolling them drives up the cost states must pay to expand coverage to the uninsured. For instance, officials in Rhode Island reported a net savings of $2.8 million from their premium assistance plan in 2003, but that savings resulted from transferring enrollees from traditional Medicaid into employer-plans, not from enrolling newly insured families.[104]

Even if premium assistance does save the state money, these cost savings—being built around employer contributions—do not necessarily make the program attractive from the perspective of small businesses struggling with high health insurance costs. By reducing the cost of health insurance for employees, premium assistance may encourage workers who previously did not enroll in their employer's plan to take up coverage. The result is that the employer's total health insurance bill goes up. In addition, without subsidies that reduce the cost to employers for offering coverage, premium assistance does not encourage small employers who already cannot afford to provide coverage to start offering it.

Premium assistance supporters believe the strategy will help avoid "crowd-out," a term which refers to the replacement of private insurance with public insurance. Crowd-out is always a risk when states expand access to public insurance because many people who

qualify for and receive the new benefits may already be insured. For small firms that employ low-wage workers who are more likely to qualify for public benefits, the incentive to drop employee coverage can be particularly strong. Adding previously insured people to new public programs drives up the cost to the state. It also dilutes the programs' impact on reducing the number of uninsured. On the other hand—and from the consumer's perspective—a policy that creates crowd-out may reduce the cost currently paid by insured low-income workers for their health insurance, which is not necessarily a bad thing.

Since premium assistance would expand access to private job-based insurance rather than creating a new public alternative, proponents and some state administrators believe that it would minimize crowd-out.[105] Others, including states and the federal Centers for Medicare and Medicaid Services(CMS)) have predicted that premium assistance can actually increase crowd-out.[106] M. Susan Marquis and Kanika Kapur, in their article in the September/October 2003 issue of *Health Affairs*, for instance, point out that while a third of children who are low-income and uninsured have access to job-based benefits, only 15 percent of those who would be eligible for premium assistance are uninsured, leaving the door open for significant crowd-out.[107]

A number of states as well as CMS have proposed eligibility rules to control access to premium assistance specifically to prevent crowd-out. These regulations include waiting periods that prevent applicants from becoming eligible if they are currently insured and minimum employer contribution levels that prevent employers from reducing the amount they contribute to employee health plans.[108]

Supporters also argue that premium assistance would help parents and children find coverage under the same health plan. This is desirable because children are more likely to be insured and actually use services if they have the same coverage as their parents.[109] For example, state Medicaid expansions that include coverage for parents have proven to be more successful in enrolling uninsured children than programs that only cover children.[110] However, using premium assistance is not a very effective instrument for reaching families because it applies to a very narrow group of uninsured people. Only 17 percent of parents living below poverty have access to employer-based coverage.[111] But more than half of low-income children who have access to employer-based insurance, and who therefore might qualify for premium assistance, are already enrolled in that employer-based coverage.[112]

The problems targeting eligible children are closely related to the broader limitations of premium assistance as a strategy to expand health coverage generally. In other words, premium assistance would not increase coverage among the low-income uninsured because most of them do not have access to job-based coverage. Premium assistance programs are useful primarily for encouraging the take-up of insurance among the relatively small portion of the working uninsured who are eligible for job-based coverage but do not enroll. Nationwide, this is a small fraction of the uninsured.

While premium assistance may reduce the premium cost to individuals or families who wish to purchase private insurance, it does not lower the cost for small employers unless it is coupled with some kind of employer subsidy. For small businesses that already offer coverage to their employees, premium assistance programs may result in more employees enrolling in coverage, but the result would be a higher health-insurance bill for the employer. More importantly, premium assistance by itself does not help small businesses that do not offer insurance because of cost concerns. Some premium assistance programs, such as the one in Massachusetts, include subsidies to small employers to assist them in offering coverage. Even with this incentive, however, two thirds of the participating businesses were actually self-employed individuals, indicating the challenges policy makers face in making this strategy work for small employers who actually have employees.[113]

Medicaid Buy-ins

The concept of Medicaid buy-ins is almost the mirror image of the Medicaid premium assistance approach. With premium assistance, Medicaid dollars are used to subsidize private insurance premiums for Medicaid-eligible workers. Under the buy-in concept, private employers or individuals would be allowed to buy in to the Medicaid (or SCHIP) program on a sliding scale. This approach relies on both risk spreading and underlying cost reductions to reduce premiums. A Medicaid buy-in offers the advantage of cost-effectiveness, while providing a comprehensive benefits package with low cost-sharing.

Although the concept has been debated in several states (such as Rhode Island and Connecticut), the state that has come closest to implementing a buy-in program is Maine.[114] Under its Dirigo Health Plan, small employers in the state will be allowed to buy in to a state sponsored and regulated health plan (though the plan itself differs from Medicaid in several important respects). Workers for small firms who would otherwise be eligible for Medicaid will receive the full Medicaid package, but other workers may face higher cost-sharing and receive fewer benefits.

One of the reasons that Medicaid buy-in programs save money—and at the same time one of the reasons they are difficult to implement politically—is that Medicaid typically pays lower rates for services than do private insurers.[115] For this reason, hospitals, physicians, and other providers tend to oppose Medicaid buy-in plans. Insurers are also likely to oppose Medicaid buy-in programs since they do not welcome the competition from a state-run plan that has a greater ability to reduce prices. Opposition from health care providers and insurers probably accounts for why Maine ultimately did not use Medicaid or SCHIP as the vehicle to expand coverage to small businesses. Instead, it turned to a private, albeit more heavily regulated, insurer to offer coverage through Dirigo.

An additional barrier to using a Medicaid buy-in is that Medicaid may not be well accepted by employers and their workers as a source of coverage because it is a program associated mainly with providing coverage for the poor. If, however, a state's Medicaid

program contracts with the same commercial health plans that serve the rest of the population, this concern should be reduced.

Finally, a buy-in program for small businesses or individuals would probably be unsuccessful if not accompanied by private-sector insurance reforms. Critical reforms would include the reduction or elimination of the ability of private insurers to price-discriminate based on health status, age, and so on. Without such reforms, a public buy-in program would attract only higher-risk individuals and groups.[116] A public buy-in plan would also need a waiting period for those without continuous coverage in order to prevent people from waiting to enroll until they anticipated medical expenses.

High-Risk Pools

High-risk pools are state-run programs intended to cover people who are "uninsurable" in the individual or nongroup market. These are seriously ill or older patients who are either denied coverage by private insurers or are offered coverage that is unaffordable. In theory, high-risk pools are a good solution for states struggling to balance affordability with access to coverage for high-risk individuals. By removing high-risk patients from the individual market, pools reduce premiums for healthy people by allowing them to avoid risk. At the same time, pools try to keep premiums affordable for high-risk patients by spreading risk to other parts of the insured market through assessments on insurance companies or public financing.[117]

Thirty states have adopted high-risk pools, and many use them as an alternative to more stringent regulation of the nongroup insurance market. Unlike guaranteed issue or community rating laws, high-risk pools allow insurers to medically underwrite applicants, meaning insurers can deny coverage to or set high prices for high-risk applicants. Once applicants have been denied coverage, they are eligible to purchase insurance through the high-risk pool. Individuals who join the pool pay premiums that are higher than market rates, but all states cap premiums, generally at 125–200 percent of the cost of comparable coverage.[118]

Since these patients are by definition "uninsurable," all high-risk pools lose money, and states must supplement the premiums they collect with outside funds. Nearly all states do this by taxing insurance companies.[119] This is, in effect, a deal struck between states and insurers; insurers agree to pay the states in return for not having to bear the medical risk of the most expensive patients. Insurers favor high risk pools because they reduce the level of regulation of the nongroup market and eliminate the possibility for extreme adverse selection.[120]

Many policy makers also view high-risk pools as a good alternative to more extensive regulations. While reforms such as community rating and guaranteed issue have succeeded in reducing costs and increasing options for higher risk individuals, they also have resulted in higher premiums for healthier people, raising the specter of adverse selection by encouraging healthy people and health insurers to leave the market.[121] Evaluations of state reform efforts have shown that many of those reforms have resulted

in modest declines in health coverage. The most likely explanation is that more healthy people have given up coverage than sick people have gained access to it.[122]

While high-risk pools seem to offer a way to avoid these problems, they have failed thus far to produce the desired results. Enrollment in high-risk pools remains very low, and in most cases many more people are denied coverage by insurers than are picked up by the high-risk pool.[123] High-risk pool premiums are prohibitively expensive, especially for older people, so only relatively wealthy people can afford to join. These premiums are much higher than those in states that use other mechanisms to spread risk, such as community rating.[124] In addition, benefits offered through the pools are limited, and all states have preexisting-condition exclusions that can last up to a year.[125]

The need for state funding is an important factor limiting high-risk pool enrollment. States bear roughly 50 percent of the high cost of insuring the pool—the more people who join, the more expensive the pool becomes. As a result, states have not widely publicized the pools, and a few states have placed caps on enrollment.[126]

Overall, the results of this approach are problematic. While high-risk individuals have been kept out of the nongroup market by medical underwriting, they have not been able to get affordable coverage, even if it is technically available through the pool. In most states, the pool enrolls less than 1 percent of the individual insurance market. Only Minnesota has enrolled more than 3 percent of individual insurance buyers. Most states enroll fewer than 2,000 people.[127]

The question of whether high-risk pools can effectively provide access for high risk individuals, lower premiums in the nongroup market, and expand coverage remains a controversial one. Overall, high-risk pools have not achieved the promised results, but a few states have succeeded in enrolling a significant portion of the nongroup market. In these cases, the states have devoted substantial resources to ensure the pool is fully funded. Most analysts agree that in order to succeed, high-risk pools must be well funded, and a greater funding commitment from either states or the federal government is needed for them to enroll large numbers of high-risk individuals.[128] The Trade Adjustment Act of 2002 included $20 million to help states start high-risk pools, and $80 million to assist states that already have high-risk pools. It remains unclear, however, whether this money will solve problems affecting the pools.

Public Reinsurance

The cost of health care is not evenly distributed throughout the population. A small percentage of people use a high proportion of the services.[129] Public reinsurance involves reducing premiums for small businesses and individuals by removing a substantial portion of the expenses related to these high-cost cases from the insurance premiums, and spreading them instead across the general population. For example, a public reinsurance program could assume 75 percent of the cost of care that exceeds $15,000 for any covered individual. Such a program would reduce insurance rates by an estimated 16.1 percent for employer-sponsored insurance, and 21.2 percent for insurance through the

nongroup market.[130] Also, by covering a significant portion of the claims associated with sicker individuals, a reinsurance program could reduce the incentive for insurers to compete on risk selection.

The idea that the public sector should be responsible for paying for the highest-cost cases is already established in the Medicare and Medicaid programs, which serve the sickest and most expensive segments of the U.S. population (e.g. people in nursing homes). A public reinsurance plan would extend this government responsibility in partnership with the private insurance industry. Both the Healthy New York program and Senator John Kerry's health insurance reform proposal incorporate the idea of public reinsurance.[131] While the cost of a public reinsurance program would be substantial if applied to the entire private insurance market, reinsuring only individuals and small businesses (below twenty-five employees) would reduce the cost by over 75 percent.[132] A public reinsurance program could also be designed to stabilize premium increases from year to year, for example, by raising the reinsurance point by GDP growth instead of the rate of health insurance premium increases. This would help keep premiums affordable over time.

While public reinsurance could be part of the solution to making health insurance affordable for small groups and individuals, it is more likely to help provide some relief and stability to employers and individuals who already have insurance. It would not necessarily convince large numbers of uninsured to obtain coverage. Achieving this larger goal would likely require additional measures to make premiums affordable.

Health Insurance Rate Regulation

Most health insurance regulation has dealt with aspects of the industry other than price, such as insurer solvency and insurer rating practices.[133] While some states have regulated prices for some lines of business, the trend has been away from government intervention in prices. Massachusetts, for example, regulates price increases only for Medicare supplemental insurance. New York imposed a limit on premium increases in the small group market, but the limits were subsequently repealed in January 2000.[134] Nevertheless, with rapid escalation of premiums, a number of states are looking again at insurance premium price regulation. Some states that have considered it in recent years include California, Rhode Island, and Hawaii.[135]

The purpose of insurance premium regulation is to lower the underlying cost of health care by putting pressure on health insurers to hold costs down. Rate regulation can also force insurers to operate more efficiently, spending a larger percentage of premium dollars on benefits and less on overhead and profit. Health insurance rate regulation involves having the state oversee—and in some cases, require—reductions in the price of health insurance charged to some individuals or groups. Implicit in a move to rate regulation is the assumption that competitive dynamics among insurers are not strong enough to hold prices in check.

One reason for doubting the effectiveness of competition is the actual operation of insurance markets over recent years. Contrary to what market proponents predicted, the market has been characterized by large premium increases and increased concentration among health plans. There is reason to believe that these two phenomena may be linked.[136]

A recent analysis by the RAND Corporation argues that regulation could lead to short-run cost savings, but it also raises concerns about its long-term effects. Notably, the analysis raises the possibility that insurers would respond to price regulation by reducing the quality or quantity of health services available by seeking to discourage high-risk people from enrolling, or by exiting the market altogether. RAND also argues that profit levels in the California health insurance industry do not suggest monopoly pricing.[137]

Insurers exiting the market may not really be a problem. As noted above, there is an ironic dynamic in health insurance markets in which having more insurers means they are weak buyers who have an incentive to compete on risk avoidance rather than cost containment. On the other hand, having strong buyers relative to providers requires that insurers have a monopoly or oligopoly position, which may limit their incentive to keep prices down. Hence, there arguably is a need for regulation. Whether even stronger insurers can contain costs remains an open question. Insurers must have the ability to influence price and utilization trends. While managed care organizations had some initial success in these areas, as discussed above it appears that this was time-limited.

Insurers clearly have some control over their own cost structure, and pressure from a regulatory agency could be expected to force some economies in this realm. That will not, however, be sufficient to make a significant difference in the price of insurance. Ultimately insurers may not be able to achieve these outcomes, and a more direct government role in other areas (e.g. capital and technology expansion, prescription drug prices) may be necessary. At present, there is reason to be skeptical about the political will that would be necessary to make this level of government intervention effective. If market concentration continues though, and if breaking up the risk pool would only lead to weak purchasers and competition based on risk avoidance, some increased regulatory oversight of prices may be the only alternative.[138]

Direct Regulation of Capital and Provider Prices

If indirect control of provider prices and utilization through insurance regulation has its limits, what about the prospects for more direct government action? The results of such efforts in the past have been mixed. Methods for containing the rising cost of health care have been attempted by states in various forms. Historically, these techniques have focused mainly on the regulation of hospitals and their ability to charge patients and payers higher prices. These regulations can include restricting the rates hospitals may charge payers, and putting limits on costly hospital expansions that generally translate into higher prices for consumers. The intent of both of these methods is to maintain a degree of state control over the increases in health care costs. More recently, states have

been experimenting with "indirect regulation" of prescription drug prices through efforts to re-import prescription drugs from other countries that regulate prices.

One common regulatory tool for controlling health care costs was the "certificate of need" process (CON). CON has been used in almost every state as a way to restrict an oversupply of hospital beds and a proliferation of expensive diagnostic equipment and services. In order to enter a health care market or to expand a building or service, the provider must apply to the relevant state agency to show there is an unmet need that the new facility or service will fill.[139] The concern is that if there is an overabundance of one service, it will not be utilized, and the hospital will be required to overcompensate for the lack of demand by increasing prices.

CON began with a federal mandate contained in the National Health Planning and Resources Development Act of 1974. By the 1980s, almost every state had passed a CON law.[140] When the federal law was repealed in 1986, many states initially maintained their laws. Since the 1990s, however, a number of those laws have been amended to lessen the restrictions or have been repealed altogether.[141] Currently, approximately 35 states maintain some form of CON law.

The Federal Trade Commission (FTC) released a report in 2004 regarding competition in health care in which it recommends that states consider alternatives to the CON laws.[142] The report points out that "there is considerable evidence that [CON laws] can actually drive up prices by fostering anticompetitive barriers to entry."[143] The FTC believes that because CON laws require entities to engage in a comprehensive review process, they unnecessarily restrict new technology from entering an area, leaving consumers without the benefits of these new treatments. The regulation of new providers that want to move into an area also reduces the opportunity for new entities to bring new competition, and it leads to reductions in the cost of care.[144]

Although the FTC believes that CON has not been effective as a cost-containment tool, there is some evidence in Louisiana – one of the states that did not pass a CON law -- has created an over-saturation of hospitals resulting in an overabundance of beds. The state now has "an average of 2.8 acute-care hospitals per 100,000 residents, way above the national average of 1.7."[145] Because the existing hospitals are having a difficult time filling their beds, the hospital association is asking the state to impose a moratorium on new hospitals.

While many states are moving away from CON, some are strengthening their laws. Maine, for example, is embarking on an innovative revival of CON. Under the Maine system, which was created as part of a comprehensive health care reform package in 2003, the state will establish a plan. Proposals for capital expansion will have to address plan priorities. What is novel about this plan is providers—including nonhospital providers like ambulatory surgery centers as well as acute care hospitals—will have to compete head to head for a limited amount of capital expansion. It is too early to know what the effect will be.

The tentative conclusion is that while CON has not been effective in moderating health care costs, eliminating CON will not solve the problem either. CON attempts to avoid oversupply, but it protects oligopoly. Logically, to be successful, CON would have to be accompanied by other measures (e.g. rate setting) to control cost.

A number of states implemented rate regulation laws in the 1970s in response to high health care prices (and high hospital prices in particular). The intent was to control costs by letting the state set hospital rates and requiring every payer to pay the same price. Initially, rate regulation had a broad base of support, including insurance associations, hospital associations, and state legislatures. However, this support waned in the 1990s as insurance companies discovered they could negotiate lower rates for hospital services and manipulate the rate-setting system.[146] One by one the laws were repealed, and rate setting was largely dismantled.

Today, Maryland is the only state that has retained a hospital rate-setting system. Hospital rates are set annually by an entity called the Health Services Cost Review Commission (HSCRC). In order to set the rates equitably, this entity operates with four guiding principles:

- to keep the information about pricing public;
- to review and approve hospital rates;
- to collect information regarding transactions between hospitals and the financial interests of its trustees; and
- to keep hospitals working efficiently.[147]

Maryland has been able to maintain such a system because all pricing information is made public. Equally important is the fact that even Medicare, through the operation of a federal waiver, is required to comply with the rate setting program. This is key to the program because Medicare is the largest single payer of hospital bills.

It’s important to note that even though rate setting may be out of favor in the in the private sector, public insurers such as Medicare and Medicaid have been fairly successful in using their ability to essentially set their own prices to control costs. For example, Medicaid per capita is growing more slowly than private insurance.[148]

Another interesting development with respect to price regulation has been the surge of interest in prescription drug reimportation from Canada and other countries that regulate the price of drugs. Drugs in other industrialized countries with price regulation may cost as much as 33–55 percent less than the same drug in the U.S. [149] Interestingly, efforts at both the state and federal level have focused on importing drugs from countries with regulated prices rather than on adopting the policies that produced the lower prices in the first place. This suggests that promoting direct price regulation is very difficult in the current U.S. political environment. Even the new Medicare prescription-drug legislation eschewed Medicare’s typical cost-control strategies in favor of market orientation. That law explicitly prohibits government from engaging in price negotiations with drug manufacturers.

In sum, experience with direct price regulation has been mixed. While public payers have enjoyed at least some success, experience with CON and hospital rate setting have, on balance, been less useful in controlling health care costs. Experience with prescription drugs as well as lessons from the demise of rate setting in a number of states suggest that the barriers to effective use of price regulation are as much political as they are technical in nature.

Universal Public Insurance

An oft repeated observation is that countries with universal health insurance pay less for health care than the United States does.[150] Furthermore, public insurance programs, both domestic and foreign, are typically much more administratively efficient than the private health insurance system in the U.S.[151] Since small and nongroup insurance are the most administratively expensive segments of the health insurance market, reductions in administrative costs could potentially reduce total cost. Additionally, to the extent that cross-subsidies for the care of the uninsured are built into private insurance premiums, we would expect that a system of universal coverage would eliminate—or at least reallocate—those costs. The effect, however, of a universal public insurance program on any segment of society depends on the financing system. Thus it is impossible to ascertain with any certainty the general effect on any particular individual or employer. In addition, the rate of growth of public insurance systems in other countries has largely paralleled that of the U.S. over the long haul.[152]

Even if universal public insurance were shown to represent a definitive cost savings for small employers, or at least to those small employers who currently provide health insurance, there are formidable barriers to enacting a plan that would involve a large expansion of the government's role in health care and the resulting crowding out of private insurance providers. Those barriers make enactment of universal public insurance a long-shot strategy for making health coverage more affordable for small employers and individuals.

Quality Improvements

Improvements in the quality of health care provided could reduce the cost of health insurance. Reduction in unnecessary medical procedures, medical errors, preventable hospitalizations, and disease incidence would result in more efficient care, while improving the experiences of patients. [153]

Poor quality of care can result in a variety of preventable complications and even deaths. For example, the Institute of Medicine estimates that medical errors cause between 44,000 and 98,000 deaths per year. The cost of these mistakes, which includes the expense of providing the additional care needed because of errors, lost income and productivity, and disability, totals between $17 and $29 billion.[154] Actions that have been taken to reduce medical errors include standardization of procedures and an increasing use of technology. For example, some hospital systems have begun to build the infrastructure necessary to prescribe drugs electronically, thus reducing the chances of

incorrect medications or dosages being dispensed at the pharmacy. Increasing access to early care and treatment can also reduce costs because it will decrease the number of preventable hospitalizations.

These steps towards quality improvement may come slowly because a major overhaul of the current health information systems is needed to provide accurate and timely information on health-care performance at all levels. Routine availability of information will allow health professionals to better determine appropriate care for each patient. Health care professionals and patients must then work together to ensure that high quality care is delivered consistently.[155] While small businesses will not be expected to take the lead on these issues, they can help by being supportive of efforts to improve the quality of health care.[156]

With respect to better prevention, diagnosis, and treatment, a significant number of hospitalizations could be avoided if earlier diagnosis and treatment were readily available. For example, a study in Massachusetts found that 46 percent of outpatient visits to hospital emergency departments were preventable or avoidable.[157] Tobacco use and obesity are the two leading preventable causes of death in the United States. Tobacco use is responsible for killing more than 440,000 people every year, while excess weight and physical inactivity are causing 400,000 deaths each year.[158] Millions more suffer from a serious tobacco- or obesity-related illness. Not only do these diseases have significant human impacts, but they also have a very real fiscal impact on our health care system. In 1998, smoking caused an estimated $75 billion in health care costs annually.[159] About half of these costs were shouldered by private insurers or the patients themselves.[160]

Part VI—Recommendations

For our purposes, a solution is a package of reforms that achieves the original purposes of insurance -- spreading the financial risk and cost of illness broadly -- and keeping insurance available and affordable regardless of health status. At the same time, special attention needs to be paid to the unique qualities of the small-business and nongroup insurance markets. With this as a definition, proposals that reduce premiums for some by shifting risk onto sicker people, either in the form of dramatic cuts in benefits or pricing health insurance based on actual or expected risk, fail to qualify as solutions.

Solutions aimed at reducing underlying costs seem, at first glance, to offer more promise. Several approaches that purport to do this, such as association health plans, actually rely on cost shifting as their primary cost-reduction mechanism. Others, such as purchasing pools, have been shown to be largely ineffective at reducing premiums regardless of their other merits. Medicaid buy-in strategies are likely to provoke provider and insurer opposition. Larger systemic reforms may offer benefits that are too diffuse and uncertain in their time horizon to attract sufficient political support from small employers and individuals.

By and large, this leaves "risk spreading" as the most promising short-term approach to achieving meaningful insurance coverage for small groups and individuals at prices lower than now generally available. It is possible to imagine a package of reforms that would achieve these goals. One necessary but insufficient component would be to limit direct and indirect risk selection. Limiting direct risk selection would require enactment of provisions such as guaranteed issue, limited waiting periods, and preexisting-conditions exclusions, as well as elimination of pricing based on actual or expected health costs. These reforms are widely, though not universally, in place in the small-group market, but they are less prevalent in the nongroup market. Limiting indirect risk selection would require some standardization of benefits packages to avoid recreating segregated risk-pools by the "back door." It would also likely require some policing of insurers' commission policies so that brokers are not given a financial disincentive to enroll less desirable groups. In order to keep premiums within reach however, it is likely that such standardized packages would have somewhat higher cost-sharing requirements than those that are typically available from large employers.

In and of themselves, the above reforms are likely to raise rather than lower premiums—insignificantly in the small-group market, to the extent they are not already in place, and more substantially in the nongroup. In the context of the nongroup market though, it is important to remember that insurance pricing based on health status is not really insurance at all. Therefore, additional steps need to be taken to achieve the necessary premium reductions. Such steps could include a combination of publicly financed reinsurance to broadly spread the cost of high-cost cases, and premium or cost-sharing assistance to further reduce the cost of coverage for low-wage workers. Premiums for these market segments could be reduced further if the public sector were to absorb some of the inherently higher administrative costs associated with individual and small-group coverage. This could be accomplished by creating a publicly sponsored pool to handle some of the administrative tasks. Finally, modest savings could be achieved by obtaining

agreements from a network of providers to reduce fees for certain low-income enrollees who would, in the absence of the above-mentioned public subsidies, more than likely be uninsured.

This balanced approach, offering a moderately comprehensive package of benefits, accompanied by some significant cost sharing, and with mechanisms to broadly spread the risk for high-cost cases (an extension of the role government already plays in the health system via Medicare and Medicaid), could achieve premium reductions in the vicinity of 30–50 percent. Reductions would be even greater for the lowest-income enrollees who would have the largest premium subsidies. The main obstacle is that such an outcome cannot be achieved without a significant expenditure of public funds. In addition, in order for any approach to be stable over the long run, steps must be taken to slow the spiraling cost of health care. Therefore, initiatives to reduce medical errors, avoid preventable hospital admissions, and more rigorously evaluate new technologies and capital expenditures are essential parts of any long-term effort to address the growing problem of affordability.

Part VII—Conclusion

To date, efforts to reform the small-group and nongroup insurance markets have been only partially successful. In many states, steps have been taken to make insurance more widely available, but reform efforts have faltered when it comes to addressing affordability. It is reasonable to suppose that states have hesitated to tackle the affordability issue because doing so would require spending and, in all probability, raising tax dollars.

The failure to address the affordability problem has led to a growing inability of individuals and small employers of modest means to afford insurance. This in turn has fueled a backlash against some of the reforms of the 1990s. A return to the ethos of "every person for himself," however, will exacerbate and not solve the problems facing these groups. Risk shedding and cherry picking are dead ends with respect to health insurance coverage. Only by clearly recognizing this fact and summoning the political will for broader risk-sharing via the public sector, can we secure access to affordable insurance.

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