

HERITAGE TALKING POINTS

A Checklist on Vital National Issues

**A POLICY MAKER'S GUIDE
TO THE HEALTH CARE CRISIS**

PART IV

**THE RIGHT ROAD TO
HEALTH INSURANCE REFORM**

By Edmund F. Haislmaier



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By Edmund F. Haislmaier¹

INTRODUCTION

As Part III of this Heritage Foundation *Talking Points* series explained, there are a number of serious problems with the current health insurance system in the United States.² These problems stem largely from the fact that health insurance is provided through the workplace. This, in turn, results from federal tax policies which offer very generous tax relief for employer group health insurance but virtually no tax relief for health insurance purchased directly by individuals or families. Among the problems:

- X Health insurance is not portable for workers, who lose coverage when they change or lose their jobs, and their families.**
- X Employment-based groups can be faced with sudden cost increases or loss of coverage when members incur costly illnesses.**
- X Sick individuals can be dropped from employer group coverage and find it impossible to get new coverage.**
- X Employment-based health insurance does not guarantee long-term medical cost protection for workers and their families.**

In response to these and related problems, various proposals are being advanced to reform the health insurance market. Many of these focus on the particular problems of the small group market, that is, small employers who currently find it difficult or impossible to afford the cost of providing their employees with health insurance. The reform proposals are being offered by business groups, academics, and even representatives of the health insurance industry. Lawmakers from both parties are sponsoring health insurance reform bills in Congress, and many state legislatures are considering, or have recently enacted, health insurance reform legislation.

¹ Edmund F. Haislmaier is The Heritage Foundation's Health Care Policy Analyst.

² See Edmund F. Haislmaier, "A Policy Maker's Guide to the Health Care Crisis, Part III: What's Wrong With America's Health Insurance Market?" Heritage Foundation *Talking Points*, August 14, 1992.

Some proposals would make changes in health insurance regulations while leaving the rest of the health care financing system largely untouched. Examples include: a small group market reform proposal by The Blue Cross and Blue Shield System, and S.1872, the "Better Access to Affordable Health Care Act," sponsored by Senator Lloyd Bentsen, the Texas Democrat.

Other proposals offer a package of health insurance reform measures as part of a broader plan for health care reform. Examples include: President Bush's health care reform proposals; H.R. 5936 the "Managed Competition Act," sponsored by Representative Jim Cooper, the Tennessee Democrat; S. 1936, the "Health Equity and Access Improvement Act," sponsored by Senator John Chafee, the Rhode Island Republican; H.R. 3205, the "Health Insurance Coverage and Cost Containment Act," sponsored by Representative Dan Rostenkowski, the Illinois Democrat; and S. 3348, "The Health Care Access and Affordability Act," sponsored by Senator Orrin Hatch, the Utah Republican.

Basic Building Blocks. Lawmakers confront a difficult and confusing task when attempting to compare competing insurance reform plans and evaluate their likely effects. The reason is that the various plans are, simultaneously, very similar and very different. They are similar because they are all constructed from the same set of basic building blocks. They are different because each plan arranges those basic building blocks in a different fashion.

Each of these health insurance reform proposals is, in fact, a package containing a number of specific reform elements. Each reform element, or building block, is a discrete change in the way health insurance is regulated. While they are all constructed using the same set of basic elements, the various reform plans are distinguished by their authors' decisions to omit certain elements, include others, and even further modify some of the elements they include.

The purpose of this *Talking Points* is to help sort through the complexity and confusion surrounding health insurance reform. Rather than offering critiques of one or more of the proposed reform packages, this *Talking Points* examines and evaluates a number of the specific elements commonly found in various reform packages. These include concepts such as community rating, small employer purchasing groups, and guaranteed issue, to name a few examples. It explains the rationale behind each type of proposed change in health insurance regulations, and analyzes the likely results of adopting that particular change.

In examining the basic concepts and elements of health insurance reform, this *Talking Points* relies on the discussion of the economics and principles of insurance set forth in *Talking Points* Part III. This *Talking Points* also examines some of the fundamental, common premises underlying health insurance reform proposals. It argues that starting from the wrong premises leads many would-be insurance reformers to advocate changes which, if enacted, would have undesirable results.

Finally, this *Talking Points* presents an alternative set of insurance reforms, based on a different set of premises, which would help to create a smoothly functioning, universal, consumer-based health care system of the kind described in *Talking Points* Part II.³

3 See Stuart M. Butler, Ph.D., "A Policy Maker's Guide to the Health Care Crisis, Part II: The Heritage

THE WRONG ROAD TO HEALTH INSURANCE REFORM

Although health insurance reform proposals may seem to vary widely in their specifics, in fact, most share the same basic reform strategy. Virtually all of the proposed reform packages begin with the premise that the current employer group health insurance system should be retained. In other words, they start by accepting as a given the system developed, largely by accident, in the 1940s. Their principal objective is to fix the gaps and problems in the existing system while retaining its basic structure. This strategy immediately distinguishes these proposals from other, more far-reaching plans, which would replace the current employment-based system with either a consumer-based system or a government-run national health insurance system.

Having started with the strategy of retaining employment-based health insurance, these reform plans then offer a number of specific changes in health insurance regulations designed to solve the system's problems. Though the various reform packages combine and modify them in different ways, many of the specific reform elements they contain are quite similar.

Rather than evaluating numerous different reform plans separately, a better approach is to break them into their constituent parts and examine each of the more common basic concepts or reform elements. Most of the basic elements used to construct various reform packages can be placed into one of four categories, according to the problems they try to address. Those categories are:

- 1) Reforms designed to make health insurance more affordable for small businesses by enabling them to buy coverage as part of a larger group.
- 2) Reforms designed to limit the ability of insurers to increase rates or dis-continue coverage for small businesses.
- 3) Reforms designed to increase access to health insurance for individuals and groups who are costly to insure, by requiring insurers to cover them at below-market rates.
- 4) Reforms designed to reduce the cost of health insurance by eliminating laws dictating the services policies must cover and how insurers must pay health care providers.

As noted, most proposed reforms are premised on retaining an employer group health insurance system. There are some, however, which would apply either to an employment-based group system or to an individual, consumer-based system. Most proposed reforms also would increase government regulation of the health insurance industry. Again, however, there are some exceptions. For example, one common proposal is to repeal state laws requiring insurers to cover specified procedures or the services of specific providers. This reform would apply to either group or individual insurance, and would decrease, rather than increase, regulation.

The following is an analysis of the various types of specific reforms, arranged in the above four categories according to the problems they seek to address.

REFORM CATEGORY #1:

Reforms designed to make health insurance more affordable for small businesses by enabling them to buy coverage as part of a larger group.

Health insurance reformers frequently note that small businesses must pay higher per capita rates for coverage than do larger businesses. And they note that when even one member of a small employer group suffers a costly illness, the group's premiums can escalate dramatically—by a much greater percentage than would be the case for a large group in similar circumstances. These higher costs make it more difficult for small businesses to afford to purchase and retain coverage for their workers and dependents.

Reformers argue that there are two reasons for the disparity in insurance costs. First, the administrative costs to an insurer of marketing and servicing a large number of small group policies are greater than the administrative costs associated with a small number of large group policies. Second, in employer group insurance each group effectively constitutes a separate risk pool. Consequently, a small group has fewer members than a large group among whom to spread the cost of a major claim.

Thus, one solution proposed by many reformers is to combine small businesses and their employees into larger groups for the purpose of purchasing health insurance. These reformers believe that such arrangements will lower the per capita administrative cost of insurance for members of the larger group and stabilize their rates by spreading claims among a larger risk pool. They also believe that the market clout of a larger group gives small businesses increased leverage to negotiate discounted coverage from insurers. Furthermore, they believe that larger insurers will have increased leverage to negotiate discounts from doctors and hospitals.

The common term for such an arrangement is Multiple Employer Welfare Arrangement (MEWA). Other terms used include Multiple Employer Trust (MET) and Health Insurance Network (HIN). The latter term is used in President Bush's health care reform proposal.

So-called managed competition reform proposals, such as H.R. 5936, the "Managed Competition Act of 1992," sponsored by Representative Jim Cooper, the Tennessee Democrat, would create similar entities called Health Plan Purchasing Cooperatives (HPPCs). Under H.R. 5936, the government would authorize the creation of one HPPC in each geographic area. Individuals and small and medium-sized employers would belong to the HPPC and choose coverage from the plans with which the HPPC negotiates agreements. Those plans would be required to meet minimum benefit and coverage standards set by the federal government.

A recent survey estimated that in 1990 there were 1,034 MEWAs covering 2,581,431 beneficiaries in 46 states.⁴ Several health insurance reform proposals contain incentives to encourage the formation of additional MEWAs. The Bush

⁴ United States General Accounting Office, "States Need Labor's Help Regulating Multiple Employer Welfare Arrangements," March, 1992.

Administration's proposal, for example, would encourage the formation of HINs by extending to them the ERISA preemption from costly state insurance regulations.⁵ Similarly, legislation (S. 1872) sponsored by Senator Lloyd Bentsen, the Texas Democrat, would provide states with grants to assist employers in creating small employer purchasing groups.

Such groups can indeed reduce administrative costs through economies of scale and can use their market clout to obtain discounts from insurers and providers. However, lawmakers should be hesitant to accept this rationale as adequate justification for public policies designed to promote greater concentration in the health insurance industry. As in other sectors of the economy, bigger is not always better.

Fixation with this line of reasoning has led some policy makers to propose health care reform plans (such as managed competition plans) which would limit the health insurance market in each geographic area to a handful of tightly regulated insurers. Indeed, proponents of the single-payer approach to health care reform, which would establish a government monopoly to fund all health care in a state or the nation, use this reasoning to project substantial administrative savings under their plans.

Few lawmakers, however, would argue in favor of legislating cartels or monopolies in other industries on the grounds that they could produce cheaper products through economies of scale. Whatever their virtues, the lack of competitive pressures on monopolies and cartels inevitably leads them to become costly and inefficient in other respects. Market competition still is the best method for creating the optimum level of concentration in an industry and the optimum prices for its products.

Q: But won't these group purchasing arrangements bring down health care costs by enabling large risk pools to be formed so as to avoid difficulties associated with small groups?

A: Not necessarily. The problem is that although premium costs may indeed be reduced somewhat in the short term, over the long term the premium savings generated by these arrangements are likely to be marginal or even non-existent for most firms. The reason is that MEWAs don't meet all of the necessary criteria for a sound risk pool.

The essential criteria for any sound risk pool are that it be reasonably large, reasonably stable, and contain a reasonably random mix of risks among the members. The size, stability, and randomness of a risk pool affect the accuracy with which an insurer can project future claims costs. The more constant the claims costs, the less the variation from year to year in renewal premiums. When insurers create their own risk pools, they have a natural incentive to structure them to meet these three criteria. Also, a very large employer group is one of the few examples of an existing group that meets all three criteria.

⁵ ERISA is the acronym for the Employee Retirement Income Security Act of 1974. ERISA permits a firm to run its own health insurance plan (called a self-insured plan), rather than buying a plan from a traditional insurance company. The advantage of a self-insured plan under ERISA is that it is regulated by federal law and is thus exempt from costly regulations imposed by states on traditional insurance plans. For a more complete discussion of ERISA, see *Talking Points* Part III, p. 17.

However, while MEWAs fulfill one of the criteria for a sound risk pool—large size—they do not fully meet the other two necessary criteria—stability and randomness.

A MEWA may have as large a group as a major firm, but it is much less stable. This is because business failures and employee turnover rates tend to be much higher for small businesses than for large corporations. MEWAs also have a greater potential for evolving over time into a less random mix of risks through adverse selection.⁶ This is because a small employer with one or more employees likely to incur high medical costs will have a strong incentive to join a MEWA. On the other hand, a small business with a young, healthy work force may find it cheaper to purchase insurance on its own. Thus, over time, firms with relatively sick employees will tend to join the group and firms with relatively healthy employees will leave it, pushing up the average medical risk of the group and thus its premiums. For this reason, a MEWA with, say, 1,000 small businesses, each with an average of ten employees, will tend over time to include far more high-risk individuals than a single large employer group of 10,000.

In addition, the more personal nature of small business likely would make the adverse selection problem worse. For example, the owner of a small business participating in a MEWA, may be inclined to give a job to a friend or relative with a costly medical condition simply so that he or she can gain insurance coverage. It is much more difficult for even top executives of a large corporation to engage in such hiring practices.

REFORM CATEGORY #2:

Reforms designed to limit the ability of insurers to increase rates or discontinue coverage for small businesses.

Two of the most common elements in current health insurance reform proposals are a legal requirement that insurers provide guaranteed renewable coverage to employer groups and limitations on how much insurers can increase renewal premiums. The latter provisions usually consist of “rating bands” or percentage limits on how much the renewal premium for a given group can vary from the average premium charged to other employer groups with similar characteristics. The idea is that groups which are similar, except for the health status of their members, should be charged similar rates. For example, a reform proposal containing rating bands might specify that insurers cannot charge a particular group a rate that is more than, say, 15 percent above or below the average rate it charges other groups which are similar in size, geographic location, demographic profile, type of industry, and type of insurance plan.

⁶ Adverse selection is the propensity of those who expect to file insurance claims to be more inclined to seek coverage than those who do not expect to file claims in the near future.

These reforms are essentially attempts to correct for the undesirable results produced by the practices of experience rating and optional renewability in employer group health insurance.⁷

Over time, the economic effect of rating band restrictions on renewal premiums would be to reduce the cost of coverage for higher risk groups but increase the cost of coverage for lower risk groups. This would create an adverse selection problem, because high-risk groups would be inclined to keep renewing their policies, while low-risk groups would find it advantageous to obtain coverage from insurers who insure only low-risk groups and thus have lower average premiums. The result would be that higher risk individuals would be concentrated in fewer and fewer plans with higher average premiums. This would particularly be the case if insurers were also prevented from discontinuing a group's coverage, a provision included in many reform plans.

In an attempt to prevent this kind of adverse selection and market segmentation, many reform plans also would require insurers to provide coverage to all employer groups that apply for insurance. This concept is called "guaranteed issue" and is discussed below.

REFORM CATEGORY #3:

Reforms designed to increase access to health insurance for individuals and groups who are costly to insure, by requiring insurers to cover them at below-market rates.

The group insurance reforms discussed above place restrictions on the premiums that insurers can charge when renewing policies for groups they already cover. Other reforms would impose restrictions on the premiums an insurer could charge a group when it first applied for coverage. The idea behind these reforms is to expand access to health insurance for higher risk groups or individuals. Most health insurance reform proposals contain one or more of the following steps:

Community Rating. Under a community rate law, insurers are prohibited from charging different premiums for different groups within a given area or "community." In other words, everyone is charged the same rate for health insurance, regardless of the potential cost to the insurer of covering the group. Community rating can also be applied to coverage sold to individuals.

Underwriting Restrictions. These provisions limit the ability of an insurer to set premiums based on an applicant's expected use of medical services, and thus potential cost to the insurer. The most common restriction is to prevent insurers from limiting or denying coverage to a group or individual because of an individual's pre-existing medical condition.

Guaranteed Issue. Under a guaranteed issue law, insurers are required to provide coverage to any employer group which applies for it. This requirement usually

⁷ Experience rating is the practice whereby an insurer bases the premiums charged in one year on the costs a policyholder incurred in the previous year. Optional renewability is a provision in an insurance contract stipulating that the insurer reserves the right not to renew coverage in the next contract year. For a more detailed explanation of these practices and their effects on the health insurance market, see *Talking Points Part III*, p. 14.

is coupled with limits on how much an insurer can vary the premiums it charges different applicants.

Technically, all of these restrictions can be called “underwriting restrictions,” because they limit the flexibility of insurers in setting the initial, or underwritten, premium for coverage, as opposed to subsequent renewal premiums.⁸

All of these restrictions are in effect price controls, limiting the price an insurer can charge for its product. And like all price controls, they always produce winners and losers, and the losers always try to evade the controls.

Under community rating, for instance, the price of health insurance is artificially lowered for higher risk individuals and groups, and it is artificially raised for those who are lower risk. Preventing insurers from considering pre-existing medical conditions in setting premiums has much the same effect. Advocates of these controls point out, of course, that there are desirable results. The controls, for instance, permit many high-risk individuals or groups to obtain coverage at affordable rates. This is because those who are low-risk pay higher premiums to cross-subsidize those who are high-risk. But there are other, less desirable cross-subsidies which would occur under a community rating scheme. Some examples:

- X Younger workers and families, who tend to have better health status but lower incomes, would be subsidizing older workers and families with generally poorer health status but higher incomes.
- X Prudent health care consumers would be subsidizing wasteful consumers.
- X Depending on how “community” is defined, people who live in relatively low-cost areas might find themselves subsidizing those who live in high-cost areas. Since individuals can be winners or losers depending on which “community” they find themselves assigned to, this can make the process of defining “community” boundaries contentious.

Q: Are there ways to deal with these problems?

A: Some proposals do try to correct for these side effects of price controls through what is called “modified community rating.” These proposals make exceptions to the basic community rating principle of charging everyone the same premium by permitting a limited degree of premium variation according to age, sex, or other demographic factors. Of course, these are steps back toward market pricing, which does reduce the problems somewhat.

As with any set of price controls, the losers have powerful incentives to evade them. A firm might decide to self-insure its young, healthy work force,

⁸ Underwriting is the process by which an insurer decides whether or not to accept an insurance application and, if accepted, on what terms. The initial underwritten premium reflects the insurers calculation of the potential probability and liability of the risk or risks it is agreeing to cover. For a more detailed discussion of underwriting and the calculation of premiums based on the probability and liability of risks, see *Talking Points Part III*, pp. 4, 7-8.

for instance, rather than facing higher community-rated premiums in a community in which older, less healthy individuals predominate. If that option were impractical, or ruled out by government,⁹ healthy workers or their employers might avoid being overcharged simply by not buying health insurance at all. This choice would be particularly attractive if there were a guaranteed issue law requiring insurers to provide coverage to all applicants, since individuals or groups could delay applying for coverage until their current or anticipated medical bills exceeded the cost of the insurance. As soon as their health care spending dropped below the premium level, the group could drop the coverage.

Q: *Wouldn't the solution to this problem be to require everyone to buy the high-cost health insurance?*

A: That would achieve only a small reduction in the problem. Such insurance still would be a bad value for healthy people. The incentive for these individuals would be to get their money's worth by increasing their use of medical services and paying little heed to the cost.

This problem already occurs when a company provides a very generous plan that all its workers—including the young and healthy—must join. As noted earlier, the workers all share the cost of these plans through reduced wages. It also occurs in countries with national health insurance where healthy people are charged more in taxes than the value of the services they would otherwise consume if they bought medical care and health insurance on their own.

In both cases, patients are encouraged to think that the bills are being paid by someone else (their employer or the government), and thus they have an incentive to ignore the costs of the services they demand. Paradoxically, this problem is made even worse when patients realize that ultimately they are the ones paying—through part of their wages in an employer-sponsored insurance system or through their taxes in a nationalized system. The reason for this is that once they realize that they are ultimately paying, but have no way to lower those payments, consumers have a stronger incentive to increase their consumption to get their money's worth from the system.

Q: *But isn't it farfetched to think that people who really don't need medical services will consume them anyway?*

A: Not at all. While it is common to think of medical treatments as something painful which people wish to avoid, this stereotype simply doesn't fit many medical services. In many cases doctors or patients have considerable discretion on choosing treatments. For example:

- ◆ Should the patient with a recurring headache immediately get a CAT scan or should less expensive tests and treatments be tried first?

⁹ In other words, if the federal government repealed the existing ERISA exemption for self-insured plans, as is advocated by some proposals.

- ◆ Should the patient with a very slight heart murmur undergo an additional very expensive test now, or wait and see if the condition develops into something more serious?
- ◆ Should a woman whose first child was delivered by Cesarean section try to deliver her second child normally, or should she and her doctor automatically plan for another C-section?
- ◆ If the condition is one where changing the patient's dietary or other habits is a promising course of treatment, should that be tried first or should the physician prescribe a drug which does not require the patient to make inconvenient lifestyle changes?

In a system in which doctors are paid more for doing more, but patients are not directly charged more, it is easy to see how doctors and patients can be encouraged to pick the more expensive option when confronted with these kind of decisions.

The most clear-cut example of patients increasing consumption to match predetermined health care payments occurs today with tax-free "flexible spending accounts." Under current federal law, employers can create flexible spending accounts for workers to use in paying medical bills not reimbursed by the employer's health insurance plan, such as deductibles and uncovered services. The rules stipulate that at the beginning of the year the employee chooses the amount (up to a set maximum) to be deducted from his pre-tax wages and placed in the tax-free account. The employee cannot increase or decrease that amount during the course of the year, and at the end of the year, any unused portion reverts to the employer. Because of this "use it or lose it" rule, employers find that workers who still have funds remaining in their accounts near the end of the year, tend to spend those funds during December on things like new eyeglasses or teeth cleaning.

Q: But isn't this true of all forms of insurance, not just health insurance?

A: No. A driver does not say, "I've paid a lot in premiums for my auto insurance and it's about time I had a wreck so that I can get something back in claims on my policy." The reason is that, with their auto insurance, consumers are buying protection against unforeseen losses. In other words, they are buying true insurance.

However, people do have a tendency to behave like this when they buy an extended warrantee on a car. They have a strong incentive to take the car to a mechanic at least once to see if they can claim any repairs on the warrantee before it expires. The similarity with health insurance is that with an extended warrantee the consumer is not buying true insurance protection. He is really buying pre-paid auto repair, and naturally wants to get his money's worth.

As noted in Part III of this *Talking Points* series, many of the problems with today's health insurance system can be traced to the fact that it really is not health insurance. It is more like an annual system of pre-paid medical care. Consequently, consumers treat it as such. Using community rating schemes to force people to pay more for what is really pre-paid medical care

will simply exacerbate this type of costly behavior. The current behavior of workers with "use it or lose it" flexible spending accounts is a prime example of what would result from forcing people into a system of community-rated health insurance.

Q: But isn't the whole purpose of health insurance to spread risks by paying the claims of sick people with the premium income from healthy people?

A: Yes. But the way to do so is not by forcing healthy people into a costly system of pre-paid medical care. The answer is to offer people true health insurance. That is, to provide them with long-term protection against major medical expenses (not routine health care), and charge them premiums that reflect their true risks. Under a true health insurance system, most people in any given year would pay premiums but file little or nothing in claims because they do not suffer a major illness. As with other forms of insurance, policyholders would accept this because they know that their premiums are buying them certainty. The certainty is that should they incur a major medical expense, the insurance company will pay the claim and they will not lose their coverage or find their rates hiked sharply the next year.

As noted in *Talking Points* Part III, with any form of true insurance, what the commodity insurers sell and policyholders buy is certainty. While prepayment of routine medical care, or any other commodity, may be an attractive arrangement for some people, it is not true insurance. True health insurance offers certainty, not prepaid services, in exchange for the consumer's premium. This makes it a good value to buy, even if the policyholder never files a claim.

REFORM CATEGORY #4:

Reforms designed to reduce the cost of health insurance by eliminating laws dictating the services policies must cover and how insurers must pay health care providers.

There are numerous existing state laws which stipulate the coverage health insurance policies must provide, or how insurers must pay certain providers. These laws fall into two broad categories: mandated health insurance benefit laws and anti-managed care laws. In general, the effect of these laws is to increase artificially the cost of health insurance policies. Consequently, many health insurance reform proposals contain provisions designed to eliminate some or most of these laws.

At the state level, insurance reform proposals either would repeal these laws outright, or provide exceptions to them for certain kinds of health insurance policies. At the federal level, insurance reform proposals would preempt these state laws with federal law. In many cases, federal insurance reform proposals would impose similar, though much less sweeping, new coverage requirements on insurers.

Mandated Health Insurance Benefit Laws. Under pressure from health care providers and advocates seeking coverage for various diseases, states have enacted during the last two decades over 800 mandated benefit laws requiring insurers to cover specified medical services or conditions.¹⁰ Examples include requiring cover-

¹⁰ For a more detailed discussion of mandated benefit laws and their economic effects, see: John C. Goodman,

age of: chiropractors, dentists, podiatrists, physical therapists, nurse midwives, acupuncture, *in vitro* fertilization, mammography screening, and prosthetic devices. The effect of these laws has been to guarantee markets for the favored health care providers with predictable results: an increase in the use of mandated services by policyholders and an increase in the fees charged by providers of those services. This, in turn, artificially increases the cost of health insurance.

Anti-Managed Care Laws. A number of states also have enacted so-called anti-managed care laws. These laws restrict the ability of managed care plans, such as Health Maintenance Organizations (HMOs), to contract with a limited number of providers to treat their enrollees. The laws also limit the cost-sharing plans can impose on enrollees who seek treatment from unapproved providers.

Managed care plans encourage patients to use certain physicians and hospitals to control health care costs or improve services for beneficiaries. Typically, a managed care plan designates selected doctors and hospitals as the preferred or exclusive providers of services to its enrollees. In return, the selected providers agree to accept the plan's reimbursement rates and any other agreed-upon restrictions. The plan then gives its enrollees incentives to seek treatment from its approved providers by offering full payment for their services, but lesser or no reimbursement for treatments obtained from an unapproved provider.

State laws requiring plans to reimburse all licensed health professionals, or to contract with any provider who accepts the plan's rates, effectively limit the ability of managed care plans to control costs, quality, and service delivery through selective contracting. Similarly, laws which restrict the degree of cost-sharing that managed care plans can impose on enrollees obtaining treatment from unapproved providers serve to limit the ability of plans to steer enrollees toward more cost efficient providers—which is managed care's primary objective. Again, the effect of these laws is to increase the cost of health insurance.

Q: If these state laws increase health insurance costs, why did states enact them?

A: Because providers lobbied for them and many consumers supported them out of a belief that such laws are a way to get someone else—namely, employers and insurers—to pay for their medical care. This is rational to many consumers because they live under the illusion that employers actually pay for health benefits. In reality, employers view such benefits as part of a worker's total compensation package. The higher the cost of benefits, the lower the money for cash compensation. Most consumers, however, usually do not make this connection.

In general, repealing or preempting mandated benefit laws and anti-managed care laws, as many insurance reform proposals would do, is a positive step. However, it is important that any such reform be structured so as to discourage the future reintroduction of these laws.

Ph.D. and Gerald L. Musgrave, Ph.D., "Freedom of Choice in Health Insurance," The National Center for Policy Analysis, *Policy Report* No. 134, November, 1988, and John C. Goodman, Ph.D., "Regulation of Health Insurance by State Governments," in Tex Lezar, ed., "Making Government Work: A Conservative Agenda for The States," Texas Public Policy Foundation, 1992.

THE SEARCH FOR IDEAL INSURANCE REGULATION

The competing health insurance reform plans proposed by policy makers include a combination of the insurance charges discussed above. The problem, as indicated in the examination of each reform tactic, is that solving one shortcoming of the current insurance system invariably creates a new difficulty. What federal and state policy makers are searching for is the mix of government regulation that will achieve the goal of universal, affordable health insurance coverage, while limiting undesirable side effects.

It is likely to be a fruitless search. Like ancient alchemists mixing chemicals in a vain quest for the combination that would turn lead into gold, most policy makers are pursuing the wrong line of inquiry because their basic premises are incorrect. Policy makers need to step back and re-examine three central premises. If they do, they will find that there is another and much better path that takes them to their goal of universal and affordable health care coverage.

MISTAKEN PREMISE #1:

Health insurance should be employment-based.

Any health care system tied to employment faces an interminable set of inherent problems not found in other systems. The first is how to maintain some continuity of coverage when workers change or lose their jobs. Even if a family is assured that it will have another policy if the bread winner changes jobs, the new policy might mean a change in covered services, or may force the family to switch doctors against its wishes. This portability of benefits problem, as it is called, would not occur in a consumer-based health insurance system in which tax relief or other help to buy coverage is channeled directly to individuals and families regardless of where the breadwinner works. A consumer-based system would allow families to obtain health insurance unconnected to the place of work—much like they now do for life homeowner's or auto insurance. Nor would the problem occur in a government-based national health insurance system, where every citizen is given government health insurance.

The second set of problems results from the natural employment patterns found in every labor market. Any health system based on an employer group model inevitably will face difficulties in adjusting for the presence of the unemployed, the self-employed, part-time workers, seasonal workers, low-income workers, families with more than one wage earner, and workers with more than one job. Again, these difficulties are absent, or more easily adjusted for, in consumer-based or government-based systems.

Third, any employment-based system must contend with a variety of problems resulting from writing health insurance on an experience-rated, optionally renewable basis since that is the natural, and only practical, way for insurers to write employer group coverage. In order to eliminate experience rating and guarantee renewability, it is necessary to create and enforce long-term insurance contracts. But a workable long-term contract is all but impossible to create without some stability in the contractual arrangement. When one party to the contract (the employer group) is constantly changing, the other party (the insurer) will be unable to make reliable projections concerning future costs.

To understand why this is a problem, consider what would happen to mortgage lenders if property owners could transfer their property, together with the mortgage, to anyone at any time without the mortgage lender having any say in the transaction. Lenders would be forced to accept the new owner as the borrower without so much as a check of his or her credit worthiness. The longer the mortgage period, the greater the risk of a defaulting borrower. Under such a scenario, few if any mortgage companies would offer long-term mortgages.

Employment based groups change constantly as a result of business expansions and contractions, employee hirings, firings, and voluntary departures, and the addition and subtraction of dependents through marriage, divorce, birth, adoption, or children attaining majority. Because of this inherent instability in an employment group, and the resulting high degree of uncertainty about future costs for the insurer, it should not be surprising that virtually all employer group health insurance contracts are written on a short-term (usually annual) basis, and that they are experience rated and optionally renewable. An insurer would face an enormous financial risk if he wrote plans in any other way.

Q: Why can't government mandate long-term health insurance contracts between employers and insurers?

A: It could. But, if the government did mandate such coverage, it would need to provide a complex web of regulation and cross-subsidies to protect insurers from insolvency. Without such guarantees, a responsible insurer would refuse to participate in the market. Yet even with this protection, it is unlikely that such a regulatory structure would function well, leading many prudent insurers still to avoid the market.

Q: But would it be possible to construct long-term insurance contracts outside of the employer-based system?

A: Yes. In a consumer-based health insurance system, long-term contracts are quite possible. This is because the contract is between two constant parties — the individual and the insurer. Such long-term contracts are common in the individual life insurance market. In the case of family health insurance policies, it is true that there would be changes in the makeup of the family due to marriage, divorce, births, adoptions, and grown children leaving home. But these would constitute only a few changes over a long period of time, and the basic contract could easily be amended to accommodate them. In contrast, there can be numerous changes in an employer group every year. In the case of a government system, long-term insurance contracts are irrelevant. Since the government is the only insurer, it has the power unilaterally to alter the "contract" as it sees fit.

Q: If reforming the employer-based system is so difficult, why do policy makers insist on operating within this framework?

A: Because most lawmakers are naturally cautious, preferring incremental reforms to sweeping reforms. As noted in Part III of this *Talking Points* series, employ-

ment based health insurance is largely an historical accident.¹¹ The two reasons for retaining it are force of habit and a fear of the political risks associated with replacing any longstanding system. But replacing the entire system may, in fact, prove to be the only solution—and the one that is, both economically and politically, the most realistic. Indeed, if America had no health insurance system today, and lawmakers decided to create one from scratch, it is very unlikely they would construct an employment-based system.

MISTAKEN PREMISE #2:

All, or most, medical care should be paid for through health insurance.

The fallacy behind this premise is the idea that health insurance is not a means of health care financing but an end in itself. This in turn results from a fundamental misunderstanding the true nature and limits of health insurance. It is an error committed by all those who see the solution to America's health care problems simply in expanding access to health insurance, whether through employer mandates, the creation of a universal national health insurance system, or heavy regulation of the health insurance industry.

Q: But isn't health insurance the best way to pay for medical care?

A: Not always. Health insurance is just one means of financing medical care. In some circumstances it is an economically efficient, and thus desirable means. But in other circumstances it is an inefficient means, and thus inferior to purchasing medical care directly.

As noted in Part III of this *Talking Points* series, certain conditions must be present to make something an insurable risk.¹² In the case of most routine health care, like most routine auto repair, those conditions are not present. Therefore, any third-party "insurance" payment system is in practice pre-payment of medical care. While pre-payment of medical care may at times be desirable, if improperly done it can lead to a misallocation of health care resources, over-utilization and over-pricing of services, and wasteful administrative costs.

Q: Does that mean prepaid medical plans are a bad idea?

A: No. There is nothing inherently wrong with individuals purchasing pre-paid medical care plans. But for such plans to function efficiently, individuals must purchase them directly, so that they realize they are buying pre-paid medical care and not insurance. As noted earlier, consumers naturally seek to get their money's worth out of any prepaid plan, whether in health care, auto repair, or anything else, by seeking more of the services the plan pays for. Even worse, if consumers do not buy pre-paid health plans directly (as is the case today where employers buy the plans for them), they tend to view the benefits as "free" and increase their consumption of health care services accordingly.

¹¹ *Talking Points* Part III, pp. 16-17.

¹² For a more complete discussion of the criteria defining an insurable risk, see *Talking Points* Part III, pp. 5-7.

Furthermore, for the market to be efficient, government tax laws or regulations should not bias—as they do now—the consumer’s decision when choosing between paying for routine medical care out-of-pocket at the point of service or buying a pre-paid plan. The consumer’s decision should be simply a question of personal preference.

Q: How exactly does the federal tax code bias a consumer’s choice between pre-paid medical plans and direct payment of routine expenses?

A: In the current system there is a tax bias in favor of pre-paid medical care offered through an employer because, while such plans are free of income and Social Security taxes, there is no tax relief for out-of-pocket purchases other than in unusual circumstances.¹³ Moreover, for all practical purposes, current tax relief is conditioned on the consumer remaining largely ignorant of the cost of his pre-paid medical care. Again, this is because tax relief is extended almost exclusively to plans purchased through employer groups, over which consumers have little direct say.

Q: If more people were to pay directly for routine medical care, what would be the role for insurance?

A: While it would be more economically efficient for consumers to purchase routine medical services out-of-pocket, assuming they were to receive tax relief for doing so, there would still be an important role for true health insurance: protection against the costs of unexpected and expensive illnesses. But the problem with the current employment-based health system is that because of the inherent inability of insurers to write group health insurance on a long-term basis, virtually all medical care is financed through what amounts to an annualized pre-payment system. Financing costly, unexpected illnesses through an annual pre-payment system makes no sense for either individuals or groups because large, unexpected costs are not spread over time—one of the key functions of insurance. In the case of small- or medium-sized groups, the costs also are not spread over a large risk pool—another key function of insurance. What does make sense, and is most economical and efficient in such circumstances, is true insurance protection.

Q: Does that mean much of what is called insurance is not insurance at all?

A: Exactly. A distinction should be made between true insurance and pre-paid medical care, and public policies should be crafted so that they account for that critical difference. While this can easily be done in a consumer-based system, it is all but impossible to do in either employer-based or government-based systems.

¹³ The tax code does allow an itemized deduction for out-of-pocket expenses in excess of 7.5 percent of adjusted gross income. However, this provision provides relatively little tax relief and few families qualify for it in any event.

MISTAKEN PREMISE #3:

Access to health insurance and medical care for the disadvantage (the poor and high risk) is best achieved through market and price regulation.

Much conflict and confusion in health policy centers on the question of how to achieve "social equity." In the case of health care, social equity is usually taken to mean universal access to affordable medical care for every family, regardless of differences in income and health status among Americans. The chosen methods for achieving this desirable goal are largely what distinguish liberal and conservative solutions in the current national health care debate.

As an abstract model for allocating scarce resources, liberals generally concede the superior efficiency of free markets. But they point out that free markets alone cannot achieve the goal of social equity. In a free market, unassisted poor families likely would be unable to afford the medical care they need. Likewise individuals afflicted with unusually frequent or severe illnesses would find it very burdensome, if not impossible, to finance the cost of their care.

In seeking social equity, liberals typically seek to adjust for differences in income and health status by heavily regulating, or eliminating entirely, most vestiges of the free market. They tend to suggest either complete government control, or restrictions on supply and distribution of goods and services, or price controls. But as tighter regulations and controls are imposed, more and more of the natural efficiency of sound markets is lost.

Conservatives take a different approach to the problem. Rather than excessively tampering with the normal operation of free markets or regulating prices, conservatives generally seek to provide the disadvantaged with the extra purchasing power they need to buy into the market on the same terms as the more fortunate majority.

Q: But why aren't government regulations and price controls an effective way to provide health care to lower income people?

A: Because such controls create more problems than they solve, and thus never work. By analogy, consider how different governments help the poor to obtain food. In some socialist countries the government tries to make food affordable to the poor by forcing farmers and stores to charge artificially low prices. In the process, these governments destroy market efficiency and incentives. The results are poor quality goods, waste, and shortages, which harm everyone—the poor and the affluent alike.

In the case of health care, efforts to achieve social equity by tampering with the normal operations of markets chiefly involve attempts to regulate the prices of medical care and health insurance. For example, under government-based national health systems the price of medical care is set at zero at the point of service, while the cost of the system to each family varies and is set by tax policy. What the government then pays doctors and hospitals determines the availability of treatments. For any given treatment, if the government pays too little, less will be provided. The same holds true when price controls are imposed on a non-government system, such as the current employer-based system. Indeed, the problems of price controls are compounded by the inherent problems with any employment-based system discussed earlier.

Consequently, the most desirable combination would be a consumer-based system, operating in a sound, free market, coupled with government tax policies and programs designed to help the disadvantaged buy into the market at the least cost to society and with the least disruption.

TRUE HEALTH INSURANCE REFORM WITHIN A FREE MARKET FRAMEWORK.

To construct the policy framework for a consumer-based health system, imagine what Americans would seek in a free and open market for medical care and health insurance. To start with, few people would want a completely unregulated market. Most would agree on the need for some basic regulations to secure property rights and ensure the enforcement of contracts. They would also like to see some regulation of providers, such as licensing requirements, to ensure that they are technically competent. Similarly, most would desire regulations to guarantee insurer solvency and prevent deceptive and fraudulent practices.

In such a market with little regulation beyond these basics, how would people buy medical care and health insurance? Likely they would make a distinction between routine and major medical care. For routine care they would tend either to pay out-of-pocket as the need arose, or to buy into a pre-paid plan to simplify or systematize their purchases. This would be like buying an extended warranty on a new car or some other type of service contract.

For emergencies and major medical care, families would tend to seek and buy insurance protection. But consumers would want protection over the long term, not the short term. It would do consumers little good to have a major illness paid for by insurance but then be unable to renew their coverage, and thus be left exposed to the full costs of any future major illness. Consequently, consumers would want policies that guaranteed them the right to renew coverage.

Q: But why would insurers operating in a free market want to guarantee consumers the right to renew coverage?

A: They would do so for two reasons. First, if they wanted to survive in the market they would have to respond to consumer demands. But second, it would be in the insurers' interest to write guaranteed renewable policies. To remain solvent, an insurer needs premium income from healthy policyholders to offset the cost of paying claims for sick policyholders. Healthy people would be willing to pay premiums but receive little back in claims if they were given a guaranteed right to renew coverage and thus obtained for their premiums certainty, the very commodity they seek from any insurance.

Q: But couldn't insurers in a free market sharply raise rates on sick people year after year, as they do today?

A: Yes they could, but such a practice of experience rating would also not be in their own best interest. If policies were experience-rated, guaranteed renewability would be, for all practical purposes, meaningless. If the year after a policyholder filed a major claim the insurer could raise his or her rates

to unaffordable levels, the effect would be the same as the insurer refusing to renew the coverage. But again, such a practice would not be in the insurer's own best interests. If the policies an insurer offered were experience-rated, the coverage would not provide the protection, or certainty, that consumers seek. In addition, if the rates were adjusted each year according to individual claims experience, healthy people would have no incentive to pay more for a policy than they expected the policy to pay out in claims during the coming year. Consequently, the insurer would lose the premium income it needed to remain solvent. Thus, non-experience rated renewable plans would drive out experienced rated plans from the market. Unless, that is, the latter were artificially encouraged by regulations and tax laws, as they are today.

Q: So, in a free market, health insurance would take on the same characteristics as other kinds of insurance?

A: Yes. In effect, health insurance would be structured in a way similar to life insurance. Like life insurance, but unlike auto insurance (where experience rating and optional renewability are actually desirable features), health insurers would be spreading costs not only over a *group* but also over *time*. Moreover, health insurance, under a market-based reform, would tend to favor strong back-ended, or catastrophic coverage. Small claims would also tend to be reduced. This would be a sound and sensible practice. Just as everyone will eventually die, virtually everyone will suffer at least one major illness during his or her lifetime. Thus for the health insurer, like the life insurer, the question is not *if* a loss will occur, but rather *when* it will occur and how *big* it will be.

Q: So, how would health insurance be sold in a free market?

A: It would probably be bought and sold on an individual or family basis. This is because individual insurance is the simplest and most effective way to provide portable coverage and long-term protection—the two things consumers are most interested in obtaining.

Q: Does this mean that in a free market large group health insurance would disappear?

A: No, but it would be different from today's employer-group health insurance. Insurers likely would offer wholesale purchase discounts to groups of individuals who bought coverage together. A term for this practice is "franchise insurance." With franchise insurance a group negotiates lower rates for its members from an insurer, but the group does not constitute a separate risk pool. Instead, the insurer separately underwrites each group member buying the insurance and gives each his or her own policy, which can be retained even after leaving the group. The different individuals also can purchase varying levels of coverage, such as the same policy but with different size deductibles. All of the group members who purchase the insurance are then placed by the insurer into a much larger risk pool, together with other policyholders who either bought coverage on their own or through a different group.

The reason why franchise group insurance purchases would be a natural development in a free market is that the insured would tend to receive a discount, because in applying as a group, the members would save the insurer much of the normal marketing costs associated with recruiting each policyholder separately. An example of this practice is discounted auto and homeowner's insurance offered to members of the American Association of Retired Persons (AARP).

Q: How would a free market approach affect insurers' underwriting practices?

A: Insurers would use their calculations of probability and potential liability in underwriting applicants. They would charge different premiums to different applicants based on such things as each applicant's age, sex, and health status at the time he or she first purchases coverage. Of course, this means that higher risk individuals initially would be charged higher premiums. But all policyholders would have a right to renew their coverage, and future changes in their health status would not affect their renewal premiums.

Q: But doesn't this mean that low-income, high-risk people would not be able to afford their premiums?

A: Low-income and high-risk individuals and families would indeed face higher costs for medical care and health insurance. But the solution to this problem is not to reimpose regulations on the market. Rather, the answer is to design tax policies and public programs which provide the disadvantaged with the extra purchasing power they need to buy into the market. The Heritage Consumer Choice Health Plan described in *Talking Points* Part II details ways that this can be done, primarily by using tax credits.

Q: Would the adoption of the Heritage Consumer Choice Health Plan eliminate the need for specific insurance reform?

A: No. Creating a consumer-based health care financing system along the lines of the Heritage plan would lead eventually to the kind of health insurance system described above, that is, insurance with a strong catastrophic component. But to smooth the transition to such a system, to deal with unusually high-risk individuals, and to further reduce the costs of health insurance in general, the Heritage plan calls for eight specific health insurance reforms:

Reform #1: Require insurers to provide guaranteed renewal of individual and family policies. Every person and every family would be protected against being dropped from insurance coverage.

Reform #2: Require insurers to base renewal premiums for individual and family policies on the carrier-wide, or policy-wide, average increase or decrease in claims costs. This means that insurers could not force sick people to drop their coverage by singling them out for steep, unaffordable rate increases.

Reform #3: Prohibit insurers from changing premiums for individual or family policies on the basis of changes in an individual or family's health status. Again, this would prevent insurers from forcing sick people to drop their coverage by hiking their premiums.

Essentially, these first three reforms simply would require insurers to begin writing policies the way they would eventually in a normal market. The first reform would ensure that guaranteed renewability becomes a standard feature of health insurance contracts. The second and third reforms would end the practices of insurers engaging in experience rating or new underwriting of policyholders when they renew coverage.

Reform #4: During the transition from the current employer group insurance system to an individual coverage system, require insurers to extend individual coverage to all persons they now cover through employment-based group plans. This means that currently insured Americans would not lose their coverage.

Reform #5: In converting from group to individual coverage, prohibit insurers from increasing premiums by more than 25 percent on the basis of age, sex, and geographical adjustments. This would protect individuals who are currently insured, but sick or high-risk, from being charged sharply higher premiums during the transition from employer-group to individual insurance.

Reform #6: During the transition, randomly assign uninsurable individuals who are currently uninsured to carriers. This would ensure that this very small minority of individuals also would be able to obtain affordable coverage.

Reforms #4 through #6 would only apply during the transition from group to individual insurance. They would guarantee that high-risk individuals who are now covered by group insurance, or are uninsured, gained individual coverage at reasonable rates. Once they received individual insurance, high-risk persons would have the same protection as everyone else against insurers dropping their coverage or charging them experience-rated renewal premiums.

Reform #7: Federally preempt state mandated insurance benefit laws. This provision would prevent states from continuing to enforce the costly mandated benefit requirements they previously imposed on insurers, thus lowering the cost of insurance.

Reform #8: Federally preempt state laws restricting selective contracting and managed care plans. This provision would prevent states from continuing to enforce the restrictions they have imposed on HMOs and other managed care plans which make it difficult or impossible for those plans to lower costs by selectively contracting with doctors and hospitals.

Essentially, reforms #7 and #8 would suspend state insurance regulations which artificially increase the cost of health insurance. Many other health insurance reform packages at both the federal and state levels contain similar reforms.

As noted earlier, under the present employment-based system consumers usually do not realize that they are the ones who ultimately pay the added costs imposed by these laws. But once consumers begin paying for their own insurance directly under a consumer-based system, they would be inclined to resist the imposition of mandated benefit laws that raise the cost of their coverage.

Furthermore, under the Heritage Consumer Choice Plan, Americans would receive tax relief for their out-of-pocket medical expenses as well as for their health insurance premiums. Because they would no longer need to buy routine medical care through insurance in order to gain a tax break on their medical expenses, consumers would have even less reason to support mandated benefit laws. Thus, a consumer-based system like the Heritage proposal eventually would remove most of the perverse consumer incentives now encouraging mandated benefit laws. Consequently, the federal preemption in reform #7 could be allowed to expire after a few years, with little danger of states reinstating these laws.

Q: Would the same federal preemption of these state laws be temporary under other insurance reform proposals, such as "play-or-pay" or "managed competition"?

A: No, because most other proposals, such as play-or-pay and managed competition would retain much of the existing employment-based system and would not provide tax relief for out-of-pocket medical expenses. Thus, consumers would still not be directly aware of how these laws increase the cost of their insurance. Consequently, under these proposals the likely result of federal preemption simply would be to shift lobbying for mandated benefits from state legislatures to Congress, with much the same results as today. While some managed competition plans would establish an independent board to set insurance coverage requirements, such a board would likely come under the same pressure to expand benefits.

HOW CONSUMER-BASED HEALTH INSURANCE WOULD WORK IN PRACTICE

Under a consumer-based health insurance system of the kind envisioned in the Heritage plan, working individuals and families would purchase their own health insurance and medical care directly.¹⁴ They would thus have portable benefits and no longer be dependent on their employers for health insurance coverage. Government health care programs for the poor and the elderly initially would be retained. But eventually beneficiaries of those programs could be given vouchers to enable them to also buy into a reformed private health insurance system.

¹⁴ For a full description of the Heritage Consumer Choice Health Plan, see Butler, *op. cit.*

The federal government would provide working American families with new tax credits to offset their total health expenses—that is, both the cost of purchasing health insurance and the cost of purchasing out-of-pocket medical care. The size of the tax credits would vary, with more generous assistance provided to those with low incomes or high health expenses and lesser credits for more affluent or healthier individuals.

Minimum Coverage. All heads of households would be required to purchase for themselves and their dependents health insurance coverage which provided at least catastrophic protection. Those who failed to purchase this minimum level of catastrophic coverage voluntarily would be ineligible for the new tax credits and would be given catastrophic coverage by their state government, under a public or private policy of the state's choosing, and charged a premium based on their ability to pay, as determined by the state. This mandate would limit the ability of irresponsible individuals to freeload and leave the taxpayers holding the bill should they suffer a major illness or accident.

To enforce this mandate and make the system function more smoothly, employers would be required to deduct the applicable health insurance premium from an employee's wages, send the premium to the employee's insurer, and adjust the employee's tax withholding to reflect the applicable tax credit. The employer would notify the state if a worker could not show proof of coverage under his or her own policy or a family member's policy. The state would then provide the worker and his or her dependents with coverage. These steps not only would provide a mechanism for enforcing the mandate, but would also ensure that workers did not need to wait until they filed their tax returns to claim the new tax credits.

However, beyond the requirement to purchase catastrophic insurance, Americans would be free to make their own decisions about purchasing health insurance and medical care. Some likely will prefer to pay for more of their routine medical care out-of-pocket and buy no-frills health insurance at a savings of hundreds, or even thousands, of dollars a year in premiums. Others will prefer more comprehensive coverage. For them, a managed care plan, such as an HMO, would be able to offer significant savings by steering them to more efficient providers. Also, many consumers will likely find that they could obtain insurance at discounted rates by purchasing it on a franchise basis through a group such as their employer, union, farm bureau, church, professional society, or fraternal organization.

Incentive Toward Better Value. Regardless of their specific choices, all Americans would have a strong incentive to buy better value medical care and health insurance, since they would pocket the savings. Regardless of the type of plan they purchased, individuals and families would all have true long-term insurance protection against costly illnesses or accidents. This is because, while insurers would be permitted to base the initial underwritten premium on the applicant's true risk, insurers could not later cancel coverage after a policyholder filed a major claim or charge steeply higher renewal premiums based on the policyholder's past experience.

In short, health insurers would no longer be in the pre-paid medical care business. Instead, they would be back in the business of writing true health insurance and accepting and managing long-term risks. This would give insurers powerful new incentives to use their claims data on the cost and performance of providers to identify those doctors and hospitals that offer the best outcomes at the best prices and steer policyholders to them. To ensure provider cooperation, insurers would likely

enlist doctors and hospital administrators in joint efforts to create fair, accurate, and reliable systems for evaluating their performance.

Consumers would pressure insurers to respond to their demands for cheaper policies and better service by cutting paperwork and bureaucracy, streamlining their administrative functions, and simplifying policies. A consumer-driven market would also unleash new demands for reliable, intelligible information that consumers could use in evaluating and selecting providers and insurance plans. As with any other market, all that it would take to exert competitive pressure on providers and insurers to improve services and reduce costs would be the willingness of a few knowledgeable consumers to shop for the best value.

Q: Wouldn't individual health insurance be much more expensive than employer-group insurance?

A: It is today, but in a universal, consumer-based system the cost of individual insurance would, for two important reasons, drop considerably from present levels. First, individual insurance is expensive today largely because of distortions in the current tax system. Current tax policies heavily favor employment-based group insurance, making it very advantageous for anyone with individual insurance to switch to employer-group insurance whenever possible, even if the group insurance is more expensive. The results are inordinately high turnover in the individual insurance sector, and much higher than normal marketing costs. The tax and insurance reforms contained in the Heritage Consumer Choice Plan would stabilize the market, eliminating this needless and costly switching of coverage.

Second, extending tax relief to out-of-pocket purchases of medical care would encourage many Americans to buy less comprehensive, and thus less costly, health insurance. Less comprehensive policies would be much cheaper, not only because they would pay out much less in claims, but also because they would not incur the disproportionately high administrative costs associated with paying small claims.

Q: In a consumer-based individual health insurance system won't insurers still compete on the basis of risk selection, taking the good risks and avoiding the bad ones?

A: No. To be sure, some insurers would compete vigorously to attract and retain low-risk policyholders. But for several reasons such a strategy would not, in and of itself, constitute a sustainable market strategy for an insurer in a reformed consumer-based system.

First, all insurers would compete for good risks on an equal footing, making it impossible for one insurer to "corner the market" on good risks. Second, as people age, they become poorer risks for health insurance, but insurers would be prevented from cancelling coverage or selectively raising rates on a policyholder when he or she became a poorer risk. Thus every insurer would, over time, wind up with a mix of low-, moderate-, and high-risk policyholders, even in all of its policyholders initially were good risks. Furthermore, even in the unlikely event that an insurer initially covered only good risks, that insurer probably still would want to expand its business and gain a larger share of the

market. But as noted, the insurer's competitors also would be trying to attract good risks. Thus the only real way to expand would be by offering coverage to moderate and high risk individuals at competitive prices. As long as government did not prevent insurers from offering competitive, risk-based initial premiums, insurers would extend coverage to individuals and families across the spectrum of risks. Indeed, this is how life insurers operate. They do not compete on the basis of risk selection, taking only the good risks and avoiding the bad ones.

Without the ability to "game" the system by taking good risks and simply dropping bad ones, health insurers would, like life insurers, be forced to compete on the basis of *value for money*. In other words, insurers would compete in the market by offering better coverage at better prices for all policyholders, whatever their risk level. In the case of life insurance, the insurer who consistently gets a better return on its investments than its competitors is able to offer lower rates for all risk categories. In health insurance, the insurer who did a better job in a consumer-based health system of controlling overhead and managing claims by steering policyholders to the best quality treatment at the best prices, also would be able to offer lower rates to all risk categories.

In this reformed system, consumers would not be able to "game" the system by repeatedly switching insurers to get better rates, as some businesses do today. Under such a reformed system, the only way policyholders could get cheaper premiums by switching insurers would be if they switched from an inefficient to an efficient carrier, which would be a desirable result of competition. Of course they could also get lower premiums by reducing their level of coverage (for example, increasing the deductible), or by accepting more restrictions on their coverage (for example, converting to a managed care plan). In all probability, the last two changes could be accomplished by changing policies within an insurance company, without switching carriers, and thus without the need for new underwriting. This is a common option in life insurance. Of course, in the same manner, coverage could later be increased, if desired, for an additional premium.

Q: *But even if insurance companies found the high-risk segment of the market to be commercially attractive, wouldn't it be the case that only the rich could afford the premiums?*

A: That would be so if high-risk individuals with low and moderate incomes received no subsidies, or only the small tax breaks available today. But the Heritage Consumer Choice Plan would solve the affordability problem in health insurance through a major reform of the tax treatment of health care, with refundable tax credits targeted to low-income and high-risk individuals. This would enable these individuals to afford the higher premiums insurers would require to accept the higher risk.

Furthermore, as noted earlier, the Heritage plan would provide targeted tax credits based on income and health expenses not just for the purchase of health insurance but also for out-of-pocket purchases of medical care. As a result, more Americans would see the value of purchasing most of their routine medical services out of pocket or through a pre-paid plan that kept costs down by steering patients to providers who offered the best value—in other words,

the best combination of high quality and low prices. This would have two very important effects on a reformed health insurance market.

First, while some comprehensive policies likely would still be available, most policies would be less comprehensive than current ones, making them much less expensive and causing the cost of coverage to increase at a much slower rate in the future. As noted earlier, these savings would come not only from lower claims costs but also from eliminating the disproportionately high administrative costs associated with paying small claims.

Second, the difference in the initial underwritten premiums charged to low- and high-risk individuals would be significantly narrower than it is today. This is because in today's health insurance system there are really two kinds of high-risk individuals: those who are higher risk because they are more likely to incur a major illness or need expensive treatments, and those who are higher risk because they use a greater volume of common medical services. Under a reformed system based on the Heritage Plan, the latter group of "high-risk" individuals would be able to buy the routine medical services they need out-of-pocket or through a managed pre-paid plan, and in the process receive the assistance they need through greater tax relief.

Removing the bulk of routine medical expenses from the health insurance system in this manner means that the difference in premiums between low-risk individuals and true high-risk individuals will be narrower. As an analogy, consider that urban drivers can be higher risk than rural drivers because the greater volume of urban traffic creates more opportunities for accidents. If, however, urban drivers relative to rural drivers are much more likely to have minor accidents, but only slightly more likely to have major accidents, then limiting auto insurance to covering only major accidents would significantly narrow the risk and premium differential between urban and rural drivers.

Q: *But wouldn't sick or high-risk individuals dissatisfied with their insurer be stuck in their plan and unable to switch to another insurer offering better service?*

A: Yes, though this potential problem would affect few individuals and could be ameliorated. As noted earlier, insurers would be prevented from adjusting a current policyholder's renewal premium to reflect changes in health status. However, if an individual decided to switch coverage to a different insurer, the new insurer would underwrite the applicant and charge him an initial premium based on his true risk. The new insurer also would likely limit coverage for preexisting conditions. For average Americans there would be some cost associated with switching insurers, but normally only a modest one. While this would tend to dampen the ability of consumers to shop for better coverage, and would be a bigger barrier to families in poor health, the effects actually would not be as undesirable as they might seem at first glance.

First, the ability to charge an applicant an underwritten initial premium reflecting the true risk is an essential precondition for insurers to conduct a true and profitable insurance business of any kind. As noted in *Talking Points Part III*, the central principle of the insurance business is that insurers voluntarily accept risks in exchange for a commensurate fee. In any line of insurance, if insurers are forced to accept risks at rates below their true cost, then insurers

naturally will seek to avoid those risks. Instead of being in the business of accepting risks, insurers will increasingly try to avoid risk by various stratagems. Attempts by insurers to avoid risks in the current health insurance system is the source of a number of the system's present problems and is one indication that today's health insurance is not really true insurance. And while government may try to prevent risk selection in a market with controlled premium prices, these efforts are rarely very successful.

Second, while new underwriting imposes a cost on individuals who switch insurers, in many instances this is not necessarily bad. For example, it discourages individuals from switching coverage for frivolous reasons or small, transitory gains. As such, it helps to stabilize the market and lower costs by reducing "churning"—the practice of low-risk individuals frequently switching coverage to obtain only marginally better premiums, or buying a high option plan for one year just to cover several expensive elective procedures. This is analogous to the fees and new underwriting imposed by mortgage lenders on new loans. These added costs deter most homeowners from refinancing their mortgages every time there is a fraction of a percentage point drop in mortgage rates. For most homeowners, mortgage rates must fall by about two percentage points before the future savings gained by refinancing outweigh the added costs associated with the new loan. Similarly, for the future premium savings to outweigh the underwriting cost of switching insurers, the new insurer must be significantly more efficient than the policyholder's current carrier, which is then a good and sensible reason for switching coverage.

There are, however, a limited number of cases in which underwriting new health insurance applicants would impose what many might view as an unfair burden on certain individuals.

Example: A policyholder in poor health whose current insurer is providing poor service, such as unreasonably disputing claims, delaying claim payments, or refusing to address complaints.

Example: A young adult with a poor health status who wishes to leave home and obtain insurance coverage on his own instead of through his parents' policy.

Example: A newly married couple, where one spouse is high-risk, who wish to replace their separate individual coverage with family coverage.

Example: A newly divorced individual with a poor health status who wishes to obtain coverage separate from his or her former spouse.

Example: A family wishing to move to another part of the country where their current policy does not provide coverage.

These problem cases can be addressed without a fundamental change in the reforms designed to achieve a real insurance market. In the case of an insurer providing poor service, for instance, the preferred course of action might be for the state government to improve its regulation of insurers. One reason for the poor service might be that the insurer is mismanaged, in which case regu-

lators should take steps to head off possible insolvency and protect policyholders. Another reason for the poor service might be that the insurer is trying to drive away costly policyholders, in which case regulators should take steps to force the insurer to comply with the contracts it has entered into with its policyholders. Both types of intervention would be consistent with government's legitimate function of assuring that a market works smoothly, by enforcing contracts and deterring negligent or fraudulent behavior.

While changing coverage would result in higher premiums in the other examples cited, under the Heritage Consumer Choice Plan, these higher costs would be offset in large part by greater tax relief or subsidies. This is because the new refundable tax credit system envisioned in the Heritage plan would provide more generous assistance to those with lower incomes or higher health care costs. Still, there would be some cases in which the premium cost still was too high for a family needing to change its plan, or where exclusions might in practice make coverage difficult. In these limited cases, some might wish to impose underwriting restrictions on insurers. But such underwriting restrictions should be applied sparingly and advisedly. Failure to do so would give insurers new incentives to avoid riskier applicants. And even if underwriting restrictions were applied, there should still be some significant, though reasonable, cost to policyholders associated with switching coverage, in order to avoid excessive churning. For example, in a limited number of cases, such as those cited above, states might prohibit insurers from charging a new, high-risk applicant an underwritten premium more than a fixed percentage, say, 25 percent, above the base rate for a standard risk applicant with the same age, sex, and geographic characteristics.

Again, this kind of underwriting restriction should be applied only if significant problems develop in the market that cannot be remedied by other means. The tax credits proposed in the Heritage plan would be adjusted for differences in incomes and health care costs. Also, by providing tax credits for out-of-pocket medical costs, the Heritage plan would encourage Americans to buy less comprehensive health insurance policies, with the result that there would be a much narrower variation in the underwritten premiums charged to low- and high-risk applicants. Adoption of these tax policies, together with sound regulation of insurer solvency and contracts, would make it less likely that lawmakers would need to impose underwriting restrictions even in unusual cases.

Q: Can government protect policyholders from being gouged by insurers who raise their rates excessively?

A: Yes, though in a sound competitive market there is little danger of an insurer engaging in price gouging. To do so, the insurer would need to charge uncompetitively high rates and would lose business as a result. However, to the extent that consumer protection is needed or desired by policy makers or the public, there are desirable and undesirable ways for providing such consumer protection. Some states have tried to protect purchasers of individual health insurance through rate regulation. But this has often proved to be costly, slow, and cumbersome for insurers. Regulation also has introduced additional uncertainty into the insurance business, since insurers are never completely sure they can gain approval for a rate increase when they need one to stay solvent.

But several states recently have adopted a method called “guaranteed loss ratios,” which provide fairer and more predictable rate regulation for both consumers and insurers.

Q: How do “guaranteed loss ratios” work?

A: Under guaranteed loss ratio regulations, before an insurer can offer a new type of policy on the market, the firm must reach agreement with the state insurance authority on a minimum loss ratio for the policy it is selling. A minimum loss ratio stipulates the percentage of premium income that the insurer will pay out each year in claims on behalf of policyholders. For example, if the agreed-upon minimum loss ratio for the policy is, say, 70 percent, the insurer agrees to pay out 70 cents each year in claims for every dollar of premium income, or refund the difference to policyholders. The remaining premium income (30 cents on the dollar, in this example) is retained by the insurer for administrative costs (such as billing, claims processing, agents’ commissions, and taxes) and profit. If the claims paid in a given year are more than the loss ratio, (say, 80 percent in this example), the insurer must absorb the loss for that year. But if the insurer anticipated higher claims costs for the next year as well, the insurer can obtain automatic approval for a premium rate increase for the coming year. Of course, if the insurer misjudged and claims costs for the following year fall below the minimum loss ratio, the firm must refund the difference.

Q: How would widespread adoption of “guaranteed loss ratio” provisions benefit consumers?

A: Consumers would be protected because collectively they would be guaranteed a minimum amount of benefits from their policies, or a refund of the difference. At the same time, insurers would be guaranteed the right to raise rates when necessary without costly delays or regulatory hearings. But insurers could not use rate increases in one year to recoup losses in previous years, and therefore would not be guaranteed a profit. On the other hand, insurers would have a strong incentive to control claims costs and administrative overhead, since any higher than expected claims or unnecessary administrative costs would reduce their profits.

Q: Does a consumer-based, individual insurance system provide incentives for preventive care?

A: Yes. In fact, a consumer-based system would provide some of the strongest incentives of any system for preventive care. There are three reasons for this:

Reason #1: Most consumers seeking the best value for their health care dollars would find that a combination of catastrophic insurance and preventive medical care gives them the best return on their money. While a financially catastrophic medical condition could devastate an individual or family, premiums for catastrophic insurance are relatively inexpensive because such occurrences are

rare. Therefore, true catastrophic insurance offers the best ratio of protection to cost. Similarly, with relatively small investments in preventive care, individuals usually can avoid serious conditions and large medical bills, making preventive care a good value as well. Since under a consumer choice system individuals and families pocket the savings from picking the most economical coverage and services, they have an incentive to choose catastrophic insurance and preventive care as the first things to buy with their health care dollars.

Reason #2: The Heritage Consumer Choice Plan would provide tax relief on all health expenses, both out-of-pocket and insurance premiums. This means that consumers would receive the same tax help in buying preventive services as in buying insurance. Because the current system gives tax relief generally only for insurance, many Americans are discouraged from buying preventive services not covered by their insurance plan, since they must pay for them out-of-pocket with after-tax dollars.

Reason #3: Requiring health insurers to provide guaranteed renewable policies means insurers would be forced to manage long-term risks, like they do in life insurance, rather than short-term risks, like they do in auto insurance. Investing in preventive care pays dividends later in the form of reduced illness and treatment costs, so health plans which encouraged preventive care would tend to reduce their total lifetime payout on a policyholder, even though the plan would face somewhat higher short-term payout costs. This is quite different from the current system. In the current system, most health insurance policies are one-year contracts offered through the place of employment. Thus an insurer who offers preventive care benefits faces short-term costs, but probably will not benefit from future savings because the enrollee will have moved on to another employer and another health plan, or the employer will have switched insurers. If policyholders could renew coverage indefinitely, however, insurers would be forced to account not only for present, but also future costs. Thus, they would quickly see that it is to their advantage to limit long-term potential liabilities by investing in preventive care.

Q: *Can government-based or employer-based health provide the same incentives for preventive care that are found in the consumer-based system?*

A: No. Neither a government-based system nor an employment-based system (such as play-or-pay) would provide significant incentives for preventive care. The reason: Both government-based systems and employment-based systems are funded on an annual basis. Therefore, the public or private administrators of such systems would not be as concerned with long-term costs as private insurers facing the potential long-term liabilities associated with guaranteed renewable policies. Governments are notoriously short-sighted, operating from budget to budget and afflicted with short-term political pressures. Like-

wise, administrators in any employment-based system have little reason to invest heavily in preventive care, even though the employees' long-term medical costs might be much lower. The reason is that because of the high mobility of the U.S. work force, a significant percentage of their employees are likely to be working for someone else in future years. Therefore long-term savings from preventive care are less attractive than, say, raising the employees' share of premiums or actually cutting back on preventive care benefits. There are exceptions, of course, to this kind of thinking among companies, and more companies today are investing their resources in preventive care programs. Still, these firms are the exception, not the rule.

Even more important, for preventive care to be effective it requires the willing and active cooperation and involvement of the patient. But neither government-based systems nor employment-based systems provide patients with as strong a set of financial incentives to participate in preventive care regimes as exist in a consumer-based system. In government or employment-based programs, patients tend to be the passive recipients of decisions made for them, either by government officials or by corporate managers.

CONCLUSION

The contending health insurance reform packages introduced in Congress or advanced by organizations are well-intentioned efforts to deal with the lack of affordable health insurance for millions of American families. While certain elements of some proposals would be desirable and beneficial, many recommended changes would compound, rather than solve, existing problems. The shortcomings of most health insurance reform proposals can, in large measure, be traced to the fact that they are based on one or more erroneous premises, namely:

- ✓ That health insurance should be employment-based.
- ✓ That all, or most, medical care should be paid for through health insurance.
- ✓ That access to health insurance and medical care for the disadvantaged (the poor and high-risk) is best achieved through market and price regulation.

In contrast, the Heritage Consumer Choice Health Plan, as detailed in Part II of this *Talking Points* series, is based on very different principles. These are:

- ✓ That health insurance should be consumer-based, with individuals and families purchasing coverage directly.
- ✓ That Americans should be encouraged to buy medical care not only through insurance but also out-of-pocket in whatever arrangements individuals and families deem most suitable to their particular circumstances.
- ✓ That government should guarantee access to health insurance and medical care for the disadvantaged by giving them the means, through tax credits and vouchers, to purchase the services they need in a sound, free market, the same as everyone else.

In health care, as in any other area of the economy, a sound, free, and consumer-driven market is the best method for creating good value—that is, high quality goods and services at reasonable prices. Any form of insurance, including health insurance, can be a desirable and efficient product in a sound market. The key is for policy makers to avoid distorting the market with unnecessary or harmful regulations.

In the case of health insurance, this means enacting reforms designed to create the kind of health insurance desired by consumers—namely, portable, individual, and family policies that offer true, long-term health insurance protection against the unaffordable costs of unlikely major accidents and illness. If lawmakers instead succumb to the temptation to achieve social goals of universal access and equity by over-regulating the health insurance market, they will succeed only in creating new problems and destroying the natural benefits and efficiency that true health insurance can offer.

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