



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C.

SECRETARY OF THE TREASURY

July 20, 2000

The Honorable Charlie Rangel
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Charlie:

Thank you for your recent letter regarding the so-called "access" tax provisions added to the House- and Senate-passed versions of H.R. 2990, the Patients' Bill of Rights legislation. Those provisions were recently attached to the Senate Labor-HHS appropriations bill on a party line vote. The President has long supported policies that expand health insurance coverage and improve long-term care. His budget includes an investment of about \$140 billion over 10 years for targeted tax incentives and programs to further these goals.

The "access" tax provisions in H.R. 2990, however, raise serious concerns. As OMB Director Jack Lew wrote in his July 17 letter to Congressman Young regarding the Administration's views on the Senate Labor-HHS Appropriations bill, the proposals are expensive, would not expand coverage significantly, and could substantially increase premiums for some Americans with traditional health insurance coverage. Moreover, the proposals disproportionately favor high-income taxpayers and provide new tax shelters for the wealthy. As such, I would recommend that he veto H.R. 2990 if these tax provisions are not eliminated or significantly altered.

In particular, the proposal to extend the Medical Savings Accounts (MSA) demonstration permanently, coupled with changes that expand the program to workers in large firms and reduce the required deductible, could significantly undermine health insurance coverage by encouraging adverse selection. Healthy, younger workers would have an incentive to choose MSAs and opt out of conventional insurance plans. This would leave less healthy, older workers in conventional plans, thereby raising premiums. As a result, some lower-income families could lose insurance since they would be unable to afford either the high MSA deductibles or the higher premiums for conventional insurance. Employers, facing rapidly growing costs in conventional health plans, also might choose to stop providing coverage.

Contrary to proponents' claims, we do not believe that MSAs will be effective at constraining health care costs. More than 90 percent of medical expenditures are made by those who spend more than the MSA deductible levels. Once deductible levels are reached, taxpayers have no further incentive to restrain their health care expenditures.

MSAs also favor high-income taxpayers and provide significant new shelter opportunities.

In addition to the fact that any tax deduction is less valuable to low and middle-income workers, low-income individuals are unlikely to choose MSAs because of the higher deductibles and the risk of large unplanned out-of-pocket health care costs. Also, MSAs would provide a new tax shelter for high-income taxpayers, particularly those with incomes too high to qualify for IRAs. High-income people could make tax-deductible contributions up to the amount of the deductible every year and earnings on the accounts accrue tax-free. Withdrawals could be made for any purpose at any age, often with no penalty.

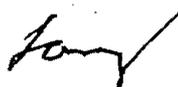
Similarly, allowing a deduction for individual-market health insurance premiums would not effectively increase the number of insured Americans. Like MSAs, the individual insurance tax deduction would provide a greater benefit to people with higher income – not moderate- and low-income families who are most likely to be uninsured. In addition, increasing tax subsidies for individual insurance, which in most states can be underwritten, age-rated, and even denied to sick people, is a poor use of taxpayer dollars if not accompanied by insurance reforms. The Office of Tax Analysis estimates that a net of about 600,000 people would gain insurance as a result of this provision, at a cost of about \$18,000 per newly insured person.

Finally, the proposal to allow an above-the-line deduction for long-term care insurance also raises policy concerns. Long-term care insurance is already heavily tax-favored, providing participants IRA-like treatment without any income restrictions. In addition, many long-term care insurance policies do not have necessary consumer protections like inflation and non-forfeiture protection. Absent effective consumer protections, most current policies lapse before long-term care expenses are ever incurred. Thus, while investment in long-term care is essential, directing it further towards private insurance is unwise.

The President has proposed a strong plan that more efficiently and effectively meets the goals of the so-called access provisions -- to decrease the number of uninsured Americans and to improve long-term care. He proposed \$110 billion over 10 years to target assistance to low-income, working families by building on SCHIP, Medicare, Medicaid and COBRA insurance. He also proposed a broad-based long-term care initiative that includes a \$3,000 tax credit to assist families with their long-term care and a state program to provide assistance to family caregivers. We would be happy to work with Congress to pass these provisions in the context of a fiscally responsible, overall budget framework.

The Administration remains committed to working with Congress on a bipartisan basis to pass a strong enforceable Patients' Bill of Rights. However, loading the legislation with fatally flawed tax provisions would undermine the ability to enact this important piece of legislation.

Sincerely,



Lawrence H. Summers

Individual Insurance Market File

DEDUCTION FOR INDIVIDUAL HEALTH INSURANCE PREMIUMS WITHOUT CONSUMER PROTECTIONS TALKING POINTS Draft 10/27/00

It is a precedent setting act by the Republican leadership to spend billions of dollars providing tax preferences for insurance premium deductions without also protecting consumers who purchase individual health insurance policies.

- **This “residual” market where few people stay willingly, is unstable and lacks basic consumer protections.** Researchers, including the GAO, have documented the magnitude of the problems consumers face in the individual insurance market. It is irresponsible for the Republican leadership to encourage consumers to buy individual policies without providing for real protections.
- **The Republican proposal allows insurance companies to continue to discriminate by denying coverage to individuals who want to purchase individual health insurance policies.** This is unprecedented. Employers are not permitted to discriminate. Insurance companies selling group insurance aren't allowed to discriminate. Why should insurance companies selling individual health insurance be permitted to discriminate?
- **In the past when Congress enacted special tax preferences for insurance, there have always been consumer protections.** Even federally qualified long term care insurance policies and medical savings accounts have basic protections for consumers.

Problems with individual (non-group) health insurance market

DRAFT

10/25/00

PROBLEM

Discrimination based on health (cherry picking). Insurance companies often discriminate on the basis of an individual's current health status, past health conditions, or potential future conditions. Insurance companies are not required to sell a policy to every individual who wants to buy it (one in every five applicants are denied coverage).

SOLUTION

Guarantee access to health insurance. A tax subsidy alone does not mean that insurance companies will issue a health insurance policy to every individual who wants to buy it. Without a requirement to do so, individuals with any current or past health conditions will not be able to buy health insurance.

Option: NAIC model protects consumers by requiring insurance companies to sell a health insurance policy to every individual.

- The model requires insurance companies to have a 30 day open enrollment period annually that would allow any individual (even those who were previously uninsured) to enroll in a plan of their choice.
- The model guarantees access to all products (including access to a standard plan) for individuals who lost their coverage within 30 days of application for new coverage.
- Insurance regulators, the insurance industry, and consumers developed the NAIC model.
- Currently, 4 states guarantee access to some policies, while 9 states guarantee access to all products.

PROBLEM

High premiums. Insurance companies typically base premiums on health conditions, claims experience, age, gender, and occupation of the individual. An individual who is not in perfect health, is of childbearing years, or is not young could pay at least a 100% surcharge over the standard premium rate. The GAO has reported that in some cases, the surcharge is as much as 2000% over the standard rate.

SOLUTION

To make health insurance more affordable, Congress should limit or prohibit insurance companies from basing premiums on one's health.

Option: limit or prohibit insurance companies from using an individual's health in establishing premium rates based on NAIC models.

- The NAIC Small Employer and Individual Availability Model Act prohibits use of health factors in premiums by establishing "adjusted community rating" (the premium rate is based on design of the product rather than on the risk factors of an individual purchasing the policy). Eleven states prohibit use of health status in premium rates.
- The NAIC Individual Health Insurance Portability Model Act establishes limits on maximum rate variations based on an individual's risk factors. Eight states use rate bands to limit the use of health status.

PROBLEM

Coverage limitations on existing or prior health conditions. When issuing a new policy, insurance companies commonly will not cover the individual's existing or past health conditions (riders for pre-existing conditions).

SOLUTION

To protect individuals, the use of preexisting condition exclusions and riders by insurance companies must be limited. Without such limits, individuals who need the excluded benefits most would continue to go without coverage for those benefits.

Option: limit use of preexisting condition exclusions based on the NAIC models.

- The models establish a 12 months maximum period of exclusion for a condition that existed within 12 months of enrollment.
- The models protect individuals who were previously insured by requiring insurance companies to reduce the 12 months period of exclusion.
- The models prohibit the use of exclusionary riders.
- 29 states have some limits on the use of preexisting condition exclusions.

Enforcement for these consumer protections

Require insurance companies to comply with substantially similar or more consumer protective state laws that apply to individual health insurance products. If a state does not adopt a substantially similar requirement within [3] years, then [HCFA/IRS] may enforce the federal requirement.

Problems with individual (non-group) health insurance market

DRAFT

10/25/00

PROBLEM

Discrimination based on health (cherry picking). Insurance companies often discriminate on the basis of an individual's current health status, past health conditions, or potential future conditions. For example, according to underwriting guidelines from the insurance industry, an insurance company will not sell a policy to an individual who uses prescribed medication or receives regular treatment for headaches. If an individual has had an angioplasty, that individual is also uninsurable for life. Non-life-threatening conditions such as chronic back pain could also make an individual uninsurable. (Deborah Chollet and Adele Kirk study)

- **No guaranteed access to health insurance.** Insurance companies are not required to sell a policy to every individual who wants to buy it. The General Accounting Office (GAO) reports that insurance companies deny coverage to one in every five applicants (in some states one in every three).
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides for guaranteed access only if an individual meets the following criteria: has 18 months of prior coverage without a significant break; most recent coverage is group-based not individual insurance; exhausts COBRA continuation coverage; and is not eligible for Medicare, Medicaid, or other health coverage. If a state has a high-risk pool for HIPAA eligible individuals, then insurance companies are not required to comply with HIPAA's access requirements.

SOLUTION

Guarantee access to health insurance. A tax subsidy alone does not mean that insurance companies will issue a health insurance policy to every individual who wants to buy it. Without a requirement to do so, individuals with any current or past health conditions will not be able to buy health insurance.

Option: NAIC model protects consumers by requiring insurance companies to sell a health insurance policy to every individual.

- The model requires insurance companies to have a 30 day open enrollment period annually that would allow any individual (even those who were previously uninsured) to enroll in a plan of their choice.

- The model guarantees access to all products (including access to a standard plan) for individuals who lost their coverage within 30 days of application for new coverage.
- Insurance regulators, the insurance industry, and consumers developed the NAIC model.
- Currently, 4 states guarantee access to some policies, while 9 states guarantee access to all products.

PROBLEM

High premiums. Insurance companies typically base premiums on health conditions, claims experience, age, gender, and occupation of the individual. (Chollet and Kirk) This practice -- different rates for different people -- is one way of discouraging individuals with health conditions or "potential future health conditions" from buying the policy (this is called fright pricing/deterrent rating). An individual who is not in perfect health, is of childbearing years, or is not young could pay at least a 100% surcharge over the standard premium rate. The GAO has reported that in some cases, the surcharge is as much as 2000% over the standard rate.

SOLUTION

To make health insurance more affordable, Congress should limit or prohibit insurance companies from basing premiums on one's health.

Option: limit or prohibit insurance companies from using an individual's health in establishing premium rates based on NAIC models.

- The NAIC Small Employer and Individual Availability Model Act prohibits use of health factors in premiums by establishing "adjusted community rating" (the premium rate is based on design of the product rather than on the risk factors of an individual purchasing the policy). Eleven states prohibit use of health status in premium rates.
- The NAIC Individual Health Insurance Portability Model Act establishes limits on maximum rate variations based on an individual's risk factors. Eight states use rate bands to limit the use of health status.

PROBLEM

Coverage limitations on existing or prior health conditions. When issuing a new policy, insurance companies commonly will not cover the individual's existing or past health conditions (riders for pre-existing conditions). Insurance companies claim that this protects them from adverse selection – individuals buying insurance only when they get sick. Although this may be a legitimate concern, insurance companies currently use riders even when an individual had prior coverage and did not wait to purchase insurance until he or she became sick.

SOLUTION

To protect individuals, the use of preexisting condition exclusions and riders by insurance companies must be limited. Without such limits, individuals who need the excluded benefits most would continue to go without coverage for those benefits.

Option: limit use of preexisting condition exclusions based on the NAIC models.

- The models establish a 12 months maximum period of exclusion for a condition that existed within 12 months of enrollment. Without such requirements, insurance companies can exclude from coverage conditions that no longer exist but an individual had years before enrollment.
- The models protect individuals who were previously insured by requiring insurance companies to reduce the 12 months period of exclusion.
- The models prohibit the use of exclusionary riders.
- 29 states have some limits on the use of preexisting condition exclusions.

Enforcement for these consumer protections

Require insurance companies to comply with substantially similar or more consumer protective state laws that apply to individual health insurance products. If a state does not adopt a substantially similar requirement within [3] years, then [HCFA/IRS] may enforce the federal requirement.

**CBO
TESTIMONY**

Insurance Reform
Small Business FL

Statement of
James R. Baumgardner
Acting Deputy Assistant Director for Health Policy

Association Health Plans

before the
Committee on Small Business
U.S. House of Representatives

February 16, 2000

This statement is not available for public release until it is delivered at 10:00 a.m. (EST), Wednesday, February 16, 2000.

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss the provision of employer-sponsored health insurance by small firms. The Congressional Budget Office (CBO) recently completed a paper on that topic entitled *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts*. I ask that it be included in the record.

My comments today will focus on three aspects of CBO's report: the circumstances that contribute to the relatively low rates of health insurance coverage through small firms, a summary of the rules that would apply to the proposed association health plans (AHPs) and HealthMarts, and CBO's estimate of how the introduction of AHPs and HealthMarts would affect the number of people insured through small firms and the premiums they face.

Factors Contributing to Lower Rates of Coverage Through Small Firms

Employees of small firms are less likely to have health insurance than are employees of large firms. For 1996, data from the Medical Expenditure Panel Survey indicate that about 40 percent of employees in small firms--those with fewer than 50 workers--obtained health insurance through their employer. In contrast, almost 70 percent of workers in firms of 100 or more employees obtained coverage through their job.

Several factors appear to play a role in the lower rate of insurance coverage through small employers:

- Workers in small firms, on average, have lower wages and lower family incomes than workers in large firms. As a result, small-firm employees are less able to afford comprehensive health insurance, and less of a tax incentive exists for providing health insurance through their employer.
- Small firms typically face higher costs for providing a given benefit package than do larger firms because of higher administrative expenses per enrollee and less purchasing power.
- Small firms generally purchase insurance that is subject to state benefit mandates and other regulations, which tend to increase average premiums. Firms that self-insure--mostly large firms--are exempted from those state insurance rules by the Employee Retirement Income Security Act (ERISA).

Association Health Plans and HealthMarts

Recent proposals would establish federally certified AHPs and HealthMarts, entities that would offer health plans to participating employers. Those plans would be exempt from most state benefit mandates. Trade, industry, or professional associations that had been in existence for at least three years could sponsor an AHP, which would have to offer its insurance products to all member firms. HealthMarts, in contrast, would have to be available to all small firms in a specific geographic area rather than be offered in conjunction with an association.

Effects of AHPs and HealthMarts on Coverage and Premiums

To explore the effects of AHPs and HealthMarts, CBO constructed an analytical model using assumptions based on the relevant economics literature. We estimate that about 4.6 million small-firm employees and their dependents would receive coverage through the new insurance vehicles, but most of those individuals would have obtained insurance even if current law remained unchanged. On balance, about 330,000 more people would be covered through small-firm employment than would otherwise have been the case. That represents a 1.3 percent increase in coverage through small firms.

Because of lower premiums, some small firms would begin to offer their employees coverage through AHPs and HealthMarts, and others would shift from coverage obtained in the traditionally regulated market to the new entities. Firms that moved to the new plans would, on average, pay premiums that were about 13 percent lower than they would have faced in the traditional market under current regulations. They would be paying less money for less insurance, however, since some of those premium savings would be the result of a less generous benefit package.

Introducing AHPs and HealthMarts would be likely to lead to some selection. For plans that were fully state regulated, the proportion of firms with higher expected health costs would rise after the new AHPs and HealthMarts became established. Consequently, firms remaining in the traditional insurance market would see an average increase in premiums of about 2 percent.

The impact of AHPs and HealthMarts would vary from state to state, depending on the extent of state insurance regulation. In general, states that were more highly regulated would be riper markets for the new entities, as would areas with greater concentrations of small firms. The actual outcome of the proposed legislation would also depend on the activities of the regulatory authorities responsible for AHPs and HealthMarts.

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CBO PAPER

INCREASING SMALL-FIRM HEALTH
INSURANCE COVERAGE
THROUGH ASSOCIATION HEALTH
PLANS AND HEALTHMARTS

January 2000

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

NOTES

Numbers in the text and tables of this paper may not add up to totals because of rounding.

All dollar values are expressed as 1999 dollars.

PREFACE

The large and growing number of uninsured people in the United States, particularly uninsured workers in small firms, continues to be a concern to policymakers. In the 105th Congress and again in the 106th, the House passed legislation that would create two new vehicles, association health plans (AHPs) and HealthMarts, to facilitate the sale of health insurance coverage to employees of small firms. The effects of AHPs and HealthMarts on premiums and coverage in the small-group health insurance market are the subject of this Congressional Budget Office (CBO) paper.

James Baumgardner and Stuart Hagen of CBO's Health and Human Resources Division prepared the paper under the direction of Joseph Antos and Linda Bilheimer. Michelle Jewett checked the paper for accuracy. A number of people at CBO offered helpful comments and suggestions, including Nabeel Alsalam, Tom Bradley, Jennifer Bullard, Steve Lieberman, Karuna Patel, David Torregrosa, Bruce Vavrichek and Greg Waring. Additional assistance was provided by Thomas Buchmueller, Cathi Callahan of the Actuarial Research Corporation, Matthew Eichner, and Gail Jensen.

Leah Mazade edited the paper, and Chris Spoor proofread it. Sharon Corbin-Jallow prepared the report for publication. Laurie Brown prepared the electronic versions for CBO's World Wide Web site (www.cbo.gov).

Dan L. Crippen
Director

January 2000

CONTENTS

SUMMARY AND INTRODUCTION	1
THE HEALTH INSURANCE MARKET FOR SMALL GROUPS	3
ASSOCIATION HEALTH PLANS AND HEALTHMARTS	6
Association Health Plans	6
HealthMarts	7
HOW AHPs AND HEALTHMARTS WOULD AFFECT PREMIUMS AND COVERAGE	7
Premiums in the AHP/HealthMart Market	8
Premiums for Traditional Insurance Plans	11
Coverage	12
ESTIMATING THE EFFECTS OF AHPs AND HEALTHMARTS ON PREMIUMS AND COVERAGE	14
Main Findings	14
Findings Under Alternative Assumptions	17
CONCLUSIONS	18
APPENDIX: MODELING THE EFFECTS OF AHPs AND HEALTHMARTS	20

TABLES

1.	Health Insurance Coverage by Size of Firm	2
2.	Estimated Effects of Association Health Plans and HealthMarts on Coverage in the Small-Group Health Insurance Market	15
3.	Estimated Annual Effects of Association Health Plans and HealthMarts on Total Premiums in the Small-Group Health Insurance Market	16
4.	Estimated Effects of Association Health Plans and HealthMarts on Average Premiums in the Small-Group Health Insurance Market	17
A-1.	Estimated Lower and Upper Bounds of Effects of Association Health Plans and HealthMarts on Coverage in the Small-Group Health Insurance Market	29
A-2.	Estimated Lower and Upper Bounds of Annual Effects of Association Health Plans and HealthMarts on Total Premiums in the Small-Group Health Insurance Market	30
A-3.	Estimated Lower and Upper Bounds of Effects of Association Health Plans and HealthMarts on Average Premiums in the Small-Group Health Insurance Market	31

BOX

1.	Health Insurance Purchasing Cooperatives	9
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SUMMARY AND INTRODUCTION

The rising number of people who lack health insurance continues to be a major concern to policymakers. According to the Census Bureau's Current Population Survey, about 43 million people under age 65 were uninsured in 1997. That estimate represents about 18 percent of the nonelderly population, compared with less than 15 percent who were uninsured a decade earlier.¹

Given that the primary source of private health insurance coverage in the United States is employment, one might reasonably assume that people who lack insurance also lack jobs. Yet most uninsured people are members of families with at least one full-time worker. Uninsured workers are usually employees of small firms (those with fewer than 50 employees), and small firms typically face higher costs for health insurance than do larger firms, which may make small firms less likely to offer it. In 1996, 42 percent of small-firm establishments offered health insurance to their employees (see Table 1). (An establishment is a single geographic location of a firm.)² By contrast, more than 95 percent of establishments in firms with 100 or more employees offered insurance. Another reason for lower rates of health insurance coverage for workers in small firms is lower take-up rates when insurance is offered. In 1996, about 81 percent of employees in small firms accepted insurance coverage when it was offered by their employers, compared with 87 percent of employees in firms with at least 100 employees.³

Concerns about low rates of coverage for employees of small firms have led to a number of initiatives at both the state and federal levels as well as in the private sector. One example is the formation of group purchasing cooperatives, some private and some sponsored by state or local governments, in which firms join together to purchase insurance in larger volumes at more affordable prices. By one estimate, almost a third of small firms purchase their health insurance through some form of cooperative purchasing arrangement.⁴ Even so, concerns persist about the affordability of insurance coverage and the lack of sufficient alternatives for reducing its cost. Recently, the House passed H.R. 2990, the Quality Care for the Uninsured Act of 1999, which among other things calls for establishing association health plans (AHPs) and HealthMarts, two new vehicles for offering health insurance coverage

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1. Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey*, Issue Brief 204 (Washington, D.C.: Employee Benefits Research Institute, 1998), pp. 1 and 4.
 2. A firm may have many establishments; however, most small firms have only one.
 3. This paper considers only private-sector for-profit and not-for-profit firms.
 4. Stephen H. Long and M. Susan Marquis, "Pooled Purchasing: Who Are the Players?" *Health Affairs*, vol. 18, no. 4 (July/August 1999), pp. 105-111.

TABLE 1. HEALTH INSURANCE COVERAGE BY SIZE OF FIRM

	All Firms ^a	Firm Size (Number of Employees)		
		1 to 49	50 to 99	100 or More
Number of Private Establishments (Thousands)	5,999	4,708	213	1,078
Percentage Offering Health Insurance	53	42	85	95
Percentage Offering a Self-Insured Plan ^b	28	11	20	63
Number of Employees (Millions)	104	31	8	65
Percentage Offered Health Insurance	70	50	73	80
Percentage Who Take Up Health Insurance When Offered	85	81	83	87

SOURCE: Congressional Budget Office calculations using data from the insurance component of the 1996 Medical Expenditure Panel Survey, Agency for Health Care Policy and Research (available at <http://www.meps.ahrp.gov/data.htm>).

NOTE: An establishment is a single geographic location of a firm. Most small firms (less than 50 employees) have only one establishment.

- a. Specifically, private-sector for-profit and not-for-profit firms.
- b. As a share of establishments offering health insurance. Under self-insured plans, firms bear the financial risks of their employees' health care costs themselves rather than purchase coverage from a health insurer or health plan.

to small employers. (The House passed similar legislation—H.R. 4250—in the 105th Congress, but the bill was never considered by the Senate.) Several other proposals for AHPs and HealthMarts have also been introduced in the House.⁵

This paper considers how the introduction of AHPs and HealthMarts would affect premiums and coverage in the small-group health insurance market.⁶ (Although entities known as association health plans already exist, all of the legislative proposals would create federally certified AHPs operating under a different set of rules.) The

5. See H.R. 448, H.R. 1136, H.R. 1496, H.R. 1687, and H.R. 2926.

6. At least one of the bills would create individual membership associations, or IMAs, that would face some regulatory rules similar to those for AHPs and HealthMarts. Unlike those proposed insurance arrangements, however, IMAs would not be sold as part of an employee benefit plan. This paper focuses on the market for employer-sponsored health insurance available through small firms and does not consider IMAs.

new entities would be exempt from some state insurance regulations that apply to insurance plans offered in the small-group market. Such regulations tend to increase premiums for those traditional plans.

Currently, about 48 million people either work for a small firm or are a dependent of someone who does. Under the most likely scenario for AHPs and HealthMarts, the Congressional Budget Office (CBO) estimates that approximately 4.6 million of those people might obtain their coverage through the proposed new insurance arrangements. But overall enrollment in employer-sponsored health insurance would increase by only about 330,000 people, because most firms purchasing coverage through an AHP or HealthMart would be switching from traditional insurance coverage—that is, insurance plans subject to the full array of state insurance regulations.⁷ On average, premiums paid by small firms that purchased health insurance through an AHP or HealthMart would be about 13 percent lower than the premiums they would otherwise pay under current law. With AHPs and HealthMarts in place, the firms that continued to purchase traditional coverage would face an average increase in premiums of about 2 percent.

THE HEALTH INSURANCE MARKET FOR SMALL GROUPS

As noted earlier, small firms are less likely than large employers to offer health insurance coverage to their employees, and small-firm employees are less likely to take up coverage when it is offered. Factors contributing to those lower rates of coverage include the characteristics of workers in small firms, firms' costs for providing insurance benefits, and state insurance regulations.

The earnings of employees in small firms are one of the chief reasons for lower rates of health insurance coverage among small employers. Compared with employees in large firms, those in small firms tend to be paid lower wages and have lower family income, although some employees are members of households with higher-paid workers. Given their lower income, employees of small firms may be unwilling to accept the even lower wages that would result if their employer sponsored a health benefits plan. Furthermore, because lower-income workers probably have fewer assets to protect in the event of a large medical expense, they may place less value on having insurance. Their lower wages also mean that small-firm employees have less of a tax incentive to purchase insurance than do higher-paid workers. (Because employees are not taxed on their employer's contribution for

7. Of nonelderly people in families headed by someone working for a small firm, CBO estimates that almost 26 million are currently insured through a small employer, a further 13 million are uninsured, about 3.5 million purchase coverage in the individual market, and the remainder obtain coverage from other sources.

health insurance, workers in higher tax brackets gain a larger subsidy for health insurance than do workers in lower tax brackets.)⁸

The cost of health insurance for small firms may be another factor in their lower rates of coverage. Health insurance premiums for equivalent benefit packages are higher for small firms than for large ones. The premiums themselves do not differ consistently on the basis of firm size, but the benefit packages that large firms offer their employees are more generous than those offered by small firms.⁹ In addition, the administrative costs included in the premium are higher for small firms because they have fewer employees among whom to spread the fixed costs of a health benefits plan, including costs for marketing and enrollment. Premiums are also likely to be higher for small firms because they do not have as much purchasing power as large firms, which limits their ability to bargain for lower rates from providers and insurers.

State insurance regulations may also contribute to higher premiums for small firms. For example, premium compression regulations, although reducing premiums for some firms, have raised premiums for others. Because of their size, small firms may experience much greater variation than large firms in their expenses for health benefits. One employee's serious illness can dramatically boost a small firm's health expenses, and in the absence of regulatory intervention, the firm's health insurance premiums could also rise substantially (since, in general, premiums are set to reflect those expenses).¹⁰ Such significant rate variation, and even cancellation of policies, characterized the small-group market during the late 1980s.¹¹ In response, many states imposed new regulations that guaranteed availability and renewability of insurance and limited the degree to which premiums could vary among small firms.¹² In California, for example, the highest premium that an insurer may charge for a particular policy can be no more than 20 percent above its lowest premium for that policy. To comply with that kind of regulation, known as premium (or rate)

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8. For an extended discussion of this issue, see Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance* (March 1994). The average employee in a small firm has a relatively low income and therefore receives little benefit from the tax subsidy. However, the tax advantage is significant for employees in those small firms, such as law firms or other professional groups, that usually pay higher salaries.
 9. See Len Nichols and others, *Small Employers: Their Diversity and Health Insurance* (Washington, D.C.: Urban Institute, June 1997).
 10. That issue is discussed in Rick Curtis and others, "Health Insurance Reform in the Small-Group Market," *Health Affairs*, vol. 18, no. 3 (May/June 1999), p. 1.
 11. Elliot K. Wicks and Jack A. Meyer, "Small Employer Health Insurance Purchasing Arrangements: Can They Expand Coverage?" *New Directions for Policy*, National Coalition on Health Care (May 1999) (available at <http://www.americashealth.org/releases/stevesedit.html>).
 12. Federal law—specifically, the Health Insurance Portability and Accountability Act of 1996—also incorporates guaranteed availability and renewability of health insurance.

compression, the insurer must increase the premiums it charges its lowest-cost, or healthiest, firms and reduce the premiums it charges its highest-cost firms. The result is cross-subsidization—the increased premiums paid by the healthiest firms are used to help pay for the expenses of less healthy firms, whose premiums are no longer high enough to cover their expected costs.

Another way in which state regulations may have boosted premiums for small firms is by mandating the inclusion of certain benefits in all health insurance plans. (In a number of states, those mandates cover treatment for alcoholism, drug abuse, and mental illness as well as chiropractic care and bone marrow transplants.) If such regulations force insurers in the small-group market to provide benefits that firms would not otherwise purchase, the mandates will, in effect, push up premiums by more than the additional coverage's value to employees. Mandates may also discourage some small employers from offering coverage, particularly firms with employees who are relatively healthy and who—given the choice—would probably forgo at least some of the mandated benefits to obtain lower premiums. Another way in which state regulations may increase premiums is through premium taxes, which are paid by insurers. In 1996, such taxes ranged from less than 1 percent to as much as 4 percent of premiums.¹³

Although, in principle, mandates and premium taxes affect the premiums of any firm (regardless of size) that purchases insurance from a licensed insurer, they frequently have a greater impact on small firms. The reason is that larger firms can avoid such regulations by self-insuring—that is, by bearing the financial risks of their employees' health care costs themselves rather than purchasing coverage from a health insurer or health plan. The federal Employee Retirement Income Security Act (ERISA) exempts firms' self-insured health plans from most state insurance regulations. However, small firms are less likely than large firms to self-insure because they have fewer potential enrollees (employees and their dependents) among whom to spread expenditures and as a result are vulnerable to greater financial risk (see Table 1 on page 2). Small firms that offer coverage are much more likely to purchase it from a health insurer and must therefore bear the full cost of state insurance regulation.¹⁴

13. General Accounting Office, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance*, GAO/HEHS-96-161 (August 1996), pp. 26-27.

14. Some small firms have chosen to partially self-insure by combining a self-insured plan with stop-loss insurance (an insurance policy that covers catastrophic health care expenditures). Partially self-insuring limits a firm's exposure to the risk of excessive health care expenditures—a critical consideration for a small firm—yet allows the firm to benefit from the advantages of self-insuring. Depending on the regulations of their state, firms that partially self-insure may avoid providing mandated benefits and paying premium taxes. However, states may limit the attractiveness of this option by effectively restricting the amount of stop-loss coverage that firms may purchase.

ASSOCIATION HEALTH PLANS AND HEALTHMARTS

AHPs and HealthMarts are intended to reduce the cost of health insurance for small employers. Like group purchasing cooperatives, they could enhance the purchasing power of their members, and they might reduce some administrative costs. But AHPs and HealthMarts would have two additional advantages compared with cooperatives: they would be exempt from most state benefit mandates, and they could avoid the full effect of state regulation of insurance premiums.

Association Health Plans

AHPs would operate subject to several important requirements. Trade, industry, or professional associations that had been in existence for at least three years could sponsor an AHP, which would have to offer its insurance products to all member firms. Those products could constitute a full range of health plans, including a self-insured plan, under certain conditions: generally, the AHP would have to offer at least one fully insured plan (purchased from a licensed health insurer), and the sponsoring association would have to meet other qualifying criteria designed to limit favorable selection (attracting enrollees that are healthier than average) and the risk of financial insolvency. Both the AHP's self-insured and fully insured plans would be exempt from state benefit mandates, but they would not be exempt from state premium taxes.¹⁵

Because of their structure, AHPs would be subject in only a limited way to state laws that regulate premiums in the small-group health insurance market. In general, AHPs would have to abide by the premium-setting regulations of each state for their enrollees who resided in that state. Some states require insurers that offer small-group policies to community-rate their premiums (a practice in which the price for a given health policy must be the same for all purchasers despite variations in those purchasers' expected costs per enrollee). Other states limit the degree to which premiums for a particular policy can vary among firms. AHPs would have to follow the state's rating rules, but the premiums they offered would be based on the average expected costs per enrollee of only the association's member firms—not on the costs of the broader (and potentially more expensive) groups that insurers offering traditional coverage serve. As a result, AHP premiums are likely to be lower than they would be if they reflected the availability rules applying to traditional (fully regulated) plans.

15. Under some proposals, including H.R. 2990, states could charge premium taxes on self-insured AHP plans commencing operations after enactment of the legislation.

HealthMarts

In many respects, HealthMarts would be similar to AHPs, but certain features—in particular, eligibility based on geographic location rather than association membership—would set them apart. HealthMarts would be nonprofit organizations that offered health insurance products to all small firms within their geographic service area, which would have to cover at least one county or an area of equivalent size. All of the health benefits plans that a HealthMart offered would be available to any small employer within its service area. Employers who chose to participate would have to agree to purchase health insurance only from the HealthMart. (That is, participating employers could not offer their employees plans from the traditional market in addition to HealthMart plans.)

Like AHPs, health plans offered through HealthMarts would be exempt from most state benefit mandates but would have to pay state premium taxes. HealthMarts would also be subject to state premium regulations that applied within their service area.¹⁶ Unlike AHPs, however, HealthMarts could offer only fully insured plans from insurance issuers licensed in the state; self-insurance would not be an option.

HOW AHPs AND HEALTHMARTS WOULD AFFECT PREMIUMS AND COVERAGE

The effects of AHPs and HealthMarts on the premiums of and number of people enrolled in traditional plans would depend on the response of small firms to health insurance policies comprising fewer benefits coupled with lower premiums. Coverage might increase if AHPs and HealthMarts could offer plans with premiums that were lower than those for traditional coverage. Firms that do not currently offer insurance to their employees might choose to do so if the price was lower, even if the benefits were not as comprehensive as in some plans. Yet that response is only part of the coverage picture. Firms that already purchase traditional coverage might instead seek lower-cost coverage through an AHP or HealthMart. If the firms that dropped traditional coverage had healthier-than-average employees, and thus lower costs for insurance, fewer of those so-called low-cost firms would remain to subsidize the premiums of higher-cost firms. As a result, premiums for at least some firms purchasing traditional plans would have to rise, which could lead those firms to drop coverage.

16. Depending on the specific proposal, a HealthMart might be required to charge the same premium to every participating employer.

Premiums in the AHP/HealthMart Market

AHPs and HealthMarts could offer premiums that were lower than those for traditional coverage to the extent that they were exempt from state benefit mandates and could avoid some of the effects of state premium-setting regulations. Group purchasing of health insurance through AHPs and HealthMarts could also lower the cost of health insurance for small firms if it reduced administrative costs or increased firms' purchasing power. AHP premiums might undergo further paring depending on whether a particular AHP could achieve savings through self-insurance.

Avoiding State Regulation. According to their advocates, reducing the cost of state regulation is one of the principal attractions of AHPs and HealthMarts. Unlike the purchasing cooperatives that can now be found in many states, AHPs and HealthMarts would not be subject to state benefit mandates and might also avoid some restrictions on premiums. (Box 1 briefly discusses several kinds of purchasing cooperatives.) For example, small firms could obtain lower premiums if AHPs and HealthMarts dropped some of the benefits that states required insurers to cover and offered less generous benefit packages than were available in traditional plans. The extent of such savings and their effect on premiums would depend on whether employees of small firms still desired some of those mandated benefits. Firms take into account the preferences of their employees in designing their benefit packages and will not necessarily sponsor policies that omit all mandated benefits. (One study of self-insured employers found that many of those firms offered mandated benefits despite their exemption from state regulations under ERISA.)¹⁷

Exempting AHPs and HealthMarts from offering mandated benefits might substantially affect selection. With the exemption, AHPs and HealthMarts could design benefit packages that had fewer benefits and were relatively unattractive to firms whose employees had costly health care needs. Those firms would want more extensive benefit packages and would probably maintain their enrollment in traditional (fully regulated) plans. As a result, their high health care costs would not affect the premiums offered by AHPs and HealthMarts, which might allow those plans to lower their costs by more than the savings from the mandates exemption alone. Lower-priced plans with leaner benefit packages would appeal more to healthy firms (with lower-than-average expected health care costs)—both those that offered no coverage at all to their employees and those that already offered insurance. Some firms with higher-than-average expected health costs might also be attracted by the lower premiums, but they would be less likely to participate because of the leaner benefits.

17. Jonathan Gruber, "State-Mandated Benefits and Employer-Provided Health Insurance," *Journal of Public Economics*, vol. 55 (1994), pp. 433-464.

BOX 1.
HEALTH INSURANCE PURCHASING COOPERATIVES

Health insurance purchasing cooperatives are relatively popular among small firms. A recent study estimated that 33 percent of establishments in firms with fewer than 10 employees and 28 percent of establishments in firms with 10 to 49 employees purchase health insurance through some type of group purchasing cooperative.¹ Such group purchasing arrangements can be divided into three broad categories: state-sponsored health insurance purchasing alliances, multiple-employer welfare arrangements (MEWAs), and multiemployer union-sponsored plans (also known as Taft-Hartley plans).

To encourage small firms to purchase health insurance, a handful of states sponsored health insurance purchasing alliances beginning in the early 1990s.² (An example is California's Health Insurance Purchasing Cooperative.) Typically, state alliances offer a variety of plans, including one or more managed care options, to any qualifying employer who wishes to purchase insurance through the alliance, and employees then enroll in the plan of their choice. The health plans that alliances offer are subject to normal state insurance regulations, including premium-setting rules and benefit mandates, although a few states exempt alliance plans from some of those requirements.

MEWAs can take many different forms including privately sponsored alliances, which function like the state-sponsored type, and association health plans, which can offer coverage only to members of their sponsoring association. (Those existing association health plans should not be confused with the proposed association health plans that are the focus of this paper.) The association-sponsored plans are employee benefit plans as defined by the Employee Retirement Income Security Act, or ERISA. They are more likely than purchasing alliances to offer a limited selection of health insurance options, and they can self-insure if they choose. In general, both fully insured and self-insured MEWAs are subject to state insurance regulations, including benefit mandates and premium-setting rules.

Union-sponsored plans are the only type of purchasing cooperative that does not have to adhere to state insurance regulations. Even though Taft-Hartley plans may involve many employers, ERISA classifies them separately from MEWAs and exempts them from state regulations such as benefit mandates and premium-setting rules.

There is little direct evidence about the effect of cooperatives on premiums. According to a study of a major purchasing alliance in California, the premiums that participating insurers offered to qualifying small employers were not as low as those offered to large firms.³ Long and Marquis's analysis of a national survey of small firms found that premiums for cooperatives were roughly the same as those offered by traditional plans. The advantages of alliances appear to be primarily choice and information. For about the same premium, firms purchasing their coverage through a cooperative are more likely than other small firms to offer a choice of health plans to their employees. They also have better access to information about those plans, such as the benefits offered and the quality of care provided.

1. Stephen H. Long and M. Susan Marquis, "Pooled Purchasing: Who Are The Players?" *Health Affairs*, vol. 18, no. 4 (July/August 1999), pp. 105-111.
2. Susan S. Landicina and others, *State Legislative Health Care and Insurance Issues: 1996 Survey of Plans* (Chicago, Ill.: Blue Cross/Blue Shield Association, 1996).
3. Jill Yegian and others, *Health Insurance Purchasing Alliances for Small Firms: Lessons from the California Experience* (Oakland, Calif.: California HealthCare Foundation, May 1998).

In the long run, one would expect the most successful AHPs to be sponsored by associations whose members had lower-than-average health care costs. Similarly, the most successful HealthMarts would probably be located in lower-cost areas of the country or areas where the costs of regulation and mandates were high.

Group Purchasing. To a limited extent, the advantages offered by group purchasing might enable AHPs and HealthMarts to offer premiums that were lower than those for traditional coverage. Like other group purchasing arrangements, AHPs and HealthMarts would probably have more negotiating power with health insurers than would small employers negotiating on their own. The larger the number of potential enrollees, the more willing health insurers and provider networks would be to discount their rates to attract business. Another advantage of group purchasing that might be reflected in lower premiums would be lower administrative costs—with group purchasing, some fixed costs would be shared among a larger number of enrollees.

Savings from group purchasing, however, are unlikely to induce many small firms to add coverage, because the group purchasing option, with its associated advantages, is already available to them through purchasing cooperatives. One exception may be AHPs and HealthMarts in states that have not been particularly supportive of cooperative purchasing arrangements.

Self-Insuring Through AHPs. Although AHPs would be able to offer self-insured plans, several factors would limit the attractiveness of that option. For example, all plans offered by AHPs, whether self-insured or fully insured, would be exempt from benefit mandates and would have to pay premium taxes. As a result, self-insured AHP plans would offer no advantage in those areas over fully insured AHP plans.¹⁸ Other advantages of self-insuring might also go unrealized. For example, firms that self-insure can retain and earn interest on the money that they would ordinarily pay in premiums to a health insurer until the money is needed to pay medical claims.¹⁹ But small firms enrolling in an AHP's self-insured plan would still have to pay premiums to a third party—the AHP. Moreover, to curb favorable-selection practices, some of the proposals being considered would restrict the self-insurance option to AHPs sponsored by associations whose member firms had higher-than-average health expenditures or represented a broad cross-section of industries (such as a chamber of commerce).

18. Some association-sponsored plans in existence on the date of enactment of an AHP/HealthMart proposal might be able to claim an exemption from premium taxes.

19. See Martha Patterson and Derek Liston, *Analysis of the Number of Workers Covered by Self-Insured Health Plans Under the Employee Retirement Income Security Act of 1974: 1993 and 1995* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, August 1996).

The option to self-insure jointly with other firms is not new. ERISA already allows small firms to self-insure by joining together with other firms in so-called multiple-employer welfare arrangements (MEWAs). However, MEWAs might not be as attractive a vehicle for self-insuring as AHPs would be. Unlike AHPs, MEWAs must comply with some state regulations, including benefit mandates. In addition, some small firms may consider participation in a MEWA to be too risky. Overlapping state and federal laws have made regulating MEWAs a complicated and difficult task. According to the General Accounting Office, "MEWAs have proven to be a source of regulatory confusion, enforcement problems, and, in some instances, fraud."²⁰ As of December 1998, the Department of Labor had initiated 358 civil and 70 criminal investigations of MEWAs that affected over 1.2 million enrollees and involved monetary violations of more than \$83.6 million.²¹

To bypass such problems, all of the AHP proposals include requirements to facilitate effective regulation of small firms that self-insure collectively. AHPs that offered self-insured plans would be subject to federal solvency standards, including requirements to set aside adequate reserves and to purchase stop-loss and indemnification insurance. Stop-loss insurance, which insures against the risk of unusually high claims, would apply to claims for a specific enrollee as well as aggregate claims for the plan as a whole. Indemnification insurance would pay outstanding claims if the plan was unable to meet its obligations. Thus, although self-insured AHP plans might not offer many advantages over their fully insured counterparts, they might still be more attractive to small firms than self-insuring through a MEWA.

Premiums for Traditional Insurance Plans

If firms with healthier-than-average employees switched from traditional insurance to AHPs and HealthMarts, premiums for some firms' traditional policies would rise. Moreover, that selection effect could be exacerbated by recently enacted federal requirements regarding the portability of insurance coverage. The Health Insurance Portability and Accountability Act of 1996 limits exclusions for preexisting conditions when purchasers of insurance switch from one policy to another. That provision could lead to the sorting of "healthy" and "sick" firms into AHP/HealthMart and traditional plans, respectively. For example, a firm with healthy employees (and thus relatively low expected health costs) might purchase a relatively inexpensive policy (covering few mandated benefits) in the AHP/HealthMart market. If one or

20. General Accounting Office, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, GAO/HRD-92-40 (March 1992), p. 2.

21. Department of Labor, Pension and Welfare Benefits Administration, Office of Public Affairs, "Fact Sheet on MEWA Enforcement" (December 1998).

more of its employees subsequently developed a serious illness, the firm could switch back to a traditional plan to obtain a more comprehensive policy, and its employees would face no exclusion (or only a limited exclusion) for preexisting conditions.²²

To discourage favorable-selection practices, the proposals covering AHPs and HealthMarts generally include requirements that would limit their ability to attract healthier-than-average groups. For example, AHPs would have to offer their plans to any small firm that qualified for membership in the sponsoring association. Similarly, HealthMarts would have to make their plans available to any small firm located in their designated geographic area. A further factor tempering favorable-selection efforts may be that increasingly aggressive attempts by AHPs and HealthMarts to attract low-cost firms would add to administrative costs. Moreover, premium-setting regulations would still apply.

Even if AHPs and HealthMarts were successful in attracting primarily low-cost firms, the resulting premium increases for traditional plans would be relatively small. High-cost firms would be a small minority of those firms retaining traditional coverage, even though some lower-cost firms would switch to less costly AHP or HealthMart options. The low-cost firms that continued to purchase traditional health insurance would cross-subsidize the higher-cost firms, just as they do now.

Coverage

How AHPs and HealthMarts affected coverage would depend on how small firms responded to changes in premiums and benefits and, more specifically, on the differential responses by low-cost and high-cost firms. The effect on coverage of reforms in the small-group market that were enacted by many states in the early 1990s—reforms that AHPs and HealthMarts would weaken—may provide some insight into the potential impact of the proposed new insurance vehicles. Although the reforms may have stabilized premiums and made health insurance more available in the small-group market, they may also have led to reduced coverage: between 1987 and 1996, enrollment of small-firm employees in employer-sponsored health insurance declined by about 3 to 4 percentage points.²³

22. For a limited set of categories, federal portability regulations allow plans to impose limitations on coverage of preexisting conditions if a person's previous plan did not cover those conditions. The coverage categories are mental health, substance abuse treatment, prescription drugs, dental care, and vision care.

23. See Philip Cooper and Barbara Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, vol. 16, no. 6 (November/December 1997), p. 14.

New insurance laws—including benefit mandates and premium compression requirements—that raised premiums for low-cost firms in the small-group market probably contributed to that loss of coverage. Benefit mandates may have caused firms to pay for benefits that their employees did not value highly. When those mandates resulted in higher-priced insurance policies, some losses in coverage probably occurred. Premium compression requirements, which lead to low-cost firms cross-subsidizing the coverage of higher-cost firms, raise the cost of insurance for firms with healthier employees and lower it for firms with less healthy employees.²⁴ Some empirical studies suggest that because low-cost firms and their employees have less immediate need for health insurance, they may be more sensitive to price changes than high-cost firms and their employees (see the appendix). Consequently, the studies show that the number of employees in low-cost firms who dropped coverage when their premiums rose was greater than the number of employees in high-cost firms who gained coverage when their premiums fell.

The differential responses to changes in premiums by firms with different expected health care costs is key to understanding the net effect of AHPs and HealthMarts on coverage. AHPs and HealthMarts would weaken some of the effects of state premium reforms; as a result, some low-cost firms would gain access to lower premiums, but some high-cost firms would see their premiums rise.²⁵ If, indeed, high-cost firms respond less to price changes than do low-cost firms, the resulting net coverage loss among high-cost firms would probably be less than the net coverage gain among low-cost firms, so overall coverage levels would probably increase. In addition, the mandates exemption of the AHPs and HealthMarts would allow them to offer plans with fewer benefits and at a lower price than the traditional plans can offer. The new plans are likely to be particularly attractive to low-cost firms, which would encourage some firms and workers to add coverage.

24. Because premium compression requirements also effectively impose an upper limit on the price of policies sold to higher-cost groups, insurers may have responded by not aggressively marketing their plans to as many firms with relatively less healthy employees as they would have if they had been allowed to charge higher rates.

25. That statement would be true only in general. A number of low-cost firms might remain enrolled in traditional plans, even though some of them would face increased premiums as other low-cost firms switched to AHPs and HealthMarts. In addition, some high-cost firms might obtain access to an AHP or HealthMart with predominantly healthy firms, enabling the high-cost firms to pay lower premiums than they would have paid if they had purchased traditional coverage.

ESTIMATING THE EFFECTS OF AHPs AND HEALTHMARTS ON PREMIUMS AND COVERAGE

CBO constructed an analytical model to project how small firms and their employees would respond to the introduction of AHPs and HealthMarts. Two measures of the potential impact of those proposed new insurance arrangements are the net increase in the number of people covered by insurance and the increase in total premiums paid to insurers. The latter measure reflects both the additional people covered by insurance and the net overall changes in the value of benefits offered to people with coverage. Changes in coverage might accompany either an increase or decrease in the total premiums paid. The estimates reported here indicate the long-term changes in premiums and coverage that would occur after the market had fully adjusted to the introduction of AHPs and HealthMarts.

Main Findings

The model's main findings rely on assumptions that were developed from the results of empirical studies about how firms and employees respond to changes in premiums and insurance regulations (see the appendix for details). Under those assumptions, the introduction of AHPs and HealthMarts would increase net coverage through small firms by about 1.3 percent, or 330,000 people, including employees and their dependents (see Table 2). The increase in the overall number of people with insurance, however, would be slightly lower, because some of those who gained employer-sponsored coverage through AHPs and HealthMarts would have otherwise obtained coverage through the individual market. The 330,000 figure represents a net increase of about 340,000 enrollees among low-cost firms that would be slightly offset by a net drop of 10,000 people among higher-cost firms. (For these estimates, low-cost firms are those with expected claims costs per enrollee in the lower 90 percent of the distribution for all small firms.) Altogether, CBO estimates that about 4.6 million people would be insured through AHPs and HealthMarts, with most of those people switching from the fully regulated market to the new plans.

Once AHPs and HealthMarts were in full operation, total premiums paid annually by small firms and their employees would be approximately \$150 million more than they otherwise would be, which represents about a 0.3 percent increase in total spending for health insurance in the small-group market (see Table 3). Firms that continued to purchase traditional health insurance plans would pay an additional \$800 million in premiums. That increase would be more than offset by the \$1.2 billion in net premium savings that would result because firms faced lower premiums in AHP and HealthMart plans. In addition, the net increase in coverage among low-cost firms would add \$600 million in premiums; among higher-cost

TABLE 2. ESTIMATED EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON COVERAGE IN THE SMALL-GROUP HEALTH INSURANCE MARKET

	Number of Enrollees ^a
Coverage Under Current Law (Millions)	24.6
Changes When AHPs and HealthMarts Are in Full Operation	
Low-cost firms ^b	340,000
High-cost firms ^c	<u>- 10,000</u>
Total	330,000
Coverage When AHPs and HealthMarts Are in Full Operation (Millions)	
AHP or HealthMart plans	4.6
Traditional plans ^d	<u>20.3</u>
Total	24.9

SOURCE: Congressional Budget Office.

NOTE: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

- a. Workers and their insured dependents. However, these figures exclude an estimated 1.3 million people who participate in self-insured employer-sponsored plans under current law.
- b. Firms with expected health costs in the lower 90 percent of the cost distribution.
- c. Firms with expected health costs in the upper 10 percent of the cost distribution.
- d. Subject to full state regulation.

TABLE 3. ESTIMATED ANNUAL EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON TOTAL PREMIUMS IN THE SMALL-GROUP HEALTH INSURANCE MARKET

	Millions of Dollars
Total Premiums Under Current Law	50,400
Changes When AHPs and HealthMarts Are in Full Operation	
Premium savings from net enrollee movement to AHPs and HealthMarts	-1,200
Increased premiums for firms covered under traditional plans ^a	800
Net increase in coverage among low-cost firms ^b	600
Net decrease in coverage among high-cost firms ^c	<u>-50</u>
Total	150
Total Premiums When AHPs and HealthMarts Are in Full Operation	50,550

SOURCE: Congressional Budget Office.

NOTES: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

The term "enrollee" includes insured workers and their insured dependents but excludes an estimated 1.3 million people who participate in self-insured employer-sponsored plans under current law.

- a. Traditional plans are subject to full state regulation.
- b. Firms with expected health costs in the lower 90 percent of the distribution.
- c. Firms with expected health costs in the upper 10 percent of the distribution.

firms, the increase in the price of traditional plans would lead to a cut of about \$50 million worth of coverage.

The price of a policy would be lower for some firms as a result of introducing AHPs and HealthMarts. On average, premiums paid by firms that participated in AHPs and HealthMarts would be about 13 percent lower than the premiums they would pay in the small-group market under current law (see Table 4). Five percentage points of that reduction come from the benefit mandate exemption and savings from group purchasing (see the appendix). The other 8 percentage points stem from the expected health costs of firms in the AHP and

TABLE 4. ESTIMATED EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON AVERAGE PREMIUMS IN THE SMALL-GROUP HEALTH INSURANCE MARKET

	Percentage
Change in the Average Premium Paid by Firms That Participate in AHPs or HealthMarts	-13
Change in the Average Premium Paid by Firms That Retain Traditional Coverage ^a	2

SOURCE: Congressional Budget Office.

NOTES: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

Changes are calculated relative to premiums under current law.

a. Traditional coverage is subject to full state regulation.

HealthMart market that are generally lower than average and that allow participating firms to avoid some of the premium-boosting effects of rate compression laws.

Once AHPs and HealthMarts became available, firms that continued to purchase traditional plans would, on average, see some increases in their premiums arising from the shift of some low-cost firms to the new insurance vehicles. CBO's projections indicate a net transfer of approximately 4.3 million enrollees in low-cost firms from fully regulated plans to an AHP or HealthMart plan. Those transfers would cause premiums offered to firms with traditional coverage to rise, on average, by 2 percent. The increase is relatively small because low-cost firms would continue to be a substantial part of the market for traditional plans.

Findings Under Alternative Assumptions

To determine a plausible range of possible outcomes once AHPs and HealthMarts were introduced, CBO varied its assumptions about the behavioral responses of firms and employees (see the appendix). At one extreme, the model estimated that coverage through small firms would increase by only 10,000 enrollees. That figure is associated with a negligible increase in premiums for small firms purchasing traditional insurance and a 9 percent reduction in premiums for participants in AHPs and HealthMarts. At the upper end of the range, the model estimated that coverage could increase by as many as 2 million people. The accompanying changes in

premiums would be an increase of 2 percent for firms retaining traditional coverage and a reduction of 25 percent for firms participating in AHPs and HealthMarts. Under those alternative scenarios, the total number of enrollees in AHPs and HealthMarts ranges from less than 1 million to 5.7 million.

CONCLUSIONS

CBO projects that the introduction of AHPs and HealthMarts would have only slight effects on insurance coverage nationwide, increasing the number of people insured through small firms by about 330,000. Although about 4.6 million people would enroll in the new plans, the net boost in the number of people insured through small firms would be far smaller because many enrollees in the new plans would otherwise have been insured through traditional plans and because the increase in enrollees from some firms (those that gained coverage through AHPs and HealthMarts) would be offset by the decrease in enrollees from others (those that dropped their traditional coverage). Although coverage among small firms would grow by about 1.3 percent, total spending for health insurance would actually rise by only 0.3 percent, for two reasons: some coverage would be less comprehensive—because AHPs and HealthMarts are exempt from most state-mandated benefit requirements—and the mix of low-cost and high-cost firms with coverage would change.

If low-cost firms moved to AHPs and HealthMarts, some firms with traditional coverage would see their premiums rise because fewer low-cost firms would remain to cross-subsidize the high-cost firms. In response, some firms and workers covered under traditional plans would drop coverage, but most would continue to be covered and pay slightly higher premiums. After summing the changes in enrollment in both AHP/HealthMart and traditional plans, CBO estimates that, on balance, high-cost firms would drop coverage and low-cost firms would add coverage. Consequently, among firms that have coverage, the proportion of low-cost firms would increase, and the share of high-cost firms would decrease.

Among the states, the impact of AHPs and HealthMarts would probably be uneven because states differ in the extent and intensity of their regulations. States that have imposed relatively strict premium compression rules would be likely to attract more of the new plans than states that allow insurers to charge a wider range of premiums. The reason is that in states with more tightly compressed premiums—where the most cross-subsidization occurs—low-cost firms would face the greatest potential difference in price between traditional and AHP/HealthMart plans. Similarly, states with benefit mandates that are more costly or that cover benefits perceived as having little value to the average employee would be riper markets for AHPs and HealthMarts, as would areas with greater concentrations of small firms.

In addition to considering who would gain and who would lose under these proposed new insurance arrangements, policymakers must address issues of regulatory authority and solvency standards. Much uncertainty attends the overlapping of federal and state jurisdiction over AHPs and HealthMarts. States, for example, would exercise considerable regulatory authority over HealthMart plans—which could only be fully insured products offered by state-licensed insurers. But the Department of Health and Human Services would also be given regulatory authority over HealthMarts. States would have some authority over AHPs but might rely on the Department of Labor to oversee those plans—especially since self-insured AHPs would have to comply with federal solvency standards. How great a role the federal government or the states played in regulating the new entities would depend, in part, on the resources that the two designated federal oversight agencies devoted to that function.

APPENDIX: MODELING THE EFFECTS OF AHPs AND HEALTHMARTS

In modeling the effects on the small-group market of introducing association health plans and HealthMarts, the Congressional Budget Office based its analysis on legislation recently introduced in the Congress, although the analysis may not reflect the specific provisions of any particular bill. CBO's model took into account how benefit mandates affect insurance costs and how firms respond to changes in premiums. Its estimates of premiums are based on the expected insurance costs of participants in the small-group market after factoring in state regulatory rules that restrict the range of premiums an insurer can charge.

The analysis considered two regulatory environments. In the first, which follows current law, small firms purchase traditional, or fully state regulated, insurance plans. In the second, firms may either purchase an AHP or HealthMart plan or obtain traditional coverage. By comparing the outcomes under the two sets of circumstances, the model estimated how AHPs and HealthMarts would affect coverage and premiums among small firms.

Assumptions

To choose assumptions to feed into the model, CBO reviewed studies of the health insurance market and tabulations from available data files. The major assumptions used in modeling the effects of AHPs and HealthMarts covered the following areas:

- o Savings achieved through exemption from state benefit mandates;
- o Savings from group purchasing arrangements;
- o Coverage changes in response to a change in the price of insurance;
- o Insured firms' willingness to switch to less expensive, less comprehensive plans;
- o Differences in insurance costs between firms with healthy employees and those with sicker employees; and
- o Premium reductions in the AHP/HealthMart market from avoiding rate compression.

Savings Achieved Through Exemption from State Benefit Mandates. The main findings reported earlier were based on the assumption that AHPs and HealthMarts

would save 5 percent of insurance costs because of their exemption from state benefit mandates. CBO developed that assumption after analyzing empirical studies whose results imply a wide range of costs imposed by such requirements.

Some firms and employees will drop coverage when the price of an insurance policy rises. Therefore, studies of how mandates affect coverage will also yield some insight into how they affect costs. Gruber studied how state mandates influenced insurance coverage in firms of less than 100 employees and found that they had a negative but not statistically significant effect.¹ He estimated that states passing all five of the mandates he designated as expensive (which included mental health services and drug abuse treatment) would see coverage drop by 1.2 percentage points, measured from a base of 46.5 percent of workers with employer-sponsored insurance in firms with less than 100 workers. He also found that a 1 percent increase in the actuarial costs of mandated benefits reduced coverage by 0.17 percentage points. (Actuarial costs are the costs of the claims paid for those benefits.) As Gruber recognized, a reason for the small effects he found was that his measure of costs overstated the actual additional costs that a mandate law imposes on insurance plans because many plans would have covered some benefits even in the absence of a legal mandate.

Summarizing studies that examined several states, the General Accounting Office found that the actuarial costs of mandated benefits ranged from 5.4 percent to 22.0 percent of total claims costs.² But the potential savings from the mandates exemption are smaller than the actuarial costs of the required benefits to the extent that health plans would have covered those benefits anyway. To adjust the results of studies that looked at actuarial costs, CBO used data on the frequency with which a health plan covered certain benefits (those that fell under the mandates Gruber designated as expensive) even though the state in which the plan operated did not require such coverage. Those calculations suggest a range of 0.28 percent to 1.15 percent as the effective marginal cost of state mandates.

Compared with the evidence noted above, the work of other researchers indicates that mandates impose greater costs and exert much larger and statistically significant effects on coverage. Such studies suggest that firms' and workers' decisions about coverage are more sensitive to premiums than is typically assumed. For example, Marsteller and others found that a mandate to cover alcoholism or drug abuse treatments significantly reduced private insurance coverage by about 2.5

1. Jonathan Gruber, "State-Mandated Benefits and Employer-Provided Health Insurance," *Journal of Public Economics*, vol. 55 (1994), pp. 433-464.

2. General Accounting Office, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance*, GAO/HEHS-96-161 (August 1996).

percentage points.³ And Jensen and Gabel's study of small firms indicated that about one-fifth to two-fifths of firms not offering coverage would do so if state mandates were eliminated.⁴ Sloan and Conover analyzed individual-level data gathered from multiple states over time and concluded that removing the average number of benefit mandates would increase coverage by 4 percentage points—a figure suggesting that the lack of coverage for between one-fifth and one-fourth of the uninsured is attributable to benefit mandates.⁵ The findings from Jensen and Gabel and Sloan and Conover are consistent with either or both of the following statements: firms' and workers' decisions about coverage are more sensitive to premiums than is generally assumed, and the marginal cost of mandates could be 10 percent or more.⁶

Savings from Group Purchasing Arrangements. As discussed earlier, CBO assumed that cost savings arising from the group purchasing feature of AHPs and HealthMarts would be negligible. The work of Long and Marquis supports that assumption; they found no substantial evidence that joining a purchasing cooperative produced lower insurance costs for firms.⁷

Coverage Changes in Response to a Change in the Price of Insurance. Elasticity of demand is a way of gauging responsiveness to price changes. For the estimates presented in the text, CBO assumed that the overall elasticity of demand for insurance through small firms is -1.1, meaning that an increase of 1 percent in the price of insurance will reduce coverage by 1.1 percent. That elasticity is larger than many researchers would typically use in evaluating the health insurance market in general. Nevertheless, studies focusing on the insurance-purchasing behavior of small firms suggest that an elasticity of that size is reasonable and that compared

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3. Jill A. Marsteller and others, *Variations in the Uninsured: State and County Level Analyses* (Washington, D.C.: Urban Institute, June 1998).
 4. Gail A. Jensen and Jon R. Gabel, "State Mandated Benefits and the Small Firm's Decision to Offer Insurance," *Journal of Regulatory Economics*, vol. 4 (1992), pp. 379-404.
 5. Frank A. Sloan and Christopher J. Conover, "Effects of State Reforms on Health Insurance Coverage of Adults," *Inquiry*, vol. 35 (Fall 1998), pp. 280-293.
 6. Selecting the most "reasonable" assumption from among a wide range of empirical findings is not always an easy task. Yet models require such choices to produce estimates of effects. Other researchers besides CBO analysts have also had to make assumptions about the savings achieved through the exemption from state benefit mandates. In a recent study, for example, Blumberg, Nichols, and Liska developed a microsimulation model that required such an assumption. Like CBO, they reviewed the literature and chose to assume that AHPs and HealthMarts would save 5 percent as a result of the exemption. See Linda J. Blumberg, Len M. Nichols, and David Liska, *Choosing Employment-Based Health Insurance Arrangements: An Application of the Health Insurance Reform Simulation Model* (Washington, D.C.: Urban Institute, March 1999).
 7. Stephen H. Long and M. Susan Marquis, "Pooled Purchasing: Who Are the Players?" *Health Affairs*, vol. 18, no. 4 (July/August 1999), pp. 105-111.

with large firms, small firms are significantly more responsive to changes in the price of insurance.

For example, Feldman and others analyzed decisions about coverage made by small firms in Minnesota and found elasticities that ranged from -3.9 to -5.8.⁸ Blumberg, Nichols, and Liska used a more representative data set covering firms in 10 states and found that the smaller the firm, the greater its sensitivity to price.⁹ They calculated elasticities of about -1.5 for firms with fewer than 10 workers. Jensen and Gabel studied losses in coverage as a result of mandates. On the basis of their findings, CBO estimated that if the costs to a firm for mandated benefits are 15 percent of premiums, then the elasticity of demand for coverage by small firms is about -1.8.¹⁰ If mandates cost a firm less than 15 percent, the implication is that small firms are even more responsive to price changes than a -1.8 elasticity would indicate.

Studies that have examined the demand for health insurance more generally—that is, not restricting the analysis to small firms—have for the most part found less responsiveness. That viewpoint is illustrated by CBO's 1993 survey, which adopted an elasticity of -0.6.¹¹

Insured Firms' Willingness to Switch to Less Expensive, Less Comprehensive Plans. CBO's model also required assumptions about the willingness of otherwise insured employees and employers to switch to less expensive, less comprehensive health benefits plans. For its main findings, CBO thus assumed that more than 20 percent of otherwise insured people would switch to an AHP or HealthMart plan in exchange for a premium reduction of 13 percent. High-cost firms and their employees were assumed to be only one-fourth as willing as low-cost firms to switch to a lower-priced but less comprehensive plan.

CBO considered the results of several empirical studies in developing its assumptions about this factor. For example, Buchmueller and Feldstein, who examined the willingness of employees to switch health plans in response to changes in premiums, found that a \$10 increase in the monthly premium would cause about 26 percent of enrollees to switch to a less expensive plan, whereas an increase of

8. Roger Feldman and others, "The Effect of Premiums on the Small Firm's Decision to Offer Health Insurance," *Journal of Human Resources*, vol. 32, no. 4 (Fall 1997), pp. 637-658.

9. Blumberg, Nichols, and Liska, *Choosing Employment-Based Health Insurance Arrangements*.

10. Jensen and Gabel, "State Mandated Benefits."

11. Congressional Budget Office, *Behavioral Assumptions for Estimating the Effects of Health Care Proposals*, CBO Memorandum (November 1993).

\$20 per month would cause about 30 percent to switch.¹² Those findings are consistent with an assumption that a price discount of 15 percent relative to the price of a more comprehensive plan would cause about 26 percent of policyholders to switch, whereas a 30 percent discount would cause about 30 percent to switch. Morrisey and Jensen focused on small firms switching from fee-for-service plans to managed care plans in response to premium changes.¹³ They found that a change of 10 percent in premiums would cause an increase of only about 3 percentage points in the fraction of firms switching plans. In its model, CBO used Buchmueller and Feldstein's results for its central assumption, but analysts reduced those results by their statistical margin of error to reflect the overall range of findings in the literature.

Differences in Costs for Low- and High-Cost Firms. CBO designated firms as either low or high cost depending on their average expected health expenses. For the main findings reported in the text, CBO defined low-cost firms as those with expected costs per enrollee in the lower 90 percent of the distribution of expected health costs among small firms; high-cost firms were those with costs in the highest 10 percent. CBO further assumed that low-cost and high-cost firms would be segregated in the AHP/HealthMart market because AHPs and HealthMarts face less sweeping availability requirements than those confronting insurers offering traditional plans. CBO chose to divide firms at the 90th percentile because of the skewed nature of expected health costs—relatively few firms have unusually high expected costs. Since small firms with high expected costs stand out in the distribution much more than do firms with low expected costs (which tend to cluster together toward the bottom), AHPs and HealthMarts could probably avoid enrolling those few least-healthy (high-cost) groups, but they would have difficulty limiting their enrollment only to the healthiest groups. Moreover, AHPs and HealthMarts would face association-wide or geographic availability requirements that would limit the degree of favorable selection they could achieve.

Direct data on the distribution of expected costs among small firms were not available, but since premiums reflect expected costs, CBO used data on premiums to estimate the distribution. CBO drew premium data for small firms from the late 1980s; its estimates are consistent with the results from Cutler's 1994 study of the small-group market, which was based on data from the early 1990s.¹⁴ The advantage of using data from the late 1980s or early 1990s is that they predate the

12. Thomas C. Buchmueller and Paul J. Feldstein, "The Effect of Price on Switching Among Health Plans," *Journal of Health Economics*, vol. 16 (1997), pp. 231-247.

13. Michael A. Morrisey and Gail A. Jensen, "Switching to Managed Care in the Small Employer Market," *Inquiry*, vol. 34 (Fall 1997), pp. 237-248.

14. David M. Cutler, *Market Failure in Small Group Health Insurance*, Working Paper 4879 (Cambridge, Mass.: National Bureau of Economic Research, October 1994).

widespread introduction of premium compression laws by the states (which reduce the variation in premiums relative to the variation in expected costs). More recent data on premiums would have reflected the laws' effects and would therefore be less accurate in indicating how expected costs were dispersed among firms. Under CBO's definitions of low- and high-cost firms, the data indicate that average annual expected health costs per enrollee would be \$1,810 for low-cost firms and \$4,200 for high-cost firms.

Premium Reductions in the AHP/HealthMart Market from Avoiding Rate Compression. Under the proposed legislation, AHPs and HealthMarts would face different availability rules than those applying to insurers offering traditional plans. As a result, low-cost firms purchasing coverage through AHPs and HealthMarts could obtain lower premiums (in addition to the reduction stemming from the benefit mandates exemption) because state premium compression rules would exert less of an upward effect. Premium compression laws differ among the states. To simplify the analysis, CBO assumed that on average, the state rules allowed premiums to vary around a 20 percent band. It also assumed that low-cost firms switching to AHPs or HealthMarts would pay premiums that reflected only the expected costs of low-cost firms.

Several studies have found that overall, premium compression rules decrease coverage. Marsteller and others found a decrease in private coverage of 1 percentage point when premium compression laws were imposed on the small-group market.¹⁵ CBO estimated that the drop in coverage reported in the Marsteller study would translate into a loss of approximately 2.3 million enrollees (in 1999 population figures). Simon's study of insurance coverage using a nationally representative sample and the microsimulation study by Buchanan and Marquis also support the finding of a significant loss in coverage as a result of premium compression laws.¹⁶ In contrast, Sloan and Conover found no significant effect on coverage in the small-group market.¹⁷ Buchmueller and DiNardo found no effect on coverage but noted a switch from fee-for-service plans to managed care plans in response to premium compression rules.¹⁸

15. Marsteller and others, *Variations in the Uninsured*.

16. Kosali I. Simon, "Did Small-Group Health Insurance Reforms Work? Evidence from the March Current Population Survey, 1992-1997" (draft, Department of Economics, University of Maryland, March 1999); and Joan L. Buchanan and M. Susan Marquis, "Who Gains and Who Loses with Community Rating for Small Business?" *Inquiry*, vol. 36 (Spring 1999), pp. 30-43.

17. Sloan and Conover, "Effects of State Reforms on Health Insurance Coverage of Adults."

18. Thomas Buchmueller and John DiNardo, *Did Community Rating Induce an Adverse Selection Death Spiral? Evidence from New York, Pennsylvania, and Connecticut*, Working Paper 6872 (Cambridge, Mass.: National Bureau of Economic Research, January 1999).

A decrease in coverage stemming from premium compression laws can occur if low-cost firms and their employees, in deciding to buy coverage, are more sensitive to changes in premiums than are high-cost firms. On the basis of the above studies, CBO assumed for its main estimates that low-cost and high-cost firms have different elasticities of demand for coverage and, as a result, that prevailing rate compression laws are responsible for 1.7 million fewer people having health insurance.

Sensitivity of the Estimates to Alternative Assumptions

As the preceding discussion suggests, the range of estimates in the economics literature for some of the key assumptions in CBO's model is quite large. The findings from the model that are reported in the text are based on assumptions that tend to fall near the middle of those ranges. To test the sensitivity of CBO's estimates to those assumptions, analysts reestimated the model using plausible upper and lower bounds. (The parameters used in the alternative assumptions fall short of the most extreme estimates in the literature when those extremes are clearly unreasonable.)

CBO used the following ranges of alternative assumptions in testing the model's sensitivity:

- o Savings achieved through exemption from state benefit mandates—1 percent to 15 percent of premiums;
- o Coverage changes in response to a change in the price of insurance—elasticities of -0.6 to -1.8;
- o Insured firms' willingness to switch to less expensive, less comprehensive coverage:
 - For the lower bound, about 3 percent of otherwise insured employees would switch for a 10 percent reduction in price;
 - For the upper bound, about 28 percent would switch in response to a 25 percent savings in premiums; and
- o Degree of favorable selection in the AHP/HealthMart market (which relates to cost differences between firms with healthy employees and sicker employees and to reductions in premiums from avoiding rate compression):

- For the lower bound, AHPs and HealthMarts would avoid enrolling firms with expected costs in the top 10 percent of the expected cost distribution of small firms (this is the assumption CBO used to generate the model's main findings, discussed earlier); and
- For the upper bound, AHPs and HealthMarts could avoid enrolling firms with expected costs in the top 20 percent of the cost distribution.

For all estimates, CBO maintained the assumption of no net savings arising from the economies of group purchasing.

Lower-Bound Estimates. Establishing AHPs and HealthMarts would have a minimal impact on coverage and premiums under the following conditions: the potential for mandate savings is small, AHPs and HealthMarts can achieve only modest favorable-selection effects, rate compression laws have no effect on coverage, and firms are minimally responsive to changes in premiums and unwilling for the most part to switch to less expensive, less comprehensive coverage. In those circumstances, the net increase in coverage among low-cost firms would be small (representing an increase of about 10,000 enrollees), and relatively few firms (representing 700,000 enrollees) would be covered through AHPs or HealthMarts, despite the somewhat lower premium costs (see Table A-1). Total premiums paid by small firms would decrease only slightly because the number of people covered by insurance would change very little (see Table A-2). For people who already had coverage, the net effect on total premiums would be only a slight drop because some people would switch to coverage that omitted some mandated benefits. Average premiums for firms that participated in the new AHP/HealthMart market would be only 9 percent lower than they would have been for traditional coverage in the absence of any regulatory changes (see Table A-3). Premiums for firms that retained traditional coverage would increase by less than 0.5 percent.

Upper-Bound Estimates. AHPs and HealthMarts would have the largest effects in the following circumstances: the potential for mandate savings is great, AHPs and HealthMarts are able to achieve a substantial degree of favorable selection, and firms respond strongly to changes in premiums and are more willing to switch to less expensive, less comprehensive coverage. Under those assumptions, coverage in the small-group market would increase by almost 8 percent (about 2 million people), with low-cost firms adding about 2.1 million people to coverage and high-cost firms reducing coverage by about 100,000. In that case, total premiums paid by small firms and their employees would increase by about \$1.8 billion, or about 3.6 percent. That relatively large increase occurs because this scenario is based on assumptions that give an upper-bound increase in coverage. The almost \$3.1 billion in total premiums paid for employees and their dependents who become covered by an

employer-sponsored plan exceeds the reductions that would occur as some high-cost groups dropped coverage and some firms and enrollees that were already covered switched to the new, lower-priced plans. The price of a policy for firms desiring traditional coverage would increase by 2 percent, and firms switching to the AHP/HealthMart market would pay premiums that were 25 percent lower than they would otherwise have been.

TABLE A-1. ESTIMATED LOWER AND UPPER BOUNDS OF EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON COVERAGE IN THE SMALL-GROUP HEALTH INSURANCE MARKET

	Number of Enrollees ^a	
	Lower-Bound Effect	Upper-Bound Effect
Coverage Under Current Law (Millions)	24.6	24.6
Changes When AHPs and HealthMarts Are in Full Operation		
Low-cost firms ^b	10,000	2,130,000
High-cost firms ^c	<u>d</u>	<u>-100,000</u>
Total	10,000	2,030,000
Coverage When AHPs and HealthMarts Are in Full Operation (Millions)		
AHP or HealthMart plans	0.7	5.7
Traditional plans ^e	<u>23.9</u>	<u>20.9</u>
Total	24.6	26.6

SOURCE: Congressional Budget Office.

NOTE: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

- a. Workers and their insured dependents. However, these figures exclude an estimated 1.3 million people who participate in self-insured employer-sponsored plans under current law.
- b. For the lower-bound effect, low-cost firms are those with expected health costs in the lower 90 percent of the cost distribution. For the upper-bound effect, low-cost firms are those in the lower 80 percent.
- c. For the lower-bound effect, high-cost firms are those with expected health costs in the upper 10 percent of the cost distribution. For the upper-bound effect, high-cost firms are those in the upper 20 percent.
- d. Decrease of less than 5,000.
- e. Subject to full state regulation.

TABLE A-2. ESTIMATED LOWER AND UPPER BOUNDS OF ANNUAL EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON TOTAL PREMIUMS IN THE SMALL-GROUP HEALTH INSURANCE MARKET

	Millions of Dollars	
	Lower-Bound Effect	Upper-Bound Effect
Total Premiums Under Current Law	50,400	50,400
Changes When AHPs and HealthMarts Are in Full Operation		
Premium savings from net enrollee movement to AHPs and HealthMarts	-100	-1,900
Increased premiums for firms covered under traditional plans ^a	100	900
Net increase in coverage among low-cost firms ^b	c	3,050
Net decrease in coverage among high-cost firms ^d	e	-250
Total	e	1,800
Total Premiums When AHPs and HealthMarts Are in Full Operation	50,400	52,200

SOURCE: Congressional Budget Office.

NOTES: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

The term "enrollee" includes workers and their insured dependents but excludes an estimated 1.3 million people who participate in self-insured employer-sponsored plans under current law.

- a. Traditional plans are subject to full state regulation.
- b. For the lower-bound effect, low-cost firms are those with expected health costs in the lower 90 percent of the cost distribution. For the upper-bound effect, low-cost firms are those in the lower 80 percent.
- c. Increase of less than \$25 million.
- d. For the lower-bound effect, high-cost firms are those with expected health costs in the upper 10 percent of the cost distribution. For the upper-bound effect, high-cost firms are those in the upper 20 percent.
- e. Decrease of less than \$25 million.

TABLE A-3. ESTIMATED LOWER AND UPPER BOUNDS OF EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON AVERAGE PREMIUMS IN THE SMALL-GROUP HEALTH INSURANCE MARKET

	Percentage	
	Lower-Bound Effect	Upper-Bound Effect
Change in the Average Premium Paid by Firms That Participate in AHPs or HealthMarts	-9	-25
Change in the Average Premium Paid by Firms That Retain Traditional Coverage ^a	b	2

SOURCE: Congressional Budget Office.

NOTES: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

Changes are calculated relative to premiums under current law.

- a. Traditional coverage is subject to full state regulation.
- b. Increase of less than 0.5 percent.

**THE KAISER PROJECT ON
INCREMENTAL HEALTH REFORM**

**Insurance Market Reforms
and the Individual Insurance
Marketplace: Implications for
Coverage Expansions**



October 1999

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**INSURANCE MARKET REFORMS
AND THE INDIVIDUAL INSURANCE MARKETPLACE:
IMPLICATIONS FOR COVERAGE EXPANSIONS**

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EXECUTIVE SUMMARY

Proposals that attempt to expand coverage in the private individual insurance market will only provide new coverage opportunities if individuals can obtain insurance within that market. This paper describes how the current individual marketplace will affect the ability of such proposals to assure equitable access to affordable coverage.

Today, in many states, insurers can refuse to cover individuals, charge them significantly higher rates if they are sick, or limit the extent to which they offer some of the benefits needed most by people with higher health risks. Proposals that enhance the deductibility of coverage or provide tax credits could improve the affordability of coverage for some of these individuals. But any such positive effect could be outweighed by a person's inability to obtain any type of coverage or by disproportionately higher insurance prices for these individuals. As a result, without a change in the rules, such coverage expansions might not reach many of those most in need of health care coverage.

This paper identifies and details certain policy interventions that could help enhance the pooling of risk and the social protections risk pooling provides. It also provides examples of policy and implementation decisions that can and did stymie the success of insurance reforms in some states. The evidence suggests that potentially effective reforms can be undermined by choices made in the implementation process.

Several national and state studies are also discussed. Certain national studies have found an association between insurance reforms and coverage deterioration. However, some of these studies have been deficient because they failed to identify and analyze specific reform elements and did not examine changes in coverage levels within the segments of the market targeted by certain state reforms; in addition, in one case, the study did not control for any economic or other market factors. By contrast, several state-level studies addressing small group reforms found a positive association between insurance reforms and small employer group coverage.

In conclusion, insurance reforms are an important component of efforts to expand private coverage. If one wants to promote the ability of the private insurance market to meet the needs of a broader segment of society, coverage expansion proposals need to be pursued alongside insurance reforms that minimize discrimination based on health status.

INTRODUCTION

Incremental improvements in health insurance coverage will be implemented within an insurance marketplace that, as currently structured, raises issues of access and affordability associated with how much--or how little--the insurance market actually pools risk. Insurance has the potential to pool risk by bringing together persons of low, medium and high health risks--spreading the costs of illness across the whole group and protecting individuals against the full cost of illness if they get sick. In practice, markets differ with respect to the degree of risk pooling they provide.

The way in which incremental coverage expansions interact with or alter existing insurance markets will have considerable impact on the extent to which--across the whole population--our insurance structure shares or fragments risk. This paper explores factors that contribute to, or detract from, the spreading of risk.

In the current market, insurance provided by large employers--which covers the largest share of Americans under age 65--achieves some degree of risk pooling simply because each group being insured has considerable breadth of risk within it. Small employers lack that breadth, but federal and state rules result in some pooling of risk across firms. Large employers and small employers, however, are not pooled together. They are insured in different markets; that is, their risk pools are different. The employer market is further fragmented because employers have the opportunity to insure themselves (self-fund), that is, to pull themselves out of the insurance risk pool. Employers can move back and forth between insured and self-funded coverage as their risk profiles change--leaving the pool when their employees are healthy and low cost; entering the pool when their employees are less healthy and higher cost. The result is to make uncertain the breadth of risk in the insurance pool at any given point in time.

The insurance market in which individuals seek insurance coverage on their own generally provides the least pooling of risk. Any pooling that occurs is a function of market practices and regulations, since, unlike the employer market, there is nothing intrinsic to that market that brings individuals of different risks together. Current market practices tend to fragment rather than pool risk, and except in a few states, rules do not exist to achieve a broad pooling of risk. Creating a broad pool is complicated by the fact that individuals move in and out of this market with considerable frequency.¹

Proposals to expand insurance coverage on an incremental basis in the individual market will be subject to its underlying rules and behavior, unless they change those rules. They also could affect the group markets as well as the interaction between these markets and the individual market, although a more in-depth discussion of this topic is beyond the scope of this paper. This paper illustrates how existing individual market arrangements will undermine the ability of

¹D. Chollet and A. Kirk, "Understanding Individual Health Insurance Markets," (Washington: The Alpha Center, prepared for the Henry J. Kaiser Family Foundation, March 1998): 12.

coverage expansion proposals that rely on private insurance to assure equitable access to affordable coverage, regardless of people's health status. Instead, they will perpetuate a system of health insurance that favors the healthy over the sick and limits the value and affordability of coverage as individuals' health status alters over time.

PROMOTING ACCESS TO THE CURRENT INDIVIDUAL MARKET

Proposals that attempt to expand coverage in the individual market, without changing its structure and underlying rules, will only provide new coverage opportunities if individuals can obtain insurance within that market. Today, in many states, insurers can refuse to cover individuals, charge them significantly higher rates if they are sick, or limit the extent to which they offer some of the benefits needed most by people with higher health risks. Proposals that enhance the deductibility of coverage or provide tax credits could improve the affordability of coverage for some of these individuals. But any such positive effect could be negated by a person's inability to obtain any type of coverage or could be outweighed by disproportionately higher insurance prices for these individuals. As a result, without a change in the rules, such coverage expansions might not reach many of those most in need of health care coverage.

The Current Individual Insurance Market

The current individual market operates within the following parameters:

- In most states, insurers are free to accept or reject individuals based upon their health status.
- The federal Health Insurance Portability and Accountability Act ("HIPAA"), requires states or insurers to offer some type of coverage option to a very narrow class of individuals ("federally eligible individuals").² States have the ability to expand upon these options, and twenty-two do so through requirements on their insurers. Of these 22, *however*, only six states guarantee all individuals unrestricted access to all individual products.³ The remaining sixteen states have access requirements that exceed federal law but do not guarantee such broad access.⁴

²"Federally eligible" individuals must: 1) have had at least 18 months of continuous coverage, most recently under a group plan; 2) have exhausted any COBRA or state continuation coverage; 3) not be eligible for any public program or group coverage; and 4) not have allowed more than 63 days to elapse between their prior coverage and their application for individual coverage.

³States that only limit individual market eligibility by requiring that individuals cannot be eligible for group or public program coverage (e.g. N.H. and N.J.) are considered to be within this category. K. Pollitz, N. Tapay, and J. Curtis, "Summary Comparison of Individual Market Reforms in Fifty States and the District of Columbia," (hereinafter referred to as "Summary/Individual") (Washington, D.C.: Georgetown University, Institute for Health Care Research and Policy, April 1999). See www.georgetown.edu/research/ihrp/chep; e.g., Materials for Maryland Session, April 26, 1999, Session 5. This survey reflects legislation passed as of 1/1/1998, with the exception of a few states for which the survey includes more recent activity.

⁴*Ibid.* Several states mandate access to more individuals than those who are "federally eligible" under Kassebaum-Kennedy (HIPAA). In five states, the Blue Cross/Blue Shield carrier or other designated carriers must accept all individuals. Rhode Island requires carriers to accept any individual with 12 months of prior group

- Federal law requires insurers to renew individual market coverage, with some limited exceptions.⁵
- Thirty-nine states impose limits on the use of preexisting condition exclusions by at least some plans in the individual market; however, eleven states and the District of Columbia have no such limits. Furthermore, twenty-two states do not provide for portability in their individual market; in these states, individual health plans are not required to reduce any preexisting condition exclusion by the length of prior coverage.
- In most states, insurers have the flexibility to set higher rates for higher risk people. Ten states limit the extent to which rates for all individual policies can vary based upon health status (“modified experience rating”), and twelve states prohibit insurers from considering a person’s health status in determining their premium in at least part of the individual market (“community rating”).⁶ Federal law does not contain stringent rating requirements, but for some types of coverage offered to federally eligible individuals under HIPAA, it requires some mechanism to address the pooling of risk within or among insurers.⁷
- States often require insurers to offer a minimum set of benefits. However, in most instances, insurers can vary the benefits they offer in the individual market in a way that may limit coverage as well as separate sicker populations into different coverage pools. Only thirteen states require insurers to offer one or more standard benefit packages in the individual market, and some of these states limit the individuals eligible

coverage. Four states require insurers to offer specified products to some individuals and seven states require mandatory open season (also referred to as a limited annual enrollment period) during which anyone may enroll in at least some plans. Pollitz, Tapay, Curtis, “Summary/Individual.”

⁵ An individual insurer is not required to renew coverage if: 1) the individual has failed to pay premiums or contributions or has not done so in time; 2) the individual has performed fraud; 3) the insurer is ceasing to offer coverage in the individual market; 4) the individual no longer lives or works in the service area of the issuer; or 5) for coverage offered only through certain types of associations (“Bona fide associations,” as defined in HIPAA), the individual is no longer a member of the association. Also, if an insurer discontinues offering an individual insurance product, it must offer those covered under that policy a choice of all other individual policies it offers in the state; if an insurer discontinues offering all health care coverage in the individual market in a state, the insurer may do so, but may not reenter that market for 5 years in that state. HIPAA Section 2742.

⁶ Pollitz, Tapay, and Curtis, “Summary/Individual.” Three of the twelve states with some type of individual market community rating mandate this type of rating for certain individual products only; the remaining states require it for all individual products.

⁷ With respect to several of the options for insurer compliance with HIPAA’s individual market availability requirements, HIPAA requires a mechanism that “provides for risk adjustment, risk spreading or a risk spreading mechanism (among issuers or policies of an issuer) or otherwise provides for some financial subsidization for eligible individuals, including through assistance to participating issuers....” Section 2744(c)(3)(A). Exceptions from this requirement include insurers that choose to offer their two most popular policies, state high risk pools (which are subject instead to a rate cap of 200% of the standard rate) or a system requiring guaranteed issue of all products.

for such plans.⁸ In most of these states, insurers still have the option of offering packages other than the standardized packages, still leaving open the possibility that risk may be segmented among various benefit packages.

Given the nature of the individual market, coverage expansions that do not alter its underlying structure may result in enhanced coverage for those who are healthy, but will likely leave those who are sick with inadequate assistance.

Mechanisms to Limit Risk-based Availability and Pricing

Certain policy interventions could help enhance the pooling of risk and the social protections risk pooling provides. These policies include mechanisms to reduce the extent to which coverage availability depends on risk--specifically through a "guaranteed issue" requirement, limitations on the use of preexisting condition exclusions, requirements to standardize the benefits available, or the creation of high risk pools to provide coverage of "last resort." Additional mechanisms reduce the extent to which variation in the price of coverage depends on risk--through rating restrictions such as community rating or modified experience rating. At the same time these mechanisms ease access for the uninsured high risk population, however, they may also have an impact on price for the already insured. The following first describes possible policy interventions, then explores their implications for the pooling of risk.

Guaranteed Issue

"Guaranteed Issue" prevents insurers from excluding high risk individuals by requiring that insurers offer some or all of their products to all applicants. Requiring insurers to make all of their products available -- "all product guaranteed issue" -- reduces the possibility that the pool of those covered by guaranteed issue packages will be less healthy than those covered by packages available on a selected basis. Federal law (HIPAA) requires small group insurers to guarantee issue all of their products to small employers (defined as those with between 2-50 employees, or more expansively in a limited number of states).⁹ However, as noted above, federal law does not contain a similarly broad requirement in the individual market; state law determines whether individuals who are not federally eligible have access to an individual product.

"Portability" Protections: Limiting the Use of Preexisting Condition Exclusions

When insurers impose "preexisting condition exclusions," they restrict coverage of medical conditions already present at the beginning of an individual's coverage. If used appropriately,

⁸Pollitz, Tapay, and Curtis, "Summary/Individual."

⁹ Six states treat the self-employed the same as other small employers under their laws and seven states apply a more limited number of group market reforms to the self-employed. Pollitz, Tapay, and Curtis, "Summary Comparison of Small Group Reforms in Fifty States and the District of Columbia." (Washington, D.C.: Georgetown University, Institute for Health Care Research and Policy, April 1999). See www.georgetown.edu/research/ihrp/chep; e.g., Materials for Maryland Session, April 26, 1999, Session 5. This survey reflects legislation passed as of 1/1/1998, with the exception of a few states for which the survey includes more recent activity. See also www.georgetown.edu/research/ihrp/hipaa.

preexisting condition exclusions can help prevent “adverse selection,” the practice whereby individuals and employer groups wait and purchase coverage only when they need it. However, exclusions can also be used inappropriately—for example, if insurers extend exclusions indefinitely or impose such exclusions repeatedly against persons who have maintained coverage, but simply wish to change plans or jobs. Requirements that limit these practices are known as “portability” requirements. Before HIPAA, most states already had limitations on preexisting condition exclusions and portability requirements in their small group markets; HIPAA applied these requirements uniformly across all group plans and permitted states to retain certain more generous protections for insured plans. HIPAA also prohibited the imposition of any preexisting condition exclusions against federally eligible individuals. However, unlike the case in the group market, federal law does not include broad portability requirements in the individual market nor does it contain similarly broad limitations on the use of preexisting condition exclusions. As noted earlier, many states also lack protections in these areas

Standardization of Benefit Packages

Rules that specify the combination of benefits within insurance policies (“standardization” of benefit packages)¹⁰ both ensure that a range of benefits are available and prevent insurers from designing products that do not include certain costly benefits that high risk people are likely to need (such as prescription drug or mental health coverage), thereby indirectly “selecting” the range of risk that they cover. States can prohibit insurers from offering anything other than standardized plans, require guaranteed issue of a select number of standardized products, or not require the sale of any standardized products. Allowing a choice between a standardized and non-standardized product increases purchaser choice of products, but also makes it possible for insurers to create offerings that may attract individuals of lower risk, resulting in a higher risk composition for the “pool” created by those with standardized products.

High Risk Pools

High risk pools offer a mechanism to promote the availability of insurance coverage to people of high risk without eliminating risk fragmentation in the private market. In essence, their establishment reflects a decision not to fully pool risk across policies sold in the private marketplace, but instead to concentrate risk in a public program. In structure or function, a high risk pool is essentially a public program, eligibility for which is dependent upon one’s health status.

In practice, high risk pools have significant limitations. The cost of pools is often high (reflecting the health status of its enrollees) and the resources made available are often limited. As a result, benefits may be narrow and waiting lists may develop. In most instances, states limit eligibility to those who have been refused coverage by a private insurer, or those who are federally eligible.

¹⁰Standardization is not the same as uniformity of policies, as several different standard packages can be offered. A limited set of options is consistent with the goal of preventing risk selection.

However, in one state, Connecticut, the risk pool is open to a broad class of individuals: residents between ages 19 and 65.¹¹

How much and across whom high risk pools spread risk depends on their structure -- the method and degree to which premiums are subsidized and the source of financing for the subsidies provided.¹² Insert footnote.¹³ Risk pools are funded by a combination of enrollee premiums and subsidies. Premiums for risk pool coverage are often between 150% and 200% of the standard rate charged healthy people -- a level that may put this coverage out of reach for many people who need it. In addition, many pools are funded through assessments upon the insurance industry.¹⁴ In a sense, therefore, the industry is participating in covering those of high risk, although this participation is indirect and the expenses limited and more predictable. However, in some states, insurers are able to "write off" these assessments from their state premium taxes, therefore ultimately drawing money from the general state revenue fund to help fund the pools.¹⁵ Consequently, the mechanisms for funding such pools are more similar to other public programs than might at first appear to be the case.

Ultimately, the concept of a risk pool, a publicly funded health coverage program, is not inherently different than other public programs, such as Medicare or Medicaid. However, unlike other public program eligibility, which might focus on certain demographic or economic factors independent of health status, the risk pools' participation criteria generally require that individuals must have been rejected for private coverage or demonstrate that they are of high health risk. Therefore, these pools are structured to accompany a private insurance system whose risk profile benefits from the presence of the pool. If one views the underlying function of insurance to include a broad pooling of risk, risk pools relieve insurers of some of this responsibility and raise issues of the appropriate role of government and the private sector within a private health care system.

¹¹The Connecticut risk pool charges between 125% and 150% of average rates for a group of ten, for its individual coverage. Thus, those individuals who may be able to obtain less expensive coverage outside of the market are likely to do so. Hence, the high risk pool is likely to cover individuals of higher risk despite its broader eligibility requirements. Nonetheless, it is possible that the pool serves a broader population, in terms of risk profile, due to its broad eligibility requirements.

¹²Coverage through these pools often includes significant premiums and out-of-pocket liability and coverage for some high-cost conditions may face annual or overall maximums. Some high-risk pools have annual or overall limits, after which the pool does not cover costs incurred by the enrollee present

¹³ For example, nine pools have coverage that includes a high deductible and/or low benefit ceiling and seven of the pools have premiums that exceed 150% of the standard market rate. Nonetheless, risk pools with premium caps may still be less expensive than private individual coverage in states without rate restrictions in that market.

¹⁴Pools are often subsidized by an assessment made to insurance industry carriers in the state on a proportional basis, or through some other state funding mechanism. Other funding options pursued by states include state appropriations in California, Illinois, Maine and Utah, and funds from unclaimed business association property in Colorado. See "Comprehensive Health Insurance for High-risk Individuals: A State-by-State Analysis," (Fergus Falls, MN: Communicating for Agriculture, Inc. in cooperation with the National Association of State Comprehensive Health Insurance Plans, 1997): 5, 10.

¹⁵ For example, this is the case in South Carolina, Washington, Missouri and Montana.

Restrictions on Price Variations Based Upon Health Status

Rating rules that prohibit variation based upon health status are collectively known as "community rating." "Pure community rating" refers to rules which also prohibit variation in rates based upon other factors, such as age or geography (although variation based upon family size typically still is permitted). "Adjusted" or "Modified" community rating refers to rules which prohibit the use of health status but which permit variation based upon factors specified under state law such as age or geography. "Experience rating" refers to the insurer practice permitted in most states' individual markets¹⁶ under which insurers can charge rates based upon the health status of an individual at the time of enrollment. In many states with an experience rating system, subsequent to enrollment, insurers can increase individual market rates based upon an individual's age or the overall experience of the pool or "block of business," but not based upon an individual's health experience after they have enrolled (although this is permitted in some states). "Modified experience rating" (sometimes called "rating bands") refers to rules which restrict, but do not prohibit, insurers' ability to increase rates based upon the health status of individuals or groups at the time of enrollment. Such rules often also limit the extent to which rates can increase over time based upon the overall health status of the block of business, or "pool" of policyholders.

For example, in the small employer market, states which have adopted the NAIC's small employer act (as adopted in 1993)¹⁷ permit carriers to establish up to nine separate "classes of business." These classes serve as separate pools for rating purposes. Under this modified experience rating approach, carriers can consider several additional characteristics within limits when determining rates: group claim experience, health status and duration of coverage, industry, age, gender, geographic area, family composition and group size. There are restrictions on the extent of rate variation permitted between and within classes of business. Nonetheless, under such a modified experience rating approach, rates can vary significantly based upon a combination of factors including the health status, industry, location and gender composition of a small employer group.

The NAIC's Individual Health Insurance Portability Model Act outlines an approach to modified experience rating in the individual market. The Model Act restricts the extent to which rates of different blocks of business can vary and limits increases in rates due to health status or claim experience of each block of business. Individuals' premiums cannot change based upon changes in individuals' health status or claims experience, although premiums for the block of business can change, within limits.¹⁸ This contrasts with pure and adjusted community rating approaches

¹⁶ Forty-three states and the District of Columbia allow for consideration of health status in rating in at least a portion of their individual market. Ten of these states restrict the extent to which rates can vary based upon health status in all of the non-conversion, individual market and four of these states mandate some type of community rating for a segment of their individual market.

¹⁷ Small Employer Health Insurance Availability Model Act (Prospective Reinsurance With or Without An Opt-Out), NAIC 1993. The NAIC since has adopted a revised version of this model act, which includes a modified community rating approach.

¹⁸ Individual Health Insurance Portability Model Act (NAIC: June, 1996). The NAIC also adopted another model law containing a different approach to individual market reform that includes guaranteed issue and community rating, The Small Employer and Individual Health Insurance Availability Model Act (NAIC: June,

which prohibit consideration of health status as well as many, if not all, of those characteristics considered under a modified experience rating approach.

Decisions about which rating rules to apply are ultimately decisions about how broadly risk is to be spread among covered persons. In addition, depending upon the rating rules at play, there could be a decision to provide insurers with some subsidy if they cover a disproportionately sick population. This could then raise questions as to whether other portions of the coverage market, such as group insurance or providers, should contribute to any subsidies available in the individual market. Such broader taxation could reflect a view that, since the individual and group markets are not distinct and individuals sometimes purchase individual coverage for brief periods before moving into group coverage, the broader private coverage market could at times appropriately contribute to the more fragile component of the private coverage system.

IMPACT OF REFORMS ON ACCESS TO COVERAGE FOR HIGH-RISK INDIVIDUALS

Although all the reforms listed above (except high risk pools) have the potential to broaden the risk profile of the individual market to include high as well as low risk individuals, whether they do so in practice depends in large part on the nature of their implementation. The evidence suggests that some reforms work better than others in achieving these goals--and that potentially effective reforms can be undermined by choices made in the implementation process.

HIPAA's Impact in the Individual Market

HIPAA provides an example of a "partial" reform with limited impact in the individual market. Although states' insurance reforms in the individual market prior to HIPAA typically addressed both availability and rating practices, HIPAA imposed an availability requirement without significantly addressing insurance pricing.¹⁹ In practice, many insurers have responded to the availability requirement by pricing policies at prohibitive rates---thereby undercutting HIPAA's potential to improve availability of insurance for a specified class of individuals. In the thirteen states that enacted the federal standard under HIPAA,²⁰ which includes a guaranteed issue requirement for two products without a clear rating restriction, the General Accounting

1996). Both of these model laws are referenced as state options for individual market compliance under HIPAA, Section 2744(c).

¹⁹ HIPAA did include provisions that required some type of "risk adjustment, risk spreading, or a risk spreading mechanism (among issuers or policies of an issuer) or otherwise provides for some financial subsidization for eligible individuals" for certain types of carrier and state HIPAA compliance strategies. See footnote 7. However, to date, federal regulations have failed to clarify what types of mechanisms comply with this requirement. In practice, there have been little, if any, restrictions imposed under HIPAA relating to the rates charged by insurers, or the risk-spreading mechanisms insurers use, in states which have adopted the federal standards, or where the federal government is the primary enforcer of HIPAA's requirements.

²⁰ HIPAA provided the states with significant flexibility to determine how to make coverage available to federally eligible individuals. However, it also contained its own provisions which states could enact, or which apply in the absence of complying state legislation.

Office (GAO) found that the impact of this requirement had been significantly reduced by carrier rating and marketing practices. GAO reported that in these states, “[s]ome initial carrier marketing practices may have discouraged HIPAA eligibles from enrolling in products with guaranteed access rights... Premiums for products with guaranteed access rights may be substantially higher than standard rates. In several of the 13 federal fallback states... anecdotal reports... suggest that rates range from 140% to 600% of the standard rate.... We also found that carriers typically evaluate the health status of applicants and offer healthy individuals access to their standard products. Although these products may include a preexisting condition exclusion period, they may cost considerably less than the HIPAA product and... are likely to draw healthy individuals away from HIPAA products.”²¹ Consequently, carrier rating practices likely have impacted HIPAA eligibles’ access to health coverage. The extent to which these rating practices reflect any assessment by the carriers of each individuals’ actual health risk, or the proportional increased burden of covering such individuals, is at best unclear. At worst, such rating practices may be divorced from increased risk borne by insurers and designed to deter consumers eligible for guaranteed issue coverage.²² Insurers’ pricing responses not only call into question the likely effectiveness of availability requirements in the absence of accompanying rating reforms; they also raise questions about the assumptions regarding individual behavior that these responses purportedly reflect. Insurers’ concern is that the availability of guaranteed issue insurance policies discourages individuals from purchasing coverage until they need it. They claim that such a structure results in “adverse selection” and a disproportionately sick pool. Insurers’ high prices are consistent with their fears that purchasers under such a regulatory scheme are very likely to be sick and in need of health services.

It is not clear, however, that actual purchaser behavior practice follows the pattern insurers fear. Certain requirements can and do accompany guaranteed issue and rating reforms, and mitigate the potential for (or effects of) adverse selection. States with all-product guaranteed issue requirements in the individual market, including New Jersey, couple these requirements with an allowance that carriers may impose preexisting condition exclusions on those that enter with no prior coverage, or with a significant gap in coverage. The length of these permitted exclusions vary by state. HIPAA’s access requirements reflect an even more cautious approach and only allow persons who already had coverage for a significant amount of time to benefit from its availability requirements.

State Experience

The likelihood that certain insurance reform requirements will improve risk spreading is heavily influenced by the detailed contents and structure of specific reforms, the timing of the reforms’ implementation, and purchaser responses to reforms. States have had both negative and positive experiences, based on their particular approaches.

²¹ U.S. General Accounting Office, “Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators,” (Washington: 25 February 1998) (HEHS-98-67): 7-8.

²² The State of Colorado Division of Insurance’s December 1997 survey of market shares and rates in the Colorado individual health insurance market revealed that, on average, enrollment of federally eligible individuals constituted, on average, only 0.08% of responding insurers’ total covered lives, yet the average premium for these individuals with preexisting conditions was 335% of the carriers’ “best new business rate.”

For example, New York implemented pure community rating in its individual market without any transition period. The “rate shock” that some individuals consequently experienced was widely cited as a direct consequence of community rating. Instead, such a requirement can be phased in over a period of time, such as five years, and this can mitigate the potential for rate shock.

When states have provided an “escape hatch” or “loophole” for carriers from their reforms, they also have experienced difficulty in implementing guaranteed issue and community rating reforms. For example, in 1994, Kentucky enacted a guaranteed issue requirement in the individual market coupled with a community rating requirement. However, soon after the enactment of the legislation, the Kentucky Health Policy Board entered into an agreed order through a lawsuit settlement that exempted certain associations from modified community rating.²³ Furthermore, in 1996, a statute was enacted that exempted qualified associations selling insurance to their members from the modified community rating requirements imposed on the small group and individual markets.²⁴ (The association market remained subject to other components of the market reforms²⁵ and therefore is still considered part of “the reform market.”) This exemption resulted in an extreme market reaction under which many individuals flocked into association plans, which could charge premiums based upon health status, and therefore offer less expensive policies to healthier individuals. In addition, some existing non-standardized plans were not subjected to community rating right away (although they were going to be subject to these requirements at a later date). Consequently, a significant portion of the market did not participate in the community rating pool. By the end of 1996, only 176,594 of the 444,294 covered lives in the reform market (composed of individual, small group and association coverage) were subject to modified community rating.²⁶ Policies that were community rated tended to cover disproportionately those who would not benefit from experience rating--the unhealthy. Therefore, community rates were not able to accomplish their goal of spreading risk across a broad pool.²⁷

There is evidence that the number of covered lives in Kentucky’s community rating market quickly underwent a further decline. The magnitude of the migration into association plans was significant. The Kentucky Department of Insurance reported that there were 90,793²⁸ covered

²³Kentucky Department of Insurance (George Nichols III, Commissioner), “Market Report on Health Insurance” (April 1997): ix.

²⁴Ibid., 1-9.

²⁵Other components of the reforms included standardized benefit plans, guaranteed renewal and limitations on preexisting condition exclusions.

²⁶Ibid., 1-2. The numbers used for association coverage in this report derive from different sources at times, (either the carriers or the associations). Ibid., 1-9.

²⁷ The report notes that “Because associations are exempted from the modified community rating requirements and are allowed to risk rate, healthy insureds covered through association plans will not be transitioning into the modified community rated market. On the other hand, older and less healthy insureds are likely to move from associations to the modified community rated market.” Ibid., 1-2.

²⁸The report states that this number was derived from carrier reports reflected in Section 1; however, Section 1 referred to 90,297 lives in association coverage rather than 90,793. In either case, however, the

lives in the association market as of December 31, 1996; only three months later, on March 31, 1997, the number had climbed to 151,332--further reducing the lives covered under community rating.²⁹ This dramatic shift demonstrates the extent to which loopholes in an insurance scheme can undercut and destabilize a risk-spreading scheme. Healthier populations took advantage of the loophole and opted out of the community rating scheme, which in turn limited the risk-spreading potential of the reform. Instead, community rating became the pooling system chosen by those of poorer risk who would not benefit from a rating system that considered health status (like that for association plans and non-standard plans).

Another state provided its insurers with a different type of "loophole" from its reforms. When implementing its guaranteed issue and community rating reforms (enacted in 1994), New Hampshire exempted ("grandfathered") some individual policies in existence prior to the reforms from these requirements (without intending to transition them into the system).³⁰ This had the result of applying these reforms to a much smaller proportion of their extremely small individual market. In 1994 there were 10,150 policies that were, and could remain, subject to "pre-reform" rules, and 11,151 policies that were already under "post-reform" rules.³¹ In other words, from the outset of the reforms, just over half (approximately 52%) of the policies in an already extremely small individual market were required to be subject to the community rating rules. Carrier loss ratios suggest that an anti-selection spiral ensued. Rates in the community-rated individual market went up, and over the next few years the number of covered lives in the individual market decreased.³² It is important to note, however, that an equally significant proportion of individual policies (approximately 49%) remained exempt from community rating as of 1997. Thus, over time, the community rated pool never gained a significant share of the overall market -- as it might have done had its risk pool not been segmented from the start. As of the end of 1997, there were only 57% (approximately) as many individual policies in force in the New Hampshire market as there had been in 1994. It is not clear whether the problems would have been so substantial if the rating rules had applied to the larger pool of individual policies, rather than to about half of the

December 1996 numbers were significantly lower than the number of covered lives reported to be in association plans as of March 1997.

²⁹The total reform market (individual, small group and association coverage) was reported as 444, 294 covered lives. *Ibid.*, 1-2.

³⁰New Hampshire Insurance Department Bulletin, 28 December 1994, "Re: Ch. 294, Laws of 1994." This bulletin permitted carriers who had had the ability to impose exclusion riders to their policies (whether or not they did) to continue those policies under the previous rating rules, at the policyholders' option. This had the effect of exempting existing policies of most individual market carriers from community rating, except for the Blue Cross/Blue Shield carrier. See also A. Lee et al., "An Investigation Into the Effects of the New Hampshire Health Insurance Reform Law, RSA 420-G: Final Report" (Washington: Center for Health Economics Research, December 1997): 12.

³¹New Hampshire Insurance Department Bulletin, "An Analysis of the Nongroup Market with Recommendations for Change" (Concord, N.H.: State of New Hampshire Insurance Dept., 27 October 1997), Exhibit B.

³²"The average loss ratio over the four year period, 1994-1997 [in the individual market], is 92%. This is higher than the average loss ratio experience reported by...group carriers...[of] 87%." An example of the rating impacts of this spiral is BlueCross and BlueShield of New Hampshire, for whom annual average premium increases of over 20% did not significantly decrease the company's loss ratio. *Ibid.*, 8.

potential pool. New Hampshire changed its individual market rating rules in 1998 and instituted a risk-spreading/subsidy mechanism together with rate bands that permits some consideration of health status. New Hampshire's move reflects concern with the state of its nongroup market. The future of the individual market in New Hampshire remains unclear.

By contrast, some other states have had positive experiences in which reforms resulted in increases in coverage. For example, contact with states indicated that Maryland, Minnesota and New Jersey had documented such experiences, albeit focusing on the impact of small group market reforms. In Maryland, a study released by the state's Health Care Access and Cost Commission³³ indicated that the state's small businesses experienced a 9% increase gain in coverage since Maryland's small group reforms were put into effect in July 1994; these reforms included both issuance and rating reforms.³⁴ Similarly, in Minnesota, enrollment in the state's small group market increased subsequent to their reforms, which also included a combination of issuance and rating reforms.³⁵ Total member enrollment in the Minnesota small employer market before and after implementation of reforms (measured from 6/94 to 6/95) increased by 8-12%.³⁶ Furthermore, more recently, a 1997 survey from the Minnesota Department of Health found that "enrollment in small group products for employers with 2 to 49 employees has increased considerably in the past several years."³⁷ New Jersey also experienced an increase in covered lives in the small group market following its reforms. Soon after the implementation of New Jersey's small group reforms, there were over 694,000 covered lives in New Jersey's small employer market. By the first quarter of 1999, there were over 891,000 covered lives, an increase of about 28%.³⁸

New Jersey's experience with the individual market has been harder to interpret. However, a close examination of that experience suggests that looking only at covered lives may be a misleading way to evaluate the impact of reforms. In New Jersey, prior to the reforms, the individual market was in crisis. Experts examining the history of New Jersey's reforms indicate that if the state's system of subsidizing Blue Cross-Blue Shield, in its role of insurer of last resort,

³³REDA International, Inc., "Maryland Survey of Small Businesses, Final Report" (Maryland: Health Care Access and Cost Commission, 23 March 1998) at v.

³⁴ Maryland's small group reforms included guaranteed issuance, renewability, limitations on use of preexisting condition exclusions, and exclusive standardized plan and modified experience rating requirements.

³⁵Urban Institute report at 13, citing Minnesota Department of Commerce, "The Minnesota Department of Commerce Study of Small Employer Health Insurance Reform," (St. Paul: Minnesota Department of Commerce, January 1995).

³⁶Minnesota Department of Commerce, "The Minnesota Department of Commerce Study of Small Employer Health Insurance Reform," (St. Paul: Minnesota Department of Commerce, January 1995): 8-9. When enrollment in state-run purchasing pools is considered, the study's survey indicated that enrollment increased by 8.3%(without counting purchasing pool enrollment, enrollment increased by 7.9%). This study also noted that the increase in employees and members enrolled in the small employer market likely was greater than indicated by the survey and estimated the increase to be between 11-12%.

³⁷Minnesota Department of Health, "The Small Group and Individual Health Insurance Markets in Minnesota: Recent Experience," Health Economics Program, Issue Brief 97-15: 1-2.

³⁸ Statistics obtained from the New Jersey Small Employer Health Benefits Program Board.

had not been altered, the individual market would have collapsed and the number of individuals covered by individual insurance would have dropped dramatically.³⁹ The number of covered lives in New Jersey's individual market has varied, as have the specific reforms in place. Not only has the state changed some of the specifics of its reform rules; it has both implemented and withdrawn subsidies for the purchase of insurance since the initial adoption of insurance reforms.⁴⁰ Without a careful look at the details and timing of reform as well as a better understanding of the context into which they were placed, evaluations may draw inaccurate conclusions.

National Studies

Some recent national studies have concluded that state insurance reforms have a detrimental effect on coverage. The Galen Institute compared coverage in states it identified as having enacted significant reforms and found substantial declines in private coverage in these states.⁴¹ Similar findings are contained in an executive summary of a report of the Health Insurance Industry of America ("HIAA") that is not yet released in its entirety (therefore even a brief examination of these results is premature).⁴² Two other studies call these findings into question. The Urban Institute found no impact on coverage where small group reforms included a combination of certain availability and rating reforms, and attributed some detrimental impact to individual market reforms, although it qualified its nongroup findings.⁴³ Another study concluded that "the main impact of community rating is likely to be redistributive,"⁴⁴ in other words, it affects who gets coverage—such as sick versus healthy individuals.

However, some of the national studies identified above have failed to carefully identify and analyze key components of certain state reforms, or their implementation. Consequently, they have incorrectly assumed that disparate reform approaches are similar or have failed to address the potential impact of key features of the reforms, such as those reform components discussed above. Furthermore, several of the recent national studies raise analytic issues.

The Galen Institute study evaluated state reforms in relation to changes in the percent of the population with private health insurance generally, with private individual health insurance, and the uninsured, using U.S. Bureau of the Census Current Population Survey (CPS) data from

³⁹K. Swartz and D. Garnick, "Lessons from New Jersey's Creation of a Market for Individual Health Insurance," *Journal of Health Politics, Policy and Law*, (January/February, 2000) (forthcoming); and K. Swartz and D. Garnick, "Hidden Assets: Health Insurance Reform in New Jersey," *Health Affairs*, (July/August 1999): 182.

⁴⁰New Jersey Individual Health Coverage Program, "Historical Comparison of Covered Lives," 6/21/99.

⁴¹M. Schriver and G. Arnett, "Uninsured Rates Rise Dramatically in States With Strictest Health Insurance Regulations," (Washington: The Galen Institute, August 1998).

⁴²W.S. Custer, "Health Insurance Coverage and the Uninsured," (Georgia State University: Center for Risk Management and Insurance Research), funded by the HIAA.

⁴³J. Marsteller et al., "Variations in the Uninsured: State and County Level Analyses," (Washington: The Urban Institute, June 1998): 3.

⁴⁴F.A. Sloan, C. J. Conover, "Effects of State Reforms on Health Insurance Coverage of Adults," *Inquiry* 35 (Fall 1998): 291.

1989-1996.⁴⁵ Yet this study did not control for any of the economic or other market factors that could affect coverage rates. Furthermore, the authors' methodology did not enable them to compare coverage before and after reforms within the only segment of the group market targeted by such state reforms, the small group market. Instead, by looking at overall private insurance rates, the study considered data on covered populations which the state reforms cannot or do not reach: those covered by self-insured ERISA plans, as well as the large group market, (which was outside of most of these state-level reforms during the time period studied). It would therefore appear difficult to draw firm causal links between certain small group reforms and overall coverage numbers. Finally, the study selected states which had many of several reforms identified by the authors, but did not distinguish among reforms to better indicate which, if any, resulted in particular alleged effects.

The Urban Institute study does take into account a wide variety of potentially influential factors. It concluded that small group reforms had a neutral effect on coverage and that nongroup reforms have caused declines in coverage. However, it qualifies its own findings with respect to the individual market, and also notes that the "significance of this result falls below conventional levels when California is removed,"⁴⁶ it is therefore possible that the national significance of these findings is diminished. This study too does not distinguish between different types of rating rules or different types of guaranteed issue requirements when attempting to ascertain the effect of such rules on coverage, even though there is significant variation in the stringency and breadth of such reforms.

Furthermore, and possibly more significantly, by examining the impact of coverage rules on overall levels of coverage, the Urban Institute study is subject to one of the same critiques made of the Galen study above: it fails to capture the impact of reforms on the market and population that the reforms specifically aimed to address.

IMPLICATIONS OF INSURANCE MARKET REFORMS FOR COVERAGE EXPANSIONS

Some have used national studies to argue that market reforms result in rate increases that drive both the healthy and the sick out of the market. State experiences, however, demonstrate that reforms often have complex and interacting components; it is important to identify and analyze them before drawing broad conclusions about their effects. More thorough evaluation suggests that some states have implemented reforms that enhanced coverage. Most of that experience, however, is in the small group market. Whether similar results have been or are achievable in the individual market requires further study and will likely depend at least in part on the affordability of these policies and the size of the market.

Subsidies to make coverage more affordable have the potential to broaden the individual market. However, subsidies without access and rating requirements--in other words, under the rules in

⁴⁵Schrivver and Arnett, endnote 12. The authors also note that many more data were analyzed.

⁴⁶Urban at 19.

place in most states-- will fail to reach many people in poorer health and in most need of such coverage. Furthermore, without such requirements, subsidies could reduce the spreading of risk across the population--if they cause people to move from the shared risk that occurs in employer-based coverage into an individual market that ties the availability and prices of insurance policies to people's health status. The employer market currently enjoys broader risk-spreading than occurs within individual markets in all but a handful of states. For all employers, federal law ensures some basic risk-spreading by prohibiting any employer from charging individuals within firms any different amount based upon health status. Thus, in theory, individuals covered by the same employer plan should not face higher coverage costs because of their health status. Therefore, it is important to consider the impact of coverage expansions on the current, broad risk pool in the employer market.

Proposals to expand coverage that depend upon the individual market without changing its rules may somewhat reduce the cost of coverage for some people, yet they also will retain a system that discriminates based on health status. In essence, they will fail to achieve one of the fundamental goals of insurance—the spreading of risk. If one understands the role of insurance to be the sale of a product to insure a broad range of individuals against the potential that they would get sick, these proposals fail to achieve these goals. Equally important, however, it should not be assumed that insurance reforms by themselves can substantially increase coverage. The purpose of insurance reforms is to make insurance equitably available. If one wants to promote the ability of the private insurance market to meet the needs of a broader segment of society, it would seem that coverage expansion proposals need to be pursued alongside insurance reforms that minimize discrimination based on health status.

HEALTH TAX/COVERAGE IDEAS BEING CONSIDERED IN CONGRESS

EXTENDING DEDUCTIBILITY TO INDIVIDUAL INSURANCE

Policy: Allow certain taxpayers to deduct up to x percent of the cost of purchasing health insurance in the individual market. Qualifying taxpayers include those who (a) do not have access to employer-based insurance; (b) are not self-employed.

Background: Under the current system, the employer share of employer-based health insurance is deductible. Additionally, allowing 100 percent of the cost of individual insurance for the self-employed to purchase individual insurance is being phased in.

Pros:

- **Equity.** This policy addresses the last group of people who cannot deduct their health insurance premiums: workers with no access to employer-based insurance. These people probably need the tax preference the most, since they do not benefit from employers purchasing on their behalf.
- **Typically people ages 55 to 65.** Older, non-elderly Americans are twice as likely to purchase individual health insurance as younger people (9% of people ages 55-65 versus 5% of people ages 18-55). It is even higher – 12 percent – for people ages 62 to 64. This is because they are more likely to be transitioning to retirement and do not yet have access to Medicare coverage.

Cons:

- **Concern about equity overstated.** Most moderate to liberal analysts oppose this proposal because (1) it is almost pure substitution – because it is a deduction (not a credit) and the amount is small, it will have a negligible effect on increasing the number of insured Americans; and (2) deductions typically favor higher over lower-income people.
- **Weakens employer-based insurance.** Limiting the deduction to employer-based insurance creates an incentive for firms to offer this insurance. If an employee could get the same deduction in the individual market, employers could be less inclined to offer coverage. Moreover, healthier workers may prefer to purchase in the individual market since they would not longer have to pay premiums that reflect the entire workforce at the firm.
- **Concerns about individual health insurance market.** The quality of individual health insurance varies dramatically and is frequently expensive. Only 18 states place restrictions on how much insurers may charge. One study found that 33 percent of applicants to individual insurance were denied.

Estimates: About 16 million nonelderly Americans are covered by individual insurance -- some of these people are self-employed and are already becoming eligible for the deduction. Nearly

75 percent have income above 200 percent of poverty (\$16,000 for a single, about \$22,000 for a couple). Nearly 40 percent have income above 400 percent of poverty. There are no good data on how much individuals and families pay on average for individual insurance. In 1998, a community rated premium cost about \$2,500 in 1998.

LONG-TERM CARE: INCREASING THE SIZE OF THE CAREGIVER CREDIT

Policy: This would build on the President's budget proposal to double the size of the credit from \$1,000 to \$2,000 or \$2,500.

Pros

- **More in line with actual costs of caregiving.** An article published in Health Affairs (March/April 1999) estimated that the average cost of caregiving could be about \$7,600 annually when taking into account the number of hours of care provided and multiplying it by the wage rate for a home health aide.
- **Favored by aging groups.** In developing the President's policy, we learned that, given the cost of care, the aging groups would state that \$1,000 is the minimum acceptable credit amount.

Cons

- **Does not help additional people – just gives those eligible more.** There has been some concern that the policy is not refundable and that its definition of who has a long-term care need is too narrow.
- **Increasing the credit does not help lower-income families as much.** Because the credit is non-refundable, lower-income families either get no help if they have no tax liability or limited help if their tax liability is less than \$1,000. For these people, raising the amount of the credit does not help.

Estimates: The President's policy cost about \$5 billion over 5 years, \$12 billion over 10 years. Increasing the credit. You can multiply this by the ratio of the new credit to the existing credit, although it will be slightly less because of the issue with people getting partial credits.

USING USA ACCCOUNTS FOR LONG-TERM CARE AND CATASTROPHIC HEALTH COSTS

Policy. Allow people to use USA accounts for long-term care and catastrophic health car costs .

Pros

- **Strong alternative to deductibility of long-term care insurance premiums.** Although we support the careful development of the long-term care insurance market, we think that middle-class families rarely
- **Conducive to savings.** Experts argue that a major part of long-term care costs are similar to other retirement costs, and thus should come from savings, not insurance. Long-term care expenditures account for nearly half (44 percent) of all out-of-pocket health expenditures for Medicare beneficiaries.

Cons

- **Can be done from savings accounts today.** There is nothing precluding people from using money for these needs – could be criticized as not a real policy.

Estimates. Would probably not change estimates.

PARENTS OF CHILDREN ON MEDICAID AND CHIP

*Later Version.
I'm going into hiding to
do drug report -
am way behind.*

IDEAS FOR HEALTH & LONG-TERM CARE BEING CONSIDERED IN CONGRESS

EXTENDING DEDUCTIBILITY TO INDIVIDUAL INSURANCE

Policy: Allow certain taxpayers to deduct up to x percent of the cost of purchasing health insurance in the individual market. Qualifying taxpayers include those who (a) do not have access to employer-based insurance; (b) are not self-employed. [Costs can be increased or decreased based on amount of premiums that may be deducted; phase in]

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LOWER THE 7.5 PERCENT MEDICAL DEDUCTION

Policy: Lower the threshold for being able to deduct medical expenses from 7.5 percent of AGI to 5 percent.

Background: Policy changes in the last several years have allowed additional types of expenditures to be deducted as medical expenses – most notably, premiums for private long-term care insurance – but the threshold itself has been criticized as being too high.

Pros

- **Helps more people with large medical expenses.** This change allows more people to qualify for the deduction as well as making the value of the deduction greater. In 1996, the average annual medical expenses for people using this deduction was over \$7,000.
- **Middle class most likely to use medical deduction.** A much higher proportion of taxpayers with income between \$15,000 and \$50,000 use this deduction than those with income above \$100,000. Although the value of the deduction is less for these people, more of them use it.
- **Indirectly helps with long-term care** and other types of services like mental health not generally covered by typical health insurance policies.

Cons

- **Tax amount per person higher for higher income people.** Like any deduction, people with higher tax rates get greater assistance.
- **Favors direct spending rather than insurance.** Some would argue that we should focus incentives on buying and improving insurance products rather than out-of-pocket spending. Insurance better protects against catastrophic costs.

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Cons

- **Can be done from savings accounts today.** There is nothing precluding people from using money for these needs – could be criticized as not a real policy.

Estimates. Would probably not change estimates.

PARENTS OF CHILDREN ON MEDICAID AND CHIP

Policy: Add money to Children's Health Insurance Program (CHIP) allotments and provide higher Medicaid matching rate to states that opt to insure the parents of children eligible for CHIP or Medicaid. This provides an incentive for states to expand coverage to these low-income adults through existing programs. The eligibility rules for children would apply to the adults as well (e.g., if a state covers all children with family income up to 133 percent of poverty through Medicaid and 133-200 percent of poverty through CHIP, the parents would be eligible for the same programs).

Background. Medicaid generally covers children with income below 100 percent of poverty; CHIP is targeted to children with family income between Medicaid eligibility and 200 or 250 percent of poverty (about \$33,000 in 1999). Last summer, the President issued a new regulation that allows states to cover through Medicaid two-parent as well as single-parent families. However, there is no option to cover the parents of children in CHIP.

Pros

- **Efficiently targets the uninsured.** Uninsured children usually have uninsured parents. Thus, allowing the parents of uninsured children who get covered by Medicaid and CHIP into those programs is a highly targeted way to find and cover the uninsured. It also focuses on lower income families, where the probability of being uninsured is higher. According to one study, 1.5 million uninsured parents have children already enrolled in Medicaid, another 3.1 million uninsured parents have uninsured children eligible for Medicaid, and 2.7 million uninsured parents have uninsured children eligible for CHIP.
- **Builds on existing programs and eligibility systems.** This policy would simply add the parents to the policies already being used by states to cover children. As such, virtually all of the infrastructure exists and no new bureaucracy is needed.
- **Widely supported by academic and most policy communities.** There is widespread consensus that the next step in addressing the uninsured is targeting these parents. The only concerns get raised by Medicaid advocates who fear that using CHIP to expand further undermines the Medicaid entitlement.

Cons

- **Does not cover uninsured adults without children.**
- **Could be expensive if putting proportionate amount of grant funding in CHIP.** The Balanced Budget Act of 1997 allocated \$24 billion over 5 years, and \$48 billion over 10 years to CHIP. Because (a) states had already expanded to most poor children before CHIP

and (b) parents are typically more costly than children, it would probably cost \$30 billion over 5 years, and \$60 billion over 10 years to cover 3 million adults a year.

- **States may object to Medicaid part.** States currently only cover parents up to about 50-75 percent of poverty. They would rather cover all additional adults only through CHIP, since it is not an entitlement program and they can charge them premiums and cost sharing (not allowed in Medicaid).

Estimates. The costs can be dialed up or down using the (a) matching rate increase in Medicaid; and (b) the amount that is put into the CHIP grants. Probably the minimal credible amount would be \$20-25 billion over 5 years, \$40-50 billion over 10 years.

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