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A Checklist on Vital National Issues

A POLICY MAKER'S GUIDE TO THE HEALTH CARE CRISIS

PART III

WHAT'S WRONG WITH AMERICA'S HEALTH INSURANCE MARKET?

By Edmund F. Haislmaier

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INTRODUCTION

There is a consensus that America's present health system costs too much and that too many people cannot obtain affordable care—and that both problems are getting worse. But, beyond this general agreement, opinions diverge sharply over the reasons for the system's problems and the best reforms to solve them.

Parts I and II of The Heritage Foundation's *Talking Points* series on health care examine the problems and proposed solutions for America's health care crisis. Both publications focus primarily on health care financing issues, and the likely outcomes of the three principal competing proposals for reforming the health care financing system—the "single-payer," "play-or-pay," and "consumer choice" approaches. Part II discusses in detail the Heritage Foundation's Consumer Choice Health Care Plan, an example of the consumer choice approach.

While much of the current debate centers on health care financing issues, an equally important, but often inadequately examined, aspect of health care reform centers on the nature, purpose, and structure of health insurance. Like the health care financing system, there is also a broad consensus that major deficiencies exist in the structure and operation of health insurance. And just as in the case of health care financing, there is also strong disagreement over the true causes and best remedies for problems besetting America's health insurance system.

Almost everyone agrees that the present health insurance system is the one sector of American health care which is most clearly broken and needs to be fixed. Even though 65 percent of non-elderly Americans are covered by some form of employer-based health insurance, hardly anyone has a good word to say about the health insurance industry. Policy makers and the general public do not like the way it functions, and neither do business, labor, doctors, and hospitals, or even some representatives of the health insurance industry itself.

Every major proponent of health care reform wants to change the insurance system. Some want to abolish private health insurance altogether, or at least turn

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health insurance into a new government monopoly.[1] Others want basic changes in federal or state rules governing insurance, so that it operates very differently from today.

However, as federal and state lawmakers try to "do something" on health insurance reform, there is also a danger that they will adopt solutions that will only make a bad situation worse and create even more problems in the future. As in medicine, so too in public policy, an erroneous or incomplete diagnosis of the problem can lead to ineffectual or even harmful remedies.

Parts III and IV of the Heritage *Talking Points* series seek to aid policy makers by providing a road map through the confusing complexities of health insurance reform. Part III explains the nature and purpose of health insurance and the central problems that reforms are intended to remedy. Part IV evaluates proposals to reform the insurance system.

WHAT IS INSURANCE?

To understand the current problems of the health insurance system, it is necessary to grasp the basic principles underlying all forms of insurance. Otherwise, the central issues quickly become submerged in a confusing sea of jargon.

Insurance is a Contract. At its most basic level, insurance is merely a type of contract: an agreement between two or more parties with terms stipulating the rights and responsibilities of each party. What distinguishes insurance from other types of commercial contracts is that it concerns the allocation of costs associated with chance events, as opposed to contracts governing the purchase or sale of specific goods or services. Some chance events are beneficial or relatively harmless, and thus no cause for anxiety. However, many chance events are harmful, like a major illness or an automobile accident. People naturally seek to avoid them, but failing that, they try to mitigate their adverse effects. It is to reduce the costs or losses imposed by undesirable chance events that people buy insurance.

As with any contract, there are at least two parties to an insurance contract—namely, the buyer or "insured" and the seller or "insurer." The insured is anyone who is at risk of suffering a loss as the result of some specified, unforeseen chance event, and who contracts with an insurer willing to "make good" or compensate for the loss, should it occur. Often times, the insured is referred to as the "policyholder." The insurer is anyone who agrees to compensate the insured for a specified, potential loss should it occur, in exchange for monetary payment from the insured.

A "beneficiary" is anyone who receives the stipulated benefits of an insurance contract, if a loss occurs. In most cases, the insured and the beneficiary is the same person, such as the homeowner who buys fire insurance. In some cases, like life insurance, the insured and the beneficiary are different individuals.

1 For instance, H.R. 1300, "The Universal Health Care Act of 1991," sponsored by Representative Marty Russo, the Illinois Democrat.

The Economics of Insurance

Since the insurer offers to assume all or part of the costs associated with a specified potential loss the insured otherwise would bear, in exchange for some payment, the insurance business basically is the business of assuming and managing risks. There are several unique features of the economics of insurance as a business that are key to understanding it.

Economic Feature #1: The commodity which the insurer sells, and which the policyholder buys, is certainty.

The insurer sells certainty to individuals faced with uncertainty or risk. The insurer cannot offer the certainty that a harmful chance event will not befall the policyholder. No one can do that. What the insurer can offer, however, is the certainty of making good or compensating for a loss due to a chance event.

People buy insurance not only because it offers a predictable method for managing unpredictable losses, but because it is more efficient than other methods of budgeting for unforeseen losses. In other words, insurance is a *cost effective* way of replacing uncertainty with certainty. Consider, for example, the car owner who wants to be prepared to replace his car if it is wrecked or stolen. He could set aside sufficient funds against such an eventuality, but he then would be unable to use those funds for other purposes. Buying auto insurance, however, gives him the same ability to, if necessary, replace the car, but requires that he dedicate fewer of his resources to that task, thus freeing the balance of his funds for other uses.

Furthermore, not only does the car owner not know whether he will suffer the loss of his car, he does not know when such a loss might occur. Thus he has another reason to prefer buying insurance over a strategy of setting aside funds to cover the potential loss. If the loss occurs soon, he will not have had enough time to accumulate the necessary savings.

Economic Feature #2: Insurance spreads risks between people, and over time.

It is commonly said that insurance works by spreading risks. More precisely, insurance spreads the losses (or costs) associated with chance events. Insurance spreads risks (or losses) in two ways—among a group of individuals and over time. These two methods of risk spreading exist in different combinations depending on the type of insurance.

In most cases, insurance spreads risks primarily among a group. Each member of a group pays a small amount in premiums to cover the large losses sustained by a few unfortunate members. This matching of premiums to losses is done on a short-term basis, for example, annually.

In some cases, such as certain forms of life insurance, much of the risk spreading is done over time. All life insurance policyholders eventually will die. So, the question is not if the loss will occur, but rather when it will occur. The insurer calculates that in most cases he will collect more in premiums from the policyholder during his lifetime than the insurer will pay in benefits upon the policyholder's death.

It is possible with any type of insurance that some policyholders will pay little in premiums but collect much more in claims. Conversely, it is also possible (except for some types of life insurance) that policyholders can pay a large amount in premiums but collect little or nothing in claims. However, those who collect little or

nothing from their insurance have not wasted their money. They have bought certainty or peace of mind. Furthermore, insurance has given them that certainty at a lower cost than they would have incurred if they had relied on their own resources instead.

Economic Feature #3: The price the insurer charges is called a premium, and the amount of the premium is based largely on the size of the expected risk.

Insurance premiums, like prices in other sectors of the economy, are the product of several factors. Part of the premium reflects the insurer's operating costs, such as administration, claims processing, marketing, agents' commissions, and premium taxes. This overhead component sometimes is referred to as the "expense loading" of an insurance policy, and as a percentage of the premium will vary according to the type of policy and the operating efficiency of the insurer. Part of the premium also reflects the insurer's expected profit. Of course, just as inefficiency or poor sales in any business will result in reduced profits, or even losses, so too insurers can suffer losses or diminished profits if they are inefficient or must pay out higher than expected claims.

The bulk of an insurer's premium, however, reflects the risks the insurer assumes —that is, what the insurer expects it will pay out in claims against the policies it has written. In determining the amount to charge for the risk portion of the premium, insurers rely on historical data to predict the cost and frequency of future claims. For example, auto insurers examine data on frequency of accidents by age, sex, and geography, and data on frequency of theft and cost of repairs by geography and type of vehicle.

In general, the risk portion of an insurance premium reflects the insurer's calculation of the likelihood, or probability, of a specific event occurring and the cost, or liability, to the insurer should the event occur. How insurance premiums differ based on probability and liability, can be seen from the following hypothetical examples:

- ✓ **Two healthy 30-year-old men buy life insurance. One purchases $50,000 of coverage and the other $100,000. Both men have an equal probability of dying, but the insurer faces a greater liability if the one with $100,000 of coverage dies. Therefore, he is charged a higher premium.**

- ✓ **Two men, one aged 30 and the other aged 50, each buy $50,000 of life insurance. The potential liability to the insurer is the same for both policies, but statistics on life expectancy show the probability of the 50-year-old dying sooner than the 30-year-old is greater. So the insurer is likely to receive fewer premium payments from the 50-year-old, yet pay out the same amount to his beneficiary. Consequently, he is charged a higher annual premium.**

Of course, there are numerous different possible combinations of probability and liability. Hence, there are many variations in insurance prices or premiums.

Q. Given the economics of insurance, can anything be insured?

A. No. Because insurers sell certainty to replace uncertainty, the first precondition for insuring something must be the presence of risk, or uncertainty. An event which has occurred, or is occurring, is not a risk but a certainty. Therefore, it is uninsurable. There cannot be insurance against the cost of rebuilding a house that has already burned down or is already on fire. Similarly, a disease with a known course, or a broken leg, cannot be insured against after a person has contracted the disease or had the accident. This is why health insurance companies routinely exclude "pre-existing conditions" from coverage. A law can require an insurance company to cover such pre-existing conditions in a policy. But such a law cannot technically require the company to "insure" the medical condition, only to pay for it —like requiring a homeowner's insurance company to "insure" someone's house that has just burned down.

Only what is called an "insurable risk" can be the subject of an insurance contract. In general, there are five basic conditions which must exist in order for a risk to be insurable.

Condition #1: The peril insured against must not be under the control of the insured.

In many cases an individual, at any time, can turn an uncertainty into a certainty by his own actions. In such cases there is no real risk involved, and hence insurance is not possible. For example, property insurance policies insure against the peril of accidental damage or destruction of a building, or intentional damage or destruction by someone over whom the policyholder has no control. But they do not cover losses due to intentional damage or destruction by the policyholder or someone acting on his behalf.

In the case of health care, this is why many insurance policies generally either do not cover preventive tests and services, or limit payments for those items. Without such restrictions, policyholders, who have a great deal of discretion over the frequency and number of such procedures, could potentially run up huge bills.

Condition #2: The loss must be definable and calculable.

For a risk to be insurable, it must be possible for the insurer to do three things: specify what kind of loss the policy will cover; establish criteria for determining when a loss has occured; and calculate the amount of the potential loss.

In other words, the insurer must be able to define the potential loss associated with a risk in terms of what, when, and how much. For example, in the case of home owner's insurance, the risk of the owner suffering a loss because the house decreases in value is too vague to insure against. Houses can lose value for a host of reasons including normal deterioration, changing tastes in architectural styles, or the government building a prison next door.

The insurer can offer coverage only against specific events, like fires or hurricanes, which can be blamed for specific, tangible losses, like broken windows or holes in the roof. These lead to losses of a specific, calculable amount, such as the cost of repairing or rebuilding the house.

Still, an insurance policy can define risks broadly or narrowly, which will be reflected in the price of the coverage. Furthermore, the inability to calculate value precisely does not necessarily make something uninsurable. It is impossible, for example, to calculate the economic value of a human life. So in life insurance, an arbitrary and agreed value is assigned to the life being insured. The arbitrary value is assigned when the policyholder picks the level of coverage—in other words, the amount of the benefit to be paid upon the policyholder's death.

Condition #3: The loss produced by a peril must have the potential to be financially serious and the cost of insuring it must be economically feasible.

Small losses, even if they are frequent, may be technically insurable but in practice are not insured against. This is simply because the economic value of the insurance protection is less than the premium cost needed for the insurer to administer the contract and pay claims. The administrative costs for processing an insurance claim are roughly similar whether the claim is a large or small one. Therefore, administrative costs add a disproportionate amount to the cost of paying small claims. This is why auto insurers usually will offer lower premiums if accident costs only above a minimum amount are submitted for a claim.

This problem of small or routine loss has important implications for health insurance. The reason: some items covered by today's typical health insurance policies actually are small losses which are not cost effective to insure against. Given the cost of processing a claim for, say a $20 prescription or a $40 office visit, it would make far more sense for an individual to pay the "loss" out of his own pocket rather than obtain insurance for it. The reason small claims are covered by many health insurance policies is because employer-provided health insurance is a form of compensation that is tax-free for workers. This special tax relief can subsidize the cost of the uneconomical coverage sufficiently that it becomes cheap enough for an individual policyholder to gain from having his employer buy it for him. But the effect of the tax break on the health system as a whole is simply to encourage overinsurance by offsetting the administrative expenses of insuring against minor, usually predictable costs. Thus the tax code serves to drive up administrative costs of private health insurance, aggravating the problem of extra paperwork and claims processing that clog the current system.

Condition #4: The risk must be one of a large number of "homogeneous exposures."

When setting premiums, insurers calculate not only the size of a potential loss, but also the probability of the loss occurring. Insurers rely on historical data to predict the probability of future occurrences, in much the same way pollsters rely on the opinions of a few people to predict the behavior of a large number of people.

In both cases, the larger the data set, or sample, the more accurate the predictions will be. Just as the pollster cannot reliably predict an election based on one person's opinion, so too an insurer cannot reliably predict the risk of a future loss based on one past experience.

However, while insurers and pollsters use similar statistical methods, they apply these methods to data sets with opposite characteristics. To make accurate predictions, the pollster needs a varied (or heterogeneous) data set. For example, if all the people polled have the same age, sex, income, and geographic characteristics, the

poll would not be valid. In contrast, the insurer needs a similar (or homogeneous) data set. If an insurer wants to reliably predict the risk (or exposure) to fire of a wood house in California, he has to exclude from the data on the prevalence and cost of house fires, those that occurred outside of California or in houses made of stone or brick.

In sum, if an insurer cannot predict the probability of a risk based on reliable data about numerous past exposures to the same or similar risk, then the risk is uninsurable.

Condition #5: The peril must be unlikely to affect all those insured simultaneously.
If all policy holders potentially could suffer the same major loss at the same time, the insurer might not be able to pay the total claims. The only way an insurer would be able to make such payments is if he previously charged the policyholders an equal or greater amount in premiums—in which case the cost of the insurance would not be economically feasible for the policyholder.

Q. **Isn't insurance just a form of gambling?**

A. **No.** While insurance and gambling are similar in that each involves the risk of a chance event, there is an important difference. Insurance is protecting against losses associated with an existing risk. Gambling is intentionally placing at risk something which otherwise would not be at risk in the hope of gain. For example, there is always a risk that a racehorse could break a leg and thus become less valuable to its owner. Therefore, the owner could buy insurance against such an unforeseen loss. But a spectator at a horse race is not naturally at risk of losing money if a particular horse fails to win. He must first place his money at risk by making a wager, which would be gambling.

Q. **What is the difference between an indemnity policy and a service benefit policy?**

A. **In general, an indemnity policy pays the policyholder a predetermined fixed amount when a covered loss occurs, while a service benefit policy pays for specific services covered by the policy when the policyholder needs them.** Early hospital insurance policies were of the indemnity type. They paid a fixed, per-day amount to the policyholder for each day he or she needed hospital care. While it is still possible to buy such policies, almost all present-day health insurance policies are of the service benefit type. They pay for necessary medical care services when needed by the policyholder.

Q. **What is "underwriting," and what role does it play in the economics of insurance?**

A. **Underwriting is the process by which an insurer decides whether or not to accept an insurance application and, if accepted, on what terms.** In underwriting, the insurer first determines whether or not there is an insurable risk present which would lead him to accept an application for insurance. If an insurable risk is present, then the insurer calculates the probability and potential liability of the risk to determine the premium he will charge. He then decides what conditions or restrictions to place on the coverage in the contract, such as stipulating the maximum

the policy will pay for certain losses or benefits. For example, a health insurance policy may have an annual maximum of $1,000 per year in dental benefits or a lifetime maximum of $50,000 for mental health benefits. Some other common limitations insurers include in policies are exclusions, deductibles, and coinsurance.

In practice there is usually considerable leeway for the insurer and the applicant to negotiate the conditions and restrictions of the contract. In general, the fewer the restrictions the greater the potential liability faced by the insurer and thus the greater the premium he will charge.

Q. What is an "exclusion?"

A. An exclusion is a specific condition or circumstance listed in an insurance policy for which the insurer will not pay benefits. For example, an insurer may exclude coverage for flood damage in policies written on homes located in a river flood plain, or a life insurance policy might not cover death resulting from a dangerous sport. Similarly, a pre-existing medical condition exclusion is typical in most health insurance policies. Such an exclusion might specify, for example, that during the first six months following the purchase of the policy, the insurer will not pay for treatment of a medical condition for which the policyholder received treatment in the twelve-month period preceding his purchase of the policy. Such an exclusion also could apply to diseases which the policyholder had at the time he purchased a policy.

Since most of today's health insurance is provided through employers, health insurance exclusions usually apply to new workers or dependents when they join an existing employer group plan, or to existing workers and dependents when the employer switches to a new health plan.

Q. What is a "deductible?"

A. A deductible is one form of restriction on an insurance policy. It specifies a minimum amount below which the insurer will not pay a claim. When a loss occurs, the policyholder must pay for it up to the amount of the deductible and the insurer will pay only that portion, if any, which exceeds the deductible. A deductible can be levied either per occurrence—in other words, on each claim submitted—or cumulatively, such as an annual deductible for health insurance. Deductibles normally are included in insurance policies to exclude small claims or limit payments on larger claims. Of course, the less an insurer must pay out on claims and spend on processing small claims, the lower the premiums it needs to charge.

Q. What is "coinsurance?"

A. Coinsurance also is a restriction on an insurance policy. It limits the percentage of each claim that the insurer will pay. For example, a health insurance policy might contain a coinsurance provision stating that the insurer will pay only 80 percent of a claim, with the policyholder responsible for paying the other 20 percent. Like deductibles, coinsurance provisions also reduce costs to insurers and thus help to lower premiums.

The savings come in part from the fact that under a coinsurance provision, the insurer does not have to pay the whole claim but only part of it. In the case of service benefit policies, like health insurance, coinsurance also reduces costs by discourag-

ing policyholders from obtaining services that are unnecessary or only marginally beneficial, since the policyholder must pay a portion of the bill out of pocket. In general, the more discretion the policyholder or the service provider has in deciding the cost and quantity of the services demanded or provided, the larger the coinsurance will be. This is why, for example, under some health insurance policies the insurer will pay 100 percent of the costs of emergency services, but only 80 percent of the cost of elective, acute care services, and only 50 percent of the cost of mental health services. In a medical emergency the course of treatment generally is obvious. The patient usually has little say in the treatment, and if the doctor must make decisions, those decisions usually will not, and probably should not, be influenced by financial considerations. In elective cases, however, there may be more than one course of treatment, in which case the doctor and patient should consider the relative costs and benefits of each option. With many mental health services, decisions about the type, length, site, and cost of treatment are much more subjective than similar decisions about physical treatments.

Q. **What is a "copayment cap" or "stop loss?"**

A. **A copayment cap or stop loss is a provision in an insurance policy stating the maximum amount which the policyholder must pay in deductibles and coinsurance under the policy.** Once the cap is reached, the insurer pays 100 percent of the remaining cost of the claim or claims. In other words, the policy places a limit or cap on the portion of losses a policyholder must pay. For example, a health insurance policy might include a $200 annual deductible, with 20 percent coinsurance on medical bills above the first $200 and an annual copayment cap of $1,000. In this example, the most the policyholder could have to pay out-of-pocket per year in deductibles and coinsurance is $1,000.

Q. **What is a "risk pool?"**

A. **A risk pool is a group of policyholders all covered by the same insurance policy.** A risk pool can be created by the insurer combining into a single group numerous individuals who separately purchased the same coverage. This is how risk pools are created for auto, life, and homeowners insurance, to name some examples. Another way is for an insurer to sell the same coverage to all the members of an already existing group. The most common example of this practice is employer group health insurance, where the insurer provides the same coverage to all the workers and dependents of an employer and treats them as their own separate risk pool.

As noted previously, insurance is the business of accepting and managing risks. While a large number of people may be at risk of suffering the same loss, no one knows which of them actually will suffer the loss. Based on historical data, however, the insurer has an approximate idea of how many people likely will suffer the loss—or in the case of health insurance, the frequency and cost of the medical care covered by the policy. The insurer can then sell coverage to a large number of people and reimburse the losses of the unfortunate few out of the premiums paid by the fortunate many.

When policyholders are grouped together into a risk pool, the insurer is able to spread the cost of losses associated with the potential risk among all the members of the pool. If an insurer can manage risks in this manner successfully, he not only

will be able to cover losses and administrative costs out of his premium income, he also will retain some of that income as profit, while still offering premiums low enough to attract policyholders away from his competitors.

SPECIAL PROBLEMS WITH HEALTH INSURANCE

While the economics of insurance work quite well in areas like homeowners insurance, auto insurance, and life insurance, there are widespread complaints about health insurance. But this is not because of some inherent shortcoming of the health insurance market. It is in part because various well-meaning government policies have introduced distortions into the market, which have undermined the smooth running of health insurance. And it is in part because Americans and their representatives expect health insurance to provide services that insurance cannot really provide.

A number of health insurance practices have given rise to strong complaints about health insurers. Among them:

- ✓ **Imposing limits on the extent of coverage offered by policies, which means that a family may find a particular condition is not covered, or is covered only up to a certain amount;**
- ✓ **Limiting or denying coverage to individuals with pre-existing medical conditions, which means that when a company hires a worker, its insurance plan refuses to pay for treatments related to an existing or previous illness for which the worker, or a dependent of the worker, has been treated in the past;**
- ✓ **Denying coverage to individuals or the employees of businesses engaged in certain occupations likely to incur high medical costs;**
- ✓ **Limiting coverage for preventive health services, such as annual physicals;**
- ✓ **Charging steep premium increases to renew coverage for groups in which one or more individuals previously have filed large claims, or refusing to renew coverage for the group unless individuals with expensive medical conditions are dropped from the group's policy.**

These practices are most common, and cause the greatest problems and concern, in what is called the "small group market"—meaning workers and dependents of small businesses. In this context, a small group generally is defined as one with between two and 25 members. Small businesses also face the highest per-capita costs for health insurance, and small business employees and their dependents are more likely to lack health insurance than those employed by large or medium-sized firms.

Added to these are the more general complaints about the already high, and constantly escalating, cost of employer-based health insurance and the lack of portable benefits in the employer-based system, which means that individuals lose health care coverage when they change or lose their jobs.

The Problem of "Adverse Selection." Complaints about the health insurance system are not confined to employers and employees. Insurers also complain about the behavior of both policyholders and their competitors.

For example, insurers fret about the problem of "adverse selection." This refers to the natural tendency of sicker than average groups or individuals to choose, if they can, a more comprehensive insurance plan which will pay for more of the cost of their medical care. This problem generally arises in situations where an insurer is prevented by regulation from charging these groups or individuals higher premiums commensurate with their higher costs. If an insurer is being "selected against" —meaning he is getting more than his proportional share of high-risk and high-cost individuals—he may not be able to raise premiums fast enough to cover very large claims costs. In such a situation, the insurer could incur substantial losses.

Cherry Picking. Some insurance companies also frequently complain about "cherry picking" or "cream skimming" by some of their competitors. These terms refer to the practice of an insurer agreeing to cover only healthy groups or individuals. It is essentially the reverse of "adverse selection." To spread the costs of claims, an insurer must have a sufficient number of policyholders who file little or nothing in claims to offset those who file large claims. If one insurance company gets more than its share of low-cost individuals, it can turn a handsome profit while saddling its competitors with costly individuals denying the latter companies the low-cost individuals they need to spread claims costs. The effect of this is that the other companies will have to charge much higher premiums for their sicker enrollees.

Low Balling. Another controversial practice by some insurers is called "low balling." This refers to an insurer selling health care coverage at rates below cost. It uses these low rates to attract customers and increase market share. Of course, the insurer initially loses money on such contracts. But the insurer may low ball to force competitors out of the market. Later he tries to recoup early losses by charging steeply higher rates when the contracts come up for renewal in subsequent years.

Low balling by health insurers is analogous to "dumping" by manufacturers, in which firms sell their products below cost to gain market share. After they have forced their competitors out of business, they raise prices without consumers being able to switch to a competitor. But like dumping, low balling is never a sustainable long-term market strategy. The reason: to recoup the initial losses from selling at below market prices, the "low baller" or "dumper" eventually must raise prices above the market level. When that happens, any remaining or new competitors can, in turn, offer more favorable prices and win away customers.

Still, in the short term, low balling is disruptive. It encourages insurance buyers to switch insurers frequently to take advantage of the low rates being offered. This practice is known as "churning." This high turnover of consumers also adds to the aggregate administrative cost of insurance, including screening and claims processing.

Q. **Do these practices and problems occur in other forms of insurance?**

A. **Sometimes, but they are not as prevalent or disruptive as in health insurance.** The present health insurance system is more susceptible to these problems because it is affected by a unique set of government policies and regulations.

To start with, health insurers are not all governed by the same regulations. The difference originated in the 1930s when states moved to apply traditional insurance regulations to the then newly formed Blue Cross and Blue Shield plans. The "Blues" were created by hospitals and doctors during the Depression as a way to guarantee themselves predictable incomes. When states tried to regulate the Blues like commercial insurers, the hospital and medical associations balked and lobbied state legislatures for special treatment for the Blues. The resulting compromises typically gave the Blues special non-profit status, lower reserve fund requirements, and exemptions from premium taxes, in exchange for restrictions on their ability to underwrite applicants—that is, to vary the premiums charged to applicants with different risks.

As a result of these deals, the Blues had lower overhead costs than their competitors. The Blues also were controlled by doctors and hospital executives, leading them to adopt reimbursement policies favorable to providers, which further encouraged providers to prefer patients with Blue Cross and Blue Shield coverage. The Blues also got hospital discounts. These advantages enabled the Blues to dominate the then emerging health insurance market.

However, these deals also left the Blues with an Achilles' heel. Their special underwriting restrictions meant the Blues were forced to charge higher risk customers below-market value rates. While this helped higher risk individuals gain more affordable coverage through the Blues, it also meant that they had to charge lower risk customers above market rates to cover their losses.

In essence, the Blues found themselves in the position of being the insurers of last resort, and set up for a classic case of adverse selection. The commercial insurers naturally responded by exploiting this one point on which they actually had a competitive advantage over the Blues. The commercials turned to targeting lower risk groups and individuals, selling them lower cost coverage based on their true risk—something the Blues could not match.

Initially, these government-induced distortions in market competition caused few problems for two reasons. First, the more limited scope of medical practice fifty years ago meant there was less variation in the cost of coverage between high and low risk individuals. Second, most of the health insurance was sold to employer groups, few of whom had workforces with an average health status that was significantly better or worse than the norm.

Over time, however, advances in medical science widened the differences in cost of coverage between high and low risk individuals. In addition, changes in the economy left companies in declining industries with older workforces, while new industries attracted younger workers. These changes increased the potential for adverse selection against the Blues, while also making it more lucrative for some commercial insurers to engage in cherry picking, by aggressively seeking low risk customers.

Some states in recent years have permitted their Blue Cross and Blue Shield plans to adopt underwriting and rating practices similar to those of commercial insurers. However, other states still regulate the Blues more tightly than they regulate commercial insurers, resulting in continuing problems of adverse selection and cherry picking.

Today, some of the Blues are on the brink of insolvency and are desperately trying to gain approval to use more flexible rating and underwriting. However, many policyholders have an incentive to lobby against government regulators granting such concessions to the Blues. At the same time, some of the most aggressive commercial insurers may have taken cherry picking one step further and engaged in low-balling, though this is difficult to prove.

Had the states never established different regulations for the Blues and commercial insurers, most of today's problems would have been avoided. In other forms of insurance, where all the insurers use the same or similar rating and underwriting methods, it is difficult for adverse selection against one or a few insurers to occur. It is also difficult for cherry picking to occur since all insurers have an equal ability to attract low risk customers. In less distorted insurance markets, competition among insurers tends to focus not on differences in rating methods, but on differences in product design and price differences based on the relative efficiency of the competing companies. Thus, undistorted insurance markets function more like markets for other goods and services.

However, most of the other health insurance problems encountered by workers and families, such as gaps and limits in coverage, would still occur. The reason: those problems are largely the product of longstanding federal tax policy which heavily favors employer-group health insurance over other methods for purchasing health insurance and medical care. This federal tax policy creates yet another set of distortions in the health insurance market which are not found in other insurance markets. The adverse effects of this tax policy will be examined in greater detail below.

Why Today's Health Insurance Is Not Really Insurance

In a very real sense, America currently does not have a genuine health insurance system. What it does have can be more accurately described as a system of annualized pre-payment of medical care. The reason for this is that many of today's health insurers actually are not in the business of assuming and managing risks in exchange for a fee. It would be more accurate to say that they are in the business of processing claims, shuffling paper, changing money, and taking a percentage off the top.

The most telling evidence in support of this seemingly harsh characterization is simple: Health insurance customers actually receive very little of the commodity they get when they buy other kinds of insurance. That commodity, as noted earlier, is protection against uncertainty. But the only certainty for health insurance customers is that the insurer will charge a fee to pay most of their medical bills in the current year. But next year the customer (or his employer) often will be charged premiums that reflect the cost of last year's medical bills. Thus the premiums charged to an employer group each year reflect the anticipated amount the group will file in claims for the year. This means that "insurance" turns out to be merely a method of pre-payment of medical care. Because of this, the insurer uses "experience rating" to determine the premium for the group. The insurer sometimes even will refuse to renew the health insurance policy of the customer if the individual or group has a "bad" experience.

Q: What is meant by experience rating?

A. Experience rating is the practice whereby an insurer bases the premiums charged in one year on the costs a policyholder incurred in the previous year. In other words, the new rates reflect past experience. In the case of most health insurance, the experience rating is done on an employer group basis. This is the health insurance which is generally sold and purchased due to the unique support that employer-based insurance enjoys from the federal tax code.

In some forms of insurance, experience rating is a desirable practice; auto insurance is the most common example. In the case of auto insurance, most losses result from bad driving. Charging higher premiums to drivers who cause accidents while keeping premiums low for those who are victims of accidents creates a powerful deterrent against bad driving.

Q: What is "optionally renewable" insurance?

A: It is a policy in which the insurer reserves the right not to renew coverage in the next contract year. Most auto insurance contracts, for example, are optionally renewable. This is really an extreme form of experience rating. If a policyholder's past experience is bad enough, the auto insurer simply may refuse to renew the policy, and other insurers also may refuse to sell him coverage. This, of course, adds to the desirable deterrent against risky behavior.

Some states try to prevent these practices in the area of auto insurance. But laws which prohibit insurers from writing experience-rated, optionally-renewable auto insurance create more problems in the auto insurance market than they solve. With the deterrents to risky behavior removed, losses increase rapidly and the overall cost of auto insurance increases rapidly as well—for all policyholders. The effect is to reward careless drivers with lower than appropriate premiums and penalize careful drivers with higher than appropriate premiums.

Q. Why is experience rating and optional renewability such a concern in health insurance?

While experience rating and optional renewability are desirable practices in writing auto insurance, they are undesirable practices in health insurance. Unlike auto accidents, illnesses rarely are the clear and immediate result of an individual's behavior. Poor health habits, like over-eating, lack of exercise, and excessive drinking, are difficult for an insurer to monitor and are usually contributing factors to an illness—not the clear and immediate cause of an illness. Generally speaking, then, experience-rated and optionally renewable health insurance unfairly penalizes those who may suffer illness through no fault of their own. It also unfairly rewards those with the good fortune to remain healthy, even if they indulge in risky behavior.

What policyholders want from any kind of insurance is certainty. In health insurance, they want the certainty that they will have the means to pay for medical care if they need it. But experience rated and optionally renewable health insurance does not give them that certainty, or at least not for very long. Under such policies, if a policyholder incurs major medical bills, he will simply see his premiums (or his share of them) raised the next year. Even worse, the insurer could refuse to

renew his coverage and other insurers might refuse to cover him as well because of his past medical history. This means that when the policyholder most needs health insurance he will not have it or will soon be unable to afford it. Conversely, if the policyholder is healthy and likely to remain that way, there is no point in buying health insurance, because it will not give him much protection even if he does become seriously ill.

THE ROOT CAUSES OF THE SPECIAL PROBLEMS IN AMERICA'S HEALTH INSURANCE SYSTEM

Virtually all of the problems in today's health insurance market, including the undesirable practices of health insurers, result from the fact that health insurance is experience rated, optionally renewable, and because the tax code favors health plans based on employer groups.

Q. **If today's health insurance is such a bad value, why do people buy it?**

A. **Because they don't buy it directly.** Instead, their employer buys it for them, using part of their wages. Most health insurance today is written on an employer group basis, because that model is so heavily favored by the tax code. As a result, individuals have little or no choice in buying health insurance. Their employer either does or does not buy it for them. Furthermore, when an employer buys health insurance, the workers usually have little or no say in who it is purchased from or the policy's benefits and coverage terms.

People would not tend to buy this kind of health insurance if they were purchasing it in a free market on their own as individuals or families. On their own, individuals would no more tend to buy optionally renewable, experience rated health insurance than they would buy optionally renewable, experience rated life insurance. Life insurance policies specify a period—usually five, ten, or twenty years—during which coverage cannot be withdrawn. During that period, the buyer of life insurance pays for coverage according to a fixed schedule of annual premiums. The reason for this is obvious: Imagine a life insurer offering a policy which stipulated that, if a policyholder later suffers a major illness or accident, the insurer would reassess the policyholder's risk of dying and steeply increase his premiums or cancel his coverage altogether at the end of that year. Few people, if any, would consider buying such a policy because it would not offer the certainty, or protection, they want.

Q. **Why then is health insurance written on an employer group basis?**

A. **Because the federal tax code provides enormous tax advantages for buying health insurance through an employer group and virtually no tax breaks for buying it individually or through any other type of group.** Money spent by an employer on a worker's health insurance is really part of the worker's compensation. But under federal tax law, it is not counted as taxable income to the worker, who thus avoids paying any federal income or payroll taxes (FICA), or state income taxes, on it. This is called the "tax exclusion" for a worker with employer-

sponsored health insurance. The amount foregone by the federal Treasury through this tax break is $66.6 billion in 1991 dollars.[2]

Q: **What does this special tax break mean to the individual worker?**

A: **For those lucky enough to be enrolled in a company plan, it can be very generous.** The per capita value of this tax exclusion can be more than twice the value of an income tax deduction to the average worker. For example, if a worker in the 15 percent income tax bracket claims a dollar in a tax deduction, say for mortgage interest or charitable contributions, he avoids paying 15 percent income tax on that dollar. But he has already paid payroll taxes on the money. In contrast, if the worker's employer spends a dollar on his health insurance, instead of giving him that dollar in cash wages, the worker avoids paying not only 15 percent income tax on that dollar but also the 15.3 percent combined employer/employee payroll tax. Thus, the worker has avoided 30.3 percent in federal taxes on that money, plus any state income taxes he otherwise would owe.

For most Americans, this tax break for employer-sponsored insurance is, in percentage terms, the biggest tax break they can get. Not surprisingly, it is an extremely powerful incentive for buying health insurance through an employer-sponsored group. In contrast, few Americans can qualify for a tax break for purchasing health insurance or medical care on their own, and even in those rare circumstances, the tax breaks are much less generous than the tax exclusion for employer-sponsored insurance. Thus, if the average American buys medical care out of pocket or buys health insurance other than through an employer, he usually cannot get any tax break at all.

Q: **Why does the federal government provide this tax exclusion for employer-sponsored health insurance?**

A. **It does so largely as the result of an historical accident resulting from the imposition of wage and price controls during World War II.** At that time, the large number of men serving in the armed forces meant employers faced a tight labor market. But wartime wage controls prevented employers from raising salaries to attract workers. Companies instead turned to noncash benefits, particularly health insurance, as a back door way of offering employees additional compensation.

Even though these benefits were really part of workers' wages, the IRS ruled at that time that the value of the benefits did not count as taxable income to workers. This preserved the fiction that the wage controls had not been breached. But it also made employer-sponsored health insurance a giant tax break.

Unions gained even more leverage to demand employer-sponsored health insurance when the National Labor Relations Board ruled in 1948 that such benefits were a legitimate subject of collective bargaining. This further accelerated the

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2 See: Stuart M. Butler, Ph.D., "A Policy Maker's Guide to the Health Care Crisis, Part I: The Debate Over Reform," Heritage Foundation *Talking Points*, February 12, 1992, and Stuart M. Butler, Ph.D., "A Policy Maker's Guide to the Health Care Crisis, Part II: The Heritage Consumer Choice Health Plan," Heritage Foundation *Talking Points*, March 5, 1992.

spread of company plans after World War II, even though the initial incentive of wage controls had by then been removed. In other words, the current system evolved out of wartime economic policy, rather than health care policy. Those events, not any national consensus that employers are the best people to organize health benefits, brought about the system that determines the kind of health care available to most Americans.

Q. **What is a "self-insured" employer health plan?**

A. **A self-insured plan is one where the employer acts as its own insurance company, instead of buying health insurance for its workers from a commercial insurer.** Today, about half of all workers covered by employer group insurance are in self-insured plans. The spread of self-insurance in recent years can be attributed directly to a federal law called the Employee Retirement Income Security Act of 1974 (ERISA). While ERISA was designed primarily to regulate pensions, some of its provisions apply to employer-sponsored health benefits. ERISA prohibits states from treating self-insured firms as insurance companies and making them subject to state insurance regulations. Thus, by establishing a self-insured plan which meets federal ERISA standards, a firm can avoid state insurance regulations, such as requirements that insurers maintain reserve funds of a specified size, pay state insurance premium taxes, or comply with a multitude of state laws dictating the benefits health insurance policies must provide. Avoiding these state mandates can mean big savings on their workers' health care costs for self-insured firms.

Acting as its own insurance company, the self-insured firm sets the benefits and terms of health insurance coverage for its workers, funds the cost of its health plan directly, and pays claims to doctors and hospitals either directly or through a firm it hires to manage the plan. Self-insured firms often buy what is called "stop loss" insurance to protect themselves against unusually large claims. The stop loss insurance covers unexpected annual losses above the level for which the self-insured firm has budgeted.

The only real difference between self-insured plans and commercial insurance plans is the cost of the regulatory burden. But self-insured firms often contract with commercial insurers to handle the claims processing paperwork for their plans. The similarity between commercial health insurance plans and self-insured plans underscores the fact that employer-sponsored health insurance is not true insurance, but rather a system of pre-paid medical care.

Q. **How is health insurance written on an employer group basis?**

A. **A company buys insurance for its workers as a group.** The insurer then sets the premium based on the combined risk of the group's members. The insurer does not underwrite the individual members of the group, but rather underwrites the group as a whole. Thus, companies whose workers tend to be younger or healthier than average are charged below-average premiums, while those with a larger share of older or sicker workers are charged above-average premiums. As noted, employer group health insurance is usually written on an annual basis, and is experience rated and optionally renewable.

Q. What are the adverse consequences of writing health insurance this way?

A. Workers and their families cannot obtain the certainty they need and want from health insurance. Economically, this makes it a bad value for them. There are five specific adverse consequences of writing health insurance on an annual, employer group, experience rated, optionally renewable basis.

Adverse Consequence #1: The insurance does not guarantee long-term medical cost protection for workers and their families. The insurer can decide to change the premiums or refuse to continue coverage each year when the contract comes up for renewal. Of course, the employer can also decide at renewal time to switch to another insurer offering different coverage or to completely discontinue health insurance coverage for its workers.

Adverse Consequence #2: Insurance coverage is not portable for workers and their families. Workers and their dependents are covered by an employer group health insurance policy only so long as they remain members of that group. But if the worker is laid off, or takes a job with a different employer, the family may encounter pre-existing condition exclusions or other undesirable changes of coverage. Furthermore, if the worker moves to a firm without a group insurance plan, the family will receive no tax break for buying its own policy. In contrast, individuals and families changing jobs do not face this disruption in coverage with other kinds of insurance they personally purchase such as auto, home, or life insurance.

Adverse Consequence #3: Groups can be faced with sudden cost increases or loss of coverage. When the costs of health insurance claims filed by an employer group increase, the insurer either raises the cost of their coverage (renewal premium) or refuses to continue covering the group. These cost increases can be the result of increases in the prices charged by doctors and hospitals, increases in the volume of medical services consumed by members of the group, or increases due to one or more members of the group receiving very expensive medical treatment during the year.

Adverse Consequence #4: Artificially small employment-based risk pools drive up the cost of coverage for workers and their families. The health care costs of individuals with employer group insurance generally are spread only over the members of their particular group, who effectively constitute the risk pool for the insurance.

While many people seem to believe that by obtaining employer group insurance individuals automatically become members of larger risk pools, in fact the opposite is more generally true. This is most obvious in the case of very small firms. But even most large firms often are smaller risk pools than those created by insurers for other types of individually purchased insurance. For example, when individuals buy home, auto, or life insurance, the insurer internally assigns them to a risk pool typically consisting of a very large number of individual policyholders. Such risk pools are created by the insurers themselves. In large part, the artificially small risk pools of employer groups explains why small or medium-sized firms can see huge increases in their health insurance premiums, or cancellation of coverage, even if only one worker or dependent incurs major medical bills.

By way of example: Consider what would happen if homeowner insurance were employee-based with the risk pool for homeowner insurance limited to the employees of the firm where the policyholder works. In the case of most small or medium-

sized firms, there would be few people among whom to spread the very large costs of replacing a house that burns down. The smaller the firm, the higher the premiums would need to be for protecting the worker's home. Furthermore, an employer group would see its premiums hiked sharply if even one worker's house was destroyed.

In real life, of course, homeowner insurance rates are relatively low and do not increase sharply even when several houses in a community are destroyed by a fire or natural disaster. This is largely because the policyholders belong to huge risk pools (created by the insurers), even though they may have purchased coverage individually.

Adverse Consequence #5: Sick individuals can be dropped from coverage and find it impossible to get new coverage. To limit costs in an employment-based risk pool, an insurer may insist on dropping coverage for an individual with very high medical costs as a precondition for renewing existing coverage, or obtaining new coverage, at reasonable rates for the rest of the group. Employers often reluctantly agree to exclusions when faced with the realization that if they do not, the insurance will become unaffordable for the entire group and all their workers and dependents will become uninsured.

This dilemma is most common in smaller employment-based groups. Because of their small size, they do not have enough healthy people among whom to spread the costs of even one very sick individual and still keep insurance rates affordable. Of course, very sick individuals "carved out" of an employer-based group face financial catastrophe. Their principal recourse is for a family member to seek employment with an employer that is so large that the family's high costs have a negligible impact on the firm's experience-rated premium. The only other alternatives may be for the family to qualify for a special subsidized state-sponsored risk pool, or for the family to become dependent on public assistance so that Medicaid (the federal-state health program for the indigent) picks up the cost of their health care.

Q. **Without the bias in the tax code favoring employer group health insurance, would it ever make sense for insurers to sell such policies?**

A. **Yes, but only in certain very limited circumstances.** In normal insurance, where policies are bought and sold individually, the insurer underwrites each individual separately and charges different individuals different premiums based on their different risks. The insurer then groups those policyholders into large risk pools of his own creation.

The essential criteria for any sound risk pool is that it be reasonably large, reasonably stable, and contain a reasonably random mix of risks among the members. In other words, there is little chance that a large number of policyholders will suffer similar losses at the same time. When insurers create their own risk pools, they have a natural incentive to structure them such that they meet these three criteria.

However, if an insurer can find an existing group which meets all three of the essential criteria for a risk pool, that insurer can skip the costly process of separately underwriting each individual. The insurer instead can offer coverage to the entire group for one premium, based simply on underwriting the combined risk of the group's members. While many groups may meet one or two of the essential criteria

for a risk pool, very few meet all three. A very large employer group is one of the few that meets all three criteria.

But there are still problems with writing health insurance this way, even for a very large employer group. One of the major problems is that the members of such a group still would not have portable benefits. That is, they would lose their insurance when they left the group because they changed jobs.

Aside from the question of portability, writing health insurance on an experience rated, optionally renewable, employer group basis is an inherently costly and unstable practice beyond the rare exceptions of very large employer groups. Virtually all of the problems with the current health insurance system stem from government policies which try to induce or force this inferior method of writing health insurance to function in circumstances to which it is not naturally suited. Furthermore, almost all pending insurance reform proposals would continue or compound these misguided policies, resulting in even more problems.

CONCLUSION

Americans understandably are dissatisfied with the present health insurance system. It is a system plagued with problems, not only for workers and their families, but for employers and even insurers.

As the costs of health care continue to escalate, millions of workers and their families are uninsured because they and their employers cannot afford costly health insurance. Millions more worry that they could lose coverage if they lose their jobs, or if their employer is forced by financial difficulties to discontinue coverage.

When workers change jobs, they can find that the health insurance coverage offered by their new employer is very different from that offered by their old employer, with new limits and restrictions. They can find also that their new employer's insurance plan will not cover their—or a family member's—pre-existing medical condition.

Unpleasant Surprises. Some families suddenly discover that their health insurance does not offer the protection they thought it did. For example, a family member may need a type of expensive treatment for which the insurance policy refuses to pay or for which it provides only limited reimbursement. Worse yet, if a worker or family member incurs an extremely costly illness, they could find themselves "carved out" of their employer's insurance and left uninsured with no possibility of obtaining new coverage.

In sum, the basic problem with today's health insurance system is that it fails to provide its customers with what they rightfully expect from any type of insurance—namely, peace of mind, or protection against uncertainty.

Not surprisingly, employers, workers, and their families are demanding that federal and state lawmakers reform the health insurance system. While it is easy to blame insurers for the problems, lawmakers should remember that insurers are largely responding to the rules and incentives established by government. Such rules and incentives include not only state insurance regulations but, most important, federal tax policy which created and sustains the unique system of employer-based health insurance and the multitude of attendant problems it generates.

Rethinking Basics. If lawmakers truly want to solve the problems and create a reformed, smoothly functioning health insurance system that provides genuine protection and peace of mind to consumers, they must start by rethinking basic government health care policies. Part IV of this Talking Points series will examine the likely effects of various proposals for health insurance reform. It also will offer a set of recommendations for how lawmakers can create a health insurance system that is truly responsive to the needs of consumers.