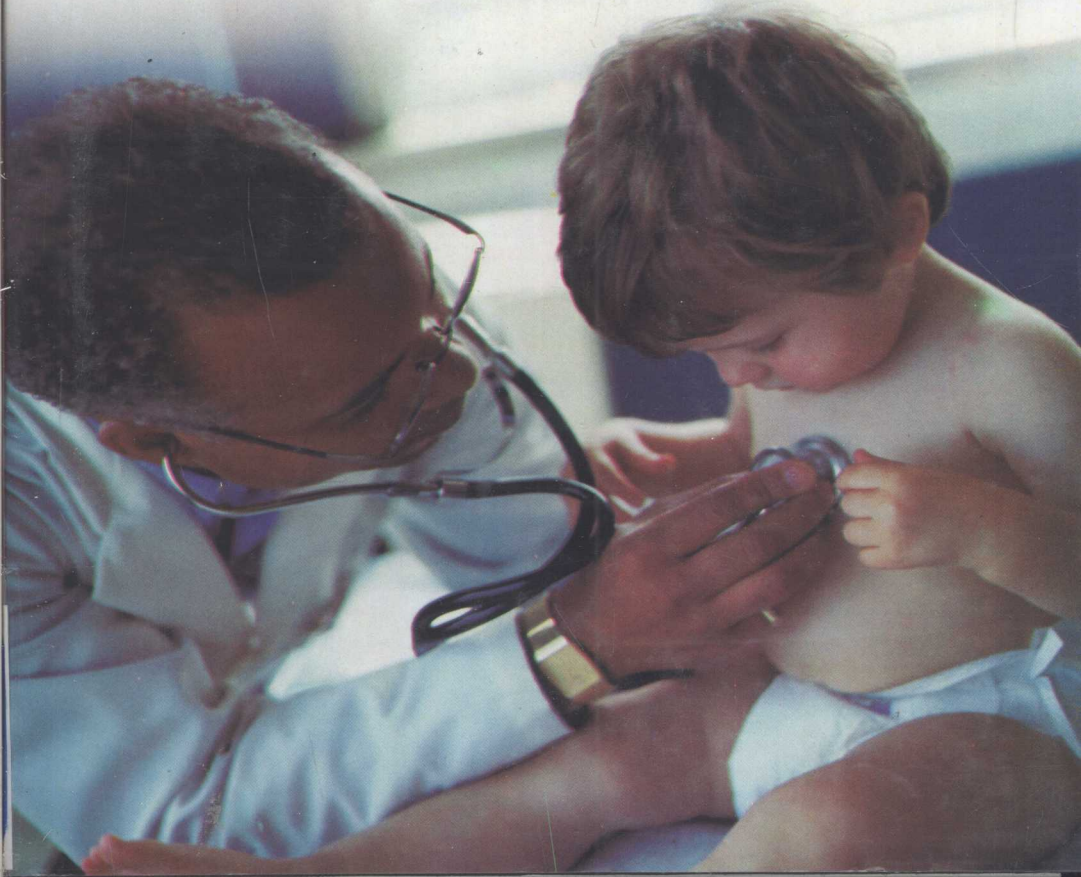
CHALLANGES *and* STRATEGIES *of* HEALTH INSURANCE

DR. SAKET SAHANI



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Dr. Saket Sahani

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Preface

Insurance is a valuable protection for life's many unexpected events. However, researching the different types of Insurance and finally deciding which policy best fits your needs can be an overwhelming process. This book tries to simplify this process by explaining the different types of Insurance, what they cover, what their limitations are and whom to contact for information. This book also offers general advice on how to buy Insurance and what types of questions to ask the Insurance company or agent.

This book covers automobile Insurance, including liability insurances, uninsured/underinsured motorist coverage, personal injury protection, collision insurance and comprehensive insurances. It also discusses other types of insurances like homeowner's/renter's insurance, life insurance, health insurance, Medicare Supplement (Medigap) and long term care insurance.

Author

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1.
Introduction

In brief, my main points are as follows:

- Small employers face substantial disadvantages relative to large employers when providing health insurance to their workers. These problems can largely be summarized as higher administrative costs of insurance, limited ability to spread health care risk, and a workforce with lower wages. All of these problems must be addressed if insurance coverage is to increase significantly among workers in small firms.
- Fixed administrative costs make it inefficient for insurers to sell coverage to small employers. The per-person price of buying insurance for a small group of individuals will always be higher than buying those same benefits for a large group. Allowing small employers and individuals to purchase coverage through organized purchasing pools, such as the Massachusetts Connector, state employees benefit plans, or other such group is an approach that could provide small employers and individuals with an avenue for more efficient purchasing.
- With regard to the second problem facing small employers—the limited ability to spread risk—small employers tend to have workforces with greater variance in year-to-year health care costs than large employers. While strategies are available to more broadly spread the risk associated with small-group and individual purchasing, some multigroup

purchasing entities, such as proposed federally licensed association health plans, would tend to further segment the risks of small-firm workers, as opposed to spreading them more broadly. While that approach might lead to some savings for the healthy, it would do so at increased cost to the unhealthy, leading to no expected increase in insurance coverage.

- The third general problem—that small employers tend to have lower wage workforces than large employers—means that expansions of insurance coverage will require significant income-related subsidies to make coverage affordable for many uninsured workers. Because employers largely finance insurance by paying lower wages to their workers, expecting low-income workers to voluntarily seek out that type of trade-off is not practical.
- Once one accepts that significant subsidies will be required to expand coverage significantly, a host of design issues come into play. These include defining what families at different income levels can afford to contribute to the cost of their medical care—including protecting the unhealthy from excessive out-of-pocket costs; mechanisms for making voluntary participation in insurance coverage as easy as possible; ensuring that each individual has a guaranteed source for purchasing coverage; keeping the administrative costs associated with delivering subsidies as low as possible; and, critically, identifying sufficient sources of financing.
- With regard to financing, serious consideration should be given to a redistribution of the current tax exemption for employer-sponsored insurance. The level of this tax expenditure is sufficient to finance comprehensive health care reform and is already dedicated to subsidizing health insurance. The current exemption is not particularly effective in expanding coverage, however, since it subsidizes most those who are most likely to purchase coverage even in the absence of any subsidy. But any changes to the current tax treatment can be highly disruptive to the existing system of

employer-based health insurance, and so must be preceded with significant reforms to the private individual insurance market to ensure that access to insurance coverage for those already insured not be adversely affected.

The Scope of Health Insurance Problems Facing Small Employers and Their Workers

Only 36 percent of establishments in firms of fewer than 10 workers offer health insurance to any of their workers, compared with 99 percent of establishments in firms of 1,000 or more workers (figure 1).1

Approximately 46 percent of workers employed by firms with fewer than 10 workers are offered and are eligible for enrollment in their own employer's health insurance plan, compared with 88 percent of workers employed in firms of 100 or more workers (figure 2).2 Workers in the smallest firms are also less likely than their large firm counterparts to take up employer offers when they have one, although some of these workers receive coverage through a spouse employed by a larger firm (figure 3).

The lower rates of offer and take-up among small firms and their workers results in roughly 36 percent of workers in the smallest firms being uninsured, while only 10 percent of workers in the largest firms lack coverage (figure 4).

These lower rates of coverage among small employers are due, at least in part, to that fact that small employers must pay significantly more for the same health benefits than do large employers. Smaller firms face much larger administrative costs per unit of benefit. Administrative economies of scale occur because the costs of enrollment and other activities by plans and providers are largely fixed costs.6 Insurers simply have fewer workers over which to spread these fixed costs in small firms. In addition, insurers charge higher premiums to small employers, because small employers experience greater year-to- year variability in medical expenses than do large firms 7 simply

because there are fewer workers over which to spread risk.

Another barrier to small employers providing health insurance is that the average worker in a small firm is paid significantly less than workers in large firms.8 Economists believe that there is an implicit tradeoff between cash wages and health insurance benefits.9 In other words, workers actually pay for the cost of their employers' contributions to their health insurance by receiving wages below what they would have received had no employer health insurance been offered. The lower wages of small-firm workers imply that they are far less able to pay for health insurance through wage reductions; consequently, their employers are less likely to offer them such benefits.

Workers in small firms that do not offer health insurance are often left with few options for health insurance coverage. Those that do not have a spouse with an employer offer and who are not eligible for public insurance programs have the option of pursuing coverage in the private individual insurance market. In most states, there is no guarantee that an individual can purchase health insurance in this market at any price. If a policy is made available, premiums in most states can be set very high as consequence of current or prior health status, and benefit exclusions may permanently or temporarily exclude coverage for particular conditions, body parts, or body systems. Policies in this market also tend to have considerably higher cost-sharing requirements than is the case in the employer group market, as insurers perceive demand for more comprehensive policies as a signal for high expected medical care use. As a consequence, affordable policies in this market may still pose significant medical service access limitations for modest-income workers.

While increasing the offer rate among small employers might appear to be an obvious strategy for increasing employer-based insurance, doing so means pressing for an expansion of coverage

by purchasers relatively inefficient at buying health insurance. Because small-employer purchasers face higher prices for the same set of benefits and tend to face barriers related to having a lower-wage workforce, changing their offer decisions absent a mandate is unlikely. It is important to keep this in mind when considering reform options and the incentives they implicitly create, and for this reason, I would not encourage a strategy of subsidizing small employers to provide additional coverage directly. At the same time, reforms should be structured in such a way as to not undermine the efforts of small employers who do provide coverage to their workers.

II. Possible Approaches for Addressing the Insurance Problems of Small Employers

A number of mechanisms can be used to address the problems facing small employers in the provision of health insurance to their workers. Some are strategies that apply to reducing the problem of the uninsured in general, and some are of particular interest to small employers and their workers. I focus my comments here on incremental types of reforms that deal explicitly with the small-business problems of high administrative loads, limited ability to spread health care risk, and low relative wages.

Purchasing Groups. Allowing small firms to band together for purchasing health insurance has some potential for lowering administrative cost loads. This has been the motivation of a number of purchasing pools that have been set up in various states. These purchasing pools often provide the additional benefit of making it more feasible for small employers to offer their workers a choice of health insurance plans. Instead of shopping for plans independently, small employers (and sometimes individual purchasers) pay premiums to the purchasing pool on behalf of their workers, and the pool performs the administrative functions of plan choice, premium negotiation, enrollment, etc. Ideally, the insurance plans interact with the

pool's administrator instead of each member firm, with marketing and screening activities performed more centrally.

While small-employer purchasing pools have met with success in some cases, realizing the efficiencies of large-scale purchasing has been difficult for several reasons. Chief among them has been the limited ability to reduce the role and inherent expense of insurance agents in the process.10 So while purchasing pools can lower the administrative loads for small-group purchasers, these savings are more difficult to capture in practice than many policymakers and analysts have presumed. The most well-documented positive impact of purchasing pools to date has been an increase in the availability of plan choice for enrollees. Some pools have been plagued by adverse selection, due in large part to low enrollment, which has led to their eventual dissolution.11 This highlights the need for additional risk-spreading approaches (discussed below) or of other strategies that would increase the size of purchasing pools.

These types of purchasing pools also have significant potential for acting as the organizing entity for more comprehensive health care reforms.13 In such a capacity, the pools would offer families and individuals both easier access to and a broader choice of health plans, provide consistency in coverage as people move from one job to another, and would lower administrative costs relative to those in the private nongroup market. This type of pool could also focus on the administration of subsidies, eliminating the complexities of providing subsidies in a dispersed and varied market. These roles are consistent with what policymakers envision for the Massachusetts Connector. If large enough, an organized purchasing pool could also provide an administrative structure that would manage competition among private plans to control the growth in premiums.

It is important to note that the purchasing pools described here do not include the legislatively proposed entities known as

federally licensed association health plans (AHPs). The implications of AHPs are altogether different in that they are designed to allow particular multiemployer and multistate purchasing entities to avoid compliance with state health insurance regulations. As a consequence of the AHPs' ability to limit membership to select groups and to have their premiums determined separately from the traditional commercial insurance market, they are largely a tool for segmenting health care risk rather than for generating economies of scale.14 In addition, analysts have concluded that AHPs are unlikely to increase health insurance coverage.

Subsidization of Insurance Coverage for High Cost Individuals. Insurers and others recognize that small employers are not large enough to have stable annual average health expenditures. Large firms have average health expenditures that are generally comparable to averages for the whole insured population; this is not the case for small firms. Even a single seriously ill worker or dependent enrolled in a small-group insurance policy can have tremendous effects on the average expenses of the group in a particular year, whereas a small number of high-cost cases in a large group would not substantially affect the group average. Unfortunately, regulatory reforms implemented thus far have been unable to sufficiently spread these risks, perhaps, in large degree, due to the voluntary nature of insurance. State insurance regulations served to spread the risks within the small-group insured population itself. But because firms can opt to provide coverage or not, when insurance regulations increased premiums for the healthy and decreased prices for the sick, some healthy groups opted out of insurance coverage in this market. The result was generally no net change in the number insured.

Other risk-spreading mechanisms could work much more effectively, however. For example, many states have established high-risk pools. These pools are generally available to

individuals who have been refused insurance coverage in the private market, and who do not have offers of employer-sponsored insurance. However, due to the limited public funding through state sources (frequently premium taxes on private insurance policies), these pools may have enrollment caps and usually charge premiums well in excess of standard policies in the private market. Some offer very limited benefit packages and most maintain preexisting condition exclusion periods and/or waiting periods. All of these limitations hamper the effectiveness of high-risk pools in absorbing risk from the private market. However, broadening the base for financing these pools, loosening eligibility criteria for enrollment, making the insurance policies more comprehensive, and offering income-related premiums have the potential to make these high-risk pools powerful escape valves for the high cost in the small-group insurance market. Allowing small employers to buy their high-risk workers into well-funded high risk pools would decrease the level and variability in the expenditures of the remaining small-group workers and consequently would lower their premiums. The cost of subsidizing the medical care of the high risk could be spread across the entire population using a broad-based tax.

Another proposal would combine the concepts of purchasing pools for administrative efficiency with explicit subsidization of the high-cost and low-income populations.18 This proposal allows groups wishing to purchase insurance coverage in current markets under current insurance rules to continue to do so. However, it would provide structured insurance purchasing pools in each state in which employers and individuals could enroll in private health insurance plans at premiums that reflect the average cost of all insured persons in the state. Broad-based government funding sources would compensate insurers for the difference between the cost of actual enrollees and the statewide average cost.

Under the reforms being implemented in Massachusetts, the state has merged the small-group and individual markets for premium rating purposes, and requires that premiums charged for plans within the Connector not be higher than those charged for the plans outside the Connector. Effectively, these rules spread risk across the small-group and individual markets and across both the Connector and non-Connector plans. Whether this spreads risk sufficiently remains to be seen; the mandate that all adults have insurance coverage is likely to make the approach more sustainable than it would be in strictly voluntary markets.

Subsidization of Insurance Coverage for Low-Income Individuals. Extensive research has demonstrated that low-income individuals are less likely to have health insurance than their higher-income counterparts. This holds true for workers in small and large firms. Analysis has also shown that higher-income individuals are significantly more likely to take up an employer offer of health insurance than are lower-income workers. In addition, there is evidence that low-income workers' decisions to take up health insurance offers are more responsive to price than are the decisions of higher-income workers.

The average wage of workers in the smallest firms (fewer than 10 workers) is 63 percent of that of workers in the largest firms (500 workers or more).20 Workers in these small firms are more than twice as likely to have family income below 200 percent of the federal poverty level (FPL) than are workers in firms of 500 or more. This information, taken together with the analyses described above, suggests that affordability of health insurance is a significant barrier to coverage for many small-firm workers, as it is for the uninsured population at large. Consequently, significant inroads into reducing the number of uninsured in this population will require income-related subsidization of insurance coverage.

Subsidies to low-income families can take a number of

forms: tax credits, vouchers, or other direct subsidies. What they are called is not important, but how they are designed, administered, and guaranteed a source of insurance for using the credit are clearly critical to their potential for expanding coverage and for the governmental costs associated with delivering them. but how they are designed and administered is clearly critical to their potential for expanding coverage and for the governmental costs associated with delivering them. The more generous the subsidies relative to the price of insurance, the greater voluntary participation in health insurance coverage will be. However, it is highly subjective as to how much should be considered "affordable" to a family of a given income.

In work done to support the reforms being implemented in Massachusetts, my colleagues and I developed benchmarks that policymakers could use to determine the maximum amounts individuals and families should be expected to pay for insurance premiums and overall health spending.21 In order to ensure affordable access to necessary medical care, we feel strongly that one must consider standards for both premiums and out-of-pocket expenses. If an insurance premium is low because the benefits provided are limited and/or require high cost-sharing, then the policy may not improve affordability of care, which depends on a combination of premiums and out-of-pocket expenses. This is especially a problem for those with chronic illness and others with above-average health needs. We have studied affordability by analyzing the family financial burdens of medical care relative to income of those between 300 and 500 percent of the FPL. This group is largely insured and does not have its financial burdens relative to income skewed downward as a consequence of extraordinarily high incomes. For families in this income group with full-year employer-sponsored insurance, median spending on premiums and out-of-pocket expenses constitutes just over 6 percent of family income. We suggested that those with lower incomes have

affordability standards set below typical levels of spending for those with incomes of 300 to 500 percent of the FPL, with individuals at very low incomes (say below 150 percent of the FPL) not required to make any significant contributions to their medical care. Setting affordability standards and related subsidy schedules using designated shares of medical spending relative to income allows the policy to protect families from the likelihood that medical expenses continue to grow faster than wages.

Part of an individual's perception of what is affordable is whether the subsidy is made available when premium payments are due and whether there is any uncertainty as to what the subsidy will be. These issues relate, in particular, to practical concerns with the design of tax credits. Many low-income workers are likely to not have sufficient liquidity to front the full cost of health insurance premiums today on the promise of a refund after filing their tax return. Some mechanism for advancing the value of the credit to the insurer will be necessary for them to purchase coverage. While the Health Coverage Tax Credits (HCTC) for workers displaced by international trade will advance tax credits to health insurers, there are delays in doing so, and that is with a very small program. Also, if, under a new program, tax credits were to vary with income and advanced tax credits were to be reconciled with end-of-year taxable income, a family might not know today what their final subsidy amount would be. Such uncertainty in the price they ultimately face for insurance could dissuade some from voluntarily purchasing coverage. Allowing subsidies to be determined based on prior-year income and/or limiting end-of-year reconciliation to very large changes in income could be helpful in this regard.

To get the largest possible bang for the government's subsidy dollar, the approach should also be sensitive to the administrative costs of delivering the subsidy. Some recent experience through the HCTC suggests that the administrative costs associated with

delivering health-insurance tax credits may be very high relative to administering subsidized insurance coverage through public programs. One recent estimate indicates that in FY 2007, only 66 percent of the cost of the HCTC went to pay for health care. The rest went to the Internal Revenue Service (IRS) (21 percent) and the cost of health plan administration (13 percent).23 And the value of the HCTC does not vary with income; administering an income-related tax credit would surely cost significantly more to administer.

I believe that we could streamline the administrative costs of delivering subsidies if they were made available only for the purchase of coverage through organized guaranteed issue purchasing pools, eligibility determination were done centrally following the most successful models used in public programs today, and mechanisms were developed for sharing data among public programs,24 the IRS, and the new purchasing pools.

Financing the subsidies is, however, where the rubber meets the road in health care reform. I am quite confident that we can design a policy approach that would significantly expand health insurance coverage, would spread health care risk more broadly, and would do so at a reasonable administrative cost. Designing such a reform, complex as it may sound at first, is actually the easy part. The most difficult truth is that financial resources are necessary for ensuring accessible, affordable, and adequate insurance for all Americans. There are many options for identifying the necessary funding. If asked for one potential funding source, I would suggest we turn to a redistribution of the current tax exemption for employer-sponsored insurance, providing those with the greatest needs the greatest assistance, as opposed to the opposite, which is true today. The current level of this tax expenditure is sufficient to finance comprehensive health care reform and is already dedicated to subsidizing health insurance. The current spending is not particularly effective in expanding coverage, however, since it