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The Political Economics Of Health Insurance Market Reform

by Mark A. Hall

Our country’s system for financing health care cannot be fundamentally reformed without significant compromise by all affected interest groups. Providers must yield on cost containment; consumers must accept restrictions in benefits; personal injury lawyers must tolerate tort reform; employers must pay either higher employee compensation or taxes; and private insurers must change the way they do business. So far, the insurance industry is the only one of these groups to come forward with an unconditional offer to make a significant concession. The Health Insurance Association of America (HIAA) and the National Association of Insurance Commissioners (NAIC) have drafted model legislation that imposes extensive restrictions on the pricing, marketing, underwriting, and design of small-group policies. These reforms are also endorsed by the Blue Cross and Blue Shield Association.

It is remarkable for any industry to invite such heavy regulation of itself. It is even more surprising, given the wide divergence of opinion among various interest groups on how best to carry out other aspects of health financing reform, that the basic structure of small-group market reform has broad political support in states and in federal policy circles. Hence, it is instructive to examine the social dynamic that prompted the industry to propose these reforms and that is influencing their likely acceptance by various political constituencies. This Commentary synthesizes a political and economic analysis of the insurance industry’s reform proposals based on interviews with and documents from a wide variety of industry, governmental, and interest-group sources.

Role Of Private Health Insurers In The National Policy Debate

In recent months, the health insurance industry has taken on an increasingly visible role in the national health policy debate; it has frequently been called on to provide congressional testimony and to

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participate in televised and published debate of the issues. This high profile is in stark contrast with the interest-group politics-dominated by the provider community (doctors and hospitals) and by consumer groups (principally the elderly and groups representing labor interests) that has influenced earlier health care financing reforms. The public is most content when insurers stand in the background, leaving the important decisions to doctors, employers, and government. Until recently, private insurers were happy to accommodate this “out-of-sight, out-of-mind,” sentiment, because the industry’s position was safeguarded by these other interest groups. Providers have always fought to preserve a private financing system, and labor and consumers have always joined providers in making this insurance system more extensive.

Now, however, the insurance industry has been forced into the limelight of national policy debate. The public perception that the industry is to blame for the steeply rising costs of health insurance forces the industry to take an opposing position to providers, and national health insurance has served as the wedge between it and traditional labor interests. This political dynamic has prompted the industry to take an independent stance, for it must identify the provider community as the fundamental source of cost escalation, and its very existence depends on defeating the most radical reform measures.

Nor is the industry at ease with more moderate liberal solutions such as an employer mandate or a play-or-pay requirement. A mandate for employers to purchase insurance could not work unless insurance were more affordable. Employer mandate proposals usually call for flat community rating (unadjusted for age and sex), which both commercial insurers and Blue Cross oppose. Insurers are concerned that community rating in a market of many competing carriers will randomly produce winners and losers according to which companies happen to have relatively older, sicker subscribers.1 Flat community rating may arbitrarily drive some insurance companies out of business, because a disproportionate share of expensive risks will deny them the pricing flexibility to attract a more balanced cross-section of the market. Ironically, companies like Blue Cross that historically have had more generous enrollment practices would be the most disadvantaged under community rating, because their existing pool already consists of higher-than-average risks.

A play-or-pay option has, in the industry’s view, the additional flaw of creating a slippery slope toward socialized health insurance. For a play-or-pay requirement to be politically feasible, the price of the “pay” option would have to be set well below the actuarial costs of high-risk groups. Insurers fear that the resulting losses in the public program will cause government to set such stringent reimbursement limits that
providers will raise prices for private payers, thereby making the “play” option even less attractive for those who remain. The end point might be a public program that virtually swallows the private market.²

The industry proposes instead to shore up the private insurance market where its erosion is the most serious: among small employee groups. For firms with three to twenty-five full-time employees, insurers propose a three-part solution: (1) guarantee that insurance will be offered and will remain available to any willing purchaser; (2) limit the degree of price variation among purchasers; and (3) allow insurers to spread the costs of their high-risk cases across the industry through a private reinsurance mechanism. Paradoxically, then, the industry prefers to mandate itself, not its customers. The industry’s fundamental motivation is self-preservation, or at least some control over its own destiny. Some reform of the private insurance system is necessary for the system to survive, and the industry is more comfortable with the complex regulatory scheme it proposes than with the more simplistic approaches such as flat community rating contained in other proposals.

**HIAA model for small-group insurance reform.** Details vary slightly among various industry proposals, and they vary greatly among legislative proposals, but the HIAA model serves as a good basis for introductory discussion.³ Guaranteed availability requires insurers that do any business in the small-group market to sell or renew at least a minimum benefits package to any willing purchaser.⁴ Insurers may not exclude any individual within an eligible group; they may not exclude specific health conditions; and they may not extend preexisting condition exclusions beyond twelve months for conditions that manifested themselves within six months of coverage. The second component of this reform proposal constructs a variety of complex rating bands aimed at dampening extreme price increases or variations. Premiums may not increase more than 15 percent above the carrier’s “trend,” defined as the market-driven increase in the least-expensive new business. Moreover, premiums at a moment in time may not vary more than 35 percent above or below the median for groups with similar coverage and demographic characteristics. There are no restrictions, however, on the degree to which different rating bands (defined by age, sex, location, and coverage characteristics) may vary among each other, except that only a 15 percent price variation is allowed based on industry classification. The third component creates a private reinsurance mechanism that allows issuing carriers to cede over their high-risk cases by paying a reinsurance premium set at 150 percent of the market average for an entire group, or 500 percent for a high-risk individual. The issuing carrier remains responsible for servicing the contract and merely receives indemnification

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³ This option is not explained in detail here.
⁴ This is the standard community rating option used in many states.

from the reinsurance pool. Excess losses of the reinsurance pool are spread back onto the insurance industry through a premium tax, perhaps supplemented by general tax revenues.

The Internal Industry Dynamic

These reform proposals were prompted by the rapid disintegration of the private insurance market at its small-group end. Only 36 percent of firms with fewer than twenty-five employees offered their workers health insurance in 1990, as compared with 87 to 99 percent of larger firms. Among employers that do not offer coverage, 98 percent have fewer than twenty-five employees, according to HIAA's employer survey. These dramatic statistics have resulted in part from a recent shift in underwriting practices. Historically, small-group insurance was offered under a modified form of community rating, while larger groups were rated according to their claims experience. Only individual health insurance applicants were medically underwritten (that is, selectively assessed for prospective health risk). Now, however, steeply rising costs of health care and aggressive marketing practices of some commercial carriers have caused virtually all insurers to abandon modified community rating for small groups. Insurers either use experience rating techniques, which due to the law of large numbers produces highly unstable rating practices, or they treat small groups more like individuals.

Various destructive medical underwriting techniques carry different labels. "Tier rating" stratifies small groups according to their members' particular health risks and their industry's claims experience. "Dura-tional rating" offers a low rate at first but then imposes large increases in subsequent years after the predictive effects of the initial medical screening begin to dissipate and workers are no longer under preexisting exclusion periods. These practices have led to allegations that some companies purposefully "cherry pick" only the best risks and "chum" subscribers by "low-balling" in the first year and then refusing or discouraging renewal as claims mount up. Even employee groups that survive these practices are still affected by "job lock," the inability to change jobs without undergoing new, lengthy preexisting exclusion periods.

Larger, established insurers (including Blue Cross) deplored the growing pressure to adopt these practices. They were forced into the bind of either losing significant market share to small, upstart companies or adopting practices that would lead to the destruction of one end of the private health insurance market and would be used to cast the entire market in a negative light. Minor repairs such as "multiple employer trusts" and high-risk pools for uninsurable persons were largely unsuc-
cessful because of regulatory barriers and adverse selection.9

Thus, as early as 1988, when few others realized there was even a problem, industry leaders were convinced of the need for fundamental, structural reform of the small-group market. In fall 1989, HIAA board members, following an earlier resolution, began working on detailed legislation, which was finalized in February 1991. NAIC and Blue Cross also formed study groups to address small-group market reforms. In December 1990, NAIC issued a model legislative package on the rating and renewability components of small-group market reforms, which has received rapid acceptance in the states. Rep. Nancy L. Johnson (R-CT) introduced a federal bill, H.R. 1565, in March 1991 that contains elements of both the HIAA model and the NAIC rating provisions. Blue Cross announced its endorsement of the NAIC rating limits and of the broad confines of guaranteed availability and reinsurance in early 1991. The NAIC completed its legislative package in December 1991 with statutory models for guaranteed issue and reinsurance.

Areas of disagreement. Below the surface of this consensus, however, lies considerable disagreement over the particulars of small-group market reform. The precise structure of the reinsurance mechanism is an especially problematic source of division within the insurance industry. These differences, while technical in appearance, provide an illuminating window into fundamental differences in the philosophy and structure of indemnity, service benefit, and capitated insurance.

For commercial insurers, reinsurance is the most critical component of their reform proposals, for it provides a private market mechanism for the equitable distribution of high-risk cases. In effect, reinsurance is a play-or-pay option for insurers to decide individually whether to keep the premium and assume the risk of a particular subscriber or forgo the premium and pass the risk on to the entire market. Without reinsurance, some companies would disproportionately suffer the full brunt of bad risks beyond the pricing restrictions, with no avenue for relief. Reinsurance also eliminates the need for intensive policing of possible gaming and circumvention tactics. Indeed, the rating limitations themselves may be largely superfluous since, in a competitive market, the reinsurance price will tend to set a natural ceiling on the market price. Thus, for commercial insurers, reinsurance is essential to their acceptance of guaranteed availability and to rating restrictions.

A sharply contrasting view is held by health maintenance organizations (HMOs). The HIAA private reinsurance mechanism does not fit well with the classic, fully integrated HMO model epitomized by Kaiser Permanente. Reinsurance assumes a claims-based, indemnity model of insurance whereby the ceding carrier will seek reimbursement for par-
titular claims from the reinsurance pool. Because some HMOs have no need to maintain fee-for-service pricing structures, it is not clear how they would mesh with this system. Moreover, HMOs view it as unfair that they would be taxed proportionately for the costs of all reinsured claims when their managed care techniques contribute lower-than-average costs to the pool.

Blue Cross takes an intermediate position. Some of its members favor reinsurance, but others who still engage in modified forms of community rating are quite accustomed to bearing their high-risk cases internally and are not as sophisticated at the underwriting analysis necessary to determine prospectively which customers to reinsure. Blue Cross also believes that it is better able to manage high-cost cases through its ability to engage in selective provider contracting and negotiation of fee schedules. Therefore, Blue Cross argues that reinsurance should be voluntary—that is, each company should be allowed to go it alone, neither ceding high risks nor contributing to the marketwide tax assessment.  

Most legislative proposals, including the NAIC models, recognize these competing concerns by allowing for the development of a variety of reinsurance mechanisms and by allowing carriers who traditionally have engaged in community rating with open enrollment to opt out. These competing positions reflect philosophical differences in the fundamental purpose of insurance. Commercial insurers believe that the insurance function is best served if the costs of random risks—those that cannot be predicted accurately—are borne by the individual carrier, while predictable risks either are borne by the policyholder or, where social conditions warrant, are spread across the market as a whole. A prospective, first-dollar reinsurance mechanism is designed to achieve this result. Blue Cross, on the other hand, believes that insurers should accept all risks so that the pooling mechanism of insurance absorbs both predictable and unpredictable costs. The Blues criticize commercial carriers for not wanting to accept any high-risk cases and for using the reinsurance mechanism as a method to continue competing based in part on their skills at risk prediction.  

Despite this internal divergence in perspectives and interests, the insurance industry was able to achieve a remarkable level of consensus. The industry was motivated by the fundamental contradiction in the logic of insurance entailed in practices such as churning and durational rating. These practices violate the basic appeal of private insurance to the public: after an insured person faithfully pays premiums during periods of low claims, protection should not vanish when health problems arise. The industry was also motivated by the increasing attention that the private insurance market was receiving during 1988 in the
deliberations of the Pepper Commission and in response to the calls for employer mandates heard from then Massachusetts Governor (and former Democratic presidential candidate) Michael Dukakis, Sen. Edward Kennedy (D-MA), and Rep. Henry Waxman (D-CA). Industry leaders realized that avoiding simplistic solutions such as flat community rating required a consensus on a detailed and complete regulatory program capable of immediate implementation.

The Economic Theory Of Regulation

It should come as no surprise to students of political economy that the insurance industry’s reform proposals are not motivated solely by altruism. Indeed, some theorists are skeptical that true, disinterested altruism ever exists in any setting. Although Blue Cross has long staked out a higher moral ground and even commercial insurers lay claim to public-spiritedness, the industry itself would be the first to admit its interest in keeping the frayed ends of the private insurance rope from unraveling any further. This perspective on the industry’s call for its own regulation is not based simply on unadorned cynicism. It is consistent with the economic theory of regulation introduced by recently deceased Nobel economist George Stigler. According to Stigler, “As a rule, regulation is acquired by the industry and is designed and operated primarily for its benefit,” as opposed to the idealistic view that regulation is “instituted primarily for the protection and benefit of the public at large.”

Usually, this Stiglerian explanation of the motivation for regulation carries a strong negative connotation. It characterizes regulation as an ordinary economic good that can be bought and sold in the political marketplace, and it suggests a raw abuse of government authority that coopts sovereign power for private ends. In the words of another theorist, “There is essentially a political auction in which the high bidder receives the right to tax the wealth of everyone else.” This Stiglerian framework has been used to mount the most strident attacks on the brand of occupational licensure that proliferates within organized medicine. Similarly, it might be charged here that the insurance industry is promoting regulation for anticompetitive reasons, to suppress price discounting or product enhancement.

But this distrustful view is not always accurate. As a matter of pure theory, it is at least possible for an industry’s self-interest to coincide with the larger public interest. Small-group market reforms may be one such happy case in which the regulatory capture and public interest theories intersect. Both the industry and the public have a strong interest in dampening the worst effects of excessive competition.
reforms are designed to accomplish two important efficiency objectives. First, they move the small-group market back toward the halcyon days of open enrollment and minimal underwriting. Private reinsurance seeks to achieve these goals through an incentive-based approach rather than by imposing laborious regulatory oversight of underwriting techniques such as redlining, tier rating by industry, and churning. Reinsurance diminishes the incentive for companies to surreptitiously screen out bad risks, and the funding mechanism internalizes to the industry as a whole the costs of its continuing medical underwriting practices.

The second efficiency objective of these reforms is to reorient the industry from competition based on risk selection to competition based on risk management. This objective may be the most far-reaching and so merits elaboration. For traditional lines of insurance such as life, fire, liability, and casualty, risk selection—not risk management—is the primary means of competition. More accurate risk selection serves the social objective of imposing on individual subscribers the cost of their own risk-generating activity. This places the risk management incentive with the subscriber, who usually is in the best position to take protective measures. Thus, for traditional lines of insurance, underwriting serves social welfare by inducing subscribers to optimize their risk-avoidance efforts. Health insurance plays a markedly different social function, however. It has assumed more of a financing function for predictable costs than a risk-transference function for unexpected costs. The social goal is payment for care rather than the instrumental goal of signaling costs to subscribers. Therefore, the very activity that enhances social welfare for conventional lines of insurance—more accurate assessment of risks—undermines the social function of health insurance.

Health insurers can best contribute to social welfare, first, by insuring as broadly as possible, and second, by actively managing the risks they insure. Risk management takes the form of policing the costs of care through provider controls imposed collectively on behalf of subscribers. At the same time, some price variability is desirable, since individual subscribers do control their health risks and attendant costs of treatment to some degree. Small-group market reforms attempt to balance these competing objectives by guaranteeing availability, allowing limited price variation, but minimizing underwriting and risk selection in favor of competition based on efficiency in the delivery of medical care.

The Political Viability Of The Reforms In Congress

Given the emerging weight of opinion for incremental reform of the public/private financing system, the most compelling increment on the
private side is the small-group market. In the small-group market, these reforms hold out the prospect of making insurance available to approximately one-quarter of all uninsured persons and possibly twice that number if the reforms are extended to part-time workers. Apart from sheer numbers, these reforms respond to the portion of the uninsured or potentially uninsured that has political clout. Universal access did not become a political obsession until it became an issue for the politically active middle class, not just for the poor. Steep increases in employee cost sharing, the quickly shrinking availability of insurance for employees of small firms, and the concern that coverage will be compromised with a change of jobs have contributed to a much-heightened public awareness of access and cost issues. Small-group market reforms respond directly to the heart of this political constituency. More important, because of the reliance on a private reinsurance mechanism, these “off-budget” reforms are hugely attractive to politicians desperate to do something positive without increasing the budget deficit or increasing taxes. Finally, no major stakeholder is seriously harmed by the reforms. The only voice of discontent comes from those whose preference for more radical reforms might cynically cause them to favor the rapid disintegration of the private insurance market.

However, political forces emanating from the impending presidential election threaten to stall federal adoption of insurance market reforms. At present, the campaign is being defined in terms of competency over domestic affairs. Congressional Democrats would obtain great advantage by passing one of their comprehensive reform packages and forcing President Bush to veto it during the 1992 election campaign. Naturally, the politically astute Republican administration recognizes this risk and is prepared to counter it. The president’s initial response was a stand-alone health insurance reform bill, S. 2732, introduced in May 1992 by Sen. Robert Dole (R-KS). Similar bills have also been introduced by Rep. Nancy Johnson (R-CT), H.R. 1565; by Sen. Dave Durenberger (R-MN), S. 700; and by the entire Republican leadership of the Senate, S. 1936 (sponsored by John Chaffee, R-RI). Small-group market reform has received glowing praise in speeches made by Health and Human Services Secretary Louis W. Sullivan and is a central piece of Bush’s health care reform proposals and in the recommendations of the Advisory Commission on Social Security (chaired by Deborah Steelman).

Thus, small-group market reform would seem to be the perfect Republican cooption of one of the Democrats’ principal domestic policy planks. Democrats confronted with a stand-alone small-group reform bill would be hard pressed to oppose it, given their nearly unanimous endorsement of this component as essential to any reform approach that
continues to rely on private insurance. Rep. Dan Rostenkowski (D-IL), who chairs the powerful House Ways and Means Committee, and Rep. Pete Stark (D-CA), who chairs the Ways and Means Subcommittee on Health, have introduced free-standing small-group reform bills (H.R. 3626 and H.R. 2121) on which hearings have been held. The Senate has already approved a similar bill introduced by Sen. Lloyd Bentsen (D-TX), S. 1872. Thus this issue remains capable of rapid legislative development. However, in view of the highly politicized climate that surrounds any domestic issue legislation, Democrat-controlled committees in the House are not eager to present Bush with an incremental reform measure that he is willing to sign and claim credit for.

**Political Forces In The States**

Meanwhile, at the state level, reform efforts are proceeding at a much faster pace. This is where the insurance industry favors implementation of its proposals. Insurers have deep-seated opposition to federal intervention in all spheres of insurance. They are comfortable with the known scheme of state regulation; they believe state regulators are more responsive to varying local market conditions; and they fear that federal oversight will result in a second layer of regulation rather than displacement of state authority. These fears are particularly acute for health insurance, as the industry observes the level of micromanagement that Congress exerts over Medicare. Insurers are supported in their views by a long legal tradition of federal abstention from insurance matters generally and by the NAIC, whose centralizing role has helped to preserve the viability of multistate regulation of a national industry.

Nevertheless, there is growing congressional sentiment and legislative precedent in favor of federal oversight of insurance regulation, particularly in the health field. Congress broke the ice in 1980 with the Baucus Amendment to the Medicare law, which, as strengthened in 1990, set minimum federal standards that states must meet in regulating the content of Medigap policies. Similar legislation is pending regarding the sale of long-term care insurance, and Rep. John Dingell (D-MI) is inquiring into the very core of insurance regulation: state solvency requirements. Yet even if the federal government were to initiate small-group market reforms, it is highly likely they would do so in a manner that defers to the states. The joint state/federal model pioneered by the Baucus Amendment is contained in some fashion in most of the federal bills that address this issue. This model calls for the federal government to endorse model standards developed by the NAIC, which states are then to implement, possibly by choosing from a list of options.
or by imposing more demanding requirements.

Accordingly, whether or not there is an overt federal role, much of the small-group market reform initiative will be played out at the state level. At the time of this writing, almost half of the states have passed one or more of the basic components of small-group market reform—mostly, some version of the rating bands, but a handful (Connecticut, North Carolina, Oregon, and Vermont) have enacted guaranteed availability and private reinsurance as well, and at least a dozen more are now considering insurance market reform. The political forces at play in the states, therefore, merit at least a brief inquiry.

State-level politics relating to health insurance reform are influenced in some cases by the make-up of the local insurance market. In Connecticut, a Republican state that is the home of the largest commercial health insurers and where Blue Cross has a small market share, the state adopted the HIAA model essentially whole cloth. In contrast, in Vermont, a more liberal state with a dominant Blue Cross plan that still engages in community rating, Blue Cross helped to initiate a mandatory community rating bill in an attempt to require all insurers to play by the same rules. The bill passed despite the opposition of the commercial insurers, although they were able to loosen somewhat the rating restrictions contained in the final enactment, but not as much as they would have liked, and they were able to add a voluntary reinsurance mechanism. A similar scenario is unfolding in New York.

Reform initiatives in other states have been governed by more conventional party politics and therefore serve as microcosms of possible federal scenarios. Oregon, a liberal state, passed a full set of small-group reforms, similar to but more stringent than the HIAA model, as a precursor to an employer mandate scheduled to take effect in 1995. Consistent with the federal Democratic bills, the pricing limits in the Oregon law come very close to flat community rating. California is in a stalemate similar to the present federal logjam. Its Republican governor and Democrat-controlled legislature have been unable to agree on a comprehensive reform package. Democrats there have been pushing for an employer mandate, while Republicans have been countering with industry-sponsored small-group market reforms. The 1992 ballot in California is expected to contain one or more referendum items that may provide a populist resolution to this debate.

The Effects Of Small-Group Reforms

Despite the economic logic and political appeal of small-group market reform, the industry proposals, as now structured, will not enhance
access to health care to the extent the industry would hope. First, these reform proposals reach only full-time employees in groups of up to twenty-five workers. This fails to protect those uninsured workers who are part time, self-employed, or in increasingly larger groups. Second, the industry proposals fail to dampen price variations to the extent that is claimed. In both the HIAA and the NAIC models, as well as the Bentsen, Johnson, and Bush bills, the rating bands are fully adjusted for geographic and demographic characteristics so that no limits exist on variation according to age, sex, and location. Therefore, at the extreme, these reforms could still allow as much as a sixteenfold difference in the rates charged two groups at either end of the possible combinations of risk factors, although these distant outliers might be very rare.

It is a relatively simple matter to make the rating restrictions more severe, as several of the federal bills propose, by moving closer to modified community rating. However, insurers dislike the precedent that would be set if traditional age and sex rating categories were abandoned. Age is highly predictive of risk for both health and life insurance, and unisex rating is a particularly sensitive issue in other lines of insurance such as automobile and life. But insurers almost certainly will have to live with some limits to present a workable reform package. Possibilities include: (1) setting outer limits on the overall allowable variation; (2) limiting the degree of variation that can result from specified component factors, much as the HIAA model currently limits industry factors to a 30 percent spread; or (3) setting the reinsurance price to limit a carrier's exposure for demographic outliers, which would remove the incentive to use widely varying rating factors.

Even then, these reform proposals might still fail to achieve universal access to health care. These reforms do not reach the fundamental social goal of health care financing reform unless most presently uninsured employers given the chance to purchase insurance in fact choose to do so. While some highly publicized cases of insurance denial for small employers may involve chronically ill people desperate to purchase at any reasonable price, this scenario does not appear to characterize the bulk of the working uninsured, whose employers may not be willing to purchase insurance at virtually any price.

Demonstration projects sponsored by The Robert Wood Johnson Foundation over the past several years have shown that small employers have a frustrating degree of resistance to offering even highly subsidized health insurance. Most of the demonstration sites achieved far less than 10 percent penetration of their target markets of previously uninsured small groups, despite subsidies of one-quarter to one-half of market value. Similar results were experienced in two pilot projects in New
York, where an evaluation found that “at most, the proportion of [small, previously uninsured] firms offering insurance increased 3.5 percentage points” despite a 50 percent subsidy. Based on survey information, the evaluators concluded that nearly 60 percent of small-firm owners still would not buy insurance even with a 75 percent price subsidy.31

Worse still, small-group reforms have the prospect of aggravating this entrenched price sensitivity by raising the average market price. Rating bands are a zero-sum game; they do not lower total costs but only redistribute them among groups, making insurance more attractive only to higher-risk groups.32 When their costs are spread back onto the market as a whole, inevitably some low-risk purchasers will be priced out at the margin. Since their withdrawal from the market will raise average prices even more, these reforms conceivably could cause a severe adverse selection spiral that results in many fewer small groups voluntarily purchasing than before.33 Various estimates presented at recent congressional hearings suggest that the initial increase in average market prices may be as high as 10 percent, with some low-risk groups experiencing increases of more than 100 percent under the more tightly set rating restrictions.34 Families USA projects that, under some versions of these reforms, losers may outnumber winners by as many as four to one.35

As politicians begin to understand the complexities of the cross-subsidies inherent in any form of rating restriction, their enthusiasm for these reforms may begin to fade. The political flak scattered by the disintegration of the Medicare Catastrophic Coverage Act serves as a stinging reminder, particularly to House Ways and Means Committee members, to beware of the voter backlash that might result if tighter rating bands were to impose heavy price increases on younger, healthier workers.36 But loosening the bands to avoid this effect creates the dilemma of making insurance less affordable for older or higher-risk groups. Therefore, it may be impossible to move ahead with even this most agreeable of incremental steps apart from more systemic reforms that address the underlying costs of care.

Conclusion

Small-group market reforms are likely to be successful in the short term in achieving the industry’s objectives by suppressing destructive competitive forces, but they are only one piece in a much more complex puzzle that must be solved to achieve society’s long-term objective of universal access and effective cost constraint. In an incrementalist environment geared toward building on the status quo, it is highly likely that substantial insurance market reforms will be enacted over the next year.
or two at either the state or the federal level. These gains will provide the industry with a proactive stance in the national policy debate and will help to preserve a mixed private/public financing system. A well-constructed set of reforms will allow the industry to say that it has done its part by making insurance available to any willing purchaser. However, making insurance available does not equate with making it affordable. Lasting reform will continue to elude us until we can decipher the riddle of health care cost containment.

This Commentary is based on research undertaken while the author was a Robert Wood Johnson Foundation Health Finance Fellow at the Health Insurance Association of America. The opinions and conclusions it contains are solely those of the author.

NOTES


2. S. Zedlewski, G.P. Acs, and C.W. Winterbottom, “Play-or-Pay Employer Mandates: Potential Effects,” Health Affairs (Spring 1992): 62–83. Findings from this study have led some people to label play-or-pay proposals as a back door to nationalized health insurance.


4. A subtle distinction exists between “guaranteed issue,” which would require all insurers to adopt this modified form of open enrollment, and “guaranteed availability,” which would require only the top ten carriers in each state to do so but would encourage others to elect this role. Thus, coverage would always be available, but not every company would necessarily have to issue it, which makes it easier for new insurance companies to enter the market more gradually. The industry supports either version.


10. Blue Cross also advocates “retrospective reinsurance” as an option, meaning that reinsurance would provide stop-loss coverage for groups or individuals that in fact incur very large expenses, rather than prospectively reinsuring those cases that insurers expect will be high cost. The NAIC declined to adopt this option.

11. An excellent discussion of these reinsurance issues is contained in R. Bovbjerg, “Reform of Financing for Health Coverage: What Can Reinsurance Accomplish?” *Inquiry* (forthcoming). A further source of division lies in the choice of a guaranteed-issue requirement versus an assigned-risk mechanism. The latter allows insurers to decline any applicant and then forces each insurer to accept an allocated proportion of declined cases, much as many states handle high-risk auto insurance. HIAA feared that the assigned-risk method would be unpopular with the public by denying a choice among competing insurers, whereas Blue Cross accuses commercial insurers of not wanting to accept any high-cost cases. The NAIC also compromised on this issue by approving guaranteed-issue and assigned-risk alternatives.

12. The HIAA reinsurance proposal is also subject to criticism for minimizing the degree of cost sharing borne by the ceding carrier. HIAA calls for a transfer of the entire risk (less a $5,000 deductible for individuals), to provide the greatest encouragement to accept high-risk cases, but this also removes any incentive to control costs and manage care for the most expensive cases. Therefore, it is highly likely that any enactment of these reforms would include a substantial cost-sharing requirement or a much higher stop-loss threshold. For instance, the NAIC model calls for a $5,000 deductible in all reinsurance cases plus 10 percent cost sharing for the next $50,000 of annual claims.


17. One indication of the coincidence of public and private interest is the currency of political exchange that is required to “purchase” votes to support industry-favored regulation. Typically, one thinks in terms of raw political influence through campaign contributions, but health insurers do not wield the same financial influence as does the insurance industry generally. For instance, HIAA’s political action committee contributes less than $150,000 annually to federal legislators—a substantial but modest amount compared with other strongly influential interest groups such as the American Medical Association (AMA), which contributed over $2 million to federal candidates in the 1990 elections. HIAA and Blue Cross are attempting to influence the political
debate principally by supplying the policy and research community with essential data about the workings of the private insurance system. Thus, the industry has been able to “sell” insurance market reforms with relative ease simply by the force of the policy arguments in their favor. Indeed, these reforms are generating considerable federal interest despite the industry’s efforts to oppose federal usurpation of state enactment.


27. The California electorate is capable of strong activism on insurance regulation, as demonstrated by Proposition 103 of the 1986 election, which rolled back auto insurance rates by 20 percent. However, as this rollback exemplifies, referendum measures tend to be excessively simplistic. The threat that an extreme referendum measure might succeed puts even greater pressure on the affected interest groups to work toward a more acceptable but more complex legislative measure.

28. Most proposals limit the variation between blocks of insurance (defined by type or source of business, such as HMO versus indemnity or field agent-generated versus association-based), but they do not constrain variation within blocks. Thus, even though each block’s midpoint must be within a limited range (20–40 percent) of other blocks’ midpoints, each block is allowed to contain an unlimited number of rating bands arrayed according to demographic classes.


31. However, these findings were likely biased by severe restrictions in eligibility for the program. For instance, the firm owners were precluded from participating and from requiring employees to pay any portion of the premium. K. Thorpe et al., “Reducing the Number of Uninsured by Subsidizing Employment-based Health Insurance,” Journal of the American Medical Association 267 (1992): 945–948.

32. These reforms also increase prices by reducing preexisting exclusion periods and by imposing minimum benefits packages.


35. Statement of J. Waxman, Hearing before the House Ways and Means Subcommittee on Health, 12 March 1992. The HIAA estimates that, using the Rostenkowski rating bands (H.R. 3626), more than twice as many groups would receive a “major” (more than 5 percent) increase as would receive a major decrease. Statement of Richard Helms, Hearing before the House Ways and Means Subcommittee on Health, 12 March 1992.