



Health Insurance

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What are the different types of private health insurance plans?

For the past decade and a half, managed care has become the predominant form of health coverage for some 185 million Americans. This is a sharp increase from 1992, when only about 70 million people were enrolled in managed care.

Twenty years ago, “managed care” referred to a specific plan, a health maintenance organization (HMO) that contracted with employers to provide all care to their enrollees for a prepaid, capitated price (a monthly payment per enrollee regardless of what care the individual actually received). Today, this so-called “closed panel” model is less common, and the definition of managed care has changed to refer to any of several systems that use or give an incentive for using a defined set of providers for a defined population, based on pre-paid premiums, and have some system for controlling care or costs. Table 1 lists some of the various health plans.



| Term | Description |
|---|---|
| Indemnity (Traditional) | Insurance plan reimburses provider chosen by enrollee on a fee-for-service basis. |
| Health Maintenance Organization (HMO) | Any of a variety of health plans that combine financing and delivery of care. Plans contract with a defined group of providers (usually on a capitated basis). |
| Point of Service (POS) | A managed health care plan that encourages subscribers to stay within a network of providers by imposing higher out-of-pocket costs for treatment received outside the approved network. Subscribers are assigned a primary care provider who makes referrals for specialty and inpatient care. |
| Preferred Provider Organization (PPO) | A managed care plan that offers full or high coverage for a defined network of providers (who accept discounted fees) and more limited coverage for care outside the plan. Subscribers can directly access specialty and inpatient care. |
| Health Savings Account/High-Deductible Health Plan (HAS/HDHP) | A tax-free savings account used to pay out-of-pocket health care costs, tied to a health plan with a high deductible. Also referred to as consumer-direct care. |
| Source: National Conference of State Legislatures, 2008; Rexford Santerre and Stephen Neun, <i>Health Economics: Theories, Insights and Industry Studies</i> , Fourth Edition, 2006. | |

In 2007, 91 percent of all covered workers were enrolled in managed-care plans.¹ In the same year, only 3 percent of covered workers were enrolled in traditional indemnity plans, down from 10 percent in 1999. The share of enrollees in consumer-directed plans is increasing. In 2007, 5 percent of covered workers had health savings accounts tied to high-deductible health plans (*See health savings accounts discussion, below*). A significant portion of those enrolled in publicly funded insurance programs also are served through managed care. In 2004, 61 percent of Medicaid enrollees and 11 percent of Medicare enrollees (down from 16 percent in 1999) were insured through managed care plans.

What role do states play in regulating health insurance?

Historically, states have served as the primary regulators of the private health insurance industry. State-licensed health insuring organizations, including for-profit commercial insurers, not-for-profit plans and HMOs, all are regulated under state law. All states also have mandated benefit laws, which require insurers to cover certain benefits or types of providers (*See mandates discussion, below*).

During the 1990s, most states adopted insurance market reforms to improve access to private insurance. State reforms typically required insurers to guarantee the availability of and ability to renew policies, limit preexisting condition exclusions to less than one year and allow portability. Many of these market reforms were incorporated into federal law in 1996, when Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). HIPAA regulates both state-licensed health insuring organizations and ERISA plans. Many large employers choose to self-insure and, therefore, are regulated under ERISA and not by states (*See ERISA discussion, below*).

While HIPAA limits preexisting condition exclusions in the small group market and requires that insurers offer health plans to small employers (with between 2 and 50 employees), it does not address the price of coverage. Most states have set some sort of standard limiting the variation in costs insurers may charge policyholders based on their health status, prior claims or other factors, such as age or gender. The majority of states enforce rate bands, which set the allowable gap between the lowest and highest premium insurers can charge for the same coverage, but the factors excluded from the laws (i.e. medical history,

claims, age) vary from state to state.² Most states have enacted laws restricting the cost of premiums for the small group market and some have issued similar reforms for the individual market.

Community rating is another method states may use to control variation in premium pricing. Under community rating an insurer must charge all policyholders, under one plan, the same amount based on their collective medical history and claims experience. A less strict model, modified or adjusted community rating, allows insurers to charge higher premiums for some individuals based on geographic location or age. Most states have chosen to regulate premiums in the small group market through rate bands, but approximately ten states enforce adjusted community rating.³

What is ERISA and why should it matter to state legislators?

Sooner or later, most state health policymakers will deal with the federal Employee Retirement Income Security Act of 1974 (ERISA). The law primarily deals with pension plans, but it includes a crucial paragraph (Section 514) that limits states' ability to regulate employer-based insurance.

ERISA preempts all state laws "relating to" employer benefit plans (including health plans). However, although a state is not allowed to tell an employer what insurance it must buy, it can tell insurance companies what they are allowed to sell. Finally, ERISA prohibits states from treating self-insured employer plans as insurance. Table 2 shows how ERISA divides jurisdiction.

| Type of Plan | State-Regulated | Federally-Regulated |
|---|-----------------|---------------------|
| Individual coverage, state and local government | X | |
| Insurance policy, "insured plan" | X | |
| Employer policy, "self-insured plan" | | X |
| Employer-purchased plan | X | X |
| Source: National Conference of State Legislatures, 2008. | | |

ERISA figured prominently in the patient protection state legislation campaigns of the early 1990s. More recently, the law has become a factor in state efforts to encourage businesses to provide health benefits to their employees and to help finance public health care coverage programs.

Some lawmakers want to expand access to the uninsured by enacting so-called "play-or-pay" bills. Generally, the bills call for employers to provide coverage to their employees ("play") or to help fund public health insurance programs ("pay").

Maryland's experience with the Fair Share Health Care Fund Act of 2005 demonstrates how ERISA can affect such schemes. Dubbed the "Wal-Mart law"—since the retailer would have been the only company in the state affected—it required employers with more than 10,000 employees to spend at least 8 percent of their payroll on health benefits or to deposit the spending shortfall into a fund for the state health insurance program for the poor.

The law was contested in court by the retail industry's national association. The federal court of appeals ruled that ERISA preempted the law because it would have enabled the state to interfere with the uniform national administration of Wal-Mart's employee benefit plan.⁴

Although ERISA was found to preempt the Maryland law, some policy experts believe that states may legally tax employers to fund public health care programs if that tax has only incidental effects on ERISA plans. In other words, such laws may survive a legal challenge if they do not single out one or more companies that self-fund. In 2006, Massachusetts and Vermont enacted legislation to allow them to collect a tax from employers for each uninsured employee. Two years after passage, neither law has been challenged in court.

How do mandated affect the cost, availability and value of insurance? Do "mandate-light" plans improve coverage?

All states have requirements regarding what must be included in the health plans that insurers sell. These insurance or coverage mandates take several forms.

Some require health plans to cover specific services (e.g., breast reconstruction after mastectomy), treat specific conditions (e.g., mental illness), or pay for particular types of providers (e.g., chiropractors). Others require plans to cover certain groups of people (e.g., job-leavers, pregnant spouses, adopted or dependent children).

Critics claim that mandates increase the cost of insurance and make it unaffordable for marginal purchasers, and that they reduce plan and provider flexibility. Others say the mandates may ultimately hold down costs by ensuring that enrollees receive care as needed rather than in the emergency room.

Although state policymakers continue to introduce benefit mandates, the trend has slowed in recent years. Lawmakers have placed more emphasis on reaching the uninsured and controlling the cost of health insurance premiums.⁵

Some states are deliberating whether offering less expensive, "bare-bones" or "mandate-light" plans will encourage individuals and small businesses—that previously were priced out of coverage—to purchase policies. Under federal law, since 2004 every jurisdiction must allow high-deductible health plans (HDHP), which are exempt from virtually all mandates until the annual deductible of at least \$2,200 for families has been paid. (*See health savings accounts and HDHPs discussion, below*)

As part of its 2006 comprehensive health reform, Massachusetts allowed insurers to offer lower-cost, mandate-light plans to young adults between the ages of 19 and 26—a population that historically has not had coverage. At least 20 states now require some type of mandate review or special study before additional mandates can be enacted.

In other states, some policymakers have begun to use mandate-light provisions less frequently. Ohio legislators introduced a bill that would have permitted mandate-lite plans to be offered to small businesses. The provision was removed after lawmakers reviewed studies that showed the plans were not popular with small businesses and produced minimal cost savings.⁶ More studies are needed to better understand the effects of mandates on both health outcomes and health care costs.

How are states seeking to expand coverage to small businesses? What are insurance connectors?

As the number of uninsured has grown, some analysts have focused on the fact that small businesses are less likely than larger ones to provide health insurance. Coverage for small businesses is more costly for several reasons. Small businesses are riskier to cover because the insurer is less able to spread the costs incurred by a severely ill employee over a large pool of beneficiaries. Small employers also lack the bargaining clout of larger ones, so it may be more difficult for them to obtain lower-cost products.

Pooling insurance purchasing has become a common state strategy to make health insurance affordable for small businesses and individuals. One example, a purchaser coalition, brings together public and private purchasers to gain a greater market share and influence with suppliers.⁷ (*See cost control discussion, below*)

A few states have incorporated health insurance exchanges—insurance connectors—into their health reforms to provide a single marketplace for residents and small businesses to purchase insurance coverage. The Commonwealth Health Insurance Connector, a central concept of Massachusetts' comprehensive 2006 health reform, is a state-created insurance exchange that aims to provide adequate and affordable health coverage options through transparency and competition. These exchanges generate cost-savings by pooling purchasing power and sharing overhead costs. A 2007 Washington law implemented a connector mechanism; in 2008, a handful of other states are considering similar reforms.

Some argue that the role of a health insurance exchange as an insurance marketplace does not go far enough to ensure that health plans are affordable for individuals and small businesses. The Center for Studying Health System Change suggests that perhaps the most important role for the directors of a health insurance exchange is to influence the quality, affordability and availability of health insurance products, rather than to simply act as a forum for the purchase of insurance.⁸

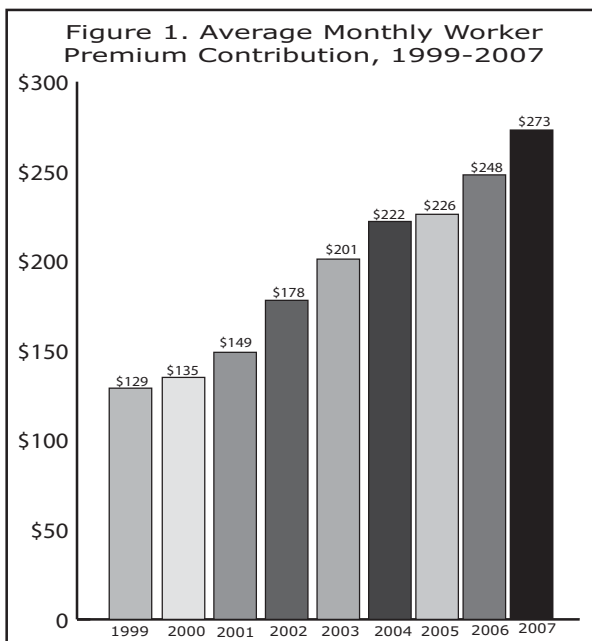
What are disease management and care management? Do they really work? What other techniques can control costs?

In the face of double-digit health care inflation, corporate and government buyers encouraged insurance companies and health care providers to join to form entities that would provide care and keep costs down. This type of tightly focused managed care is credited with stalling health care inflation in the 1990s.

Today, however, insurance premium rate increases are again outpacing inflation, as underlying costs overtake the one-time savings achieved by reorganizing care systems. To reduce these increases, many employers and public health care programs have increased cost-sharing by imposing higher premiums, copayments and/or coinsurance, deductibles and tiered pricing.

In 2006, approximately four of five workers with single coverage contributed to their monthly health insurance premium, and 94 percent of workers contributed to their family coverage premium. The average monthly contribution made by an employee for his or her family health insurance coverage has risen from \$129 a month in 1999 to \$273 a month in 2007 (Figure 1).⁹

Both private and public payors are seeking to control costs and improve care through disease management. This approach to care involves identifying and actively managing the care of patients who have a chronic condition for which treatment likely will be costly. Management may be as intensive as individualized health coaching and support groups for people with similar needs, or may be as “hands off” as occasional written communications about medications.



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2007, www.kff.org/insurance/7672/upload/7693.pdf.

The 2007 Kaiser/Health Research and Educational Trust survey found that, when choosing among different health care cost-savings strategies, employers believed disease management to be most effective. Most employers said that disease management was either very effective or somewhat effective at containing health insurance costs (60 percent of small firms and 82 percent of large firms), and they rated it more highly than other cost-savings measures such as consumer-driven health plans and greater employee cost sharing.

Not surprisingly, a growing number of states are managing chronic care. In 2006, Vermont lawmakers passed the Health Care Affordability Act (H. 861) that, in addition to creating a new insurance program for the uninsured, integrated a comprehensive model of chronic care management. Under the Catamount Health program, a system of early and coordinated

screenings for certain chronic conditions are required, many preventive care or recommended services for chronic conditions are free, and provider reimbursement rates will be adjusted to encourage greater chronic care management.

Although many believe that these programs reduce costs, measuring the actual results has been difficult. Benefits such as improved health, quality of life, workplace or school attendance, and productivity may need to be estimated, in addition to changes in use of health care services. Identification and management of prospective program participants usually are proprietary, which makes it difficult to determine whether good results are due to better management or because healthier patients were selected to participate. Methods to estimate savings—return on investment—for spending on disease management is the subject of Medicare coordinated care demonstrations under the 2003 Medicare Modernization Act.

States are using other techniques to try to control costs. One method is to expand the risk pool by getting more people into coverage. A larger risk pool can mean more predictable costs for a state, and fewer uninsured can lower uncompensated costs. States are also implementing greater value-based purchasing, a practice that aims to improve the quality and cost-effectiveness of care purchased through such activities as tying tiered copayments and premiums to provider quality and performance, establishing pay-for-performance incentives and setting health information technology standards. A handful of states, including Massachusetts, Wisconsin, Washington and Minnesota, have formed public-private purchasing coalitions which adopt common value-based purchasing principles to increase the overall value of care and standardize the demands on suppliers.¹⁰ Several states are also using wellness and prevention programs to drive down future health care costs in both their state employee insurance and Medicaid programs.



What does "medically-uninsurable" mean? What's a high-risk pool?

According to the American Academy of Actuaries, about 5 percent of people in large employer groups generate up to half the total annual medical expenses, and five to 10 in 100,000 can be expected to have costs of more than \$250,000.¹¹ An estimated 1 percent to 3 percent of people who seek insurance have known health conditions that either will or are likely to incur higher costs than an insurer can charge or for which the buyer would be willing to pay. Cancer, hypertension, diabetes and major mental illness are examples of conditions that insurance companies underwrite, that is, take into account when setting insurance rates. The near-elderly are particularly likely to be found medically uninsurable. Although this age group is more likely to be insured than younger workers, a noticeable increase in uninsurance in this group signals a growing gap in coverage for some of the most vulnerable.

Medical underwriting usually is not an issue for people enrolled in large employer or government sponsored groups. It can be a severe problem, however, for small groups and individuals. Insurers commonly require a health history before they will sell coverage. Although federal law prohibits them from refusing to sell to groups based on the members' health, carriers still may charge what they believe to be a fair price and may refuse to sell to individuals. If state law does not prohibit it, insurers can refuse coverage to a company by setting a high premium.

To help this group of "medically uninsurable" individuals, at least 34 states now have a state-sponsored insurance program, often called a medical high-risk pool.¹² The high-risk pool sells insurance to people whose condition is included on a specific list, who have been refused a policy or who have been offered coverage at rates that are a specified multiple of the standard rate. Premiums typically are 1.5 to 2 times higher than those outside the pool, but still are usually less than actual expenses. The remaining expenses are covered from an assessment on insurers, general revenue or other funding sources.

Recent federal policies promote risk pools. The 1996 Health Insurance Portability and Accountability Act (HIPAA) allows states to designate the pools as their mechanism for ensuring that people who lose employer coverage will be able to purchase an individual policy. In 2003, Congress appropriated \$100 million under the Trade Adjustment Act (TAA) to encourage states to create high-risk pools. The TAA included \$20 million for grants of up to \$1 million each for states that start up "qualified high-risk pools," and \$40 million per year for 2003 and 2004 to cover some of the losses in states with qualified pools.

This federal funding program was extended in 2006 through a grant program authorized by the Deficit Reduction Act of 2005 and the State High-Risk Pool Funding Extension Act of 2006. Through 2010, the federal government will appropriate \$75 million annually for existing pools and \$15 million annually to help states start high-risk pools. States that were not operating high-risk pools by the February 2006 program enactment date are eligible for individual seed grants of up to \$1 million. Federal funds for existing pools can be used to cover some of the operating losses states experience and benefits for pool participants, such as premium subsidies. As of January 2007, 190,000 people were insured by high-risk pools, an increase of 37,000 people since 2001.

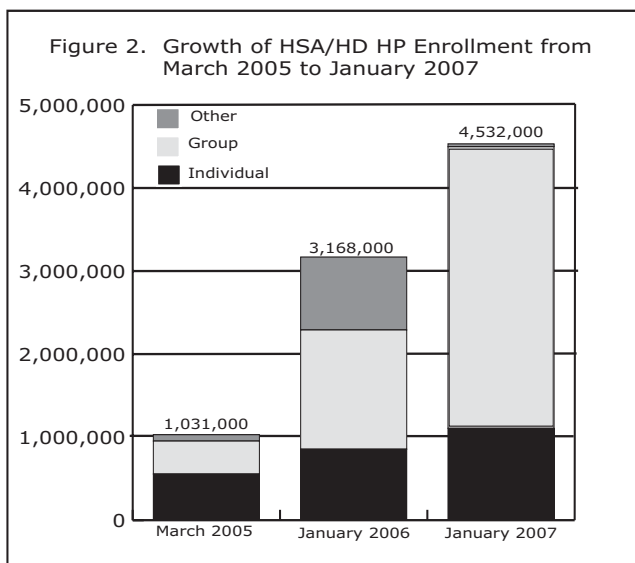
What are the various kinds of health spending accounts? What are the advantages, and what are the risks?

During the past two decades, the federal government, the private sector and states have tested a substantially different form of health insurance: individually owned policies and accounts that are free from federal—and sometimes from state—taxes.

Supporters of individually owned insurance believe that such coverage not only will lead to more responsible health decision making and a more disciplined health-care market, but also will ultimately make care more affordable and available. Critics say that individually owned insurance could undermine the existing employer-based system, and that individuals with such policies may cut back both needed and optional care.

Federal law excludes employer payments for third-party insurance from employees' taxable income, but it has historically taxed any accounts set up by individuals to pay for health care expenses. In 1996, Congress created a pilot program that allowed the self-employed and businesses with fewer than 50 employees to fund tax-free medical savings accounts (MSAs).

Proponents of individually owned coverage said the pilot program was too small to be a real test, and Congress was deadlocked for years on whether to increase the availability of these accounts. In 2003, the Treasury Department defined a fully employer-funded health reimbursement account (HRA). These accounting obligations are not controlled by employees until health expenses are incurred, and they cannot be converted to other uses.



Source: America's Health Insurance Plans, 2007.

also has dramatically increased (Figure 2). In January 2007, there were 4.5 million enrollees, an increase of 3.5 million people from March 2005.¹³ By 2007, 5 percent of all covered employees were enrolled in some type of high deductible or consumer-directed health plan, compared to 3 percent in traditional indemnity plans.¹⁴

The latest incarnation of these plans, created under the Medicare Modernization Act of 2003, is the health savings account (HSA). These can be purchased in any combination by individuals or employers. Account holders must have a high-deductible insurance policy (at least \$1,100 for individuals and \$2,200 for families) that also limits out-of-pocket costs. The individual owns the account and can treat it like other tax-preferred savings accounts.

The HSA share of the market has grown significantly in recent years. In 2003, only 5 percent of large firms offered high-deductible policies; by 2005, however, that number had increased to 20 percent. The number of people enrolled in HSA/high-deductible health plans

Only one state to date has put HSAs at the center of its recent health-care expansion. Indiana enacted a law in April 2006 to expand coverage to many of the state's uninsured by setting up POWER accounts, similar to HSAs, that are funded by both the individual and the state government to pay for medical care. An individual's initial medical costs are covered by the POWER accounts, which hold up to \$1,100; a high-deductible, traditional commercial benefits package covers costs once account funds are depleted.

Questions remain as to whether HSA/high-deductible health plans are cutting costs by reducing unnecessary care or by compelling enrollees, through cost-sharing, to forego necessary care. A UnitedHealth Group study reported that employees enrolled in HSA/high-deductible health plans were more likely to use primary and preventive care examinations than those enrolled in traditional health plans. The same study also found that employer costs for employees enrolled in HSA/high-deductible health plans decreased by nearly 5 percent between 2003 and 2005, compared with the nearly 10 percent increase in costs for those enrolled in traditional health plans. However, an Employee Benefits Research Institute study concluded that enrollees in HSA/high-deductible health plans are more likely to delay or forego necessary care—such as skipping a recommended follow-up appointment or not filling a prescription—than those in traditional health plans.¹⁵

Glossary

Bare-bones plans. Defined basic insurance plans, usually with few mandates.

Capitation, capitated payment. A monthly payment per enrollee, regardless of the amount of care the individual actually receives.

Community rating. The same premium for all, regardless of health or demographics. Modified community rating allows demographic, but not a health, rating.

Disease management. Identifying patients with chronic conditions and actively managing their care.

Drug formularies. Defined list of covered pharmaceuticals.

Experience-rate. Different premiums are charged for different people, depending on their expected costs.

Medical underwriting. Setting premiums based on experience or characteristics of the insured.

MSAs. Medical savings accounts are tax-free savings accounts that allow individuals to carry deductible medical savings forward from year to year.

Pool. Group that shares insurance risks.

Risk selection. Basing the decision to buy coverage on the expectation that care will be needed.

Notes

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Other sources

The Henry J. Kaiser Family Foundation <http://kff.org/>

- StateHealthFacts.org <http://www.statehealthfacts.org/index.jsp>

America's Health Insurance Plans (AHIP) <http://www.ahip.org/>

Health Research and Educational Trust (HRET) <http://www.hret.org/>

Employee Benefits Research Institute (EBRI) <http://www.ebri.org/>

The National Academy for State Health Policy (NASHP) <http://nashp.org/index.cfm>

The Commonwealth Fund <http://www.commonwealthfund.org/>

The National Conference of State Legislatures, Forum for State Health Policy Leadership, Critical Health Areas Project (CHAP) <http://www.ncsl.org/programs/health/forum/chap/index.htm>

The National Conference of State Legislatures - webpage on health insurance and the states
<http://www.ncsl.org/programs/health/healthmc.htm>

Robert Wood Johnson Foundation <http://www.rwjf.org/programareas/programarea.jsp?pid=1132>

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