

The Insurance FIX

We need targeted reforms, not a federal takeover

**BY JAMES C. CAPRETTA &
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EVEN in June, well before those rowdy August town-hall meetings laid to rest all doubt about where the public stands on Obamacare, the administration knew it had a problem. For months the president had been trying to make his case for health-care reform but had mostly offered vague pronouncements about the need to extend insurance coverage and “bend the cost curve.” When the details began coming to light in late spring, and the public got a good look at what the administration and its allies in Congress actually have in mind, the polls showed a decisive and almost instantaneous shift against enactment of anything so sweeping. Americans intuited that what the president was pushing would not lower their costs but would instead saddle them with heavy new taxes and additional government debt, while an extended federal bureaucracy would interfere with what they like about their health care today.

So Team Obama went back to the drawing board—but they didn’t draw up new policies, only a new political game plan. They decided that what was needed was not new ideas but a new marketing catchphrase for the existing ones. And, so, gone for good is “health-care reform.” What Congress is working on this year is “health-insurance reform.”

The president’s speechwriters got the memo and have peppered his recent addresses on health care with the language of insurance reform, which apparently resonates better in focus groups than does talk of “cost curves,” a term that suggests the reduction of benefits rather than their expansion. The reason to pass a health-care bill, the president now says, is to prevent insurance companies from excluding patients with preexisting conditions from coverage and to require them to issue policies to all comers at rates that do not take into account individual health risks.

So far, the change in messaging has not worked. The health-care plans now under consideration in Congress are becoming more unpopular with each passing month despite a full-court public-relations press by Democrats and interest groups allied with them. For good reason, the public is simply not buying the notion that \$1 trillion in new federal spending, massive new taxes, employer mandates, deep cuts in Medicare, an entirely new government-run insurance plan, and federal intrusion into

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the practice of medicine is going to lower their costs and improve the quality of their care.

Moreover, most Americans are satisfied with their current insurance and do not believe a government takeover of all insurance arrangements is needed to eliminate unfair discrimination. And they’re right: It isn’t necessary.

At the same time, Americans have serious misgivings about the operation of some portions of the insurance market, and with some justification. There are cracks in it, and people fall through them—not necessarily through any fault of their own. The precise number of people who do so is not known, but it is certainly far fewer than what is implied by overheated rhetoric. For example, the last definitive survey by the federal government found that less than 1 percent of the total population under age 65 (about 2 million people) had ever been denied insurance because of a medical condition. But most Americans know that this possibility exists, either from direct experience or from anecdotal information, and President Obama is playing upon their fear of it to create pressure for his much more sweeping policy ambitions. If conservatives want to prevent a full and irreversible government takeover of health care, they must address the public’s insecurity with an alternative solution—one that makes it plain that Obamacare is entirely unnecessary.

THE principle informing a sensible insurance-reform bill is straightforward and politically appealing: If Americans remain in continuous coverage in today’s system of voluntary private insurance, they should be guaranteed access to coverage, with premiums that do not unduly penalize them for developing health conditions that raise their risk profiles. This objective is achievable with a few changes in existing insurance laws.

The chief problem with the present system is that health insurance is not truly portable. Workers getting insurance from their employers don’t own their policies—the firms do. So when an employee leaves a company, for whatever reason, he has to switch insurance plans. In the process, he may become vulnerable to coverage exclusions and to spikes in premiums.

A 1996 law called the Health Insurance Portability and Accountability Act (HIPAA) tried to give workers with continuous insurance coverage a measure of protection against these risks. Today, owing to HIPAA, when a worker goes from one job-based plan to another without an extensive lapse in coverage (the cutoff is about two months), a preexisting condition cannot be excluded from the coverage offered; the worker must be given coverage on the same terms as everyone else in the employer group.

But sometimes workers go from group-rated (i.e., employer-owned) policies to the individual health-insurance market, in which policies are sold directly to consumers, not to their employers—for instance, when they lose their jobs, retire early, or join companies that don’t offer insurance. In theory, HIPAA extended portability protections to these workers, too, but its provisions aren’t satisfactory for a number of reasons. This is where most of the cracks need to be filled.

To begin with, many workers moving from group insurance to the individual market end up with no protection at all, because they don’t know about the law’s fine print: In order to have guaranteed access to individual coverage that cannot exclude a



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preexisting condition, workers must first exhaust their right to continuous coverage with their former employer's plan. But paying for insurance in an ex-employer's job-based plan—an arrangement called COBRA coverage, for the federal law that enabled it—is rarely cheap. The premium paid by the former employee must cover the full cost of coverage, including the share that the employer used to pay, and workers insured through COBRA also lose access to certain tax preferences. (This year's stimulus legislation provided more generous terms for some recipients of COBRA coverage, but for only a limited time.) Additionally, employer-based plans usually are quite comprehensive, and therefore costly, with premiums often amounting to more than the ex-employee will be willing or able to pay, particularly if he has become unemployed. Many people therefore inadvertently waive their HIPAA rights by declining COBRA coverage; then, when they try to buy policies on the individual market, they discover that they are vulnerable to exclusions based on preexisting conditions.

Even if workers satisfy HIPAA's continuous-coverage requirement, the law gives them no relief from the premiums they face in the individual market. Many states impose some form of rating restriction (price controls on premiums) and guarantee access to at least two choices of policy in the individual market; but in most states, insurers are allowed to "underwrite" new entrants into the individual market, meaning that they can demand a health screening and take particular risks into account when calculating the premium they will charge. So a family with a child suffering from a chronic ailment may suddenly find itself facing premiums several times the average simply because it has moved from a job-based to an individual plan.

Likewise, HIPAA provides no premium protections for persons moving between individual insurance policies. A healthy worker who leaves an employer plan for the individual market could probably find an affordable plan—but if he ever wanted to switch insurers, he would face the prospect of having his premium recalculated based on a new assessment of his health status. If he should become seriously ill while enrolled in an individual plan, he cannot be reassigned to a different risk category so long as he remains with the same insurer. But he loses that protection if he changes insurers—which he might be forced to do if, for instance, he moves to a new state. In effect, the existing rules lock many people into plans—and therefore employment and living situations—they might otherwise wish to leave.

TARGETED changes are in order here, not a trillion-dollar government takeover of the health-care industry. The appropriate changes are reasonably straightforward.

First, workers leaving job-based plans for the individual market should be able to do so without being penalized for failing to exhaust their COBRA rights. Any such worker should be protected from having coverage denied based on a preexisting condition.

Second, the premiums insurers may charge customers moving from the group market to the individual market should be limited to no more than 1.5 times the standard rate. That means insurers could take higher health risks into account when calculating premiums, but the maximum rate would be no more than 50 percent above what is charged to customers without unusual risk factors. (States should be permitted to continue to allow premium differentials above this limit based on geographic and demographic factors, including age.)

It is inevitable that some entrants into the individual market will have ailments that are more costly than what can be covered under the premium ceiling. Who will cover the excess costs? Most congressional Democrats' preferred solution is to use coverage mandates and price controls to legislate higher premiums for the healthy. In a voluntary marketplace, this would be entirely self-defeating. Every state that has tried it has seen an exodus of healthy people out of the insurance market, which pushes up the average costs for all who remain. Hence the Democrats' push for an "individual mandate"—an insurance market you can never leave—and for tighter insurance-rating restrictions. The bottom line is that this approach would force healthy people to pay higher prices for a limited menu of government-approved insurance plans.

A better alternative, and one much less disruptive to current policyholders, would be to provide adequate and sustainable funding of high-risk pools. Today, most—but not all—states have subsidized high-risk pools that are intended to reduce premiums in the

individual marketplace for people with expensive preexisting conditions. They are the most common way for states to comply with HIPAA's requirement that workers leaving group plans have access to the individual market.

Unfortunately, these pools haven't worked well, largely because they have invited a mismatch between funding and demand. State and federal subsidies for high-risk pools have been meager relative to the size of the problem they are intended to address, and insurers have been able to steer applicants toward the pools with impunity. Politicians tend to prefer rate restrictions and hidden subsidies to more transparent and straight-forward funding for high-risk pools, because the former measures are off-budget and seemingly costless to taxpayers. In truth, that approach backfires, imposing heavy burdens on a very narrow base of private purchasers in the individual market.

There should be substantial new federal funding for these high-risk pools—but also new operating rules. If an applicant's health status argues for a premium higher than 1.5 times the standard rate, insurers should be able to apply for a high-risk-pool subsidy. The job of determining eligibility for the subsidy should be contracted out to a neutral third party with experience in medical-insurance underwriting. If that party, based on mutually agreed-upon underwriting criteria, finds no basis for designating

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the applicant an unusually high risk, the insurer making the application would be required to take the applicant at no more than the maximum rate of 1.5 times the standard premium.

New funding for high-risk pools could come from a number of federal and state sources, including a reduction in payments made to hospitals for care provided to the uninsured and a penalty on individual-market insurers that forward too many unqualified risks to the high-risk pool.

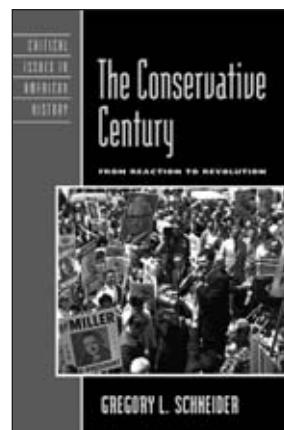
The third necessary change is a requirement that insurers participating in the individual market offer coverage without a new risk assessment to anyone who has a current individual policy in the state. This would mean that market entrants would face a risk evaluation only once and then would have the right to policy renewal at their rate class from any licensed insurer in the state.

FINALLY, there is the question of the uninsured. The intent of the proposals we have outlined is to establish strong protections for those who remain in continuous coverage, but there ought to be an opportunity for those outside of the system to opt back in based on the new protections they would gain. The risk of moral hazard requires that it be a one-time offer. Moreover, these uninsured applicants would have to face some sort of health evaluation, because of their high expected costs. One approach would be to allow premiums for this group to go as high as twice the standard rate before an insurer could apply for high-risk funding.

Of course, many of the problems in the insurance market, including the problem that many persons who wish to be insured are not, would be greatly diminished if we ended the current preferential tax treatment for employer-based insurance and instead offered a tax credit for the purchase of individual insurance. But even absent such a reform, we can provide more insurance security, and we need not authorize a federal takeover of the health-insurance market in the process. Most Americans want health insurance and will secure it, given the right incentives. The targeted changes described here would help many more of them do so—without punishing everyone else.

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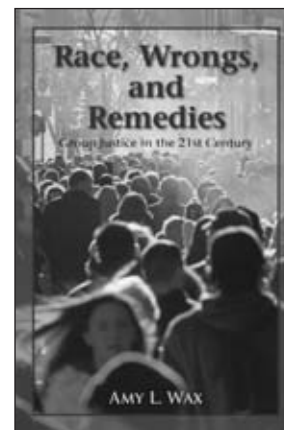


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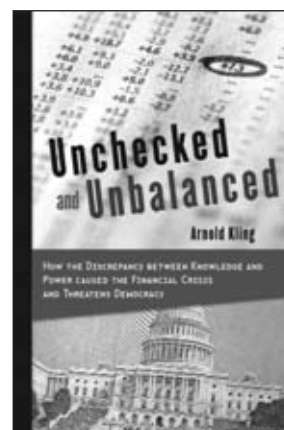
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