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HEALTH POLICY ISSUE:

Should Healthy People Pay More For Health Insurance?

"President Bush's goal: people who are sick should be able to buy health insurance for the same price as people who are healthy."

As part of his new health care plan, President Bush announced his goal for health insurance reform: sick people should be able to obtain health insurance for the same price as healthy people.[1]

The Bush Proposal. According to the President's proposal, no employer or insurance company should be able to deny coverage or charge a higher premium to people who have expensive-to-treat illnesses. Thus:

- A person with AIDS should be able to purchase health insurance for the same price as someone who does not have AIDS.
- People in hospital cancer wards should be able to buy health insurance for the same price as people who do not have cancer.

To one degree or another, this belief is shared by many large health insurance companies and various trade associations and activist groups. The idea is incorporated in plans for small group health insurance reform by both Republicans and Democrats in Congress.

Paying for the Proposal. The cost of providing health coverage for someone who already has AIDS is obviously much higher than for someone who does not. How would this higher cost be paid? One way would be to use taxpayer dollars to subsidize health insurance premiums for sick people through a government program. But this is not what the President has in mind.

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The Bush proposal would require insurers to subsidize the cost of health insurance for the ill by charging higher premiums to the well. Thus people who do not have AIDS would be forced to pay higher premiums so that people who already have AIDS could pay lower premiums.

This may sound like a great deal for sick people. But what about those who are healthy? Their premiums would skyrocket. Insurers would be forced to charge the healthy a premium sufficient to cover the real cost of their own health insurance plus an additional amount to cover the medical bills of newly insured people who are ill.

Applying the Concept to Life Insurance. One way to appreciate how radical this reform would be is to imagine applying the same concept to life insurance. Suppose people could buy life insurance for a family member who was terminally ill. Clearly, there would be a huge demand for life insurance among the families of people on death's doorstep. If people could buy life insurance for the same price regardless of how sick they are, there would be no reason for the healthy to buy it. Life insurance premiums would soar. And since the premium for a $1 million death benefit for someone about to die would be $1 million, real life insurance as we know it would cease to exist.

"Why buy health insurance while you are healthy if you can buy it for the same price after you get sick?"

Similarly, if you knew you could buy health insurance after you became sick for the same price charged to the healthy, there would be no reason to purchase it while you were healthy. Only sick people would buy it and premiums would be exorbitant.

The Bush Plan: Would Any Healthy People Buy Health Insurance?

On the positive side, the President's proposal would give tax deductions and tax credits to families who purchase their own health insurance.[2] Since the tax law currently subsidizes employer-provided health insurance, this is a reform that is long overdue on grounds of fairness alone.

On the negative side, the President's health insurance reforms would more than wipe out any advantage the tax incentives create for moderate-income families. For a family in the 15 percent income tax bracket, a tax deduction lowers the price of health insurance by 15 percent. But the proposed one-price-for-all rule would cause premiums to increase by much more than 15 percent.

The laws of economics apply here. People who are undercharged tend to buy more of something. People who are overcharged tend to buy less. And as more healthy people drop out of an insurance pool, the premium charged to those who remain must continue to rise.

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The Effects of Price Controls. Figure I illustrates what can happen when government regulations prevent risk from being priced accurately. In this example, 20 people who are known to have expensive-to-treat illnesses are allowed to enter an insurance pool for the same premium charged to 1,000 people already in the pool.

"The Bush plan would exacerbate the nation's most pressing health policy problems: rising insurance costs and an increasing number of uninsured."

Because health care costs for each of the 20 newly insured, high-risk individuals are $5,850 greater than the premiums they pay,[3] the premium must be immediately increased by 6 percent for all policyholders. Because of this increase, some of the healthiest people begin to drop their coverage. (One percent are assumed to drop coverage for every one percent increase in premiums.)

As healthy people drop their coverage, they reduce income to the pool but have little effect on the pool's health care costs. As a result, each time a healthy person drops out, premiums must be increased again. In this case:

- After seven adjustment periods, health insurance premiums have increased by more than 60 percent.
- Because of these premium increases, more than one-fourth of all policyholders have dropped their coverage.

Although this is only a hypothetical example, it illustrates some consequences of the vast majority of "reform" proposals. In almost every case they would exacerbate the nation's two most pressing health policy problems: rising health insurance costs and a rising number of uninsured.

"Under the Bush plan, people could become insured as they enter a hospital and drop coverage as they leave."

Particulars of the Bush Plan. George Bush is not the first person to propose charging the healthy and the sick the same premium for health insurance. "Community rating" is about to be implemented in Vermont and variations on that idea are under consideration in a dozen states. The only important difference among the proposals is the ease with which sick people can enter a pool and healthy people can leave.

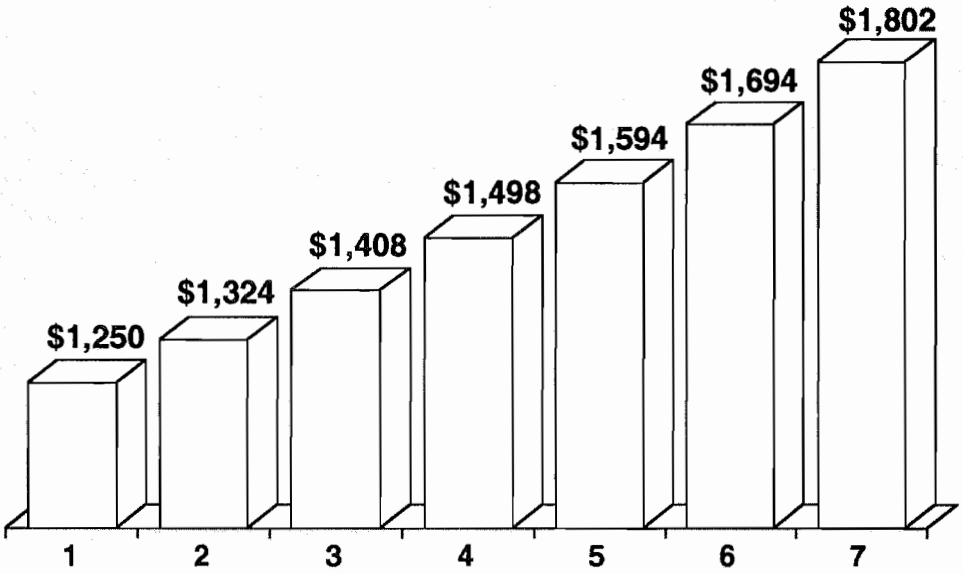
Most proposals give healthy people at least some incentives to buy health insurance. For example, a typical provision is that preexisting conditions are not covered until after a 12-month waiting period. Thus someone who purchases insurance *after* an illness occurs risks 12 months of medical bills before the insurer starts paying the tab. The Bush proposal, by contrast, has no waiting period.

Page 22 of the President's "white paper" on health policy proposes that hospitals be able to get patients insured the moment they enter the emergency room. Uninsured people would face no financial risk. They could get insurance coverage as they enter a hospital and drop it as they leave.[4]

"As sick people enter the pool and healthy people leave, premiums increase by more than 60 percent."

FIGURE IA

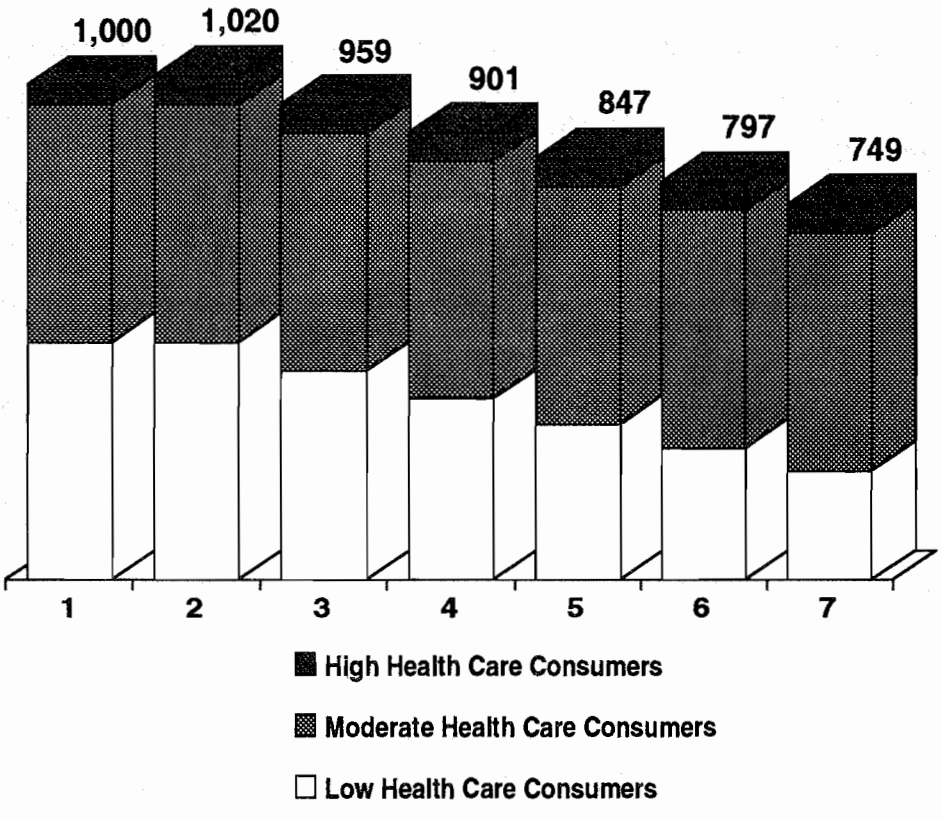
Premiums Increase As Healthy People Drop Out



"The attempt to insure 20 additional people causes 271 people to become uninsured."

FIGURE IB

Number of People Insured



Other Reform Proposals

Although the Bush health insurance reform proposal is by far the most radical of those under serious consideration, there are many other proposals that would also impose price controls and force insurers to charge higher premiums to healthy people.

- A bipartisan bill introduced by Lloyd Bentsen (D-TX) and Dave Durenberger (R-MN) would force insurers to sell to all small groups and cover all employee medical bills after a waiting period (for preexisting illnesses) of only six months.[5]

- A similar approach has been adopted by House Ways and Means Committee Chairman Dan Rostenkowski (D-IL)[6] and by John Chafee (R-RI) and other Senate Republicans.[7]

- Even the health insurance industry has proposed sell-to-all-comers legislation, including proposals by the Health Insurance Association of America (HIAA) — a trade group which represents many commercial insurers — and the National Association of Insurance Commissioners (NAIC), which often sees eye-to-eye with the industry it regulates.

"Many other proposals would impose price controls — forcing insurers to charge higher premiums to healthy people."

Short-Run Cost Estimates. For small group health insurance reform (which does not include individual and family policies), here are some estimates of the likely increase in premiums:

- The HIAA estimates that its proposed small group reform would raise premiums by 2.5 percent to 4.0 percent, but this estimate makes unrealistically low assumptions about the numbers of sick people who would buy health insurance and the number of healthy people who would drop their coverage.[8]

- Community Mutual (a Blue Cross/Blue Shield company) estimates that the HIAA plan would increase premiums by 20 to 25 percent.[9]

- Tillinghast estimates that a similar plan in the state of Ohio would increase premiums by 11 to 47 percent.[10]

- And Golden Rule Insurance Company's actual experience was that "guaranteed issue" policies led to an increase in claims costs of over 50 percent in the second year and 30 to 35 percent thereafter.[11]

Long-Run Effects. The estimates described above do not consider the ways in which healthy people will seek and find lower-priced policies in the long run.[12] Nor do they consider the problems that will be created when artificial prices cause some insurers to be overloaded with sick people who incur large costs. Initial reforms will invariably lead to demands for further reform.

"Should your insurance premium include the cost of other people's current medical bills?"

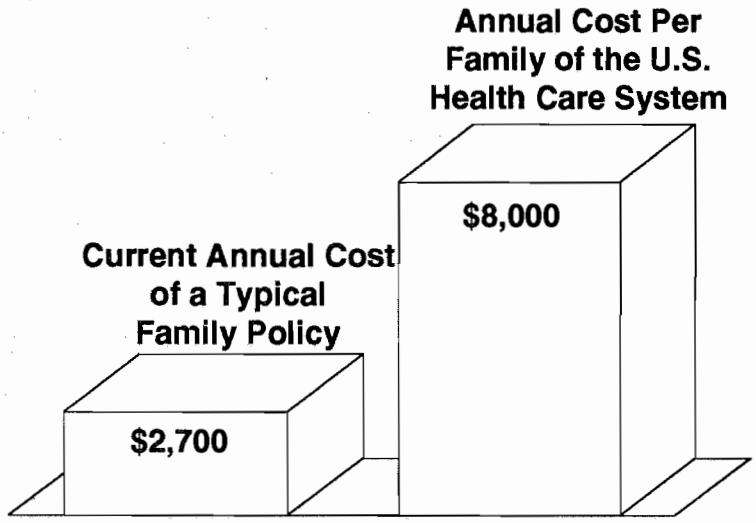
In order to appreciate where the reform process might lead us, consider that it would require healthy people who buy health insurance to bear two different costs: (1) the cost of their own health insurance and (2) the cost of medical bills for others who are already sick. Once the principle is accepted, the logical end-result is a system in which each family's insurance premium reflects that family's share of the whole nation's annual health care costs (including the cost of Medicare, Medicaid and public health programs).[13] As Figure II shows:

- A typical family living in a city with average health care costs can buy a health insurance policy today for about $2,700.
- If that policy included the family's share of the cost of the entire health care system, however, the premium would be $8,000.
- If an $8,000 premium caused half the families in America to decide not to buy health insurance, the premium for the remaining half would be $16,000 — almost 40 percent of the average family's income.

"A typical family's share of everyone's current medical bills is $8,000."

FIGURE II

What if Health Insurance Premiums Included the Cost of Other People's Medical Bills?



Source: Cost of a typical family policy in a city with average health care costs: Golden Rule Insurance Company. Cost per family of the U.S. health care system: C. Eugene Steuerle, "Finance-based Reform: The Search for an Adaptable Health Policy." Paper presented to the American Enterprise Institute Conference on American Health Policy, Washington, DC, October 3-4, 1991. All figures are for 1992.

What's Wrong With Charging Healthy People More For Health Insurance?

When people who do not have health insurance become sick and generate large medical bills, they frequently cannot pay those bills from their own resources. Yet because we generally require hospitals to provide health care to people regardless of ability to pay, a social problem is created. Who should pay the costs of uncompensated care?

The obvious answer is to pay for it with public funds, placing the ultimate burden on taxpayers. But rather than raise taxes to pay for what clearly is a social problem, many proponents of reform want to raise health insurance premiums instead. What's wrong with that?

"Rather than raise taxes to pay for a social problem, politicians want to raise health insurance premiums instead."

Imposing a Regressive, Hidden Tax. By forcing insurance companies to pay the medical bills of people who are already sick, politicians would be indirectly shifting the cost (through premium increases) to healthy people who buy health insurance. In so doing, they would be imposing a hidden tax on unsuspecting families. It is a tax which is highly regressive. Whereas the income tax system is designed so that higher-income families pay higher tax rates, many health insurance reform proposals would impose the highest hidden tax rates on the lowest-income families. For example:

- If health insurance reform causes the premiums for family policies to rise by $1,000, that's a 10 percent tax on a family with a $10,000 annual income but only a 1 percent tax on a family with $100,000 in annual income.

- Thus the tax rate on a family with a $10,000 annual income would be ten times as high as the rate for a $100,000-a-year family. [See Figure III.]

Increasing the Number of People Without Health Insurance. Contrary to widespread impressions, most of the 33 to 34 million people who are currently uninsured are healthy, not sick. Sixty percent of the uninsured are under 30 years of age and in the healthiest population age groups.[14] They have below-average incomes and few assets. As a result, they tend to be very sensitive to premium prices.

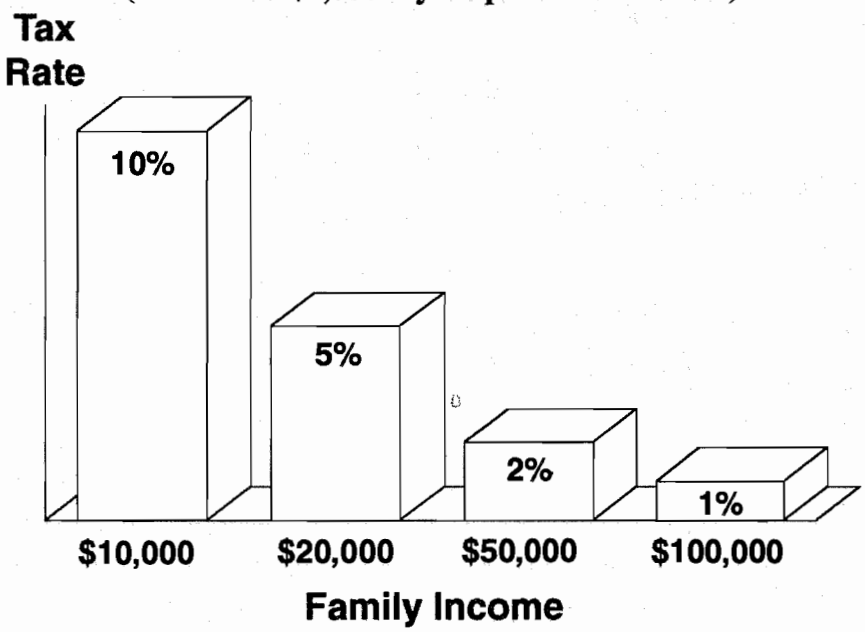
Moreover, the primary reason why most of the uninsured lack health coverage is that they have judged the price too high relative to the benefits. Very few have been denied coverage.

"Most reform proposals would impose a hidden tax — with the highest rates paid by the lowest-income families."

FIGURE III

The Hidden Tax Created by Health Insurance Reform

(Based on a $1,000-a-year premium increase)



- According to one estimate, only 1 percent of Americans under the age of 65 are "uninsurable."[15]

- And according to an HIAA survey among employers who do not provide insurance to their employees, 86 percent cite high costs as the reason.[16]

The artificial premium increases that would result from many health insurance reform proposals would substantially increase the number of employers who fail to provide coverage for their employees and the number of individuals who are uninsured by choice.

Subsidies vs. Price Controls. The worse feature of the Bush plan and other price control solutions is that they cause enormous harm in order to accomplish a small amount of good. A much better approach would be to tackle the problems of sick people directly and allow healthy people to buy real health insurance. For example:

- In Figure I, the attempt to subsidize the medical bills of 20 people led to a 60 percent price increase for 1,000 people and caused 271 people to become uninsured.

- Those negative consequences could be completely avoided by directly subsidizing the medical bills of the 20 sick people through a government program.

Medical Bills for the Sick: Small Numbers, Big Costs

Under most insurance contracts, a few policyholders generate most of the claims. For example, only small numbers of people with life insurance policies die each year, but they account for almost all life insurance company payments. Similarly, in health insurance:

- The experience of most large groups is that 4 percent of insured people account for about 50 percent of all insurance claims costs.
- If this relationship holds for the nation as a whole, it means that 4 percent of the population will generate an estimated $324 billion in personal health care costs in 1992.[17]

This is one reason why it is so important to encourage a healthy insurance marketplace in which risk is priced accurately. In an ideal system, people would buy health insurance before they got sick, and the premium paid by each would reflect the probability that the person would generate a large claim. In such a system, insurers would collect enough in premiums to pay claims as they came due.

If risk is not priced accurately, however, the potential for enormous instability is created. If sick people could pay artificially low prices for health insurance after they became sick, in theory 4 percent of the population could immediately dump $324 billion in costs on insurers — more than enough to bankrupt the entire private insurance industry.[18]

The Language of Reform

"Reformers often try to disguise the fact that their real goal is price controls."

The goal of President Bush's health insurance reform proposal is to force healthy people to pay higher premiums in order to subsidize the medical expenses of less healthy people. Since most people would not voluntarily pay higher premiums, the President's proposal would create an elaborate price-fixing scheme — designed to prevent insurers from charging healthy people fair prices.

This goal is not clearly stated in the White House health policy position paper, however. Nor is it clearly stated in similar reform proposals. Instead, the advocates of price control talk of "pools," "medical underwriting" and the like. But, as Table I shows, such industry jargon bears little relationship to real problems and real solutions.

Do We Need Larger Insurance Pools? An argument often made by price control advocates is that insurance cannot work unless people are placed in large pools. What they often neglect to say is that everyone who has health insurance is already in a large pool. Large insurance companies automatically group policyholders with other policyholders around the country. Most small companies reinsure in a larger, national market.

"Most 'reform' proposals are designed to prevent insurers from charging low prices to healthy people."

President Bush's proposal would not lead to larger pools. In fact, it might lead to smaller ones (e.g., as states are encouraged to create self-contained pools). The Bush reform proposal would regulate the *price of entry* into the pool and the *price of remaining* in the pool. The proposal is not really about pools, it's about prices.

What's Wrong With Medical Underwriting? As in the case of life insurance and property and casualty insurance, most health insurers try to base the premiums they charge on the likelihood of future claims. Thus, less-healthy people can expect to pay higher premiums or face exclusions and riders.[19] In this respect, the health insurance market is no different from any other insurance market. To the extent that underwriting is successful, it leads to the more accurate pricing of risk; which leads to lower and more stable prices; which leads to more insured people; which leads to less uncompensated care; which leads to still lower prices, etc.

Many advocates of reform, however, view the accurate pricing of risk as a *problem* rather than a *solution*. In their view, the social purpose of medical insurance is to pay medical bills rather than to price and manage risk.

TABLE I

The Language of Reform

REFORMERS' ASSERTIONS	REALITY
"In order for insurance to work, people need to be combined into large pools."	**Almost all insured people are already combined into large pools.**
"Some insurers try to take all the good risks, leaving others with the bad ones."	**If insurance is priced accurately, "good" risks are no more profitable than "bad" ones.**
"Medical underwriting (basing premiums on the health condition of potential policyholders) is destabilizing the market."	**There is no evidence that the accurate pricing of risk causes instability. There is a lot of evidence that the failure to price risk accurately causes instability.**
"Competition among insurers should be based on skills at managed care, not on skills at guessing who will become sick."	**Predicting the likelihood of claims and pricing based on those predictions is what the business of insurance is all about. Managing expenses is a different business — one that does not necessarily require insurance companies.**

One frequent argument is that underwriting is destabilizing because some companies try to take all of the "good" risks, leaving other companies with all of the "bad" ones. If risk is priced accurately, however, a good risk is no more profitable than a bad one. Lloyds of London has prospered for more than 100 years insuring risks that other insurers avoided.

Moreover, there is nothing in economic theory and no historical evidence to support the contention that markets in which risk is priced accurately are unstable. To the contrary, both theory and evidence demonstrate that instability is created when risk is not priced accurately.

Managing Care vs. Insuring Risks. Many large health insurers are no longer in the health insurance business. Since they focus on processing claims and helping large employers to manage their health care expenses, they are actually in the *managed care* business. But their choice to specialize in managed care does not mean that all other insurers should do the same.

Managed care is a market with many competitors, and one that does not require a background in traditional insurance. No matter how this market develops, however, there will still be a need for insurance companies to price and manage risk.

Two Visions of Health Insurance

Behind the debate over health insurance reform are two competing visions of the social role of health insurance.[20] The following is a brief summary.

"In a competitive insurance market, there is a natural tendency to price risk accurately."

Health Insurance as Real Insurance. The purpose of real insurance is to protect a person's assets against the cost of a risky event. Individuals must decide to what extent they wish to self-insure (bear the risk personally) rather than to buy insurance (and transfer the risk to someone else). They are able to make good decisions only to the extent that risk is priced accurately. If insurance is underpriced, they will over-insure. If it is overpriced, they will under-insure.

Health Insurance As Prepayment for the Consumption of Medical Care. For most of the post-World War II period, the health insurance market has been dominated by a different idea. In this view, health insurance need not involve a risky event. Instead, it exists to pay for the consumption decisions of policyholders in the medical marketplace. If people consume more (e.g., see doctors more often), premiums must be raised to cover the increased costs. Viewed in this way, health insurance is not real insurance; it is prepayment for the consumption of medical care.

The view that health insurance should be prepayment for the consumption of medical care explains why health insurance, unlike most other types of insurance, usually pays for expenses that have nothing to do with a risky event (e.g., checkups, diagnostic tests, etc.) In general, each policyholder is free to spend other people's money in a market that is continually creating new options for buyers. Indeed, *the primary reason health care costs are soaring in the United States is that, to a large extent, health insurance has become prepayment for the consumption decisions of policyholders.*[21]

How Should Health Insurance Be Priced To New Buyers?

The two different visions of the social role of health insurance lead to two different answers to this question.

Competitive Markets. If the health insurance marketplace is competitive, there will be a natural tendency to price risk accurately. Different people will pay different premiums depending upon the likelihood that they will incur claims. Policies sold to individuals will be combined with other policies in a larger market. The price charged to a specific buyer will reflect the risk that individual adds to the large pool.

Currently, the cost of insuring a 60-year-old male is about four times that for a 25-year-old male. The likely cost of insuring someone living in Los Angeles is about four times that of someone living in Vermont. In competitive markets, premium prices would reflect these expected costs. Buyers would each pay for what they get.

"Under community rating, there is no relationship between individual premiums and health insurance risks."

Pure Community Rating. At the other end of the spectrum is a pricing system called "community rating." Under this system, once practiced by many Blue Cross/Blue Shield plans, everyone is charged the same premium — regardless of age, type of work, medical history or any other indicator of health risk. Since the price charged must reflect the average cost, combining the sick with the healthy, under community rating the ill are undercharged and the well are overcharged.

Community rating cannot work in a normal marketplace. It can be sustained only by the force of law or in markets where there is a single, monopoly insurer. In the days when Blue Cross practiced community rating, it had a monopolistic position. When commercial insurers entered the market, they succeeded by charging healthier people lower premiums. Blue Cross had to either abandon its pricing policies or be left with only sick policyholders.

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Today, community rating exists only where it is mandated by law and within the confines of large companies.[22]

Mixed Systems. Most of the proposals discussed here do not try to implement pure community rating. They do try to push the market in that direction, however. In one way or another:

- Virtually all of these proposals are designed to prevent insurers from charging lower prices to healthy people.
- The focus of these proposals is on paying the bills of people who are already sick, not on making real insurance available to healthy people for actuarially fair prices.

How Should Health Insurance Be Priced To Current Policyholders?

Some of the most troublesome problems in the health insurance industry relate to the experience of policyholders who become sick. To appreciate why these problems arise, it is helpful to once again compare health insurance with life insurance.

"There would be fewer problems if health insurance functioned like life insurance."

Life Insurance Successes. Most life insurance contracts are guaranteed renewable. This means that the insurer cannot cancel the policy after a person has a life-threatening illness. Terminally ill people, for example, have the right to continue paying premiums, often at guaranteed rates. In addition, there are usually limits on how much the premiums can rise in future years, and the insurers cannot increase the premium for one policyholder without increasing the premium by the same amount for everyone else who holds that same type of policy.

Health Insurance Failures. Not long ago, the health insurance marketplace functioned in a similar manner. Policies that were guaranteed renewable were common. Insurers could not cancel coverage simply because a policyholder became sick, and a premium increase for one had to be matched by increases for all others.

There is some evidence that state regulation is responsible for the virtual disappearance of guaranteed renewable policies in the market for individual and family policies. Even bigger problems have arisen in the market for small group coverage, for a different reason.

The Source of Failure: Insurance as Prepayment for the Consumption of Health Care. For all practical purposes, large companies have not been able to purchase real health insurance for years. Under a common arrangement, this

year's premiums equal last year's health care costs. What the employer pays in premiums must equal whatever the employees consume in the medical marketplace.

When insurers try to force this philosophy on small businesses, however, havoc results. Many small employers are shocked to learn that after an employee incurs an expensive-to-treat illness, the insurer can cancel the policy or raise the rates without limit. Thus insurers can change the rules of the game unilaterally, *after* the risky event has occurred.

The insurers argue that, as in the case of a large company, an employer's premiums must be increased to pay the employees' medical expenses. The employer reasonably asks, "If our premiums have to equal our medical costs, what's the purpose of buying insurance?"

Real Problems, Real Solutions

"In order for people to make good decisions about the purchase of health insurance, risk must be priced accurately."

There are real problems in the health insurance industry. These problems arise because the traditional insurance philosophy has been abandoned. To solve the problems, legislation is probably needed. But a workable solution must be one which encourages a competitive market for real insurance — one in which risk is accurately priced.

Solutions must be found for the problems of four separate groups of people: (1) healthy people who choose not to buy health insurance, (2) unhealthy people who are uninsurable, (3) sick people whose policies are canceled or whose premiums are unfairly increased by insurance companies and (4) employees who experience "job lock."

Problem: Healthy People Who are Uninsured. As noted above, most uninsured Americans are healthy, not sick. They lack health insurance because they have been priced out of the market. Part of the answer is to encourage insurers to charge these people low premiums that reflect their low level of risk. Moreover, the tax law should grant every bit as much encouragement (about a 30 percent subsidy) for individually purchased insurance as it now grants for employer-provided health insurance.

Problem: People Who Are Uninsurable. A small but important group of people cannot buy health insurance because they are sick or at high risk. Government can help by creating risk pools or subsidizing the purchase of conventional health insurance with tax dollars, rather than by artificially raising the premiums charged to healthy people. And the amount of subsidy should depend on family income. Low-income families need government help. Ross Perot does not.

Problem: Unfair Cancellations and Premium Increases. Sensible reform is needed for people who already have insurance. Insurers should not be able to change the rules of the game after a risky illness has occurred. They should not be able to cancel a policy or unreasonably raise premiums. As noted above, terminally ill people who have life insurance can continue their coverage at pre-agreed premiums. There is no reason why health insurers can't follow the same practice.

Problem: Job Lock. Thirty percent of Americans say they or someone in their household has stayed on a job they wanted to leave because they did not want to lose employer-provided insurance coverage.[23] Even though economists are almost unanimous in the belief that health insurance costs are fully paid for by workers (as a fringe benefit which substitutes for wages), our outmoded employee benefits system treats the policy as belonging to the employer, not the employee. This might be acceptable if employees worked for the same employer for the whole of their work life. In fact, most do not.

A reasonable solution is to insist that health insurance benefits be personal and portable if they are to receive favorable treatment under the tax law. Thus employers who want the tax advantages of employer-provided coverage would have to purchase (or provide) a conversion option that would allow employees (or a new employer) to continue coverage after the employee leaves the firm.

Conclusion

"Solving real problems requires a competitive market for real health insurance."

President Bush's health care plan is not a solution to the problems of private health insurance in the United States. It would cause health insurance premiums to soar, lead to an increasing number of uninsured people and impose its greatest burdens on moderate-income families.

The nation's health care crisis will not be solved by regulating private health insurance out of existence. To the contrary, we need a competitive insurance market in which premiums reflect real risks.

John C. Goodman

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Footnotes

[1] "President's Comprehensive Health Reform Program," February 6, 1992. During an initial transition period, premium "bands" would allow some variation in premiums for individuals of the same age and sex. Ultimately, however, through a reinsurance mechanism, "insurers would be able to provide coverage at a near uniform premium for the sick and the healthy." [p. 23.]

[2] Ibid. People with income below the tax filing threshold (approximately the poverty line) would receive tax credits of $1,250 (for an individual) and $3,750 (for a family of three or more). The amount of the credit would decline as income rises, and taxpayers would have the option of taking the credit or a tax deduction. No health insurance credit or deduction would be available to individuals or families with incomes above $50,000 or $80,000, respectively. [p. 2.]

[3] According to the Bush proposal, the least healthy Americans incur per capita health care costs of $7,100 per year. Yet these people would be able to buy health insurance for premiums of only $1,250. The 20 unhealthy people represent the approximately 1 to 2 percent of the population who are uninsurable.

[4] "In cases where a hospital emergency room is an individual's first point of contact with the system, rotating assignment would be used to enroll an uninsured credit-eligible individual to a specific health plan if the individual were unable to make a choice. So for example, a homeless person entering the hospital and having no preference for any carrier would be assigned to an insurer by rotation and the credit would automatically flow to the insurer." [p. 22.] Technically, a "credit-eligible" person is defined as a person whose annual income does not exceed $50,000 (for an individual) or $80,000 (for a family). However, since the hospital will almost certainly not know the emergency-room patient's income until several days after treatment, and since there is no waiting period, the proposal apparently envisions a mechanism that will insure any uninsured patient entering the hospital.

[5] S. 1872. Better Access to Affordable Health Care Act of 1991.

[6] H.R. 3626. The Health Insurance Reform and Cost Control Act of 1991.

[7] S. 1936. Health Equity and Access Improvement Act of 1991.

[8] HIAA memo dated August 29, 1991.

[9] "Perspective on Small Group Market Reform," study conducted by Community Mutual Insurance Company, September 1991. See Supplemental Reading section, p. 30.

[10] Ted A. Lyle and Janet M. Carstens, "Actuarial Review of Proposed Small Group Reform Legislation in Ohio," study conducted by Community Mutual Insurance Company, November 29, 1991. See section 3924.05.

[11] Source: Golden Rule Insurance Company. Golden Rule offered no-questions-asked health insurance policies for employers with 10 to 25 employees. There was a surcharge for the no-questions-asked groups that ranged 15 to 20 percent above what the same group could get if they provided health information in their application. There were also some restrictions.

[12] Almost all of the proposals leave healthy people, whom the proposal intends to overcharge, with some options. Thus most small group reform proposals would allow healthy people to escape to the market for individual policies. The Bush proposal would force artificial pricing in individual policies which qualify for a tax subsidy but would leave unsubsidized individual insurance as an unregulated alternative.

[13] With the increasing tendency to "shift" the cost of Medicare, Medicaid and indigent health care to the private sector, this example is not as far fetched as it might first appear.

[14] Jill D. Foley, *Uninsured in the United States: The Nonelderly Population Without Health Insurance* (Washington, DC: Employee Benefits Research Institute, April 1991), p. 16.

[15] Employee Benefits Research Institute (EBRI) *Issue Brief,* No. 110, January 1991.

[16] Congressional Budget Office, "Rising Health Care Costs: Causes, Implications, and Strategies," *CBO Papers,* April 1991, p. 97.

[17] U.S. Department of Commerce, *U.S. Industrial Outlook '92,* January 1992.

[18] Of the $800 billion we will spend this year on health care, about $648 billion will be for personal health expenses. The figure includes spending for Medicare and Medicaid patients.

[19] Exclusions and riders are additions that become part of an insurance policy, excluding or limiting benefits otherwise payable.

[20] See the NCPA Task Force Report, "Solving America's Health Care Crisis: An Agenda for Change," National Center For Policy Analysis, NCPA Policy Report No. 151, May 1990.

[21] See John C. Goodman and Gerald A. Musgrave, "Controlling Health Care Costs With Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992.

[22] To the extent that employees pay part of the premium, most large companies charge every employee the same premium, regardless of age, location, job task — or any other indicator of risk. As a result, these companies face some of the same problems faced by community rating in a health insurance market. Since the actuarially fair premium for a 60-year-old male is about four times higher than for a 25-year-old male, under community rating older workers view health care as cheap and pressure the employer to provide more of it. Younger workers view it as expensive and increasingly are declining coverage, even though their premium is partly "subsidized." One of the fast-growing segments of the market for individual policies is for dependents of insured workers — who apparently find that health insurance outside the company is cheaper than the artificial premiums employers charge them.

[23] Erik Eckholm, "Health Benefits Found to Deter Job Switching," *New York Times*, September 26, 1991.