Chapter VII

FOUR STEPS TO PERSONAL AND PORTABLE HEALTH INSURANCE

If one looks at the major health policy reform proposals both at the national level and at the state level, portability is rarely a concern. Yet NCPA polling and focus groups with swing women voters (women who sometimes vote Republican and sometimes vote Democrat and therefore determine election outcomes) show that "insurance you can take with you from job to job" receives higher support than almost any other issue.[1]

Why the disconnect? Part of the reason is that health reform proposals are invariably constructed either by people who pay the bills or by people who do the billing and neither group ordinarily includes patients.

Yet the case for portability is strong and goes far beyond the fact that most people want it. First, as noted above, portability allows a long-lasting relationship with a health plan, which in turn allows a long-lasting relationship with providers of care. This means that people who switch jobs

frequently can still have continuity of care — which is usually a prerequisite for high quality care. Second, people who have portable insurance (as well as portable retirement and other benefits) will not be "locked into jobs" solely because of the nonportable nature of their benefits. Portable benefits are consistent with a mobile labor market, which is a necessary component of a dynamic, competitive economy. Finally, a system of portable benefits is one in which the employer's role is financial, rather than administrative. Employers, therefore, can specialize in what they do best, leaving health insurance to the insurance firms.

If the case for portability is so strong, why isn't it available? As noted, federal tax law favors employer-specific, nonportable insurance and discriminates against individually purchased and individually owned insurance. So the simplest and easiest way to achieve portability nationwide is to change the federal tax law. In the absence of that, what can individual states do to create portability?[2]

The Massachusetts Health Plan offers a limited solution. Individuals (and their employers) buy coverage through a health insurance "Connector." The insurance is individually owned and travels with the employee from job to job. However, since these insurance contracts last at most 12 months (after which, the individual must again choose among competing plans in an annual open season), this type of portability falls far short of the ideal.

A second approach to portability was pioneered by the National Center for Policy Analysis and Blue Cross/Blue Shield of Texas. Under this system, employers would initially buy individually owned insurance for all their employees, the way they buy group insurance today. On day one, all the employees of a firm would have the same insurance. Over time, however, as employees come and go, a typical place of employment would have employees in many different plans. But each employee would likely have the same individually owned policy he or she had initially. The employer's obligation would be to make a defined contribution for each employee,

deduct any additional premium owed from the employee's wages each pay period and remit the total premium to the employee's insurer. However, in carrying out this reform the states risk violating certain federal laws.[3]

A third approach is to take advantage of Health Reimbursement Arrangements (HRAs), which specifically allow employers to reimburse employees for insurance premium expenses. Interpreted literally, this means the premium check is drawn on the employee's bank account and the employer reimburses the employee with another check. Most states prohibit (either directly or indirectly) the use of employer contributions for individually owned (and individually underwritten) insurance, and some argue that federal law requires such prohibitions. As a result, many insurers ask employees to claim that they are not being reimbursed by their employers for individual insurance premiums. In most states, however, the de facto practice is don't-ask-don't-tell on the part of the regulators.[4]

Clearly, better federal guidelines are needed. The following is a brief summary of what could be accomplished.

Step No. 1: Free the Employee.

Given the federal tax code, money used to purchase tax free health insurance must originate at the workplace. But in an ideal world, insurance premiums should pay for insurance that each employee has selected, owns and controls. A model is the 401(k) plan (in the for-profit sector) or the 403(b) plan (in the nonprofit sector). Although employers make matching contributions to these accounts, the accounts are owned by the employees, and they select their portfolio of investments. In health insurance, each employee could, in principle, be enrolled in a different plan. Further, employees would not lose the right to participate in the plan of their choice as a result of a job change, unemployment or even retirement.

Step No. 2: Free the Employer.

When benefits are company specific, the employer is necessarily involved in the management and administration of those benefits. Manufacturers of automobiles, housing or appliances, for example, find that they are in the health insurance business as well. Most employers, and certainly all small employers, would prefer not to be in the health insurance business, however. In a world of portable insurance, they would not be.

Rather than offering a defined benefit health insurance fringe benefit, employers could offer a defined contribution benefit instead. They could do so by offering a monetary contribution to be applied to the health insurance premiums of each employee, each pay period. Again, the 401(k) retirement plan is a model. New employees would know not only their salary, but also how much the new employer would be willing to pay toward the premium cost of insurance which they already would own and bring with them to the new place of employment. In this way, the employer's role in health insurance is purely financial. In fact, employers would have no more involvement in the employee's health plans than they would have in their employee's 401(k) portfolio.

Step No. 3: Free the Health Insurer.

In many ways the health insurance marketplace is very dysfunctional. In fact, to a large extent it is not insurance at all; it is instead prepayment for the consumption of health insurance. Life insurance provides an interesting point of contrast. Once a contract is signed, an individual's future life insurance premiums are independent of changes in health status (which presumably change an individual's probability of dying). That is because the life insurance contract transfers the full financial risk of death to the insurer.

Health insurance contracts are very different. For large companies, virtually all insurance is actually self insurance. A self-insured firm maintains

reserves equal to expected treatment costs and pays bills directly, or through a health plan administrator. That is, the large company's insurance costs are roughly equal to the employees' health care costs. So no risk is being transferred to any other entity.[5] As a result, large firms rarely buy genuine insurance.

In the small group market, a form of insurance exists, but only for periods of brief duration. Typically, after a 12 month period, the insurance ends and must be recontracted. But the new insurance rates are dependent on changes in the health status of the employees of each firm. Companies that have experienced unexpected bouts of employee illness (as indicated by unexpected increases in health care spending) must pay higher premiums in order to insure again. By contrast, companies whose employees remain healthy or have unexpectedly low health care spending face smaller premium increases, no increase or perhaps even a decrease. It is as if the small firm is able to join an insurance pool for 12 months; then is kicked out of the pool and forced to rejoin at rates that reflect changes in the health status of the employees over the previous 12 months.

In all states the small group market is governed by "guaranteed issue" regulations (insurers must take all comers) and many also have rating bands (setting a limit on how much the highest premium charged can exceed the lowest). Yet far from improvements, these regulations are likely to make things worse. Suppose the same thing happened in life insurance. The ability of the insurer to recontract every 12 months would harm those who develop a life threatening condition, such as AIDS. Their premiums would unfairly rise. Yet the existence of rating bands would compound the problem because the rise in premiums for the AIDS victim would not rise enough to compensate for the new higher risk, and the premiums for the healthy would not fall enough. As a result, the AIDS victim would buy more insurance (even at a higher rate). To cover those costs, insurers would have to raise premiums for the healthy, resulting in their buying less insurance. Furthermore, if insurers were required to accept new people into the pool (who may also have AIDS), it would encourage everyone to

go without life insurance until it is really "needed." Life insurance, in this case, would become just as dysfunctional as health insurance.

Today's dysfunctional health insurance market could work more like today's functional life insurance market if insurers were freed to (a) form long-term relationships with those whom they insure and (b) charge every new entrant to the insurance pool an actuarially fair price, but (c) make subsequent premium increases the same for all enrollees. Such arrangements would allow people to buy a product that is much closer to real insurance. Policy changes are needed that actually allow health insurers to get into the business of insurance.

Step No. 4: Transition Rules.

Moving to a new health insurance system is easy if all the participants are healthy. It is much less easy when some people are sick. For example, some employers have ended their group health insurance plans and offered a defined contribution reimbursement for individually incurred health insurance expenses through an HRA. The employees are free to buy insurance in the individual market and get reimbursed (up to a predetermined sum) with pretax dollars. This works well for healthy employees who are able to obtain individual insurance, despite medical underwriting. However, those with health problems may find they are shut out of the individual market or face exclusions and/or higher premiums.

Most states now have risk pools with standard Blue Cross-type plans. However, even with state subsidies the premiums are higher than what others pay. As a result, an HRA approach is likely to impose increased financial costs on those employees with the highest-cost health problems.

Policymakers must decide whether this type of transition is acceptable. If it is not, there are other options to consider. For one, employers could risk-rate their contributions (at least during a transition period) so that high-cost employees (and their families) get higher reimbursements than

healthy ones. Another option is to use state funds to subsidize premiums for those with high expected costs. A third possibility is to have employers initially buy individually owned insurance for all their employees at premiums that vary only by age. That is, employers would start out buying individually owned insurance the same way they buy group insurance (and realize the economies of group purchase). After a transition period, people would be free to switch plans.[6]

Notes

1 Also rating high were "flexible benefits," such as allowing people to choose between nontaxed health, and retirement benefits and taxable wages.

2 John C. Goodman, "Employer-Sponsored, Personal and Portable Health Insurance," *Health Affairs*, Vol. 25, No. 6, November/December 2006, pages 1,556-66.

3 Ibid. The standard interpretation is that employers cannot use pretax dollars to purchase individually owned insurance.

4 Paul Zane Pilzer, *The New Health Insurance Solution: How to Get Cheaper, Better Coverage without a Traditional Employer Plan* (New York: John Wiley & Sons, 2007).

5 The exception is the ability of employers to buy stop-loss insurance, covering all costs above a very high amount.

6 See the discussion of how such a transition can be made at actuarially fair prices in John C. Goodman, "Employer-Sponsored, Personal and Portable Health Insurance."