**Policy Study** The Heartland Institute

No. 91 – August 27, 1999

# Extending Affordable Health Insurance to the Uninsurable

By Conrad F. Meier[1]

## *Good news from Texas*

Jane Cox has uterine cancer and could not purchase health insurance.

Going without insurance wasn't an option, so Mrs. Cox found help from the state of Texas. She now has health insurance coverage through the state's community-based Health Insurance Plan (HIP), designed to help people with special medical needs.

Texas' health insurance safety net, funded by the 1997 legislature, provides insurance to people who can't otherwise get it because of their medical histories.

Mrs. Cox is just one of thousands of people who have received health insurance through the Texas Health Insurance Plan since its debut January 1, 1998. This health insurance safety net, funded by the 1997 legislature, provides insurance to people who can't otherwise get it because of their medical histories.

"What we're serving here is a group of people who obviously have a need for insurance, and they also have the ability to pay a premium," said Rep. Kip Averitt (R-Waco), who sponsored the 1997 legislation. "But if we do not help subsidize the cost, we are going to ruin their lives by draining their total income to pay for medical bills."[2]

---

[1]Conrad F. Meier is health policy advisor for The Heartland Institute. He can be reached by email at cmeier@mail.coin.missouri.edu. The author thanks Heartland policy advisors John J. Bethune, Victoria C. Bunce, Steven Horwitz, and Edwin S. Mills for their comments on an earlier draft of this manuscript. Any errors that remain are the author's only.

[2]*Dallas Morning News*, Knight-Ridder/Tribune Business News, Business News Section, April 30, 1998.

As of April 1999, HIP administrators reported 4,300 medically uninsurable citizens have gained quality health insurance through the Texas HIP. New participants are being insured at a rate of 300 per month, and participation is expected to increase to at least 10,000 within three years. Enrollees' premium payments are expected to cover at least half of the plan's cost. The balance comes from assessments on health insurance companies operating in Texas.

If Texas had not established its plan, Jane Cox and thousands of people with pre-existing medical conditions would have gone without health insurance.

By choosing to establish a health insurance plan, rather than relying on radical fallback provisions like guaranteed-issue mandates, Texas has protected all its responsible citizens from the serious negative consequences of federal and state over-regulation of the health insurance industry.

## *Protecting uninsurable persons*

More than 187 million Americans rely on private health insurance for their health care needs. Health insurance payments exceed $292 billion annually (not counting deductibles and co-pays).

> Health insurance plans, or HIPs, increase access to health insurance by choice rather than by government mandate.

Over the years, state and federal governments have enacted a number of measures to help people obtain and keep health insurance. States have mandated conversion policies, continuation requirements, and portability provisions. The federal government enacted portability requirements as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and, in 1996, passed the Health Insurance Portability and Accountability Act (HIPAA), a law imposing broad access and portability measures. In addition, some 66 million poor and elderly Americans rely on Medicaid and Medicare, respectively, for their health care needs.

But what happens when persons lose coverage, have serious medical problems, and cannot or do not take advantage of these safety nets?

For over 100,000 uninsurable persons who could otherwise be uninsured, the answer is state-created Health Insurance Plans. HIPs increase access to health insurance. They permit people to finance their health care needs by heavily subsidizing their claims. Some even help lower-income persons finance their share of the premiums.

HIPs are not new. Many have been around for years, providing comprehensive medical coverage for individuals who could be considered uninsurable. Currently, 28 states offer access to insurance through HIPs for residents who can't get coverage elsewhere. Enrollment ranges

from 198 people in Alaska's five-year-old program to about 26,314 in Minnesota's 22-year-old plan.[3]

HIPs are a *targeted* response to a *specific* problem: a government-sponsored program that really works, helps people, does so with a minimum of bureaucratic interference, and costs very little for everyone involved.

> In Part 3 of this analysis, data are reported on the effects that health insurance plans have on the uninsured population, on premiums charged to those with pre-existing health conditions, and on the rest of the health insurance market.

This analysis looks at the problems faced by people whose serious pre-existing health conditions make them ineligible for private health insurance. Part 1 describes the problem: Who is uninsured and uninsurable, and why aren't they able to find insurance in the private market?

Part 2 describes one promising solution: the community-based health insurance plan. It explains how this health care safety net works and how such plans "fit" in the new regulatory order created by the 1996 Health Insurance Portability and Accountability Act.

Part 3 presents a new evaluation of the cost-effectiveness of health insurance plans. Data are reported on the effects that health insurance plans have on the uninsured population, on premiums charged to those with pre-existing health conditions, and on the rest of the health insurance market.

Part 4 summarizes the best practices of the most effective health insurance plans, while Part 5 offers a brief summary and concluding remarks.

[3]For operating statistics, model legislation, premium data, funding mechanisms, and state contacts, refer to *A State-by-State Analysis—Comprehensive Health Insurance for High Risk Individuals*, 12th Edition, 1998, published by Communicating for Agriculture.

## PART 1

# The Problem:
# Pre-Existing Health Conditions

### *How private insurance markets work*

Private insurance companies compete with each other to write policies for individuals, families, and employer-groups. Companies offer a variety of insurance packages that differ in price, deductible levels, limits on payments, conditions covered, and the regional composition of doctors and hospitals who may deliver services. The record shows that the private market for health insurance can, with a minimum of regulation and oversight by government, deliver insurance at a competitive price with a minimum of bureaucracy and waste.


> Competition rewards private insurers with increased profits and market share when they offer the best products at the most appropriate prices.


Insurance companies set their premiums based on the actuarial science of their estimated cost of risk assumption and the willingness of customers to pay. If a company prices its coverage too high, other companies will bid away its customers by offering to sell the same or similar coverage at a lower premium. If the price is set too low, costs will exceed income from premiums. This in turn can force financial problems and possibly require the insurer to abandon the market as states impose minimum solvency requirements, making sure companies have sufficient reserves to pay claims.

Competition rewards private insurers with increased profits and market share when they offer the best products at the most appropriate prices. Insurers who charge too much for inferior products are penalized by falling profits and declining market share.

Health insurers typically price their products by broad "classes" or "pools"; in fact, virtually every state enforces regulations requiring this for individual and small group coverage. Experience rating—charging different rates for healthy and sick persons or groups—is strictly limited or even outlawed in some states. In other words, sick persons or groups may not be singled out for abusive rating practices or terminations.

The "right" price for an insurance product will depend on many things, but especially the insurer's prediction of what a customer's claims experience will be. A young and healthy customer, for example, is likely to have fewer claims than an older customer with a record of medical problems. Consequently, younger people usually pay lower health insurance premiums than do older people. Similarly, men pay lower premiums than women at younger ages (but more at older ages), and people with pre-existing health conditions may pay more than those without such histories.

The tailoring of insurance premiums to cover expected medical costs is not a problem in most cases. In fact, it generally produces very positive results. Charging only the true cost of insurance ensures that customers will buy the right amount: buying more or less coverage than is necessary would be a waste of society's limited resources and represent what economists call a "social cost."

Tailoring insurance premiums can also create incentives toward better public health. Many health conditions can be influenced by individual conduct: smoking, over-eating, not exercising, and engaging in risky forms of recreation such as sky-diving can all raise a person's expected health care costs, and under a private insurance system all can result in that individual paying higher insurance premiums. This practice works to discourage unsafe and unhealthy conduct, and comports well with general notions of fairness. In fact, some insurance companies offer discounts for healthy lifestyle practices and participation in wellness programs.

## *What private insurance markets cannot do*

Health insurance is very effective at pooling large numbers of persons, collecting affordable premiums from all, and paying the claims of those who unfortunately get seriously sick or hurt. But insurance is not an appropriate device when an uninsured person with a known medical condition tries to buy coverage. There is no longer any element of risk; it is simply a known claim seeking someone to pay it.

In the absence of some kind of government intervention (or assistance from religious, fraternal, or other charitable organizations), these people might have to go without health insurance.

**Table 1**
**Health Insurance Coverage in the U.S.**

| Coverage | Percent |
|---|---|
| Private group health | 37.0% |
| ERISA | 27.0% |
| Medicare | 11.3% |
| Medicaid | 7.0% |
| Private individual health | 4.0% |
| Uninsured, in good health | |
| above 1.5 x poverty line | 7.0% |
| below 1.5 x poverty line | 6.0% |
| Uninsured and uninsurable | 1.0% |

Source: Communicating for Agriculture Inc., 1996

It is therefore not surprising to find that many programs and institutions developed to fill in where private insurance is inappropriate (see Table 1). The most obvious programs are Medicare, which guarantees access to medical care for the elderly, and Medicaid, which guarantees access for the poor. Whereas about 14 percent of the U.S. population is without insurance at any given time, only 1 percent of the population of the U.S.—about 2.5 million people—is thought to be both uninsured and uninsurable due to a pre-existing health condition.[4]

[4] Conrad F. Meier, *Heartland Policy Study* No. 78, "How to Implement Kassebaum-Kennedy: A State Legislators Guide to the Health Insurance Portability and Accountability Act of 1996," The Heartland Institute, March 25, 1997, page 3.

Private insurers often are required to extend insurance coverage to persons with pre-existing conditions. State governments historically used their regulatory authority over insurers to limit the ability of insurers to collect and base policy-writing decisions on the health histories of their customers, and most states enforce portability and collective renewal laws that prevent insurers from removing high-risk individuals from group policies. Passage in 1996 of the federal Health Insurance Portability and Accountability Act (HIPAA) placed a series of mandates on state governments to increase their portability, access, and renewal rules. (For more about HIPAA, see Part 2 below.)

> If society expresses a determination that uninsured persons with known medical conditions be assured access to health care services, we need to look beyond the private insurance marketplace to provide such access.

The Council for Affordable Health Insurance (CAHI) uses the image of an inverted pyramid to illustrate the problem. "The people in the individual market comprise a very small area at the bottom of this inverted pyramid," write Victoria Bunce, David Lack, and Rod Turner in an April 1999 CAHI paper.[5] "To force that small group of people to fund the burden of all of the uninsurable people coming from the rest of the pyramid [large groups, small groups, self-funded programs, government programs, etc.] simply cannot work because it requires a price that is far too high for this market to bear."

If society, through its political or other institutions, expresses a determination that persons with such medical conditions nevertheless be assured access to health care services, then we need to look to institutions beyond the private insurance marketplace to provide such access. As the CAHI authors note, "The only way to solve this social problem is for each segment of the insurance market to participate in funding health coverage for the uninsurable population. This can be done through high-risk pools or private risk-spreading mechanisms . . ."

[5]Victoria Bunce, David Lack, and Ron Turner, "Understanding the Individual Health Insurance Market," Council for Affordable Health Insurance, April 1, 1999, page 4.

PART 2

# Health Insurance Plans

## *Health Insurance Plans defined*

Health Insurance Plans (HIPs) are state-created nonprofit associations offering access to the highest quality medical care to people with pre-existing medical conditions. These plans are usually comparable in coverage to private plans, and in some cases are even richer in benefits due to the severity of the known medical condition being insured. And, while no two state health insurance plans are alike in design and implementation, they all share a common purpose: to help finance medical treatment for uninsured people with serious medical conditions who would otherwise be uninsurable.[6]

Following legislative guidelines, health insurance policies for people eligible to enroll in the HIP are sold by the administering insurer, a single private insurance company chosen through competitive bidding to play that role. Agents are typically compensated by commissions and renewal fees. Some states allow an agent a one-time finder's fee.

> While no two state health insurance plans are alike in design and implementation, they all share a common purpose: to help finance medical treatment for uninsured people with serious medical conditions.

HIPs have to be heavily subsidized because the premiums collected from participants in a health insurance plan generally cover only about 50 percent of the claim cost of the plan. Over the years, states have adopted a variety of financial arrangements to cover losses. The typical insurance plan's losses are funded through assessments on private insurers operating in the state (generally a percentage of the premiums collected by those insurers for policies sold in the state). In a few cases, funds are provided from a state's general revenue fund.

Table 2 on the following page lists the states with HIPs, the number of people enrolled in them, and the year they became operational. It has been over 21 years since the first state HIPs were created by the Connecticut and Minnesota legislatures. Enrollment ranges from just 198 people in Alaska's five-year old program to about 26,314 in Minnesota's plan. Nationally, approximately 100,000 people were enrolled in HIPs in 1998.

[6] From interviews with health insurance plan directors and administrators conducted by the author from September to November 1998 at the Center for Advanced Social Research, The University of Missouri-Columbia.

**Table 2**
**State Health Insurance Pools**

| State | 1998 Enrollment | Year Operational |
|---|---|---|
| Alabama | 600 | 1998 |
| Alaska | 198 | 1993 |
| Arkansas | 588 | 1996 |
| California | 19,995 | 1991 |
| Colorado | 1,058 | 1991 |
| Connecticut | 1,290 | 1976 |
| Florida | 1,095 | 1983 |
| Illinois | 6,400 | 1989 |
| Indiana | 3,997 | 1982 |
| Iowa | 482 | 1987 |
| Kansas | 1,019 | 1993 |
| Louisiana | 747 | 1992 |
| Minnesota | 26,314 | 1976 |
| Mississippi | 1,700 | 1992 |
| Missouri | 1,032 | 1992 |
| Montana | 704 | 1987 |
| Nebraska | 3,997 | 1986 |
| New Mexico | 792 | 1988 |
| North Dakota | 1,328 | 1982 |
| Oklahoma | 783 | 1996 |
| Oregon | 4,135 | 1990 |
| South Carolina | 943 | 1990 |
| Tennessee* | n/a | 1987 |
| Texas | 1,354 | 1998 |
| Utah | 920 | 1991 |
| Washington | 766 | 1988 |
| Wisconsin | 7,318 | 1981 |
| Wyoming | 531 | 1991 |

* Tennessee risk plan participants have been merged into the TennCare Medicaid program. High-risk individuals are not tracked separately.

Source: Communicating for Agriculture, *Comprehensive Health Insurance for High-Risk Individuals*, 1996 and 1998.

State plan directors report that HIP enrollment is a temporary experience for many individuals. The number currently insured through HIPs, consequently, is much lower than the total number served. Minnesota's health insurance plan, for example, has helped over 250,000 citizens since its inception.[7]

The average time spent enrolled in a state plan is about 30 months. The most common reason given for leaving a HIP is a change in the employment status of either the enrollee or his or her spouse (making them eligible for group insurance) or becoming eligible for Medicare. HIPs largely serve the self-employed, employees of small businesses that do not offer insurance, farmers, and others who are not part of a large-group health insurance plan. Small employer group plans are now required by federal law to have open-enrollment periods and guaranteed-issue for handling employees who otherwise would be uninsurable.[8]

The philosophy behind health insurance plans is that members of this group of uninsured are victims of medical circumstances beyond their control. These health care safety nets are not created to serve the indigent or the poor, although many people with chronic medical problems also face economic hardship. For the most part, the needs of low-income citizens are served by Medicaid, state and county assistance programs, and, more recently, the federal and state children's health insurance program. To keep the HIP from becoming a catch-all safety net for all manner of other uninsured problems, eligibility requirements must be carefully established and enforced.

[7] Ibid.

[8] Ibid.

## *Health Insurance Plans and HIPAA*

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required that all states implement by July 1998 policies that guarantee access by small businesses (2 to 50 employees) and "eligible individuals" to health insurance of some kind. More specifically, small-group insurers must sell and issue coverage to every small employer with 2 to 50 employees. No small employer group may be rejected because of medical conditions existing among the employees or their dependents. All the carrier's plans must be made available under these terms. Large-group insurers may issue insurance on an "accept-reject" basis to employers with 51 or more employees. That is, if the insurer accepts the group it may not exclude high-risk employees or those with pre-existing conditions, and if it rejects a group it must reject the whole group and not the high-risk members only. Once insured, all timely new additions to the group (small or large) must be guarantee-issued.

No group insurer is allowed to condition individual eligibility for a group plan on health status, medical condition (physical and mental condition), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including hazardous activities and conditions arising out of domestic violence), or disability of any member of the group.

> States can meet the HIPAA provision requiring access to insurance for eligible individuals with pre-existing conditions by establishing a qualified health insurance plan.

HIPAA requires the "collective renewal" of health insurance in all markets. All group and individual insurance must be collectively renewable. An insurer who elects to cancel a policy or block of business is forbidden from offering any insurance in that market in that state for five years.

HIPAA further requires that "eligible individuals" be guaranteed access to some type of coverage regardless of pre-existing medical conditions. To be considered an "eligible individual" for whom coverage is guaranteed, an applicant must have had 18 months of prior coverage under a group plan, must have elected and exhausted continued benefits coverage under COBRA (typically 18 months), and must not be eligible for any other group health coverage.

The idea behind "eligible individuals" is that people who act responsibly and maintain health insurance, perhaps for many years, may nevertheless find themselves out of health insurance through no fault of their own. For example, COBRA may run out, and if the person cannot find a job that includes a group insurance plan, he or she may not be able to purchase private individual health insurance.

States are given the authority to enforce HIPAA, and virtually every state has passed enabling legislation to do so. Also, HIPAA gives states flexibility to meet its requirements for "eligible individuals." Of particular relevance to the present study, states can meet the HIPAA

provision requiring access to insurance for eligible individuals with pre-existing conditions by establishing a qualified HIP following the National Association of Insurance Commissioner's (NAIC) Model Health Plan for Uninsurable Individuals Act.

Illinois, which already had a successful health insurance plan, created a separate health insurance plan to meet the HIPAA requirements. The state's new HIP was enrolling customers some six months before the July 1, 1997 federal deadline. By February 1998, the Illinois HIP had enrolled more than 700 HIPAA-eligible individuals. While other states are struggling with the negative consequences of federal fallback provisions that disrupt the individual and small-group insurance markets (a point addressed further below), Illinois legislators were able to use the experience they gained from the state's standard HIP operations to develop a successful health insurance plan.

Anecdotal evidence of the plan's success comes from Amy Marie Gardner of Glenview, Illinois. Gardner was one of the first 500 Illinois residents to take advantage of the health insurance plan created specifically for HIPAA-eligibles.[9]

While other states are struggling with the negative consequences of federal fallback provisions that disrupt the individual and small-group insurance markets, Illinois legislators were able to develop a successful health insurance plan.

Gardner was diagnosed with a potentially fatal kidney disease during a routine physical while a college student. Her health insurance coverage while a dependent on her parents' plan had been exhausted, and she became eligible for Medicare for three years after a kidney transplant in 1993.

Gardner graduated and began a career in teaching. While her job provided good health insurance, the classroom contact with children exposed her to more germs than her immune system could tolerate. She needed to leave her chosen profession. Health insurance became a major concern, since her previous medical history made her uninsurable in the private market. Regular lab testing fees and immuno-suppressive prescription medications were costing over $2,000 a month.

Because Illinois has a HIPPA/health insurance plan, Gardner was able to look for and find a new job without insurance being the deciding factor. She is now fully insured with no exclusions for her pre-existing medical condition.

Richard W. Carlson, executive director of the Illinois HIP, believes "the use of our existing state high-risk pool to comply with the individual requirements of HIPAA clearly has been the right decision for Illinois. By using a broad-based assessment, we have been able to spread the cost of these high-risk individuals across the entire health industry."[10]

---

[9]As reported to the author and published in *Illinois Insurance*, June 1998, page 3.

[10] Unless otherwise noted, all quotes from Richard W. Carlson are from a personal interview with the author on October 28, 1998.

Carlson followed up with some significant details: "For the first two years, the assessments for this purpose have been levied against the nearly $10 billion in premiums collected by all of the health insurers and HMOs doing business in the state. This has amounted to less than 8/100th of 1 percent of these total direct Illinois premiums. As a result, the individual health insurance market in this state, which is very price-sensitive and amounts to about $800 million in annual premiums, has not been forced to fully absorb and subsidize the costs of these individuals."[11]

"This has allowed the individual health insurance market in our state to remain stable and not experience the significant increases in premiums that have occurred in many of the 'federal fallback' states," Carlson noted.

[11] Letter dated November 12, 1998, to the author from Richard W. Carlson, executive director, Illinois CHIP.

## PART 3

# An Evaluation of Health Insurance Plans

### *Effect on Uninsured Rates and Insurance Premiums*

As noted in Part 2, HIPAA granted states flexibility in addressing the requirements for "eligible individuals." Most states made one of two choices. About half require insurers serving the individual health insurance market to guarantee-issue at least one plan. The other half opted to expand or create HIPs to meet the needs of those persons.

In a recent report to Congress,[12] the General Accounting Office concluded that carriers in states that chose the first option are charging an average rate of $381 per month for "eligible individuals." By contrast, states using HIPs to insure "eligible individuals" charge an average subsidized rate of $221 per month.

> HIPAA granted states flexibility in addressing the requirements for "eligible individuals."About half require insurers serving the individual health insurance market to guarantee-issue at least one plan. The other half opted to expand or create HIPs to meet the needs of those persons.

The report does not make adjustments for medical costs, demographics, or market shares. In fact, I believe that the rates charged are much closer than the GAO reports.

For the present analysis, I first calculated the rates charged for certain demographics by the Illinois HIP. Next, I surveyed several individual health insurers and asked them to calculate the rate they would charge "eligible individuals" had Illinois not used its HIP to serve them. Comparing what private insurers would have charged HIPAA-eligibles and the premiums charged by the HIP, I found the difference in rates to be negligible. A survey conducted by the Council for Affordable Health Insurance found similar results, reported in Table 3 below.

[12]"Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards," publication #GAO/HEHS-99-100 (Washington, DC: General Accounting Office, May 1999), page 3.

| Table 3<br>Average Monthly Premiums,<br>Deductibles, Co-Pays, and Benefits<br>for HIPAA-Eligible Individuals<br>in Peoria, Illinois | State HIP/CHIP | Private HIPAA Insurance |
|---|---|---|
| **Gender** | | |
| Male, age 29 | $142.00 | $152.46 |
| Female, age 29 | $178.00 | $185.72 |
| Male, age 47 | $276.00 | $335.41 |
| Female, age 47 | $327.00 | $360.36 |
| **Deductible** | $1,000 | $1,000 |
| **Co-pay** | 80/20 to $7,500 | 80/20 to $5,000 |
| **HMO or fee for service?** | Fee for service | Fee for service |
| **Maximum benefit** | $1,000,000 | $2,000,000 |

Source: Survey of insurance companies marketing individual health insurance policies conducted by the Council for Affordable Health Insurance in November and December 1998. Methodology available upon request.

While the premium rates charged to HIPAA-eligibles by private insurers and HIPs are not significantly different, the differences in *enrollment* are astonishing. Carriers I surveyed for this study reported issuing coverage to "eligible individuals" in states that require the guarantee-issue model (first option above) in very small numbers. By contrast, the Illinois HIP enrolled nearly 1,000 HIPAA "eligible persons" in the first year alone.

## PART 4

# Lessons for the Design of Health Insurance Plans

We can derive from the experiences of states with successful programs some of the principles and practices that make for a highly effective health insurance plan. Table 4 presents five key steps in the process of creating a successful HIP. Every successful state effort to date has followed these steps. In addition, three "best practices" have been distilled from the author's interviews with plan administrators, NAIC model legislation, and examination of the legislation authorizing the country's most successful efforts at insuring the uninsurable.

**Table 4**
**Steps for Creating a Successful HIP**

**Step One: Create a Board**
The Illinois CHIP is one of the most successful and efficiently run HIPs in the nation. Its board consists of 17 members, 10 of whom are voting members representing a cross-section of disciplines, including insurance, medicine, law, finance, consumer interests, and actuarial sciences. There are seven non-voting statutory members: the director of insurance, the attorney general, a representative from the private sector, and four legislative members.

**Step Two: Conduct a Survey of Eligible Uninsureds**
Once the board is created, the association should hire an executive director and request a statewide survey to determine the number of people who might qualify for HIP coverage. Such a survey is useful in determining adequate initial funding requirements along with actuarially sound premiums. Such a survey can be conducted as stand-alone research at a state university research center or through the facilities of the state health department. Every state, in conjunction with the Centers for Disease Control, already conducts monthly Behavioral Risk Factor Surveillance System (BRFSS) interviews and allows other state health-related agencies to include specific health-related questions for targeted research.

**Step Three: Set Eligibility Standards and Premiums**
Once the full scope of the state's medically uninsured population is understood, the association can proceed to develop an insurance policy that defines benefits, deductibles, eligibility for enrollment, premiums, and operational procedures.

**Step Four: Select an Insurer to Administer the Plan**
A private insurance company is selected through a competitive bidding process to administer the HIP.

**Step Five: Decide on a Funding Mechanism**
Illinois is sensitive to the fact that cost continues to be the principal barrier to obtaining health insurance—standard or high-risk. A subsidy from the general revenue fund, rather than an assessment on premiums, allows the cost of insuring Illinois' uninsurable population to be spread across a broad segment of the state's population. Only two other states, California and Utah, use this method, while 25 states rely on assessments paid by insurance companies doing business in the state.

Source: State of Illinois Comprehensive Health Insurance Plan, *1997 Annual Report*.

Illinois funded its original HIP with general revenue. When it expanded its HIP to insure HIPAA "eligible individuals," it created a separate pool within the HIP and assesses health insurers based on their market shares. Most states follow the assessment method, and some of those permit the carriers to offset their premium taxes by the amount of their assessments. All things being equal, the broader the base, the fairer the subsidy.

## *Best Practice #1: Eligibility standards*

One of the comments I heard most often during my interviews with state HIP directors and administrators was their desire to expand coverage. All HIPs cap the premium rates that can be charged to HIP participants. The caps generally range between 125 percent and 150 percent of average individual insurance premiums, though some are substantially higher.

For example, California, Connecticut, Illinois, Minnesota, Nebraska, North Dakota, Oklahoma, Oregon, and Wyoming all cap premiums rates at 125 to 150 percent of standard individual insurance premiums. HIPs in all these states serve at least twice the percentage of the state's uninsured as do Missouri or Louisiana's HIP, which have a much higher premium cap. No state approaches the enrollment success demonstrated by Minnesota, which has a 125 percent eligibility cap.

> Most states fund their HIPs through assessments on health insurers, and some of those permit the carriers to offset their premium taxes by the amount of their assessments. All things being equal, the broader the base, the fairer the subsidy.

It would appear that lowering the premium cap to 125 percent above standard can significantly increase a HIP's reach into the uninsurable population. Setting caps between 125 percent and 135 percent emerges as a second-best choice. The state comparisons are outlined in Table 5 below.

**Table 5**
**Relationship Between HIP Premium Caps, HIP Participation, and the Number of Non-elderly Uninsured**

| State | Premium Cap | Non-Medicare HIP Participants | # of Nonelderly Uninsured in State | % of Uninsured Population Enrolled in HIP |
|---|---|---|---|---|
| Minnesota | 125% | 22,082 | 500,000 | 4.20 |
| Nebraska | 135% | 3,997 | 200,000 | 2.00 |
| Wisconsin | 200% | 7,318 | 400,000 | 1.83 |
| North Dakota | 135% | 1,328 | 100,000 | 1.33 |
| Oregon | 125% | 4,135 | 500,000 | 0.82 |
| Montana | 150-200% | 704 | 100,000 | 0.70 |
| Indiana | 150% | 3,997 | 600,000 | 0.67 |
| Wyoming | 125-150% | 429 | 100,000 | 0.43 |
| Illinois | 125-150% | 4,855 | 1,300,000 | 0.37 |
| Mississippi | 150% (1998) | 1,700 | 500,000 | 0.36 |
| Kansas | variable | 1,019 | 300,000 | 0.34 |
| Connecticut | 125-150% | 1,290 | 400,000 | 0.32 |
| California | 125-135% | 19,995 | 6,400,000 | 0.31 |
| New Mexico | 150% | 792 | 400,000 | 0.20 |
| Alaska | 200% | 198 | 100,000 | 0.20 |
| Colorado | 150% | 1,058 | 600,000 | 0.18 |
| South Carolina | 200% | 943 | 600,000 | 0.16 |
| Missouri | 150-200% | 1,032 | 700,000 | 0.15 |
| Oklahoma | 125% plan out-of-pocket up to 40% | 783 | 600,000 | 0.13 |
| Alabama | 200% | 600 | 500,000 | 0.12 |
| Washington | 150% | 766 | 800,000 | 0.10 |
| Arkansas | 150% | 588 | 600,000 | 0.10 |
| Texas | 137.5% (1st year), 200% renewal years | 4,300 | 4,700,000 | 0.09 |
| Louisiana | 150-200% | 747 | 900,000 | 0.08 |
| Florida | 200-250% | 1,095 | 2,700,000 | 0.08 |
| Iowa | 150% | 482 | 600,000 | 0.08 |
| Tennessee | graduated by incomes | N/A; plan merged with Medicaid | 800,000 | N/A |
| Utah | varies yearly | 888 | 200,000 | N/A |

Source: Communicating for Agriculture, *Comprehensive Health Insurance for High-Risk Individuals*, 12th edition, 1998. Correlation and analysis by author.

### *Best Practice #2: Funding*

Of the 28 states with HIPs, only three (Illinois, California, and Utah) use general tax revenues to offset fund losses. The others rely primarily on assessments against the premiums charged by private insurers. (Colorado gets additional funds from unclaimed business property; Louisiana mandates medical services charges; and the California CHIP receives over $30 million a year from the State Cigarette and Tobacco Surtax Fund.)[13]

While it is true that broad-based assessments are more fair than narrowly funded subsidies, political realities usually weigh in. Larger employers use ERISA as a shield to avoid direct assessments. Insurers seek premium tax offsets for their assessments, in effect transferring the cost to the state's taxpayers. Federal Medicare and Medicaid plans and the federal employees' plan cannot be directly reached, either.

State HIP directors report that it is more risky to rely on state appropriations rather than adequate premiums and assessments, since appropriations must be lobbied for each year. In states where general revenue funds are used, the number of people who can be admitted to the plan is politically determined, and thus likely to be influenced by factors that have nothing to do with either genuine need or the efficiency of the private insurance market. While using general revenue funds is not necessarily the *wrong* way to help fund health insurance plans, a cautionary note is in order: With general revenue funding, the political composition of a state legislature will have a direct bearing on how high a priority is placed on health insurance plan funding.

Many state HIPs suffer from a lack of awareness of their program.

Anecdotal accounts reported by HIP administrators and others also suggest that many state HIPs suffer from a lack of awareness of their program. This seems most likely to be the result of limited funding for promotion and advertising, a practice budget-conscious bureaucrats and elected officials might deliberately undertake to keep spending on the program down. In turn, this problem is most likely to occur when the difference between HIP premiums and costs is paid by state appropriations rather than assessments on premiums.

HIP enrollment tends to develop slowly, and by assessing a modest but larger-than-needed amount at the outset, reserves can grow and interest income can be earned. Eventually, when the HIP grows to a few thousand people, the earlier investment helps hold down later assessments. Mississippi followed this practice when it established its HIP in 1992, and assessments remain moderate, despite insuring some 1,700 persons. Illinois did likewise when it expanded its HIP for "eligible individuals."

[13] Communicating for Agriculture, supra note 3.

### *Best Practice #3: Choice of service providers*

In an effort to hold down premium costs, some states have begun to offer eligible residents their choice of insurance options, ranging from traditional fee-for-service plans to cost-conscious HMO managed care plans with varying deductible levels.

Access to affordable health insurance can be enhanced by amending HIPs to offer Medical Savings Accounts and the high-deductible, low-premium catastrophic insurance coverage MSAs provide. HIPs should clearly state that MSAs may be used in conjunction with health insurance plan coverage.

> The medically uninsurable are easily as deserving of a tax break to help offset the premiums they pay to enroll in HIPs.

HIP participants should be permitted to take tax credits on state and federal income tax returns for the premiums they pay to participate. For HIP participants with no reportable income, the earned income tax credit could be used. Wisconsin further helps low-income persons in its HIP with a sliding subsidy for the premiums. Tax breaks are already available to self-employed persons who buy insurance on their own and employees with employer-provided insurance. The medically uninsurable are easily as deserving of a tax break to help offset the premiums they pay to enroll in HIPs. This would serve to lower the premium cost per participant and encourage greater participation for those otherwise "locked out" for economic reasons.

## PART 5

# Summary and Conclusion

Private insurance markets appear to do a good job providing affordable and high-quality insurance to most of the population of the United States. In states where competition and choice still exist, and where companies are permitted to tailor the cost of their product to consumer demand rather than regulatory demand, premium inflation has been moderate when compared to the inflation experienced in highly regulated markets.

There is a small group of people, though, whose high-cost medical expenses are very predictable. About 2.5 million people in the U.S.—about 1 percent of the population—suffer from pre-existing medical conditions that make it likely their future medical expenses will be extremely high.

We can attempt to ensure access to medical care for the medically uninsurable simply by forcing private insurers to write policies for them. Many states already do this . . . and they are creating serious problems for the vast majority of their residents who do not suffer from medically uninsurable conditions. Evidence from Kentucky and recent studies done by The Galen Institute/Heritage Foundation and Dr. William Custer show that such regulations increase premiums, increase the number of uninsureds in a state, and do serious damage to the insurance marketplace.[14]

A better way to provide access to care for people with special medical needs is through a state-chartered, nonprofit health insurance plan. In order to keep premiums affordable, a subsidy is needed: It can come from general revenues, a small assessment on the premiums paid by those outside the health insurance plan, or from special taxes or revenue "windfalls," such as that offered by tobacco settlements. Capping HIP premiums at no more than 125 to 135 percent of standard individual insurance premiums appears to be a "best practice" for keeping HIPs affordable.

A better way to provide access to care for people with special medical needs is through a state-chartered, nonprofit health insurance plan.

By 1998, the number of states with HIPs had grown to 28, providing coverage to over 100,000 people with special medical needs and extraordinarily high medical costs. HIP benefits are comparable and often superior to employer-provided plans offered in the private sector and, in most cases, demonstrably superior to Medicare and Medicaid coverage.

---

[14]Melinda L. Schriver and Grace-Marie Arnett, "Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations," *Backgrounder #1211*, The Heritage Foundation, August 14, 1998; Grace-Marie Arnett, "Rising Costs and Reducing Access: How Regulation Harms Health Consumers and the Uninsured," *Backgrounder #1307*, The Heritage Foundation, July 20, 1999; William S. Custer Ph.D., *Health Insurance Coverage and the Uninsured*, December 10, 1998.

HIPs accomplish the social goal of assuring access to quality medical care for those who need it, *without* the disruptions and negative side effects caused by heavy-handed regulation of the insurance industry. HIPs ought to be popular with elected officials, as they provide aid to the unfortunate with a minimum amount of regulation and bureaucracy.

Some state legislators remain a step away from fully endorsing the integration of a Health Insurance Plan into their states' private health insurance market. The author hopes the research and commentary presented here helps fill the knowledge gap that presently prevents some 22 states from doing the right thing.

# # #

Conrad F. Meier is health policy advisor for The Heartland Institute. He is the author of "How to Implement Kassebaum-Kennedy: A Legislators Guide to the Health Insurance Portability and Accountability Act," a *Heartland Policy Study* (Chicago, IL: The Heartland Institute, March 1997), and "New Era of Health Care Regulation: Patient Protection Laws and Mandated Health Benefits at the State Level" (Washington, DC: American Legislative Exchange Council, December 1998). Meier writes a monthly opinion column for Broker News Publishing Group and is Assistant in Research, Center for Advanced Social Research, University of Missouri. He is a retired health insurance benefits consultant and former state chairman of the health insurance committee for the National Association of Life Underwriters.

Distributed by **The Heartland Institute**, a nonprofit and nonpartisan public policy research organization. Nothing in this *Heartland Policy Study* should be construed as reflecting the views of The Heartland Institute, nor as an attempt to aid or hinder the passage of legislation. Additional copies of this study are available for $10 from The Heartland Institute, 19 South LaSalle Street #903, Chicago, IL 60603; phone 312/377-4000; fax 312/377-5000; email think@heartland.org; Web http://www.heartland.org.

Copyright 1999 The Heartland Institute. Permission is hereby given to quote from this *Policy Study*, provided appropriate credit is given to the author and to The Heartland Institute. Please send tearsheets.