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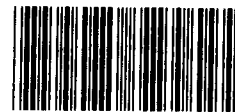

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Private Health Insurance: Problems Caused by a Segmented Market

Statement of
Mark V. Nadel
Associate Director
National and Public Health Issues
Human Resources Division

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SUMMARY OF GAO TESTIMONY GIVEN BY MARK V. NADEL
PRIVATE HEALTH INSURANCE: PROBLEMS CAUSED BY A SEGMENTED MARKET

The problems of availability and affordability of private health insurance are particularly acute for small businesses. The disadvantages these firms face when seeking to offer health insurance include:

-- The competition among insurers to insure low risk/low cost groups and the decline in community rated health insurance products have made insurance for groups with higher-risk employees expensive and potentially unaffordable.

-- The insurers of small firms and others in the commercial market face state insurance regulation, premium taxation, and mandates to offer specific coverage while larger firms self-insure and are exempt from these requirements.

-- Restrictive underwriting practices have made insurance impossible for some individuals and groups to obtain or retain. These practices hurt individuals with expensive medical conditions and firms such as logging companies, physicians' offices, and beauticians which are expected to have high medical costs.

-- Small businesses generally face higher costs than larger firms when purchasing health insurance. Small businesses have experienced a higher rate of increase in health care costs. They are often charged a larger portion of their premium for overhead expenses. They lack the market clout that large firms have in negotiating discounts with providers. Unincorporated small businesses do not receive the same tax treatment for employee health benefits as incorporated businesses.

Private groups and states have proposed and implemented reforms targeted toward the small group health insurance market. Some of these reforms aim to make insurance more affordable for small firms. Others aim to alter rating and underwriting practices so that groups and members of groups are not denied coverage, and the market--as a whole--is more stable and predictable for small firms. While the reform attempts could potentially improve the situation for small firms wishing to purchase health insurance, they are not without problems. It will be difficult to move from the segmented system we have into one that spreads risks more broadly.

Also, the reform initiatives do not address the problems of ever increasing health care costs, nor can they directly address the different regulatory treatment of health benefit plans resulting from ERISA. These issues will need Congressional action if they are to be resolved.

Mr. Chairman and Members of the Committee:

I am pleased to be here today to testify concerning health insurance options and the reform of private health insurance. My statement today is based on both an update of a past report[1] we completed on this issue and additional ongoing work we are performing on state and state-oriented health reform initiatives.

Because of rising health care costs and resulting competitive insurance practices, there is growing concern that the continued availability of employer-sponsored health insurance is coming under pressure. Traditionally, the United States has relied on voluntary employer-provided health benefits to insure Americans under age 65. Between 1980 and 1988, however, the number of people covered by any private insurance fell by about 5 million despite employment growth of more than 15 million.

My testimony this morning focuses primarily on small businesses[2] and their employees, for whom the affordability and availability of health insurance are especially acute problems. The smaller the firm, the less likely it is to offer health insurance. About one third of all the uninsured--almost 10 million people--work for or are dependents of people who work for small businesses.

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[1]Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting, GAO/HRD-90-68, May 22, 1990.

[2]Companies with 25 or fewer employees

The difficulties small businesses face appear to be increasing. Last year, a survey by the National Federation of Independent Business found that about 19 percent of firms not currently offering health benefits had offered it in the near past.

Restricted availability and higher premium prices for small firms result from the workings of the competitive insurance market. There is concern that the competitive insurance practices and market conditions that result from rapidly increasing health care costs threaten the viability of the voluntary employer-based system. Specifically, the competitive insurance practices and market conditions that affect small businesses and their employees include:

-- competition among insurers to offer coverage only to the best risks, and the subsequent decline in availability of community-rated health insurance products;

-- incentives to self-insure, created by the increasing prevalence of experience-rated health insurance policies and the less stringent regulation of the self-insured, that small businesses generally cannot take advantage of;

-- restrictive underwriting practices, including the exclusion of individuals (or dependents) from an insured group or excluding an individual's preexisting medical conditions, as well as insurers' refusal to renew coverage or offer coverage for certain industries and groups; and

-- purchasing power advantages available to large firms, both in the amount of their health care expenditures used for administrative overhead, and in their ability to negotiate discounts with providers.

I will discuss each of these in turn.

Competition among Insurers and the Decline of Community Rating

The purpose of insurance is to transfer the risk of economic loss from an individual to an insurer. The insurer agrees to pay losses suffered by the insured in return for a premium. This agreement is possible because the insurer is able to pool the risks of a large number of insured individuals and to predict, for the group as a whole, the probable claims to be filed during a given period.

In the past, companies selling health insurance assured that premiums they collected covered claims they paid by placing all their beneficiaries into one very large group and actuarially

projecting their claims. Premiums, then, would be an equalized charge across the entire group to cover the future claims costs and administration. This process is called community rating.

Under community rating, the premium is based on the average cost of the anticipated health care used by all subscribers in a particular geographic area, industry, or other broad grouping. Premiums do not vary for subscribers (individual companies) included in each grouping--companies with healthy employees subsidize the health care costs of companies with less healthy employees. Therefore, an individual firm's premium is not increased even if the firm employs individuals with health problems, nor are premiums reduced if a company has only healthy employees. Thus, community rating allows small firms, even those with an employee or employees with high health care costs, to continue providing health insurance at the same price as all other firms.

As health care costs grew, commercial insurers found that they could attract businesses with relatively low-risk employees by offering those businesses lower rates. In addition, many medium and large firms left the insurance market and self-insured--that is, assumed the risk for their employees' health care costs themselves rather than paying an insurance company to perform this role. As the businesses opting to self-insure and the firms employing relatively low risk employees left the

community-based risk pool, the rates needed to cover the costs of serving the remaining firms rose. As the competing commercial insurance companies continued to siphon off the firms with the lowest expected health costs, the ability to spread risks in community-rated plans diminished because the remaining pool contained mainly firms with one or more high-risk employees. Rising health care costs and increased insurance market segmentation have made community-rated health insurance products less available. As a result, small firms with one or more high-risk employees may find policies that cover these individuals unaffordable.

Not only is the small group health insurance market smaller and more segmented, but insurance companies also are modifying the rates they offer a particular firm to reflect the age, sex, and health status of the individuals working there. The average premium costs for women in their twenties can be nearly twice as high as those for men of the same age, partly because of costs associated with pregnancy and partly because of generally higher use of services. Premium variation by age is also becoming more common. In one insurance plan in northern Virginia, for example, a company pays approximately $135 per month to insure an individual age 29 or under, while it pays $410 per month to insure an individual age 60 or above. Thus, firms that employ many young women or elderly employees may find employee health insurance unaffordable.

As the risk pool of insurance purchasers has been narrowed by insurance companies competing to insure only the lowest risks, and as insurance companies increasingly base premiums on individual differences, some have questioned whether health insurance is performing its traditional insurance role. Is insurance still acting to spread risks over a pool of enrollees, or has it become merely a prepayment mechanism for health care costs?

Self-Insurance Complicates Problems in Traditional Market

The market is further segmented by the trend toward self-insurance. The rise of competition among commercial insurance companies led to the development of experience rating for large firms[3]--that is, a rating that bases a group's premiums on their cost experience. Given experience rating, employers with sufficient resources found that they could reduce their health care expenditures by self-insuring rather than paying an insurance company to perform this role. Most large employers now self-insure.

The reasons larger companies are more able to self-insure include their ability to spread the risk of health care costs over their large employee populations--making costs predictable--and their tendency to have stronger financial bases that allow them to

[3]Companies with 500 or more employees

absorb any potential claims irregularities. A small firm is generally not able to self-insure because a single unexpected high-cost medical condition among its employees could jeopardize its financial situation.

The self-insurance trend has been thought to be furthered by financial incentives created by the Employee Retirement Income Security Act of 1974 (ERISA). Between 1974 and 1990 the number of the nation's employees covered by self-insured firms grew from 5 percent to 56 percent. While regulation and taxation of the health insurance industry are generally state prerogatives, for self-insured firms, ERISA supersedes "all State laws . . . relat[ing] to any employee benefit plan," including health benefits. Thus, firms that self-insure are exempt from what could be costly state regulation and state premium taxes.

ERISA was originally designed to protect employee benefit rights. Its emphasis was on employer-sponsored pension plans, and it contains detailed specifications for their operation. ERISA also regulates health plans, but contains only minimal requirements for them, while state regulations for health insurance are more comprehensive.

The financial incentives to self-insure created by ERISA include exemptions from state mandated benefits (such as pre-natal and well-baby care or services provided by a chiropractor),

state insurance premium taxes (ranging from 2 to 3 percent of premiums), and state risk pool contributions that require assessments on insurers. In addition, ERISA does not require insurance reserves so self-insured firms are not required to have them. The self-insured firm, rather than an insurance company, receives the use of such funds, from which they can generate interest. Self-insured firms also earn interest income by paying claims as they arise rather than prospectively. Firms purchasing traditional insurance, meanwhile, remain subject to the state laws requiring particular benefits and state taxes imposed on insurance premiums.

Although most self-insured firms cover the majority of state-mandated benefits, such firms do have the option not to offer certain benefits and they generally do not contribute to the state premium taxes or risk pools. This forces the traditionally-insured firms to shoulder more of the burden of any risk pool subsidy.

Restrictive Underwriting Practices

Within the traditional insurance market, small businesses face additional problems from medical underwriting used by some insurers to move costly industries, firms or individuals out of their pool. These restrictive practices often result in the exclusion of some employees from coverage if they have preexisting conditions, such as cancer, diabetes, heart disease or other high-

cost illnesses. Such individuals may be denied coverage altogether, and in other cases only the specific preexisting condition is excluded. This underwriting also may limit the coverage available to employees' spouses and dependents.

A method used by insurance companies to limit their liability for high-cost diseases and conditions is to set limits for the total amount they will pay for selected diagnoses. Some insurance companies now sell two-tiered insurance plans. These plans divide benefits into two groups with different lifetime benefit levels. Tier 1 may have a limit of $1 million, and tier 2 may have a lifetime limit set substantially lower. Conditions falling into tier 2 often include: mental illness, alcoholism, drug abuse, and Acquired Immune Deficiency Syndrome (AIDS)--all high-cost medical conditions.

As an example, a plan offered by an employer in Indiana is currently being challenged on discrimination grounds. This employer offered a health insurance plan to his employees which set a lifetime limit for AIDS-related care at $50,000.

Some insurers do not cover a number of industries where, as a group, the risk of illness or injury appears to be greater than average. As examples, some insurers do not cover:

-- logging, roofing or other high-risk occupations, where the concern is not only with the health care costs but also the legal expenses of determining whether workers' compensation or health insurance is to be the primary payer;

-- physicians or lawyers because they believe it is too expensive to deal with fraud, abuse, and litigation for small firms in these fields;

-- entertainment or sports industries because they perceive a high risk of drug abuse and their treatment costs; and

-- barbers, beauticians, and decorators because they assume a high risk of AIDS and sexually transmitted disease.

Even when a firm and its workers have a comprehensive health insurance plan, they may still be affected by their insurance company's underwriting practices. Policies can be written for a set time, and at the end of that time, an insurance company may subject covered individuals to medical underwriting criteria. This practice, known as renewal underwriting, can result in exclusion of coverage for any person who has developed an expensive medical condition while he or she is insured. Renewal underwriting allows an insurance company to renegotiate its business contract so that currently existing conditions can be

excluded as preexisting conditions and new policy limitations can be added on an annual basis.

Workers with preexisting conditions may face particular problems if their employers change insurance companies--a frequent occurrence. Nearly a third of insured firms either are dropped by their insurance companies or leave their insurance companies each year.

First-year costs for a small business policy are considerably lower than the costs for subsequent years because of medical underwriting and preexisting-condition exclusions. In the second and subsequent years, some preexisting condition exclusions expire and the covered population begins to develop new conditions leading to higher costs. Higher costs generate the need for rising premiums. In the face of these higher premiums, many small businesses respond by seeking a new insurer who will offer them a lower first year rate. An employee with a serious illness or even a pregnancy that began under the lapsing insurance contract may not be covered. These employees may find themselves excluded from necessary coverage under the new insurance company.

Small Businesses Face High Costs in Offering Health Insurance

In addition to the problems created by competitive insurance practices, there are other reasons purchased insurance may impose

higher costs on smaller businesses. Small firms and their employees have been particularly hard hit by the general rise in health care costs. During 1988, health care costs for firms with fewer than 25 employees increased by 33 percent--a rate of increase 1 1/2 times the rate experienced by the nation's largest firms.

An important component of the high insurance costs faced by small businesses is administrative cost--the cost of administering and providing health insurance other than actual payments for medical services. Administrative costs vary among purchasers of health insurance. A Congressional Research Service (CRS) study found that smaller businesses pay a much larger portion of their premium for administrative costs than do larger businesses. Table 1 shows that smaller businesses are charged more for all aspects of administrative expenses--administration of claims, risk premium charges, and commission payments.

Table 1: Breakdown of Insurance Company Administrative Expenses (Percentage of Incurred Claims)

Number of employees	General[a]	Profit & risk	Commission	Total
1 to 4	23.1	8.5	8.4	40.0
5 to 9	21.0	8.0	6.0	35.0
10 to 19	17.5	7.5	5.0	30.0
20 to 49	14.9	6.8	3.3	25.0
50 to 99	10.0	6.0	2.0	18.0
100 to 499	8.9	5.5	1.6	16.0
500 to 2,499	7.8	3.5	0.7	12.0
2,500 to 9,999	5.9	1.8	0.3	8.0
10,000 or more	4.3	1.1	0.1	5.5

Source: CRS - Private Health Insurance: Options for Reform, Sep. 20, 1990.

[a]Includes claims administration, general administration, interest credit, and premium taxes.

A further advantage of large firms is their ability to use their size as market clout in negotiating discounts with providers if they self-insure. Small firms do not have the size or market power to do this. Discounts offered to large firms, as well as the ability of Medicare and Medicaid to set provider reimbursement rates, may drive up the costs to those still purchasing health insurance, as providers attempt to make up the cost differential of the discounts.

Small firms that are unincorporated face additional higher insurance costs because of the differing tax treatment of benefits offered by incorporated and unincorporated businesses. In 1989, using an IRS classification, there were about 14 million self-

employed, sole proprietorship, partnership, and S-corporation[4] firms. Such firms are allowed a 25-percent deduction for health insurance premiums paid for themselves and their employees. Incorporated businesses, on the other hand, are allowed a 100-percent deduction for these expenses. The higher tax rate imposed on health benefits provided by unincorporated businesses contributes to the higher costs this type of small firm faces when purchasing health insurance.

ATTEMPTS AT REFORM

The problems with the small business health insurance market have been recognized by a number of groups who are initiating reforms targeted at the state level. These reforms fall into three main categories: (1) rating and underwriting reforms; (2) state mandate exemptions; and (3) subsidies for purchasing insurance.

Rating and Underwriting Reforms

The Health Insurance Association of America (HIAA), the Blue Cross and Blue Shield Association, and the National Association of Insurance Commissioners (NAIC) have recently developed packages of

[4]A small corporation that elects to be taxed as a partnership for Federal income taxation purposes

similar rating reforms that aim to ensure the availability of health insurance to any small business, regardless of its employees' health conditions. The proposed reforms aim to introduce predictability and stability to the small employer health insurance marketplace. These proposals include the following common elements:

-- a guarantee of availability of coverage for all groups wishing to purchase health insurance;

-- a ban on exclusion of coverage of any individuals who are part of employed groups purchasing insurance;

-- a ban on insurance companies' imposing preexisting-condition exclusions once an individual has obtained coverage and fulfilled the preexisting-condition requirements of any plan, even if an employer switches insurance plans or an employee changes jobs;

-- a requirement that insurance purchased by a group is renewable upon expiration, despite any health status changes of members of the group;

-- a limit on the range of premiums insurance companies can charge similar firms and a limit on year-to-year rate increases for any particular firm; and

-- a reinsurance mechanism for insuring high-cost members of a group or high-cost groups.

The Blue Cross and NAIC proposals include a recommendation for changes that would increase states' regulatory authority over their insurance markets. Greater state control would require amendments to ERISA so that all groups providing insurance--insurance companies and firms that self-insure--operate under state regulations. Several states, including Connecticut and Maine[5], have already adopted components of these reform proposals.

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[5]In Connecticut, legislation was enacted in May 1990 that includes the following provisions: (1) carriers in the small group market are: required to accept all applicants for coverage, prohibited from dropping employers from coverage because of bad experience, and limited in the use of a group's own heath status or experience in determining the group's rates; (2) a mandatory, private reinsurance program is established to spread the costs associated with accepting all small groups; losses from this program are financed from the small group market, first, and then from the rest of the private insured market; and (3) currently uninsured small groups (that have not provided coverage for the past two years) will be able to purchase special lower-cost products from all carriers; these products are available at a lower cost because they establish provider reimbursement at 75 percent of Medicare rates. Balance billing of insured individuals with incomes below 200 percent of poverty is prohibited.

In Maine, legislation was enacted in April, 1990, that limits pre-exiting condition exclusions to two years, and requires continuity of coverage for these conditions when one group policy is replaced by another.

Exemptions from State-Mandated Benefits

Within the last year, nine states passed laws allowing insurance companies to offer packages exempt from most state-mandated benefits to small businesses. State-mandated benefits require health insurance policies to cover specific diseases and health care services. Mandate exemption laws attempt to reduce the cost of health insurance for small businesses by allowing them to provide a limited benefits package.

Proposals for reform introduced by HIAA and the Blue Cross and Blue Shield Association include provisions that would allow carriers to develop lower cost products for small employers by exempting insurers in the small group market from state mandated benefits.

Subsidies for Purchasing Health Insurance

Six states have enacted legislation that authorizes tax incentives to small firms for insuring their employees. Generally, these laws establish temporary state tax credits to small firms that purchase health insurance to reduce their initial expense.

Private groups, such as the Robert Wood Johnson Foundation, have developed insurance reform initiatives that offer subsidized

health insurance to make it more affordable. The Robert Wood Johnson Foundation, along with several state and local governments, funded 15 different programs designed to increase the availability of health insurance. Several of these projects provide direct subsidies to small businesses or employees of small business to purchase health insurance. Most of the projects offer new insurance through health maintenance organizations (HMOs) or tailor existing insurance packages to meet the needs of the small business insurance market.

ISSUES REFORMS LEAVE UNRESOLVED

The state and private reform efforts provide some models for Congress to consider in addressing health insurance reform. They begin to address the access problems faced by groups that currently find it difficult to obtain insurance. The proposed rating reforms begin limiting the insurance practices that often exclude high-risk groups and group members from health insurance coverage. Mandated benefits exemptions and subsidies should lower premiums for small businesses wishing to purchase health insurance. These proposals, leave two major issues unresolved.

Rating Reforms Redistribute Costs Among Employers

First, by requiring the inclusion of high-cost individuals in group plans, the recommended reforms will cause those currently paying the lowest premiums to pay higher premiums because they will begin subsidizing high-cost individuals. Excluding more expensive individuals lowers costs for others purchasing insurance. With costs increased for some purchasers of health insurance and decreased for others, what remains unclear is how much more (or less) insurance will be purchased.

Cross subsidization equalizes the burden of health costs between the sick and the healthy. It may, however, be difficult to move from the segmented market we have now to one in which risks are spread more broadly. Some insurers have expressed concern about the transition from the segmented health insurance market to a more inclusive market. Requiring insurers to community rate could penalize insurance companies that already have larger numbers of high-risk groups in their plans. Companies now are able to charge higher rates to groups expected to be less healthy. Under community rating, these insurers would have to charge higher average premiums than insurers who now cover lower-risk groups. Therefore, they could lose their current enrollees and fail to attract new enrollees.

Also, the proposed rating reforms only address purchased insurance. While insurance costs may be reduced for some employers, those that opt out of the insurance market retain some advantages that small businesses cannot generally obtain. States and private groups are unable to resolve the difference in regulatory environment caused by the ERISA pre-emption; Congressional action would be required. Without amendments to ERISA, reform targeted on the small group market preserves the split between traditional and self-insured plans because the incentives to self-insure remain. This leaves mainly small businesses to bear the brunt of state regulation and taxation. Moreover, states remain limited in their ability to regulate and attempt reform of health benefits offered by employers.

Reform Proposals Do Not Address Overall Cost Growth

Finally, the reform efforts neither stop nor reduce the rising cost of health care. Health care cost inflation has components outside the realm of insurance reform. Even a portion of costs originating within the insurance industry--the high cost of overhead for small businesses' health insurance--is not addressed. Therefore, health insurance costs will continue to increase and firms will face pressure to drop out of the market.

CONCLUSION

In summary, the competitive workings of the insurance market disadvantage small firms wanting to purchase health insurance. Insurance companies have intensified competitive practices in order to offer lower cost plans to lower-risk groups. Large firms have responded to cost pressures by opting out of the health insurance market altogether by self-insuring. Smaller firms cannot exercise this option, and have faced health care costs that increased one and one-half times faster than the rate experienced by larger firms. Small firms also bear the brunt of both competitive insurance practices and state regulation. As a result, it is becoming more difficult for many small firms to offer health insurance at all. The proposed reform attempts I described begin to address some of the problems of rating, underwriting and cost. However, these reforms would lead to some cost redistribution among firms in the commercial market. They would still leave a differentially regulated industry with some health benefit plans subject to state insurance regulation and taxes and others not. Finally, they do not address the need for cost control.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions at this time.