

Affordability

Key Issue for the Uninsured

Paul Mahoney

The recent economic downturn has heightened concerns about Americans without health insurance coverage. Numerous organizations have called for action: Families USA, the Association of Academic Health Centers, the Healthcare Leadership Council, the American Association of Health Plans, and various business organizations and labor unions. Few have provided details on how to combat this long-standing problem effectively. A broad consensus regarding what must be done is likely to be elusive.

Cost

The rapid rise in insurance premiums has made cost the number one issue in health care. Despite political rhetoric about “patients’ rights,” and the need for more insurance regulation, what the public really wants is basic, affordable insurance. Cost continues to be the major barrier to obtaining insurance. A recent survey of small employers conducted by the Employee Benefit Research Institute (EBRI) found that 70% of employers did not offer coverage to their workers because of cost concerns.

This situation is steadily worsening. The federal government’s annual report on national health expenditures shows a 6.9 % increase in 2000, following a 5.7 % increase in 1999. The Centers for Medicare and Medicaid Services called this “the greatest acceleration seen since 1988.” North Carolina insurance premiums rose sharply in 2000 and 2001 and will likely continue to rise. NCAHP’s HMO Cost and Utilization Study found that the “per member, per month” cost of pharmaceutical benefits has risen from \$12 in 1995 to more than \$30 in 2000, primarily because of increased

utilization. Costs for outpatient procedures were also up considerably, without the proportionate drop in inpatient costs expected as “same-day surgery” approaches replace inpatient operations.

Our nation’s employer-based coverage system is increasingly threatened by rising costs. A recent survey of more than 4,000 companies by the Florida Chamber Federation found that the number of companies offering health insurance has dropped from 91 % in 1999 to 77 % last year. Of respondents not providing insurance, 92% cited high costs or limited access to group health insurance as the reason; 42% indicated they might have to eliminate insurance benefits if cost increases continued.

Benefit costs are rising for a variety of reasons. The ability of private-sector health plans to manage care, and hence control cost, has been eroded in recent years by consumer demand for more loosely managed insurance products. For example, preferred provider organization (PPO) plans offer ready access to any physician. Pharmacy coverage has moved to “open” formularies that cover virtually all drugs. Strict gatekeeper models are giving way to “open-access” networks that allow directly access to specialists.

New insurance laws and regulations make it illegal to require preauthorization for childbirth and emergency care, reducing a health plan’s ability to manage these events effectively. While the industry strongly supports external appeals of health plan decisions, the cost of the appeal process does mean that “just pay it” may be the cheapest approach for low-cost services of questionable value.

Health insurance costs are also affected by our changing demographics: as the population ages, it tends to use more medical care. Finally, medical treatment has simply gotten better. Breakthroughs in technology have produced remarkable treatment options, but these medical marvels are not without cost. Some advances in technology primarily enhance the *convenience* of health care services. This is particularly true in pharmaceuticals, where new products that are

The author is Executive Director of the North Carolina Association of Health Plans, Inc. Address correspondence to him by email at: pmahoney@ncahp.org.

easier to use are very popular (for example, oral treatments versus injections). Direct-to-consumer advertisements for these products tend to increase both drug use and related physician office visits.

Strengthening Employer-Based Coverage

The key public strategy should be to maximize the stability of the existing employer-based private market. While legislators continue to focus on mandating more benefits and consumer protections against alleged abuses (documented by anecdotal evidence, if at all), policymakers must realize that the public is primarily concerned with having access to affordable, basic insurance. Lawmakers should reject legislation that increases insurance premiums, as these rising costs exacerbate the uninsured problem.

This will require a significant policy shift due to the immense popularity of sound-bite-driven “reform” legislation. Many of these reform efforts, ostensibly passed to protect consumers, have driven up the cost of providing benefits while doing little to improve quality.

Insurance legislation should be entered into with extreme caution, because such laws frequently produce unintended consequences and raise administrative costs. Shifts in health policy generally result in “winners and losers,” assisting one group at the expense of others. For example, North Carolina’s compression of small business rating bands was aimed at making insurance more affordable for older, sicker groups. But moving North Carolina toward a community rating system sharply raises rates for younger, healthier groups. As these “good risks” turn to self-funded arrangements exempt from state laws or drop their insurance coverage entirely, rates for sicker groups tend to rise again. Furthermore, laws limiting what carriers can charge high-need groups have led to shortages of carriers in some parts of the state.

Benefit mandates are a classic example of this pattern. While additional benefits are always popular with consumers and advocacy groups, they drive up costs, pushing insurance out of the reach of more groups or influencing them to pursue self-insured options. In the end, providing ever-richer benefits to a diminishing portion of the population is poor public policy. North Carolina’s General Assembly took a strong step in the right direction last session when it enacted a bill (introduced by Representative David Redwine) calling for a moratorium on benefit mandates.

Legislators should consider moving in the opposite direction by allowing insurers to pilot a “basic coverage” policy targeted at low-income workers. If health care providers would agree to accept reduced reimbursement rates for these policies, coverage could be offered at rates likely to attract many small businesses. These programs could be structured to phase in state-mandated benefits over a three-

to four-year period. This would nudge employers toward comprehensive coverage while allowing immediate access to affordable policies.

North Carolina must also consider tort reform to limit the costs of lawsuits. North Carolina is already suffering from a “hard” market for malpractice insurance, and a major insurance carrier will soon cease North Carolina operations. Since the General Assembly has recently created new ways to sue health plans, costly tort suits are likely to inflate premium rates, leading to more uninsured citizens.

Targeting Efforts

It is important to target uninsured initiatives precisely, as people lack coverage for diverse reasons. Those who lack access primarily because of health status appear to be a minority. The General Assembly is expected to study high-risk health insurance pools in the 2002 Session. While such pools provide a safety net for those with few current options, they affect only a narrow portion of the uninsured population. Pools established for a public purpose should be supported by broad public funding; relying on fees imposed on state-regulated employer health plans would create an unfair burden on an extremely narrow segment of the population.

Policymakers should also acknowledge that, while most people without coverage would much prefer to carry this protection, some people (especially young adults with limited assets) turn down affordable insurance options, and may continue to make that choice.

Persons who have recently been laid off from jobs that provided health coverage should be key targets for uninsured initiatives. Even though they are eligible for coverage under COBRA or state continuation laws, the premiums may be beyond their financial means. Providing limited subsidies to purchase continuation coverage is a cost-effective method of extending temporary insurance protections.

High Cost of Avoiding the Issue

Progress is most likely to occur when all stakeholders are persuaded that they already pay a high price for uninsured citizens. With or without insurance, people always have access to healthcare, although it may be obtained in a highly inefficient manner (at advanced stages of disease, via emergency rooms, etc.). Failing to fund programs that minimize the uninsured population itself carries a significant cost that will ultimately fall on employers, employees and local taxpayers. County commissioners need to understand how significantly costs for indigent care soar when insured rates drop.

Healthcare Is a Business

Public debate on the uninsured rate must acknowledge that healthcare is a trillion-dollar business. The assumption that all stakeholders only want to hold down healthcare costs is patently absurd. The motivations of a market economy are undeniable: like any other sector of the economy, health care providers aim to maximize their income. Voluntary agreements to hold down prices won't work, and government price controls inevitably lead to shortages.

In a market economy, it is competition that keeps prices in balance and so government policies should encourage active, effective competition. This implies strict enforcement of anti-trust laws to promote competition between health care providers. Sadly, the reverse has been true in North Carolina. A spate of mergers has given some health care systems what amounts to monopoly power. While hospitals understandably seek economies of scale and strong market leverage, the public must be protected from the anti-competitive effects of such arrangements. To date, neither the state nor federal government has seriously challenged the increasing concentration of provider ownership in North Carolina, with devastating consequences on the cost of care. Furthermore, an unintended consequence of state insurance laws aimed at encouraging health plans to build broad networks has been the creation of incentives for providers to refuse to contract with managed care organizations. Requiring health plans to pay providers more *not* to join a network seriously undermines efforts to keep healthcare affordable.

Reforming the State Medicaid Program

State lawmakers should consider private-sector options for the state Medicaid program. Private employers have overwhelmingly turned to managed care organizations to maximize the value of their healthcare purchases. Shouldn't government programs strive for similar efficiencies with taxpayer funds? An extremely successful Medicaid HMO pilot started in Mecklenburg County in the early '90s was never expanded, largely because of political resistance to change. A state with a billion-dollar shortfall should be willing to consider innovative approaches to the problem, including private sector options.

Tax issues

It's just not fair that employees of large corporations can purchase health insurance on a pre-tax basis, while employees of small firms and the self-employed must pay with after-tax dollars. While state tax credits are somewhat helpful, this is largely a matter for Congress, which is in the process of

phasing in broader deductibility. The timeframe for this phase-in should be accelerated as much as possible.

For persons working at low-wage jobs who do not qualify for Medicaid, federal and state governments should consider tax credits that can be used to purchase private insurance, perhaps taking the form of a voucher for citizens with little or no tax liability.

Medical savings accounts (MSAs) encourage people to view health costs as "their own money," which may help reduce unnecessary utilization. The idea of allowing people to accumulate funds tax-free for health costs certainly has merit. However, MSAs linked to high-deductible insurance plans attract primarily the healthy and financially well off, driving up insurance costs for everyone else. Also, consumers face significant financial risk in the early years of an MSA, when a serious illness could leave them with few dollars in their MSA and high out-of-pocket costs. MSAs linked to more comprehensive products may prove more workable than earlier versions of this concept.

Employer education

The EBRI study found that 50% of employers did not know that individual premiums were not tax-deductible; 60% were unfamiliar with laws requiring insurers to issue group coverage regardless of health status. The full benefits of existing laws can't be realized if employers making decisions don't know about them.

Employer education is also the key to finding better ways to encourage preventive healthcare. The first step is to develop measurements credible to employers that link preventive efforts to increases in productivity and health care savings. Of course, employers will be most strongly motivated to support efforts that produce *immediate* savings, such as management of asthma and diabetes. Public health efforts must continue to promote preventive efforts that will pay off in the more distant future, e.g., those targeting heart disease and cancer. Employers should consider offering discounted contributions for employees who eat a healthy diet, quit smoking, or exercise regularly. Sharing some of the savings with employees would encourage such healthy choices. No incentive program should have the effect of levying surcharges on the sick; such initiatives should reward positive lifestyle choices that virtually anyone can make.