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Commentary
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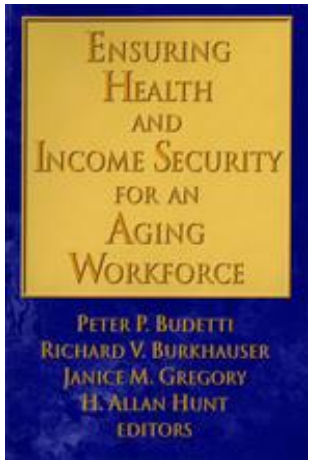

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Mathematica Policy Research

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The fact that older women are less likely to have health insurance coverage than they were a decade ago is not surprising, but the fact that they are about half as likely to have individual coverage than a decade ago is surprising. That they are about half as likely as younger women to have health insurance coverage as a dependent is sobering, as is the fact that nearly a quarter of older working women with health problems have no health insurance at all.

From the CPS, we have evidence that small firms are more likely than large firms to employ low-wage workers. We also see persistently lower wage levels among women, and especially among older women. It shouldn't altogether surprise us that these paths converge in a way that disadvantages older women in the workforce.

So there are a couple of problems to be solved. Len was charged with solving those problems—and did indeed think outside the box—and he certainly is a good seller of his perspective. But his discussion raised at least two questions in my mind: what would be the source of coverage for this population and what would be the source of subsidies? These are low-wage individuals and low-wage families; as was mentioned in the last session, we know that these families require subsidies to buy insurance. While I wouldn't expect to dictate what an individual should pay for health insurance, I would guess it would be something less than a tithe, less than 10 percent of family income. Therefore, I would guess that virtually all families below 200 percent of poverty, and perhaps higher, would need a significant subsidy to buy health insurance.

Len raises several possibilities for pooling risk, including FEHBP and state employee plans. We have been the route of mandated employer coverage in the private sector, and we abandoned it for a couple of reasons. Groups of any size don't like to accept individuals. From an underwriting perspective, individuals are a very different cast of characters. Employee plans are groups that form not for the purpose of insurance, individuals arrive explicitly for coverage, raising signifi-

cantly the potential for adverse selection. People who seek coverage when they are sick are more expensive than the population average and more expensive than a group community rate. The only question is how much more expensive will these people be? It is not a question of whether individuals would like to be pooled with employee groups, but, from an insurance perspective and from an underwriting perspective, the two are very different. We have to worry also about people dropping away and destabilizing the group when they believe that they no longer need health insurance. Pools of employees don't pose that problem to the extent that pools of individuals do in a voluntary system.

The program that Len envisions is appealing in some dimensions, but I would argue it is very unappealing in others, such as equity. Why would we want to construct yet another narrow program for a narrow subset of the deserving whomever? Why does an older woman who is sick and of low income deserve coverage more than a younger woman who is sick and of low income, or an older man who is sick and of low income? I don't understand why we would discriminate across a population on the basis of age and gender, when in fact we don't allow that discrimination in any other aspect of our civic life.

We already have some programs expressly for people who are low income and people who are sick: Medicaid and Medicare. We have additional, usually very small programs in many states. In 28 states, there are more or less well-functioning high-risk pools. I would like to spend a few minutes talking about what those high-risk pools are and why HIPAA, the Health Insurance Portability and Accountability Act that Karen Pollitz talked to you about yesterday, might be a model for helping them to work better.

As I mentioned, 28 states have high-risk pools, although in five big states—California, Florida, Louisiana, Illinois, and Utah—they are closed to new enrollment. Despite the fact that high-risk pools are struggling in these and many other states, there are only seven states in this country that have no provision at all for high-risk individuals. Among the states that provide for high-risk individuals, one requires guaranteed issue and risk adjustments. Another caps the proportion of high risk that any one insurer must accept relative to its total business. TennCare blends Tennessee's high-risk pool with its Medicaid and CHIP programs. But the most common model is a separate high-risk

pool, and the most common source of funding for these high-risk pools is an assessment on commercial insurers and Blue Cross/Blue Shield plans.

Well, you see the problem. States that fund a high-risk pool with a tax on insurers in effect reward employers who are self-insured. In turn, the tax base to support high risk becomes smaller as employers remove themselves from it. Hence, without federal action helping high-risk pools, they may be a lost cause; but with federal action on the model of HIPAA, they might work quite well by reaching across group plans, individual plans, insured plans, and self-insured plans, treating them as an insurance system that would support high-risk individuals without access to group coverage.

There are other aspects of high risk that might be fixed with HIPAA-type federal legislation. Many states have narrowed insurers' rating practices, especially in the small-group market but also in the individual market. At present, six states limit rate variation for health to less than two to one in the individual market, and eight states prohibit health rating altogether in this market. The latter is the community rate that Len talked about; there are indeed problems with low-risk people dropping coverage. But if there were a high-risk pool that would readily accept and fully subsidize excess risk, the community rate could be much lower in the general market.

In fact, the literature on the effect of a community rate on coverage in the individual market is extremely meager. I have not yet seen a study only of the individual market that evaluates the impact of regulation. Nevertheless, Len's comment that some kinds of regulation depress coverage in the small-group market seems true from what we know thus far, and it is probably also the case in the individual market. Yet, if a high-risk pool accepted all extreme risks, then one would expect the standard rate in the conventional market could be significantly lower and prohibition of health rating would not depress coverage. For example, Minnesota has the largest high-risk pool in the country, with over 25,000 people participating. Minnesota is a market in which insurers underwrite aggressively, and the high-risk pool actually has a distribution of risk. Its rates are affordable because of the distribution of risk in the pool as well as the usual subsidy to the pool.

At present, 11 states limit age rating in the individual market significantly, and 3 states prohibit rating on age altogether in the individ-

ual market. Eleven states also limit composite rating: that is, all rate factors taken together cannot produce greater variation in rates than the statutory limit. Those markets have not fallen apart, and they deserve closer investigation as potential models for new federal law constraining insurer rates, especially in the presence of a state program to absorb high risk.

In closing, I would argue that a principal danger is to try to fix too much. That is especially a danger when looking at private/public combinations that rely heavily on private markets to resolve problems of noncoverage. One example of attempting to fix too much may be states' efforts to reduce the waiting period for coverage of preexisting conditions, eliminating it or making it very brief. There I would argue that HIPAA offers a reasonable model. HIPAA provides that, if you do not come from an insurance plan, you have a waiting period on preexisting conditions up to 12 months, with a 6-month look-back. It is not perfect, but it recognizes the frailties of a voluntary system. If we are not going to require coverage, either of individuals or employers, then we must deal in reasonable improvements, knowing that they assure neither seamless protection nor universal coverage, especially for people with health problems.