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# ACROSS STATE LINES EXPLAINED

Why Selling Health Insurance Across State  
Lines is Not the Answer

JOHN M. BERTKO  
LEN M. NICHOLS  
ELIZABETH CARPENTER

HEALTH POLICY PROGRAM

NEW AMERICA FOUNDATION

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## Executive Summary

As we enter the home stretch of a long presidential campaign, the good news is that both major candidates recognize that our health care system, especially the insurance marketplace, does not work well. The concept of selling health insurance across state lines has been included in health care proposals put forth by several Members of Congress and most recently in the campaign plan of Republican presidential nominee, Senator John McCain.

Allowing insurers to sell insurance across state lines would not work as advertised. While it may help the young and healthy, it will have a devastating impact on the

insurance market for everyone else (and none of us will be young and healthy forever). Premiums would rise for many people, benefits would be less-generous, and more Americans would likely become uninsured over time. This policy approach fails to provide the incentives necessary to transition insurers to a 21st Century business model that values care coordination and high value care over underwriting and marketing. Without substantial additional reforms, the proposal to sell insurance across state lines will not work for most Americans.

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# IN BRIEF: ACROSS STATE LINES EXPLAINED

Allowing insurers to sell insurance across state lines would not work as advertised. While it may help the young and healthy, it will have a devastating impact on the insurance market for everyone else (and none of us will be young and healthy forever). Premiums would rise for many people, benefits would be less generous, and more Americans would likely become uninsured over time. This policy approach fails to provide the incentives necessary to transition insurers to a 21st Century business model that prioritizes care coordination and high-value care over underwriting and marketing. Without substantial additional reforms, the proposal to sell health insurance across state lines will not work for many Americans.

*Myth: Purchasing insurance across state lines will lead to substantially lower health care premiums for consumers because they will not have to buy insurance plans that include expensive benefit mandates.*

**Authors' Analysis:** Selling health insurance across state lines would lead to higher premiums for Americans seeking comprehensive insurance policies. In addition, allowing the purchase of insurance across state lines would eliminate any guarantee that important benefits like maternity and emergency care will be included in insurance packages in the future. Consumers would get little in exchange – overwhelming evidence shows that benefit mandates per se are not why health insurance costs so much.

*Myth: Allowing health insurance to be sold across state lines will make it easier for individuals to find health coverage because they will have access to more products.*

**Authors' Analysis:** The purchase of insurance across state lines would make it harder and more expensive for many Americans to buy quality health coverage by leading to fewer guaranteed issue insurance policies and higher premiums for people with health conditions.

*Myth: Allowing insurers to sell health insurance across state lines would let individuals purchase any insurance product from any state and increase competition among insurers. This would lower premiums.*

**Authors' Analysis:** Many insurance products would not be sold to residents of every state under an across state lines proposal. And, it is unlikely that out-of-state insurance products would cost less. Furthermore, a proposal to sell across state lines could undermine the ability of integrated health systems and Blue Cross/Blue Shield plans to be competitive.

## What is “Across State Lines?”

Proposals put forth by several Members of Congress and Republican presidential nominee Senator John McCain, include provisions that would allow Americans to buy and insurers to sell health insurance across state lines. Under these proposals, insurers could sell their products to Americans in any state. The insurer would have to follow the rules and regulations in the state where it is based or “domiciled” – not the rules of the state where the consumer or policyholder lives. Allowing the state laws chosen by the insurer, rather than the laws of the state where the consumer lives, to govern health insurance regulation is what makes this policy so controversial.

*Myth: Eliminating the tax preference for employer-provided health insurance while allowing Americans to purchase insurance across state lines will “level the playing field” between group and non-group insurance and substantially increase Americans’ access to coverage.*

**Authors’ Analysis:** Eliminating the employer tax exclusion in conjunction with an across state lines proposal would lead to more uninsured or underinsured Americans over time. Fewer employers would offer coverage and millions of Americans would have to find coverage in the virtually unregulated individual insurance market. Individuals transitioning from the employer-sponsored system to the across state lines marketplace would face higher premiums based on their health history and insurance policies that lack many benefits regularly covered by employer-sponsored insurance.

*Myth: Typical high risk pools will ensure that all Americans have access to affordable coverage.*

**Authors’ Analysis:** High risk pools combined with the sale of insurance across state lines would force many Americans to pay very high premiums or forgo insurance. In addition, high risk pools would encourage insurers to raise premiums for people with health conditions or deny coverage. This kind of aggressive underwriting would leave millions of people in high risk pools at a high cost to the government (who would subsidize the policies) and the consumer (who would likely face higher than average premiums).

*Myth: It is impossible to make an across state lines marketplace and high risk pools function in a way that makes insurance markets work for all Americans.*

**Authors’ Analysis:** An across state lines proposal and high risk pools could function in a way that benefits all Americans, but only in the context of: 1) guaranteed issue and low-income premium subsidies or adequately funded high risk pools, and 2) federal licensure and regulatory oversight of insurers.

## Notes

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All of the information in this Brief comes from “Across State Lines Explained,” by John M. Bertko, Len M. Nichols, and Elizabeth Carpenter,\* New America Foundation, October 2008.

\*John M. Bertko, FSA, MAAA is an Actuarial Consultant with the Health Policy Program. Len M. Nichols, PhD is the Director of the Health Policy Program, and Elizabeth Carpenter is a Senior Program Associate with the Health Policy Program at the New America Foundation.

As we enter the home stretch of a long presidential campaign, the good news is that both major candidates recognize that our health care system, especially the insurance marketplace, does not work well. Senators Barack Obama and John McCain diverge widely in how they would overhaul the insurance market (less so in how they would try to modernize the health care delivery system). Yet both have called for sweeping federal legislation aimed at improving the insurance market's performance, particularly for those Americans who purchase their health policies in the individual or small group markets.

This policy paper does not aim to provide an exhaustive critique of the candidates' health reform proposals. We encourage readers to study the candidates' positions on their official web sites,<sup>1</sup> as well as comprehensive reviews by reputable analysts.<sup>2</sup> Our goal is to shed analytic light on one particularly controversial policy: allowing Americans to buy and insurers to sell health insurance across state lines.

The concept of selling health insurance across state lines (hereafter ASL) has been included in health care proposals put forth by several Members of Congress and most recently in the campaign plan of Republican presidential nominee, Senator John McCain.<sup>3</sup> Under the proposal, insurers could sell their products to Americans in any state. The insurer would have to follow the rules and regulations in the state where it is based or "domiciled" – not the rules of the state where the consumer or policyholder lives. Allowing insurers to do business with residents of a given state without requiring them to follow the laws governing solvency and consumer oversight in that state is highly controversial.<sup>4</sup> Our analysis, however, focuses on what ASL means for insurance market performance. Understanding ASL is essential because the idea holds great risk for the Americans who would purchase health insurance in this new market and health reform in general. Rather than making health insurance more affordable and accessible, ASL would likely lead to de facto deregulation and a race to the bottom – less comprehensive benefits, more costs shifted to families, and reduced access to care.

Theoretically, it is possible to modify ASL to make insur-

ance markets work for all Americans. To do this, two major reforms are necessary:

- Insurers would need to sell to all customers, regardless of health status (i.e. guaranteed issue), or high risk pools would need to be subsidized sufficiently to make them genuinely accessible to millions of Americans.
- Insurers selling across state lines would have to be licensed and monitored at the federal level to prevent the market from devolving to the standards set by the state with the lowest regulatory threshold.

These reforms, which we will address in more detail below, are theoretically feasible but not typically supported by ASL proponents. Yet without these modifications, ASL will not work as advertised. The idea should be eliminated from health policy debate no matter who wins the November 2008 elections.

## Motivation for the proposal

Since Representative John Shadegg (R-AZ) originally introduced the ASL concept, it has been included in several pieces of legislation in the House and the Senate. The House included ASL as part of a broader measure passed in 2005; it has never been approved by the Senate.<sup>5</sup>

The basic motivation behind ASL is a legitimate frustration with insurance market performance. Health insurance costs too much. Costs are rising too fast. In addition, in some markets (small group in particular) relatively few insurers offer competitive rates, a trend that is unlikely

to improve without significantly changing how insurers operate.<sup>6</sup> ASL has also appealed to small business owners seeking to make health insurance more affordable and accessible for their employees.<sup>7</sup>

Nevertheless, the fundamental empirical assumption that underlies ASL—that state regulation is the primary reason for high insurance costs in the small group and individual markets—has far less support from reputable evidence than proponents claim.<sup>8</sup>

## Likely impact of across state lines

Under an ASL proposal, Americans could buy any health insurance product from any state. Insurers could pick the set of non-group or small group regulations that would govern their business by choosing where they domicile. In theory, this could serve competition and consumers in three ways:

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Under an ASL proposal, Americans could buy any health insurance product from any state.

Insurers could pick the set of non-group or small group regulations that would govern their business by choosing where they domicile.

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- it would pressure states to reduce “unnecessary” regulations because costs would be higher for firms who are based in high regulation states,
- it would give certain consumers more insurance options (and prices) than they have today,
- it would allow insurers to “tailor” insurance packages to fit individual needs and preferences, ending the “forced” standardization and risk pooling that benefit mandates, guaranteed issue, and community rating entail (i.e. a 60-year-old man could purchase a policy that had no maternity benefits).

The first two goals are laudable; the problem is not with

ASL’s objectives but with its execution. Insurers cannot compete if their competitors are operating under more flexible market rules. The least restrictive rules will allow insurers domiciled in low regulation states insurmountable advantages, including the ability to drive others out of business by attracting and selecting the healthiest customers. Given this reality, ASL would lead most insurers to domicile in the state with the least restrictive rules. That state’s relatively hands-off approach to regulation would become the de facto national standard, as in the credit card industry.<sup>9</sup>

Therefore, ASL would lead some young, healthy individuals who live in high cost states—such as states with guaranteed issue or many benefit mandates—to find a better deal elsewhere. The insurers in low regulation states will further segment the market by separating people into risk classes, and then selling primarily or even exclusively to the low risk class. Let us be clear: the primary source of “savings” under ASL is not more competition or more efficient insurers. The savings come from separating the healthy from the sick.

ASL may well help the young and healthy but it will hurt everyone else. And since none of us will be young and healthy forever, ASL would ultimately help risk-segmenting insurers far more than most people. The market would be effectively deregulated, and many groups would see higher premiums.

### Benefit Mandates

*Myth: Purchasing insurance across state lines will lead to substantially lower health care premiums for consumers because they will not have to buy insurance plans that include expensive benefit mandates.*

**Authors’ Analysis: Selling health insurance across state lines would lead to higher premiums for Americans seeking comprehensive insurance policies. In addition, allowing the purchase of insurance across state lines would eliminate any guarantee that important benefits like maternity and emergency care will be included in insurance packages in the future. Consumers would get little in exchange – overwhelming evidence shows that benefit mandates per se are not why health insurance costs so much.**

ASL would lead to fewer mandated benefits, as insurers relocate to states with fewer requirements. Yet, as the

Congressional Budget Office (CBO) concluded after an exhaustive study, benefit mandates do not raise health care costs significantly. The impact in the small group market is no more than five percent of premiums (even less in the individual market, where there are fewer mandates).<sup>10</sup>

Experiences in Texas and California provide two examples. In 2003, the Texas Department of Insurance estimated that its own mandates, which included inpatient treatment of alcoholism, added between zero and three percent to small group premiums.<sup>11</sup> More recently, the California Health Benefit Review Program determined that eliminating all 44 of California's mandates would reduce premiums by no more than 4.8 percent.<sup>12</sup> Eliminating some of the most expensive mandates—maternity, mental health, and preventive care for children—would bring an even smaller reduction.<sup>13</sup> While five or even two percent of a \$12,000<sup>14</sup> family insurance policy is not trivial, eliminating benefit mandates does not address the root causes of health care cost growth nor does it make health insurance affordable for all Americans.

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## ASL reduces aggregate costs by reducing the scope of benefits, not by increasing the value of care.

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Serious illnesses, not benefit mandates, are the main cost for insurers. Typically 70 to 80 percent of costs are incurred by 20 percent of enrollees, the people who experience a serious illness in any given year.<sup>15</sup> These individuals receive a standard set of “medically necessary” services for common, yet expensive conditions such as cancer or a heart attack. Most of these expenditures are for conditions and services that are covered by comprehensive insurance policies; they are not the result of specific mandates.

In an ASL context, however, difference in benefit mandates could have a large impact on premiums because of the health status of individuals drawn to certain benefits. This would further segment the risk pool and lead to higher premiums for those seeking comprehensive policies.

Imagine two insurance companies, A and B, competing for a family's business. Insurer A operates in a high regu-

lation state that mandates maternity coverage. Insurer B domiciles in a low regulation state where maternity benefits are not mandated. Under this scenario, Insurer B in the low regulation state can offer the family a policy without maternity benefits. All else being equal, Insurer A in the high regulation state is at a small price disadvantage with family customers who do not plan on having more children because Insurer A must factor in maternity costs into its premiums.

The catch is making sure that all things are indeed equal. If people seeking maternity benefits are more likely to have higher health care bills, then the enrollees in the maternity package will be higher cost to the insurers than those willing to forego maternity coverage. Thus, the premium for Insurer A will be higher than the premium for Insurer B – not because of the cost of maternity per se, but because of the risk pool that the maternity benefits attracted. Likewise, you could say that the parsimonious benefit package of Insurer B drove the higher use and higher risk customers to enroll in a policy offered by Insurer A.

This presents a troubling economic picture for Insurer A, which now has two choices. The company can relocate to the low regulation state. Or it can stay in the high regulation state and accept that it will only be able to sell to families who are willing to bear the small cost of maternity benefits along with the much higher costs of being in a risk pool with higher risk enrollees. If Insurer A stays in the high regulation state, premiums will increase. Yet if Insurer A opts to domicile in the low regulation state, families may no longer be able to purchase policies that include maternity care. Both scenarios reduce the pooling of maternity care across the insured population, and increase market segmentation.

This example can be applied to every single coverage service or condition, from well baby visits to chemotherapy. In the long run and in all cases of explicit benefit mandates, ASL would lead to lower premiums for those who want more parsimonious or less comprehensive insurance packages. Only a small portion of the price decrease, however, could be attributed to actuarial impact of dropping the mandated benefit itself. A much larger portion would stem from the healthier-than-average risk profile of those who prefer more parsimonious benefits.

In equilibrium under ASL, it is unlikely that maternity care

(or any specific benefit) will be included in health insurance packages. Insurers would always be able to sell less expensive policies to a far healthier population by domiciling in a state with the fewest mandates. ASL reduces aggregate costs by reducing the scope of benefits, not by increasing the value of care.

### Guaranteed Issue

*Myth: Allowing health insurance to be sold across state lines will make it easier for individuals to find health coverage because they will have access to more products.*

**Authors' Analysis: The purchase of insurance across state lines would make it harder and more expensive for many Americans to buy quality health coverage by leading to fewer guaranteed issue insurance policies and higher premiums for people with health conditions.**

In addition to its impact on benefit mandates, ASL would also affect the availability and price of guaranteed issue policies. Consider the same insurers, A and B, selling to a family. The high regulation state requires insurers to sell products to anyone who wants to buy them (guaranteed issue) for the same price regardless of health status (community rating). The low regulation state, in contrast, allows full underwriting and unlimited premium variation (no guaranteed issue, no community rating). Insurers can refuse to sell to anyone, can exclude specific health services or conditions from coverage, and can charge higher premiums based on the current or predicted health status of an individual.

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**Insurers operating in guaranteed issue states would find it difficult to compete. The number of guaranteed issue policies would decline and the price of those available would rise considerably.**

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To demonstrate likely outcomes, we developed a model of expected health expenditures using insured individuals who are included in the Agency for Health Research and Quality's Medical Expenditure Panel Survey.<sup>16</sup> To reflect

underwriting, we postulate that the insurer will use all available information (at least as much as researchers can access through the MEPS questionnaires) to identify those people who are most likely to end up in the top 10 percent of the overall expenditure distribution. In the low regulation state, insurers could legally deny these high risk (high cost) individuals coverage, and it would be smart business to do so. The data in Table 1 report the results of our model's simulations and suggest the nature of outcomes were ASL adopted nationwide.

**Table 1. Predicted Health Expenses, Adults 19-64, 2005.**

Population Group	Predicted health expense per person
All	\$3,394
Predicted top 10% of spenders	\$19,469
Predicted bottom 90% of spenders	\$2,715

Source: Authors' model, using AHRQ MEPS Household Component 2005 Data, details available upon request, explanation on p. 8.

If the insurer in the low regulation state can deny coverage at will, our model suggests that it could offer an average premium to those it chose to insure—the healthiest people—of \$2,715. On the other hand under the status quo, Insurer A, who must cover all applicants in the guaranteed issue state, would have to charge at least \$3,394. In fact, the premium would probably be even higher than \$3,394 because without a purchase mandate, some healthy people would forgo coverage. This would increase the average risk profile and therefore raise premiums.

Under this scenario, insurers in the low regulation state (no guaranteed issue, no community rating) could offer at least a 20 percent discount to its customers. As we have seen, these customers are healthier than average. At the same time, individuals denied coverage by insurers in the

## Table Explanation

As we mentioned previously, a very small percentage of the insured population accounts for the majority of health care spending. Therefore, it is beneficial for insurers to be able to predict who will fall in the top percentages of health care spending before they choose to insure them. To simulate this process, we used a two year longitudinal sample to see how well we could predict who would likely be a high cost enrollee in the second year, knowing only what we know about the person and first year expenditures. To simplify our example, we assume administrative loads are zero, so that the premium would equal expected medical costs. In actuality, premiums would be 25-40 percent higher than expected claims costs in most non-group markets.

The first line of the table serves as a point of reference. It shows what all individuals in the sample are expected to spend (and did spend) on health care on average. The average premium would be \$3,394 if everyone in the sample purchased insurance and community rating were in effect. The second line shows the individuals who we predicted to fall in the top 10 percent of health care spenders. These individuals are expected to spend \$19,469 on health care on average. This is what the insurer (in competitive equilibrium) would charge an individual if the insurer was allowed to underwrite based on health status, and if they predicted (as we did) that the individual would be a high cost enrollee. The final line, then, is the rest of the sample—or, everyone who was not predicted to cost in the top 10 percent. The average health expense of this group is \$2,715. Compare this to \$3,394, when everyone is included in the same pool. This table then shows how insurers would use underwriting in the absence of guaranteed issue to weed out the sick in order to attract the healthy through lower premiums.

low regulation state would be forced to buy more expensive insurance from insurers domiciled in the higher regulation state – or be uninsured. Over time, rates for these people buying from Insurer A (still subject to guaranteed issue and community rating) would continue to increase as the risk pool becomes increasingly segmented and expensive.

ASL would lower premiums for the healthiest Americans, but it would raise premiums and reduce coverage options for everyone else. Insurers operating in guaranteed issue states would find it difficult to compete. The number of guaranteed issue policies would decline and the price of those available would rise considerably. Individuals with troublesome health histories would have to pay more, or go without coverage.

This outcome effectively forces states to reduce regulation or lose insurers. It forces insurers to re-domicile to “choose” the least regulatory state environment, so they can compete in the long run. The scenario entails serious risk. ASL would have the ultimate effect of standardizing state regulation to the least restrictive level, thus de facto de-regulating individual insurance markets. Politically, this allows the de-regulatory preferences of one state to negate the regulatory preferences of the 49 other states,

without either a national or a state-specific vote.

ASL undermines the very essence of comprehensive health insurance. While most of us feel healthy on any given day, nearly all of us will get sick at some point and many of us will develop a chronic condition long before retirement and Medicare eligibility arrive. Thus, without our suggested modifications, ASL is not a useful element of reform aimed at making insurance markets work for all Americans.<sup>17</sup>

## Additional risks

ASL would have additional consequences beyond its impact on insurance market regulation. In this section we will examine other implications of this policy – how it could in fact hamper some insurers’ ability to compete, how it could encourage more aggressive underwriting instead of a 21st Century approach to high value health insurance, and how eliminating the employer tax exclusion in conjunction with ASL could worsen its effects.

## Barriers to Competition

*Myth: Allowing insurers to sell health insurance across state lines would let individuals purchase any insurance product from any state and increase competition among insurers. This would lower premiums.*

**Authors' Analysis: Many insurance products would not be sold to residents of every state under an across state lines proposal. And, it is unlikely that out-of-state insurance products would cost less. Furthermore, a proposal to sell across state lines could undermine the ability of integrated health systems and Blue Cross/Blue Shield plans to be competitive.**

ASL proponents implicitly assume that insurers who enter new markets outside their current domiciled state could instantaneously obtain the same provider price discounts that the large insurers already in that marketplace have achieved. For example, some state markets are dominated by the local Blue Cross/Blue Shield plan (hereafter referred to as Blue plans). With up to a 60 percent market share, Blue plans can negotiate provider discounts that let them offer premiums 20 percent or more below those of competitors with a smaller market share. Entry into these markets will be difficult and may not look profitable for many insurers.<sup>8</sup> It is therefore unlikely that all Americans would be able to purchase coverage from insurers in all states under ASL.

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At the same time, ASL could undermine the ability of some insurers, especially the Blues and integrated health systems, to compete successfully. For example, non-profit Blue plans, chartered by individual states to sell insurance within that state, would not have the freedom to re-domicile. Likewise, integrated health systems would not be able to relocate to parts of the country where their network of providers and hospitals do not exist. Kaiser, for instance, could not enter the Mississippi market, which lacks its infrastructure and coordinated care medical culture.

In effect, ASL would potentially give small insurers who underwrite aggressively an advantage against dominant Blue plans and integrated delivery systems (where much of the innovation in care delivery and disease management is unfolding). This may explain why ASL is so popular among smaller, risk-selecting insurers,<sup>9</sup> and not among

the Blue plans, integrated health systems, or larger care-coordinating insurers who serve as third-party administrators for self-insured employers. Ultimately, enabling risk-selectors to ramp up competition on their terms could be good for healthy residents of the home state. However, it also engenders a form of competition that creates lower premiums for the healthy at the expense of the sick (which includes most of us at some point), and does nothing about the delivery system inefficiencies we simply must address.

ASL uses heightened risk-selection as a cost containment strategy. This ignores the fundamental reality that much of health care spending adds no clinical value.<sup>20</sup> Indeed, the point of combining insurance market reforms such as guaranteed issue and community rating with subsidies and purchase requirements is to incentivize insurers to work with providers to improve the quality of patient care at lower prices, as opposed to underwriting.<sup>21</sup> A superior health insurance business model for the 21st Century would reward insurers who use the best providers, information tools, and financial incentives to engender high-quality treatment patterns that maximize health at minimum average cost.

### The Employer Tax Exclusion

*Myth: Eliminating the tax preference for employer-provided health insurance while allowing Americans to purchase insurance across state lines will “level the playing field” between group and non-group insurance and substantially increase Americans’ access to coverage.*

**Authors' Analysis: Eliminating the employer tax exclusion in conjunction with an across state lines proposal would lead to more uninsured or underinsured Americans over time. Fewer employers would offer coverage and millions of Americans would have to find coverage in the virtually unregulated individual insurance market. Individuals transitioning from the employer-sponsored system to the across state lines marketplace would face higher premiums based on their health history and insurance policies that lack many benefits regularly covered by employer-sponsored insurance.**

Some ASL advocates, including Senator McCain, would eliminate the current employer tax exclusion and convert it into a fixed dollar tax credit that could be used toward the purchase of health insurance. Reducing or eliminating the employer tax exclusion could be helpful in financing

a system of coverage, but not without significant market reforms that extend the advantages of the large group market—administrative efficiencies, economies of scale, large risk pools—to all Americans.<sup>22</sup>

Nevertheless, this tax change would end one of the major incentives for employers to offer health insurance coverage to their workers. Employers would scale back their contributions towards workers' premiums or stop offering coverage altogether.<sup>23</sup> Tens of millions of Americans would need to buy health insurance in the individual market or forgo insurance. In addition, healthy individuals would be incentivized to abandon employer-provided coverage immediately in favor of the individual market (where they could buy less comprehensive coverage at a lower rate).<sup>24</sup>

This scenario would only exacerbate the consequences of ASL described above. Individuals transitioning to the across state lines marketplace would face higher premiums based on their health history and find insurance policies that lacked many benefits routinely covered by employer-sponsored insurance, if they were able to find an insurer willing to cover them at all

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In addition, individual insurance policies generally have much higher underwriting, selling, enrollment, and billing costs than employer-sponsored plans.<sup>25</sup> Therefore, ASL would lead to higher administrative loading costs for individuals transitioning from the employer to ASL marketplace. This difference is substantial and could result in more expensive premiums or individuals choosing policies with much lower benefit levels because of cost.

## Potential—but unlikely—ASL solutions

Some ASL proposals, including the McCain campaign plan, provide for high risk pools to try to address ASL's negative implications for those with preexisting conditions.<sup>26</sup> Other analysts also suggest that guaranteed renewal of policies might lessen the effects of ASL. In this section, we show why high risk pools and guaranteed renewal will not solve the flaws we have identified in ASL and further outline reforms that could make ASL and high risk pools work for all Americans.

### High Risk Pools

*Myth: Typical high risk pools will ensure that all Americans have access to affordable coverage.*

**Authors' Analysis: High risk pools combined with the sale of insurance across state lines would force many Americans to pay very high premiums or forgo insurance. In addition, high risk pools would encourage insurers to raise premiums for people with health conditions or deny coverage. This kind of aggressive underwriting would leave millions of people in high risk pools at a high cost to the government (who would subsidize the policies) and the consumer (who would likely face higher than average premiums).**

Thirty-two states have established high risk pools, but they cover less than one percent of Americans. These pools are health plans that cover individuals who have been denied non-group insurance because of their health status or history. They subsidize premiums for enrollees, typically by making assessments on insured policies. In theory, high risk pools allow the voluntary, risk-selecting insurance market to work better by removing the highest risk and sickest people from the commercial marketplace and allowing their costs to be spread over society as a whole.

In practice, however, most current high risk pools are open to a very small number of people (most have fewer than 3,000 enrollees; there are only 200,000 nationwide).<sup>27</sup> The average subsidy is \$4,125 per person. Yet, the premiums found in a high risk pools are typically 200 to 250 percent of the standard premiums in the individual market, leaving many individuals to pay more than \$5,500 per year for coverage.<sup>28</sup> This remains too expensive for many individuals despite the subsidy.<sup>29</sup> Oklahoma Commissioner of Insurance, Kim Holland, said it best in recent testimony before the U.S. Senate Finance Committee:

“High-risk pools have been created in many states to help address the issue of the medically ‘uninsurable,’ but they are often under-funded and can lock people into limited, but expensive, coverage choices. In Oklahoma, our high risk pool has facilitated insurers’ ability to cherry-pick the very healthiest, shifting risk to the pool.”<sup>30</sup>

In addition, high risk pool premiums are typically age-rated, so older individuals pay more. For example, a 58-year-old might have a standard non-group policy premium of \$800 per month.<sup>31</sup> In the high risk pool, the premium could be twice as large – \$1600 per month. For someone earning \$40,000, that’s nearly half of his or her gross income.

High risk pools that are not exceptionally well-funded do not remedy ASL because ASL in effect encourages insurers to maximize underwriting. In long run equilibrium, it is hard to imagine how any insurer could “compete” across state lines unless it did as much underwriting as its competitors. The more aggressive underwriters could offer lower premiums for those it chose to cover, while the least aggressive underwriters would have higher premiums and relatively sick enrollees.

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This suggests the financial obligation necessary to fund high risk pools under an ASL proposal would likely be an order of magnitude larger than what has been proposed to date.

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Given what we know about the cost of insuring high risk individuals and the level of underwriting ASL would engender, the price tag of subsidizing high risk pools to the extent necessary to make them available for all Americans would be significant. The number of people who would be denied coverage under this combination of measures—eliminating the tax exclusion, ASL, and high risk pools—would be very large. At current rates and averages, it would cost nearly \$18.9 billion to subsidize just 10 percent of the 46 million uninsured Americans in high risk pools (assuming they could afford the average \$5,500 per person like their counterparts do now).<sup>32</sup> This suggests the financial obligation necessary to adequately fund afford-

able high risk pools under an ASL proposal would likely be an order of magnitude larger than what has been proposed to date.<sup>33</sup>

## Guaranteed Renewal

*Myth: Requiring insurers to renew policies will make ASL and well-funded high risk pools work seamlessly for all Americans.*

**Authors’ Analysis: Even with guaranteed renewal, insurers could and do still separate the healthy from the sick, which would raise premiums for many Americans.**

Mark V. Pauly, a respected policy analyst and health economist, has argued that guaranteed renewal rules (along with well-funded high risk pools) could make ASL work for all Americans.<sup>34</sup> Pauly’s argument would be correct if insurers treated everyone covered by a particular policy at a given time equally in perpetuity. Under this assumption, guaranteed renewal would mean that if an individual became ill they would still be treated like everyone else who had originally bought that policy. The sick could not have their premium raised more than the healthy, they could not have their coverage terminated, and they could not be discriminated against vis-à-vis healthier policyholders. Their insurance would protect them against deteriorating health over time.

This is how Mark Pauly would enforce guaranteed renewal.<sup>35</sup> But alas this is not how guaranteed renewal often works in the real world. Guaranteed renewal requires the insurer to renew a customer’s original policy. The insurer cannot raise one individual’s premium based on health status (apart from certain legal variations based on age and geography). It does allow the insurer to raise premiums of everyone covered by a specific policy or product based on the entire group’s health experience. Ample evidence and research suggest that insurers routinely offer healthy customers a “new” product – remarkably similar to their original policy but available only to the healthiest customers.

Therefore, even under guaranteed renewal laws, the insurers can siphon off the healthy individuals, leaving a risk pool with sicker people covered under the original insurance product. The insurer can then raise the premium for this entire pool precipitously—but legally—based on the entire pool’s experience, technically unrelated to any single individual’s health status. As long as insurers have the freedom to segment their market and decide who has

access to “new” policies they can and do frustrate the intent and theory of guaranteed renewal rules everywhere.<sup>36</sup>

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Modified ASL and High Risk Pools could benefit all Americans in the context of 1) guaranteed issue and low-income premium subsidies or sufficiently funded high risk pools, and 2) federal licensure and regulation of insurers.

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### Making ASL and High Risk Pools Work for All Americans

*Myth: It is impossible to make an across state lines marketplace and high risk pools function in a way that makes insurance markets work for all Americans.*

**Authors’ Analysis:** An across state lines proposal and high risk pools could function in a way that benefits all Americans, but only in the context of: 1) guaranteed issue and low-income premium subsidies or adequately funded high risk pools, and 2) federal licensure and regulatory oversight of insurers..

As we have demonstrated, a fundamental flaw with ASL is that many Americans would be unable to find accessible and affordable health insurance. To make ASL and high risk pools work for all Americans two fundamental reforms are necessary.

- Insurers would need to sell to all customers, regardless of health status (i.e. guaranteed issue), or high risk pools would need to be subsidized sufficiently to make them genuinely accessible to millions of Americans.
- ASL as typically proposed would lead to a de facto national standard of minimal regulation, which would be problematic for consumers with health conditions and many insurers alike. To address this, we suggest federal licensure of insurers (either by a new entity or an existing agency).<sup>37</sup> Federal licensure would accomplish three primary goals:

1. Allow a common set of minimum rating rules and benefit mandates (so that the entire market does not devolve to the standards set by the least regulated state);
2. Provide the capacity necessary to regulate market conduct and solvency nationwide (to protect states who may become overwhelmed by insurers pouring into their market under ASL);
3. Streamline licensing and save administrative costs by standardizing requirements for multi-state insurers.

### Conclusion

Proponents of ASL cite worthy goals: affordable health insurance, more choice, and fewer uninsured Americans. We have argued, however, that the likely consequences of ASL are unsatisfactory, unless very generously funded high risk pools (or guaranteed issue) and federal licensures of insurers are also part of the package. Without these additional reforms, ASL fails to provide the incentives necessary to transition insurers to a 21st Century business model that prioritizes care coordination and high value care over underwriting and marketing. There are better ways to improve insurance markets as we reform our health care system. A health care marketplace in which insurers compete on price and value will help bend the health care cost growth curve and create a high quality, sustainable system for all Americans.

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**MAIN OFFICE**

1630 Connecticut Avenue, NW  
7th Floor  
Washington, DC 20009  
Phone 202 986 2700  
Fax 202 986 3696

**CALIFORNIA OFFICE**

921 11th Street  
Suite 901  
Sacramento, CA 95814  
Phone 916 448 5189  
Fax 916 448 3724



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