The Politics of Reform

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The articles on individual health insurance market reform in this issue raise fundamental questions about the role of competitive markets in promoting access to health care. The decision to impose new restrictions on insurers, or conversely, not to regulate insurers' rating and enrollment practices, rests on certain core assumptions about how the world works (Thompson 1981). In New Jersey, for example, policy makers viewed rating and enrollment reforms in the individual health insurance market as a means to reduce the number of uninsured persons (Garnick, Swartz, and Skwara 1998). This basic policy hypothesis undergirds individual insurance market reforms such as the removal of preexisting-condition clauses, limitations on underwriting practices, and the introduction of community rating. If this assumption is flawed, however, incremental reforms will be ill-equipped to address many of the most significant shortcomings of the marketplace.

The articles in this issue return to the familiar “competition versus regulation” debate which dominated the health policy literature in the 1970s and 1980s. First, what lessons can be gleaned from the case studies? Should state government reject insurers' claims of “actuarial fairness” in enrollment and rating in favor of reforms designed to protect certain groups from discrimination? What are the consequences of doing so? Second, can incremental reforms which regulate the rating and enrollment practices of insurers effectively limit discrimination against chronically ill persons or other high-risk subscribers? Or are regulatory cures worse than the disease? Finally, what are the political dynamics of reforming the individual health insurance market? Under what circumstances are reforms most likely to surface?

The Politics of Lesson Drawing

Before investing scarce political capital and resources into promoting health care reforms, legislators and other state policy makers frequently turn to colleagues and think tanks for insights about which groups will benefit and lose from the proposed changes. State policy makers draw on closely knit intergovernmental networks to keep abreast of recent developments in health policy—organizations such as the National Governors’ Association, the National Council of State Legislatures, and numerous policy centers and think tanks provide updates of recent legislative initiatives, policy debates, and court cases for decision makers. The diffusion of innovations is a two-way street—while successful reforms are quickly emulated by others, policy disasters can be avoided by following the experience of others. The case studies in this issue raise an important policy question: Why did insurers withdraw from states which reformed their individual health insurance markets? Were the reforms so restrictive that insurers found it impossible to sell individual policies and make a profit?

As the articles by Adele M. Kirk and Mark A. Hall demonstrate, while the number of insurers selling policies in a state may decline in the wake of reform, individual market reforms do not invariably lead to a market implosion. Although reforms clearly cut into insurers’ profit margins by enabling previously “uninsurable” persons to enter the individual market, the decision of insurers to exit the individual market seems out of proportion to the scope and timing of the changes passed by state legislatures. In Kentucky, for example, most reforms never took hold, but insurers left anyway and have failed to return. Nevertheless, the experiences of Kentucky and Washington have become policy anecdotes (Rochefort 1998) or symbols (Stone 1997) of the perils of state intervention in the individual health insurance market.

The decision to exit the individual health market is not preordained for indemnity carriers. Instead, as Albert Hirschman (1970) observed, firms may respond to a changing market environment in three ways, which he terms exit, voice, and loyalty. Kentucky’s and Washington’s experiences illustrate the exit option: insurers chose to leave the market when faced with the threat of adverse selection. Alternatively, insurers may also seek to shape reforms through the legislative process (voice) or seek new ways to earn a profit under the new regulated market, using the threat of exit as a bargaining chip to exact concessions from subscribers in the form of leaner benefits (loyalty). Few indemnity insurers, however, pursued a
voice or loyalty strategy following the passage of reforms in Kentucky, New York, and Washington. Why did insurers choose to exit those particular marketplaces, rather than seek to modify the new regulations or change their pricing and enrollment policies?

The obvious, and most common, answer to this question is that insurers could not earn a profit in a reformed marketplace. This view, however, is not fully supported by the cases. The case studies of Kentucky and New York raise questions about insurers’ claims that they have lost millions in the individual market. In addition, the individual market represents a small share of most insurers and HMOs’ total enrollment; profits from the small group or group markets could be used to cross-subsidize the sale of individual policies if insurers desired to stay in the market. Furthermore, even in states with extensive oversight of insurance premiums, state officials have generally allowed insurers to raise rates in the individual market substantially to compensate for adverse selection. As Hall notes in his case study of individual market reforms in New York, the state department of insurance denied requests for substantial rate increases by Empire Blue Cross and Oxford Health, limiting both to a 10 percent premium increase. At the same time, however, state officials approved a cash infusion from the state’s risk-adjustment pools to offset expected losses. In sum, efforts to revamp the individual health insurance market need not result in fiscal catastrophe for “loyal” insurers who do not exit the market. If this is the case, why did the reforms in Kentucky and the like lead to a mass exodus from the marketplace?

The decision of insurers to exit the marketplace following the passage of reforms sent a powerful message to policy makers contemplating similar initiatives in other states. In effect, the exit option can be viewed as a symbolic strategy. Based in large part on the experiences of Kentucky and Washington, the policy image of individual insurance market reforms is now decidedly negative, although much of the conventional wisdom about the consequences of the reforms in Kentucky and New York fails to jibe with the states’ actual experiences. Nevertheless, the mass exodus of insurers from Kentucky, New York, Vermont, and Washington provides a powerful policy anecdote for prospective reformers by illustrating the perils of interfering with the “normal” operation of free markets.

In reality, the changes in the individual health insurance market are more complex. Conservative critiques of reform (Malkin 1997; Litow and Davidoff 1994) bear an eerie resemblance to Elizabeth McCaughey’s (1994) well-publicized diatribe against the Clinton administration’s Health
Security Act. In both cases, public debate over proposed health care reform was shaped by opponents' rhetorical broadsides long after new information became available which questioned the conventional wisdom (Fallows 1995). Despite evidence from Massachusetts, New Jersey, New York, and Vermont that reforms need not destabilize individual health insurance markets in the long run, the policy image of individual market reforms continues to be shaped by the negative images associated with the experiences of Kentucky and Washington.

Individual health insurance markets do not exist in a policy vacuum but reflect ongoing political and economic forces within their states. Implicit in many critiques of many reform proposals, such as community rating, is the notion that unfettered markets were performing well prior to the enactment of reforms. Long before the passage of individual market reforms in the 1990s, insurers used high premiums, limited benefits, and selective marketing to limit their financial exposure to adverse selection (Gabel 1991). An important counterfactual question remains unasked by critics: What would the market look like in the absence of reform? As Katherine Swartz and Deborah W. Garnick note in their article, the individual health insurance market in New Jersey was “on the verge of collapsing” before the passage of reform. Furthermore, other factors apart from the enactment of market reforms contributed to declining enrollment in the individual market. Independent insurance agents and brokers are critical players in the individual health insurance market, both in offering information about products and in selling policies to consumers (Garnick, Swartz, and Skwara 1998). Hall’s discussion of New York illustrates that insurers’ own actions (e.g., lowering or eliminating commissions for agents who sold individual policies) effectively reduced demand for their products. Some insurers even told prospective customers that they did not sell individual policies, when in fact they were legally obligated to do so. If agents have few incentives to sell individual health insurance policies, the fact that fewer policies are sold in the wake of guaranteed-issue and community-rating reforms raises the possibility that other factors may have contributed to declining enrollment in the individual market. Although states such as New York, which implemented pure community rating in the individual market, saw premiums rise following the passage of reforms, premiums had also increased substantially in the small group and individual markets prior to the enactment of reform (American College of Physicians 1996).
The Limitations of Individual Health Insurance Market Reform

A reformed individual health insurance market appears an unlikely vehicle for increasing the number of persons with health insurance. A steady decline in the percentage of Americans with employer-sponsored health insurance over the past decade has contributed to a corresponding rise in the percentage of the population without health insurance. Significantly, the ranks of the uninsured have continued to increase during a period of economic expansion. The principal shortcoming of individual insurance market reforms in addressing the plight of the uninsured, however, is that all markets discriminate against those who cannot pay. In health care, the market for health insurance also discriminates against those who are sick; competition among insurers is based as much on risk selection as it is on price (ibid.).

Reformers face several dilemmas in reshaping the individual health insurance market. While higher prices may force some consumers from the market, lower prices appear unlikely to attract a substantial number of new subscribers. Recent studies suggest that neither insurance market reforms nor state subsidies of health insurance coverage have had an appreciable effect on decreasing the number of uninsured Americans (Sloan and Conover 1998; Marquis and Long 1995). In addition, the discussion of rising costs in the individual market tends to focus on the absolute, rather than the relative, cost of health insurance coverage. Premiums for even modest individual coverage may be out of reach for many working-class families. Finally, the existing practices of risk-rated health insurance penalize those individuals who most need access to affordable coverage.

The hopes of reformers that lower premiums, whether achieved through market competition or subsidies, would encourage the uninsured to purchase individual health insurance policies appear to be misplaced. Generally, insurance market reforms have not succeeded in their goal of increasing insurance coverage. To the contrary, individual insurance enrollment has declined in the cases presented in this issue following the enactment of reform. Furthermore, economic analyses of consumers’ sensitivity to changes in insurance premiums suggest that relatively few uninsured workers would purchase individual coverage on a voluntary basis even if it was substantially less expensive (Marquis and Long 1995). As Swartz and Garnick note, “Even competitive insurance markets cannot drive the cost of health insurance so low that healthy, low-
income people will decide to purchase it." Implicit in many economic analyses of insurance market reforms is an assumption that individuals with a greater willingness to pay for health insurance will be able to purchase coverage. The cost of coverage for part-time workers, the working poor, and other families of modest means effectively places even bare-bones coverage beyond the reach of millions of potentially eligible individuals.¹

The desire of insurers to link premiums and coverage to subscribers’ perceived level of risk creates significant barriers for many individuals to obtain even modest health insurance coverage. The practice of risk rating suffers from several fundamental flaws. “Even the most widely used risk categories such as age have poor predictive value because within-group variations are so great relative to between-group variations” (Light 1992: 2505). Len M. Nichols observes in his article that “the inability to ask health status questions and to set premiums based on health status means that the insurers’ effectiveness in screening risks is reduced. . . . Post-reform, insurers know with certainty there is a category of previously identifiable risks on whom the company will now lose money.” While this is true, the passage of reforms does not condemn insurers to unprofitability, but rather reduces their ability to engage in health-based discrimination against medically vulnerable individuals. This behavior, of course, was precisely what motivated lawmakers to enact reform in the first place.

As Lynn Etheredge (1986: 312) noted more than a decade ago, “insurers are also ethically responsible for their activities, particularly where these are self-determined, and for their impact on society.” The enactment of enrollment and rating reforms within the individual health insurance market reflects a profound sense of unease among policy makers regarding the ethical foundations of insurers’ behavior. Although community rating and explicit cross-subsidization of sicker members of the community was integral to the development of Blue Cross plans in the 1940s, by the 1990s both the Blues and commercial insurers sought to

¹ Swartz and Garnick’s discussion of individual market reform in New Jersey in this issue illustrates the following point: In the fourth quarter of 1997, the cost of a monthly premium for single coverage ranged from $160 for the lowest cost indemnity plan to $196 for the cheapest HMO plan. A part-time employee working thirty hours a week at the rate of $10 an hour would pay a minimum of 12.3 percent of her $15,600 annual gross income for indemnity coverage. An individual seeking to enroll in an HMO would spend more than 15 percent ($2,352) of her $15,600 annual salary on health insurance premiums. This actually understates the proportional impact of individual health insurance coverage, for unlike most employees who purchase group health insurance, premiums for individual health insurance policies are not paid on a pre-tax basis, but instead must be deducted from employees’ disposable income after taxes.
screen prospective risks and to charge different premiums from different risk categories. Nichols also argues that premium increases are likely to be examples of insurers getting “pessimistic about their likelihood of drawing low-risk enrollees, compared to their competitors” in a regulated market, and thus insurers set prices higher to deter high risks from purchasing coverage. As a result, “unprofitable” individuals are likely to be driven from the market altogether. In addition, Nichols’s concern over the demise of “actuarial fairness” in reformed markets misses the point that all insurance involves some degree of cross-subsidization. As Deborah Stone (1989: 598) noted more than a decade ago, “If actuarial rating were carried out perfectly, that is, if we could predict each person’s precise risk of incurring the particular harm and charge him or her accordingly, then in effect each contributor would be paying for him or herself.”

The Path Not Taken

The articles in this issue illuminate the dynamics of insurers’ response to regulation, but they leave a number of important political questions either unasked or unanswered. Health care reform does not emerge from a black box; the political dynamics which lead up to reform hold important lessons for policy makers. A more complete understanding of the politics of individual market reforms at the state level requires answers to the following questions:

- Was the demand for insurance market reform broad based, or did it reflect the interests of one company or group?
- How diverse was the interest group network which produced the reform proposal? How did groups outside of the insurance industry (e.g., consumer advocates, social workers, hospitals, pharmacies, businesses, etc.) view the reforms? Was the legislative process inclusive or closed?
- How were reforms framed? Were efforts to reform the individual health insurance market high-profile affairs which generated considerable media attention and lobbying, or were they relatively obscure matters?
- Since reforms to the individual health insurance market have redistributive consequences, it would be useful to understand how different segments of the industry responded to the proposals. In particular, how did individual agents, HMOs, Blue Cross plans, and indemnity carriers seek to affect legislation under consideration?
- How did various population subgroups affected by the reforms respond? Did healthy young adults, for example, organize to protest their higher premiums or simply leave the market?
- What role did legislative and gubernatorial leadership play in placing reform on the formal agenda?

Proponents of individual health insurance market reform face a number of significant political obstacles. Since most of the insured population obtains health coverage through employers or federal and state programs, the political constituency for individual market reforms is weak. Reformers face "imbalanced political markets" at the state level (Marmor, Witman, and Heagy 1976). Insurers, particularly Blue Cross plans, continue to be major players in state legislative debates over health care reform (Hackey 1998). Purchasers of individual health insurance policies, in contrast, are a more diverse group. Although most are wage and salary workers and their families, their health insurance needs vary widely. In short, sick and healthy individuals will be affected differently by reform proposals. Guaranteed issue, limits on risk rating, bans on preexisting-condition exclusions, and other reforms designed to minimize or eliminate "medical redlining" will win little support from young, healthy individuals seeking inexpensive policies to protect themselves from the costs of a major illness. Indeed, since these individuals are most likely to pay higher premiums in the wake of reform, their interests are threatened by reforms aimed at increasing access to the health insurance market. As "low risks," they are lucrative customers for insurers who are unlikely to encounter difficulties obtaining coverage. In contrast, individuals with chronic illness stand to benefit the most from guaranteed issue, guaranteed renewability, and limits on the use of medical underwriting by insurers. For this population, the difficulty of obtaining coverage rivals cost as a policy concern. Proposals that eliminate barriers to purchasing coverage or introduce some form of community-rated premiums are likely to increase demand for health insurance among "high-risk" patients.

Differences in the political interests of persons seeking individual health insurance coverage extend beyond health status to include income, employment status, and age. The diversity of the individual health insurance market inhibits collective action, as a disorganized, heterogeneous group is difficult to mobilize for the trench warfare of legislative debates. In contrast, health insurance coverage is an important issue in many union contract negotiations, as workers sharing a common health plan are bound together by a common interest and mobilize easily for politi-
cal action (e.g., informational picketing, strikes, grassroots lobbying). Policy makers contemplating individual health insurance market reforms face a dilemma: Should reforms seek to lower costs for the majority of subscribers who are healthy or should they attempt to address the concerns of persons with persistent health problems who are most at risk of discrimination?

**Prospects and Pitfalls for Reformers**

To date, reforming the individual health insurance market has not attracted the prominence afforded expanded eligibility for Medicaid, children's health insurance initiatives, managed care regulation, and similar policy initiatives on state policy agendas. While many states have reformed their small group insurance markets, few have required guaranteed issue and limited rating or required insurers to offer community-rated products in the individual market. The low visibility of the individual market vis-à-vis the small group and group markets is also evident in the federal Health Insurance Portability and Accountability Act (HIPAA). Although the HIPAA required insurers to sell products to consumers in the individual market, the act neither limited the prices which could be charged for individual coverage nor protected the interests of persons who had not previously held insurance coverage. Alternative policy instruments for improving access to health insurance for the chronically ill have enjoyed limited success. Although high-risk pools have been established in half of the states to provide coverage for persons who are otherwise "uninsurable," their high cost has limited their ability to extend coverage to more than a small percentage of potential beneficiaries (Kuttner 1997).

Policy debates over insurance market reforms such as community rating and guaranteed issue will resemble James Q. Wilson's (1980) description of "entrepreneurial politics" in which concentrated costs are imposed on an industry in an effort to provide diffuse benefits for society. Securing the passage of such reforms is difficult, for disorganized consumers face concerted opposition from industry groups who view insurance market reforms as a threat to their ability to avoid adverse selection and segment risk. Under such conditions, efforts to enact similar reforms in most states will falter in the absence of entrepreneurial leadership from key legislators, the governor, or powerful interests (e.g., Blue Cross).

As in previous debates over hospital rate setting (Hackey 1998), a
looming fiscal crisis creates a new political environment and breaks down traditional barriers to reform. In Massachusetts, New Jersey, New York, and Vermont, concerns over the deteriorating fiscal condition of local Blue Cross plans provided the catalyst for individual market reforms as a means of supporting their role as "insurers of last resort." The aura of crisis was particularly acute in New Jersey, where state officials faced a court order to revamp its system of financing uncompensated hospital care that had provided Blue Cross with extensive cross-subsidies. In the absence of reform, Blue Cross plans warned that they would be forced to seek substantial premium increases or withdraw from the market altogether. As Nichols observes in this issue, the role of Blue Cross in sustaining (if not dominating) the market for individual health insurance policies legitimized state action to stabilize the marketplace. The significance of crisis in framing individual market reforms did not diminish after the passage of legislation. Instead, the mass exodus of indemnity insurers following the implementation of community rating, guaranteed issue, and limits on underwriting precipitated a new crisis in the marketplace.

Unlike recent legislation aimed at regulating the perceived excesses of managed care organizations, the political appeal of individual health insurance market reforms to policy makers is limited. Intense opposition from commercial health insurers and HMOs, coupled with the negative policy image associated with other states’ experiences with reform, make the process of coalition formation difficult in state legislatures. Legislators interested in polishing their health policy credentials will find more attractive targets in proposals to regulate the perceived shortcomings of managed care or expanding access to health insurance for children. Broad-based reforms to the individual health insurance market follow a different, and much slower, pattern of diffusion among the states than other health care reforms in recent years. Compared to the rapid diffusion of state legislation banning "drive-through deliveries" in the mid-1990s (DeClercq and Simmes 1997) and laws which guaranteed direct access to obstetricians and gynecologists for women (American College of Nurse Midwives 1998), comprehensive rating and coverage reforms in the individual market have been slow to take hold.

Building a constituency in support of community rating, guaranteed issue, and limits on underwriting is not easy, particularly in light of the horror stories told by insurers and other opponents of reform from cases such as Kentucky and Washington. To date, opponents of reform in the insurance industry have dominated the policy discourse over reforming
the individual health insurance market by defining the principal problem in the marketplace as one of well intentioned but counterproductive over-regulation by state governments. In the early 1990s, insurers conducted a national advertising campaign to persuade policy makers and the public that risk rating benefited consumers. According to the industry, “If insurance companies didn’t put people into risk groups, it would mean that low-risk people would be arbitrarily mixed in with high-risk people . . . and would have to pay higher rates. That would be unfair to everyone” (Light 1992: 2506). This view, often echoed by conservative critiques published by the Heritage Foundation and others, blames “mis-guided” government efforts to increase access to affordable health insurance in the individual market as the cause of rising premiums, the withdrawal of indemnity insurers, and adverse selection spirals in regulated markets.

An alternative problem definition, however, offers reformers more hope of building political support for reforms such as guaranteed issue, community rating, and restrictions on waiting periods for preexisting medical conditions (Rochefort and Cobb 1994). In the absence of reforms, current industry policies blame chronically ill “victims” for their own plight. As Stone (1989: 632) argues, “The use of health-risk classification for any allocative purpose—any purpose other than treating people who could benefit from preventative measures—treats future health as if people could control it and lends scientific authority to theories of poverty and illness that locate the cause in individual will.” One of the fundamental difficulties of unreformed markets is that the individuals most in need of health insurance coverage often can’t get it. As a case in point, many individuals with recurrent genital herpes have found that insurers either exclude herpes from their coverage or deny coverage altogether to persons with herpes (Rice 1999).

The American College of Physicians (1996: 247) has expressed optimism that rating restrictions and other reforms in the individual health insurance market have expanded coverage to less healthy persons without “hemorrhaging healthy persons from the insurance pool and further destabilizing markets.” The case studies presented in this issue clearly challenge this optimistic appraisal of the impact of reform. Without the active cooperation of health insurers, incremental reforms to the individual health insurance market have limited potential to increase access to health insurance, and may reduce the choices available to young, healthy subscribers. In a health care system in which insurance remains a commodity, not a social right, policy makers must tread gingerly in
enacting reforms, for the willingness of insurers to exercise their exit option may destabilize existing markets, resulting in both higher costs and diminished choice for consumers.

References


