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Legislative Activities in the Commercial Health Market

Track: Health

Moderator: LEIGH M. WACHENHEIM
Panelist: KATHERINE SWARTZ†

Summary: Panelists discuss various legislative activities at the federal and state levels that affect health organizations doing business in the commercial market, including patient protection, the uninsured, coverage mandates and mental health parity. Attendees are informed of the status of specific legislation and the impact this legislation may have on their operations.

MS. LEIGH M. WACHENHEIM: My name is Leigh Wachenheim and I'm with Milliman. Our session today is "Legislative Activities in the Commercial Health Market." I'm going to cover patient protection, mental health parity, genetic testing and mandates. I think all but genetic testing were listed in the program. That went in because it's becoming a more and more important legislative concern.

We're very privileged to have Kathy Swartz from the Harvard School of Public Health with us. She has done a lot of research on regulation and how regulation can be used to help solve the problem of the uninsured, or to increase insurance among people. She's going to talk about a couple of papers that she has written on that topic.

There hasn't been a lot of activity on the legislative front, at least at the federal level, since September 11, 2001. There are some important bills sitting out there. The House or the Senate has passed some of them, but there hasn't been any

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†Dr. Katherine Swartz, not a member of the sponsoring organizations, is professor of health policy and management at Harvard School of Public Health in Boston, Mass.

movement on them. It's important to know what's in them, nevertheless, because chances are, sooner or later, something like them will be passed.

The first pieces of legislation that I want to go over are commonly called "patient protection" legislation, and the bills here are H.R. 2563 and Senate Bill 1052; both of these were passed by their respective chambers back in 2001. The next step that normally occurs in the process is a reconciliation conference, but that hasn't happened yet. H.R. 2563 also contains what's called the "Thomas Amendment," which provides for metropolitan statistical area (MSA) expansion and association health plans. I'm going to stick with the patient protection provisions, but I want you to know that those are in there as well.

The Bipartisan Patient Protection Act is the actual name of H.R. 2563. The applicability of this bill is quite broad. It includes both group plans and individual plans, insured and self-insured at the group level. It also includes state, federal and local employee plans.

The utilization or review program is an important part of this bill. The standards that are set include written procedures that have to be based on valid clinical evidence where it's available, and "clinical evidence" hasn't been defined yet. Those of you who have looked into this before know that there are various levels of what could be considered clinical evidence. Finding those resources and defining what that means is going to be an important part of setting up these programs. They have to be administered by a qualified health-care professional, and the bill prohibits contingent compensation that encourages denial. You can't set up a program where the reviewer gets paid based on a percentage of denied claims. The bill also prohibits provider conflicts of interest, which means that the reviewers aren't allowed to review their own work.

In terms of coverage determination, internal reviews and external reviews or appeals are an important part of this bill as well. There are standards set in terms of time frames for routine concurrent retrospective and expedited reviews. For routine reviews, health plans have 14 days. Under certain circumstances, that can be extended to 28 days, but basically they have 14 days to complete their review. The providers are supposed to provide their information within five days of a request from the health plan, so that the health plan would have nine days to look at everything. For expedited reviews that are required for medical reasons, the health plans have 72 hours. That's for prior authorization. For concurrent authorization or review, the health plans have 24 hours to make a decision. For retrospective reviews, they have 30 days. Internal appeals have to be initiated within 180 days of the denial.

A review committee independent of the health plan conducts external reviews. These are reviews of medical decisions as opposed to administrative decisions. Administrative decisions are things like eligibility questions, cost-sharing provisions and those types of things. This is for medical reviews, which means decisions that

were based on questions of medical necessity, whether a particular procedure was experimental in nature or any other decision that would require a medical evaluation to come to a conclusion. The review board considers evidence from the plan, which can include things like the plan's guidelines, the rationale that was used to deny the claim, coverage or plan documents and any other written documentation that might exist. The review board also considers material that comes from the provider, which would mainly be the medical records that contributed to the decision that was made or the suggestion to have a certain procedure, and any other evidence that it unearths during the process of the review. The reviewers are not restricted to things from the health plan and the provider. The reviewers have to be experts and they have to be independent. There is a formal process for appointing the independent review organization.

The decision of an external review is binding, and there are penalties that apply—a basic penalty of $10,000 and then another $1,000 a day. There can be additional penalties if someone decides there's a pattern of abuse by the health plan. External appeals, like internal appeals, must be initiated within 180 days.

Another important part of these bills is the liability provisions. They do differ a little bit between the House bill and the Senate bill, so I'll talk about them separately. For the House bill, the jurisdiction on administrative decisions is federal. In medical reviews, the jurisdiction is with the state with federal causes of action and federal limits on liability. Economic damages are unlimited; for non-economic damages, essentially pain and suffering, the limit is $1.5 million. Punitive damages are limited to $1.5 million.

The Senate bill is a little different. For administrative claims, the jurisdiction is federal and the medically reviewable claims are with the state. Limits on liability are subject to state rules. There's more exposure for the health plans under the Senate bill. On the administrative side, there's a $5 million cap on punitive damages, but there is no limit on pain and suffering.

There are also some important access provisions in this legislation that you should be aware of. In particular, plans that use primary-care physicians have to provide direct access to OB-GYN doctors, and also, members must be allowed to designate pediatricians as primary-care physicians for their children. They can be required to be participating physicians, assuming that the plan has specialists like that in their plan. Also, the legislation would allow access to non-participating specialists at participating cost-sharing levels if participating specialists are not accessible on a timely basis.

There are also some benefit mandate provisions in these bills that you should be aware of. They include inpatient stays for breast cancer surgery. What's considered a necessary stay will be determined by the physician and by the patient. There's no stated limit on that. Second opinions for cancer patients are included, and if there's not a suitable participating physician or specialist who can do that, the plan has to

pay for a non-participating specialist to provide that opinion. Clinical trials that are approved by the National Institute for Health(NIH), the Veterans Administration (VA) or the Department of Defense (DOD) must be covered except for costs that can be reasonably expected to be paid for by the trial.

A key thing to note is that the emergency room (ER) care is subject to a "prudent person" standard. Of course, you'd have to pay for a non-participating physician when it came to ER care. For post-stabilization care, you would have to pay if the plan doesn't respond to a request within one hour or if the plan can't be reached.

The plan has to disclose the prescription drug formulary to the providers. The plan must provide for exceptions when something that's not on the formulary might be considered medically appropriate by the physician, and that would need to be covered at the same cost sharing as a drug that's on the formulary.

For physicians that are terminated from the network, continuing care must continue for up to 90 days. There are some special rules for surgery, pregnancy and terminal illness.

If you have a completely closed panel, you have to make a point-of-service option available, although you can charge a higher premium or use higher cost-sharing levels.

Finally, on the patient-protection legislation there are some other provisions that you should be aware of, including whistleblower protection, mainly for providers. It's also for enrollees, but it's mainly there to protect the providers. There are also consumer assistance and subscriber information requirements, gag rule prohibition, provider incentive rules, provider participation guidelines, and claim payment provisions. The provider incentive rules and the claim payment rules are similar to what's used in Medicare.

There are basically two mental health bills: one is H.R. 4066, sponsored by Representative Marge Roukema (D-NJ) and the other is Senate Bill 543, sponsored by Senator Pete Domenici (R-NM). These are the primary sponsors; there are others that are co-sponsors of these bills.

Let me read the key provision for insurers. It says, "Plans providing both medical-surgical and mental health benefits may not impose treatment limitations or financial requirements with respect to coverage for mental health benefits unless comparable treatment limitations and financial requirements are imposed on medical-surgical benefits." These bills basically apply to large groups, not to groups under 50.

The way they're written right now, they cover all of the categories listed in DSM-IV. President Bush, apparently, has made some comments indicating that it might be appropriate to limit coverage to serious mental illnesses. Also, it does not cover

substance abuse or chemical dependency at this point, I just mental illness in the more narrow definition. The General Accounting Office (GAO) is required to perform a study after two years to try to figure out how it has impacted health care costs.

The Congressional Budget Office did do a study. It estimated in its original report that costs would go up about one percent in total. Then it issued a clarification, saying that "one percent" included plans that were under size 50, plans that were in states where mental health parities are already required or where there's a similar definition, and plans that don't offer mental health. It went on to say that affected plans might see a 30 to 70 percent increase in mental health costs.

There are some important definitions that show up in the legislation. Treatment limitations include frequency of treatment, number of visits or days or any other similar limits on duration or scope of treatment. Financial requirements include deductibles, coinsurance, co-payment, out-of-pocket limits, annual and lifetime limits.

The legislation does not require mental health coverage. It explicitly does not prohibit medical management programs. It does not require specific services unless disparity with medical and surgical-type coverage would result,.

It doesn't apply to out-of-network benefits as long as the rules are followed for in-network benefits. You can have higher cost-sharing limits and those types of things on your out-of-network plans as long as you have reasonable access to providers in-network.

Genetic testing is the next important topic. There are four bills sitting out there; H.R.602 and Senate Bill 318 are kind of companion bills, so they're very similar. President Bush has indicated that he does support legislation of this type. I'm focusing on Senate Bill 1995 here, introduced by Senator Olympia Snowe (R-ME), since it seems to have the most momentum right now.

In that bill, information concerning genetic tests of an individual, genetic tests of family members, or occurrence of a disease or disorder in family members, used to predict risk of disease in asymptomatic or undiagnosed individuals is the current definition of "genetic information." I understand that they're still working on the definition, so that may or may not change.

The bill explicitly does not include age or gender, clinical lab tests like chemical blood or urinalysis, or physical exam. To the extent that all those things are used in the underwriting process, we can continue to use them. The bills prohibit requesting, requiring, collecting, purchasing or disclosing genetic information. Almost anything that you might think to do with genetic information would be prohibited, except that it can be used in diagnostic and treatment situations once the person is covered, or it can be used to determine whether a certain procedure should be paid

for. But genetic information can't be used to determine eligibility or to set premium rates or contribution levels.

The Academy did put out a monograph on this topic not too long ago, called, *Genetic Information and Medical Expense Insurance.* It identified three major concerns. One concern is the definition of genetic tests, which again is something that's being actively worked on at the legislative level. The second concern is not having the same information. The person applying for insurance would have more information about his or her health condition or what might happen in the future than the insurance company would, so you would get an adverse selection problem.

The third concern is the impact on pre-existing condition provisions. The way that pre-existing conditions are normally defined or treated in our policies is that once six or 12 months has gone by, then that condition has to be covered. If a person finds out through genetic testing that he or she has a certain probability or certainty of getting a certain condition, does that fit within the pre-existing condition provisions of the policy?

Finally, I want to talk about health insurance mandates. There's not a big movement to repeal mandates, but there is something important going on. States are starting to pass requirements that there be a more disciplined approach to consideration of mandates, including some cost and benefit analysis. That was also common back in the late '80s. There were a number of states that passed that kind of legislation. There was no activity in the mid-'90s, but since the late '90s there have been a number of states that have passed those kinds of requirements. It's usually a legislative committee that's appointed or a standing committee that looks at these things.

We actually did a study for North Dakota. They have imposed legislation to do a cost and benefit analysis. They look at the extent to which the mandate would increase or decrease the cost of the service, increase the appropriate use of the service, increase or decrease administrative costs and premiums, and the impact on the total cost of health care.

We developed a scoring tool for them that would look at the prevalence of the underlying disease, the prevalence of treatment, the impact of treatment on health status, the impact on sick days or disability, the extent to which the service is already covered or available through insurance and the direct and indirect impact on premium. Certain mandates come with additional costs like false positives, for example, and certain screening tests might help reduce cost to the extent that they can catch certain conditions early.

The impact on a state level considers to what extent it would reduce other costs to the state, like the criminal justice system. For example, some people think that coverage for chemical dependency actually reduces cost to society at large

because people aren't as apt to get into criminal-related activity, even if the coverage does increase health insurance cost.

There's also the impact on the individuals. This primarily means out-of-pocket cost. Are we talking about, for example, something like mammograms where it's something that you can budget for, that affects a lot of people but is not very expensive? Or are you talking about something that would affect just a few people that would be very expensive?

I want to introduce Dr. Swartz. Her research interests focus on the population without health insurance and efforts to increase access to health care coverage, as well as health-care financing and organization. She's currently examining whether regulations of insurance markets and subsidies of premiums can effectively increase access to health insurance. She's also the editor of *Inquiry*.

DR. KATHERINE SWARTZ: Today I want to focus on two states, which have had a more innovative approach to trying to cover more people without health insurance over the last decade. In particular, they've used their regulatory powers to do this in quite different ways.

I think it is very difficult to sell health insurance to individuals in the individual market, to people who are low-wage workers or workers in small firms. Probably everybody in this room has had some experience with one of those markets, and you know what I'm talking about in terms of how difficult it is to get people to purchase insurance in these markets.

Both New Jersey and New York use their regulatory power in creative ways to try to increase access to individual insurance markets particularly, but also to their small group markets. They have, in both cases, involved private sector policy makers as well as people working either in the executive or the legislative branches of the government. That is another thing that I want to stress about both of these states' approaches—they really did reach out to people in both the private and the public sector.

What's unique about both of these states' efforts is that they have set up a way to spread the cost of very high cost people to the broader population base, so that the very high cost people are not just borne by other people who purchase policies from a particular carrier. This is an acknowledgment that these very high costs, which drive everybody to fear adverse selection, are really the responsibility of everybody who lives in the state. I'd like to see this at the federal level, where there would be recognition that this is a problem for the country as a whole, and not just for people who happen to purchase policies from Aetna or Blue Cross or whichever insurance company you want to name.

It's not easy to sell coverage in these kinds of markets, and you can creatively use regulations to achieve a policy that does spread the costs of the very high cost people to a broader population base.

First, I want to briefly talk about the uninsured today and understand who doesn't have health insurance. Then I'm going to walk you through the regulations that form the New Jersey Individual Health Coverage Program. I'm going to focus on its individual market rather than its small group market. Then I'm going to talk about the regulations and experience so far of New York's Healthy New York program, and draw out the lessons for private sector and public sector policy makers.

Who are the people who don't have health insurance? At the very end of September, the Bureau of the Census released the latest figures on the uninsured population. These are based on the March current population survey of 2002. Roughly 15 percent of our population is without health insurance. You could divide the uninsured population into essentially two groups: those who have incomes below two times the poverty level and those who have incomes that would make insurance affordable.

Two-thirds of the uninsured population have incomes below two times the poverty level, which for a family of four is about $36,000. I would argue, and I think most people who have looked at individual insurance policy premiums and small group premiums would agree, that it's really difficult for a family with income below two times the poverty level to be able to afford health insurance. So we are talking about the need for some type of subsidy if we're going to draw them into this market.

Roughly 60 percent of all uninsured adults are working and, in fact, most of them are working full time. The reason that they lack health insurance appears to be that most of them work for small employers who either don't offer health insurance or, if they offer health insurance, the part of the premium that the employee must pay is high, relative to his or her income. Many of these are low-wage workers in a small firm. But if we want, as a country, to try and lower the number of people without health insurance, we need to attract the people who have incomes above two times the poverty level who are uninsured and get them back into the market and we also need to target people who work for small firms that don't currently offer health insurance. Somehow we have to be creative about getting premiums that are low enough so that both the employer and the employee feel that they can afford this.

The reason that it is difficult to attract small firms to these markets, and both New Jersey and New York have run into this, is that the average tenure of a small firm is less than two years. Say you set up a requirement that for a small employer to be eligible for one of these subsidized types of health insurance for the small group market, it can't have offered health insurance for the last 12 months. A small firm has problems setting itself up in the first 12 months. Then if the average tenure is

less than two years, it probably has financial problems by the time it would be eligible for one of these subsidized types of policies in a small group market.

In the case of New York, where it has tried to find small firm owners and bring them in to talk about Healthy New York, one of the issues is that if you do any kind of "census" or sample from Dun & Bradstreet, a lot of the small firms just aren't there because they've failed. So this is a difficult market to work with.

Those are the background facts to bear in mind when thinking about how difficult it is to sell insurance to people who either work for a small firm and have low wages or are individuals that are low income trying to find insurance on their own. New Jersey has just under one million people without health insurance, about 12 percent of its population.

New Jersey's individual health coverage program was designed during 1992. In 1992, the estimate released of the number of people without health insurance in the state was just over one million. But in 1992, this was a shock, because the previous estimate from 1989 was that only 800,000 people were without health insurance. Remember, 1992 was also an election year for the governor in the state of New Jersey, so a jump of 25 percent from 800,000 to a million people without health insurance was a big deal. Today, the state still has a million people without health insurance.

New York has between 2.9 and 3.1 million people without health insurance. It's a higher fraction of the population. The estimates that have come out in New York of how many people might be eligible for the Healthy New York program range from a quarter of a million to a million people. Then there were different estimates of how many people might actually enroll. It seems like the legislature was operating under the idea that there might be a quarter of a million people who would enroll. I think that's a bit optimistic, but I'll come back to that.

Both states' programs, particularly in the individual market, were targeted at workers in small firms and low-income people. They were really trying to get them to come into the market and purchase health insurance. New Jersey did it by setting up the Individual Health Coverage Program and an additional program, called the Access Program. The Access Program was for people with incomes below 250 percent of the poverty level. It lived, literally, for about seven months, so it doesn't have much of an impact on what we're going to talk about.

First let me go through New Jersey's Individual Health Coverage Program and give you an overview of how it was designed and an evaluation of it. I should say that my more detailed knowledge of this is based on the first four years of experience up through 1998. Since then, there are some other people that have gotten involved in reevaluating the changes that have happened. Some of what I'm talking about is how it was set up originally, and where it's relevant, I'll tell you what has changed.

First the Individual Health Coverage Program, known as the IHCP, had a companion piece for the small group market. The small group market portion was never fully implemented. There are a couple of points I'll bring in about what happened there. The third companion piece was the Access Program I told you about, which was for low-income people.

In the beginning of 1992, Blue Cross/Blue Shield in New Jersey was the carrier of last resort for people who had no other access to health insurance. There were about 175,000 people who were enrolled in Blue Cross/Blue Shield individual policies. The losses that Blue Cross claimed it had in this individual market were about $8 million in the previous year. All of the carriers in the state had a stake in Blue Cross's losses because they paid the surcharges on hospital rates for any of their own policyholders who ended up in a hospital in the state. Blue Cross/Blue Shield enrollees did not pay the hospital rate surcharges. These surcharges have been in effect since 1970 and were a way of subsidizing Blue Cross for being the carrier of last resort.

By 1992, most of the other carriers in the state were fed up with this situation. They felt that Blue Cross/Blue Shield was inefficient, and that these losses, which they then had to subsidize by the hospital rate surcharges, were unfair to them. They felt that if they were allowed to operate in a different type of market, they would have less in the way of losses and that they could make an improvement.

There was a suit under ERISA brought before the state courts arguing that workers who had self-funded health insurance policies from their employer should not have to pay these hospital rate surcharges. In May 1992, a state judge agreed with that. So you have a situation where the carriers themselves were annoyed, to put it mildly, at their subsidization of Blue Cross/Blue Shield and a state judge who says you can't continue with the hospital rate surcharge system. That decision was immediately stayed through November 30. The state had six months to figure out what it was going to do about the individual health insurance market.

What happened was that the executives of five carriers, who had already been fretting about their subsidization of Blue Cross, pulled together a proposal. They got Blue Cross on board with the proposal by June 1992, and they also began talking with the governor's office. Now remember, the governor was in an election fight because he had raised taxes in the state, so he had to make health insurance a big issue for himself. So you have this combination of private-sector and public-sector policy makers crafting a proposal. This was all done behind closed doors. It's interesting that the executives at these carriers who led this effort to create the Individual Health Coverage Program were homegrown, that is to say that these insurance companies' headquarters had long been in New Jersey and the executives who were involved were from New Jersey. They very much wanted to improve the situation for uninsured people in the state.

They got everyone to agree that this would be a good way of solving this problem. There were no hearings held. This was a situation where they basically agreed they would go for it. The election happened in early November; Florio was reelected. Around 11:00 pm on November 29, he signed the legislation setting up the Individual Health Coverage Program, the small group market and the Access Program for the low-income people. There were no pictures taken.

It is a striking example of public- and private-sector people coming together and creating a program, which worked pretty well, at least for the first four years. It's unfortunate that we don't have more evidence of who helped create this. The Individual Health Coverage Program officially started in August 1993. Enrollment was very slow during the first four or five months, but by the end of 1993-94, it began picking up.

Let's go through what created this program (Figure 1). I've divided these regulations into two sets. The first set has to do with restricting the ability of these carriers in the market to select the people they wanted and to stay away from the people they didn't want. I want to focus on two things: one is the community rating of premiums and the second is the standardization of policies. I should add that some of this—guaranteed issue, guaranteed renewal policies—was novel back in 1992 when they were crafting this. You can see how much we've moved in a decade.

Figure 1

IHCP Regulations to Restrict Selection Procedures

- **guaranteed issue**
- **guaranteed renewal of policies**
- **community rating of premiums**
- **limits on pre-existing condition exclusions**
- **portability**
- **standardization of policies**

The community rating of premiums was something that the governor was insistent upon in negotiations. He felt that he could not, running for re-election, allow a

situation where older people would pay higher rates than younger people. He was adamant that there could be no forward movement without community rating of premiums. The carriers came back and said the thing that they hated most was going to the Department of Insurance and getting permission to raise their premiums because they felt that this was an inhibition of competition, and part of what they wanted was sharing of the responsibility for the uninsured individuals in this market so there should be competition among the carriers.

The governor's office actually agreed that, in exchange for this community rating of premiums, when they set up the Individual Health Coverage Program, it would not require the carriers to come into the insurance department and ask permission to raise or lower premiums. All the carriers had to do was give a month's notice that they were going to raise or lower the premiums to the board running the Individual Health Coverage Program. To me, this is an amazing give and take.

The second regulation I want to draw your attention to has to do with the standardization of policies. Again, the consumer groups made the argument to the governor that it was very difficult for anybody to make sense of all the different types of policies that were offered in the individual market. What was needed was a standardization of policies so that people could compare premiums to what benefits were included and what cost-sharing arrangements were included. In 1991, we got the Medigap policies that were standardized, and they are known by policies A through J. It is not, a coincidence that in New Jersey the standardized policies were five indemnity policies running A through E, and one HMO policy.

Now, those policies today look quite different than they did back when IHCP originally started. To give you a flavor of what these original ones were like, the A policy was more of a catastrophic policy. It was for people who had graduated from college, would no longer be covered by their parents' policies and who needed some kind of bridge insurance policy until they found a job that had health insurance attached to it. It only covered six days of in-hospital care.

Policies B through E were identical except for their cost-sharing arrangements. B had a 40 percent coinsurance, and E had a 10 percent coinsurance, so it just went down in 10 percent increments. They also had several different choices on the deductible level. The original deductibles were $125, $250 and $500. Those deductibles today are $2,000 and higher. All the low deductibles are gone. They just don't exist in this market anymore. The HMO policy was quite standardized. There were several different choices on the co-payment.

The second set of regulations had to do with how they would construct competition in this market. The first regulation set a minimum loss ratio, to ensure that if a carrier set a very high premium and had very low payout, then it had to immediately reduce the premium in subsequent years. I would say that the one mistake the state made in this was not creating an escrow account from the first year so that money could be saved because there was the pre-existing condition

exclusion. When you set up these pre-existing condition exclusions, during the first year, you're not going to have a lot of payouts, and they should have created an escrow account situation for this minimum loss ratio, so that the carriers would have enough money in the second year to help pay out losses.

The most important regulation was that they required all insurance companies doing business in the state to participate in this individual health insurance market. They either had to sell policies or they had to help share in the losses—that is, they had to help pay for any losses incurred by another carrier.

If a company decided that it had losses and it wanted to share, that is, have other companies help pay for those losses, it would put them into a pool. A particular carrier's share of the losses that were going to be reimbursed depended on that carrier's share of the market that was measured by net earned premium. If you had a small share of this market, your share of losses would be small. This is important because the carriers' executives that were involved in designing the IHCP were all from large carriers, and the large carriers' executives never thought about what a small carrier with a small share of the market might do.

The second part of the regulation was that a carrier could avoid paying its share of the losses if it enrolled a target number of enrollees., The target number was given to each carrier by the board of the Individual Health Coverage Program based on its share of the market. So some carriers were told if they enroll 500 people, they've met their target. Bigger carriers were told that they had to enroll several thousand people to meet their target. The original total number of people that they thought should enroll was 175,000 , based on what Blue Cross was covering in 1992. Now, the carrier could avoid paying its share of the losses if it chose to not contribute any losses it had and if it had also met its target enrollment.

This clearly reflects the large carriers' thoughts on this. The five or six largest carriers who were involved in this thought that they would be the ones sharing the individual market. It wouldn't be just Blue Cross anymore, but it would be these five or six large carriers based in New Jersey. They never envisioned that any small carriers would come into this market in any meaningful way.

What they thought would happen is that each carrier would meet its target numbers and would rather keep its own losses than put them into the pool. Once they were in the pool, a carrier would have to pay not only a share of its own losses, but anybody else's losses. So the large carriers expected that each carrier would just stay out and the loss pool would be zero.

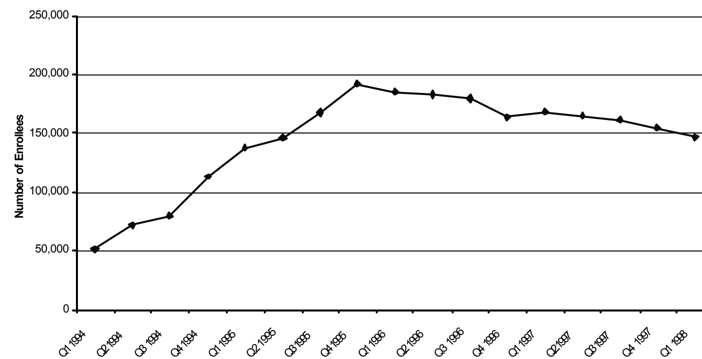
From a carrier's point of view, the decision points were, essentially, do you pay the assessment of the losses or do you sell policies? If you sell policies, what premium do you set it at? Keep in mind that there's a minimum loss ratio that restrains them from having very high premiums. If you expect reimbursable losses, do you declare them for reimbursement or not? The decision to declare reimbursable losses had to

be made by April of a particular calendar year, so it was a prospective decision, based on what you could see happening in the first three months. Based on your experience in the previous year, did you expect you would have much in the way of losses? This was forcing them to think forward and it was prospective. It was a gamble, but, as I said, most of the people involved in this believed that they would all share those losses and there wouldn't be losses submitted for reimbursement.

What happened? Figure 2 shows you the enrollment in the IHCP through 1998, which is the period that I studied. At first it actually did very well in terms of enrolling people. Part of the slowness in the first several years had to do with convincing people that they could give up their Blue Cross/Blue Shield individual policies and migrate over to the Individual Health Coverage Program and they would not have to restart a pre-existing condition exclusion. It took time for people, especially when you think about people in their 50s who had health conditions that they were concerned about, to decide whether they would move over or not.

Figure 2

Enrollment in the NJ IHCP by Quarter, 1994-98



By 1996, you start seeing a decline. Since 1998, the enrollment has continued to decline, so that today it's less than 100,000 people. There are a couple of things that explain this. One is that we have to look closely at these enrollments—what happens with losses and which carriers came into this market. There was, in fact, quite a bit of competition on the premiums. The premiums by 1998 for an individual policy were around $200 a month. You could get less than that if you went to the HMO policy. Generally, there were at least two and, more often, four carriers, who were competing at the lowest premium level. That is to say that there would be differences of $3-$5 for premiums. It was tight competition.

Now, I'm an economist and my reaction to that was, "This is terrific. These guys have gone out and tried to price this, and the fact that you get very close premiums tells you that there is competition going on in this market." However, what also happened was that a lot of very small carriers came into this market. At the height, New Jersey had 28 carriers participating in this market, which was stunning to everybody who was involved. Nobody envisioned that. Many of these carriers did not have the capital reserves to be in this kind of market. They should not have been encouraged to take this risk. The truth is that they wanted to get into this market, in part, because New Jersey went and set up the Individual Health Coverage Program.

Its small group market consisted of two or more employee lives, and anybody who was a self-employed person had to be in the individual market. Many of these very small carriers had experience with self-employed people and they thought that they would expand their small group share of the market. So they were trying to get

agents to be involved in this. The incentive here, if you have a tiny share of this market and you have losses, what happens to you?

You don't pay them. Everybody else has to pay them. But the big companies didn't think about that. They just couldn't envision that somebody might behave that way. What happened is that these small carriers came in. They lowballed premiums because they thought that if you have low premiums, you'll attract healthy younger people. But, in addition to attracting healthy younger people, they seemed to attract a few people who had very high costs. Because they were very small carriers, that caused trouble for them.

There were about eight or nine of these very small companies that quickly started to raise their premiums. It was as if nobody wanted to be the bottom premium, and they tried to shed people as quickly as possible. What you observed in this declining enrollment has to do with people, first, being told that their premium more than doubled. They might have gone to another carrier, but after you get a second carrier doubling your premium, you essentially get mad, give up and don't keep up your enrollment. So clearly people got exasperated.

The second part of the decline in enrollment came from the small group market. If you were a self-employed person, they would let you into the small group market. By the end of 1997-98, we began to hear anecdotal stories that single-life small groups essentially migrated to the small group market, which had lower premiums. The Access Program was not continued by the state. They lost about 20,000 people that way.

In 1995-96, these small carriers contributed $77 million in losses to the loss pool, so the other carriers had to take a share of that. Blue Cross had a big portion of the share of that loss pool.

In 1998, the legislature got back into the act. The legislators altered the loss reimbursement mechanism. Instead of saying, "Look at this. We should restrict which carriers can be in this market, based on their capital reserves," they basically took a hatchet to it. Instead of making it a prospective system, they made it retrospective; it involved the last two years. From my point of view, the experiment of the IHCP ended at that point. Enrollment continues to fall and the irony, of course, is that Blue Cross/Blue Shield is the major carrier of this market.

Healthy New York was created in the dead of night in December 1999. For those of you from New York, you know that Governor Pataki cut a deal with Dennis Rivera, the head of the hospital workers' union. Essentially, for the hospital workers, the gain is that by having something like Healthy New York, there will be more payments coming into the hospitals for uninsured people, so that the workers' wages can go up. From the governor's perspective, it was a great way to show that he cared a lot about individuals who don't have some kind of employer access to health insurance.

It is targeted at three groups of people. First is small firms that have at least 30 percent of their workers earning less than $30,000 in 2001. This has been increased by the rate of inflation this year. The second group that is targeted is sole proprietors, and they have to have incomes below 250 percent of the poverty level. My own guess is that income is not looked at quite as much when sole proprietors come in to enroll. The third group is individuals who have family incomes below 250 percent of the poverty level. This is clearly a program targeted at lower-income people and lower-income workers. It's different from New Jersey in that the whole program is targeted at low-income workers.

All HMOs in the state have to participate in the regular individual market, what they call the "self-pay market," as well as in this market. This is not anything new to the HMOs. In addition, there is one standardized benefits package. There are a couple of standardized benefits packages in the regular non-group market, but here it's just one standardized benefits package, and it's the same whether you're in the individual market or whether you're in the small firm market.

The third requirement is the community rating of premiums, which means that a carrier operating in a county has to offer the same premium to anybody in that county. A carrier could be in several different counties and have different premiums, if it wanted to, in the different counties. In fact, that actually doesn't seem to occur when I've looked at contiguous counties where the same carrier is operating. The difference is that even though it's the same premium regardless of whether you come in as an individual, sole proprietor or a worker in a small firm, you have a huge advantage if you come into this market as a worker in a small firm, because the employer has to pay at least half of the premium. Right out of the gate, workers in small firms have a much lower premium that they're responsible to pay out-of-pocket.

What are the design features that get to these lower premiums that the state was hoping for in Healthy New York? The most important feature is that the state acts as the reinsurer. There are stop-loss funds set aside for reinsuring. The state is responsible for 90 percent of the costs of claims for an individual between $30,000 and $100,000 in a calendar year. This is the most innovative part of Healthy New York and, indeed, I think that other states ought to think about this. I would like to see the federal government do this as well.

From a historical point of view, those of you from New York might remember that back in 1989, when the Department of Health was proposing a sort of universal New York health care, there was, at that point, a stop-loss limit proposed of $25,000. A decade later, it is quite interesting that they landed pretty much in the same spot.

The second way they helped to get lower premiums was that the benefits package is relatively lean. The third way was that the enrollee cost sharing and copayments

are somewhat higher than you would expect to see in any kind of group health insurance policy.

One of the things a lot of people are unhappy with is the notion that there should be a copayment of $500 dollars per hospitalization episode. When you're talking about low-income people, that seems pretty high. The $20 copayments for outpatient hospital services, adult preventive services or pediatric care, are at the high end of copayments that people are paying, but they're not totally out of the ballpark. They're high for low-income people.

There's no mental health or substance abuse coverage. This is an exemption that the state gave Healthy New York. That is to say that the Healthy New York benefits package does not have to adhere to the state mandate for all other health insurance policies.

For prescription drug coverage, there's a $100 deductible. There are different copayments that, again, seem like what most of us would pay with a large group insurance policy. Finally, there's a $3,000 per year maximum. I don't know whether you would call that generous or not. There are some people who worry that that's not particularly generous.

The funds for the stop-loss reinsurance come from the tobacco settlement funds. The stop-loss funds don't take up all of the tobacco settlement funds, but they're part of them. There are two pools of funds, so even though they have said that this has got to be community-rated premiums for individuals and workers from small groups, they separated them in terms of figuring out the monies that would be used by the state as the reinsurer. In part, this is because they weren't sure whether or not there would be more of the very high-cost claims coming in through the small group worker side or the individual side.

For the year 2001, which was the first year that this program was up and running, $40 million was set aside for the two pools of funds. In 2002, $106 million dollars was set aside. This program is supposed to sunset June 30, 2003, so only $73 million is set aside for that year. There are also stop-loss funds that were set up for the regular non-group self-pay market, and that started with the year 2000. They had a total of $130 million set aside for that. I think that was part of the give-and-take with the HMOs in terms of how much you are going to bring down the premiums for Healthy New York. For 2001, most people's expectation is that nowhere near $40 million will be spent to reimburse the HMOs; at most it will be $3-5 million .

What happened with these premiums? If you compare the premiums that are offered in the regular unsubsidized individual market to what's offered in Healthy New York, the premiums are about 50 to 70 percent lower. It's a huge drop. That was not true in November 2000 when they were crafting this. All the HMOs had to come in with their initial estimates of what their premiums would be. Given what I

had done with Actuarial Research Corporation, I believed that there might be a drop of around 15 percent, maybe a little higher than the HMO wanted to give. I interviewed a number of actuaries at the HMOs in the State of New York, who are quite interested in this, and that was roughly their estimate.

In November 2000, the state does not accept the initial premium offering. It was never made public. There is $130 million of stop-loss funds for the regular self-pay market, and I think that came into play. By the end of December, the insurance department announced that everything had been set and they had new premiums—the ones that are 50 to 70 percent below the regular self-pay premiums. I think there was something else that went on in terms of some amount of giving by the Department of Insurance and the HMOs so that the premiums came out lower.

It's very difficult to compare these premiums to the premiums that you would find if you were a small employer going into the small group market in New York, because you could go get any benefits package you wanted. So we looked at those small firms that went to the HMOs in the state and compared those premiums. They're somewhere between 15 and 30 percent lower in Healthy New York.

However, these premiums under Healthy New York are still more than five percent of before-tax income for most individuals. For a lot of people, they're actually above 10 percent, particularly if their income is closer to the poverty level; remember, it could be as much as 250 percent of the poverty level. Even if you are a worker in a small firm and the employer is paying half of the premium, this is still a hefty chunk of your income.

Enrollment started in February 2000 with a few people, literally. The numbers so far are what everybody connected to this would describe as disappointing. As of June this past summer, there were about 8,000 people enrolled, but, as I was repeatedly told, the enrollment was increasing rapidly. I don't know what the enrollment is today, but it's not anywhere near the 250,000 that some people had hoped for. However, the state is not totally to blame for this.

A lot more marketing or outreach could be done in this market, if you compare it to what went on with Child Health Plus, or another program known as Family Health. The state got a waiver from what's now Centers for Medicare and Medicaid Services(CMS) for parents of children who were eligible for Child Health Plus.

The state did a lot of advertising for those programs.

If you ride the subways in New York, you won't see many advertisements for Medicaid, but you'll see a ton of advertisements for Child Health Plus and Family Health Plus. I have yet to see an advertisement for Healthy New York in a New York subway, which I think is telling.

I've had a lot of phone calls from people in the western part of the state— Buffalo, Rochester and also from Albany—who are trying to help small employers offer something to their employees. It appears to me that initially very little attention was paid to how you reach out to people to let them know about the program. But, as I said before, it's very difficult to figure out who are small employers

The 2001 claims were supposed to be cleaned and audited by Labor Day. I think that is now finished, but I have not seen a public announcement yet of how many claims were paid. I'm going to be involved in another evaluation of this starting in December, and that's one of the first questions that I'll be looking at.
For the year 2001, they expect a very low number of claims because of the pre-existing condition exclusions and the very small number of enrollees for the year. The result has been that most of the $40 million for stop-loss funds for the 2001 year has been "borrowed" by the state because of the deficit situation the state finds itself in. Whether or not those funds will get back into the Healthy New York program is anybody's guess.

The innovative part of Healthy New York is the fact that the state is acting as a reinsurer. I know that the state actually did explore the notion of going into the private reinsurance market, but were basically rebuffed because nobody had a clue what the claims experience would be, particularly for people that they thought had been uninsured for a while. The state's goal here is to try and establish that claims experience and then hope that private reinsurance might take over. That is to say the state will pay premiums for this. In the meantime, the state is acting as the reinsurer. This is an incredibly innovative way of implicitly subsidizing low-income people and low-income workers in their purchase of health insurance, plus it acknowledges state responsibility for these very high-cost claims—it doesn't pay entirely because there's a cap at $100,000, but it does alter the situation because the State of New York has now said that it is responsible for a big share of the very high-cost people. From the HMOs' point of view, this is a big victory in terms of their negotiating with the state about setting premiums in the individual market.

This approach to subsidizing health insurance premiums is a big difference from the tax credit approaches that are being talked about in Washington. If you gave somebody a tax credit subsidy to go purchase health insurance in the individual market, then everybody else who already was purchasing a policy from a particular carrier has to pay for any high costs claims of these people who come in because of the tax credit subsidies. It places the burden onto people who are already purchasing health insurance from a carrier. That is to say, when somebody comes in because he or she was given a tax credit incentive to purchase health insurance, and premiums go up, especially if there's any initial adverse selection, the people who have been doing everything right by purchasing health insurance in the past may leave because the premiums went up.

New York is saying, "This is the responsibility of all of us." We need a broad population base, a tax base, to be sharing those costs, and New York chose to use

the tobacco settlement funds initially to help pay for this. Of course, those tobacco settlement funds could come in handy for a lot of other state priorities like education, rebuilding the New York City infrastructure, whatever you want. I just want to point out what unique features this set of stop-loss funds and the state being the reinsurer are.

In summary, both New York and New Jersey use their regulatory powers to increase access to the individual insurance market in particular, but also the small group market in New York. They both spread the cost of very high-cost people to a broader population base. They did this using different mechanisms. Clearly, in New Jersey's case, they're saying, "If you sell insurance in this state, you have to help pay for these losses." They implicitly went to policyholders as their "tax base" to spread these costs. In the case of New York, they very clearly went to the broader population base to help pay for this.

The other thing that is important is that both of these programs were designed with input from people who are policy makers in the private sector. I think that helped guarantee at least some measure of initial success in getting people to hold off on criticisms. Even now in New York, there is a certain amount of giving it some time to work.

People understand that September 11 impacted the rollout of this program in terms of marketing. The original insurance commissioner in New York who was responsible for this, although he was not the designer of it, was Neil Levin. Neil Levin was the head of the Port Authority of New York. He was killed in the World Trade Center. That, too, has left a lot of private-sector policy makers saying, "Let's give this program a chance." As far as the fact that these monies have been "borrowed,"—people do think of it as borrowed— the money may come back into this if people can say that there will be much higher enrollment. Everybody's hope, of course, is that there will be very little adverse selection.

MR. WILLIAM BLUHM: My question has to do with the New Jersey situation. My perception of the success of the program is very different than yours. My understanding is that about one percent of the insured people in New Jersey are insured through individual insurance today, and nationally that number is more like 10 percent. It seems that the net effect was a substantial decrease of access for people who couldn't afford it, although the people who were very sick and could afford it found the access.

It seems on the surface that a program that has guaranteed issue, a 12-month pre-existing condition exclusion and community rating is implicitly doomed to failure. The things you're building into the program are going to cause it to fail ultimately. The pre-existing condition exclusion might protect things for a while, which I think is consistent with your term of "the initial success." I didn't fully understand your explanation of the cause other than the dynamics that seem obvious to me to be built into the program.

DR. SWARTZ: I think that's an excellent question. I was trying to carefully say that my view of the success of this runs through about 1997-98. I would say right now that this program is going downhill more than rapidly. I would also say that the success of it was that there was real competition among the carriers, so that the premiums actually were maintained at low, affordable levels. With the HMO policies, in particular, there was a lot of competition and people have migrated now toward the HMO policy. The success was that there was competition on premium and the premiums were affordable.

This thing got out of hand because there was essentially a moral hazard incentive for small carriers who should not have come into that market to come in, and they're the ones that incurred the losses. They're the ones that drove premiums for their policies up and sowed the frustration on the part of people looking to purchase into this market. There could have been fixes made by 1996-97. It was pretty apparent by 1997 that the carriers that were contributing losses were the small ones that nobody anticipated. If they had moved quickly at that point to alter the loss assessment mechanism and the conditions under which somebody could be eligible to sell insurance in the state, we wouldn't have seen this dramatic drop in enrollment.

The other thing is that New Jersey, like all states, has had a decline in the number of people purchasing individual coverage largely because the market and the economic situation has been terrific until this last year and a half. So a large part of the drop, (at least I've been told) since 1998 is people getting jobs and getting employer-sponsored coverage.

The individual market consists of two types of buyers. There are those who need it long-term primarily because they have jobs that don't offer employer-sponsored coverage or they don't work anymore. But there are also people who need it short-term; people like college kids who have gone off their parents' policies and need coverage until they start working at a company that offers health insurance. It's also for people who lose a job and don't want to pay for their former employer's type of policy under COBRA, but want some kind of coverage to carry them through the period to take a new job. There have actually been far more people who purchase coverage under the IHCP than what you see in the numbers enrolled at any given quarter. In that sense, also, it's been successful at having premiums, at least up through 1998, that were viewed as affordable. I agree that for the last four years this has been a disaster.

MR. DWIGHT BARTLETT: I sense from your final remarks that you seem to be in favor of broad-based, tax-financed subsidies to these kinds of programs. Doesn't this kind of an approach, however, provide an incentive to employers to drop their traditional group insurance programs so that in effect the same kinds of benefits could be provided to employees with a subsidy from the tax base?

DR. SWARTZ: That's a good question, too. You'll notice in looking at New York, particularly, that the benefits package is leaner, and that was deliberate. It was to help prevent the so-called "crowding out" of employers, particularly large employers offering plans that they then might turn around and encourage people to go purchase coverage in this market. But in New York's case, you couldn't have had health insurance for the previous 12 months and you couldn't have access to an employer-sponsored policy. If you work for a very large employer that offers health insurance, you're not eligible for Healthy New York. That's also true if you choose not to purchase your employer's offered coverage because you think that that portion of the premium is too high. You're still not eligible. It doesn't stop an employer from saying, "I'm not going to offer coverage now. Twelve months from now, you're all eligible." That could happen, of course. It is a worry.

MR. MARK WEINBLATT: You mentioned when you were talking about Healthy New York and the stop-loss, that the program is going to sunset in about eight months. Is that the stop-loss program or the whole Healthy New York program?

DR. SWARTZ: The whole Healthy New York program.

MR. WEINBLATT: So, at this point, they're giving up on it or is it just that they expect it to renew?

DR. SWARTZ: Actually, it's the way New York State writes law. They let it run three years and then see what happens. The previous health care reform acts in New York have continuing resolutions that allow them to move forward. That's what I expect will happen.