Health Insurance Continuity

by Steele R. Stewart

Competing American ideals for the U.S. health care system include free markets which foster competition, cost effectiveness and advances in health care versus public and private assistance, which provides health care independent of a person's financial means.

Today, these ideals are partly met by Americans under age 65 financing health care through employer, individual, Medicaid/SCHIP, other public health insurance and charitable contributions. Each type of financing is designed with different benefits, eligibility rules and contribution levels to sustain long-term fiscal viability. However, uncertain long-term medical inflation makes fiscal viability problematic. In response, the market or the plan administrator adjusts the design as necessary. This results in a fractured health care system with gaps and disconnects between the different types of insurance. How these gaps will change over time can be impossible to predict.

Americans find themselves transitioning between different types of health insurance and becoming uninsured. This essay will address ways to protect individuals—who have insurance today—from losing coverage. We will look at the obstacles that hinder insurance continuity and propose government actions to improve continuity while allowing a free market to determine insurance benefits and premiums.

Continuity Obstacles

What are the obstacles impacting individuals from maintaining insurance as they move between the three primary types of insurance (Employer, Individual and Medicaid/SCHIP), and becoming uninsured?

Enrollment Delays include:

- *Natural Delays* in enrollment take place as people shift between insurance types. Individuals must research and apply for the coverage that seems best to them. An employer's human resource department, and insurance brokers and agents are support structures to help and encourage individuals to enroll. The lighter the support structure and the more complex an insurance product, the longer the natural delays.
- *Life Events* often take place at the time when applying for insurance is needed. Lost employment, moving out of state, a severe medical condition, or starting a new job are natural stressors which can create emotional barriers and practical distractions when one tries to research and apply for insurance.
- *Coverage Delays and Limitations* are allowed by policymakers to help protect insurance pools from abuses by those who go without insurance for extended periods of time. Employers often have waiting periods or pre-existing conditions limitations for up to a year. Individual insurance products may exclude or delay when pre-existing conditions are covered.

Limited Desire for Health Insurance

One of the fundamentals of assuring continuity of coverage is having the necessary motivation to be covered independent of circumstances. As an individual's employment, eligibility for government programs, income, assets, and health status change, their desire to pay for insurance may change. Following are some examples:

- *Income, Assets and Health Status:* A person is motivated to purchase insurance based on their income, assets, perceived insurance need and willingness to risk being without insurance if their health status should change. Since approximately 20 percent of those with insurance incur 80 percent of the claims, most people will not realize the value of the insurance premium they pay over the next several years. However, as a person's health status becomes questionable, he or she will tend to have a greater desire to buy insurance.

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- *Other People's Money:* A strength of employer-sponsored insurance and Medicaid/SCHIP is also one of the major weaknesses in maintaining continuity of coverage. With both, individuals are offered insurance that is entirely or significantly paid for by someone else. Unintended consequences include people not realizing the following: the cost of health insurance, their responsibility to pay for insurance, and the need to save for when a third-party will no longer be covering their premiums.

  While employed, group insurance will often have rich benefits with low employee premiums that are desirable to the employee. Once unemployed, the same COBRA group benefits—but without the employer's premium contributions—are most often perceived as a financial burden. Therefore, most people will drop the COBRA coverage in favor of becoming uninsured, or if financially reasonable, decide to purchase individual insurance with significantly lower benefits.

- *Medical Inflation:* This includes the increase in the cost of known and advances in medical care. Americans expect that effective new treatments will be covered independent of the cost. Improved benefits and escalating cost of care is passed on to the consumer in higher insurance premiums. These changes impact the perceived value of insurance.

Discontinuous Insurance Laws and Regulations

To protect consumers and encourage insurance, policy-makers have passed laws and regulations that help define specific types of health insurance. For example, ERISA and COBRA apply to employer coverage; state individual insurance laws apply to individual coverage; and government program regulations to Medicaid/SCHIP. Individuals who shift between insurance types are faced with rules and funding mechanisms that encourage coverage within a type, but discourage continuity of coverage from one type to the next. The following illustrates how insurance laws and regulations contribute to discontinuity.

- *Individual to Employer Insurance:* Individual state laws may require individual insurance to pay claims even when a person has group coverage. Instead of requiring employer insurance to be primary and reducing individual premiums by the actuarial value of the group benefits, the individual insurance company must provide benefits as if no group coverage exists. Most people drop individual coverage if the group coverage offered has richer benefits or is less expensive, but lose the long-term protection that individual coverage guarantees.

- *Employer to Individual Insurance:* As discussed earlier, due to the high cost of employer-sponsored benefits, most people will forgo COBRA coverage when moving to the individual market. Since the individual market is significantly different than the group market, people will need to cross many of the obstacles previously listed.

- *Medicaid/SCHIP:* This requires income and non-income eligibility criteria. However, once these criteria are no longer satisfied, a person will lose coverage benefits, but may not be able to afford individual insurance. Therefore, the prospect of employment or higher income may not always be beneficial, unless group coverage is provided.

  For those who lose group or can no longer afford individual insurance, eligibility in government programs is not guaranteed, and becoming uninsured may be the outcome.

Additional Money Required

The underlying rationale for many of the above obstacles is preserving the financial soundness of each insurance type. Thus, mitigating these obstacles will include providing or motivating others to provide or set aside money for continuity benefits.

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Options To Increase Continuity

The following proposals intend to improve continuity of coverage by creating a legal framework where private insurance and government programs can operate efficiently, and minimize changes to the current insurance markets.

- Require educational material to be provided by an individual's current insurer. The material would include long-term limitations of their current insurance, descriptions of other insurance options and contact information.
- Create more fluid insurance laws and regulations. For example, allow employers to replace COBRA coverage with other insurance mechanisms which in turn allow the employer and employees to choose and prefund individual insurance products that would be activated upon employment termination. Or, create a class of Secondary Payer Individual Insurance Products (SPIIP) that are tax deductible and have premiums that reduce to the actuarial value of a secondary product when a person has group insurance.
- Create a Continuity Insurance (CI) Market through tax incentives to encourage insurers to sell, employers to support, and individuals to purchase continuity coverage. CI provides SPIIP when a person terminates group or government insurance. The individual insurance provided would have benefits and premiums agreed to when the CI policy is purchased.

  CI could be sold when an employee first enrolls in an employer's insurance or upon the employer's annual open enrollment period. CI is not a group product, but an individual product and thus would be priced based on an individual's insurance needs and risk characteristics. But insurance laws and tax regulations would need to be modified to be advantages to employers to help promote the CI in the workplace. The monthly cost of CI could be about 5 percent of the agreed upon individual health insurance premium.
- Allow Health Savings Accounts (HSA) for those with CI or SPIIP and allow the funds to be used for medical expenses and health insurance when unemployed.

In conclusion, the advantages of above proposals would help bring together many of the fractured aspects of our health insurance system. Specifically 1) Enrollment delays are avoided since the research, learning and application for insurance takes place long prior to employment termination. 2) CI's low monthly cost, the significant risk insured (being uninsurable), the timing of sale (outside of unemployment circumstances), employer promotional efforts, and government tax incentives combine to provide significant motivators for individuals to purchase CI. This in turn brings the needed money to cover these needed benefits. 3) Integrating the use of HSAs, SPIIP and CI will also bring needed money that will help reduce the number of uninsured long term. 4) Government agencies could also purchase or provide CI for Medicaid/SCHIP enrollees to assist with this population's need for continuity of coverage.

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