

**Feasibility Study  
on Use of  
an Interstate Compact  
to Provide  
Individual Health Insurance**

December 1, 2008



**Mike Kreidler** - *State Insurance Commissioner*

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December 1, 2008

TO: Senator Karen Keiser, Chair, Senate Health and Long Term Care Committee  
Representative Eileen Cody, Chair, House Health Care and Wellness Committee

Dear Senator Keiser and Representative Cody:

The individual insurance market reform law passed by the 2008 Legislature directed my office to analyze the feasibility of using a multistate compact to deliver individual health insurance.

This report includes a brief history of how health insurance evolved in the United States, examines the issue of affordability, and evaluates the challenges and benefits of forming a compact to provide health insurance across multiple states.

I support the report's conclusion that, while adopting a compact is technically feasible, a business model does not exist at this point. Until best practices are identified and agreed upon, using a multi-state compact to provide individual health insurance is not a viable solution to make individual health insurance more affordable or reduce the number of people who are uninsured.

If you have any questions about this report, please call me at 360-725-7100.

Sincerely,

A handwritten signature in black ink that reads "Mike Kreidler".

Mike Kreidler  
Insurance Commissioner

cc: House Health Care and Wellness Committee Members  
Senate Health and Long Term Care Committee Members

## Executive Summary

The 2008 Washington state individual insurance market reform law directed the Insurance Commissioner to analyze the feasibility of using a multistate compact to deliver individual health insurance<sup>1</sup>. This overview addresses all three elements of feasibility: whether it can be done, if it is suitable and how likely it is to be done<sup>2</sup>.

### Vision of success

Health insurance addresses immediate needs (i.e., paying for medical care and treatment, rather than longer-term financial requirements addressed by products like life insurance and annuities). We pay for health care either out-of-pocket, through insurance or through public entitlement and safety net programs. Health insurance has three distinct markets: large group, small group and individual. Supplemental insurance for some public programs, such as Medicare, is also sold individually.

Whether this insurance is affordable depends on the cost of the insurance, the benefit design and out-of-pocket costs. One view is that inexpensive policies that offer little coverage lower the number of uninsured, but don't support access to health care when it is needed. Another viewpoint advocates greater individual responsibility in paying for health care, and supports higher deductibles for that reason.

A successful health insurance market provides meaningful coverage that saves costs for the insured and the insurer. Those who were uninsured are living sicker and dying earlier. Their numbers have increased each year for the past eight years, nationally and within Washington State<sup>3</sup>. While recent national statistics showed a decrease in the number of uninsured for 2007—driven primarily by new state health plans in Massachusetts and other places. Washington's uninsured population increased in 2007. And even nationally, the trend of a decrease in private coverage continued. How we achieve affordable, meaningful coverage has and will continue to foster spirited political, business and personal debate. This study is one starting point to evaluate a possible piece of the puzzle: using a multistate compact agreement to provide individual health insurance.

### Compacts support multistate action

Compacts are contracts between governments, often states, permitting cooperation on multistate or national issues while retaining state control. Model legislation is crafted and passed by "compact states," which fund an administrative entity responsible for implementing the agreed-upon approach to the compact's subject matter. To create a multistate compact to provide individual health insurance,

<sup>1</sup> Chapter 303, Laws of the State of Washington 2008, section 8, (SSB 5261)

<sup>2</sup> feasibility. Dictionary.com. *The American Heritage Dictionary of the English Language, Fourth Edition*, Houghton Mifflin Company, 2004. <http://dictionary.reference.com/browse/feasibility> (accessed: July 30, 2008).

<sup>3</sup> Office of the Insurance Commissioner, *Threatening the Health Security of Washington: The Uninsured & the Rising Costs of Uncompensated Medical Care Washington State 2006* (2006).

participating states would:

1. Agree on an approach to providing coverage
2. Establish model legislation authorizing the compact to act on their behalf

Once passed, the compact itself would carry out the business model authorized by the model legislation.

States benefit from compact agreements when confronted with problems requiring uniform or coordinated solutions, and resources beyond the capacity of a single government. Every state in the union belongs to at least one compact. Washington state was a leader in creating the Interstate Insurance Product Regulation Commission (IIPRC) that supports insurance products in life annuity, and long-term care lines, but does not include property/casualty or health insurance.

Because a compact is essentially a contractual agreement, the question of using a compact to provide affordable individual insurance is not really the question requiring analysis. Contracts and organizational documents can be crafted to reflect any business plan.

The real question is whether an approach to the individual market exists that makes individual insurance more affordable, and whether it is feasible if done at a multistate level. Underlying that question is defining the benefit of improving affordability:

- Are there fewer uninsured?
- As more people enter the individual health insurance market, does their health improve?
- Is the issue affordability or will there be additional challenges to address?
- Would there be additional choice of health carriers and plans if a compact shifted the marketplace itself to a multistate pool of insureds?

To answer those questions with assurance, the compact's business and management model must be selected. A compact in and of itself is not a business model; it is a legal framework within which the business model operates.

### **Broad change requires a compelling reason, compact doesn't yet meet that test**

While a compact is technically feasible, whether the ends justify the means must be determined. There are significant obstacles to creating a compact, most importantly:

**Political viability** - Compacts require consensus and champions to be successful. They must be adopted by multiple states' legislatures on a word-for-word basis. While states share a common policy goal of reducing the number of uninsured and improving health outcomes, there isn't sufficient consensus about what will work.

**Policy viability** - States do not have sufficiently common regulatory approaches to make a compact structure feasible for offering health insurance. While a compact could establish that common regulatory environment, the likelihood of agreement on uniform approaches is slim until more data tying outcome to practice is available.

**Market viability** - The current health delivery model uses insurance to pay for care and services based on contracted rates. A compact would challenge that model, because it would require a leveling of the varying cost of services based on provider availability, demographic differences in health care needs, and other business considerations that vary between states.

**Business and management model viability** - An interstate compact to provide health insurance can take many forms, all dictated by the selected business and management model. Until that model is chosen, a meaningful cost-benefit analysis can't be done. The variety of strategies being tried by the states to make health insurance affordable and to provide access to coverage will inform that decision. It generally takes two to three years to develop a compact's management model once a business plan is framed.

**Economic and financial model viability** - The financial model associated with most compacts suggests that a compact acting as an administrator makes the most sense for providing individual health insurance. Member states fund the effort; for this purpose, premiums collected would also finance operation of the compact. Administrative simplification of both health plan administration and compact administration would need to be a priority. A key risk is that the cost of compact operation eliminates any gains in affordability resulting from enlarging the pool of insureds.

## Introduction

About 13 percent of Washingtonians under age 65 are uninsured<sup>4</sup>. This is an increase from the 10.4 percent identified in 2006<sup>5</sup>. Washingtonians with private health insurance total 72.8 percent of the population<sup>6</sup>.

The Washington State Insurance Commissioner's Office has studied the problem of the uninsured since 2004, establishing the scope and severity of the issue for our state through a series of monographs and data reports<sup>7</sup>. During the same time frame, other state agencies and educational and policy institutes similarly evaluated the reasons Washington citizens are uninsured and underinsured.

Solutions are being proposed as well. The Insurance Commissioner's Guaranteed Health Benefit Plan is part of a potential solution for the uninsured, proposing to fund insured catastrophic care for all residents through a small payroll tax, while reducing premiums by eliminating a key area of risk for health carriers.

This study responds to the Legislature's desire to explore a possible solution to one piece of the uninsured puzzle – affordability of insurance for the individual insurance market. Presumably, if insurance is “affordable,” people will buy it, reducing the number of uninsured. The 2008 Legislature directed the Insurance Commissioner's office to “Explore the feasibility of entering into a multistate health insurance plan compact for the purpose of providing affordable health insurance coverage for persons purchasing individual health coverage...” This study:

- Provides an overview of the current individual health insurance marketplace.
- Assesses the customer dynamics of the uninsured and the individual health insurance market.
- Evaluates whether market expansion through a compact would make individual health insurance more affordable.
- Discusses the business-to-business and business-to-consumer market factors affecting affordability and outcomes of such a change.
- Identifies key barriers and risks to such an enterprise, based on industry reaction, business model challenges, sales and marketing issues, and operating requirements.

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<sup>4</sup> Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements).

<sup>5</sup> Bovbjerg, R., Clemas-Cope, L., Masi, P., and Bowen Garrett, A., “Reinsurance in Washington State” The Urban Institute (February 2008) at 6, citing Washington State Office of Financial Management, *2006 Washington State Population Survey: The Uninsured Population in Washington State*, Research Brief No. 39 (Revised)1, November 2006 (Contributor: Erica Gardner). <http://www.ofm.wa.gov/researchbriefs/brief039.pdf>

<sup>6</sup> State Health Access Data Assistance Center, “Squeezed: How Costs for Insuring Families are outpacing Income,” Robert Wood Johnson Foundation (April 2008) 1 at 6. In 2005, 542,812 persons in Washington were enrolled in individual health insurance plans. Office of the Insurance Commissioner, Annual Statements filed by companies (2006).

<sup>7</sup> Washington State Blue Ribbon Commission on Health Care Costs and Access, *Final Report* (January 2007);

- Briefly identifies some regulatory and other issues that would need to be addressed to adopt a compact for delivery of health insurance.

### **Methodology and approach**

The Insurance Commissioner's staff has evaluated a myriad of reform proposals for the individual market, as well as studies of the individual market's sensitivities, and analyzed several existing compacts, including an insurance compact and other types of consumer product delivery.

The legislation asked for a proposed model. However, devising a true model requires actuarial and other resources unavailable for this study. Precise cost estimates require defining additional details of the policy approach, creating a detailed list of assumptions about the ways behavior would change once the approach was in place, and applying a complex, economic modeling approach taking into account the many factors, outcomes and net effect of the proposed change.

Most solution models currently being discussed and applied involve either public coverage or subsidies for private coverage in the form of direct payments or tax incentives. All solutions require an analysis of the uninsured as well as the individual insurance market, which is constantly changing. Some people who are currently uninsured will gain coverage, while others who are insured will lose it. As a result, the discussions of this topic are based on averages.

While many feasibility studies involve consulting with stakeholders, the community and users in addition to research and analysis of detailed modeling, this study is an initial response to the Legislature's specific request. Too many possible business models exist to perform a cost-benefit analysis that would support such modeling.

Our statutory charge for this study is to evaluate whether a multistate compact structure can "provide affordable individual health insurance<sup>8</sup>." This study does not discuss whether insurance as a product is the correct solution to providing health care for those currently uninsured or whether state government should be in the business of providing individual health insurance outside its safety net obligations<sup>9</sup>.

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<sup>8</sup> The OIC is required by Chapter 303, Laws 2008, section 8, (SSB 5261) to:

"Explore the feasibility of entering into a multistate health insurance plan compact for the purpose of providing affordable health insurance coverage for persons purchasing individual health coverage. The office of the insurance commissioner shall propose model state legislation that each participating state would enact prior to entering into the multistate health insurance plan compact. If federal legislation is necessary to permit the operation of the multistate health insurance plan, the office of the insurance commissioner shall identify needed changes in federal statutes and rules. "

<sup>9</sup> "Two-thirds of uninsured Americans have incomes below 200% of the poverty line (\$35,200 for a family of three); three-quarters have incomes below 300% of the poverty line (\$52,800 for a family of three)," citing Center on Budget and Policy Priorities analysis of 2007 Current Population Survey Data, Center on Budget and Policy Priorities, *New Georgia and Florida Health Plans Unlikely to Reduce Ranks of Uninsured* (July 1, 2008).

## Affordability

The litmus test posed by the legislative charge to explore compact feasibility is whether individual health insurance would become more affordable. A common definition of affordability for individual health insurance doesn't exist. It can mean:

**What you're willing to pay:** Some economists deem health insurance affordable if the majority of people in similar circumstances purchase coverage.

**What you can pay:** Consumer willingness to purchase insurance on a sustained, rather than emergent basis is an indication of affordability, based on the assumption that consumers only purchase that which they can afford. Under this definition, affordable means "what you have the financial means for."<sup>10</sup>

**What you do pay:** Others define it slightly differently as what people are actually spending on health care and insurance<sup>11</sup>.

A 2002 federally-funded study on Income Adequacy and the Affordability of Health Insurance in Washington state<sup>12</sup> used a self-sufficiency standard to gauge affordability. The study determined that "public policies aimed at making private insurance, particularly individual coverage, affordable for low-income families would need to include substantial subsidies of both premiums and non-covered out-of-pocket expenses<sup>13</sup>." The study concluded that affordability in Washington state varies based on geography, and that affordability is an important factor in the insurance purchasing decision, other factors such as values and risk aversion may be equally, if not more, important<sup>14</sup>.

Historically, because most large group employers have subsidized the premium for employees' health coverage, the cost for employees is "affordable." The cost of health insurance has been built into the price of products and services these employers offer. As the cost of health insurance increases, employer subsidies are insufficient, resulting in increasing deductibles and other cost-sharing strategies. For many individuals, without any subsidy, health insurance isn't affordable<sup>15</sup>.

10 For example, the Massachusetts "Commonwealth Care Health Insurance Program" mandates adults to obtain coverage if it is affordable or face tax penalties. CommCare's affordability standard is based on a percentage of income. Their starting point was the recognition that large numbers of people with incomes below 300% of poverty do not have coverage, suggesting that available premiums combined with out of pocket medical care expenses are too high for many in these income ranges. Blumberg, L., Holahan, J., Hadley, J., Nordahl, K, "Setting a Standard of Affordability for Health Insurance Coverage" *Health Affairs* 26, no. 4 (2007) W463-473, at 469.

11 Holahan, J., Hadley, J., Blumberg, L., Setting a Standard of Affordability for Health Insurance Coverage in Massachusetts The Urban Institute (August 2006).

12 "Income Adequacy and the Affordability of Health Insurance in Washington State," HHS Grant No. P09OA00002-01, Research Deliverable 3.3, (June 2002).

13 *Id.* at 2.

14 *Id.* at 33. *See also*, "Threatening the Health Security of Washington: The Uninsured & the Rising Costs of Uncompensated Medical Care Washington State 2006," Office of the Insurance Commissioner at 4 – 5 (2006).

15 It is instructive to remember that two-thirds of the nation's uninsured come from families earning less than \$40,000 for a family of 4 in 2006. This income level qualifies them for subsidized coverage through a public program, and the question of the affordability of the individual market does not apply to them. By comparison, the high

This study addresses the affordability of individual non-group and non-subsidized health insurance by noting those elements of affordability that a multistate compact can, and probably cannot, affect. Important components of the public policy discussion are not included in this study. If the ultimate objective is to reduce the number of uninsured, affordability is only one consideration. Generating enrollment, meaningful levels and types of coverage and access to necessary care are also critical.

## The Business of Insurance

Insurance originated as a financial tool to make risks affordable, and provide some financial predictability to businesses and individuals. As risks are pooled or spread among many, they become more affordable. Social benefits were an outcome but not an objective of the business of insurance.

The U.S. Supreme Court ruled in *Paul v. Virginia* in 1869 that states have the sole power to regulate insurance business conducted within their borders. In response to that ruling, state insurance commissioners formed the National Association of Insurance Commissioners (NAIC) in 1871. The NAIC helps resolve regulatory differences between states and identifies policy approaches related to the business of insurance. Health insurance is addressed by the NAIC through workgroups and the development of model acts recommending specific regulatory approaches.

A new phase in insurance regulation began after Congress enacted the McCarran-Ferguson Act<sup>16</sup>, passed after the U.S. Supreme Court ruled that insurance was commerce, and establishing anti-trust exemptions for insurance to the extent the business was regulated by state law<sup>17</sup>. Health insurance did not become a material factor in that marketplace until later in the 20<sup>th</sup> century.

## The Unfolding of Health Insurance

A limited market existed for health insurance until advances in medical care made obtaining the care desirable and paying for that care a financial issue for people. Prior to the 1930s, households purchased sickness insurance to pay for loss of income caused by illness, similar to disability insurance today. Sickness insurance rather than health insurance dominated the market because until medicine advanced, there was only the hope of healing and paying for care was not the issue.

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income uninsured (greater than \$50,000 in 2002) make up 26.2 percent of the uninsured. “Higher-Income & Uninsured: Common or Rare?” 26 *Health Affairs* (6): 1745, at 1750 (November/December 2007). “Among the uninsured who were high income one-third of children and one-sixth of adults can be described as high income now but not always or as uninsured now but not for more than a year.” *Id.* at 1751. Those who stayed uninsured for more than a year were more likely to be self-employed. Recent analyses conclude that unless health reform includes subsidies to make coverage affordable, an increase in the number of people insured won’t occur. Center on Budget and Policy Priorities, “*New Georgia and Florida Health Plans Unlikely to Reduce Ranks of Uninsured*” (July 1, 2008).

<sup>16</sup> Act of Mar 9, 1945, c 20 s 2, 30 Stat. 33, 15 USCA s 1011 et seq.; as amended by Act of July 25, 1947 c 325 61 Stat. 448, 15 USCA s 1012.

<sup>17</sup> *U.S. v. Southeast Underwriters*, 322 U.S. 533 (1944).

In the 1930s, following advances in medicine such as vaccine development, standards for physician practice and medical technology discoveries, the nonprofit Blue Cross and Blue Shield organizations began offering insurance to pay for health care, reimbursing providers on a pay-as-you-go basis. Commercial insurance companies started entering the market in the 1940s.

Regulatory differences between nonprofit organizations and for-profit companies impacted the growth of the individual and group markets. Blue Cross/Blue Shield had to community-rate their policies, charging the same rate regardless of a person's health. Commercial insurers could experience-rate, offering healthy people lower premiums. This meant that group policies could be offered to healthy groups at a lower premium than Blue Cross/Blue Shield, resulting in huge growth in the commercial market by 1960.

Commercial health insurance was also blessed with regulatory support. Beginning in the 1940s, federal policies encouraged health insurance, promoting health benefit packages as a way to secure workers, defining insurance benefits as part of "wages" for union contracts, and providing tax benefits to employers that offered health insurance plans to their employees.

In 1965, Medicare Part A and B were adopted. Doctors were allowed to bill "their usual, customary and reasonable rate" as an incentive to treat Medicare patients, and balance billing was permitted. Medicaid was enacted in the 1960s as well. Unlike Medicare, Medicaid lets states determine eligibility and benefits within federal guidelines.

Federal legislation continued to shape the employer-sponsored marketplace in the 1970s:

- The Health Maintenance Organization Act (HMO) was enacted in 1973.
- Employee Retirement Income Security Act (ERISA) was enacted in 1974.
- Regulations governing Medicare and Medicaid, as well as the enactment of state laws governing health insurance began in this time frame as well.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) followed in 1986, requiring employers with more than 20 employees to continue job-based coverage under certain circumstances.

In 1996, the federal Health Insurance Portability and Accountability Act (HIPAA) extended coverage protections to workers and their families who change or lose jobs, and limited health plan restrictions on benefits for pre-existing conditions. The law also left it to the states to decide whether and to what degree to regulate premiums insurers might charge groups with high medical needs. Enforcement involves both states and the federal government, as states have an opportunity to enact laws providing at least the protections that are in federal law. HIPAA began an administrative simplification effort designed to ultimately affect affordability by decreasing overhead and enacted information privacy protections for patients.

Different models from the insurance-based model for delivering health care coverage have been discussed since the '40s as well. In 1945, California's legislature considered (and rejected) universal coverage by one vote. Nationally, universal coverage was first proposed by President Truman in 1949, followed by President Nixon in 1971 and President Clinton in the 1990s.

## The Individual Health Insurance Market Differentiation

Most health insurance reform efforts have focused on employer-sponsored insurance. Some states, including Washington, have addressed the individual market by providing similar guarantees or relief related to benefits, rates and underwriting. While all states have solvency standards for insurers and require the ability to pay claims, standards vary among states for various patient protection statutes. These include different programs such as access to emergency services, access to specialists and external review requirements.

Access has similarly been treated differently by the states, particularly for small businesses (groups of less than 51 people) and individuals. In a typical insurance market, insurer practices seek to minimize risk to avoid loss, which for individual health insurance includes denying coverage to those whose health history identifies health conditions or a history of problems. In the individual market, an estimated 10 percent of individuals account for about 70 percent of health care spending<sup>18</sup>.

Mandated benefits are part of the access issue. They spread risk and support affordability because the cost is spread across a broad population. They also can encourage preventive care, which lowers health care costs. If a benefit is not mandated, then the market begins to segregate and premium costs increase for richer policies.

Differing types of guaranteed issue laws similarly provide protection to individuals, guaranteeing them access to insurance regardless of health conditions. HIPAA requires health plans to offer small businesses at least two health insurance policies regardless of the medical conditions of the employees or their dependents, and to offer small group policies on a guaranteed issue basis. In the individual market, many fewer states require insurers to sell coverage on a guaranteed issue basis; others have limited guaranteed access requirements. Washington also has guaranteed renewability requirements, although carriers are permitted to exit the market.

## Use of a Compact to Provide Individual Health Insurance

The individual health marketplace is the smallest segment of the health insurance market. Delivering individual health insurance that is affordable through a compact requires suspension of state laws and agreement on a single approach. For example, all states would have to agree to a uniform approach on mandated benefits and how those benefits are handled, most likely resulting in a loss of

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<sup>18</sup> Berk, M. and Monheit, A., "The Concentration of Health Care Expenditures, Revisited," *Health Affairs* (March/April 2001); 145-149.

benefits for some and gains for others. Guaranteed issue and renewability would suffer the same fate. Insurers under a compact typically follow the rules of the state in which they are domiciled, and apply policy forms or receive approvals based on rule-making authority conferred on the compact by state legislation approving its formation.

### **Compact vs. across-state-lines approach**

Congress has been evaluating multistate approaches to the individual market for several years. The concept of selling insurance across state lines was first proposed by Representative John Shadegg (R-AZ), in a bill that passed the House in 2005, but has never been approved by the Senate<sup>19</sup>. Association health plans, and health insurance purchasing pools rated on a national basis have been proposed in Congress in recent years<sup>20</sup>, and opposed by state regulators on the basis that they provide insufficient consumer protections. Most recently, senators proposed legislation allowing small businesses and the self-employed to pool across state lines, providing tax credits for premiums and prohibiting health status rating<sup>21</sup>. The program proposal was tabled by the Senate in 2008.

One state is considering an across-state-lines approach as well. In 2008, The New Jersey Healthcare Choice Act, permitting health insurers licensed in other states to provide coverage in New Jersey under certain circumstances, was introduced into the New Jersey legislature<sup>22</sup>. As of September 18, 2008, the bill had not been considered by committee. Proponents assert the bill would make individual insurance affordable, especially if the insurance is a high-deductible policy used in connection with a health savings account.

The difference between the across-state-lines model and using a compact to deliver insurance lies in the uniformity of regulation. Most across-state-lines proposals address the lack of uniform policy by permitting state-of-domicile rules and regulations to apply, regardless of where the plan is sold. This means that states with the lowest regulatory threshold become the most attractive, and deprives consumers of hard-won protections, such as mandated benefits or guaranteed issue. While a compact could take that same approach, compact members could agree on a different model to address the lack of uniformity and establish consistent standards.

Concerns include whether health carriers would participate if the coverage were offered through compact-approved plan designs, and what methods would be

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19 H.R. 525 (July 2005).

20 See, e.g., H.R. 4664, 108<sup>th</sup> Congress 2d Session, Proposed Amendment to the Public Health Service Act to provide for cooperative governing of individual health insurance coverage offered in interstate commerce," (introduced June 23, 2004); Health Care Choice Act of 2005; Senate bill 1955, the Health Insurance Marketplace Modernization Act (HIMMA) (2006);

21 CITE for the Small Business Health Options Program (SHOP) proposed by Snowe, Durbin, Lincoln and Coleman, April 2, 2008; Abelson, R., "Small Business is Latest Focus in Health Fight," *New York Times* (July 10, 2008).

22 State of New Jersey 213<sup>th</sup> Legislature, Assembly Bill No. 2767 (introduced May 22, 2008).

adopted to preclude adverse selection (where only the sickest members of the individual market participate and healthy individuals choose leaner plan designs or remain uninsured). It's not a given that a broader multistate pool of purchasers would result in a more competitive set of offered plans. Other incentives or controls on the market would probably be needed.

### **The high-risk market**

It is probably for this reason that where a compact has been proposed to provide individual insurance, it has focused on the high-risk market. In late 2007, the Maine Heritage Policy Center proposed a model bill creating a New England Health Insurance Compact to coordinate regional insurance and increase access and availability of health maintenance organizations for people who have been excluded from the individual market primarily due to underwriting issues. While not necessarily affordable, these types of programs provide access to coverage that is cost-effective compared to paying for health care out-of-pocket.

Washington's high-risk insurance pool is an example of using a pool to provide health coverage to high-risk individuals. Mandatory carrier participation, both financially and through product offering, is a hallmark of the plan design. The main reason for this: Without mandatory participation, it is unlikely health carriers would offer plans to a high-risk group because of adverse selection issues. Other states have similar programs.

### **Other reform efforts**

Other current reform efforts in the states suggest many solutions (none of which include use of a compact). Examples include:

- Maine continues to adjust its DirigoChoice subsidized insurance program.
- Pennsylvania's *Cover All Pennsylvanians* proposal targets making insurance affordable for small business employers, and includes business assessment proposals.
- Hawaii, Delaware, Illinois, Maryland, Minnesota, Missouri and New Mexico are considering forms of universal health coverage.
- New Jersey adopted universal coverage in July 2008.
- Universal coverage failed in Wisconsin in March 2008;
- The governor of California vetoed a universal coverage bill in September 2008.
- Georgia is considering high-deductible health plans.
- Florida is creating limited health benefit package programs.

To be successful, a compact model would have to address the roots of affordability: how we pay for care, the quality of the care and how we use the care. Clearly, the array of possible program designs is vast. This study does not address which

solution is best; we note that there is no consensus, and suggest that the number of efforts being applied, in the works or being debated will provide answers over the next year.

### **The Interstate Insurance Compact**

The National Association of Insurance Commissioners (NAIC) has studied the issue of providing insurance through a compact, and specifically rejected it for health insurance and property/casualty insurance.

Washington state joined a multistate Interstate Insurance Compact in 2005. The compact was created when the first two states, Colorado and Utah, enacted legislation. Once the compact reached the threshold requirements of 26 states or 40 percent of premium volume nationwide in May 2006, it created the Interstate Insurance Product Regulation Commission (IIPRC), an entity that now governs and oversees the compact. Today, the IIPRC has 33 member states representing over half of the premium volume<sup>23</sup>.

The IIPRC intentionally excludes health insurance and property/casualty insurance<sup>24</sup>. The products covered by the compact are purchased and retained regardless of domicile. Underwriting standards for individual health and property/casualty coverage are tied to geographic criteria in addition to factors related to the insurable interest. For this reason, they are considered 'local' and would require a different compact structure than the financial products<sup>25</sup>.

Lessons learned from forming the IIPRC are instructive. The compact was developed in response to specific industry criticisms of state-by-state regulation of life insurance products. Unique form requirements and other standards meant insurers were filing state-specific forms and waiting for approvals, making their products less competitive to similar products offered through other markets. The clear mission of the IIPRC is addressing speed-to-market issues without sacrificing consumer protection oversight. A compact to provide individual health insurance would only be feasible with a similarly clear guiding principle to assist in developing the business model.

As designed, the compact or a state to which the insurer is admitted grants rate and form approvals for covered lines of insurance. Filing with the compact entitles an insurer to use the approved policy form and rate structure in all states participating in the compact. States may opt out of specific standards adopted by the compact, but the goal is to have uniform standards for regulated product lines. The IIPRC adopts the standards following comprehensive public notice and comment procedures, much like typical administrative rule-making.

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<sup>23</sup> This report was developed and researched through September 30, 2008.

<sup>24</sup> Articles, Interstate Insurance Product Regulation Compact (National Association of Insurance Commissioners Model Compact).

<sup>25</sup> "What type of insurance policies would the Compact cover?" Frequently Asked Questions about the Interstate Insurance Product Regulation Commission July 1, 2008. [http://www.insurancecompact.org/compact\\_faq.htm](http://www.insurancecompact.org/compact_faq.htm)

Getting to that point took time. The NAIC provided a forum for states to work toward consensus on governance, scope of authority, jurisdiction, applicable lines and other key operational issues. It took several years to develop draft articles and bylaws; states then had to individually consider and pass the compact authorizing their state and insurance regulator to participate.

The IIPRC is not a compact that provides insurance products. Instead, it offers streamlined product approval and rate development – it provides key regulatory functions in a uniform way. A compact that actually provides health insurance would need an organizational structure similar to a third party administrator, or a public purchasing body similar to the Washington State Health Care Authority, or would need to establish itself as a carrier competing in the marketplace.

The most basic assessment is that a compact is technically feasible, for compacts are simply agreements between states to accomplish a common goal. A compact may use different business models based on its purpose and marketplace. State legislatures enact laws, adopting the compact’s governance, policy and operational structure, and committing time and resources to manage joint functions or resolve problems shared by states, and, as a result, erase jurisdictional boundaries. Adoption binds legislatures, requiring them to pass a law repealing the compact for states to exit the arrangement.

The U.S. Constitution recognizes compacts<sup>26</sup>. Congress may, but such approval is not required to approve a compact, unless the subject of the compact affects a power delegated to the federal government, or the balance within the federal system<sup>27</sup>. Insurance does not fall into that category.

Simply saying that a compact is technically feasible doesn’t imply that it is a viable solution. A deeper examination of why the IIPRC does not include health insurance informs a feasibility assessment.

## The Individual Health Insurance Hydra

### **Customers are segmented, transitory and growing**

There are twin aspects to the individual market – those in the market and the uninsured. Quite often, small groups (2-50 members) are included in the definition of the individual market, because where small employers may offer coverage, employees’ family members still participate in the individual market because the coverage is unaffordable for the entire family.

During nearly every year between 1994 and 2006, the number and percentage of individuals in the United States without health insurance coverage has increased<sup>28</sup>.

<sup>26</sup> U.S. CONST., art.1, sec. 10, clause 3.

<sup>27</sup> Northeast Bancorp, Inc. v. Board of Governors, 472 U.S. 159 (1985); Virginia v. Tennessee, 148 U.S. 503,509 (1893) (seminal case).

<sup>28</sup> Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau’s March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements); Fronstin, P., Employee Benefit Research Institute, “The Impact of Immigration on Health Insurance Coverage in the United

In 2007, the number decreased largely because of major state programs, such as Massachusetts' program that resulted in an additional 300,000 insured individuals.

Because individual health insurance is a local product, using national data provides generalized information. The table below compares Washington data to the national characteristics:

Characteristic	Washington	National
Percent of total population uninsured	13 percent	17.2 percent
Age	54 percent are age 35-64	50 percent are age 45-64
Long term lack of insurance (> 1 year)	9 percent	14.2 percent
Uninsured for part of last year	12.2-20 percent	21.5 percent (median), range 10.9-31.9 percent
Health status	16-19 percent report fair or poor health status	2/3 report very good or excellent health
Employment status	70 percent are employed, many are self-employed	75 percent work for business with <25 employees or self-employed
Income status	<ul style="list-style-type: none"> <li>• 62 percent earn less than 200 percent of federal poverty level</li> <li>• 38 percent earn more               <ul style="list-style-type: none"> <li>◦ 28.1 percent of those earn &gt; \$50,000 each year</li> <li>◦ 9.6 percent earn &gt;\$75,000</li> <li>◦ 18.5 percent earn \$50-74,999</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• 65.3 percent earn less than 200 percent of federal poverty level (low-income)</li> <li>• 34.6 percent earn more</li> </ul>
Market size compared to group market	Smaller <ul style="list-style-type: none"> <li>• 64.6 percent covered by employer</li> <li>• 5.7 percent individual policies</li> </ul>	Smaller <ul style="list-style-type: none"> <li>• 60.9 percent covered by employer</li> <li>• 5.5 percent individual policies</li> </ul>
Average premium	<ul style="list-style-type: none"> <li>• \$11,018 – family policies;</li> <li>• \$2,015 – individual</li> </ul>	<ul style="list-style-type: none"> <li>• \$12,107 – family policies</li> <li>• \$4,288 – single, age 55-64</li> <li>• \$1,580 – under 40</li> </ul>

Sources: For total uninsured and market size, both state and national: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements)

For Washington data: Office of the Insurance Commissioner, "Threatening the Health Security of Washington: The Uninsured and the Rising Costs of Uncompensated Medical Care, Washington State 2006"

States, 1994-2006," 29 NOTES 8 (August 2008) at 2. Fronstin posits that the reason immigrants make up 55% of the increased uninsured is largely because federal law prohibits immigrant enrollment on public assistance for five years after entering the United States. In Washington State, immigrants make up 19.3% of our uninsured. *Id.* at 7.

(2006); Gardner, E., Washington State Office of Financial Management, “Characteristics of the Uninsured: 2004,” Research Brief No. 32 (February 2005).

For other national data: Coburn, A., Ziller E. and McBride, T. “Bridging the Gap: The Role of Individual Health Insurance Coverage” for Health Care Financing and Organization, (February 2006); Cohen, R., Makuc, D., Center for Disease Control and Prevention, “State Regional, and National Estimates of Health Insurance Coverage for People Under 65 years of Age: National Health Interview Survey, 2004-2006,” National Health Statistics Reports, Number 1, June 19, 2008. The data in these reports comes from the same time frame.

For premium: State Health Access Data Assistance Center, “Squeezed: How Costs for Insuring Families are Outpacing Income” Robert Wood Johnson Foundation (April 2008) at 2; Kaiser Family Foundation and Health research and educational Trust, ‘Employer Health Benefits: 2007,’ 2007.

For the split of family/individuals, see. U.S. Census Bureau, “Income, Poverty, and Health insurance Coverage in the United States: 2006” (August 2007).

### Why uninsured?

A prior report by the Washington State Office of the Insurance Commissioner identified the following reasons why Washington residents are uninsured:

- They can’t afford the premium.
- Insurance is not available through work place.
- They temporarily lack coverage.
- Key family members have coverage, and healthy ones don’t need it.
- They don’t meet health screening criteria.
- They are healthy and choose not to purchase insurance <sup>29</sup>.

Many of these reasons are unique to specific segments of the individual market. However, across the board, premium costs influence the decision to keep or drop health insurance. In California, for example, the California Healthcare Foundation identified that a 20 percent increase in premiums causes a 2 percent decrease in enrollment<sup>30</sup>. Boise State University’s Center for Health Policy evaluated health insurance affordability decisions through a year-long data collection and survey effort, and concluded that, “Cost is the primary factor in consumer decisions to participate in health insurance.” The study also noted that, “When coverage is free, 72-83 percent of the uninsured would be expected to participate...”<sup>31</sup>.

The average annual growth rate of private health insurance premiums is 8.7 percent, a rate which has held steady since 1986<sup>32</sup>. Premiums are sensitive to market

<sup>29</sup> Office of the Insurance Commissioner, “Threatening the Health Security of Washington: The Uninsured and the Rising Costs of Uncompensated Medical Care, Washington State 2006” (2006) at 6.

<sup>30</sup> California Healthcare Foundation, *Snapshot: Individual Health Insurance Market* (2005) at 18.

<sup>31</sup> Center for Health Policy, Boise State University, “Health Insurance Affordability: Consumer Preferences in Cost Sharing,” (2003).

<sup>32</sup> American Health Insurance Plans, “A Shared Responsibility: Advancing Toward a More Accessible, Safe, and Affordable Health Care System for America,” *Policy Brief*, (2008) at 7

conditions; in Washington state, premium rates must be filed and approved by the Insurance Commissioner. Rating systems vary from state to state:

- Washington is one of seven states that use adjusted community rating to set small-market rates.
- Only four states have no rating restrictions.
- Two use pure community rating.
- The remainder of states use rate bands<sup>33</sup>.

In Washington state, the average annual premium for individual coverage is \$2,015. By comparison, in Oregon it is \$1,297; Idaho is \$2,006 and Montana is \$2,866. The national average is \$2,813<sup>34</sup>. The premium buys coverage that is significantly lower than what is provided under group coverage, and is affected by differences in states' minimum requirements for the individual market and demographic differences.

Premium payments cover administrative costs, pay for benefits and accord a profit if the insurer is a for-profit company. If health care costs rise, premiums must increase. If utilization increases, premiums must also increase.

In addition to the cost of care, the health of those insured and the quality, necessity and frequency of care all affect affordability. For this reason, health plans actively encourage wellness of members, negotiate standards and care criteria with providers, and contract for specific price levels for services, in order to establish boundaries and incentives that lower costs.

Out-of-pocket expenses also contribute to the affordability of insurance. As benefit packages are richer (and premiums higher), out-of-pocket expenses go down<sup>35</sup>.

In 2005, an Urban Institute study determined that a person in the individual market spends an average of 8.2 percent of his or her income on medical expenses, including both out-of-pocket and premium costs<sup>36</sup>.

The individual market is being intensely studied and its influence on the number of uninsured evaluated. The policy consensus is that the lower the number of uninsured, the better the health of the population because with insurance, citizens are more likely to seek medical care. As more uninsured join the individual market, overall health outcomes improve.

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33 Kaiser Family Foundation, State Health Facts, Data current as of December 2006.

34 "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability and Benefits," AHIP Center for Policy and Research, (December 2007) at 8.

35 Being "underinsured" – spending more than 10% of income, or 5% of income if income is below the poverty line, on out-of-pocket medical expenses results in going without needed care. Center on Budget and Policy Priorities, *New Georgia and Florida Health Plans Unlikely to Reduce Ranks of Uninsured* at 3 (July 1, 2008).

36 Holohan, J., et al, *supra*, at 2.

## **Why isn't a multi-state individual pool more frequently identified as a solution?**

Pooling is often discussed as a mechanism to offer affordable individual health insurance. Many policymakers regard pools as a viable way to aggregate large numbers of small purchasers, thereby realizing administrative economies of scale and negotiating favorable rates with health plans. This is based on the theory that insurance is affordable when the risk is spread amongst a large group. This theory proves true in the group market where large employers provide sufficient risk-spreading so that insurance carriers do not individually underwrite the employees and their families, but offer coverage based on market experience and the carrier's costs. Employer-based group insurance affordability is supported by employer contributions.

Such subsidization would probably need to be part of any program design for the individual market as well because the fluidity of the individual market requires any pool design to include cost estimates for healthier members leaving the pool, and those with higher costs remaining. Beyond that, the actual experience of purchasing pools belies their ability to reduce health insurance premiums or raise the offer rates of plans to small businesses<sup>37</sup>. This makes it difficult to identify a business model for an individual health insurance compact.

### **Individual health insurance is local**

In comparison to other types of insurance, and some group health insurance, health insurance carriers view the individual market as local. For example:

- Your policy can't travel with you to another state because the pricing doesn't include the risk factors present in a new location. In order to fund the risks presented by the marketplace, carriers calculate premium based on the variances in geographic cost of care and health of the population.
- Most medical care and service networks only cover 100-mile geographic areas. Physician, clinic and hospital contracts create local networks of pricing. Insureds access less expensive care through these networks. If the insured moves out of a covered area, the same carrier may or may not be able to continue to provide service.
- Many states do not grant consumers the protections that Washington has enacted. Variances in the regulatory framework further strengthen this perception of the market's local nature. The difference in the regulatory framework reflects material differences in policy between the states.

### **Individual health insurance is underwritten**

Unlike group policies, where members are entitled to coverage if they meet pre-determined eligibility requirements such as length of employment, individual health insurance is issued only if the carrier accepts the individual after an

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<sup>37</sup> Long, S. and Marquis, S., "Have Small Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs* 20:1 (January/February 2001), pp. 154-163.

underwriting evaluation unique to that person<sup>38</sup>. In some states, before an individual is accepted, he or she is medically underwritten, not just screened, and must pass physical examinations in addition to providing health information. In Washington state, if an applicant's health doesn't meet standardized screening criteria, the carrier provides an application to the Washington State Health Insurance Pool (WSHIP), a state-created program funded by the state and health insurance carriers, that provides people who are deemed "medically high-risk" with access to health insurance<sup>39</sup>. The program serves approximately 3,087 people and costs approximately \$50 million per year<sup>40</sup>.

Only 22 states offer programs like WSHIP. In many states, individuals who do not qualify for the individual market cannot obtain health insurance. If an applicant has experienced prior health issues or problems, medical underwriting screens them out of the market. The limitations on underwriting practices vary from state to state. Agreeing on a uniform regulatory standard for medical underwriting in individual markets is crucial to crafting an individual health insurance compact.

### **The Basic Health Plan and comparable programs**

Washington is also among a unique subset of states that offer the Basic Health Plan, a subsidized program for lower-income people administered by the state's Health Care Authority. Many of its members are employees of small employers who don't offer health insurance, are self-employed or were previously uninsured<sup>41</sup>. Thirty percent of its members enrolled because the cost of their insurance was too high<sup>42</sup>. The Basic Health Plan is one of the reasons why Washington's level of uninsured is in the second lowest of four tiers for the nation (tier of 12.4 – 16 percent uninsured).

Maine offers a health plan that is similar in concept to the Basic Health Plan. Also subsidized, there are various categories of eligibility for enrollment and it has an underwritten rate structure. Maine took its program a bit farther, however, and learned how difficult it is to address the number of uninsured without additional controls compelling participation (such as those Massachusetts put in place).

In 2003, Maine's governor created the Office of Health Care Policy and Finance with the goal of expanding coverage. The reform act created a new private health insurance program called DirigoChoice for individuals, sole proprietors and small businesses at any income level, and subsidized applicants with low and moderate

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38 Depending on the state, some exceptions exist for health screening. In Washington, the exceptions include those situations where an applicant is moving from continuing coverage on another group plan directly to the individual market, provisions for guaranteed renewal, or if the new insured is a newborn or adopted minor. See, e.g., RCW 48.43.012, RCW 48.43.038, and 48.44.212.

39 RCW 48.41., et seq.

40 Blue Ribbon Commission, Washington State, "Addressing the affordability of coverage for high-cost individuals," March 1, 2007, at 4 – 6 [citing WSHIP annual reports for 2005 and 2006].

41 Joint Legislative Audit and Review Committee, "Basic Health Plan Study – Part 2: Who is Enrolled? What Services Do They Use?" Briefing Report 06-9, (November 29, 2006) at 25.

42 Id.

incomes. Maine also included Medicaid program reform in its effort. Today it needs significant infusions of cash to continue to operate.

Maine's health plan is administered by a private insurance carrier under contract to the state. Recently, the legislature was asked to authorize the state to self-administer the program, and in the interim, Maine solicited a new carrier. Cost containment efforts are also being reviewed in proposed legislation.

During a recent session, Maine's state legislature rejected many of the reforms suggested by the Governor's Office of Health Care Policy and Finance, including a requirement that all individuals obtain health insurance and requiring employers to participate or pay (similar to Massachusetts's program); increasing medical loss ratios, reducing employer premium contribution; and proposing a reinsurance program for the individual market.

The new health plan was financed by mandatory assessments on insurers and third party administrators (much like Massachusetts's plan, and, from a conceptual standpoint, similar to how Washington funds its high-risk insurance pool). The funding mechanism was validated in May 2007 by Maine's Supreme Court, based on findings by the state insurance superintendent and the program that the reforms had saved \$43.7 million in Maine's health care system<sup>43</sup>. By comparison, the cost of the program for 2007 is estimated at \$40 million.

DirigoChoice took two years to get to market, and was first offered in 2005. At the time the program was introduced, Maine's uninsured level was about 12 percent. The 2007 census data shows the uninsured rate dropped to 10.6 percent.

A November 2007 evaluation of Maine's efforts concluded that the program provides more affordable health coverage to small business employees, self-employed individuals, part-time workers, early retirees, household workers and the unemployed<sup>44</sup>. The program's July 2007 enrollment report showed that 50 percent of enrollees were individuals, 23 percent were enrolled through their employer, and 27 percent were sole proprietors. The program caps individual enrollment at 50 percent.

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43 Maine Association of Health Plans, et al. v. Superintendent of Insurance, et al., <http://www.courts.state.me.us/opinions/2007%20documents/07me69di.pdf>.

44 "Maine's Dirigo Health Reform of 2003," *Families USA* (November 2007) at 2. See also, Lipson, D. et al, "Leading the Way? Maine's Initial Experience in Expanding Coverage through Dirigo Health Reforms" *Mathematica Policy Research, Inc., Robert Wood Johnson, and The Commonwealth Fund*, (November 2007) [concluding that the high cost of health care and high premiums made making affordable products available especially difficult (at 14); gains in number of uninsured individuals who enrolled is modest (at 34), the program is well designed to enroll small business employees if the small business number more than 2 employees (at 41-42; and that coverage expansion programs without forceful cost control mechanism will sooner or later likely face affordability problems (at 59)].

The report includes these additional lessons learned:

- Social marketing to the target population is necessary, much like that done through state CHIP programs. The program is also competing with private insurance products for the same market; the carrier providing the contract has other products in the same market.
- Enrollment hasn't met initial projections, although some segments of the uninsured met the caps placed on their category.
- Affordability is difficult to achieve in a product influenced by private market forces. Providing coverage based on the ability to pay is critical to expanding access. Subsidies are required for out-of-pocket costs such as premiums, deductibles and expenses beyond covered care.
- Cost containment is critical to making coverage affordable.

As the Mathematica analysis of Dirigo (cited previously) referenced, strategies for expansion of coverage rely on interrelated, complex factors, which include:

- Characteristics of the insured population.
- Policy goals reflecting preferences of pace or scope of reform, and types of coverage for certain segments of the uninsured population.
- Coverage content.
- Fiscal capacity.

Many states have programs that address the same issues as Maine's DirigoChoice. These are, of course, the same issues that a compact would face. For example, Massachusetts, Maryland and Missouri have programs that offer private coverage through public programs.

In Oregon, the Family Health Insurance Assistance Program (FHIAP) helps thousands of families pay the monthly premium for high-quality, private health insurance plans. FHIAP pays 50-95 percent of the premium for Oregonians who are uninsured and meet income and other guidelines. Individuals and families use FHIAP subsidies to pay for insurance at work or to buy individual health plans if insurance is not available through an employer. Oregon has committed to study universal health coverage proposals.

New Mexico and Montana permit small businesses to pool together as health insurance purchasers. Colorado and Connecticut are capping premium increases and charges. Other states are considering differing proposals to address the number of uninsured as well.

The National Conference of State Legislatures lists health reform bills pending for 2008-2009<sup>45</sup> and notes that states are using four main approaches to increase access and affordability of insurance:

- Market-based initiatives.
- Medicaid expansion.
- State CHIP expansions.
- Public-private partnership.

Many of these proposals are limited or targeted in scope. For example, most of the bills that target young adults require insurance providers to cover dependent children through age 24. Washington enacted this legislation during the 2007 session.

### **Washington's regulatory approach is consumer-oriented – a compact may put these reforms at risk**

While the majority of the market is enrolled with three carriers, eleven carriers participate in the individual health insurance market in Washington state<sup>46</sup>. The Office of the Insurance Commissioner regulates these carriers by:

- Evaluating the rates and forms filed for compliance with regulations.
- Deeming rates approved within 60 days of their filing unless rejected.
- Confirming the actuarial basis for the rates.
- Requiring specific benefits in policies, operational practices and content in consumer communication.
- Overseeing cancellation of plan product designs and withdrawal from the market.

Washington's regulatory environment for this market varies significantly from that of other states. We provide greater protection than many states, and have a lower percentage of uninsured. States with the fewest uninsured, such as Hawaii and Massachusetts, have enacted a form of mandatory offer or mandatory enrollment and offer to the small group and individual markets. Even with those programs, their level of uninsured is 9.5 percent and 8.9 percent, respectively<sup>47</sup>. Massachusetts' rate may be even lower now, a report to the Legislature in July 2008, *Comprehensive Review of Mandated Benefits in Massachusetts*, demonstrated an additional 300,000 insured as a result of their program<sup>48</sup>.

<sup>45</sup> <http://www.ncsl.org/programs/health/universalhealth2007.htm>

<sup>46</sup> Company Filed Annual Statements – Office of the Insurance Commissioner (2007).

<sup>47</sup> Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements).

<sup>48</sup> Massachusetts Department of Health and Human Services, Division of Health Care Finance and Policy, "Compre-

A generalized regional comparison of the regulatory environment explains this further.

State – uninsured rate	Guaranteed issue all products	High-risk pool	Limits on rating	Credit for prior coverage	Maximum exclusion period
Washington – 13%	No – access guaranteed based on health questionnaire results	Yes – based on health questionnaire results	Yes – adjusted community rating	Yes	9 months
Oregon – 19.7%	No – some portability with six months prior coverage	Yes	Yes – adjusted community rating	Yes	24 months
Alaska – 18.9%	No	Yes	No	No	No limit
Nevada – 20.7%	No	No	Yes – rate bands	No	No limit
Idaho – 16.7%	No	No – must offer certain types of policies for high-risk	Yes – rate bands; caps on high-rate policies	Yes	12 months
Montana – 18.7%	No	Yes	No	Yes	12 months

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements). Note: when compared to 2007, the percentage of uninsured increased 2.1-3 percent in each state. Washington, for example, was 10.4 percent in 2007. Kaiser Family Foundation, *Protections in Individual Markets*, [www.statehealthfacts.org/comparetable.jsp?ind-355%cat=7](http://www.statehealthfacts.org/comparetable.jsp?ind-355%cat=7)

None of these differences diminishes the technical feasibility of using a compact structure, but they do highlight the lack of consensus for standards that a compact would require. Based on the number of reform efforts targeting affordability, there are multiple models. There isn't reliable outcome data to inform a choice as to which model would best suit a compact providing individual insurance.

## Other states

State programs to address individual health insurance affordability generally include a selected combination of the following elements:

- Mandatory participation by insurers.
- State subsidies of premium, either through tax credits or direct payment for part of premium to the participating carriers.
- Establishment of an agency or administrative body.
- Mandatory participation or payment by employers.
- Mandatory participation or payment by individuals.
- Limitations on insurer ability to refuse and cancel coverage based on health status of enrollees.
- Mandated coverage for basic services.
- Designation of state as a reinsurer for the individual health insurance market.
- Continuing high-risk pools to manage high cost individuals.

## Aspects of a compact providing individual health insurance market

The individual market is highly concentrated. The limited level of competition can form a barrier to affordability. This concentration means that regulation of the marketplace is important to protect consumers. The regulatory oversight of individual health insurance is susceptible to uniform standards in some areas and challenged by it in others. Each aspect of regulation affects affordability.

The design of the insurance product impacts overall affordability. Cost-sharing requirements can be overly burdensome, particularly for individuals with a greater magnitude of needed medical care. Carrier efforts to manage enrollee medical conditions and lower the cost of medical care creates overhead, but also contributes to lower premiums, impacting affordability. All are regulated activities.

If a compact were to focus on regulatory modernization to promote administrative efficiency and the reduction of associated costs, carriers might be able to reduce premiums. Historically, conventional wisdom is that well-run carriers typically structure premiums so that administrative expenses are only 3-5 percent. Depending on how administrative expenses are categorized, this standard may be shifting. In Washington state, the three largest health carriers' 2007 administrative expenses ranged between 6 and 11 percent, and none are considered financially impaired.

Area of regulation	Uniformity	Local in nature
Rate setting	Adjusted rating standards and factors could be made uniform. Need to study price impact.	Current community rating for individual market is based on geographic locale – very local in nature.
Mandated benefits	With adjustment, possible.	A lot of variation state to state – policy disagreement.
Privacy of health information	Federal standard is in place now.	Some states provide additional protections – would need to adjust.
Access to care: Provider contracting and payment issues	Contracting possibly could be uniform (CMS model).	States have varying laws in place now; provider contract terms and payment issues are part of major health reform efforts underway in many states.
Access to care: Provider network vs. out-of-network		Network development largely local in nature. Some access issues may affect plan provisions or design, preventing uniform standards.
Care management	Individual in operation, but can have uniform standards for delivery.	Standards of care and availability of types of care vary depending on location.
Quality control	Individual or local in operation, but can have uniform standards.	Many states share regulation of quality with other agencies such as Department of Health. Medical directors must be licensed under laws of individual states.
Forms	Yes	
Advertising	Yes as to standards and disclosures.	
Marketing and sales	Yes as to standards and disclosures.	All marketing is local, as are sales. Different types of campaigns and benefits appeal to different areas, often because health issues can be local in nature.

### Can it be done?

The charge underlying this study focuses on actually offering health insurance coverage through a multistate compact. Based on the laws governing compacts, a multistate compact to offer health insurance to the individual market is legal. Each participating state would have to pass the same legislation, without variation. As a practical matter, the compact would require a champion – a lead state or organization – to build the consensus and draft the actual compact documents.

Benefits could include greater risk-sharing, increased market competition amongst insurers (if the program design included using insurance carriers), lower costs

through consistent administration and regulation, and decreasing the negative effect of geographic health insurance markets.

The key challenges are:

- Deciding which regulations are delegated to the compact or retained by each state.
- Identifying a state entity as liaison and champion for the compact.
- Creating effective marketing and change management strategies to support the compact.
- Establishing funding mechanisms.
- Setting levels of subsidization.
- Engaging carriers in developing plans for multistate marketing.
- Aligning standards between states for benefit levels, rate setting, policy design and enforcement.
- Deciding whether the compact is a regional effort or targets every state.
- Determining program design and interaction with state Medicaid and CHIP programs, and other public benefit programs. This particularly affects financing considerations for states operating on Medicaid waivers.

Changes in law would be required as well, depending on which model was chosen. At the federal level, adjustments to HIPAA's requirements for the individual market would require revision, and a thorough analysis of whether to extend group employer tax subsidies for insurance purchases to the small group market, or to eliminate them for the large group market would be required. Both approaches have been floated in Congress and elsewhere, and both would require specific cost benefit analysis. Analysis of the first would focus on risk of adverse selection; analysis of the second on whether the individual market would be flooded as employers stopped offering coverage.

Because insurance is in itself a contract, some believe that a larger consumer market would eliminate the leverage market concentration affords carriers. As discussed above, the unique mindset of many individual market participants results in sporadic participation, and places the concept of a larger pool spreading risk in question.

## Findings

The following table outlines the key issues analyzed in this study and the key findings for each issue.

Questions considered	Findings
<p>What are the common factors affecting the affordability of individual health insurance?</p>	<ul style="list-style-type: none"> <li>▪ Affordability of individual health insurance affects whether someone is uninsured or insured.</li> <li>▪ Factors affecting affordability of individual health insurance differ depending on where you live.</li> <li>▪ Affordability isn't always the salient issue for the individual market, and not everyone wants insurance.</li> <li>▪ Rural and urban differences call for different solutions, largely based on the cost and availability of care.</li> <li>▪ Individual health conditions matter the most when determining the cost and availability of individual health insurance.</li> <li>▪ Market segments of the type of uninsured share common issues related to affordability.</li> <li>▪ Those who want individual health insurance are often unhealthy, creating financial viability issues for the insurance company.</li> <li>▪ Best practices aimed at affordability are not one-dimensional. They must address cost of care, cost of regulation, cost of benefit, utilization, diversity of risk and profit-seeking of carriers.</li> </ul>

Questions considered	Findings
<p>What are the individual market segments and the differences in making individual insurance available to them?</p>	<ul style="list-style-type: none"> <li>▪ Studies categorize the uninsured market based on age, employment status, health status, income and ethnicity.</li> <li>▪ Studies most often look at the individual insured market in terms of age, employment status, health status, income and length of time in the market.</li> <li>▪ Medical underwriting is the largest barrier to accessing the individual market, and is directly tied to the health status of the applicant.</li> <li>▪ Public programs offering high-risk individuals mandatory pooled coverage work to provide necessary individual coverage to those with chronic or pre-existing conditions. Washington state has such a program (WSHIP).</li> <li>▪ Affordability is another barrier to accessing the individual market, but not the only reason otherwise eligible people do or do not enroll.</li> <li>▪ Many uninsured or those participating in the individual health insurance market are employed. If their health risk could be insured across a broad enough pool, the cost of insurance could become more affordable. Most current federal and state proposals try to increase the number of insureds by improving the affordability of small employer insurance. There are 45,657,193 uninsured people in the United States, more than 700,000 of those are in Washington state<sup>1</sup>.</li> <li>▪ Making insurance affordable still doesn't mean that small employers will offer it to employees or that they will buy it.</li> <li>▪ State programs have gotten results, reducing the numbers of uninsured by subsidizing premiums for small employers. This approach has lowered the number of uninsured in Montana, Iowa, Oklahoma and Maine. The common denominator is providing government subsidies to offset premium costs.</li> </ul>

Questions considered	Findings
What makes health insurance affordable?	<ul style="list-style-type: none"> <li>▪ Most initiatives to make individual health insurance affordable focus on a specific aspect of the uninsured population (e.g., mandating employer and individual participation, creating mandated risk pools, providing incentives to small employers to purchase group coverage). All programs assume that being uninsured is undesirable, and that people and society benefit if more people are covered. The question then becomes who pays what share, and what type of coverage is provided.</li> <li>▪ Health insurance – whether group or individual – best manages affordability in two ways: by widely spreading the risk of payment for care or by lowering the cost of the care for which it pays.</li> <li>▪ Widely spreading the risk means the carrier collects premiums for a large number of people, ensuring premiums exceed claims.</li> <li>▪ Lowering the cost of care means that although premiums may be higher for a smaller group, the coverage is still affordable because the cost of claims is lower. Cost of care is affected by payment terms with doctors, hospitals and pharmacies and how often members use a medical service, which is in turn affected by the member’s health, access to care and level of preventive care.</li> <li>▪ Many carriers control costs by not covering sick people (through medical underwriting), by managing the care made available to sick people (through case management and utilization review programs), and by changing member behavior toward health care (through education, benefit design such as co-payment levels, and incentive programs).</li> <li>▪ Cost of care is also lowered if fewer health services are covered or only less expensive or less frequently accessed health services are covered.</li> <li>▪ Shifting the way premiums are applied can use the same amount of money to provide more care. This is the principle behind the Guaranteed Health Benefit Plan currently proposed by Washington’s Insurance Commissioner. It permits affordable coverage for all residents, inclusive of making individual insurance more affordable.</li> </ul>

Questions considered	Findings
<p>What can a compact do in relation to health insurance?</p>	<ul style="list-style-type: none"> <li>▪ A compact creates a legal and operational framework to accomplish a specific task or carry out a policy in a uniform way across states.</li> <li>▪ Compacts are flexible ways to achieve economies of scale, consistency of policy and good solutions to common problems.</li> <li>▪ Using a compact to administer an individual health insurance program is possible. For example, a New England compact designed by a think tank envisions the compact acting across state lines as a third party administrator.</li> <li>▪ The National Association of Insurance Commissioners rejected a compact structure for health insurance products, defining the market as “local” in nature largely because there is little similarity in the way states currently regulate the market, and adoption of the compact was unlikely if health insurance were included due to the high level of variation.</li> <li>▪ Compact design would need to account for differently sized states, so that the economics of one state do not dominate the overall function of the compact.</li> <li>▪ Compacts require consensus among the states to work. State legislatures must vote to join. Given the disparity in regulatory policy for the individual market, and the variety of current state initiatives, reaching the necessary consensus isn’t likely to happen in a reasonable period of time.</li> <li>▪ A regional compact might have a better shot at fruition, since fewer states would be required for consensus.</li> <li>▪ The mixture of federal and state laws governing health insurance would require significant legislative change. Identifying the legal changes and program design would probably take several years to develop prior to any effort at adoption could be made.</li> </ul>

Questions considered	Findings
<p>Would a compact make individual health insurance more affordable?</p>	<ul style="list-style-type: none"> <li>• Without mandatory participation, healthy individuals may still not participate. The risk of adverse selection may make health carriers reluctant to participate.</li> <li>• Without adequate incentive, small employers may decide not to participate knowing that individuals can buy insurance on their own.</li> <li>• A multistate program broadens the risk base for coverage, but must also account for geographic variations in the cost of care, health of populations and patterns of use.</li> <li>• Experience in other states and studies correlate affordability with a willingness to participate in insurance. Subsidies to make care affordable have generally been required.</li> <li>• Uniform product design(s) and administrative efficiencies will result in savings. Whether those savings are sufficient to reduce carrier overhead enough to create meaningful reductions in premiums depends on how the program is crafted, and whether the states devise a method to address cost-containment for health care itself.</li> <li>• States would need to continue existing high-risk programs or establish one as a part of the compact offering to address individuals otherwise excluded from the market by underwriting. In the alternative, universal coverage eliminates underwriting and could be administered by a compact.</li> <li>• Carrier competition and products vary between states. The compact would have to address that variation, and the market share issues a multistate market creates.</li> </ul>

## Conclusion

One area of consensus between the states exists: Affordable individual health insurance would benefit our residents. The details of reaching that goal and the answer to the accompanying challenges of ensuring participation, cost containment and adequate coverage are currently being tested and debated across the country. Until best practices are identified, using a multistate compact to provide individual health insurance is technically feasible but premature from a practical standpoint.

