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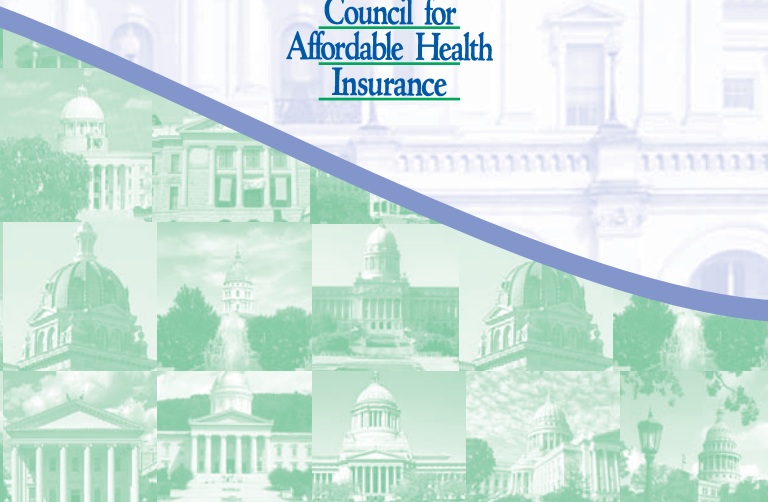
State Legislators' Guide to Health Insurance Solutions and Glossary

AMERICAN LEGISLATIVE EXCHANGE COUNCIL

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Council for
Affordable Health
Insurance



The Council for Affordable Health Insurance (CAHI) is a research and advocacy association of insurance carriers active in the individual, small group, HSA and senior markets. CAHI's membership includes health insurance companies, small businesses, physicians, actuaries and insurance brokers. Since 1992, CAHI has been an advocate for market-oriented solutions to the problems in America's health care system.

The American Legislative Exchange Council (ALEC) is the nation's largest nonpartisan, individual membership organization of state legislators, with nearly 2,400 members across the nation. ALEC is governed by a 23-member Board of Directors of state legislators, which is advised by a 23-member Private Enterprise Board representing major corporate and foundation sponsors. ALEC's mission is to discuss, develop and disseminate public policies which expand free markets, promote economic growth, limit government and preserve individual liberty.

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2008 State Legislators' Guide to Health Insurance Solutions And Glossary

Legislative interest in health insurance and health care reform is at an all-time high. In recent years:

- Maine, Massachusetts and Vermont enacted sweeping health insurance expansion programs;
- States as politically diverse as California, Illinois, Pennsylvania and Wisconsin are now pursuing major reform of their health insurance systems; and
- Many other states have passed legislation mandating the study of various health reform alternatives.

Of course, policymakers are reflecting the concerns of voters who have seen health insurance premiums rise substantially, coupled with the related rise in the uninsured rate.

Fortunately, health insurance increases may have moderated recently. The Kaiser Family Foundation reported premium increases in the employer market of 6.1% for 2008 — the lowest in nearly a decade, and coming after several years of declining premium increases. However, the impact of previous double-digit increases has left voters concerned about the viability of the private health insurance market.

These concerns have been, in part, fueled by a “glass half empty” mentality. In his movie “SiCKO,” Michael Moore focuses on both real and imagined problems of our overall health system — especially access issues — and suggests that a single-payer system is the best solution. Of course, he gets it wrong. Many of the problems with our health care and health insurance system have been caused by well-meaning, but harmful, government solutions (see discussions below of Massachusetts, Maine and New York, to name a few).

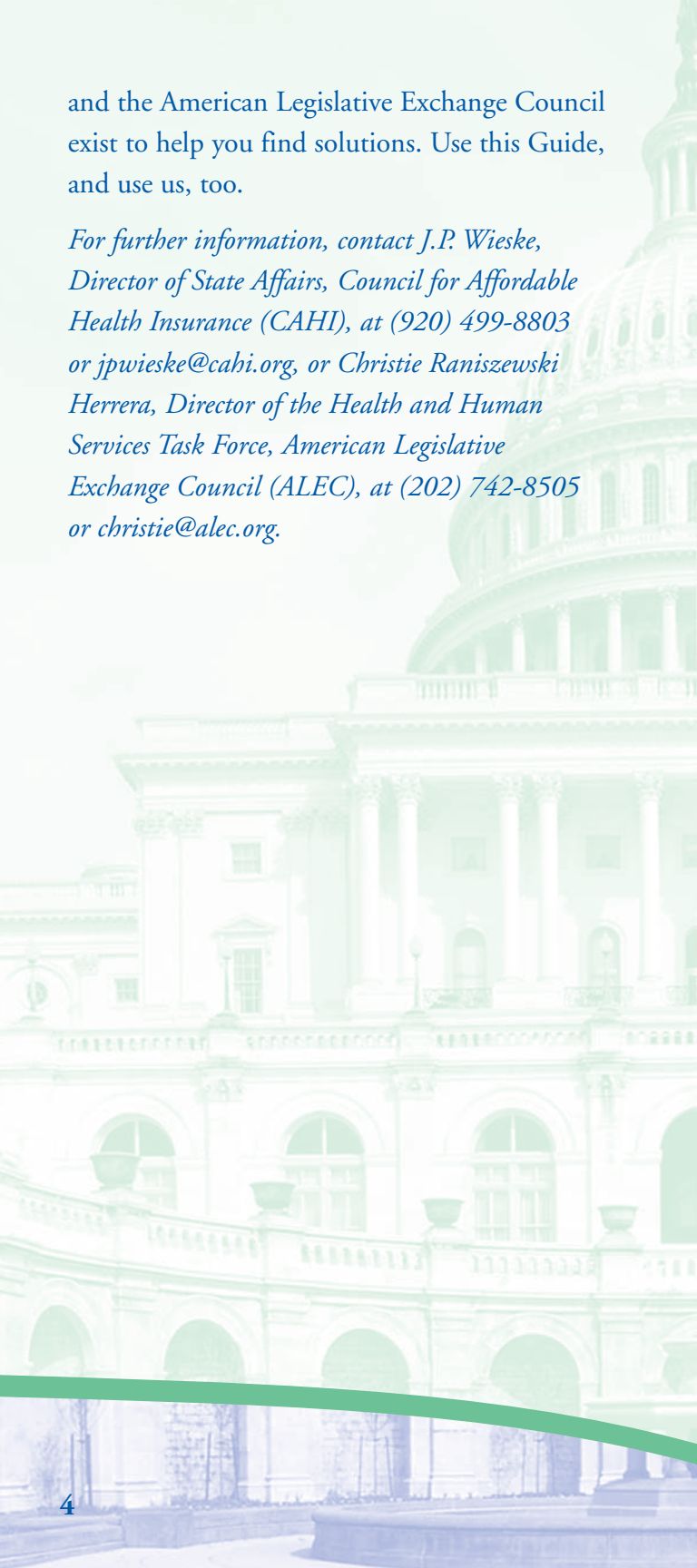
In addition, our government programs often exacerbate the number of uninsured. A recent article in the journal *Health Affairs* highlights the number of uninsured currently eligible for existing government health care programs — up to 25% nationally — but not enrolled.

The good news is that the private sector and some states have found ways to attack the uninsured problem without breaking the bank. In the private market, companies have created unique benefit plan designs that have attracted younger purchasers — the so-called “invincibles” — which not only include health insurance coverage, but add dental and vision benefits rolled into one low-cost package.

Some states are also experimenting with mandate-lite and mandate-free plans for the young and healthy, and some have implemented a mandated benefit review process to stop mandates from being steamrolled into existence.

Other state approaches have focused on programs specifically targeted at the truly needy populations. For example, North Carolina and Tennessee enacted laws covering people with chronic conditions under a high-risk pool program, and Tennessee created a separate program that provides low-cost insurance to some individuals and small businesses through a plan with limited benefits.

This Guide is meant to identify the issues and help you sort through the solutions that work, as well as the public policies that do more harm than good. We explain who the uninsured are and what can be done to address that problem. Plus we have summarized various issues facing state legislators, highlighted actions already taken by states, and offered solutions. We have also included a glossary that explains a number of industry terms. We invite you to use this Guide as a starting point for your deliberations and proposals. And call us. We can expand upon the issues and the ways in which our solutions can help you deal with each of them. Now is the time to act. You have a mandate from your constituents to tackle health insurance problems. The Council for Affordable Health Insurance



and the American Legislative Exchange Council exist to help you find solutions. Use this Guide, and use us, too.

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Enhancing Consumer Protections

Anyone who seeks to understand the health insurance market finds that it is complicated. As legislators increase regulatory oversight or administrative burdens, the health insurance industry inevitably looks to other solutions with fewer regulatory burdens.

Throughout this Guide we discuss a variety of issues facing policymakers, including new ways to expand access to affordable health insurance. We also discuss the most important safeguards for consumers.

We believe a number of consumer protections are vital, but legislators and regulators need to set priorities. Some protections are more important than others. Listed below are what we believe are the most vital consumer protections.

- 1. Affordable Coverage** — Consumers should have access to a wide range of affordable policies that meet their needs, not just low-deductible, comprehensive major medical insurance.
- 2. Access** — Consumers should be able to get coverage regardless of their health status, but that doesn't mean "open access," which can lead to "adverse selection" (i.e., people waiting until they are sick to get health insurance). Solutions such as high-risk pools ensure that even those with medical conditions have access to health insurance.
- 3. Financial Solvency** — Consumers purchase insurance policies for financial protection — a hedge against risk — and insurance companies should be there when needed. Appropriate solvency standards ensure that companies will have the financial means to pay claims when they are due. Financial statements provided by insurers should follow uniform standards and be clear and consistent. Pooling arrangements like Multiple Employer Welfare Arrangements (MEWAs) should be required to meet similar solvency standards, to offer coverage

in conjunction with a licensed health insurer, or to utilize reinsurance to protect consumers.

4. **Claims Payment** — Health insurers should be obligated to pay *every* penny they owe, but not one penny more. And health insurers have an obligation to pay claims in a timely manner, consistent with a review of all appropriate policy terms and conditions. Regulators should review appeals seriously, but understand that the consumer is not always correct — no matter how heartbreaking the story.
5. **Rate Review** — Health insurance rates should be adequate to meet insurer obligations and should be considered objectively. Where regulators find rate review a necessity, a loss ratio or another similar standard should be used to ensure that premiums are fair to policyholders and protect the solvency of the health insurer.
6. **Policyholder Relations** — Consumers face a host of issues ranging from pre-existing condition limitations and late payment issues to appeals processes. Consumers should expect that insurers will treat them fairly and consistently and according to the policy terms and provisions.
7. **Eliminating Fraud** — Insurance policies contain many provisions that protect consumers and insurers from the costs of fraud. Insurance companies need time and the legal rights to find and eliminate fraud.

Understanding the Uninsured

And What to Do About Them

The biggest health policy issue facing state legislators is access to health insurance. Nationally, the U.S. Census Bureau reports that the percentage of uninsured has grown to 15.8% — reaching 47 million Americans in 2006.

However, focusing on the overall uninsured percentage misses the fact that the uninsured population is very diverse. That's both because there are many reasons why people don't have coverage (e.g., they have low incomes, or they are in job transition or they don't think they need it, etc.) and because the relative importance of those reasons varies from state to state.

As we look more closely below at the different circumstances faced by diverse segments of this population, it becomes apparent that the “problem of the uninsured” *cannot* be resolved by a one-size-fits-all solution. (For a longer discussion, see “Understanding the Uninsured” at www.cahi.org.)

Understanding the Uninsured — There are several reasons why people lack health coverage:

- *Eligible for Current Government Programs* — A recent study in the journal *Health Affairs* estimates two-thirds of uninsured children are eligible for public coverage but aren't in a program. And it's not just for lack of awareness; the same study shows that one-third of uninsured children in 2006 had been enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP) the previous year.
- *No Access to Employer-Provided Coverage* — According to the Census Bureau, about 74% of the uninsured worked at some point during the year. In most cases they are lower-income workers, and the employer doesn't offer health insurance.

- *The Chronically Ill* — The chronically ill — those with long-term medical conditions, though not all of which are costly or debilitating — may be denied coverage or have to accept a medical rider when applying for coverage in the individual health insurance market.
- *The Temporarily Uninsured* — Most people are uninsured for relatively short periods of time, usually as a result of job transition. The federal government estimates that about 45% of the uninsured are uninsured for six months or less.
- *Workers Facing Tax Discrimination* — Federal tax policy allows employees and the self-employed to pay for health insurance on a pretax basis; but employees whose employers do not offer coverage get no such tax break when they buy their own policies. As a result, those without access to the tax break must pay a higher effective price for coverage.
- *Low-Income Individuals* — Income is one of the most important predictors of who has coverage and who doesn't. The Census Bureau estimates that among those with incomes below \$25,000, 24.9% are uninsured while among those with incomes above \$75,000, only 8.5% are uninsured. Even those with access to employer-provided coverage occasionally decline the offer because of their lower incomes.
- *The “Invincibles”* — Despite assertions that the uninsured population is made up primarily of older people with medical conditions, the majority of the uninsured are young and, not coincidentally, healthy. According to the Census Bureau, 59% of the uninsured are under 35 years old.
- *The Voluntary Opt-Outs* — About 9 million uninsured Americans, which amounts to 20% of the uninsured, have good incomes but choose not to buy coverage. Ironically, higher-income Americans — in

this case, Americans earning more than \$75,000 — now constitute the fastest growing segment of the uninsured population. They can afford coverage, but most simply choose not to buy it.

- *Minorities* — While the Census Bureau reports that non-Hispanic whites have an uninsured rate of 10.8%; blacks and Hispanics face a much higher uninsured rate — 20.5% and 34.1%, respectively.

Are States Making the Uninsured Problem

Worse? States play an important, and often negative, role in determining whether their residents have access to a wide range of health policies at affordable prices.

For example, a few states have passed guaranteed issue and community rating laws, which require insurers to accept any applicant regardless of health status and to charge everyone the same price, respectively. Together, they dramatically drive up health insurance premiums within just a few years of implementation. If states with guaranteed issue and community rating did nothing more than repeal those laws — allowing health insurers to underwrite again — premiums would begin to fall and competition would return.

Or consider Massachusetts' comprehensive reform, which includes a mandate that people buy insurance and creates a new health insurance market aggregator called the "Connector." This fix has already proven to be problematic.

- Insurance premiums remain unaffordable for thousands of Massachusetts residents;
- The reforms have yet to draw new companies into a stagnant market;
- Existing carriers face sustained political pressure to offer ever-richer benefit plans; and
- The overwhelmingly Democratic legislature may ultimately move to convert the Connector into a single-payer mechanism.

Maine also passed a government-run insurance plan, Dirigo Health, meant to provide lower-cost insurance. Of course, the state taxed those with private insurance to pay for it, further exacerbating the problem. Today, many stakeholders there acknowledge that Dirigo Health has been a failed effort.

What Should States Do to Increase Access to Affordable Coverage? The following are some common policies that have been successful at targeting the uninsured, and are discussed in more detail in the Issues Section:

- *High-Risk Pools* — High-risk pools provide coverage to those who are medically uninsurable, often the chronically ill. Nearly 200,000 Americans currently participate in 33 state-based high-risk pools. Sample model legislation can be found in ALEC’s *High-Risk Health Insurance Pool Model Act*.
- *Individual Tax Credits/Tax Deduction for Medical Expenses* — Both Republicans and some Democrats support tax credits for employees without access to employer-provided coverage. These tax credits would help lower-income workers afford coverage. There is also some bipartisan support for allowing a state income tax deduction for out-of-pocket medical expenses. Sample model legislation can be found in ALEC’s *Health Care Tax Relief Equity Act*.
- *List Billing* — List billing allows an employer who is not contributing to premiums to help employees purchase individual health insurance. Individuals sign up for their own policy in the individual market and agree to have the premiums payroll-deducted from their wages. The employer receives a monthly bill for all the employees (hence, a “list bill”) and remits premiums to the insurer.
- *Plan Design Flexibility* — Many insurers have designed unique benefits that have been successful in attracting the uninsured. Unfortunately, some states have not been willing to approve these policies.

- *Limited-Benefit Plans* — Many of the invincibles (18- to 30-year-old adults who are usually very healthy) would get coverage if they had access to affordable policies. Limited-benefit plans provide more affordable, stripped-down coverage with reimbursement for medical care either in the aggregate (e.g., a \$50,000 annual limit as proposed by the Colorado 208 Commission) or with a schedule of benefits (e.g., \$3,000 per day of hospital confinement). Robust disclosure is very important to ensure that consumers understand the coverage limitations.
- *Medical Waivers* — An exclusionary waiver, or rider, provides an applicant with a minor chronic medical condition an additional coverage option. In exchange for waiving coverage for the specific condition, the applicant receives overall coverage at reduced premiums.
- *Mandate-Lite Policies/Mandated Benefit Review* — By eliminating some (or all) mandated benefits, health insurers are able to offer more affordable health insurance products. States may also provide an institutional check on proposed and existing mandates through a mandated-benefit review process. Sample model legislation can be found in ALEC's *Mandated Benefits Review Act*.
- *Out-of-State Insurance* — Access to affordable coverage can vary significantly from state to state, depending on state regulation. For example, community rating and guaranteed issue have made policies in the individual market unaffordable except for the wealthiest residents of Maine, Massachusetts, New Jersey and New York. If residents living in states with unaffordable health insurance could purchase policies currently being sold in other states, they too would have access to affordable coverage. Sample model legislation can be found in ALEC's *Health Care Choice Act for States*.

- *Short-Term Medical Insurance* — Short-term medical insurance is an affordable option for those seeking coverage between jobs or for other limited periods.
- *Employer and Individual Subsidies* — Several states have enacted narrowly targeted coverage subsidies as an incentive for small employers who have not provided their employees with health insurance coverage. Other states provide premium assistance directly or indirectly to uninsured individuals.
- *Leveling the Playing Field for Individual Purchasers* — Those workers — not the self-employed, who already get a 100% deduction — who pay for health insurance out of their own pockets should be granted the same pretax treatment of premium payments afforded to employers and their employees.
- *Wellness* — We know that a healthier population will have lower overall health care costs and lower health insurance premiums. The private health insurance market is trying to incorporate more wellness programs into its plans.

(For Census data, please see http://www.census.gov/hhes/www/hlthins/hlthin06/p60no233_table6.pdf)

(For Health Affairs, please see <http://content.healthaffairs.org/cgi/content/full/hlthaff.26.5.w560v1/DC1>)

Issues Facing State Legislators

Association Group Insurance: Health insurance sold through an association to its members. In many states, it may be known as “out-of-state” group insurance because neither the health insurer nor the association is principally domiciled in the state.

Most associations provide their members with a variety of benefits. For example, the American Automobile Association (AAA) provides its members with towing insurance, travel discounts, travel planning service, access to auto and life insurance, and many other benefits. Association benefits are used, in part, to attract new members to the association. Better benefit packages lead to better retention and increased membership.

As a result, associations spend a great deal of time and effort in designing attractive benefit packages. The packages often include discounts on a variety of services and insurance products — including health insurance. After designing the benefit package with the health insurance company, the association makes the individually underwritten health insurance plans available to all of its members on a non-discriminatory basis.

Not only has association group insurance been valuable to associations, it has proven invaluable to consumers as well. Although most nonelderly Americans (those under age 65) obtain coverage from their employer, many do not have access to employer-based coverage. Millions of consumers nationwide have turned to the association group market for their health insurance. Association group insurance provides a valuable alternative to the traditional health insurance market in a number of states.

In response, 46 states have imposed statutes and regulations to guide the advertisement, sale and administration of these insurers and policies. Most states have already passed laws that define the types of groups through which health insurance plans may be sold (including association plans) and the rules governing

the groups. The recently revised National Association of Insurance Commissioners' *Group Health Insurance Definition and Group Health Insurance Standard Provisions Model Act* recognizes association group insurance and provides a framework to ensure that consumers can rely on association group insurance.

Note: Association group insurance is often confused with Association Health Plan (AHP) legislation being considered by Congress. They are two separate approaches. Associations can already sell health insurance if they are using a state-licensed insurance company to underwrite the policies, and those policies are subject to many state requirements. The federal legislation would allow associations, among other provisions, to bypass traditional insurance companies and has raised questions about whether they would be adequately funded.

Solutions: Association group insurance helps lower the cost of providing health insurance and provides a valuable option for millions of Americans who do not have access to employer-based coverage. Association group insurance should continue to be protected from requirements like rate regulation and mandates that will further complicate the sale of these policies and increase costs. Additionally, associations should be permitted to offer health insurance coverage to their members across state lines without having to meet the burdensome filing and approval regulations for every state, so long as the association plan is based in an NAIC-accredited state. Those states that have imposed unnecessary regulations on association plans should consider ways to limit or remove those restrictions.

Business Group of One: A unique law that treats individuals (usually the self-employed) as a group for insurance purposes. This approach allows individuals to take advantage of group rules like guaranteed issue and limits on an insurer's ability to underwrite.

“Groups of one” create the ideal environment for adverse selection. Because individuals have the option of seeking coverage in either the rate-limited and guaranteed-issue small group market or in the risk-rated individual market, they are able to use the system to their advantage — seeking coverage in the group market only when they develop a serious medical problem.

This approach also poses an administrative problem. It is often difficult to verify whether or not an individual is legitimately self-employed, therefore qualifying as a group of one, or is simply gaming the system. In one case an agent submitted the application of an individual who claimed to be a self-employed writer. When the income tax statement revealed that the applicant only earned a few thousand dollars as a writer, the agent argued that the individual worked full-time as an author, but just “wasn’t very good.”

Solutions: The reason some states have taken this step is to help individuals with pre-existing medical conditions get coverage on a guaranteed issue basis without requiring that all individual policies be guaranteed issue. However, the individual and small group markets are separate and distinct and should be kept that way. They serve different populations. Combining the markets leads to increasing costs, adverse selection and other problems. The better solution for those with pre-existing medical conditions is a well-functioning state high-risk pool.

Catamount Health: Vermont’s initiative to help solve its uninsured problem. It includes a subsidized health insurance plan as well as changes in Medicaid payments and care management for the chronically ill.

The Catamount Health insurance plan, which is currently offered by Blue Cross and Blue Shield of Vermont and MVP Health Care, is subsidized by the state. It provides a very generous mix of benefits which, combined with limited cost sharing and premium rates starting at just \$60 a month, will almost

certainly cost the state millions in coverage subsidies while crowding out private coverage. The plan also includes a reinsurance component.

Catamount Health also includes reforms intended to help the health care system at large, including loan repayments for primary care physicians and higher reimbursement rates for primary care. In the Medicaid program, cost sharing is substantially reduced (or eliminated) for necessary care to treat chronic illnesses.

Finally, Catamount Health must reduce Vermont's uninsured to 4% of the state's population by 2010, or else an individual mandate will be imposed that requires everyone to purchase coverage — regardless of affordability.

Solutions: Like many other states, Vermont has conveniently ignored the damage done by requiring guaranteed issue and community rating. For many of the states in the Northeast that are concerned about affordability, repealing these so-called “reforms” should be the first step.

Clean Claims/Prompt Pay Laws: Requires health insurers to pay health insurance claims in a specified period of time. As part of the requirement, the law may define which claims are “clean” and thus eligible for prompt payment.

Clean claims laws seek to balance the dual obligation of insurance carriers to pay claims both accurately and quickly. While the majority of claims (in most cases, more than 50%) are paid electronically in fewer than 10 days, some claims require more scrutiny. For example, some suspicious claims may involve fraud. Others may involve complicated or rare procedures, and in some cases extensive pre-existing-condition investigations require additional scrutiny to ensure that payments are appropriate. If carriers do not have the time to appropriately investigate these kinds of claims, they

face the difficult choice of either paying a claim and seeking repayment, or denying the claim outright.

Paying inappropriate claims is only part of the problem. Limited time frames also increase administrative expenses by requiring more staff to process the claims, to request refunds from providers who were overpaid, and to process appeals from patients whose claims were underpaid.

A number of states have passed restrictive clean claims laws only to find that their solutions have created more problems. For example, Texas passed a restrictive law that required all claims be paid within a specified time frame (30 days for electronically submitted claims, 45 days for paper claims) with no exceptions. Instead of appropriately investigating any questionable claims, insurers were required to pay the claims and then try to get any overpayments back from providers.

The law was a disaster. One company that processed more than 45,000 claims over a 20-month period paid all but 17 within the required time. For those 17 late payments (which amounted to .04% of all claims processed) the company was fined \$60,000. Insurers' administrative costs began to rise as a result, which began to push up premiums. Clearly, the 100% standard was unworkable.

Texas repealed the law and created a slightly more reasonable 98% benchmark. Other states have designed more successful claims payment standards. For example, Mississippi and Florida have established a standard that 95% of submitted claims must be paid within a certain amount of time of receipt by the insurer. These compromises balance the need for prompt claims payment with insurers' need to appropriately investigate complex or questionable claims.

Solutions: States concerned about delayed reimbursements should adopt the 95% standard to balance health care providers' need to be reimbursed quickly with the insurers' need to guarantee that reimbursements are accurate. Time frames also should allow a

limited number of exceptions for claims requiring additional information and should specify how long providers have to send the needed information.

Closed Block: When a group of health insurance policies (also known as a “block”) is no longer being sold to new clients in the individual market, it is known as a “closed block.”

Individuals who purchase health insurance for themselves are very price-sensitive. When costs in the market rise, many individual health insurance purchasers choose to be uninsured. Consumers also understand that the individual health insurance market is very competitive, and that they have the ability to switch health plans or health carriers.

In order to attract new customers that help spread the risk, it is important that health insurers continually update their products to meet new market demands and keep prices as low as possible. They do this in a variety of ways. One common way is to create newer plan designs that appeal to ever-changing consumer tastes. In many cases, the health insurer separates the claims experience of the new plans from existing health insurance plans. This is done to ensure that the new plans have very low rates.

When the health insurer stops selling new policies from an existing group of policies, it becomes a closed block. Individuals who have purchased a health insurance policy in a closed block are able to continue coverage on the policy for as long as they wish. Over time, the closed block will experience more frequent and higher claims, which drives up premiums. Those higher premiums, plus the fact that people leave the block for various reasons (e.g., they find other coverage, turn 65 and join Medicare, etc.), lead to smaller and smaller pools, which again raises premiums.

Critics of the individual market believe that closed blocks force people in the block to pay higher premiums, and so they advocate keeping the blocks open to new applicants. However, recent modeling by the American Academy of Actuaries suggests closed blocks successfully keep rates low, ensuring that the greatest number of individuals is able to afford insurance.

Others have suggested alternative proposals to limit the problems with closed blocks. A number of states have implemented a rate-review process that limits the difference between the highest and lowest premiums, thus ensuring that closed-block rates are not substantially different from open-block rates. Arkansas has contemplated requiring all carriers to pool closed blocks together. States have also proposed requiring all blocks (closed or open) to be pooled after a certain period of time — usually five years or longer. However, the most controversial proposal is known as “prefunding,” which requires consumers to pay increased rates at the outset to ensure policies are affordable later.

Solutions: Before embarking on a reform of the closed-block system, it is important to understand the individual health insurance market. For most people, the market is transitory. Most individuals leave the individual health insurance market because they become eligible for group coverage. The Academy study seems to conclude that the current closed-block approach provides the best solution to the problem (i.e., both providing the lowest rates and retaining the highest number of insured persons). Other solutions (e.g., wider rate bands and longer pooling time frames) should only be considered with broad limits.

Community Rating: A price control mechanism that limits the ability of a health insurer to vary prices based on the risk an applicant brings to a pool. Age, lifestyle, health and gender factors are banned in determining rates. Modified community rates usually allow some demographic factors, but do not allow rating based on health status or claims experience.

Insurance is usually priced to reflect the relative amount of risk an applicant brings to the pool. Most residents of Florida face a much higher hurricane risk than those living in Iowa; consequently, Floridians tend to pay more for their homeowners insurance than Iowans. Similarly, accident-prone teenagers tend to pay more for their auto insurance than their safer-driving parents. As a result of these pricing mechanisms, property and auto insurers are able to attract customers who are both high- and low-risk.

If individuals who are young and healthy are charged the community rate — the same rate everyone else pays — they are paying more than the share of risk they bring to the pool. Conversely, individuals who may be older or unhealthy will pay less than the share of risk they bring to the pool. As a result, community-rated insurance becomes more attractive to one group (older and sicker people) and less attractive to the other (young and healthy people), leading to a pool that is disproportionately populated by older and sicker enrollees. This unbalanced pool is known as “adverse selection” (i.e., the insurer is being selected against). As the young and healthy abandon the high-cost coverage, premiums rise even higher and soon the pool is left only with individuals who are too sick to obtain other coverage.

In 1992 New York passed legislation that applied both community rating and guaranteed issue to health insurance policies issued in the individual market. Before the law was passed, a 55-year-old healthy male paid about twice what a 25-year-old healthy male paid for a policy. After the law was implemented, the rates for the 25-year-old man jumped more than 60%. Faced with this kind of rate hike, younger people dropped out of the health insurance market. The health insurance “death spiral” started, and within a few years everyone was paying far more than before the law was passed.

Solutions: States that have adopted community rating must return to risk-rated premiums. Even New Jersey, the 1990s poster child for community rating, authorized a plan in 2002 that permits broad rate bands. In states where elimination is not politically feasible, moving to modified community rating that permits some underwriting is an option.

Connector: Also referred to as a “health insurance exchange,” this Massachusetts reform law mechanism is intended to provide a controlled “marketplace” for health insurance.

The Connector is a pooling mechanism that purports to provide choice of benefit plans for many small employers and individuals. The law combines the individual and small group markets, allowing individuals access to tax-preferred coverage, while providing employees with the ability to choose their own benefit plan within the Connector.

The idea of competition and allowing employees to choose health plans is attractive to many, but singling out the Massachusetts reform plan as a model for a more competitive health market would be a mistake. Health insurance exchanges have not shown that they can promote competition and — at least as practiced in Massachusetts — they have added an additional layer of costly bureaucracy that centralizes decision-making. To date, the Massachusetts Connector has only accepted a small number of insurers that were already writing coverage in the heavily regulated market, leaving consumers with fewer choices.

In truth, the states are littered with failed variations of the health insurance exchange model. Florida and California created their own insurance exchanges in the early 1990s. Health insurers concluded that participation in the first generation of exchanges was unprofitable and eventually withdrew; the pools in both states have now been permanently closed. Without the ability to evaluate risk and facing uncertain enrollment, health insurers likely will be asked to insure only the most expensive health risks.

Solutions: Fortunately, the IRS recently clarified revenue rulings regarding Section 125 premium-only cafeteria plans (please see Section 125 in the glossary for more information). Importantly, employers can now use these provisions to allow their employees to get a substantial federal tax break when they buy their own individual market policies. And states can assist them without creating a new bureaucracy to take the place of the existing market. In other words, a state-created Connector, if there ever was a need for such a mechanism, is no longer necessary to ensure that employees and individuals have access to a wide range of policies with tax-free dollars.

Dirigo Health: A state-sponsored benefit program in Maine that was intended to reduce the state's uninsured rate.

Like some other northeastern states, Maine implemented modified community rating and guaranteed issue. As a result, premiums increased dramatically, and individuals and groups abandoned Maine's individual and small group markets. In a failed effort to address this crisis, Maine passed the Dirigo Health initiative. The law creates a new state-run health plan and includes a strict new premium rate-review process.

Under Dirigo Health, a government health plan with relatively rich benefits is available to individuals, the self-employed and small groups. Participating employers are required to pay a set amount of the premium, and individuals pay based on a sliding income scale. The plan sets up some perverse incentives: the premiums individuals pay vary based on income, but so do the deductibles. As a result, an individual who receives a wage increase from his employer would be forced to pay higher premiums and higher deductibles, wiping out any wage gains.

The program was initially funded with federal dollars and a promise that it would pay for itself. Of course,

the plan subsequently began to run out of money, so Maine decided to tax health insurance to make up the shortfall — making private insurance even less affordable. The tax is built on the dubious premise that covering the uninsured will lower costs in the private market, so the state called the tax a “savings offset payment”!

Besides costing significantly more than predicted, the plan has badly underperformed. Dirigo has fallen far short of its goal to cover all the state’s uninsured, and many of those who have joined were previously covered — only now they can get the state to pick up part of their premium costs.

State policymakers have recently capped enrollment and restricted new entrants, citing severe budget constraints, and the federal government denied Maine’s request to bolster the program with federal Medicaid funds. These and other developments have prompted some state policymakers to reconsider the entire enterprise.

Solutions: Despite the best of intentions, Dirigo has actually made a bad market even worse. Taxing health insurance naturally increases its cost, leading to even more uninsured citizens. It’s a predictable downward cycle. But when a state finds itself in this self-dug hole, the first step is to stop digging. The most effective reform Maine could implement is to remove the guaranteed issue and community rating laws it enacted a decade ago. If it did so, insurance premiums would begin to decline and coverage options would increase. The state could still continue to subsidize low-income Mainers if it chose to do so, but the subsidies would build on a thriving health insurance market.

Discount Medical Plans: Non-insurance plans that provide a discount on medical, prescription drug and dental services, as well as other health-related products and services.

With the increasing uninsured rate and the popularity of consumer-driven initiatives (like Health Savings Accounts, or HSAs), consumers are more price-sensitive and want to make sure they are getting value for their health care dollars. Discount health plans can provide significant savings for routine care, prescription drugs, vision and dental services, and in some cases physician visits and even surgery. For uninsured individuals, discount cards may be a consumer's only way to access affordable care.

It is important to note that discount health plans are not insurance products — a fact missed by some regulators. Discount health plans do not share risks, pay health insurance claims, exclude pre-existing conditions or determine benefits. However, a number of policymakers — including the NAIC — have proposed to regulate discount health plans with insurance-based concepts like solvency standards and rate review. Inappropriate regulation will discourage discount cards from being sold in a state and impede consumers' ability to get access to discounted products and services.

Solutions: Discount plans will be increasingly valuable in the future as consumer-driven health plans continue their rise in popularity. State legislators should consider common-sense standards, such as a registration requirement disclosure, which says that the discount plan is not health insurance, as well as other necessary disclosures that discourage fraudulent vendors. These actions will protect consumers and ensure the availability of discount cards. Sample model legislation can be found in ALEC's *Discount Medical Plan Organization Model Act*.

Proposed legislation should also consider the impact on other existing health insurance arrangements such as PPOs, which offer discounted health care to insurers and their members. That legislation may inadvertently fall under discount medical plan definitions,

leading state legislators and regulators to try to regulate PPOs as such. But they are quite different and should be kept separate.

Employer Mandate: See entry on “Pay or Play.”

Exclusionary or Medical Waivers (Riders): A contract amendment in which an individual agrees to waive coverage for a specific medical condition. Used exclusively in the individual market, the waiver allows the applicant to still obtain coverage for all other medical conditions.

For most people, obtaining health insurance in the individual market is easy. An application is completed, premiums are paid in advance, and coverage is issued within a few days. However, individuals who have medical conditions may have a more difficult time finding coverage. In most cases they may be offered health insurance with a rate increase; but in a few cases, health insurers may decline the individual for coverage.

Exclusionary riders offer another tool to consumers, insurance agents and health insurers. Certain medical conditions, like allergies, may have a range of treatments from inexpensive, over-the-counter medications to weekly allergy desensitization shots. These procedures can be very expensive, but they may not require immediate treatment. Underwriters (employees of the insurance company who review applications) in many states must either choose to substantially increase the premium rates to reflect the possible risk or deny coverage.

An exclusionary waiver, or rider, on a health policy allows the applicant to waive coverage for the condition but still get coverage for all other health problems. Because applicants know far more about their medical condition than the underwriter, it allows them to make an informed choice. Applicants who accept the rider face lower rates but no coverage for the excluded condition. Applicants who decline a

policy with a rider may still apply to other insurers or, if available, to the state's high-risk pool — the same choices applicants would have if the state prohibited riders.

In most states, insurers may offer either temporary or permanent medical waivers. But some states have prohibited the practice. Louisiana tried to exclude medical waivers but found that did more harm than good. So that state's lawmakers voted almost unanimously to reinstate the use of exclusionary medical waivers.

Reports issued by the National Association of Health Underwriters (NAHU) and the Council for Affordable Health Insurance (CAHI) debunk the perception that affordable health care is not available to persons with chronic conditions. In some cases, an applicant may spend less money accepting a policy with a rider and paying for the non-covered care out of pocket. For example, one simulated applicant in the NAHU report received offers that limited coverage for her allergies. The lowest monthly premium offered with a rider was \$111, and the projected average cost of her allergy medicine was \$31 per month, amounting to an effective monthly cost of \$142. The average monthly premium without a rider was \$257.

Solutions: Quite simply, medical waivers provide an additional option to those having difficulty finding insurance. State legislators and regulators should permit the issuance of exclusionary riders in individual health insurance policies.

Government-Run Pools: States sometimes create their own separate state-controlled health insurance pools or sell access to the state employee plan. Such pools are thought to cost less than the private insurance market, so establishing them is supposed to save money. But the evidence suggests there are no savings.

Some policymakers believe that creating a single state insurance pool — that is, insuring every resident of the state in a single insurance plan — can lead to significant savings, and point to Medicare as an example of administrative cost savings. Unfortunately, it isn't true.

Recent studies by CAHI and others have shown that Medicare is no more efficient than the private market when you examine costs not included in the “official” administrative cost estimate. In fact, when you examine payment on a per claim basis, many believe government-administered insurance is actually more costly.

The other misunderstanding is that by creating a larger pool — i.e., spreading the risk over more people — health care costs will fall. While it is true that larger groups usually have more predictable claims, insurers already pool a very large number of risks. The average insurer covers thousands of people, all pooled together by the insurance company. Anyone who understands the economic concept known as “diminishing returns” recognizes that once a pool hits a certain size, additional people provide no economic benefit.

Moreover, health insurance premiums are designed by professional actuaries with extensive experience and underwriters evaluate those risks. Health insurers also provide numerous other services, from case management to billing assistance — services that are vital but expensive to provide. Government pools do not provide those value-added services.

Solutions: State-created pools cost money and they have never achieved any savings. States looking to provide more affordable options to small businesses or the uninsured should first examine any legislation or regulation that limits choices or increases the cost of health insurance. Passing market-based reforms such as high-risk pools, reducing the regulatory burden, and ensuring that residents have access to consumer-driven options such as Health Savings Accounts will

provide the uninsured with affordable options and won't destroy the insurance market.

Guaranteed Issue: Requires insurers to accept all applicants regardless of their health status. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required guaranteed issue in the small group market.

Guaranteed issue requires health insurers to issue health insurance coverage to anyone who seeks it. This means that individuals (or groups) who are in good health can wait to purchase insurance until they are sick, which creates a problem known as “adverse selection,” in which a pool gets a disproportionate number of sick people.

Guaranteed issue legislation leads to some very predictable outcomes. Legislation passed in the early 1990s by several states has destroyed their individual markets. The passage of guaranteed issue was made worse in a number of states because it was implemented in conjunction with community rating. The coupling of these two concepts has driven numerous insurance carriers out of the market and has increased insurance premiums beyond the reach of all but the wealthy.

When New Jersey's guaranteed issue legislation was implemented in 1994, a family policy (known as “Plan D”) with a \$500 deductible and a 20% co-payment (i.e., the insurer pays 80%) cost as little as \$463 a month and as much as \$1,076, depending on which of the 14 participating insurers the family chose.

By October 2007, New Jersey doubled the plan deductible to \$1,000 with only 10 remaining companies. And coverage now costs between \$1,726 (Oxford Health Insurance Company) and \$14,062 (Celtic) *per month* — that's \$20,712 to \$168,744 per year.

In Kentucky, guaranteed issue and community rating rules adopted in 1994 required insurers to offer a limited number of state-designed, standardized health plans. As a result, 45 insurers abandoned the state, leaving only Anthem Blue Cross, Humana (in a limited capacity) and Kentucky Kare, the state-run plan (now Kentucky Access, a high-risk pool). Legislation passed in 2000 and 2005 to reform the “reforms” has encouraged a number of insurers to return. Fortunately, Kentucky appears to be on its way to having a viable and affordable health insurance market once again.

Solutions: Guaranteed issue is a politically inspired “solution” to the problem of the uninsurable. States have more than a decade of experience proving that guaranteed issue actually decreases access to affordable health insurance coverage. It is vital that state legislators — when attempting to ensure access to coverage for the 1% to 2% of the population that is medically uninsurable — not destroy the health insurance market for the other 98% of the population. Individuals with serious medical conditions are far better served by high-risk pools, which better control rates and spread risk to the market at large.

Health Savings Accounts (HSAs): Personal savings accounts that are used to pay for qualified medical expenses. HSAs allow employers or employees to contribute pretax dollars to the accounts, which must be linked to a high-deductible health plan.

HSAs provide an affordable option for many individuals and employers. Most studies have indicated that 30% or more of those purchasing HSAs were previously uninsured. In the individual market, eHealthInsurance (an online health insurance brokerage firm) has reported that HSAs have been very attractive to the uninsured. Fifty percent of 18- to 24-year-olds who purchased HSAs were previously uninsured, and 30% of those over age 60 who purchased HSAs were previously uninsured. Despite predictions that only young and healthy people would

want an HSA, eHealthInsurance reports the average age of an HSA purchaser is actually *older* than that of purchasers of their other individual health insurance products.

Solutions: States can take several steps to ensure that HSAs are widely available. Those states that have first-dollar mandates (i.e., mandates that require payment before the deductible is met) should repeal them in order to ensure that HSA-qualified plans are available in the state. States should also ensure that their tax codes mirror the federal tax code — and model legislation to do that can be found in ALEC’s *Health Savings Account Act*. Workers covered by an HSA in certain states — Alabama, California, New Jersey and Wisconsin — may face a more complicated tax-filing process and higher taxes if those states do not make the necessary changes. Finally, because state government is the largest purchaser of health care, offering an HSA option to state employees, high-risk pool participants and even Medicaid recipients would reduce a state’s health care costs. (*Note:* For a detailed summary of state laws relating to HSAs, see CAHI’s *HSA State Implementation Report*, which tracks HSA legislation in the states, at www.cahi.org.)

Healthy New York: Healthy New York is a public reinsurance plan offered through private market health insurers. Individuals and businesses are eligible for a mandate-lite benefit plan if they are uninsured and meet the income restrictions.

Residents of the state of New York face extremely high health insurance costs, which are partly caused by the twin “reforms” of guaranteed issue and community rating. Instead of repealing these reforms, legislators created the Healthy New York program, which provides private market coverage to low-income and uninsured residents of New York. HMOs are *required* to participate in the program, while other insurers can choose to opt in.

Healthy New York achieves significant cost savings by combining a mandate-lite health insurance plan with a reinsurance program. First, the program provides limited benefits in a number of areas and does not cover all of New York's mandated benefits. Second, the program subsidizes premiums by covering 90% of claims between \$5,000 and \$75,000. The state of New York also spends heavily to promote the program and it limits other health insurer expenses.

However, guaranteed issue and community rating have made health insurance very expensive. So even with the much-needed reduction in costs, Healthy New York is still more expensive than it should be — and people have fewer benefits. Indeed, in most cases Healthy New York is more expensive than more comprehensive benefit plans offered in other states. (See CAHI's *Healthy New York: A Poor Fix to a Dysfunctional System* at www.cahi.org.)

Solutions: Healthy New York has shown some success in lowering health insurance costs, and the Census Bureau suggests that the uninsured rate in New York has actually decreased. But the program is very expensive, and it has merely replaced private insurance with a government-designed and taxpayer-subsidized plan. Plus it begs the question, if mandate-lite policies make health insurance more affordable, why restrict them to lower-income residents? States with guaranteed issue and community rating like New York would be far better served by repealing those “reforms.”

High-Risk Pool: A state-run plan that provides comprehensive health insurance to the 1% to 2% of the population that is medically uninsurable.

High-risk pools have been around for more than 25 years, and in 2007 they covered more than 186,000 people in 34 states. They are the social safety net for the uninsurable, providing access to health coverage for some of society's most vulnerable populations. High-risk pool members typically have serious

medical conditions and do not have access to guaranteed issue insurance coverage, which is required in the small group or large group markets.

Since providing coverage to these individuals is costly, most successful high-risk pools are funded through a partnership. High-risk pool members pay premiums, which are typically between 125% and 150% of standard insurance rates. Health care providers help fund the pool through discounted medical care, and health insurers are required to pay an assessment to cover the pool's losses. Generally, state governments provide either direct subsidies to the pool or tax credits for insurer assessments.

The missing piece in the puzzle is federal funding. Since 2002, the federal government has provided funding for both the operation and start-up costs of risk pools. But funding is not currently guaranteed until Congress actually appropriates the money for that fiscal year.

Solutions: High-risk pools provide a safety net for the small number of the uninsured who are without access to health insurance because of a pre-existing condition. Every state that does not have a high-risk pool should be attempting to start one, and sample model legislation can be found in ALEC's *High-Risk Health Insurance Pool Model Act*. Those that have relied on guaranteed issue as a safety net for the uninsurable should eliminate it and establish a high-risk pool instead. Those that already have pools should encourage Congress to continue and expand funding for state-run high-risk pools.

Individual Mandate: A requirement that all individuals have health insurance, either in the private market or in a government-run plan.

Massachusetts recently enacted an individual mandate on the theory that if everyone is covered, the insurance

pool will be bigger and healthier, eliminating adverse selection and the public costs of treating the uninsured.

Unfortunately, we haven't seen any evidence that the legislation will actually achieve its goal. There are also problems with compliance and enforcement. For example, most states mandate auto insurance coverage but 25% of their drivers may still remain uninsured — outnumbering the percentage of those without health insurance coverage.

The problem is that a coverage mandate requires the government to set minimum coverage standards and define who has health insurance. Over time, providers and disease advocates pressure lawmakers to heap on more and more benefits, jacking up premium costs. Another problem is created by imposing community rating and guaranteed issue requirements. Add it up, and the costs of these policies can quickly spiral out of control. As a result, Massachusetts was recently forced to back off a key plan commitment by exempting approximately 20% of its uninsured from the individual mandate.

Solutions: There are better ways to target the uninsured, as we have seen above. Individual mandates have never led to more affordable policies and should be avoided. Instead, states should focus on making health insurance coverage more attractive by reducing costs and increasing choices, and by subsidizing low-income workers.

List Billing: A billing process that consolidates numerous individual health insurance bills into a single bill and sent by an insurer to an employer. Employees agree to have 100% of the individual health insurance premiums deducted from their checks and then remitted by their employer to the insurer.

Purchasing health insurance can be an intimidating process. Some employers that do not offer health insurance have decided to make the process easier for

their employees by adopting a “list billing” procedure. Typically, the company invites an insurance agent to discuss plan options with interested employees. Once the insurer has accepted the applications for individual insurance, the employer receives a monthly bill listing the premium for each individual/employee policy. The employer, in turn, deducts the premium from the employees’ checks.

Critics fear that employers will abandon the group insurance market for individual (i.e., personally owned) coverage. This concern misses the point entirely. These plans are sold to employees of companies that do not have a group benefit plan, and the only available coverage option for individuals is in the individual market. It is also important to note that individuals who leave a company can keep their coverage, as long as they continue to pay the premium.

Solutions: List billing certainly does not solve all the problems of the uninsured. However, it can be an important tool to make the purchase of insurance easier, and if combined with a Section 125 plan (a plan that allows certain expenses to be deducted on a pretax basis) or a Health Savings Account, list billing can make coverage even more affordable because the employees’ premiums are being paid with pretax dollars.

Mandated Benefits: State laws requiring that a health insurance policy or health plan cover (or offer to cover) specific providers, procedures or benefits.

The Council for Affordable Health Insurance tracks all state mandates and identifies them in *Health Insurance Mandates in the States* (available at www.cahi.org). The number of mandates has swollen over the past 40 years to more than 1,900. And while mandates may make health insurance more comprehensive, they also make it more expensive. In certain states, mandated benefits have increased the cost of individual health insurance

by as much as 45%. As health insurance costs increase, we know more people drop or decline coverage.

According to a 1999 study conducted by the Health Insurance Association of America (now America's Health Insurance Plans), as many as one in four individuals who are without coverage are uninsured because of the cost of state health benefit mandates. At a time when consumers are counting every dollar, it is important to recognize that there is a cost to both employers and individuals who are required to purchase a benefit they may never want or use. That add-on cost may be the determining factor in whether or not the consumer can afford health insurance. Because legislators have saddled health insurance plans with so many mandates, the choice for many people is "Cadillac" coverage or no coverage at all.

Solutions: Before a state legislature passes a new mandate, it should require a comprehensive cost analysis to assess the mandate's likely impact on health insurance premiums — and sample model legislation can be found in ALEC's *Mandated Benefits Review Act*. And before imposing it on the whole citizenry, the state should include the mandated coverage in state workers' policies.

States should also consider making available mandate-free policies (as Arkansas, Colorado, Florida, Montana, North Dakota and Utah have done) or mandate-lite policies. Such policies would be much more affordable while still covering basic health care costs.

Market Conduct/Self-Audit: A market conduct examination is the review of insurance-company operations by regulators. A self-audit is the comprehensive review of a company's compliance with existing laws by the company itself.

Even though the vast majority of health insurance companies comply with existing laws and regulations, it is important for regulators to be able to verify compliance and to find the companies that, whether

intentionally and unintentionally, may not be in compliance with all of a state's laws. Comprehensive market conduct examinations can reveal many compliance problems and ensure a company's compliance with all applicable laws.

Unfortunately, market conduct examinations can also be expensive and disruptive. Space, materials and information must be provided to the examiners. Many states contract with outside examiners to provide these services, which further add to the insurer's cost. Many insurers may have more than one of these examinations being conducted at the same time and quickly find their costs exploding.

Several states have implemented tools to lessen the impact on insurers. For example, states have begun to use targeted exams rather than full-blown market conduct examinations. Some states have also agreed to defer to the home state (or domicile state) to do most compliance examinations, which limits the number of comprehensive exams faced by an insurer.

Another solution is to provide insurers with a comprehensive self-audit privilege. These exams, conducted by the insurer itself, can be viewed as both an alternative to more frequent market conduct examinations and as an additional tool to ensure company compliance with legal and regulatory requirements. Companies that regularly conduct self-audits can catch compliance problems sooner and correct them faster than waiting until the next market conduct examination.

Solutions: Regulators who have unfettered discretion to require market conduct examinations can create more problems than they solve. A more workable plan is for legislators to support separate efforts by ALEC and National Conference of Insurance Legislators (NCOIL) to limit the number of duplicate market conduct examinations in a year, focusing instead on targeted market conduct examinations that may deal with only one subject.

Health insurers should also be encouraged to police themselves with comprehensive self-audits. Self-audit legislation provides a win-win for consumers, regulators and the industry. The companies are able to do a comprehensive analysis of their compliance without providing a blueprint for plaintiffs' attorneys, who may want to file a class action lawsuit. The companies can then have any problems corrected early. That allows regulators to focus their efforts on companies that have consistent problems.

Massachusetts Health Reform: A reform plan that includes, among other provisions, a requirement that both individuals and employers must purchase health insurance or face a financial penalty, a new health insurance middleman called the "Connector," and an attempt to combine both the individual and small group markets.

It is important to know some facts about the pre-reform Massachusetts health insurance market. The fact is that Massachusetts was home to a highly unaffordable, even dysfunctional, health insurance market. In fact, the *Boston Globe* concluded that the state's pre-reform, per-person health costs were the highest in the world. This is partly because Massachusetts had already imposed the twin market-killing reforms of guaranteed issue and community rating. To make matters worse, consumer choices in the individual market were limited to two benefit plans of each type (i.e., two PPO plans, two HMO plans, etc.). The state also faced the loss of a \$385 million federal Medicaid subsidy that paid hospitals for uncompensated care.

The Republican governor and Democratic legislature were at odds over how to reform the market. The legislature favored requiring employers to provide coverage (employer mandate), while the governor favored more market-based reforms. The final bill included concepts that both liberals and conservatives could love — and hate. The most controversial aspects of the plan relate to the individual and employer mandates.

The law requires employers to provide health insurance to their employees and to create a Section 125 plan. (These salary reduction plans allow employees to pay for premiums on a pretax basis, and are not included as part of an employee's taxable income. However, any employer that wants to can do this today.) Employers not meeting these requirements are subject to a \$295 per-employee annual assessment and can be held liable for the uncompensated-care expenses of uninsured employees and dependents that exceed \$50,000. The individual mandate requires individuals to purchase health insurance or face a loss of their personal tax exemption in the first year. In later years, those who do not purchase health insurance face a penalty equal to up to half the cost of a minimum-benefit health insurance plan.

A mechanism called a "Connector," or a "health insurance exchange," lies at the heart of the new law. The Connector purports to create a new facilitative "marketplace" for health insurance, but in reality it acts like a powerful and highly restrictive regulator. Among other things, it enforces unprecedented employer antidiscrimination restrictions, sets "affordable" premium standards, defines minimum coverage requirements, and evaluates plans for appropriateness, legality and "quality." Like health insurance agents, the Connector assists with group enrollment and servicing activities; it performs certain functions typically carried out by carriers, such as eligibility determinations and premium collection; and it even conducts banking functions by completing millions of monthly financial transactions.

The new reforms have taken power away from consumers and centralized it in a nonelected Connector board. The new law is complex and some parts of it have been very difficult to implement. Surveys show that many residents don't even know it will require them to buy coverage by December 31, 2007, or else face substantial tax penalties. What's more, certain

employer-coverage provisions may be subject to an ERISA-based legal challenge.

Solutions: Massachusetts has chosen to add a new layer of regulations on an already-overburdened market by gambling on an entirely new and untested scheme, rather than repealing existing guaranteed issue and community rating requirements that have driven carriers out of the market and raised premium costs to historic levels. If a state is unwilling to repeal existing guaranteed issue and community rating requirements (as Kentucky did), it should at least consider a Healthy New York approach, which reduces the impact of state mandates and regulations. Giving people less-expensive policy options is a better way to get people health insurance coverage than simply forcing them to buy a more heavily regulated, benefit-rich policy neither they, nor the state, can afford.

Medicaid Health Savings Accounts: Medicaid Health Savings Accounts (HSAs) allow Medicaid beneficiaries to better manage their own care while saving the state money.

HSAs combine a high-deductible health insurance policy (HDHP) with a savings account. The high-deductible policy protects the insured from the cost of a catastrophic illness, prolonged hospitalization or a particularly unhealthy year. The savings account is controlled by the insured and is intended to pay small and routine health care expenses. (See the entry on “Health Savings Accounts” for a fuller explanation of how regular HSAs work.)

Medicaid is the federal-state program that provides health insurance, long-term care and other health care services to about 52 million poor, disabled and senior Americans. Medicaid has recently become more costly than Medicare and is the largest budget item in nearly half the states.

Can HSAs help the Medicaid program? For at least some of the Medicaid population, the answer is yes, but the savings will likely be relatively small given the

size and scope of the Medicaid program. The problem with the Medicaid program as it is currently structured is that people have little incentive to be prudent shoppers of medical services. A Medicaid HSA plan could change those incentives and save the program money over the long term. Iowa, Florida and South Carolina have already incorporated HSAs into their Medicaid programs.

Would this approach be a radical departure from traditional Medicaid programs? Yes, but Medicaid needs radical change in order to sustain the program, including block-grant funding to the states, eligibility caps to preserve Medicaid for the truly needy, as well as Medicaid HSAs. Some considerations when designing an HSA Medicaid plan:

- What should happen to the HSA balance once a Medicaid beneficiary leaves the program?
- Can states use methods such as electronic benefit transfer (EBT) cards to protect against misuse of the account as they do with their food stamp programs?
- Should a Medicaid HSA program be implemented as a limited demonstration project to test and evaluate it (as Florida has done)?
- Since HSA plans already include a financial incentive to use the funds wisely, would frequently used state cost-control restrictions — such as prescription drug lists and formularies that limit patient choice — also be imposed on the Medicaid HSA population?

Solutions: States should consider adding an HSA to their Medicaid program. The state could continue to be the insurer, but increase the deductible, depositing part or all of the savings in the Medicaid beneficiary's HSA. Or, the state could simply provide a defined contribution to a private sector insurer or third-party administrator selling HSA plans. Sample model legislation on

Medicaid reform can be found in ALEC's *Access to Medicaid Act*, *Market-Based Medicaid Reform Act*, and *Medicaid Consumer-Directed Care Act*.

Medical Malpractice Reform: Efforts to limit the size of punitive damage awards or to require arbitration, which would reduce the cost and increase the availability of malpractice and health insurance.

The United States has become the most litigious society in history. The Towers Perrin Tillinghast annual report says that medical liability costs grew by 8.5% from 2003 to 2004, and by another 3.5% in 2005. The group expects to see increases of 4.5% for 2006 and 2007. And the U.S. Department of Health and Human Services estimates that defensive medicine — doctors prescribing additional services that may not be necessary so that they can legally protect themselves — costs between \$70 billion and \$126 billion per year.

A 2004 report by the Pew Charitable Trusts Project highlights an even more important issue — the impact of liability concerns and the quality of health care delivered by hospitals and physicians. In states without liability reform, doctors had a higher tendency toward dissatisfaction in their profession, which affected the care they delivered and limited their investment in new technologies.

Many states have adopted provisions intended to contain the rise in malpractice premiums by limiting the volume of malpractice litigation and the size of malpractice awards. Some states passed laws shortening the statute of limitations for malpractice claims; others imposed ceilings on the amount of attorneys' fees recoverable as a result of malpractice actions. Some states imposed damage caps — some on noneconomic damages only, others on pain and suffering awards, and still others on both.

Solutions: The Pew study indicates that reducing medical liability costs not only lowers health care costs, but also improves patient care. Legislators should consider

following the example of California's 1975 Medical Injury Compensation Reform Act (MICRA), which among other reforms limits noneconomic damage awards to \$250,000 and limits contingency fees charged by trial lawyers. Legislators might also require arbitration before litigation. The National Arbitration Forum has suggested language for such a requirement. Research by the American Bar Association indicates that arbitration can save as much as 95% of the cost of a lawsuit. And while 54% of individual plaintiffs win their lawsuits, as many as 70% of individual claimants win their arbitration cases. Requiring arbitration as a conditional precedent to filing a lawsuit could be a win-win situation for consumers, insurers, medical practitioners and lawyers.

Finally, legislators might consider that in Nebraska punitive damages awarded in malpractice suits are directed to the state's education fund. States might also consider directing such monies to a state's high-risk pool to cover the state's uninsurables.

Other approaches to medical malpractice reform can be found in model legislation approved by ALEC's Civil Justice Task Force (available at www.alec.org).

Pay or Play Law: A state or federal requirement that an employer purchase health insurance or pay a penalty in the form of an additional fee (or tax).

“Pay or play” laws require employers to provide a state-defined minimum level of health insurance coverage to their employees or else pay the state to provide health insurance to their employees. If employers choose to provide the coverage, they must pay at least a minimum percentage of the cost of the plan (California legislation that was rejected required employers to pay 80% of the plan's cost). Employers who choose not to provide health insurance coverage are required to pay a new tax to the state meant to

offset the state's costs for creating its own state-run benefit plan.

Supporters mistakenly believe pay or play laws meet the twin goals of achieving universal coverage and preserving the private market. However, a substantial bureaucracy is required to define minimum coverage (which will likely be very comprehensive and very expensive), create a state-run health plan, monitor employers, review all health insurance plans for minimum standards, and sign up the uninsured. Opponents believe this is the first step in a government-run universal health scheme. Additionally, such pay or play legislation would lead to wage, benefits or job cuts for workers, and it would likely not affect a state's uninsured rate. For example, in 1974, Hawaii became the first state to require employers to provide health insurance for their workers. More than 30 years later, Hawaii's uninsured rate still hovers at 10% — higher than some states with no employer mandate. Many Hawaiian employers escaped the mandate by shifting work to (exempt) part-time employees.

Solutions: Better approaches for states include providing tax credits for individual health coverage, allowing targeted subsidies of private plans for poor workers, providing a list billing option, and passing legislation to allow the sale of low-cost, mandate-free or mandate-lite plans. These approaches better target the low-income uninsured and make insurance more affordable for small employers.

Preferred Provider Organizations (PPOs)/Rental Networks: Provide access to discounted medical care to insurers, employers, plan members, and sometimes to discount medical plan members. Health care providers agree to discounted rates in order to attract new patients.

Rental networks are PPO networks that are not owned by the insurer. The insurer pays an access fee to the PPO network in exchange for access to the network.

PPOs have been providing access to discount medical care for more than two decades. They serve as an intermediary between health care providers and insurers. Health care providers agree to provide discounted medical care in exchange for various contract terms, often including faster claims payment, and access to new patients. Health insurers seeking access to these discounts agree to the contract terms and pay an access fee to the PPO. These increasingly integrated arrangements have been established and defined by various contracts between carriers or other payers, PPOs and providers.

These arrangements have worked very well for most doctors and patients. Without them, many patients would likely have access to fewer qualified physicians located in the communities where they live and work. However, in the 1990s physicians sought the contracting advantage of unionization. By collectively bargaining, physicians hoped to increase their reimbursement rates. Largely unsuccessful in their efforts, physicians — led by the American Medical Association — are now promoting “managed care reform.” In their lexicon, managed care reform means more favorable contracting terms governed by legislative action. For example, physicians are seeking to limit the kinds of companies that are allowed to access PPO discounts, as well as a requirement that the sale of every new insurance policy must be approved by every PPO physician before discounts are accessed (a logistical impossibility).

Solutions: Payers and PPOs can only gain access to in-network providers and providers, in turn, can only gain in-network patient volume if they jointly enter into contracts that grant these benefits. Payers, PPO networks and physicians should continue to be free to enter such agreements to their mutual benefit, without interference from third parties. Still, some lawmakers seek to regulate these contracts on behalf of

providers who want their help in obtaining benefits that they are unable to negotiate on their own. It is in this context that new rules proposed by the American Medical Association should be considered carefully. These rules could deny carriers the ability to enter into networking agreements that provide their insureds the broadest possible choice of qualified physicians conveniently located in the communities where they live and work. To the extent that they restrict the ability of carriers and PPOs to negotiate physician discounts, they could also lead to substantial increases in the costs of medical care.

Prompt Pay Laws/Clean Claims Laws: See entry on “Clean Claims.”

Rate Bands: Limits on the ability of insurers to underwrite — that is, to increase or decrease rates for health conditions. This means that younger and healthier people will be charged more, and older and sicker people will be charged less, than the true risk they bring to an insurance pool.

Limits on a carrier’s ability to underwrite in the large group market (usually more than 50 medical lives) and the individual market are rare. In the small group market (usually 2-50 medical lives, as defined by HIPAA), most states have adopted some limits, usually referred to as a “rate band.” Very few states have either community rating or “modified community rating” (see entry on “Community Rating”), which eliminates underwriting. Similarly, few have the opposite of community rating, “unlimited underwriting” (which means no rate band). The most commonly adopted standard is the 1991 NAIC model law, which allows carriers to increase or decrease rates by 25% from the base rate. This regulation essentially means an insurance carrier is allowed to lower rates up to 25% for healthy risks, and raise them up to 25% for unhealthy risks. Since most of the population is healthy, most health insurers provide premium rate quotes at the lowest possible rate.

A popular misconception is that narrowing rate bands (limiting them to a smaller range, say +/- 10%) leads to either overall rate reductions or rate reductions for some segment of the population. Nothing could be further from the truth. As demonstrated in the Heartland Institute's *Destroying Insurance Markets: How Guaranteed Issue and Community Rating Destroyed the Individual Health Insurance Market in Eight States* and other studies, narrow rate bands inevitably lead to higher overall insurance rates. An even greater concern is that the higher rates caused by rate bands disproportionately fall on the young, healthy and relatively poor. In the end, health insurance markets fall into a death spiral — meaning fewer insured persons in the pool with higher overall health costs.

Solutions: The failure of this government-imposed “solution” typically leads to recriminations against the insurance industry and calls for further government intervention. A broad rate band — say +/- 35% — can lead to lower overall health insurance costs, more people insured, and eventually lower and more stable rates for those who pay the highest rates.

Single-Payer System: A health care system in which taxes are collected so that a government agency can pay all covered medical claims. Currently, the U.S. Medicare program for seniors operates like a single-payer system, as does the federal-state Medicaid program for the poor.

Since 1992, several states have considered adopting a single-payer system, and some have passed enabling legislation, but no state has been able to implement the program. Last year, California passed a single-payer bill — without a funding mechanism — that was vetoed by the governor. In the November 2002 elections, Oregon voters rejected a state-based, single-payer plan by a 4-to-1 margin. Illinois has also considered a single-payer plan, and Maine has implemented

its Dirigo Health plan (a scaled-back version of a single-payer system) that is already a failure. Many other states have considered studies of single-payer health plans or have introduced legislation on the subject.

The biggest problems facing states considering a single-payer system are cost and implementation. Federal law supersedes state law, and about half of the employees who get health insurance through the workplace are in self-funded ERISA plans. The federal government, not the states, has authority over those policies. In addition, seniors in the federal Medicare program are outside of state law. Thus, there are simply too many people whose health insurance plans are outside of state control to create an effective, state-based single-payer system.

Single-payer health care in other countries has been a disaster. Pets in Canada have better access to medical care — and advanced technology like MRIs — than their owners. The British health system continues to struggle with waiting times, with the new goal being to start treatment for medical conditions within 18 weeks, an almost unthinkable delay in the United States.

Solutions: The vast majority of people in every state have health insurance coverage. States should look at the populations that are chronically uninsured and devise a targeted, affordable and achievable solution for them rather than looking to a costly and unimplementable single-payer system.

Speed to Market: Proposals that streamline the regulatory environment to make it easier for companies to market new and existing products.

As the state regulatory environment has become increasingly complex and difficult to navigate, insurers have sought solutions to simplify this process. In some cases, states have streamlined their filing requirements, but in many others it may take months for rate and form filings to be completed. The extended time

needed to complete the filing requirements can result in significant financial hardships for carriers, while slowing consumers' access to new options. Carriers and regulators have proposed numerous solutions to this problem, including:

- 1. An optional federal charter** — An optional federal charter would allow a carrier to file any required rates and forms with the federal government. Once approved, the plans would be available in all states.
- 2. Interstate compact** — The interstate compact creates a new multi-state association (created and governed by states that join the compact) that would become responsible for reviewing filing based on agreed upon rules.
- 3. Health Care Choice Act** — This federal proposal would allow individuals to purchase health insurance plans being sold in other states. When one state approves the rates and forms of a company's plan, the plan could be marketed in all 50 states (assuming availability of provider networks, if applicable).
- 4. State Modernization and Regulatory Transparency Act (SMART Act)** — The act creates new limits on state regulatory authority, making the regulatory environment more predictable for companies.
- 5. Market harmonization** — Congress has proposed a few versions of market harmonization in this past year. The proposals attempt to create a health insurance environment similar to that envisioned by the Health Care Choice Act, but with certain minimum standards. Opponents have opposed such proposals on two grounds. First, there is concern with state preemption (i.e., the federal government overriding state health insurance laws). The second is concern that the federal minimum standards will eventually lead to market-killing reforms similar to those passed in New Jersey and New York.

Solutions: While state legislators should monitor these federal and NAIC proposals, it is also important that state legislators closely examine their own markets, asking such questions as:

- Does the state have a large number of carriers selling insurance in the market?
- Are carriers entering (or exiting) the market in large numbers?
- Are there a variety of plan options, including HMOs, PPOs, HSAs and indemnity plans?
- Do insurance companies view the regulatory environment as fair? Is enforcement and interpretation of state laws and regulations consistent?
- Do insurance companies view the regulatory environment as professional and efficient?

If the answer to any of these questions is no, it might be worth the time to look at the feasibility of reform.

Tax Credits: A bipartisan initiative to provide individuals and families with refundable and “advanceable” tax credits to purchase health insurance.

Federal tax credits were enacted on a limited basis in 2002 for displaced workers. The Bush administration is considering broader legislation that would make credits available to the 47 million Americans currently without health insurance.

In 2001, Mark V. Pauly and Bradley Herring published an article in *Health Affairs* that concluded that a “fixed-dollar” tax credit (i.e., a tax credit that pays a flat amount regardless of a person’s age, income or cost of a chosen policy) could cut the proportion of uninsured by one-third to two-thirds.

Solutions: Several states already have passed limited tax credit legislation. State legislators should work to supplement any federal tax breaks enacted in Congress. In addition, state legislatures should call

on Congress to authorize a broader system of tax credits immediately.

Underwriting: A process by which an insurer determines whether or not, and on what basis, it will accept an application for health insurance coverage, along with how much premium to charge the applicant based on the risk the person or group brings to the pool.

Insurance, by its very nature, assesses risk. Drawing distinctions among those applying for coverage permits the accurate pricing of the insurance protection sought. Identification and actuarial analysis of factors such as age, geographic location, health status and lifestyle choices permit insurance companies to charge appropriate and generally lower prices for health insurance coverage.

Underwriting is important for three reasons. First, it is the only way to properly assess how much a person should pay; without it some people are undercharged, while others are overcharged. Second, while many medical conditions arise through no fault of one's own, others are a direct result of lifestyle and personal choices. Underwriting forces people to take responsibility for their actions. Finally, underwriting helps to keep prices low for those who are likely to have the fewest claims. These people, estimated to comprise more than 65% of the insured population, help to subsidize the rates for those with serious medical conditions.

Solutions: Laws that severely limit underwriting should be rejected. States may want to commission a study comparing health insurance rates and availability in states with underwriting and those without it.

Glossary of Insurance Terms

Adverse Selection: The tendency for people with greater needs to be more likely to sign up for insurance, or to enroll in one plan over another, resulting in a health insurance pool containing a disproportionate share of people with medical conditions. Such a situation leads to higher premiums, which will drive healthier people out of the pool.

Ambulatory Care: Medical services provided on an outpatient (non-hospitalized) basis. Services may include diagnosis, treatment, surgery and rehabilitation.

Ancillary Services: Health care services conducted by providers other than physicians and surgeons. These services can include such services as physical therapy and home health care.

Annual Benefit: Maximum amount paid by a health insurer for medical services in one year.

Assignment of Benefits: The practice of a beneficiary instructing an insurer to pay benefits directly to the provider of services.

Balance Billing: The practice when medical care providers (such as doctors, hospitals, or other medical practitioners) bill the insured for the portion of the bill not paid by the insurer. The practice is prohibited by Medicare and some managed care companies.

Beneficiary: The person entitled to receive benefits under a plan, including the covered employee and his or her dependents.

Benefit: Amount payable by the insurance company to a claimant, assignee or beneficiary when the insured suffers a loss.

Cafeteria Plans: See entry on “Section 125 Plans.”

Claim: Demand on the insurer by an insured person for the payment of benefits under a policy.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985): A federal law that requires employers with 20 or more employees who offers health insurance to allow eligible employees leaving the company (and their covered dependents) to continue their coverage, usually for up to 18 months, if the employees pay the premiums (up to 102%) themselves.

Coinsurance (Coins): Most policies require the insured to pay some portion of the health care bills. A typical arrangement is that the insurer pays 80% and the insured 20%, up to \$5,000 out of pocket. After hitting the maximum out-of-pocket limit, the insurance company pays 100% of covered expenses during the remainder of the calendar year, up to any maximum limits of the policy.

Community Rating: The idea that an insurer should charge every insured person the same premium regardless of age, gender, geographic location or health status.

Conversion Privilege: A contractual right given to an insured person whose group coverage terminates so that person is able to convert to an individual policy without providing evidence of insurability.

Coordination of Benefits (COB): Method of integrating benefits payable under more than one health insurance plan so that the insured's benefits from all sources do not exceed 100% of allowable medical expenses or eliminate incentives to contain costs.

Co-payment (Copay): Usually a fixed-dollar amount an insured is required to pay to receive services (i.e., \$10 for a doctor's visit, \$15 for a prescription, etc.).

Cost Shifting: The shifting of health care costs from those who are uninsured or whose insurers pay very little (such as Medicaid) to other payers.

Covered Expense(s): An expense that will be reimbursed according to the terms of the plan or insurance contract.

Deductible: The amount of covered expenses that the insured must pay before a plan or insurance contract starts to reimburse.

Diagnostic Related Group (DRG): Medicare hospital payment system that pays hospitals for average hospital stays rather than based on actual charged amounts.

Disability Insurance: Coverage for injuries that prevent an insured from working. Short-term disability covers employees for periods of less than six months. Long-term disability covers longer periods of time.

Duplication of Coverage: Coverage under two or more policies for the same potential loss. (Also see entry on "Coordination of Benefits.")

Eligible Expense(s): The portion of a health care provider's services that are covered for payment under the terms of the health plan or insurance contract.

Employee Retirement Income Security Act of 1974 (ERISA):

A federal law that originally set minimum standards for funding, vesting, and termination of employer-sponsored pension and health benefits plans. ERISA applies to all employers except church and government employers. Importantly, ERISA preempts all state laws that “relate to” an employee welfare benefit plan. But it “saves” from pre-emption those state laws that regulate the business of insurance, and it “deems” that an employer providing benefits is not in the business of insurance. Large employers are advantaged because they are better able to self-fund and bypass state mandates.

Evidence of Insurability: A procedure used to review factors concerning a person’s physical condition and medical history. From this information, the plan or insurance company evaluates whether and at what rate the applicant can be offered coverage. (Also see entry on “Underwriting.”)

Exclusionary Medical Waiver (Rider): An amendment to insurance contracts limiting or excluding coverage for certain medical conditions. For example, an insurer might place a rider on the policy of an applicant with hypertension, excluding payment for high blood pressure drugs.

Experience Rating: Process of determining the premium rate for a group based wholly or partially on that group’s claims experience.

Explanation of Benefits (EOB): A document sent to an insured when the plan or insurance company handles a claim. The document explains how reimbursement was made or why the claim was not paid. The appeals procedure should be outlined to advise the insured of his/her rights if dissatisfied with the decision.

Fee Schedule: A method of paying benefits that relies on a fixed-dollar amount for each service rendered.

Fee-for-Service Reimbursement: Method of payment for each visit or service rendered. Unlike a fee schedule, FFS payments may vary according to a provider’s own charges or through a “usual, customary and reasonable” standard of payment.

Flexible Spending Accounts: Special accounts authorized under Section 125 of the Internal Revenue Code, and typically funded by an employee’s salary reduction. Deposited funds can be used to pay for certain expenses not covered by the employer’s plan or insurance contract. Because FSA deposits escape federal income taxes, participants pay for medical care with pretax dollars. However, they forfeit any unused funds at the end of each calendar year.

Gatekeeper: Usually a primary care physician in an HMO who determines the patient's access to further treatment and specialists.

Group Insurance: Policies sold to more than one person, usually at the place of employment.

Guaranteed Issue: The requirement that insurers accept all applicants regardless of their health status.

Guaranteed Renewable: The requirement that insurers renew a policy at the end of a specified time if the insured chooses to do so.

Health Alliances: Health Alliances, or Health Insurance Purchasing Cooperatives (HIPCs), are state-sanctioned entities whose primary purpose is to negotiate with health plans to provide coverage at competitive prices to members of the alliance.

Health Maintenance Organization (HMO): An organization that provides a wide range of comprehensive health care services for a specified group of enrollees for a fixed, prepaid premium. There are several models of HMOs: Group Model, Individual Practice Association (IPA), Staff Model and Network Model.

Health Insurance Portability and Accountability Act (HIPAA): A 1996 law intended to make employer-provided health insurance more "portable" by allowing continuously covered employees leaving a company to get coverage from a new employer or in the individual market without having to wait through an exclusion period. HIPAA also established guaranteed issue in the small group market and included a Medical Savings Account demonstration project.

Hospital Indemnity Insurance: Health insurance that provides a stipulated daily, weekly or monthly payment to an insured person during hospital confinement without regard to the actual accrued expenses.

Hospital Medical Insurance: Coverage that provides benefits for the cost of any or all hospital services normally covered under various health care plans.

Indemnity Insurance: Health insurance policy that pays predetermined benefits to the insured for covered services. In essence, the insured is "indemnified" for a loss. Traditionally, the insurer pays on a fee-for-service basis and plays no role in the actual delivery of health care services.

Individual Insurance: A policy purchased by the insured (rather than an employer), which provides protection to the policyholder and/or family members. Also referred to as the “individual market.”

Induced Demand: Once someone is insured, that person will be more likely to consume medical services or products, whether needed or not, because the insured pays little or nothing for the services.

Insurance: Risk management plan that, for a price, assumes some or all of the insured’s risk of serious financial loss if a covered event occurs.

“Invincibles”: Young adults who are usually uninsured and, because they are healthy, don’t see much need for health insurance, especially if the policies are expensive.

Lapse: Termination of insurance coverage for failure to pay premium.

Lifetime Aggregate or Maximum: The maximum benefit payment provided under an insurance contract. Health insurance policies often carry a \$1 million to \$2 million lifetime aggregate.

Limited Benefit Policies: The name given a variety of policies that limit reimbursement. The policies include specified disease policies (e.g., covering cancer only), scheduled-benefit plans, and “mini-meds.”

List Billing: The practice of an employer enabling employees to purchase individual insurance coverage and paying for it themselves through payroll withholding, with the employer simply acting as a conduit for those premium payments.

Loss Ratio: The ratio of claims to premiums (claims divided by premiums).

Major Medical Expense Insurance: Insurance that provides benefits for most types of medical expenses up to a high maximum benefit. Such contracts often contain internal limits and usually are subject to deductibles and coinsurance.

Malpractice: Unprofessional, incompetent or inappropriate medical care.

Managed Care: Health care delivery arrangements that are designed to control health care costs by constraining and improving utilization of services and limiting choice of providers.

Medicaid: State programs, supported by federal matching funds, that provide health insurance and other public health assistance to qualified low-income persons.

Medical Necessity: Term used by insurers to describe medical treatment that is appropriate and in accordance with generally accepted standards of medical practice.

Medicare: Federally sponsored program under the Social Security Act that provides hospital benefits and medical care to persons 65 years of age and older and to some younger persons (usually disabled or who have kidney failure) who are covered under Social Security benefits.

Medicare Part A (Hospital Insurance): Federal health insurance program primarily for seniors age 65 and over that covers medically necessary inpatient care in a hospital, skilled nursing facility or psychiatric hospital, and for hospice and home health care. The program is funded by a 2.9% payroll tax.

Medicare Part B (Supplemental Medical Insurance): Federal health insurance program primarily for seniors age 65 and over that covers medically-necessary physician services and many other outpatient medical services and supplies not covered by Part A. The program is funded by charging participants a monthly premium and by general tax revenues.

Medicare Part D: The Medicare Modernization Act of 2003 created a new prescription drug benefit for Medicare beneficiaries known as Medicare Part D. Under the legislation private insurers offer the coverage and negotiate for low prescription drug prices.

Medigap (Medicare Supplemental Insurance): Medigap insurance is specifically designed to supplement Medicare's benefits and is regulated by federal and state law. It must be clearly identified as Medicare supplemental insurance, and it must provide specific benefits that help fill the gaps in Medicare coverage.

Mental Health Services: Behavioral health care services that may be provided on an inpatient, outpatient or partial hospitalization basis.

Mini-Meds: Health insurance policies that limit coverage and annual reimbursement to a specified amount. The reimbursement limits may be as low as \$2,000 or as high as \$500,000.

Moral Hazard: The idea that insured persons are more likely to engage in risky behavior or use covered services because they are insured and therefore insulated from bearing the full cost of their actions.

Multiple Employer Welfare Arrangement (MEWA): An employee welfare arrangement designed to provide benefits to employees of two or more employers.

National Association of Insurance Commissioners (NAIC):

National organization of state officials charged with regulating insurance. NAIC was formed to provide national uniformity to insurance regulations.

Network Providers: Limited panels of providers in a managed care arrangement. Health plan enrollees may be required to use only network providers. If allowed to go outside the network, enrollees must bear a larger portion of the cost for medical services.

Non-Cancelable Policy: A policy that can be maintained through timely payment of the premiums until the policyholder decides to change. The insurer may not unilaterally change any provision of the in-force policy, including premium rates.

Non-Network Providers: Unapproved health providers who are outside a managed care arrangement and have no contract with the managed care company.

Out-of-Pocket Expenses: Those health care costs that must be borne by the insured.

Out-of-Pocket Maximum: The maximum amount that an insured is required to pay under a plan or insurance contract.

Over-Utilization: Inappropriate or excessive use of medical services.

Peer Review: Traditional quality assurance program composed of medical professionals who monitor care and investigate adverse outcomes. The goal of peer review is to find and correct medical practices that do not conform to the standard of care.

Per Diem: Literally, per day. Term that is applied to determining costs for one day of care. It is an average cost and does not reflect the true cost for each patient.

Point of Service (POS) Plans: An HMO that includes the ability to go out-of-plan to receive services on a case-by-case basis, similar to a PPO.

Policy: Legal document or contract issued by the insurer to the insured person that contains all the conditions and terms of insurance.

Pool(ing): A process used by insurance companies to combine all premiums, claims and expenses in order to spread the risk of insurance coverage.

Portability: The ability of an insured employee to retain a policy after leaving an employer. COBRA also provides a type of portability in that qualified former employees can continue to pay premiums themselves and maintain their insurance for a limited period of time.

Pre-Authorization: Previous approval required for a referral to a specialist or non-emergency health care services.

Pre-Certification: Utilization management program that requires the individual or provider to notify the insurer before hospitalization or a surgical procedure. Notification allows the insurer to authorize and to recommend alternate courses of action.

Pre-Existing Condition Clause: A clause in an insurance contract that specifies if benefits will or will not be paid for a pre-existing condition. Additionally, the clause may limit the benefit payable for treatment of pre-existing conditions until a certain time period of coverage has elapsed, usually six months to a year.

Pre-Existing Condition: A medical condition or diagnosis that existed (or for which treatment was received) before health insurance coverage began. Serious pre-existing conditions often lead to limited coverage (i.e., medical riders) or denial of coverage.

Preferred Provider Organization (PPO): Managed care arrangement consisting of a group of hospitals, physicians and other providers who have contracts with an insurer, employer, third-party administrator or other sponsoring group to provide health care services to covered persons, usually at discounted prices.

Premium Tax: A state sales tax on insurance premiums.

Premiums: Payments made to an insurer to keep an insurance policy in force.

Resource Based Relative Value Scale (RBRVS): A 1992 law that determines how much Medicare pays doctors for their services — in essence, government-determined price controls on doctors. Provider rates are calculated based on an evaluation of the difficulty of the procedure, the training required, the region in which it was performed, and other factors.

Reasonable and Customary: The maximum amount a plan or insurance contract will consider eligible for reimbursement, based upon prevailing fees in a geographic area.

Reinsurance: The transfer of part of the insurance risk — along with part of the premium — to another insurer or insurers.

Rental Network: A preferred provider network (PPN) that is made available to subscribers, primarily health insurance companies, in exchange for access fees. Rental networks allow smaller health insurance companies to compete with the proprietary networks of larger, more dominant carriers in a state.

Reserves: A specific amount of money prefunded and set aside to assure adequate funds to cover future claims. Both insurance companies and self-insured employers must “reserve” in order to preserve cash flow and protect solvency.

Retention: The portion of the insurance premium that is allocated for expenses, administration, commissions, risk charges and profit.

Risk Adjustment: Correction of capitation or fee rates based upon factors that can cause an increase in medical costs such as age or sex. In a broader context, it is the attempt to compensate insurers that take on a disproportionate share of those with medical conditions.

Risk: Chance of incurring financial loss by an insurer or provider.

Scheduled Benefits Plan: Plans that limit reimbursement for a specific kind of procedure based on a specific fee schedule. For example, hospital benefits may only pay \$500 per day, rather than the actual amount charged by the hospital.

Section 125 Plans: A plan that allows an employer to deduct certain expenses — e.g., health insurance premiums and dependent care — from an employee’s check on a pre-tax basis. This option reduces an employee’s tax liability (by reducing taxable income) and the employer’s liability (lower taxable income for FICA taxes). The IRS recently clarified that employees purchasing individual health insurance policies can also take advantage of this deduction.

Self-Insurers: Employers, businesses and other entities that choose to directly assume the risk of their beneficiaries (usually employees).

Specified Disease Insurance: Specified disease insurance, which is not available in some states, provides benefits for only a single disease, such as cancer, or for a group of specified diseases. Benefits are usually limited to payment of a fixed amount for each type of treatment.

Standard Risk: Person who, according to an insurer’s underwriting standards, is entitled to purchase insurance without paying an extra premium or accepting special restrictions.

Stop-Loss Insurance: Protection purchased by self-insured and some managed care arrangements against the risk of large losses or severe adverse claims experience.

Stop-Loss Limit: Also known as an “out-of-pocket limit.” A dollar amount the insured must pay before the health plan starts paying 100% of covered expenses.

Subrogation: The practice of a secondary insurer collecting from a primary insurer for claims paid. A health insurer may pay the claims of an insured who is hurt in an auto accident and then “subrogate” against the auto insurance carrier to recover the cost of those paid claims.

Substandard Insurance: Insurance issued with an extra premium or special restriction to persons who do not qualify for insurance at standard rates.

Substandard Risk: Persons who cannot meet the health requirements of a standard health insurance policy.

Third-Party Administrator (TPA): An outside person or firm, which provides specific administrative duties (including premium accounting, claims review and payment, arranges for utilization review, and stop-loss coverage) for a self-funded plan.

Third-Party Payment: The practice of an insurer paying providers directly for services rendered to an insured, as opposed to an indemnity contract, which pays the insured person for the losses incurred.

Trend Factors: The percentage of increase used by an actuary to reflect the projected rise in overall health care costs. Calculation factors include inflation, utilization, technology and geographic area.

Underwriting: The practice of assessing risk and assigning premiums, on either a group or individual basis. In some cases, it may lead to denial of coverage.

Uninsurables: High-risk uninsured persons whose medical condition(s) precludes them from buying health insurance.

Usual and Customary: See entry on “Reasonable and Customary.”

Waiting Period: Time period one must wait before being eligible for benefits.

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