



BRIEFLY

After the legislature imposed a radical health-care system on Washington in 1993, legislators later stripped away most it. But they left intact reforms aimed at making it easier for people to buy health insurance.

Those reforms have had the unintended effect of driving most health insurers out of the market. Private insurance for individuals is no longer available in 31 counties, except through the state's high-risk pool.

Two measures now before legislators aim to reduce or eliminate those aspects of the reforms that allow people to buy and drop insurance as needed for costly medical care.

Hope for Market-based Insurance Reform

House Health Care committee members have until Friday, Feb. 11, to vote on two competing proposals to restore the market for private individual health insurance in Washington. This is the deadline for bills to emerge from committee.

Saddled with government regulations embodying perverse incentives, the individual market has almost collapsed. Insurers no longer accept new applicants for individual coverage in 31 of the state's 39 counties.

Of the competing proposals, the one sponsored by committee co-chair Republican Linda Parlette, HB 2360, is acceptable to health insurers and apparently would draw them back into the market. The one sponsored by Democratic co-chair Rep. Eileen Cody, HB 2362, may not, because it does not sufficiently change the incentives in the current system.

Cody's bill would not fully undo the regulations that have undermined the market. Current regulations require active insurers to offer coverage to all who apply, no matter how sick; forbid insurers from withholding coverage longer than three months for applicants needing costly medical care; and require insurers to allow people to switch between low-benefit and high-benefit policies when they need more or less medical care.

These regulations help individuals with urgent health conditions in need of insurance – providing it's available – but they allow people to hold off from buying coverage until they need medical care, and to drop it without fear that insurers can then refuse them or force them to wait, say, as long as 12 months for renewed coverage.

Cody's bill would change existing regulations, but probably not enough to motivate people to buy and retain insurance, with enough coverage, before they need costly medical care. It would extend the maximum waiting period for coverage of pre-existing medical conditions to six months from three. But that would not, for example, deter women from waiting until they become pregnant to buy insurance. Insurers want a longer waiting period.

Parlette's bill would allow waiting periods of up to 12 months. Adopting a 12-month period would bring Washington's regulations closer to alignment with the federal 1996 Health Insurance Portability and Accountability Act, as recommended last year in the Washington Research Council's March report, *"Health Insurance Still Suffers from 1993 Reforms."*

Another aspect of Cody's bill that would allow for gaming the system is its portability provision. Twice a year, it would allow people with inexpensive low-benefit coverage to switch to more expensive high-benefit coverage, which could occur when they need costly medical care. (Cody's bill, however, calls for insurers to offer five standard health plans, which are undefined in the bill. So no one yet knows what benefits these plans would feature – another objection insurers have to her bill.)

108 S. Washington St., Suite 406

Seattle WA 98104-3408

PH 206-467-7088

FX 206-467-6957

www.researchcouncil.org



Parlette's bill would restrict portability to changing from one comprehensive plan to another, if a policyholder moves out of his service area or if his physician leaves his health plan. (Presumably, an individual could always change from a high-benefit to low-benefit plan without penalty, but not from low to high.)

Of the two bills, Parlette's would move Washington closer to the way the market was before 1993, when the Democratically controlled legislature launched a radically different health-care system here by adopting the Health Services Act. At the time the act was passed, 19 insurance companies competed in marketing individual coverage.

Previously, insurers were allowed to refuse applicants with severe health problems, refuse coverage of a severe problem or require the applicant to wait for a period of months before coverage began. But refused applicants, as well as those who would have had to pay more than a standard-risk person of the same age and gender, could buy coverage through the Washington Health Insurance Pool, commonly known as the high-risk pool, whose losses were subsidized by assessments on all health insurers doing business in Washington.

Since 1993, the state has required insurers to accept all applicants, so the high-risk pool has been more or less in abeyance. Parlette's bill would bring the pool back into play, because it would allow insurers to funnel 8 percent of their high-risk applicants into the pool.

Cody's bill envisions a different mechanism to ease annual net losses of insurers serving relatively more policyholders needing costly medical care. It's referred to as a "pay or play" system, and is modeled after the one adopted by New Jersey.

As described by House staff, according to Cody's bill, every health carrier will a) offer all (five) standard health plans and be eligible for subsidies for losses, b) not offer the standard health plans and pay assessments to fund subsidies to other carriers, or c) offer the five standard plans, not seek subsidies, and not be subject to assessments. In addition to health insurers, the state would assess stop-loss insurers to cover losses.

The New Jersey model was described last year in a *Health Affairs*' article, "Hidden Assets: Health Insurance Reform in New Jersey." In that model, adopted in 1993, "The regulations require guaranteed issue and renewal policies, portability of coverage across carriers, and limits to preexisting condition exclusions.

"To encourage indemnity insurance companies and managed care organizations to enter the market, all carriers selling health insurance in New Jersey must either offer policies in the individual market or share in the losses of carriers that do sell policies and incur losses.

"To give consumers more leverage in the market, carriers may only sell up to six types of policies with standardized benefit packages, a standardization that facilitates comparisons by customers."

The problem in New Jersey, according to insurance agents there, is that the individual market is caught up in a death spiral, not because of the pay-or-play

requirement but because the state requires community rating. That is, an insurer must charge the same policy price to any and all applicants, no matter their sex, whatever their age, wherever they live. Community rating has driven young, healthy males out of the market. Insurers still market policies, but they're prohibitively expensive.

In its 1999 report on health insurance, the Washington Research Council advocated that the state return to the traditional health-insurance market — together with a safety net consisting of the high-risk pool for high-risk individuals, the state Basic Health Plan for the working poor who need subsidies to afford insurance and Medicaid for the poor. A less regulated market for individual coverage is the best way to bring back insurance companies eager to compete on policies, service and price.

