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American College of Physicians-American Society of Internal Medicine

Policy Monograph on Individually Owned Health Insurance

INTRODUCTION

Despite the recent unprecedented period of economic growth, 43 million Americans still lack health insurance. Although individuals with access to health care benefit from widely available medications and treatments for chronic and episodic diseases, in addition to state-of-the-art equipment and professionals when hospitalization is required, those without health insurance experience reduced access to health care and poorer medical outcomes. The lack of health insurance has important health and financial consequences for individuals and the nation. (1)

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM), representing 115,000 physicians who specialize in internal medicine and medical students, has a long-standing history of advocating for reforms to provide *all* Americans with access to health insurance coverage. The ACP-ASIM urges all elected leaders and policymakers to focus their attention on the documented problems of uninsured Americans to ensure that all Americans benefit from the provision of health insurance.

Following the publication of a series of White Papers on the effects of the lack of health insurance, ACP-ASIM next plans to offer recommendations on specific policy proposals for expanding access. ACP-ASIM's Core Principles on access, approved by the Board of Regents in October of 2000, can serve as a guide to evaluate these proposals. (2) In this monograph, ACP-ASIM examines whether moving towards a system of individually- purchased and owned health insurance, as an alternative to employer-sponsored insurance as the basis of our health care system, could potentially help make coverage more available. Individually owned insurance could be offered as an option *along with* employer-sponsored insurance, as it is today, or it can be viewed as an *alternative* to the current system where most employees obtain their coverage through an employer. This monograph addresses the pros and cons of individually owned insurance as an alternative to employer-sponsored coverage and discusses the changes that would be needed in the individual insurance market in order for it to be viewed as an acceptable and viable alternative to employer-sponsored coverage.

BACKGROUND

Despite years of intense efforts by federal and state policymakers, the number of uninsured Americans continues to rise. Since 1980, the percentage of Americans under the age of 65 with private health insurance, either purchased individually or obtained through the workplace, has declined. In 1980, 79.5% of Americans under 65 were insured, but by 1998, only 70.2% were so insured. (1) At the same time that the vast majority of those with insurance obtain such insurance through the workplace, over three-quarters of the uninsured are members of working families (including dependents). For 80% of the latter group, the worker's employer does not offer health

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insurance coverage. Only 15% of the uninsured are in families where a worker is offered, but declines, coverage. (3)

The increase in the number of uninsured individuals, particularly those in the workforce (including their dependents), is partly a reflection of the dramatic increase in health care costs that occurred in the 1990s. In response to increasing costs, companies of all sizes shifted more and more costs to the employee by increasing co-payments and deductibles, and limited the employee's coverage options by limiting coverage and reducing health benefits. (1) As a result, many people lost or declined job-based health insurance. Last year, insurance premiums rose 8% and are expected to rise at least 11% this year. (4).

As the cost of private health insurance has increased, the number of Americans without coverage has risen, from 11.8% in 1980 to 16.3% in 1998. Between 1990 and 1995, the percentage of non-elderly Americans who received health insurance through their employers (or the employers of family members) dropped from 67% to 64%. The changing nature of jobs within and across industries – especially the growth of service-sector jobs and other small business-related jobs without health benefits and the increase in part-time and contract workers – and the unaffordable cost of the employee share of premiums account for most of this decline. (1) If the economy, as expected, continues to slow down – or goes into recession – unemployment will rise, more individuals could lose their benefits, and there will be less pressure on employers to keep their benefit levels high to recruit and retain present employees.

Given the increasing numbers of uninsured individuals who are in the workforce – or the dependents of such individuals – some health care analysts have questioned whether today's model of employer-sponsored health insurance, with its roots in the post-World War II economy, makes sense anymore. (5,6). When the employer-sponsored system was established, many Americans worked for large firms and remained with them for life. Today, however, increasing job mobility and the growth of small businesses that do not offer health benefits have created a market where employer-sponsored coverage is not available or is too expensive.

Recently, proposals have been circulated within the health care community and among policymakers that argue that today's employer-sponsored, health insurance system needs to be re-examined in favor of one that emphasizes individually selected, purchased, and owned insurance. For example, the American Medical Association (AMA) supports individually selected and individually owned health insurance as the preferred method for people to obtain health expense coverage. (7) Other groups, such as the Heritage Foundation, also endorse private market-based health insurance initiatives, rather than expansion of government programs, in which the focus is on individual choice and control instead of employer choice. (5,6) Many companies are looking at defined contribution rather than defined benefit packages for their employees, whereby the employee is given a fixed amount of money and then shops around for insurance.

Many challenges exist, however, in moving away from an employer-sponsored health insurance system towards an individually owned system. Individual choice of health plans through private markets has broad appeal. Individuals want to be able to choose their own physicians and do not want to be forced to change physicians if they lose or change their jobs. People also care about

how they are treated and resent having to stay with an employer-selected plan that has provided poor quality service. However, the vast majority of those who have employer-sponsored coverage prefer that approach as opposed to purchasing their own insurance directly from insurance companies (56% to 20%). (8) Furthermore, those without insurance also prefer employer-sponsored coverage to direct individual purchase. (8) It has been argued, however, that individuals' preferences might shift toward favoring individually owned insurance (as an alternative to employer-sponsored insurance) if they were given more options in the individual insurance market.

In addition, the individual health insurance market, as it presently functions, has many characteristics that make access for those most in need of insurance (i.e., low-income, high-risk individuals) very difficult. The individual market is very expensive and may even refuse to insure high-risk people. Community-rating or age-band limits can help to bring down average premiums for high-risk people, but they may then drive many healthier, low-risk people out of the insurance pool. If insurance plans fail to attract enough healthy people, the premiums for those left in the insurance pool may escalate beyond the reach of those who need the insurance, leading to the disintegration of the individual market. (3,9)

Several different options exist to provide incentives to encourage an individually owned system, such as tax credits or subsidies to individuals, new purchasing pools, and medical savings accounts. Separate monographs will focus specifically on tax credits and defined contributions, but aspects of these various proposals will be discussed in the context of the discussion below applying ACP-ASIM's Core Principles to the concept of individual insurance.

INDIVIDUAL INSURANCE COMPARED WITH CORE PRINCIPLES ON ACCESS

In October 2000, ACP-ASIM approved a set of core principles on health insurance coverage (reprinted at the back of this monograph). The principles are not intended to be all-inclusive, covering all problems in the health care system. Rather, they highlight critical issues that need to be addressed by policymakers as they consider proposals to reform the health care system. ACP-ASIM does not expect that any one particular legislative proposal will satisfy each of the core principles. However, the principles provide a benchmark from which to evaluate specific proposals, i.e., alternatives to the current employer-based insurance system, such as individually selected and owned insurance. In the following discussion, the relevant principles are examined in the context of addressing the issue of individually selected and owned insurance as a method of providing coverage to more uninsured individuals; a complete list of the core principles is attached for your reference.

Core principle #1 recommends expanding access to coverage with an explicit goal of covering all Americans by a specified date. This principle also recommends a uniform benefits package for all Americans, with continuous coverage and benefits independent of residence or employment status.

Core principle #2 states that sequential reforms that expand coverage to targeted groups should be considered but such proposals should identify the subsequent steps, targeted populations, and financing mechanisms that will result in all Americans having access to affordable coverage,

include a defined target date for achieving affordable coverage for all Americans, and include an ongoing plan of evaluation.

Core principle #3 advocates mechanisms to encourage individuals who otherwise might voluntarily choose not to obtain coverage to participate in the insurance pool, using incentives to participate or disincentives to discourage non-participation. The fourth core principle suggests that flexibility should be allowed for states to investigate different approaches to expanding coverage, controlling costs, identifying funding sources, and reducing barriers to access and quality. However, state-based approaches should contribute to the overall goal of providing all Americans with access to affordable coverage, subject to national standards to ensure portability and access to a basic benefit package.

The question of whether a system of individually owned insurance would be consistent with principle #1 depends to a large extent on individual preferences, and the extent to which there is the political will to correct flaws in the individual insurance market that currently make it an unsatisfactory option for expanding health insurance coverage. Such flaws are discussed extensively in the remainder of this paper. Although this option could be part of a goal of covering all uninsured Americans by a specified date, it would be difficult to achieve on its own, because many people who receive health benefits through the workplace may want to continue to have that option available to them. In addition, individually owned insurance would have to be heavily subsidized—from employers, the government, or indirectly through the tax system through a system of tax credits—in order to make the costs of health insurance coverage affordable to individuals.

Further, care would need to be taken to assure that the transition from an employer-sponsored health insurance system to one in which individuals purchase and maintain their own coverage, did not result in an increase in the number of uninsured. This could occur if the tax deduction as a business expense of employer-paid health insurance was eliminated prior to establishing an organized system to facilitate individually owned coverage.

Individually owned insurance potentially could satisfy the continuous coverage and portability elements of principle #1, because one of the major characteristics of individually owned insurance is that job status or geographic location would no longer determine insurance status.

However, unless health plans that market to individuals are required by law to offer a uniform package of benefits packages, as proposed in ACP-ASIM's Core Principles, the result likely would be that many Americans would purchase health insurance that *under-insured* them for the care that they need. Health plans should be able to offer more benefits than are required in the uniform package, but a uniform package of benefits would have to be mandated nationwide in order for coverage to truly be continuous and portable. Many proponents of individual insurance argue, however, that any requirement that health plans offer a standard package of benefits would be inconsistent with individual insurance, since consumer choice of health plans is one of its main attractions. Proponents argue that individuals should be free to choose the benefits they most need, and should not be required to pay for additional benefits.

Individually owned insurance potentially could be consistent with principles #3 and #4 depending on how it is implemented. Providing certain incentives to purchase health insurance, through tax credits or deductions, or subsidies, could give individuals some of the advantages enjoyed by large groups. Some of the current proposals are income-based. Some argue, however, that income-based incentives alone are unlikely to succeed in significantly reducing the number of uninsured because income is not a good predictor of how much individuals use medical services.

Proposals to provide incentives to low-income people so that they will purchase individual health insurance may not be successful unless they deal with the underlying tension between the interests of low-risk and high-risk people who buy individual coverage. Because of fears of adverse selection, carriers compete in terms of their ability to use risk selection mechanisms. This means that high-risk individuals generally are unable to either access or afford coverage in most states' individual insurance markets. But, if states force carriers to cover all applicants and to community rate premiums, low-risk individuals will drop coverage or not apply for it because their premiums will rise. If this happens, the insurance pool is left with more high-risk individuals who are more expensive to cover. Katherine Swartz, of the Harvard School of Public Health, argues that, for incentive programs to be successful in individual insurance markets, attention should be paid to how alternatives to simple income-based subsidies might be used to spread the burden of the costs of high-risk individuals broadly, rather than on low-risk people who purchase individual coverage. (9)

ACP-ASIM believes that a viable system of individual insurance would require that federal standards be enacted governing issues such as community (or modified community) rating, pre-existing condition exclusions, discrimination against high-risk individuals, genetic screening, and other insurer practices that can make individual insurance unaffordable, or unavailable, to sicker patients. In 1996, ACP-ASIM published a Position Paper that proposed insurance reforms in a voluntary insurance system, including guaranteed issue and renewal requirements, prohibition of pre-existing condition exclusions, standardized benefits, and rating rules. (10) Although the Health Insurance Portability and Accountability Act (HIPAA) established some of the changes that are needed in the insurance market, the law has failed to eliminate egregious rating and underwriting policies that make coverage unavailable or unaffordable for many Americans. (11)

The problem of individuals voluntarily opting out of the system would also need to be addressed. Some argue that there should be an explicit requirement that everyone participate in the insurance pool. Coverage could be made mandatory, similar to the requirements in many states that individuals obtain automobile insurance. Enforcing a mandatory health insurance ownership requirement would raise significant political, practical, and philosophical issues, however. It would be morally unacceptable to deny care to individuals who refuse to purchase insurance. Because health care is a right, it is fundamentally different than linking the privilege of driving to a requirement that an individual obtain automobile insurance. Moreover, as the failure of the Clinton health reform plan illustrated, mandating coverage through the legislative process is politically challenging.

Core principle #6 states that financing should be adequate to eliminate barriers to care. Core principle #7 states that health reform proposals should address sources of patient and physician

dissatisfaction with the current system, including micromanagement of clinical decision-making and the diversion of health care dollars away from patient care to administrative inefficiencies. Principle #8 states that health care reform proposals should be designed to reduce administrative and medical liability costs that do not improve access and quality. Core principle #9 states that patients should have a choice of physician. Principle #13 states that health reform proposals should promote accountability at all levels of the system for quality, cost, access, and patient safety.

Depending on how it is designed, an individually owned insurance system could either exacerbate or decrease patient and physician dissatisfaction with the current system. The amount of financing that is provided to individuals would need to be generous enough to make coverage truly affordable, to create incentives for a wide range of physicians and health care providers to participate in the plans that are offered, and to encourage competition from a wide variety of health plans, including those that offer a wide choice of physician. If the premium subsidy is too low, individuals will be faced with an inadequate choice of health plans and could be forced to select the "cheapest" managed care plans that offer the least choice of physician and the greatest administrative barriers to obtaining necessary care.

Administrative costs could actually increase under an individual insurance system, because the costs of marketing to individuals would tend to be higher than the costs of marketing to employers. (12) Physicians could also be faced with having to deal with a larger number of insurers, each with their own duplicative and inconsistent claims processing, credentialing, and payment requirements. Patients could also be subjected to misleading marketing practices. Therefore, under an individual insurance market, systems would need to be put into place to assure accuracy in the marketing materials used by health plans, to provide individuals with standardized descriptive materials on health plans to assist them in making an informed choice, and to create independent ombudsman offices to answer questions that individuals may have about the insurance plans that are offered to them. State and federal regulators would also need to work with the physician community and insurers to eliminate unnecessary administrative requirements. The fact that most Americans currently prefer to obtain their insurance through an employer suggests that policymakers must tread carefully in assuming that individuals would be more satisfied with a system of individual insurance than they are with the current system.

Finally, a system of accountability would need to be established in an individual insurance system. Currently, large employers, the government, and the medical community have been the driving forces behind efforts to measure and promote quality in health plans. Large employers have had the clout to insist that health plans receive accreditation from entities such as the National Committee on Quality Assurance and URAC. It is not clear that individual consumers would have the clout or understanding to assure that the health plans offered to them meet certain quality standards. Therefore, federal standards relating to health plan quality and consumer rights would also need to be a prerequisite for moving to an individual insurance system.

RECOMMENDATIONS

1. **ACP-ASIM believes that moving to a system of individually owned insurance merits further consideration as a potential strategy for making coverage affordable for all Americans. Any such approach, however, would need to correct existing flaws in the individual insurance market in order to have a positive impact on reducing the number of uninsured Americans. Expansion of individually owned insurance could be part of an overall sequential plan that would expand coverage in stages to uninsured individuals within a defined period of time. However, expansion of individually owned insurance as part of an overall sequential plan that would increase coverage in stages to uninsured individuals, within a defined period of time, will depend on enactment of legislative reforms to correct flaws in the individual insurance market.**

2. **ACP-ASIM believes that any decision to move to a system of individual insurance must be approached very cautiously. Moving from an employer-sponsored system to one that encourages individually owned insurance will be very complex and, if done improperly, could have the unintended consequence of increasing the number of uninsured and under-insured.**

3. **More study and discussion is needed on how to design such a system to assure that it truly makes coverage affordable and available to all Americans, rather than creating new gaps and inequities in coverage. Federal and state law and regulations will need to be significantly changed to make an individual insurance system a viable alternative to employer-sponsored insurance. Specifically, national rules would need to be established relating to:**

   - **minimum benefits,**
   - **rating and under-writing practices,**
   - **renewability,**
   - **consumer protections and patient rights,**
   - **health plan quality,**
   - **marketing practices, and**
   - **adequacy and types of tax incentives and direct subsidies that would be made available to individuals to help them purchase insurance.**

   An infrastructure would need to be created to assist individuals in evaluating the health plan choices that would be available to them. In addition, policies will need to be developed to prohibit or discourage individuals from voluntarily opting out of the insurance market.

4. **Until agreement is reached on the necessary changes in federal and state law and regulations that are needed to make individual insurance a viable alternative to employer-sponsored coverage, Congress should not enact abrupt changes—such as eliminating the deductibility of employer-paid health insurance premiums—that would discourage employers from providing health insurance coverage to their employees.**

ACP-ASIM CORE PRINCIPLES FOR EVALUATING PROPOSALS TO INCREASE ACCESS TO HEALTH INSURANCE COVERAGE

1. Include an explicit goal of resulting in all Americans being covered by adequate health insurance by a specified date.
   a. Includes a mechanism for determining scope of benefits.
   b. Includes a uniform minimum package of benefits for all.

2. Consider sequential reforms to expand coverage.
   a. A sequential plan identifies the subsequent steps, targeted populations, and financing mechanisms.
   b. A sequential plan identifies a target date for achieving affordable coverage for all Americans.
   c. A sequential plan identifies an ongoing plan of evaluation.

3. Include strong incentives for participation in the health insurance pool or strong disincentives to discourage non-participation.

4. State flexibility to investigate different approaches that contribute to the overall goal of providing all Americans with access to affordable coverage, subject to national standards to assure portability and access to the basic benefits package.

5. Create mechanisms to make prescription drugs more affordable. Does not allow formularies that are determined solely or principally on the basis of cost.

6. Financing should be adequate to eliminate barriers to care:
   a. Highest priority towards assuring adequate financing for "critical access" institutions and providers with a higher burden of uncompensated care.
   b. Reimbursement level for covered services must be fair and adequate to reduce barriers to care. Mechanisms to improve ease of administration should be included to enhance physician participation.
   c. Substantial portion of federal budget surpluses should provide funds to expand health insurance coverage.
   d. Financing for public insurance programs should be progressive. Explicit means testing should be discouraged.

7. Should address sources of patient and physician dissatisfaction with the system:
   - Micro-management of clinical decision-making
   - Diversion of health care dollars away from patient care to administrative inefficiencies
   - Excessive pressure on physicians to reduce time spent with patients
   - Duplicative and inconsistent coverage and payment policies by payers
   - Lack of continuity of care
   - Erosion of physician-patient relationship
   - Unnecessary or excessive administrative burdens
   - Excessive documentation requirements
   - Lack of choice of insurance plans and physicians

8. Should be designed to reduce administrative and medical liability costs that do not improve access and quality of care:
a. Public and private research bodies should support research on information systems to make administration and financing more efficient.
b. Reforms should be enacted to limit excessive medical liability costs.
c. Should include a description of mechanisms to assure that health care dollars are directed principally for patient care, not administrative tasks.
9. Patients should have a choice of physicians:
a. Should be designed to respect the importance of patients being able to select a primary care and specialty care physician of their choice.
b. Patients should be able to stay with the physician of their choice from year-to-year.
c. Patients should have sufficient and prompt access to specialty care with a real choice of specialist.
d. Use of hospitalists should not be mandated.
e. Requiring a reasonable but higher level of patient co-payments for open-ended access to a physician of their choice is an acceptable mechanism to control costs while providing patients with greater choice of physician than would be available through closed network or staff model health plans.
f. Research ways to provide patients with meaningful quality measurements that will factor into their choice of physician.
10. Decisions on expansion of the scope of practice of non-physician health care professionals should be based on evidence that they have the requisite skills and training:
a. Should establish a defined level of responsibility, based on skills and training, for each type of non-physician provider.
b. Physician directed health care teams, with sufficient built-in controls.
11. Provide incentives to encourage individuals to take responsibility for their own health, seek preventive care, and pursue health promotion activities.
12. Should have as a goal elimination of disparities in the medical care of patients based on social, ethnic, racial, gender, sexual orientation, and demographic differences:
a. Should be designed to address barriers to care in inner city, rural, and other underserved communities.
b. Should recognize that lack of health insurance is in itself a cause of disparities in the quality of care received by patients.

13. Should promote accountability at all levels of the system for quality, cost, access, and patient safety:
a. Should include incentives for physicians and other health care professionals to participate in the design systems of accountability (non-punitive and educational approaches should be favored).
b. Decisions on medical necessity, coverage, and appropriateness of care should be based on evidence of the clinical effectiveness of medical treatments as determined by physicians and other health care professionals based on review of relevant literature.
c. Should foster innovation and improvement, including innovation in use of Internet technologies with safeguards to protect the confidentiality of medical information that is transmitted electronically.
d. Patients should have certain basic consumer protection rights, including the right to appeal denials of coverage to an independent external review body, the right to hold a health plan accountable in a court of law, the right to be informed about how health plan policies will affect their ability to obtain necessary and appropriate care, and the right to have confidential health information protected from unauthorized disclosure. Denials of care by insurance companies for a particular problem or perceived problem should be based on evidence of clinical effectiveness and pre-determined benefits.
14. Medical profession must embrace its responsibility to participate in the development of reforms to improve the US health care system:
a. The tenets of professionalism and the highest ethical standards, not self-interest, should at all times guide the medical profession's approach to reforms.
b. The medical profession should partner with government, business, and other stakeholders in designing reforms to reduce barriers to care, to improve accountability and quality, to reduce medical errors, to reduce fraud and abuse, and to overcome disparities in the care of patients based on social, ethnic, gender, sexual orientation, or demographic differences.

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