MARKETS FOR INDIVIDUAL HEALTH INSURANCE: CAN WE MAKE THEM WORK WITH INCENTIVES TO PURCHASE INSURANCE?

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EXECUTIVE SUMMARY

This paper examines how the provision of incentives to purchase health insurance (tax credits or deductions, or subsidies) could give individuals some of the advantages enjoyed by large groups. The paper outlines three alternatives to current proposals that base the provision of such incentives on income alone.

Income-based incentives are unlikely to succeed in significantly reducing the number of uninsured because income is not a good predictor of the extent to which individuals use medical service. Insurers in the individual health insurance markets want to avoid "adverse selection," or unknowingly covering too many people who use a lot of services.

Insurance carriers have typically responded to this threat through market niche strategies, offering a variety of policies, differentially priced and targeted at different groups, to screen out risk. The result is something less than the perfect competition many current proposals envision. Government regulation can force more standardization of policies, making it easier for consumers to compare alternatives. But when this happens, insurers tend to adopt a high uniform price as a defense to potential adverse selection.

This paper describes three alternatives to simple, income-based incentive programs. One uses risk adjustments and two rely on reinsurance so that carriers are compensated for the higher costs of covering high-risk people who use incentives to buy insurance. One alternative also permits risk selection by insurance carriers. Criteria for measuring success with such alternatives are also detailed.

The paper shows that proposals to provide incentives to low-income people so they will purchase individual health insurance will not be successful unless such proposals address the inherent tension between the interests of the low-risk and high-risk people who rely on individual coverage. Fear of adverse selection drives carriers to compete in terms of their ability to use risk selection mechanisms to avoid covering high-risk people. This type of competition has meant that high-risk people are generally unable to access most states' individual insurance markets. But if carriers are forced to cover all applicants and to community rate premiums, low-risk people will drop coverage or not apply for it because premiums will exceed their expected need for insurance. If this happens, the individual market will become inaccessible for low-risk people, especially those with lower incomes. Policymakers must be mindful of the needs of both low- and high-risk

groups and of how the individual insurance market operates when considering proposals to expand access.

Concern for people who currently have access to individual coverage calls for a careful examination of options to permit incentive programs to be successful with the individual insurance markets. In particular, attention needs to be paid to how alternatives to simple income-based subsidies might be used to spread the burden of the costs of high-risk people broadly, rather than on low-risk people who purchase individual coverage. Incentives for lower-income uninsured people to buy coverage provide an opportunity for reducing the number of Americans without health insurance. At the same time, they provide an opening for making individual health insurance more widely accessible rather than shifting accessibility from low-risk to high-risk people. Both of these goals need to be kept in mind if incentives are to be successful.

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Introduction

A number of current proposals seek to reduce the number of uninsured individuals by providing incentives (tax credits or deductions, or subsidies) to lower-income people to purchase health insurance. These proposals raise two main analytical issues. The first is the proper design of such incentives. The second is the functioning of the market for individual and small-group insurance. Other papers presented here address the first issue (Glied 2000). They also suggest alternative venues for purchasing coverage so as to obtain the benefits of large groups—for example, the creation of private purchasing pools or permitting individuals and/or small businesses to purchase coverage through federal or state employee health benefits programs, Medicaid/CHIP, or Medicare.

The purpose of this paper is to address how the markets for individual health insurance could be reformed to gain some of the advantages of large groups if incentives to purchase insurance were implemented.[1] Without an understanding of the individual and small-group markets—actually, the fifty different state markets—and their inherent access problems, any incentive program is unlikely to achieve its goal of significantly reducing the number of uninsured.

The ideas in this paper can be summarized as follows. Insurers in the individual health insurance markets (hereafter the individual market) are constantly concerned with the threat of adverse selection.[2] Firms have typically responded to this threat through market niche strategies, offering a variety of policies, differentially priced and targeted at different groups, to screen out high risks. The result is something less than the perfect competition many proposals envision. Government regulation of the individual market can force more uniform offerings—uniformity that makes it easier for consumers to compare alternatives. But when this happens—when government removes firms' initial defense against adverse selection—insurers adopt a high uniform price as an alternative defense.

The result is a trade-off locus between the policy premium for the highest-risk groups and the policy premium for the lowest-risk groups. While government regulation

[1] Throughout the paper, the words "incentives" and "subsidies" are used interchangeably. However, incentives include tax credits, tax deductions, and straight subsidies such as vouchers or payments made to insurers in the name of an eligible person. All of these incentives subsidize the purchase of insurance.

[2] Many of the same arguments can be made for the small-group health insurance markets, but the focus of this paper is on the individual markets, so I will direct the discussion to the individual markets.

can move the market along the locus, any point on the locus may cause large numbers of persons (albeit different persons) to continue to be priced out of the market under most current proposals.

Alternatively, the incentive proposals could include provisions that would permit carriers to be compensated for the difference between the average costs of low-risk people and the costs of high-risk people who buy coverage with subsidies. Risk adjusting the income-based subsidy or providing reinsurance for claims above some level would compensate carriers for such marginal costs. If the funds for compensating the carriers come from general revenues, it would shift the burden of high-cost people from low-risk people who currently purchase coverage (or would purchase coverage with subsidies so long as the premiums were low) to a broader population. Shifting the burden greatly reduces carriers' fear that subsidy programs will cause low-risk people to drop coverage, and it thereby maintains the carriers' participation in the individual market.

The remainder of the paper elaborates on these ideas.

How Individual Insurance Markets Operate

In most markets, competition between sellers generally involves competition over the price at which the product is sold, with a degree of competition over product quality if the product is not strictly homogeneous. A key factor that drives markets to price or price-and-quality competition is the presence of good information. In the case of individual health insurance markets, however, lack of perfect information about the various alternative insurance products and about the people who wish to be covered by insurance make it difficult for the markets to be competitive in terms of price. Consumers in the insurance market have a difficult time finding out about all the alternative insurance products and comparing their "value"—i.e., determining and comparing what services are covered at what premium and required cost-sharing. Carriers (indemnity insurers and managed care plans) also have a significant information problem—it is impossible to know precisely what the health care costs of different people are going to be in the coming year. In particular, they cannot tell which insurance applicants know or suspect they will have high medical costs. Adverse selection occurs when people who expect to incur high medical costs are more likely to purchase insurance than people who expect to have low medical costs. If a carrier unexpectedly were to cover a disproportionate number of high-cost people because of adverse selection, it would lose money and eventually be driven out of business. Thus, whereas the drive to maximize profits in competitive markets involves price competition and efforts to minimize costs, insurance markets are characterized by competitive efforts to reduce adverse selection. That is, the drive to

maximize profits in insurance markets leads to competition in terms of how best either to avoid risk altogether or to charge higher premiums to compensate for expected risk.

Adverse selection fears have led to two features of insurance markets. The first is the presence of market segmentation. The market for health insurance is not one market, but instead comprises three distinct markets—the large-group market, the small-group market, and the individual/non-group market. (One could also argue that there are separate markets for government-sponsored health insurance products but since government programs do not involve competition between carriers, they are not included here.) Carriers frequently specialize in terms of selling policies in one or two of these markets but not all of them.

The second feature consists of the selection mechanisms that carriers use to screen out potentially high-cost applicants (Newhouse, 1982; Newhouse, 1984; Newhouse, 1996; Chollet and Kirk, 1998; Swartz and Garnick, 1999b, 2000a, 2000b). Carriers' strategies to avoid high-cost enrollees include medical underwriting practices, refusing to issue a policy, excluding coverage of services for preexisting medical conditions, and differentiating their policies from their competitors' by generously covering some types of services (e.g., preventative screening) while limiting other services (e.g., substance abuse treatment) (Stone, 1993; Frank et al., 1997).[3] By differentiating their policies and trying to enroll only specific types of people, carriers attempt to develop monopolistic market niches within whichever insurance market segments they compete. Carriers differentiate their product by varying the selection mechanisms described above, by tailoring policy deductibles and cost-sharing requirements to the preferences of specific types of people, and by selective selling practices, as for example in selling only to individuals who are self-employed. As a result, few carriers in a state market actively compete for business among

[3] Medical underwriting (sometimes called experience rating) is the process by which insurers determine as best they can each individual applicant's expected medical care costs. The process usually entails asking questions about the applicant's history of health care use, whether the applicant or a family member has any of a list of specific medical conditions, and sometimes through a medical exam. Thus, if a person has poor health status, actuarial underwriting practices would yield a higher premium than for a similar person in excellent health. When carriers set premiums for policy renewals, medical underwriting can yield high premiums for people who have had expensive medical care in the previous six to 12 months or outright denial of renewal of coverage.

In contrast, community rating is when everyone — regardless of age, sex, occupation, and other characteristics — is charged the same premium for the same policy. Some states permit what is termed modified community rating, which permits different rates by factors such as geographic area of residence, age, and sex. Community rating is always for a particular type of plan — single, husband/wife, adult plus child(ren), and family.

all consumers seeking individual policies, and people whom insurers perceive as high cost have few, if any, options for obtaining health insurance.[4]

Observers often assume that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has restricted these selection practices in the individual market. In fact, HIPAA provides portability of coverage and protection from some selection practices only for a limited group of statutorily defined "eligible individuals," people who had prior group coverage for at least 18 months, have exhausted COBRA benefits, and lack current access to group coverage or public programs (Nichols and Blumberg, 1998).[5] HIPAA does not prohibit carriers from applying selection practices to the great majority of individuals who seek coverage in the individual health insurance markets.

Thus, although some analysts believe individual insurance markets offer a large choice of policies to people (Pauly and Percy, 2000), there is strong evidence that individual markets for health insurance are not fully accessible to all uninsured people. In particular, individual markets are not easily accessible to people who may be perceived to have high risks of using expensive medical care.

Efforts to Open Access to Individual Insurance Markets

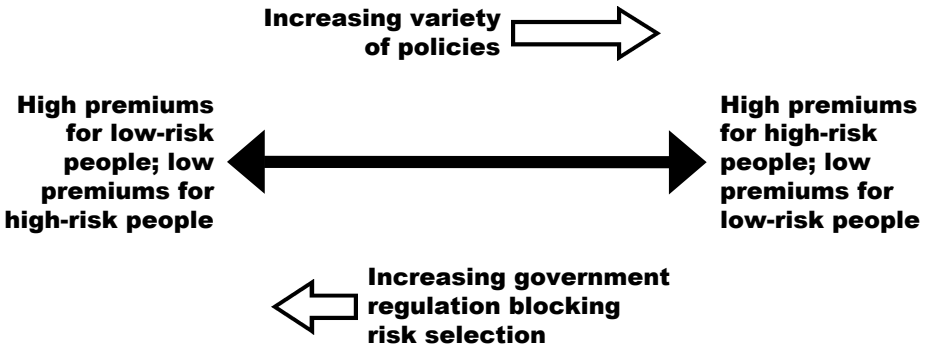
Trade-offs Between Low-Risk and High-Risk People: Given the fear of adverse selection in individual insurance markets, it is clear that there are trade-offs in terms of how such markets might be regulated. Figure 1 provides a conceptual framework for thinking about the trade-off between the premiums available to low-risk people and the premiums available to high-risk people. Seen here, as the number of policy types that can be sold increases, the premiums for low-risk people fall, and conversely, as the number of policy types declines, the premiums for high-risk people fall. In addition, as premiums are allowed to vary more widely with expected health risk, premiums decline for low-risk people and increase for high-risk people. The premium differential for low-risk and high-risk people increases as more variation is permitted both in benefits covered and in how

[4] In the GAO's survey of seven states' individual health insurance markets, the vast majority of the companies did not actually sell individual insurance to any applicant. Instead, these companies had a book of business of individual policies that were conversions from group policies or were restricted to people who were self-employed and belonged to associations of similarly self-employed people (GAO, 1996).

[5] COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1986, which required firms of 20 or more employees to offer access to the firm's group insurance policy following a "qualifying event" for up to 18 months for a work-related event, and 36 months for a family-related event. Work-related events include termination of employment; family-related events include loss of dependent coverage due to divorce or death of an insured worker. People who qualify for COBRA coverage pay a premium not to exceed 102% of the sum of the employer and employee shares of the premium. See Flynn (1994) for more details.

premiums can respond to potential health risk factors. This is because more variation encourages a greater number of insurance pools—making it easier to attract low-risk people. Note that the extent of government regulation of the individual insurance market affects the variety of policy types and the extent to which premiums can vary by risk, causing the total number of policy types in a market to be large or small.

Figure 1
Trade-Off Locus Between Premiums for Low-Risk and High-Risk People in Individual Markets



As Figure 1 shows, government policy regarding the number of insurance policies that can be sold in a market impacts who buys health insurance: low-risk or high-risk people. As the number of policy variations (in terms of benefits covered and how premiums can reflect individuals' risk factors) increases, carriers can tailor policies to meet the preferences of more types of people. As a result, people who are perceived to be low-risk, low-cost individuals will be able to obtain policies at relatively low premiums since the premiums will be determined by the costs of the people who are covered by each carrier under each policy type. Such people will also be more willing to purchase individual coverage since the policies meet their preferences and the premiums are likely to be close to their expected costs of medical care. But as we just discussed, when many types of policies are permitted in individual insurance markets, people perceived to be high-risk either are unlikely to obtain coverage or, if they are offered coverage, will face high premiums. The premiums will reflect the high expected medical costs of similar people with whom they will be grouped by virtue of the type of policies available to them.

The trade-off curve in Figure 1 also has implications for the types of people who will be covered by insurance as government regulations do or do not limit the variety of policies that can be sold. As we noted earlier, when carriers are permitted to offer a wider range of policies, they can create more pools of homogeneous people based on expected medical care costs. The premiums for each pool then more closely reflect the medical care costs of the individuals, and lower-risk people will be more likely to purchase coverage since their expected costs are close to the premiums they face. Low-risk people will then be a larger proportion of all people covered by individual policies. On the other hand, when fewer types of policies are permitted, carriers have to pool more heterogeneous people in each policy type, causing low-risk people to cross-subsidize the higher-risk people in each policy pool. Inevitably, this causes low-risk people to drop coverage because they do not think the premiums reflect their own likely health care expenditures, and they systematically underestimate the actuarial risk they face. But restricting the number and types of policies that can be sold in the individual market makes it possible for more high-risk people to obtain coverage since their expected medical costs are pooled with lower-risk people, which reduces the premiums for high-risk people relative to what they would pay when they are pooled just with other high-risk people. Hence, restricting the number and types of policies available in the individual market causes high-risk people to be a larger proportion of all people covered by individual policies.

As Figure 1 implies, the trade-off locus leaves policymakers in the uncomfortable position of choosing which types of people will have lower premiums and be more likely to have insurance coverage in the individual market. If a state wants to increase access to individual insurance for all types of people, it has to block carriers' abilities to use selection mechanisms—i.e., it has to create a limited set of standardized policies. But if a state wants to keep average premiums lower so that large numbers of low-cost people will purchase coverage, it has to permit a variety of policies. Thus, the choices open to policymakers concerned about increasing access to individual health insurance markets need to be considered in the context of the trade-offs pictured in Figure 1.

Efforts to Increase Access: Efforts to increase access to individual insurance markets have been conducted almost exclusively at the state level—the one exception being the HIPAA of 1996. Most of this effort has been directed at implementing regulations that block carriers' use of the selection mechanisms described earlier. In addition, a few states (Maine, Washington, Minnesota, New York, New Jersey) have tried to induce uninsured people to purchase coverage by providing subsidies to individuals with low incomes or who are employed by small firms. These subsidy programs have generally been tied to specific health insurance policies rather than the full set of policies that might be available

in the state's individual insurance market. Usually these specific policies have contained a set of benefits that is less than the state's full list of mandated benefits for health insurance policies and/or have involved particular managed care plans with a restricted set of health care providers. Thus, the subsidy programs were not intended to be used in the general individual insurance market.

States that have implemented regulations blocking carriers' use of selection mechanisms and experience-rated premiums have done so with at least some intention of increasing access to individual coverage for people who are older or have chronic health conditions (Nichols and Blumberg 1998). Over half the states have proposed or passed regulations for their individual insurance markets that require guaranteed issue of policies to anyone who applies or standardization of policy benefits (GAO, 1996; Chollet and Kirk, 1998). Many states have also implemented regulations that place time limits on exclusion of coverage of preexisting medical conditions, and require pure community rating or modified community rating of premiums (Pauly and Percy, 2000). All states must now comply with the HIPAA and require guaranteed renewability of policies.

Although more than half the states have implemented at least one regulation to restrict carriers' ability to select among applicants, the majority of states do not substantially limit carriers' ability to use the types of selection mechanisms just described. The reason for this is that most states have imposed only one or two of these regulations, and carriers have easily switched to using other mechanisms to attract low-risk applicants and avoid high-risk applicants. Moreover, many states permit carriers to medically underwrite and experience-rate premiums in the individual market. The combination of selection mechanisms and experience rating allows carriers in most states to charge low premiums to younger, healthier people while older or chronically ill people often face prohibitively high rates. The effect of the prohibitively high rates is that among high-risk people, only those with high incomes buy such expensive policies. Thus, to date, almost all states have not used their regulatory authority to restrain carriers' use of selection mechanisms and increase access to individual health coverage for all types of people.

New Jersey, with its Individual Health Coverage Program (IHCP), implemented in August 1993, is the only state that has imposed simultaneously a large number of restrictions on carriers' ability to select whom they insure. The IHCP was created with six regulations that restrict what carriers can do to attract or avoid enrolling individuals, a seventh requirement that affects carriers that offer policies, and an eighth requirement that all carriers must participate in the IHCP (either by selling policies or by paying a share of the losses incurred by carriers that sell individual policies and seek reimbursement of their

losses) (Swartz and Garnick, 2000a). Of particular note were the regulations that restricted the number of policy types that could be sold in the IHCP (originally six types) and required carriers to community rate the premiums for each type of policy. Since 1998, for a variety of reasons that are not directly related to the IHCP, the Program has faced declining enrollments and unraveling of the mechanism that forced carriers to participate. However, in the initial four years of the IHCP, New Jersey was able to attract enrollment in the individual insurance market and participation of carriers in the market by use of its regulatory powers (Swartz and Garnick, 1999a). The result was a market for individual health insurance that was competitive in terms of premium, and open to all types of individuals regardless of their health status or prior use of health care services. However, as the trade-offs possibilities curve in Figure 1 illustrated, the premiums for the individual policies in the IHCP were not cheap (Swartz and Garnick, 1999b, 2000a).

New Jersey is also the only state to have had experience with a statewide income-based subsidy program that eligible people could use to purchase from a choice of policies in the individual market. New Jersey's program (known as the Access Program) was a companion program to the IHCP, but it was only permitted to accept enrollees between May 1 and December 31, 1995. People had to have family incomes below 250% of the poverty level to be eligible, and they were told what their subsidy would be when they were deemed eligible. They then had a choice of the HMO plan offered by five different carriers and one indemnity plan from among the plans offered in the IHCP. Thus, they knew what each carrier's premium was (and they were not equal) and could determine their own net premium when they chose a policy. At its enrollment height (April 1996), almost 22,000 people were enrolled in the Access Program (Swartz and Garnick, 2000b). The cutting off of new applications after December 31, 1995, plus the continuing financial jeopardy of the program does not permit us to evaluate it in terms of take-up rates among eligibles and its effects on the individual market.

What Might Improve the Ability of Tax Credits or Premium Subsidies to Increase Coverage? Possible Alternatives

So far, we have discussed one tool that states might use to achieve greater availability of coverage in the individual health insurance market—i.e., their regulatory authority to restrict carriers' ability to risk select. What happens if we add an income-based tax credit or premium subsidy that can be used by any eligible person to purchase any policy available in the individual insurance market? What types of government actions might enable such income-based incentives to increase the total number of people with insurance coverage?

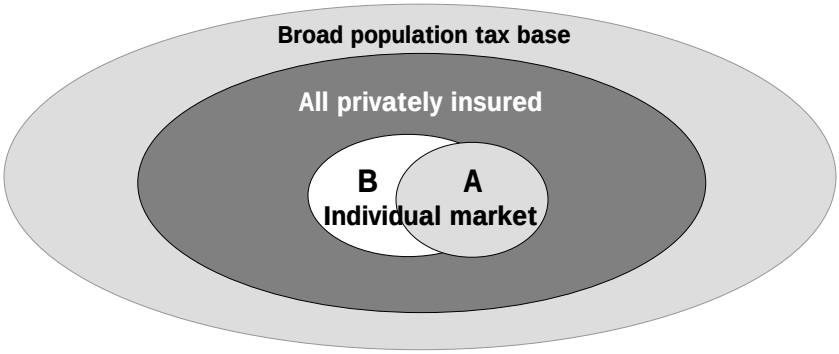
The popular rhetoric surrounding the proposals to provide incentives to purchase health insurance is that all that prevents lower-income uninsured people from buying insurance is that they cannot afford the premiums. It is more complicated than that. As we have been discussing, people differ in terms of their expected use of medical care subsidies and hence their perceived risk of being expensive to insure. Because of this, subsidies based only on income will not help many high-risk people gain coverage unless there is some further government interaction with the individual market. This brings us back to Figure 1—any government policy that affects the types and numbers of available insurance policies, and the ability of carriers to select whom they will insure, involves trade-offs between the interests of low-risk and high-risk people. Policymakers have to achieve two simultaneous objectives: to assist people who frequently have trouble gaining access to individual coverage; and not to so restrict the individual market that low-risk people cannot obtain coverage at premiums they feel are good value and reflect their likely need for insurance. Just using regulations to block carriers' ability to risk select, together with income-based incentives, will not meet these objectives.

Three Alternatives: Three alternatives to current proposals to create income-based subsidies offer a better chance of succeeding in terms of the two objectives above. They all address the issue of risk by allowing the burden of the costs of high-risk people to be shared widely rather than being borne only by low-risk people who have individual coverage. (Figure 2 provides an illustration of how the burden of the costs of high-risk people who purchase individual insurance with the subsidies might be distributed increasingly more widely and the percentages of the population affected.) The alternatives shift the burden via risk adjustments to income-based subsidies or by having the state provide reinsurance for high-cost claims. Spreading the burden more broadly, however, requires additional public funds to pay for the higher medical care costs of the high-risk people who take advantage of the subsidies to purchase insurance, as well as the funds for the subsidies themselves.

In what follows, I begin by briefly describing each of the three alternatives. To simplify the discussion, the first two alternatives are described assuming they would exist in tandem with a highly regulated market that permitted only one standardized health insurance policy. That is, all people with individual policies would have the same set of benefits and cost-sharing requirements, although they could choose to purchase this standard policy from different carriers. Community rating of the premium would be required so that the premiums would differ by carrier only to the extent that carriers differed in their reputations for quality and their ability to be efficient—and the risk pools of the people who purchased their individual policies. The rationale for the one-choice

Figure 2

How the Burden of Medical Costs for High-Risk People Could Be Distributed in an Individual Market with Premium Subsidies



A = people currently covered by individual insurance (9%)
B = people continuing individual coverage, plus new enrollees with subsidy

Size of Market B depends on premium incentives, entry and exit, and whether portion of medical costs for high risk is shifted to broader base.

model is that it facilitates transparency in determining the extent to which additional monies are needed to compensate each of the carriers for the costs of high-risk people who purchase coverage in response to income-based subsidies. After describing Alternatives 1 and 2 with only one standardized policy, I outline the effects of permitting some choice of policies. Then I describe Alternative 3, and briefly comment on the advantages of the different alternatives.

Alternative 1—Risk Adjust Income-Based Subsidy: This alternative relies on simple risk adjustments of the income-based subsidy so as to account for some easily observed factors that affect a person's use of health care. Age and sex are the easiest risk-adjustment factors since they can be obtained from enrollment forms, and therefore are applied prior to a person enrolling with a carrier. (In this context, they can be considered *ex ante* risk-adjustment factors since they affect the income-based subsidy before a carrier or the state knows more about the person's health.) If a person stays with a carrier longer than a year, the subsidy might be further adjusted based on health status, which will then be known to the carrier and the state. With risk-adjusted subsidies, carriers will receive more funds for people who are expected to cost more on the basis of their age and sex, and perhaps their health status. This also permits the premiums faced by low-risk people to be maintained at a level close to what they would be without the higher-risk subsidized people added to the pool of people with individual policies. Without risk adjustment of the subsidies, the burden of subsidizing uninsured low-income people falls on low-risk people who had coverage prior to the subsidy program (see Figure 2). This is because the

subsidy program restricts their choices of policies and causes them to pay higher premiums than under an unregulated market without subsidies.

Alternative 2—State as Reinsurer for High-Cost Claims: A second alternative involves the state taking on the role of reinsurer for high-cost claims. If there is a lack of consensus on how well the subsidies could be risk adjusted on the basis of age and sex, and perhaps health status, the state could take on the role of guarantor of claims that exceed some level per person per year—say $30,000.[6] This reinsurance role could be designed in many ways—a strict reinsurance role for claims in excess of some amount; a soft reinsurance role whereby the state and the carrier share the expenses of claims between, say, $30,000 and $100,000 per person per year, and then the state pays all of the claims in excess of $100,000; or a more complex variation on sharing the claims.

As with Alternative 1, the burden of high costs due to the high-risk people who buy individual coverage in response to the subsidy is shifted from low-risk people covered by individual policies to the general public by the reinsurance mechanism. This occurs because the revenues for the risk adjustments or the reinsurance would be raised by general taxes or specific taxes that are paid by broader groups of people than just the people covered by the individual market now (see Figure 2).

Alternatives 1 and 2 with Limited Choice of Policies: Allowing more choices of insurance policies in the individual market complicates the process of calculating how much compensation carriers should receive for covering high-risk people who enroll because of the subsidies. In particular, increasing the number of available policies (say, to five) in the individual market reduces the transparency of the effect on a carrier's costs due to the additional people who enroll as a result of the subsidies. Permitting more policy choices allows carriers to use the differences in benefits structures in the policies to separate the high-risk people from the low-risk people who buy individual coverage. This makes it more difficult for the state to determine how much compensation it should provide to the carriers for the higher costs of high-risk people so as to enable carriers to maintain the low premiums they would set without the presence of high-risk people. The difficulty is caused by the fact that some of the higher costs allegedly from high-risk people could be due to differences in cost-sharing requirements and types of services covered by the insurance policies (which most likely would be designed to attract high-risk people). Some of the higher costs also could be due to inefficiencies in the way the carriers handle

[6] The Actuarial Research Corporation has estimated that the top 1% of the non-elderly population have expenditures in excess of $30,000 (Memo of 12 September 2000). If their costs above $30,000 are ceded to a reinsurer, the premium would decrease by 14%. If all the claims of these high-cost people were ceded to a reinsurer, the premium would decrease by 28%. These estimates illustrate the magnitudes of the effects of various reinsurance alternatives.

claims for high-risk people. As much as possible, government policies should not create incentives either for unnecessary expenditures of medical care or for carrier inefficiencies.

On the other hand, if a state and the carriers could agree on a method for determining the difference between what high-risk people and low-risk people might cost under each of the standardized policies in a choice set, a state would be able to set risk adjustments or reinsurance rates that encourage appropriate use of health and efficient operations of the carriers. Permitting a wider choice of insurance policies would benefit low-risk people both because they have a choice of policies and do not face higher premiums due to the costs of high-risk people. It also is a benefit to high-risk people who may want insurance coverage for services that might be omitted from a single standardized policy.

Alternative 3—Permit Carriers to Select People for High-Risk Pools: A third alternative for strengthening the ability of subsidy programs to be successful in individual insurance markets also involves the state providing reinsurance for high-cost claims. This option would permit carriers to offer a limited choice of individual policies (say, five) that would be standardized by the state. It also encourages carriers to use risk selection mechanisms to sort people to different policies based on their risk profiles, but carriers would be required to issue policies to all applicants. In essence, this alternative relies on the carriers to determine who is a high-risk person.

Under this option, subsidized people who are perceived to be high-risk by the carriers would be sorted into risk pools of similarly high-risk people. The design of the set of choices would have to be creatively done so that one or two would be expected to attract low-risk people without much effort on the part of the carriers. Then the low-risk people would face low premiums and not bear the burden of higher premiums due to subsidized people entering the market for individual coverage. The remaining choices of policies could be made more attractive to high-risk people. The benefits structure might be designed so as to be favored by people with high medical care needs, including the use of case managers so as to increase efficiency in the delivery of care and lower costs to the enrollees. Since carriers would be permitted to use selection mechanisms but would have to issue policies to anyone who applied for coverage, they would have clear incentives to pool low-risk people with each other and to pool high-risk people separately. The carriers could then continue to attract low-risk people via relatively low premiums.

To pay for the medical costs of the subsidized high-risk people—so they would not face unaffordably high premiums—a state would be the reinsurer for high-cost claims, which could only come from people who have the one or two policy choices designed for

high-risk people. The actual form of reinsurance could be one of the choices described previously in Alternative 2. Under Alternative 3, however, carriers are permitted to risk select so state regulations would have to restrict carriers from placing most people in the higher-risk pools. Unless this is done, carriers would have strong incentives to shift people first considered low-risk to the higher-risk policies as soon as their medical costs exceeded some level. Opportunities for gaming of the system would need to be blocked by regulations and audits of the claims presented for reinsurance.

By permitting a limited set of insurance policies and the ability of carriers to sort people into different risk pools, this option does not place the burden of higher costs of subsidized people on the low-risk people with individual coverage. As with the previous alternatives, this alternative explicitly relies on the broader population to fund the costs of high-risk people brought into the individual market via the subsidies for low-income people (see Figure 2). Equally important, this option takes advantage of carriers' abilities to sort people into policies by perceived risk level rather than requiring state governments to construct *ex post* premium risk-adjustment methodologies.

In sum, what I have outlined here is a framework for considering how state regulations of the individual market might be used to balance the interests of the low-risk and high-risk people who rely on the individual insurance markets for coverage. If income-based subsidies for individuals are combined with subsidies to carriers—in the form of *ex ante* risk adjustments or reinsurance for high-cost claims or high-risk pools—subsidies may work to increase the number of high-risk and low-risk people with private insurance.

Measuring Success with Incentive Programs for Individual Insurance

One measure of the success or failure of an income-based incentive (tax credit or deduction, or subsidy) to buy insurance is the take-up rate among the eligible people. That is, does a respectable fraction of the eligible people take advantage of the subsidy and purchase coverage? Is there a significant decline in the number of eligible uninsured as a result of the incentives?

However, this measure is simple. It misses three other criteria that need to be addressed by any subsidy program that is intended to work with the individual insurance market:

- availability of individual coverage for low-risk and high-risk people

- the risk pools of the carriers that continue to sell individual coverage

- the incidence of the costs of high-risk people.

These criteria are not completely separable. However, they provide markers for comparing the effects of the alternatives I outlined in the preceding section and the effects of simply adding income-based subsidies to individual insurance markets

Availability of Individual Coverage for Low-Risk and High-Risk People: As noted in the Introduction, and illustrated in Figure 1, there is a trade-off locus between the policy premium for the highest-risk groups and the policy premium for the lowest-risk groups. While government regulation can move the market along the locus, any point on the locus may cause large numbers of persons (albeit different persons) to continue to be priced out of the market under most current subsidy proposals. Thus, in evaluating a subsidy program for the individual market it is important to determine the types of people for whom availability of individual coverage increases and the types who feel that availability has been reduced because of restrictions on the carriers' ability to risk select. In other words, we need to pay attention to how the composition of the types of people with individual insurance changes as a result of a subsidy program.

There are four subgroups of people potentially affected by a subsidy program. The subgroups can be delineated by whether or not a person is eligible for the subsidy, and whether the person is high-risk or low-risk. In simple terms, if premiums for low-risk people rise in the individual market because of the subsidy program, the non-subsidized low-risk people are likely to drop their coverage. If this occurs, the non-subsidized high-risk people will face yet higher premiums because the overall risk level of the underlying pool will be higher. Both of these types of people will be disadvantaged by the subsidy program unless there is a way of shifting the burden of the higher costs of the subsidized people.

As for the people eligible for the subsidy, whether they take up coverage depends on the extent to which the subsidy covers the premium they face—which will depend on the premium variation permitted by the state. For example, if a state allows a large variety of types of individual health insurance policies in the individual market, then the premiums for the subsidized high-risk people will be higher than they would be if fewer types of policies could be sold. At the same time, however, the premiums for subsidized low-risk people will be lower than they would be if fewer types of policies could be sold. Hence, an income-based subsidy will provide more benefit to an eligible low-risk person

than a high-risk person in a state that permits a wide variety of types of policies to be offered in the individual market.[7]

Thus, a subsidy program will affect the distribution as well as the number of people who have individual coverage. If the subsidy program causes the population with individual coverage to change from non-subsidized to subsidized people, or from a mix of low-risk and high-risk to predominantly high-risk people, then availability of insurance will have been increased for some people at the expense of other people. Subsidy programs are not independent of the trade-off locus of Figure 1.

The Risk Pools of the Carriers That Sell Individual Coverage: As the previous criterion implies, the relative risk composition of the people who purchase individual insurance affects the financial health of the carriers. Most proponents of a subsidy plan implicitly assume that the subsidy will induce favorable risk selection to individual policies because the lower net premiums (to the subsidized individual) will cause a large number of low-risk people to purchase individual policies. If enough low-risk people enroll so that the risk pool for the individual policies does not become worse than it was without the subsidy program, then the subsidies will be viewed as successful. However, if a carrier's individual insurance risk pool gets worse as a result of the subsidy program, either the carrier has to be able to increase the premium for the individual policies or everyone covered by that carrier has to pay higher premiums than they would otherwise to help cover the carrier's losses. If the risk pool becomes very high-risk, and the carrier is not permitted to raise premiums sufficiently to cover the losses for the individual policies, the carrier may choose to stop selling individual policies or exit the state altogether. Obviously, such decisions would reduce the choices available to people not eligible for the subsidy program and lead to less overall competition in the insurance markets in the state.

Subsidy programs to reduce the number of uninsured people are usually conceived as an effort to assist the demand side of the individual health insurance market—in particular, the low-income uninsured. But markets only work if the suppliers—in this case, the carriers—are financially healthy and do not believe their financial interests will be hurt by participating in a subsidy program. Carriers are especially concerned about how the subsidized individual market might affect their standings in their other lines of business—particularly the small-group and large-group health insurance markets. If a carrier believes that a subsidy program will induce adverse selection so that its risk pool of individual policies will hurt its reputation or competitive standing in these other markets,

[7] The reverse of this scenario implies that a subsidy will provide more benefit to an eligible high-risk person in a state that limits the types of policies that can be offered in the individual market.

it will not want to participate. Thus, any requirement that carriers participate in subsidized individual markets has to be sensitive to the effect such a requirement may have on other people who have coverage from such carriers. Requiring carriers to accept subsidized people in the individual policies should not inadvertently provide an advantage to some carriers (and people who have insurance coverage through them) over others.

The Incidence of the Costs of High-Risk People: A major issue facing any subsidy program for individual coverage is how the burden of paying the costs of high-risk people is spread among the population. Some amount of cross-subsidization occurs with every form of insurance. (Indeed, this is the basic function of insurance.) Thus, the question is not whether cross-subsidization occurs or even whether it is fair, but whether the incidence of the costs being subsidized causes the lower-risk people to opt out of insurance coverage.

If the incidence of the additional costs of the high-risk people are spread among the entire population—that is, spread broadly—then the additional premiums costs for the low-risk people with individual coverage will be very small. In this case, they would not be likely to forego their individual coverage. However, if the additional costs of the high-risk people are sequestered such that only those people who have individual coverage face a higher premium, then the incidence falls on the low-risk people who have individual coverage. In this case, the low-risk people with individual coverage are being targeted to bear the burden of a program designed to help high-risk people. It is likely that the low-risk people will choose to drop their coverage. The result of this will be an increase in the number of uninsured (many of whom will now be low-risk people), and premiums for individual coverage will rise—making individual coverage unaffordable to many high-risk people, too.

In sum, the success or failure of a subsidy program targeted at the individual insurance market must be judged not just in terms of what the take-up rate is among eligible people but also in terms of these three criteria. They all involve trade-offs between the high-risk and the low-risk people and they in turn are affected by the extent to which states permit carriers both to offer many policies in the individual market and to risk select whom they will insure.

How do the Three Alternatives Compare? Each of the three alternatives are likely to be more successful than the simple subsidy program in terms of the take-up rate among eligible people and the three criteria just discussed. Each of the alternatives contains a mechanism for compensating the carriers for the additional costs of high-risk people who

will be encouraged to purchase coverage with the subsidies. The compensation mechanisms protect the carriers from adverse selection so they have less incentive to risk select. Equally important, the compensation mechanisms shift the burden of the costs of the high-risk people to a broader base in the population. This means that low-risk people—especially those who had individual coverage before the subsidy program was implemented—do not face higher premiums (making their coverage less available) and they do not drop coverage. As a result, the subsidy program should in fact contribute to a decline in the number of uninsured people, rather than a shifting of who has access to coverage. In turn, the retention of low-risk people keeps the risk pools of the carriers "healthy" so the carriers will continue to sell coverage in the individual market. On all of these criteria, the alternatives to the simple subsidy program are more successful.

As for choosing among the three alternatives, the relative merits of one alternative over another depend in large part on the implementation practicalities of risk adjusters and reinsurance, together with desires for choice among policy types. Simple risk-adjustments to the subsidy based on age and sex will not satisfy all carriers.[8] Many carriers will feel that such risk adjusters do not adequately compensate them for the higher costs of high-risk people. If they pass on the uncompensated costs to low-risk people in the form of higher premiums, the low-risk people will drop coverage and this could lead to a death spiral for individual policies.

Reinsurance mechanisms have the disadvantage that they inherently provide incentives to providers to continue to provide more care. However, they are more straightforward in terms of how they reduce carriers' high-cost claims than are risk-adjustments. Reinsurance has a clear impact on premiums, which makes carriers much more willing to participate in the individual market. Reinsurance also provides a simple link to the amount of funds that are needed from the general revenue fund to compensate carriers for the higher costs of high-risk subsidized people.

Whether individual insurance offerings are limited to one standardized policy or a limited set of policies depends on public preferences for choice and the ability of a state to regulate the individual market when there is a choice set. The need to guard against inefficiencies and risk selection cannot be ignored. Nonetheless, the three alternatives described above offer better chances of success with subsidized individual health insurance than simply providing income-based subsidies by themselves.

[8] To date, researchers have not been able to develop a risk adjustment model that accounts for more than 25%–30% of the predictable variance in individuals' medical expenditures (Newhouse, 2000).

Conclusions

Proposals to provide incentives (tax credits or deductions, or straight subsidies) to low-income people so they will purchase individual health insurance will not be successful unless such proposals also address the inherent tension between the interests of the low-risk and high-risk people who rely on individual coverage. Fear of adverse selection drives carriers to compete in terms of their ability to use risk selection mechanisms so as to avoid covering high-risk people. This type of competition has meant that high-risk people are generally unable to access most states' individual insurance markets. On the other hand, if carriers are forced to cover all applicants and to community rate their premiums, the low-risk people will choose to drop coverage or not apply for coverage because the premiums will exceed their expected need for health insurance. If this happens, the individual market will become inaccessible for low-risk people, especially those with lower incomes. Thus, policymakers have to be mindful of the needs of both low- and high-risk groups of people and of how the individual insurance market operates when considering proposals to provide subsidies to lower-income uninsured people.

It is also important for policymakers and analysts to think beyond simple numbers of eligible people who might use subsidies to purchase individual policies when considering how to judge the success of subsidy programs. As we saw earlier, the subsidies will affect more than just their intended recipients. How the subsidies are implemented with the individual market has effects on the availability of individual coverage for different types of people, the risk pools of the carriers who continue to sell individual coverage, and who bears the burden of paying for people who rely on individual coverage and might not otherwise have coverage. Also, how the carriers in the individual market are able to interact with the subsidized program will determine whether low-risk people choose to drop their coverage, whether some carriers choose to stop selling individual policies, and whether the market for individual coverage goes into a death spiral.

Concern for people who currently have access to individual coverage calls for a careful examination of options to permit incentive programs to be successful with the individual insurance markets. In particular, attention needs to be paid to how alternatives to simple income-based subsidies might be used to spread the burden of the costs of high-risk people broadly rather than on low-risk people who purchase individual coverage. I provided the broad outlines of three alternatives that might be considered, but the implications of these options and how carriers might respond to them need to be more completely evaluated. Other papers in this project also consider ways to open up existing group plans as venues for coverage for the uninsured (Glied, 2000). A mix of approaches

may be needed if subsidy programs are to be successful in increasing the number of people with health insurance.

Finally, incentives for lower-income uninsured people to buy coverage provide an opportunity for reducing the number of Americans without health insurance. At the same time, they provide an opening for making individual health insurance more widely accessible rather than shifting accessibility from low-risk to high-risk people. Both of these goals need to be kept in mind if the subsidy programs are to be successful.

REFERENCES

Chollet, D. J., and A.M. Kirk. *Understanding Individual Health Insurance Markets: Structure, Practices, and Products in Ten States.* The Alpha Center: Washington, D.C. March 1998.

Flynn, P., "COBRA Qualifying Events and Elections, 1987-91," *Inquiry* 31 (1994): 215–220.

Frank, R. G., T. G. McGuire, J. P. Bae, and A. Rupp, "Solutions for Adverse Selection in Behavioral Health Care," *Health Care Financing Review* 18 (1997): 109–122.

General Accounting Office. *Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs.* GAO/HEHS-97-8. November 1996.

Glied, S. A. *Challenges and Options for Increasing the Number of Americans with Health Insurance.* The Commonwealth Fund. December 2000.

Kilbreth, E. H., A. F. Coburn, C. McGuire, D. P. Martin, P. Diehr, C. W. Madden, and S. M. Skillman, "State-Sponsored Programs for the Uninsured: Is There Adverse Selection?" *Inquiry* 35 (1998): 250–265.

Ku, L., and T. A. Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry* 36 (1999/2000): 471–480.

Newhouse, J. P., "Cream Skimming, Asymmetric Information, and a Competitive Insurance Market," *Journal of Health Economics* 3 (1984): 97–100.

Newhouse, J. P., "Patients at Risk: Health Reform and Risk Adjustment," *Health Affairs* 13 (1994): 132–146.

Newhouse, J. P., "Reimbursing Health Plans and Health Providers: Efficiency in Production versus Selection," *Journal of Economic Literature* 34 (1996): 1236–1263.

Newhouse, J. P., M. Beeuwkes Buntin, and J. D. Chapman, *Risk Adjustment and Medicare.* The Commonwealth Fund. Revised June 1999.

Nichols, L. M., and L. J. Blumberg, "A Different Kind of 'New Federalism'? The Health Insurance Portability and Accountability Act of 1996," *Health Affairs* 17 (1998): 25–42.

Pauly, M. V., and A. M. Percy, "Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets," *Journal of Health Politics, Policy & Law* 25 (2000): 9–26.

Rajan, S., "Publicly Subsidized Health Insurance: A Typology of State Approaches," *Health Affairs* 17 (1998): 101–117.

Stone, D. A., "The Struggle for the Soul of Health Insurance,". *Journal of Health Politics, Policy & Law* 18 (1993): 287–317.

Summer, L. *State-Subsidized Health Insurance Programs for Low-Income Residents: Program Structure, Administration, and Costs* New York, NY: American Academy on Aging and The Commonwealth Fund. 1998.

Swartz, K. "The Demand for 'Self-Pay' Health Insurance: An Empirical Investigation." Urban Institute Working Paper (3308-04). 1988.

Swartz, K., and D. W. Garnick. "Hidden Assets: Health Insurance Reform in New Jersey," *Health Affairs* 18 (1999a): 180–187.

Swartz, K., and D. W. Garnick. "Can Adverse Selection Be Avoided in a Market for Individual Health Insurance? Evidence from New Jersey," *Medical Care Research and Review* 56 (1999b): 373–388.

Swartz, K., and D. W. Garnick, "Regulating Markets: Lessons from New Jersey's Individual Health Coverage Program," *Journal of Health Politics, Policy & Law* 25 (2000a): 45–70.

Swartz, K., and D. W. Garnick, "Adverse Selection and Price Sensitivity When Low-Income People Have Subsidies to Purchase Health Insurance in the Private Market,". *Inquiry* 37 (2000b): 45–60.

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