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POLICY NOTE

Is health insurance different than other types of insurance?

By Dr. Roger Stark, Policy Analyst, Center for Health Care January 2018

Key Findings

1. True insurance is designed to mitigate risk.
2. People view health insurance differently than they do other types of insurance. When people say they have "great health insurance," what they mean is that their insurance covers everything, with essentially no out-of-pocket expense.
3. The health insurance industry began early in the 20th century in the U.S. and within several decades was accepted and well established.
4. Congress passed the McCarran Ferguson Act in 1945 which gave states regulatory control over the insurance industry.
5. Employers and the government, through Medicare, Medicaid, and Obamacare, pay for and control 85 percent of the health insurance market in the United States.
6. Solutions to the current health care crisis in America should be based on reforms that introduce more free market ideas in all the various types of health insurance, both private and government-run.
7. Health insurance should be available in a free voluntary and open market place, just like auto and home-owners insurance.

Introduction

Every year millions of Americans buy auto, home, and life insurance from national companies in competitive market places. People are savvy shoppers and have multiple choices when buying these types of insurance.

Insurance is defined as "a practice or arrangement by which a company or government agency provides a guarantee of compensation for specified loss, damage, illness, or death in return for payment of a premium."[1]

Since the future is unknown, insurance is designed to mitigate risk. An insurance company sells policies to a large number of people who then comprise an insurance pool. If a bad event happens to a member of the pool, the insurance company pays that individual for the aspects of that event that are covered by the insurance policy.

However, people often view health insurance differently than other types of insurance. When a person says he has "great health insurance," what he actually means is that his insurance covers nearly everything related to receiving health care, with essentially no out-of-pocket expense. Covered services can include dental treatment, eye wear, and routine visits to the doctor. This is analogous to a person having auto "insurance" that pays for routine maintenance services, including gas, oil, and brakes.

Obviously, the human body is different from a car or house. However, from an insurance standpoint, which involves assessing and mitigating risk, health insurance is not fundamentally different from auto and home-owners insurance. The reasons health insurance should be understood as a way of assessing risk and preparing for possible future events, and why this fact is important to the public debate, are discussed in this paper.

History of insurance in the United States

Benjamin Franklin formed the first insurance company in the United States in 1752 to compensate customers for fire damage to their homes.[2] Growth of the insurance industry mirrored the expansion of the U.S. economy throughout the 18th and 19th centuries. Unfortunately,

1 "Google dictionary," at https://www.google.com/search?rlz=1C1GGRV_enUS751US751&q=Dictionary.

2 "The history of insurance in America," by Andrew Beattie, Investopia at https://www.investopedia.com/articles/financial-theory/08/american-insurance.asp.

a number of small, opportunistic, and underfunded insurance companies took people's money and then went out of business, leaving their customers uninsured.

In response to this problem, government regulation of the insurance industry began in the mid-1800s and varied from state to state. These regulations proved to be complex and ineffective. Insurance companies, dealing with large claims and increased competition, sought federal oversight of the industry to create consistency and stability in the sale of insurance.[3]

In 1868, the United States Supreme Court weighed in with its ruling in Paul versus Virginia. The plaintiff argued that a Virginia law requiring out-of-state insurance companies to post a large bond in order to do business in the state was illegal because it interfered with interstate commerce. The court upheld the Virginia law and thus gave states control over regulating the insurance industry. This ruling set the legal precedent for the next 80 years.

The sale of health insurance began in the early 1900s in the U.S. and within several decades was accepted and well established. Many of the early health plans were set up as pre-payment for major medical expenses, similar to current health maintenance organizations (HMOs).

By the mid-20th century, however, the insurance industry in general was consolidating and in many respects was becoming monopolistic. A second important U.S. Supreme Court decision, the 1944 United States versus South-Eastern Underwriters Association, re-examined the federal role in insurance regulation. Several insurance companies formed a six-state association, set pricing, and essentially formed a monopoly. The federal government sued the association.

The Supreme Court basically ruled that the sale of insurance did constitute interstate commerce and consequently could be federally regulated. The court went on to conclude that monopolistic associations such as the South-Eastern Underwriters violated the Sherman Antitrust Act and were further subject to federal oversight.

This second court ruling led to mass confusion, and by some reports chaos, in the insurance industry. Companies that had lobbied strongly for federal oversight now viewed state control as the lesser of two evils.

McCarran Ferguson Act

The insurance industry desperately sought clarification on regulatory oversight. Congress took up the issue and passed the McCarran Ferguson Act in March 1945. The law does several things – it gives states the power to tax and regulate insurance companies, gives state authority precedence over federal authority, and allows the use of the federal Sherman Antitrust Act only in cases of clear monopolistic behavior.

Members of Congress have understood the limitations that the McCarran Ferguson Act places on health insurance consumers. The U.S. House of

3 "Insurance and antitrust law: The McCarran Ferguson Act and beyond, " by Alan Anderson, William and Mary Law Review, Volume 25, Issue 1, 1983, at http://scholarship.law.wm.edu/cgi/viewcontent.cgi?article=2189&context=wmlr.

Representatives voted in March 2017 to repeal the law with a bipartisan vote of 416-7.[4] Specifically the House bill would have reinstated the potential for antitrust action, while theoretically leaving states the control of the insurance industry. The impact of the bill would have been that health insurance companies could face both state and federal antitrust lawsuits. The U.S. Senate has not yet passed repeal or reform of the McCarran Ferguson Act.

Health insurance – exceptions to state regulation

Since 1945, states have retained control of the insurance industry in general. Health insurance, however, has some huge exemptions. Employer-paid health insurance falls under the federal ERISA laws and is not subject to state regulations. Employers purchase health insurance in a private market place that is different from the individual and small group market. Half of all Americans receive their health insurance through their employer or their spouses' employer.

Medicare is a federal health insurance plan for seniors that began in 1965 and is heavily regulated by federal law. States can control supplemental and co-insurance, but Medicare is clearly a federal program. Fifteen percent of Americans are enrolled in Medicare.

Medicaid also began in 1965 and is a combined federal and state entitlement health insurance program for low-income people, the disabled, and people requiring long-term care. Although state taxpayers fund a substantial part of Medicaid, most regulations and control of the plan are under the federal government. The vast majority of enrollees have no out-of-pocket expenses. Twenty percent of Americans have Medicaid as their health insurance.

The health uninsured rate is now between five to ten percent of Americans, which leaves five to ten percent of people in the individual health insurance market. From a health insurance standpoint, it is this individual market that is subject to the McCarran Ferguson law.

National market places for insurance

Most Americans purchase auto and home-owners insurance from national companies, yet because of the McCarran Ferguson Act, companies are regulated by individual states. Every plan sold must conform to the laws and regulations of the state where the insurance is purchased. Pricing, however, can reflect the overall size of a company and the number of people nationally in the company's risk pool.

Auto and home-owners insurance have a good deal of uniformity across state lines. Pricing and compensation amounts may differ, but the required coverage mandates are very similar from state to state.[5] This is much different from health insurance, where special interest groups have encouraged state officials to expand the number of benefit and provider mandates included in plans. There is also a

4 "House passes McCarran Ferguson repeal bill," by Jennifer Webb, Insight + Analysis for the Independent Agent, March 23, 2017, at https://www.iamagazine.com/news/read/2017/03/23/house-passes-mccarran-ferguson-repeal-bill.

5 "GEICO home page," at https://www.geico.com/information/states/ca/, accessed November 20, 2017.

great deal of variation in the number of mandates from state to state.[6] For example, Washington state has over 50 mandates, whereas Idaho has fewer than 20. As a result, health insurance consumers are often forced by state laws to buy coverage they don't need and don't want. Obamacare compounds this issue by requiring ten "essential health benefits" in most health insurance plans sold in the country.

Although Blue Cross, Blue Shield, and private companies such as Aetna are national health insurance companies, their risk pools and pricing are set on a state or regional basis, not nationally.

Employers, especially large companies, can shop nationally for health insurance because of the federal ERISA laws. Although most employer plans are very generous, they are not subject to the specific health insurance mandates in any particular state.

Policy analysis

Medicare and to a lesser extent Medicaid have greatly distorted the health insurance market place - it is impossible for private companies to compete against a government-owned monopoly. Consequently, there is no private market for health insurance for seniors and low-income Americans. Both Medicare and Medicaid give enrollees medical coverage with no, or very little, out-of-pocket payments from the enrollee.

Private insurance pays providers 75 percent more than Medicare pays.[7] Medicaid payments are even lower. The entitlement pays at most only 90 percent of what Medicare pays providers. These low government payments cause doctors, hospitals, and clinics to shift costs, in the form of higher prices, to individual and employer-paid insurers.

Medicare and Medicaid are financially unsustainable in their present forms. In an effort to salvage the programs, the government continues to decrease provider payments using various methods such as "quality of health care over quantity" and provider payments based on satisfactory (as determined by the government) outcomes.[8]

Employer-paid health insurance distorts the market as well. Employees are isolated from the true costs of health care because their employer pays the majority of the insurance premium expense.

Consequently, 85 percent of Americans are in health insurance plans that involve a third-party, or someone else, as payer. This is obviously a very different

6 "State insurance mandates and the ACA essential benefits provisions," National Conference of State Legislatures, October 13, 2017, at http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx#Appendix 3.

7 "The growing difference between public and private payment rates for inpatient hospital care," by T.Selden, Z. Karaca, P. Keenan, C. White, and R. Krowick, *Health Affairs*, December 2015, at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.0706.

8 "Slumping Medicare margins put hospitals on precarious cliff," by Virgil Dickson, *Modern Healthcare*, November 25, 2017, at http://www.modernhealthcare.com/article/20171125/NEWS/171129969/slumping-medicare-margins-put-hospitals-on-precarious-cliff.

situation from auto or home-owners insurance, where individuals know to the dollar the cost of their coverage, because they find and pay for their own insurance.

If someone else pays for a service, there is a high likelihood people will use more of that service than they would if they paid with their own money. They will also not be price-conscious and will not feel compelled to shop for the best deal, as they do with auto and home insurance.

Recommendations and solutions[9]

There is no disagreement with the idea that people need health insurance, even though simply having insurance does not guarantee timely access to health care. Many countries with universal health insurance also have rationing and long wait times to see providers that would be unacceptable to most Americans.

The problem is how to reform the health insurance industry effectively. The free market has proven to be the most efficient, the most practical, and the fairest economic model because it allows people to choose the goods and services that are best for them. Solutions to the current health care crisis in America should revolve around reforms that introduce more free market ideas in all the various types of health insurance, both private and government-run.

- **Insurance regulatory reform**

Policymakers should change how they view health insurance. Instead of imposing government-mandated "insurance" and entitlement programs that attempt to cover every possible health-related activity, health coverage should work like auto and home-owners insurance. Just as it makes little sense to use insurance to pay for gas or to mow the lawn, policymakers should move away from the idea that health insurance should cover all our health-related events.

True indemnity insurance should be available for catastrophes and emergencies. Routine day-to-day health services should be paid for out-of-pocket as needed.

We have a good policy mechanism to do this today through the use of health savings accounts (HSAs). These tax-free accounts require a person or family to purchase a high-deductible catastrophic policy to cover high-dollar medical expenses, but allow tax-advantaged savings to be used for day-to-day medical-related purchases. Tax-free savings accumulate from year to year and the balance in an individual's personal account can be taken from one job to another.

- **Eliminate costly mandates**

Part of insurance reform would be to eliminate provider and benefit mandates imposed by government on insurance plans. Mandates set by government officials and policymakers now restrict patient choice in the purchase of health insurance. Washington state currently imposes 58 benefit and provider mandates. These go far beyond the 10 mandates required in the federal Affordable Care Act.

9 "Health care reform: lowering costs by putting patients in charge," by Roger Stark, MD, Policy Brief, Washington Policy Center, June 2015, at https://www.washingtonpolicy.org/library/docLib/Stark-_Health_care_reform_and_alternatives_to_the_Affordable_Care_Act.pdf.

Supporters of mandates say no one can predict a patient's future needs, so the government should force people by law to buy expensive coverage. That is true, but a catastrophic, high-deductible insurance plan can be designed to cover any future major medical expense.

Affordable auto and homeowner insurance policies, except in very unusual circumstances, cover any and all major problems and provide individuals and families with millions of dollars of coverage should the need arise.

Mandates are a classic example of politically powerful interest groups lobbying elected officials to include payment for their services in every insurance policy. Mandates restrict competition, drive up prices and greatly restrict choices for patients.

A reasonable first step would be to allow the interstate purchase of health insurance. Patients would see a huge increase in their choices and the voluntary market would become much more competitive. This would undoubtedly require reform or repeal of the outdated McCarran Ferguson Act at the federal level.

- **Price transparency in health care**

For patients to become informed consumers of health care, they must first know the true price of the services they receive. Doctors and hospitals should publish their prices and compete openly, not only on quality, but also on retail prices. When people spend their own money, they become smart shoppers. This would be true of health care too.

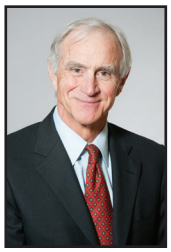
This shift would be a major change for providers and patients, but in other areas of life, Americans have a long history of consumerism. Through consumer-reports, second opinions, the internet and other tools, most patients would learn to make wise health care decisions.

- **Change the tax code to reduce dependence on employer-provided coverage**

Employer-paid health insurance is a firmly established tradition in the U.S. because the tax code rewards employers, but not individuals or families, in buying health insurance. This has caused a huge distortion in health care spending, because most employers are ill-suited to make sensitive choices about health coverage for their employees.

Everyone wants a healthy workforce, yet employers do not pay for other necessities of a healthy life, such as food, shelter and clothing. To allow individuals to control their own health care dollars, the tax code should be changed to let all individuals take the same tax deduction for health insurance costs that employers have had for 70 years. A change in mind-set is also needed to eliminate the idea that employers should provide employee health coverage.

Employer-paid health insurance is an example of tax policy dictating health care policy. Similar proposals include federal law providing a level of insurance premium support or earned tax credit. The details of the various reform proposals differ, but the core concept is based on patients as consumers controlling their own health care dollars.



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- **Medicare reform**

As a country, we have a moral obligation to seniors already enrolled in the program and to those approaching retirement age.

As it stands now, there is, understandably, no private health insurance market for seniors. Any normal market was eliminated long ago by Medicare. It is virtually impossible to compete with the government, which has monopoly power and an unlimited ability to fix prices and lose money while any potential competitors go out of business.

The private market for the elderly could be resurrected by allowing people to opt out of Medicare voluntarily and allowing these seniors to purchase HSAs and high deductible health plans.

- **Medicaid reform**

The most important first step to reforming the federal Medicaid program should be to redesign it so it no longer functions as an open-ended entitlement. Medicaid recipients should have a co-pay requirement based on income. Where applicable, enrollees should have a work requirement.

Like welfare, Medicaid should be viewed as a transition program to help low-income families achieve self-confidence, economic independence and full self-sufficiency. Allowing them to control their own health care dollars through subsidized HSAs or a voucher system would financially reward enrollees for leading a healthy lifestyle and making smart personal choices.

Local control of the management and financing of entitlement programs works best. States, rather than the federal government, should be placed in charge of Medicaid. Block grants and waivers from the federal government would allow states to experiment with program design and to budget for Medicaid more efficiently.

States have expanded the income eligibility for Medicaid enrollment. The income requirement should be dropped from the current 200 percent to 300 percent of the federal poverty level and returned to the original 133 percent. Medicaid should not be a taxpayer subsidized "safety-net" for middle-income people.

Conclusion

To control costs, increase choice and maintain or improve quality, patients must be allowed to control their own health care dollars and make their own health care decisions. Insurance is an integral part of health care and individual financial security.

Health insurance should not be treated as a price-controlled government entitlement; it should be available in a free, voluntary, and open market place, just like auto and home-owners insurance.