Ideas in Action

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Insuring an End to Montana's Health Care Crisis

Introduction

Small businesses and individuals are struggling to keep up with health insurance premium increases. There is a general feeling that costs are rising, while quality declines. Montana has a number of options for restoring accountability, transparency, and integrity in health insurance.

Health insurance and health security is eroding in Montana

Health insurance premiums continue to rise — and small businesses are feeling the squeeze

Health insurance rates are rising in the double digits,[1] and small businesses are being priced out. The smaller a business in Montana, the less likely it is to offer health coverage to any of its workers.[2] Yet because of inadequate transparency in the health insurance market, it is hard to determine exactly why premiums are increasing at such a rapid pace.

Increasing numbers of uninsured and underinsured Montanans

One in five Montanans below age 65 is uninsured,[3] and there is also growing concern about "underinsurance." This occurs when a person has health insurance, but cannot get needed care because of high out-of-pocket costs or coverage limitations. For example, many individuals and small businesses must opt for high-deductible plans because premiums are rising so rapidly.

Lack of continuous health insurance is linked to poorer health and increased chance of premature death.[4] Being uninsured or underinsured also puts a person at risk of financial ruin. A 2003 survey found that 21 percent of uninsured Montanans had accumulated medical debt in the prior 12 months.[5] When people are uninsured or underinsured, their health care needs do not go away. But the costs of increased use of emergency rooms and uncompensated care burdens health care providers, and costs are often passed onto the insured and state budgets.

Overview of Montana's Health Insurance Markets and Regulation

Insurance and spreading risk

The purpose of insurance is to spread risk among many people, making the costs of health care more predictable. Risk-spreading helps everyone in the "pool" protect themselves from the catastrophic costs of a health setback, contributing to both physical and financial health.

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Insurance companies and risk segmentation ("cherry-picking")

Insurance is less successful when it does not do a good job of spreading risk. A common industry practice is "risk segmentation." This involves treating enrollees or potential enrollees differently according to whether they are expected to need health care. This is also referred to as "cherry-picking," because insurance companies hope to attract young, healthy people and limit coverage of older people and people with health conditions. Risk segmentation undermines the purpose of insurance. It involves charging people more or denying coverage based on a person's health status. This is the opposite of spreading risk among many people.

Regulation of insurance in Montana

Montana's health insurance market is divided into the large group, small group, and individual markets. Regulation focuses on the small group market and, to a much lesser degree, the individual market. For both markets, the State Auditor's Office has very limited tools for protecting small businesses and individuals from rate increases and risk segmentation.

Montana's small group health insurance market

The following are some requirements that apply to health insurance companies selling policies to Montana small businesses (those with two to 50 eligible employees):[6]

- An insurance company must offer all small group policies to any small employer that applies for coverage, agrees to pay premiums, and meets other requirements set by the insurer. (Montana law places some limitations on the additional requirements insurers can set. For example, insurers may not use health status or claims experience as a basis for steering a small employer into one of the insurer's classes of business as opposed to another.)[7] If an insurance company sells insurance to a small business, it must offer coverage to everyone in the group.[8]
- Under Montana's rate band system, an insurance company establishes an index rate for similar employers seeking the same or similar coverage, and may charge a small employer up to 25 percent more or up to 25 percent less than the index rate.[9] For example, the insurer may charge $375 dollars for coverage with an index rate of $300 and a base rate of $225.
- For a new rating period, an insurer may set an overall rate increase for that health plan and apply that increase to the small business. (For example, if the carrier raises the overall rate by 20 percent, it may raise the small business' premium by 20 percent.) In addition, the carrier may raise premiums by up to 15 percent a year based on a small business' claims experience, health status, or duration of coverage.[10] The carrier may not refuse to renew coverage based on the health status of a member of the group.[11]
- The insurance company may impose a preexisting condition waiting period of up to 12 months, as long as it credits people for recent, previous coverage.[12]

Montana's individual health insurance market

When individuals cannot get insurance through an employer, often the individual market is their only option for coverage. The following are some of the requirements that apply to health insurance companies selling individual policies in Montana:

- Generally, an insurer may refuse to issue an individual product based on a person's health status (such as a chronic condition).[13] If the insurer provides coverage, it may impose restrictions on a person's health status.[14] Once a person is enrolled in an individual policy, that coverage may not be discontinued based on health status.[15]
- Even the weak limitations of the +/- 25% rate band do not apply to the individual market.

Small group limits on renewal rate increases also do not apply to the individual market.[16]

- Insurers in the individual market must offer a uniform health benefit plan. Coverage may include a deductible of up to $1,000 for an individual or $2,000 for a family and 50 percent coinsurance on many services (such as preventive services and well-child care).[17]
- Individuals who cannot get individual market coverage-or who can get coverage only with a restrictive rider-may be eligible for the Montana Comprehensive Health Association (MCHA).[18] MCHA plans have deductibles ranging from $1,000 to $5,000.[19] For the $1,000 deductible option in the traditional plan, premiums begin at $166 a month for a child under age 18 and run to $933 a month for a person aged 64 or over. A 40-year-old must pay $438 a month for the plan.[20]

Montana's health insurance law still has many gaps

The State Auditor has no oversight over general rate increases

Currently, there are no real limitations on the overall rates health insurers may set for their policies. The State Auditor's Office has been granted no authority to investigate why health insurers are raising overall rates and to intervene to protect the interest of the public. This authority is especially important in health insurance markets, where there is little competition and regulatory intervention can inject competition back into the market.

The rating rules allow insurance companies to price individuals and small businesses out of the market based on their health care needs

Montana law does not place rating limits on whether an insurer can charge more for an individual product based on health condition.[21] In the small employer market, Montana's 25 percent rate band and renewal provisions let carriers take health status into account and charge small businesses very different premiums for the same coverage. When carriers charge more based on health status, they shift risk onto the sick and onto small businesses that employ people with health conditions. This shifting of risk is contrary to the purpose of insurance.

There is inadequate transparency in health insurance products and insurer practices

Both Montana insurance law and carrier practices are extremely complex, undermining transparency in the market. Transparency in insurance policy pricing and insurer practices is essential for maintaining a competitive market. Without it, policyholders cannot get clear information about rates, benefits, and such things as the percentage of a carrier's premium dollar spent on health care, as opposed to marketing, administration, executive compensation, or profit.

Four ways to address the health insurance crisis

Community rating. Community rating involves charging every policyholder the same premium, without increasing premiums based on a person's age, health status, gender, or other factors. Risk is spread most evenly under community rating. It also simplifies the rating structure and increases the transparency of insurance company rating practices.

Prior approval and oversight over general rate increases. Under prior approval, rate increases are subject to review based on a generally applicable standard. Montana insurance law bars some classes of insurers from charging rates that are "excessive, inadequate, [or] unfairly discriminatory."[22] Yet this standard has not been extended to health insurance.[23] Furthermore, Montana's small business health insurance law explicitly prohibits the State Auditor from requiring small employer insurers to obtain approval of rate increases before they raise them.[24]

Public hearings. Public hearings with full public participation help ensure that the public interest is taken into account when rates are reviewed. An open public hearing system, with full notice and access to clear and accessible rate

filings, permits consumers to help maintain a well-functioning health insurance system.

Public disclosure. Information is key to decision-making, and markets function best under conditions of transparency. Consumers need clear information about prices and rate increases, covered services, how premium dollars are used, indicators of customer satisfaction, and other factors. This information equips potential policyholders to make choices and contribute to a competitive health insurance market.

Conclusion

Montana is experiencing a health insurance crisis that threatens the physical and financial well-being of the state. The hands of lawmakers are not tied, however. Montana has a number of options for restoring accountability, transparency, and integrity to its health insurance system.

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1 Kaiser Family Foundation & Health Research and Educational Trust, *Employer Health Benefits 2004 Annual Survey*, 2004, available at: www.kff.org.

2 Montana Statewide Study of the Uninsured State Planning Grant, Department of Public Health and Human Services, Final Report: Household Survey and Employer Survey Findings about Health Insurance Coverage in Montana, February 2004, p. 18. [Hereinafter referred to as State Planning Grant Report.]

3 Kaiser Family Foundation, State Health Facts, Table: "Montana: Distribution of Nonelderly 0-64 by Insurance Status, State Data 2002-2003, U.S. 2003, available at: www.statehealthfacts.org.

4 Institute of Medicine, *Care without Coverage: Too Little, Too Late*, 2002.

5 State Planning Grant Report, p. 12.

6 Montana Code Annotated § 33-22-1803(2003). "Eligible employee" is defined in section 33-22-1803(12)(2003).

7 Montana Code Annotated § 33-22-1811(2003).

8 Montana Code Annotated § 33-22-1811(3)(e)(1)(2003). The group includes eligible employees and their dependents.

9 Montana Code Annotated § 33-22-1809(1)(b)(2003).

10 Montana Code Annotated § 33-22-1809(1)(c)(2003). Rates may also be increased based on change in coverage or in case characteristics.

11 Montana Code Annotated § 33-22-1810(2003).

12 Montana Code Annotated § 33-22-1811(3)(2003). In the case of a "late enrollee," this waiting period may be 18 months.

13 Karen Pollitz, et al., Georgetown University Institute for Health Care Research and Policy, "A Consumer's Guide to Getting and Keeping Health Insurance in Montana," January 2001, p. 13. [Hereinafter referred to as "Consumer's Guide."]

14 Montana Code Annotated § 33-22-109 & 33-22-246(2003). Consumer's Guide, p. 14. Restriction include both "elimination riders" and preexisting condition waiting periods. Elimination riders are amendments to the health insurance contract to exclude coverage for a condition, body part, or system. They can last indefinitely. The Health Insurance Portability and Availability Act (HIPAA), a federal law, places some limitations on preexisting condition waiting periods for eligible individuals.

15 Montana Code Annotated § 33-22-247(2003). This limitation does not apply to disease-specific policies. "Consumer's Guide," p. 15.

16 National Association of Health Underwriters, "State Level Health Insurance Reforms/Rating," n.d., available at: www.nahu.org.

17 Montana Code Annotated § 33-22-245(2003). *See also*, New West Health Services, "Uniform Plan: Outline of Coverage," January 2002, available at: www.newwesthealth.com.

18 Montana Comprehensive Health Association, "Eligibility Requirements," n.d., available at: www.mthealth.org. Other categories of people may also be eligible.

19 Montana Comprehensive Health Association, "Plan Descriptions & Descriptions of Benefits," n.d., available at: www.mthealth.org. The sliding-scale pilot plan, which is subsidized, is currently closed.

20 Montana Comprehensive Health Association, "Traditional Plan Schedule of Payments," n.d., available at: www.mthealth.org. Rates are effective January 1, 2005.

21 National Association of Health Underwriters, "State Level Health Insurance Reforms/Rating," n.d., available at: www.nahu.org.

22 Montana Code Annotated § 33-16-201(1)(a)(2003).

23 Montana Code Annotated § 33-16-103(2)(2003). A standard for rates exists for certain Medicare supplemental plans. They "must return to policyholders or certificate holders benefits that are reasonable in relation to the premium charged." Montana Code Annotated § 33-22-906(1)(2003).

24 Montana Code Annotated § 33-22-1809(6)(2003).