Commercial Health Insurance: Smart Or Simply Lucky?

Transferring responsibility for public coverage to private insurers is unlikely to rein in escalating costs.

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ABSTRACT: Changes in the commercial health insurance industry are less a strategic shift than a defensive reaction to forces the industry cannot control and risky opportunities the industry cannot pass up. Diversification into the public sector presents short-term gains for the insurance industry but leaves unchanged the fundamental challenge it faces: rapid and apparently uncontrollable growth in health care costs. Commercial insurers have not proved to be any better than public payers at controlling costs. Unfortunately, unless the drivers of health care cost are tamed, the main benefits that people seek from insurance—stable coverage and financial protection—will erode further. [Health Affairs 25, no. 6 (2006): 1490–1493; 10.1377/hlthaff.25.6.1490]

The paper by James Robinson ably documents the evolution of the health insurance market in recent years. What it does less well is explain the underlying cause of those trends and what they might mean for public policy.

In this commentary I suggest that changes in the commercial health insurance industry are less a strategic shift than a defensive reaction to forces the industry cannot control and opportunities it cannot pass up. Although the commercial health insurance industry will survive, its future might be more troubled than Robinson predicts. Furthermore, despite its survival, the main benefits it provides to people—stable insurance coverage and financial protection—could disappear.

Employers: Retreating, Not Rejected

The fact that employment-based coverage is eroding is indisputable. The total number of people with group coverage understates these trends because the population continues to grow. In fact, a smaller share of the nonelderly had employment-based health insurance in 2004 (62.4 percent) than in 1994 (64.4 percent), and the recent decline is even sharper, considering that the percentage increased until 2000 (66.8 percent). The declines in coverage have been particularly notable among small employers. Employers also are much less likely than before to provide coverage for their retirees. Between 1988 and 2005, the share of large firms (200 or more employees) with retiree health coverage declined by half, from 66 percent to 33 percent.4

For a while, employers sought to moderate costs by encouraging enrollment in managed care plans. However, backlash from providers, consumers, the press, and policymakers led them to favor more loosely structured pre-
ferred provider plans and, more recently, various forms of high-deductible plans that put the onus of health care costs more squarely on employees. Robinson suggests that the commercial health insurance industry is accommodating these trends in its willingness to sacrifice business to preserve earnings. However, one could argue that commercial insurers don’t have much choice. Employers—not commercial insurers—bear the real burden of health care inflation. An increasing number are refusing to bear the expense of health insurance for their employees, especially as it continues to grow, and refusing to resist efforts to rein it in.

**Insurers: Benefiting More From Luck Than Strategy?**

The downturn in the employment-based sector of the insurance industry coincided with a change in political fortunes that has led government to focus on boosting the role of private insurance companies in public programs such as Medicare and Medicaid—a fortuitous combination for the commercial health insurance industry. The industry capitalized on this by helping shape changes in public programs, especially Medicare.

**Medicaid.** The Medicaid market is driven by several factors—chief among them the role that states play in the program and the national ambivalence about financing means-tested programs and the poor. Enrollment fluctuates with the economy, leaving states facing budgetary uncertainty. Risk-based managed care plans are attractive to states because they seem to offer greater budget predictability while also improving upon Medicaid’s historical problems with provider participation. Some large commercial insurers—for example, WellPoint and United-Health Group—have pursued this business, although often through specialized subsidiaries. As Robinson’s paper illustrates, however, Medicaid managed care remains heavily reliant on plans sponsored by providers that have historically cared for Medicaid patients and by private firms (such as Amerigroup, Centene, Molina, and Wellcare) concentrating almost exclusively on Medicaid.

**Medicare.** Medicare has attracted broader participation by commercial health insurers, particularly with the enactment of the new prescription drug benefit in 2006. In its authorizing legislation, Congress stipulated that beneficiaries must enroll in a private plan to receive this coverage, thus opening a large new market. Insurers have responded both with new freestanding prescription drug plans (PDPs) and selective expansion in the integrated Medicare Advantage (MA) plans, including both historically available and new options.

Most major commercial insurers are offering freestanding PDPs. Large commercial insurers such as Aetna, CIGNA, Coventry, United, and WellPoint offer nationwide plans, and other companies—including Humana, Sterling, United American Insurance Company, Pennsylvania Life Insurance, and Marquette—are nearly national in their coverage. Participation by Blue Cross and Blue Shield organizations is also extensive. Total enrollment in such plans was 16.2 million as of August 2006.

Potentially more lucrative (albeit risky) for commercial insurance plans are the expanded MA options authorized by Congress; these combine Medicare’s drug coverage with other Medicare benefits and supplemental coverage. Some commercial firms have historically avoided MA in favor of Medicare supplements that do not require them to build risk-based provider networks or accommodate fluctuations in payment rates that stem from Congress’s role in the program. Some firms, however, have benefited greatly from MA, especially United and Humana; together, they had 2.4 million enrollees in June 2006 and ac-
counted for 32 percent of MA’s 7.3 million enrollees. Further, the fastest-growing segment of the MA market today is private fee-for-service (FFS) plans. Private FFS enrollment grew to 802,068 by August 2006, up from 141,921 in September 2005. Humana and, to a lesser extent, United and WellPoint dominate enrollment in private FFS, but the relatively undemanding requirements of this option are attracting other insurers that might see it as a way to encourage retention of their current Medigap customers as the Medicare program changes. The Special Needs Plan (SNP) option also is attracting interest, in part from firms focused on Medicaid that see opportunities in new products for dual eligibles.

The Medicare Market: Opportunity Or Threat?

It remains to be seen whether commercial insurers will have any more success responding to the cost concerns of public payers than they did to those of private payers. Right now, Congress is encouraging commercial insurers to enter the market by sharing the risk for PDPs and selected MA products and by benchmarking plans’ MA bids to amounts that are 115 percent higher, on average, than Medicare itself pays for similar beneficiaries in traditional Medicare. In the face of budgetary concerns, such practices could be hard to maintain in the future. When payment increases do not keep up with inflation, history shows that firms either withdraw from the Medicare market or limit their offerings in ways that make them less attractive to beneficiaries. Wall Street places value on membership growth, but it also reacts quickly to concerns over reduced profitability. After Aetna announced, for example, that its second-quarter 2006 earnings declined from sixty-seven cents to sixty-five cents per share because of cost and competitive pressures, its stock price plunged 16.8 percent. In a 2005 Health Affairs paper, Donald Moran characterized the Medicare drug benefit as “the last hurrah of the old order...after which public policymakers...will struggle mightily to maintain existing coverage, let alone expand it.”

Private Goods, Public Interest

Whether publicly or privately administered, health insurance has a sizable impact both on its customers and on broader public policy concerns. With health care costs averaging $6,280 per person in 2004, few Americans can risk being without coverage, although the latest data show that around 46.6 million end up that way. According to one national study, the average family spent $1,245 out of pocket on health care (excluding insurance) in 2001–02. At the same time, 11 percent of families spent more than 10 percent of their family income on out-of-pocket health care costs, up from 8 percent in 1996–97. When insurance costs also are included, health care costs exceed 10 percent of income for 18 percent of families. Furthermore, high out-of-pocket spending tends to be concentrated in many of the same households year after year. High costs of health care don’t just threaten people’s ability to access care and maintain financial solvency, they adversely affect everyone—putting pressure on the safety net, adding uncompensated care for providers, and limiting the nation’s overall productivity.

Rapid growth in health care costs threatens to reduce coverage and financial protection by making health insurance increasingly expensive. Policymakers who perceive that they can rein in the rapid growth in spending within public insurance programs such as Medicare and Medicaid by transferring responsibilities to commercial health insurers will be disappointed. Analysts comparing historical growth in per capita spending for Medicare and private insurance between 1970 and 2000—when the former was mainly a government-run program and the latter was provided by commercial health insurers—found that, on average, the private sector grew no more slowly than Medicare and in fact grew faster on some measures. It is a serious mistake to assume that the cost problems plaguing our health system can be solved by changing the players rather than the rules of the game.
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NOTES


4. Ibid.


