

Practical Pooling

Bryan Dowd

Division of Health Policy and Management
School of Public Health
University of Minnesota

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What I want from my health plan

First, some things related to *health services*

- A. Prevent me from going to the doctor of my choice. (Plans have data on provider price and quality. I don't.)

- B. Interfere with the practice of medicine. (Plans have data on medical effectiveness. I don't.)
 - 1. Structure coverage to discourage ineffective care (including no coverage at all).
 - 2. Reward adherence to appropriate guidelines.
 - 3. Reward achievement of better health outcomes.

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- C. Reward me for taking steps to stay healthy.
- D. Negotiate provider fee discounts. (Notice this is last.)

But let's lay those *health care services* points aside and focus on the market for health *insurance*.

What do I want from the health insurance market?

- A. Long-term premium protection against risk redefinition ...
- That does not necessarily imply full community rating.
 - For example, I don't need premium protection against aging.
- B. ... that is portable (within the U.S.)
- That does not imply protection against geographic variation in costs, types of plans, or availability of providers in one market versus another.

What do I want from the health insurance market?

- C. That gives me *choices* among health plans during an annual open enrollment period.

Good News and Bad News

The good news :

I have all those health *insurance* features now, as long as I continue to work for the University of Minnesota.

The bad news :

I might lose my job, or want to become self-employed. In that case, if I have cancer, it all goes away, despite the fact that I have been paying community-rated premiums for nearly 30 years. Bad for me, and probably bad for the economy.

What I would have to do to get what I want

Exactly what I do now.

- Maintain continuous enrollment in the pool whether I'm healthy or sick, and thus ...
- Be willing to subsidize random illness events in others, even if the consequences for them are long-term, and I remain healthy.
- But attempts at pooling in the individual and small group market have not been terribly successful. (A somewhat controversial point.)

A Pressing Problem

In my opinion, the failure of the private health insurance industry to offer this product is the most compelling rationale for a national “public” health insurance plan and the source of most horror stories (or tied with claims denials for first place).

The private sector needs to solve this problem, perhaps in cooperation with government.

Example: The MEIP Pool

Minnesota established a pool for small groups (2 or more employees) in 1992. It offered everything I would want. **It closed in 1997. Why?**

1. Possibly because the policies were too generous and thus too expensive.
2. Possibly because out-of-pool sales picked off the healthy groups.
3. Possibly because of insurance reforms in the small group market.

The usual story about failed pools

- Everyone enters the pool at an actuarially fair premium. Equal risks pay equal premiums.
- In the “second period,” some people get sick and others don’t.
- The healthy are quoted a lower “second-period” experience-rated premium than the community-rated pool premium, and they leave the pool.
- Long-term risk protection evaporates.
- Horror stories ensue. Is anything wrong with this story?

Is there a public policy problem?

Maybe there are structural barriers (e.g., antitrust or restrictions on cross-state insurance sales) or maybe people:

1. Don't understand the choices that they have? (LIKELY)
2. Understand the choices, but act irrationally?
(POSSIBLY, BUT A DEAD-END FOR ECONOMICS.)
3. Understand the choices and act rationally (i.e., they're risk preferring)?
(MAYBE, BUT IF SO, THEN THERE SHOULDN'T BE REGRET.)

Are we talking about temporally-limited rationality?

Policy options

1. If the problem is misunderstanding the options, the answer would be better consumer information campaigns.
2. If the problem is irrationality that leads to substantial regret, perhaps there is a role for paternalism. Let's hope not.
3. If there is temporally-limited rationality (Stop me before I accept an experience-rated premium again!) then the problem gets interesting.

The key ingredient: “Glue”

The great advantage of employment-based insurance is that people generally are unwilling to change jobs in order to get a lower health insurance premium.

“Job lock” is the opposite: Unwillingness to change jobs because you might get a higher health insurance premium.

If we do away with employer-based insurance we will need another source of glue. Individual mandate/entitlement?

Potential sources of “glue” in the individual and small group health insurance market.

1. A minimum length of pool enrollment.

The Public Employees Insurance Pool (PEIP) in Minnesota requires a two year commitment and has been stable for nearly 20 years. But those are small government units.

Potential sources of “glue”

2. Non-refundable prepayment of additional premiums to encourage continued participation.

A penalty assessed at the time of exit.

Pauly, Mark V., Kunreuther, Howard and Richard Hirth.

"Guaranteed Renewability in Insurance," *Journal of Risk and Uncertainty* 10 (1995) 143-156.

Potential sources of “glue”

3. Loss of risk protection upon exit from the pool
– reassessment of risk if the person or group attempts to re-enter the pool.

A penalty assessed at the time of attempted re-entry.

Potential sources of “glue”

4. A late enrollment penalty – A penalty assessed at the time of first, delayed, entry.

Example: Part D’s late enrollment penalty for Medicare beneficiaries without creditable coverage.

A pool could install *all* these incentives.

Another proposal

“Health status” insurance policies that pay the premium increase due to deteriorating health status. Insurers can experience-rate all their enrollees. Subsidies are required for those already sick.

Cochrane, John H. "Time-Consistent Health Insurance," *Journal of Political Economy* 103:3 (1995) 445-473.

Cochrane, John H. “Health Status Insurance: How Markets Can Provide Health Security,” *Cato Institute: Policy Analysis, number 633* (February 18, 2009).

A Hybrid System

Could we preserve large-group insurance and add health status-neutral premium transitions the individual or small group market for those who want that protection? Maybe, but transitions between the large group market and the small group or individual market are problematic, likely requiring some subsidy at the start-up period (required by Cochrane, as well).

A Hybrid System

1. Insurers agree to offer a product that is sold at one health-status-neutral premium per product per insurer. Some exogenous, non-risk factors (e.g., age) may be ratable. (Same as multiple plan, large group agreement.) Some agreement on rating regulations will be required.

A Hybrid System

2. Insurers agree to take transfers from other health plans' similar products during open enrollment, given a history of continuous creditable coverage.

(Less demanding than current multiple plan, large group agreement, which includes taking new employees. But in this case, you wouldn't have the employment health-status screen.)

A Hybrid System

3. Employers could switch to portable products.
But will they want to? Does “glue” work to the employer’s advantage or disadvantage?
Healthy workers don’t leave because it’s not worth the trouble and sick workers don’t leave because they can’t (oversimplification).
4. What role would be left for employers in a portable system? Employees might prefer an option not offered by the pool, while employed.

Interesting questions

Start-up problems:

1. No problem for the healthy in the large group market as they already are subsidizing the sick. They're premiums should be fairly constant.
2. For individual and small group market – either experience rating at start-up or massive subsidies (e.g., Part D) to entice the healthy to participate.
3. The real problem is the currently sick in the large group market who are the receiving end of a health status subsidy. Again, subsidies need to continue.

Interesting questions

What is the rating basis of the new pool?

County of residence?

Who should run the pool?

In theory, anyone, and there could be multiple competing pools.

You might need risk adjustment among competing pools, however.