

# Fixing Private Health Insurance: Protection against Health Risk Redefinition

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October 21, 2009

# Staying Afloat in Leak-Proof Risk Pools

- Sizing up the problem
- Targeting funding
- Sound & sustainable high-risk pools
- New ground rules and stronger glue for longer-term pools
- Realigning compatible incentives

# Problems in Health Risk Pooling

- Insurers' unfair practices (refusing to cover, risk rating, covering too little)?
- Transitions in and out of ESI
- High loading costs, short time horizons
- Medically uninsurable vs. ability to pay vs. insecure
- Regulatory cross-subsidies vs. targeted & transparent assistance
- Confusing risk reduction w/ risk averaging

# Sizing Up the Problem: High Health Risk/Less Coverage

- Pauly/Herring: “Effect of Health Status”
- “Uninsurable” high risks
- High-cost persons (concentration, duration)
- Current state high-risk pools

# Pauly/Herring: Health Status & Risk Pooling

- No evidence: poor health = higher premium
- Guaranteed renewability limits reclassification risk
- Individ mkt works best for self-employed
- Coverage better, most stable for large groups
- Risk not signif predictor for changes in ins. Status
- Differences in pooling among ins mkt segments smaller than usually thought, much remains unpredictable
- More pooling in individ mkt than believed
- Risk rate first, then transfer subsidies to worthy

# Sizing Up the Problem: Underwriting High-Risks?

Estimates from the 2001 Medical Expenditure Panel Survey (MEPS) - Household Full Year Consolidated File

Roughly 2 million persons under the age of 65 said that they were denied health insurance coverage at some time.

The 2001 MEPS survey was the last MEPS survey to ask respondents about being denied coverage.

The number mentioned here does not necessarily represent individuals who were uninsured in 2001.

Numbers below relate to denial of insurance by health insurance status and medical reason for denial (person can state more than one reason).

All estimates are derived from the 2001 MEPS and are for persons under the age of 65.

# Underwriting High-Risks?

	Total	
Claiming denial of health insurance	1,980,000	(0.8 Percent of total pop under 65)
Denied due to diagnoses of cancer	200,000	
Denied due to hypertension	190,000	
Denied due to diabetes	410,000	
Denied due to coronary artery disease	140,000	
Denied other reason	1,210,000	

	Uninsured	
Claiming denial of health insurance	650,000	(1.3 Percent of uninsured under 65)
Denied due to diagnoses of cancer	60,000	
Denied due to hypertension	50,000	
Denied due to diabetes	150,000	
Denied due to coronary artery disease	40,000	
Denied other reason	230,000	

# High-Cost Persons Concentration & Persistence

Attenuation:

Top 1% nonelderly

- 31% total under-65 health \$ (1996)
- 24% total under-65 health \$ (2002)

Top 1% -- nonelderly in fair/poor health

- 25% total under-65, fair/poor health \$ (1996)
- 16% total under-65, fair/poor health \$ (2002)

MEPS Statistical Brief #81, May 2005

# High-Cost Persons Insurance Characteristics

## Top 5% below-65 health \$ (2002)

- 4% - uninsured
- 71% - private health insurance during yr.

## Bottom 50% below-65 health \$ (2002)

- 19% - uninsured
- 56% - private health insurance during yr.

MEPS Statistical Brief #73, March 2005

# High-Cost Persons Concentration over Two Years

All noninstitutionalized - fair/poor health  
(both 2005 & 2006)

- 3.8% of total population
- 22.1% share of those in top 5% health \$

Noninstitutionalized below 65 (2005-2006)

- 11.5% continuously uninsured
- 3.9% of continuously uninsured in top 5% health \$
- 16.6% of continuously uninsured in bottom 50% health \$

# Current State High-Risk Pools

- 35 states, 200,000 enrollees (2008)
- \$2 billion total state spending
- 3-yr avg length in HRP
- \$9437 – avg annual claim per enrollee
- \$485 – avg monthly premium
- 54% of HRP funds - enrollee premium contribution
- 23% of HRP funds - insurance carrier assessments

# Current State High-Risk Pools

- Average age – 49
- 28% enrollees HIPAA-eligible
- 28 states for HIPAA portability & g.i.
- \$41,000 - avg household income
- \$1593 - avg deductible
- 78% w/ OOP stop loss at \$5000 or less
- 14% enrollees w/income-based premium subsidies

# Expand HRPS?

- 4 million more (if one pre-ex condition) - GAO
- <1.5 million (assuming 8% med unins. enrolled) – Frakt, Pizer, Wrobel HCFR 2004
- \$ 16 billion, 2010-2019 – CBO
- 2.6 million (!% nonelderly med. unins.) – CAP 2008

# HRP Criticisms

- Still too costly for enrollees
- Or too costly for states & taxpayers
- Waiting periods, insufficient coverage
- Insufficient funds, someone else should pay
- Spoiling the big pool party



# The Case for Real Health Risk Protection

- Hold the acronyms
- Who else should be helped FIRST?
- Addressing separate policy objectives w/  
separate policy instruments
- Strengthening the rest of the market
- Concentrating resources & tools on most  
important, highest-cost cases
- Transparent, general revenue risk sharing
- Aligning incentives, curbing game playing

# The Case for Real Health Risk Protection

- Buying a “get out of regulatory jail” card
- Living in a non-universal mandate world
- Incentives to reduce risk, with realistic limits
- Less restricted pricing expands supply
- Censor the tail; loosen up the rest; &  
leave us alone

# How to Do It Right

- Fills gaps in current law & policy  
(ESI, HIPAA, g.r. pooling, Medicaid)
- Substantial federal dollar investment
- Capped appropriation, fed/state match
- Avoid mission creep
- Full, prominent disclosure; outreach
- Setting sustainable parameters

# How to Do It Right: Parameters

- Premium caps (150% vs. 200% standard)
- Eligibility events:
  - Rejection, high premium, conditions
- Third-party monitoring of underwriting
- Risk rating below cap
- Competitive, external administration
- Multiple, but not excessive, coverage choices
- Separate income-related subsidies
- Partial cost offsets

# How to Do It

## Bells & Whistles

- Special incentives (DM, CM, carve-out, multi-year, general revenue)
- Invisible among plans, or more centralized?
- Additional risk sharing (ex ante)
- Appeals, sanctions
- Bolster continuous coverage incentives
- Waiting periods, delayed enrollment penalties
- New entrants: one-time underwriting
- Out-of-state contributions if competitive federalism

# Price Tag?

- Gazillions?
- \$37B annually?
- \$20-25B seriously (50-50)

# Portable Protection against Risk Redefinition

- Once upon a time, in lifetime employer land
- HIPAA – stay in the club
- Shallow pools
- Front-end community rated purchasing pools
- Instead of tightening regulatory ratchet ...

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# Climbing the Walls around Risk Redefinition Pools

- Pauly/Herring: incentive compatible guaranteed renewability
- Cochrane: time consistent insurance
- Dowd/Feldman: tax treatment, experience rate up front, mutual unknown pooling thereafter

# New Rules for New Pools?

## Challenges

Dowd/Miller: LTRP

- Premiums relative to health risk
- How risk averse?
- Pools change over time
- Employment less binding
- Long-term contracts
- Applying binding glue

# Glue for Less Risk-Sensitive Pools

- Harder in individ & small group mkt
- Enforceable contract – minimum length
- Delayed enrollment penalty
- Front-loaded premiums, nonrefundable?
- Large subsidies
- Price discounts
- Exit payments, re-entry penalties
- Inertia, limits of risk rating
- Limited open seasons

# LTRP Options

- Make an attractive offer
- Parallel universe, w/exclusive subsidies
- Portability limits
- Pool to pool handoffs, interstate
- Creditable coverage (filling in HIPAA)
- Pool at catastrophic level
- Single insurer/multiple products, periodic rebid
- Risk adjustment
- Standard floor w/o ceiling

# Glue for Less Risk-Sensitive Pools

- Coercion vs. contract
- Induce vs. compel
- Lengthen time horizon, risk calculus
- Balance choice w/ stability
- Attractive business for insurers
- Sequence of risk classification
- Initial experience rating
- Durational effects

# Inherent Limits

- Shifting costs & risk averaging isn't cost reduction
- WTP – individual vs.. collective

“If people don’t want to go to the ballpark, nobody is going to stop them.”

