

Economic Considerations in Reforming California's Non-Group Insurance Market

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CA Market for Individual Health Insurance

- Enrollees:
 - ~2 million now (vs. >6 million uninsured)
 - Gruber projects 2.7 million under Gov. plan
- Rate regulation:
 - Currently:
 - Insurers charge more for ill, and can reject the sick
 - Proposals:
 - Modified community rating: premiums cannot vary by health (only by age, geography)
 - Guaranteed issue: Insurers cannot reject applicants due to poor health

Goal: Improve functioning of non-group insurance market

- Equity/affordability:
 - 1% of market “uninsurable” (nationwide)
 - 12% applications rejected (AHIP, 2005)
 - 22% applications rated up (AHIP)
- Efficiency:
 - Robust insurer competition based on value, not cream-skimming
 - Reduce job lock
 - Minimize moral hazard effects of subsidies

Limited success with current approaches

- State high risk pools:
 - Help only a small portion of those rated up
 - Poor incentives for appropriate treatment
 - Financing not related to risk status
- Guaranteed renewable long-term contracts:
 - Limited protections for plan switching, takes a generation to achieve
- Rating restrictions:
 - Exacerbated cream-skimming distortions

Concerns with Community Rating + Guaranteed Issue

- Can drive healthy people to drop insurance, in absence of individual mandate:
 - Drives premiums up, overall insurance rates down
- Can destabilize insurance market:
 - In the extreme, adverse selection risk spirals can lead to withdrawal of generous plans
 - Insurers left some other states, lowering competition
- Creates large predictable insurer profits/losses:
 - This can lead to distorted insurer behavior that hurts consumers

Premium Effects of Community Rating

- NJ, MA, NY highest premiums in country [AHIP]
- NY vs. CA premiums Blue Cross HMO (monthly)

	<u>NY</u>	<u>CA-low risk</u>	<u>CA-hi risk</u>
Age 25	760	264	291
Age 60	760	711	1,019

* CA hi-risk premium from MRMIP.

Uninsurance Effects of Community Rating

- Herring/Pauly: community rating causes...
 - 6% fewer insured overall
 - 12-14% fewer insured among low risks
 - 5-10% more insured among high risks

Risk spirals do occur

- Historically: BCBS community rating disappeared.
- Recent example: Harvard 1995-1997 risk spiral.
 - Employer contribution equalized across HMO, PPO. PPO enrollees were sicker, and within 3 years PPO collapsed.
- Previous state reforms:
 - Greater segmentation of healthy into HMOs.
 - E.g., NJ: Churning, risk spirals in FFS.

Can an individual mandate + regulation avert risk selection?

- No. Even with strong enforcement, strong incentives exist for inefficient behaviors that hurt consumers.
- Insurers can still cream skim by e.g.:
 - Excluding specialists from networks.
 - Poor coverage of drugs and procedures attractive to sicker individuals.
 - Selective advertising, disenrollment counseling, poor customer service for sick.

Miller and Luft (1997)

“...plans face strong disincentives to excel in care for the sickest and most expensive patients. Plans that develop a strong reputation for excellence in quality of care for the sickest will attract new high-cost enrollees...”

Next Presentations

- Jerry Fleming: Insurer perspective.
- Brent Fulton: Reinsurance increasingly discussed as a solution, but risk selection incentives still strong.
- Will Dow: Hybrid schemes that combine reinsurance with diagnosis-based risk adjustment are promising.

Reinsurance + Risk Adjustment: Hybrid Approach to Backstop Individual Market

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Risk Adjustment for Stabilizing Risk Pools

- Simple version:
 - Predict expenditure risk based on diagnoses:
 - Mr. Diabetic \$5k and Mr. Healthy \$1k => Average \$3k
 - Compensate insurers for risk selection:
 - Insurer A only insures Mr. Healthy.
 - Insurer B specializes in diabetes and insures Mr. Diabetic.
 - ⇒ Insurer A contributes \$2k to risk stabilization pool, and the pool pays \$2k to insurer B.
 - If risk adjustment is accurate:
 - Premiums: each charged same \$3k (less tax-funded subsidies), same as with community rating.
 - Reduced cream-skimming incentives: Each enrollee equally profitable, so insurers compete on efficiency.

Risk Adjustment Ameliorates Reinsurance Drawbacks

- *Reinsurance: still strong incentives to risk select*
 - Risk adjustment mitigates by rewarding insurers for taking on anyone above average risk, not just top 1%.
- *Reinsurance: insurers have dulled cost containment incentives.*
 - Risk adjustment uses diagnosis-based measures, maybe from prior year, so less moral hazard.
- *Reinsurance: large budgetary cost to lower premiums, inefficiently targeted by income.*
 - The risk adjustment mechanism can be used to proportionately assess insurers that cream skim the healthiest enrollees. (Potentially without any taxes.)

Reinsurance is a special case of risk-adjustment

- Reinsurance is risk adjustment that:
 - Is ex-post only (doesn't use prior history).
 - Uses only expenditure data (not diagnoses).
 - Only applies to a limited portion of the spending distribution (e.g., top 1%).
- But we now know how to do much better!
 - Many approaches for hybrid of risk adjustment plus reinsurance, using reinsurance to compensate for imperfections in risk adjustment predictions.

Hybrid Models are Already Being Successfully Used

- Techniques have improved greatly for diagnosis-based risk-adjustment (e.g., hybrid ex-ante / ex-post).
 - Comprehensive review in van de Ven and Ellis (2000), much literature since then.
- IS politically feasible:
 - Medicare Advantage, part D
 - State Medicaid HMO contracts
 - Internationally used (e.g., Netherlands)

Sample design for risk-adjusted premium subsidies

- State (or public/private entity) develops risk-adjustment schedule.
 - Many risk adjustment methods exist. Phase in prospective portion as data become available. Retain +/- 10% rate bands to improve model?
- Individual market insurers receive aggregate subsidy (or assessment) depending on adverse (or positive) risk selection mix of all enrollees combined.
- In competitive market, insurers subtract (or add) the individual's predicted subsidy (assessment) from the premium quote, so easy for shoppers.
- Similar to Netherlands model.

Governor's Proposal (October)

- Phase-in community rating over 6 years:
 - 1st 3 years: +/- 20% rate bands on health
 - Next 3 years: +/- 10% rate bands on health
- Immediate reinsurance mechanism to backstop market, phased out by year 7.
- Develop risk adjustment mechanism to “normalize risk” across guarantee issue plans.
 - Unclear how would subsidize new risk pools overall if they turn out to be unusually high risk as a group.

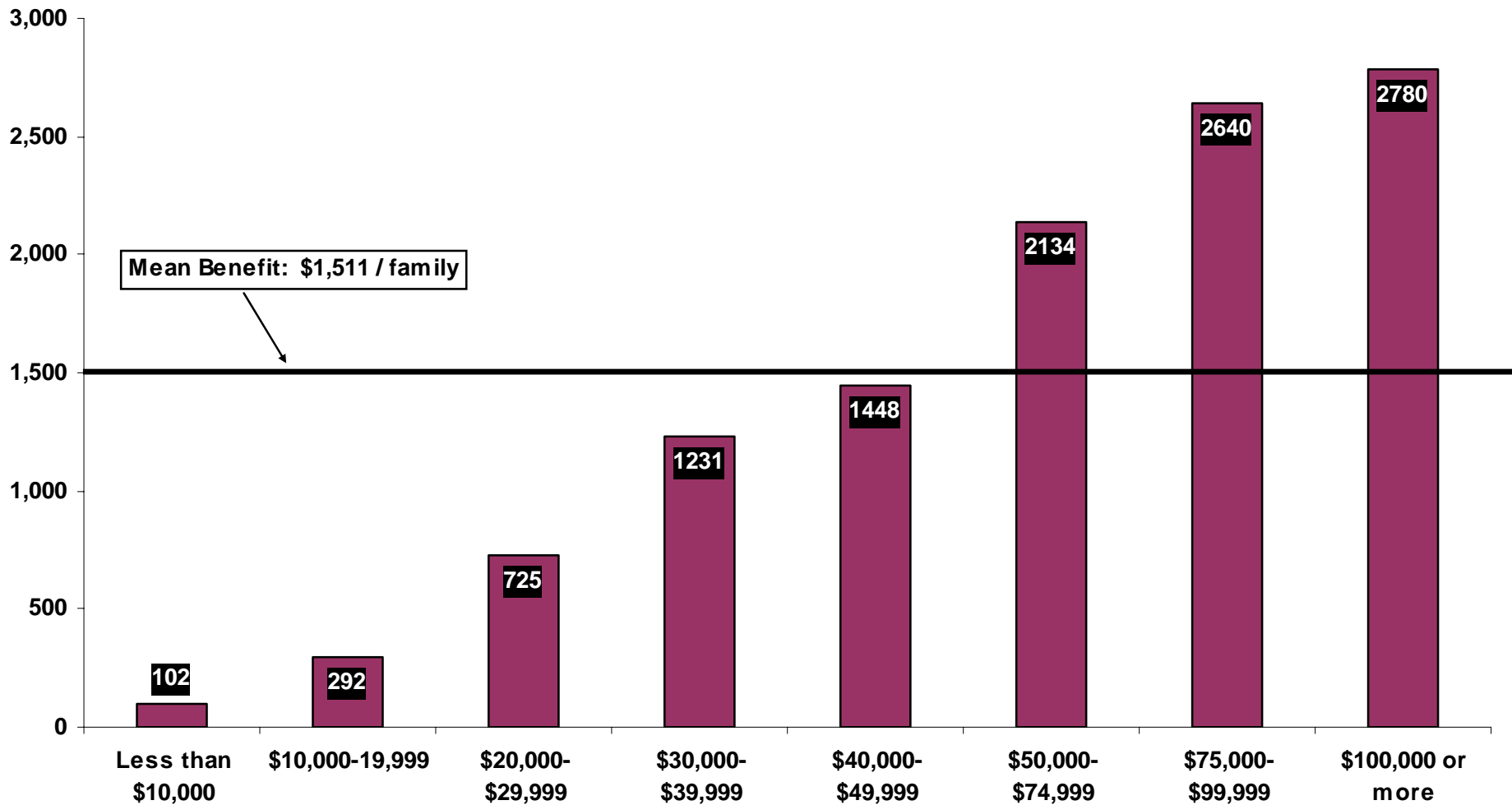
Individual Mandate: Affects Average Premiums, not Instability

- Binding individual mandate:
 - Keeps low-risks in the market: so prevents NY-type increase in average premiums
 - But strong risk selection incentives remain: so need risk adjustment type backstopping
- Without binding individual mandate:
 - Risk adjustment can decrease instability
 - More subsidies needed to keep low risks in the market and prevent average premium rise

Strong Individual Market Allows Further Reforms

- E.g.: Phase-out tax loophole for employer-sponsored insurance premiums?
 - Efficiency gain: Economists dislike tax exemption because it distorts insurance plan choices.
 - Equity gain: Current subsidy is highly regressive.
 - Revenue gain: Tax break worth > \$20 billion to Californians. But could start with revenue-neutral cap that slowly phases-in. Bonus: revenue grows at rate of medical spending growth, so sustainable revenue source.
- Challenges:
 - Requires functioning individual market.
 - Must combine with reform that compensates “losers”.
 - Must educate that unlike taxes, this would REDUCE distortions.

Estimated Average Federal Health Tax Expenditure



Data Source: Lew in Group, 2004;
Mean Benefit CEA calculation using CPS, Aug 04

Family Income

Summary: Pros/cons of risk-adjustment (vs. community rating alone)

- Can promote efficiency/equity objectives:
 - Distortionary risk selection behaviors reduced. Better patient protection, new Special Needs Plans, etc.
 - Stabilizes the insurance market. Allows broader reforms (such as phase-out of employer loophole).
 - Provides mechanism to efficiently subsidize targeted groups.
- Cons:
 - Complexity requires good governance, extensive data
 - Moral hazard still an issue, though improving with hybrid ex-ante/ex-post models.
 - Insurers capture subsidies if have market power... need guaranteed issue in public plans too?