Avoiding Side Effects in Implementing Health Insurance Reform

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All U.S. health insurance reform proposals currently being discussed now include changes in the way insurers treat some people with above-average health risks. In most states, insurers who sell policies directly to individuals now charge premiums based to some extent on characteristics thought to predict the risk of high-cost conditions; insurers also exclude some or all preexisting conditions from coverage and simply refuse to cover some people. Without such “risk rating” and coverage exclusions, insurers would be subject to substantial adverse selection — that is, consumers would seek them out primarily if and when they became ill and therefore represented higher risks to insurers — which could lead insurers needing to cover their costs to charge premiums so high they would drive lower-risk consumers to choose minimal coverage or forgo insurance altogether. A few states, having decided that hazarding greater adverse selection is the lesser of two evils, require premiums to be the same for everyone in a given geographic area (an approach called community rating) or limit the extent to which premiums can vary with risk. Such regulation can beget the worst of both worlds — “adverse selection” when lower-risk people choose not to carry insurance and “cream skimming” when insurers avoid and mistreat high-risk people in their search for profitable lower-risk enrollees — but these adverse effects are presumably considered preferable to risk rating and exclusions. Legislation currently before Congress would extend this imperfect arrangement nationwide, though the details are as yet undetermined.

Given the tradeoffs, how should such arrangements be designed, and can they be made to work better? I would argue that both laws and regulations should make strict community rating a last resort rather than the first line of defense for people with above-average risk, and the laws and regulations should do so in ways that help to avert adverse effects.

There are two complementary ways to frame the social goal of community rating: equity and efficiency. The equity argument is that it is unfair for persons who have higher health risks to have to pay higher premiums or compromise on coverage. This sentiment is strongest in regard to people with exogenous chronic conditions and low or moderate incomes. The efficiency argument is based on the idea that risk-averse people would like to avoid
“reclassification risk” — the risk that next year they might not only have high medical expenses but also develop a chronic condition that could mean higher premiums until they reach Medicare age. They would like protection against both short-term and long-term financial risks.

Avoiding reclassification risk is a good thing. So where does community rating go wrong? The goal is for high-risk people to receive a transfer of health care funds from the community of standard- or average-risk people, but basic economics says that the money for that transfer should be raised in the fairest and least distortive (most efficient) way. Community rating in effect finances a transfer to high-risk people by raising the premiums for lower-risk people; it is like an excise tax on insurance bought by those with low risk. This mechanism causes distortions — the adverse selection and cream skimming mentioned above — and it is not especially fair, since some low-risk people also have low incomes or do not deserve to pay premiums that are high relative to the benefits they will get. It would be better to finance the transfer in a way that does not distort behavior.

The reform now being debated recognizes that adverse selection would wipe out voluntary insurance if people could wait until they contracted a medical condition to buy coverage and still obtain it at the same premiums they would have been charged had they bought it sooner — hence the mandate that all individuals obtain insurance. But the relatively modest penalties proposed for enforcing this mandate will not be enough to keep the healthy and the prudent in the insurance pool as premiums increase to meet the expenses of people who become chronically ill. And the likelihood that lower-risk people will gravitate to more-limited coverage options means that regulators will have to restrict such cost-containing options lest they render impossible the transfers to people in need of a high volume of care. So, the simplistic selling points of community rating — that insurers will charge people premiums that do not take into account their risk level and will provide policies that do not exclude any preexisting conditions — simply cannot be realized.

I believe that the best alternative to this approach is one that is already in force in individual insurance markets. If consumers would gain by avoiding reclassification risk, they should want to pay a premium to protect against it. They can do so in the individual insurance market — indeed, this option is required by federal law and enforced by state insurance departments — under a provision termed “guaranteed renewability at class average rates.” Except for a small amount of explicitly temporary coverage, individual insurance policies must now include a promise not to impose any increase in premiums because of changes in the individual’s health or previous use of medical care. Of course, this protection is not free, and data show that individual insurance premiums sold to young people with moderate levels of risk are typically front-loaded to provide this coverage.

Nor is this protection bulletproof: insurers sometimes scrupulously check for ambiguous errors in initial health information when a chronic condition crops up, some insurers have tried to re-underwrite policy holders when they become sick, and some have “cancelled” whole rating classes, offered the lower-risk members of the class insurance at reasonable rates, and then raised premiums uniformly for the remaining, higher-risk enrollees. Nevertheless, the available data on risk levels, insurance premiums, and individuals’ ability to secure coverage indicate that these provisions provide a lot of risk protection: less than 20% of the variation in risk translates into variations in premiums, and people with a high risk may actually be more likely than those with a low risk to end up with individual coverage.

Unfortunately, rather than enhancing guaranteed renewability, currently debated health care reform bills will attenuate incentives for people to seek insurance while they are still healthy. If people can get insurance at an unvarying premium by waiting until they get sick and if insurers must sell coverage without exclusions, it pays to skip insurance with guaranteed renewability and just wait. Currently debated health care reform legislation does appear to envision some alternative fixes. As with Medicare Part D, people who do not sign up for coverage during enrollment periods set by insurers may be forced to wait a year for another opportunity, and premiums may be higher across the board the longer they wait. These rules will mean that more people will lack coverage than would lack it if they could simply pay higher rates to obtain it at any time during the year. It may be that, when the dust clears, people who wait to get coverage until they become high risk will end up paying higher premiums under reform just as they do now.
— but then “reform” will to some extent be an illusion.

There is a better approach. The objective should be to get people to obtain coverage with guaranteed renewability before they become high risk. One step in this direction would be to add guaranteed renewability for coverage of a worker’s family to small-group insurance. Another would be to implement strong incentives for obtaining coverage before one gets sick. Some of these could be carrots, such as larger subsidies for low-risk people to get them to buy in. Others could be sticks, such as increased premiums for people who decline coverage until they become high risk. The establishment of high-risk pools, adequately subsidized by general taxes but with higher-than-standard premiums and moderately limited coverage, may be all that is needed to get nearly everyone to do the right thing. To be sure, no incentives (not even mandates) are ever universally effective. But honestly acknowledging the logical impossibility of uniform premiums with no exclusions and then working to foster the use of already tested, practical alternatives might lead to better results from either far-reaching or pared-down health care reform.