

Addressing Adverse Selection
in Private Health Insurance Markets

Statement of

Linda J. Blumberg, Ph.D.

Senior Research Associate
The Urban Institute

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Mr. Chairman, Mr. Stark, and distinguished Members of the Committee:

Thank you for inviting me to share my views on adverse selection in health insurance and its implications when expanding consumer choice in the private market. The views I express are mine alone and should not be attributed to the Urban Institute or any of its sponsors.

I applaud the Committee for taking the time to carefully consider these issues, which are of paramount importance to individuals' access to health care coverage and medical services. In brief, my main points are:

- In order to understand health insurance markets, there is one overarching fact that must be understood. The distribution of health expenditures is highly skewed, meaning that a small fraction of individuals account for a large share of total health expenditures. Because of this fact, the gains to insurers of excluding high cost people swamp any possible savings from efficiently managing the care of enrollees. The incentives for insurers to avoid high cost/high risk enrollees are therefore tremendous.
- Greater risk segmentation of the market means setting individuals' health insurance premiums to more closely reflect each individuals' expected health care costs. Conversely, greater risk pooling implies increasing the extent to which individuals with different expected health care spending levels are brought together when determining premiums. Providing new health insurance options is one way, intentionally or not, that the extent of risk segmentation can be increased.
- Reforms that increase risk segmentation are appealing to some because they promise, and sometimes deliver, lower premiums for currently healthy persons and because the majority of people are healthy. However, gains from segmenting healthy groups can occur only if premium costs for the unhealthy are increased, or if the unhealthy are excluded from the market to a greater extent than is true today.

- Examples of proposed and already implemented reforms that will increase risk segmentation in private markets are: health savings accounts (HSAs); tax deductions for the premiums of high deductible policies associated with HSAs in the private non-group market; association health plans (AHPs); and tax credits for the purchase of non-group insurance policies.
- While risk segmentation increases the costs of coverage for the unhealthy, the isolated instances where states have forced greater risk pooling have not been successful either. Efforts at pooling have been limited to a small population base and have been foiled by individuals and groups that opt out of our voluntary private insurance markets.
- Addressing the problem will require subsidization of the costs associated with high cost individuals, with the financing source being independent of enrollment in health insurance -- ideally, all taxpayers. In this way, the unhealthy could be protected from bearing the tremendous costs of their own care while there would be little to no disincentive for the healthy to give up coverage.
- Three examples of policies that would move us closer to such a paradigm are:
 - Dramatically increasing funding for state high risk pools and making the coverage both more comprehensive and easier to access;
 - Having the federal government take on a roll as public reinsurer, particularly for the private non-group market and for modest sized employers;
 - A more comprehensive strategy would allow groups to continue to purchase insurance in existing markets under existing insurance rules, while each state provides structured insurance purchasing pools. Through these new pools, employers and individuals could enroll in private health insurance plans at premiums that reflect the average cost of all insured persons in the state.
- For the following reasons, introducing greater choice within existing insurance pools will not solve the problems I described. In fact, doing so will likely exacerbate them, even given the best available risk adjustment mechanisms:

- First, it is not sufficient to spread risks only within a particular insurance pool.
- Second, benefit package design is an effective tool for segmenting insurance pools by health care risk – offering less than comprehensive insurance will tend to attract healthier enrollees.
- Third, in private markets, where differences in actuarial value of plans can be quite large, and where people have the opportunity to opt in or out of the market, risk adjustment becomes substantially more difficult. Risk adjustment has been used in the Medicare program and is universally considered to be inadequate.
- And finally, it is not even clear that employers will have a strong incentive to want to risk adjust across plans. Although most employers want to look out for the well-being of all their workers, they face incentives to keep health care premiums down while keeping their highest paid workers satisfied. HSAs may provide employers with an effective tool for responding to these incentives, but place a greater share of the health care financing burden directly on the sick while higher paid employees can be compensated via the tax subsidy.

Further segmentation of risk will not improve social welfare in the US.

Addressing the health care needs of all Americans and protecting access to needed services for our most vulnerable populations – those with serious health problems and those with modest incomes – will require broad-based subsidization of both those with high medical costs and income-related protection for those unable to afford even an average priced insurance policy.

I. The Scope of Risk Related Health Insurance Problems in the Current Market

While estimates differ, by all accounts the number of uninsured persons in the US is large and prone to grow, both in absolute terms as the population increases and as a percentage of the population. The most recent estimate based upon the 2004 March Current Population Survey is 45 million uninsured persons below age 65, or almost 18% of the non-elderly population. There is a substantial body of evidence that shows that the uninsured have reduced access to medical care. Many researchers have also determined that those without coverage have worse outcomes in the event of an injury or illness.

The distribution of health expenditures is highly skewed. Only a small fraction of individuals account for most of our nation's health care spending. In fact, the top 10 percent of the population, ranked by expenditures, accounts for about 70 percent of total expenditures in the country.¹ The lowest 50 percent of spenders account for only 3 percent of expenditures. Because of this, insurers have strong incentives to avoid enrolling high cost individuals and to aggressively pursue enrollment of low cost individuals. The potential gains to insurers of excluding the high cost cases swamp any possible savings from efficiently managing the care of enrollees. The small group and individual insurance markets are of greatest concern with regard to adverse selection, since their variability of expenditures year-to-year is much higher than for large groups.

Fears of adverse selection and the natural drive to maximize profits, drives insurers in unregulated markets to use strategic behavior in the pursuit of a disproportionate share of low cost enrollees. These strategic behaviors can take a variety of forms, including: excluding preexisting medical conditions from coverage for defined periods; attaching riders that exclude specific conditions, procedures, or body parts from coverage for the life of the policy; engaging in medical underwriting (the process whereby insurers assess an applicant's relative health risk and then charge higher premiums to those whose risk is deemed to be higher than normal); or refusing to sell an applicant insurance altogether.² Another technique is designing insurance benefit packages in such a way as to be more attractive to healthy persons than to unhealthy ones. Harvard health economist Joseph Newhouse demonstrated how insurers, in

¹ ML Berk and AC Monheit. 2001. "The Concentration of Health Care Expenditures, Revisited." *Health Affairs*. March/April; 20(2): 9-18.

² MA Hall. 2000. "An Evaluation of New York's Reform Law." *Journal of Health Politics, Policy and Law*. 25(1): 71-99;

K Pollitz, R Sorian and K Thomas. 2001. "How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?" Menlo Park, CA: Henry J. Kaiser Family Foundation; U.S. General Accounting Office (GAO). 1996. *Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs*. HEHS-97-8. Washington, DC: U.S. General Accounting Office.

order to protect themselves from adverse selection, can offer less than complete insurance.³ This approach can take the form of offering coverage with higher deductibles, higher limits on out-of-pocket liability, tighter provider networks, and caps on benefits, among other things. In essence, insurers use lower value benefit packages to help them selectively appeal to the low risk.

The result of these various strategies is to create a market that is segmented by health care risk. This leads to markets in which premiums faced by generally healthy persons are determined as a function of the expected costs of a similarly healthy population, and the premiums for the unhealthy are determined as a function of the expected costs of the similarly unhealthy. The markets with the greatest risk segmentation are those for small employers and for individual purchasers, the markets where the insured groups are smallest and the year-to-year variation in expenditures is the greatest. While market segmentation benefits the currently healthy by providing them lower premiums than they would face otherwise, it increases the premiums faced by the relatively unhealthy, and sometimes excludes them from the insurance market entirely.

Risk segmentation has made insurance more affordable for the healthy and less affordable and accessible to the sick, contrary to the classic theory posited by Rothschild and Stiglitz.⁴ This result is consistent with the framework posed by Newhouse.⁵

The best example of how risk selection can lead to barriers to coverage for the unhealthy can be found in the private non-group insurance market. With a limited number of exceptions, state laws permit non-group insurers to exclude individuals from coverage entirely based upon health status and to set premiums

³ JP Newhouse. 1996. "Reimbursing Health Plans and Health Providers: Efficiency in Production Versus Selection." *Journal of Economic Literature*. 34: 1236-1263.

⁴ M Rothschild and JE Stiglitz. 1976. "Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information." *Quarterly Journal of Economics*. 90(4): 629-50.

⁵ JP Newhouse. 1996. "Reimbursing Health Plans and Health Providers: Efficiency in Production versus Selection." *Journal of Economic Literature*. 34(3):1236-63.

as a function of health status. They may also discontinue particular insurance products as a consequence of the insurance pool becoming too expensive, and only make alternative products available to the healthier individuals that had been in that pool. In many states insurers are also allowed to severely limit any coverage related to a pre-existing condition. For example, a study of the accessibility of non-group insurance for people in less than perfect health found examples of insurers offering one applicant a policy which excluded any care related to his circulatory system, and another excluding his entire respiratory system.⁶

A recent empirical study published in the journal *Inquiry* found that the probability of buying non-group insurance goes down significantly as a person's health deteriorates.⁷ Using this information to adjust for selection bias, an important econometric correction that has been neglected in all other studies of premiums in the non-group market, the authors also found that people with significant health problems would face non-group premiums roughly 50 percent higher than their healthier counterparts. Without the adjustment for selection bias, the data suggest that premiums do not vary with health status and support the misleading inference that poor health does not make the cost of non-group insurance unaffordable.

Risk selection incentives and dynamics can also be found in situations where individuals are offered a choice of health insurance benefit packages with significantly different actuarial values. While with most other products, choice is considered beneficial to all consumers, the case of health insurance benefit packages is considerably more complicated. Initially, multiple options allow individuals to choose the package that is most consistent with their preferences. However, the tendency for individuals' preferences to be highly correlated with

⁶ K Pollitz, R Sorian and K Thomas. 2001. "How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?" Menlo Park, CA: Henry J. Kaiser Family Foundation.

⁷ J Hadley and JD Reschovsky. 2003. "Health and the Cost of Nongroup Insurance." *Inquiry*. Fall; 40:235-253.

their health care risk means that choice in this market will tend to separate individuals into different packages by their health status. Due to the pricing differences that result, certain options may eventually be priced out of existence, because they become too expensive for people to afford. The end result may very well be a market that has no more choice than it had originally, but with the options tailored to those preferring less comprehensive coverage.

An example of this in the group insurance market can be found in the recent history of the Federal Employees Health Benefits Plan (FEHBP). For years, federal employees had a choice of a “high option” Blue Cross coverage and a “standard option” with a slightly higher deductible and a few other limitations. For the typical employee, high option was worth a little more, and, initially, premiums were slightly higher. Young, healthy employees risked having to pay the higher deductible in exchange for the small premium savings. Older, sicker employees preferred the high option. But the premium difference grew larger over time as more healthy people shunned the high option. When last offered in 2001, the high option family premium was \$1500 more than the standard option. In 2002, the high option was dropped from the plan.⁸

Over the last 10 to 15 years, well-intentioned reformers, hoping to provide protections in private insurance markets for high risk individuals and groups, have enacted legislative mechanisms for forcing more risk pooling than private insurance markets would have done on their own. In their most extreme forms, such as pure community rating, and particularly within the private non-group insurance market, such approaches appear to have increased premiums and have led to a reduction in the number of healthy individuals choosing to purchase

⁸ L Burman and LJ Blumberg. 2003 "HSAs Won't Cure Medicare's Ills." The Urban Institute. November; <http://www.urban.org/url.cfm?ID=1000578>.

health insurance. In some cases, the effect has been sufficiently great that the insurance in the community rated market may not be sustainable in the long run.⁹

II. Rationale for Changing Our Historical Approach to Pooling Health Care Risk

Equity judgments inevitably arise in any discussion of the optimal level of risk pooling. Many would consider lack of available coverage for high risk people as inequitable, while others consider it inequitable to force healthy persons to pay higher premiums than they would under stronger market segmentation conditions. I argue that neither our historical experience with the largely unregulated market outcome of risk segmentation nor with forced pooling within small group and non-group markets truly serve to maximize social welfare for the following reasons:

First, we know that individuals with their own medical problems or who have family members with medical problems often have difficulty accessing needed care if they do not have employer-based or public insurance available to them. But, additionally, all individuals age and medical expenses tend to increase over time as a consequence, and currently healthy people might face high costs someday because of illness or injury. With segmented markets, their premiums would then rise, perhaps beyond their ability to pay. Broad-based pooling preserves access to reasonably priced health insurance over time. This gives even currently healthy people reason other than pure altruism to be concerned with effective access to care for the sick, and makes the pursuit of risk segmentation much less than ideal.

Second, competition to avoid high-cost groups, and benefit designs structured to place heavier financial burdens on the sick can foreclose options that most

⁹ See, for example, AC Monheit, JC Cantor, M Koller and KS Fox. 2004. "Community Rating And Sustainable Individual Health Insurance Markets In New Jersey." *Health Affairs*. July/August;

consumers are willing to pay for if priced on a broad-based average.¹⁰ This is an efficiency loss to the society. If the risk pool were guaranteed to be sufficiently broad-based, consumers might be eager to buy coverage that was more comprehensive, for example, shorter pre-existing condition exclusion periods or lowering out-of-pocket maximums. Additionally, pharmaceutical benefits and rehabilitation benefits in the non-group market are often either severely limited or excluded altogether. Because there are many more healthy than sick people, these types of options could be available for a small premium increase – if (and this is a big if) the size of the pool over which these risks were to be spread was sufficiently large.

Third, sporadic efforts across various states to force pooling in the smallest of private health insurance markets – those for small groups and individual purchasers – have often not been constructive largely because the financial burden for covering the high cost in these markets can be avoided completely by the healthy by simply opting out of the market and not buying coverage there. The price to consumers of health insurance in these markets is a function of the health care risk of those who voluntarily decide to enter them. Because the sick, having greater health care needs, are more likely to enroll in insurance, and because these markets are quite small in total, placing the burden of the excess costs associated with bad health entirely on those voluntarily enrolling in these markets is a primary cause of their ineffectiveness at providing worthwhile coverage to individuals of all health care statuses.

I suggest that none of our policy efforts to date have focused properly on the source of the risk issues in our small group and individual markets. Therefore, sticking with what we have, or exacerbating risk segmentation relative to what we see in markets today will not solve our problems either. It is not that broad based spreading of health care risk is inappropriate, as demonstrated by the fact that all

23(4): 167-175.

individuals have some stake in maintaining access to coverage for the unhealthy and that market efficiencies result from the battle of insurers to avoid adverse selection. The problem is that our efforts at pooling thus far have been limited to too small of a population base and have been foiled by the ability of individuals and groups to opt out of sharing risk by exiting particular insurance markets, a dynamic that we know is related to expected health care risk.

Addressing the problem, therefore, will require subsidization of the costs associated with high cost/high risk individuals, with the financing source for doing so being independent of enrollment in health insurance. Ideally, the source of funding would be all taxpayers. In this way, the unhealthy could be protected from bearing the tremendous costs of their own care precisely at the time that they are both medically and financially at greatest risk, while there would be little to no disincentive for the healthy to avoid or drop health insurance coverage due to the presence of high cost cases.

III. Policies which would address our need for effective insurance for all health care risks.

There are a number of policy options that would either begin to lead us towards such a paradigm or move us most of the way there, depending upon our current level of ambition and willingness to pay.

First, we can dramatically increase funding for state high risk pools and make the coverage both more comprehensive and easier to access. These pools are available to individuals who have been refused insurance coverage in the private market, and who do not have offers of employer-sponsored insurance. While many states currently have high risk pools, due to the limited public funding through state sources (frequently premium taxes on private insurance policies),

¹⁰ LJ Blumberg and LM Nichols. 1996. "First, Do No Harm: Developing Health Insurance Market Reform Packages." *Health Affairs*. Fall; 15(3): 35-53.

these pools may have enrollment caps and usually charge premiums that are well in excess of standard policies in the private market.¹¹ Some high risk pools offer very limited benefit packages and maintain pre-existing condition exclusion periods. This means that, in order to enroll, some individuals with high cost medical conditions must be able to afford to pay the high risk pool premium and, simultaneously, all of their medical costs out-of-pocket for a year. All of these limitations hamper the pools' effectiveness in absorbing risk from the private market. However, broadening the base for financing these pools, loosening eligibility criteria for enrollment, making the insurance policies themselves more comprehensive, and offering income-related premiums have the potential to make these high risk pools powerful escape valves for the high cost in private insurance markets.¹² Allowing employers in the small group market in particular to buy their high risk workers into well-funded high risk pools would decrease the level and variability in the expenditures of the remaining small group workers and, consequently, would lower their premiums. The cost of subsidizing the medical care of the high risk could be spread across the entire population, using a broad-based tax.

A second strategy is to have the federal government take on a roll as public reinsurer, particularly for the private non-group market and for modest sized employers. In this capacity, the government could agree to absorb a percentage of the costs of high cost cases, once a threshold level of health expenditures had been reached.¹³ Reinsurance of this type would not only lower private premiums directly, due to the broader financing of these expensive cases, but would reduce the variance in expenditures considerably and therefore should reduce risk premiums charged by private insurers.¹⁴ Focusing on small

¹¹ D Chollet. 2002. "Perspective: Expanding Individual Health Insurance Coverage: Are High Risk Pools the Answer?" *Health Affairs*, Web Exclusive. October; W349-W352.

¹² LJ Blumberg and LM Nichols. 1996. "First, Do No Harm: Developing Health Insurance Market Reform Packages." *Health Affairs*. Fall; 15(3): 35-53.

¹³ K Swartz. 2003. "Reinsuring Risk to Increase Access to Health Insurance." *AEA Papers and Proceedings*. May; 93(2).

¹⁴ LJ Blumberg and J Holahan. 2004. "Government Reinsurer: Potential Impacts on Public and Private Spending." *Inquiry*. 41(2): 130-143.

employers and the non-group market could target government spending where costs are highest and insurance markets most unstable.

While private reinsurance does exist in some markets, such products do not address the critical issues which are the focus of a public reinsurance approach.¹⁵ Voluntary private reinsurance policies are subject to the same selection concerns as are the insurers that they are designed to cover. Those insurers who have historically attracted high cost individuals and high cost groups find the private reinsurance products either very expensive or inaccessible to them. In addition, the costs of the reinsurance products must be passed back to the individuals and groups purchasing the original insurance, again creating incentives for low risk individuals and groups to avoid the burden of risk sharing by opting out of the insurance completely.

A third option is to develop purchasing pools which would combine the concepts of administrative economies of scale with direct subsidization of the high cost.¹⁶ This proposal allows groups wishing to purchase insurance in existing markets under existing insurance rules to continue to do so. However, it would provide structured insurance purchasing pools in each state, through which employers and individuals could enroll in private health insurance plans at premiums that reflect the average cost of all insured persons in the state. Broad-based government funding sources would compensate insurers for the difference between the cost of actual enrollees and the statewide average cost.

Comprehensively addressing the problems of the uninsured would require additional subsidization of the low income population, aside from techniques, such as those described above, which are aimed at addressing the problems of risk selection.

¹⁵ LJ Blumberg and J Holahan. 2004. "Government Reinsurer: Potential Impacts on Public and Private Spending." *Inquiry*. 41(2): 130-143.

IV. Policies that are likely to increase risk segmentation in private markets

A number of policies, some already written into law, would tend to increase the segmentation of health care risk in today's insurance markets and/or would increase the share of medical expenses left uncovered by health insurance, without providing protections for the high risk or the low income. The implications of implementing such changes could be very harmful to these already vulnerable populations. Some could come with sizable federal price tags, without necessarily increasing health care coverage on net.

Health Savings Accounts (HSAs), passed into law along with Medicare legislation last year, are one such example. The legislation provides a generous tax incentive for certain individuals to seek out high deductible health insurance policies. Individuals and families buying these policies, either through their employers or independently, can make tax-deductible contributions into an HSA account. Annual contributions are capped at the amount of the annual deductible for the plan in which they enroll. Money in the account and any earnings are tax-free if used to cover medical costs.

These accounts are most attractive to high income people, and those with low expected health expenses. The tax subsidy is greatest for those in the highest marginal tax bracket and is of little or no value at all to those who do not owe income tax. Higher income individuals are also better able to cover the costs of a high deductible, should significant medical expenses be incurred. Additionally, those who do not expect to have much in the way of health expenses will be attracted to HSAs by the ability to accrue funds tax free that they can use for a broad array of health related expenses that are not reimbursable by insurance (e.g., non-prescription medications, eyeglasses, cosmetic surgery). Those

¹⁶ J Holahan, L Nichols, and LJ Blumberg. 2001. "Expanding Health Insurance Coverage: A New Federal/State Approach." In *Covering America: Real Remedies for the Uninsured*. J Meyer and E

without substantial health care needs may also be attracted to HSAs because they can be effectively used as an additional IRA, with no penalty applied if the funds are spent for non-health related purposes after 65. Young, healthy individuals may even choose to use employer contributions to their HSAs for current non-health related expenses, after paying a 10 percent penalty and income taxes on the funds; a perk unavailable to those enrolled in traditional comprehensive insurance plans.

The idea of lower premiums under high deductible policies also make these recent reforms attractive to some employer purchasers. However, the savings can only be modest for a fixed group of enrollees. Because the majority of spending is attributable to the small share of individuals with very large medical expenses, increasing deductibles even to \$1,000 or \$2,000 from currently typical levels will not decrease premiums dollar for dollar. The vast majority of medical spending still will occur above even those higher deductibles,¹⁷ therefore premium savings can only be modest. The reduction in premiums from moving to higher deductible plans cannot go far in encouraging more employers to offer insurance or more individuals to take it up.

The real premium savings from HSAs can occur by altering the mix of individuals who purchase coverage. By providing incentives for healthy individuals and groups to purchase HSAs with high deductible policies, insurance risk pools can be further segmented by health status. The average medical costs of those purchasing the new plans will be substantially lower if the high risk population is left in more traditional comprehensive plans. The practical effect, however, is that the most vulnerable populations (the sick and the low income) are left bearing a greater direct burden of their health expenses.

Wicks, eds., Economic and Social Research Institute.

¹⁷ LJ Blumberg and L Burman. 2004. "Most Households' Medical Expenses Exceed HSA Deductibles." *Tax Analysts Tax Facts*. Tax Policy Center: Urban Institute and Brookings Institution. August; <http://www.urban.org/url.cfm?ID=1000678>.

Another proposal, contained in HR 3901, and included in the President's fiscal year 2005 budget,¹⁸ would make the premiums associated with individually purchased high deductible health insurance plans deductible from income taxation. The deduction would be allowed regardless of whether other itemized deductions are taken. This new deduction would be available for policies purchased with HSAs.

This policy would provide a non-group insurance product whose tax advantage is almost as great as that available in the group market and which is most attractive to those with high incomes and low health care risk. Low cost/high-income purchasers, armed with yet another subsidy, would be likely to find price advantages in most states' non-group insurance markets. But as low cost purchasers leave the group market, the average cost of those staying in the group market will rise, making group insurance more difficult to afford for higher risk and lower income populations. In addition, since small employers and higher wage employees will be able to get tax breaks for the high-deductible health insurance purchased individually in the non-group market even if the firm does not provide coverage to their other employees, there will be even less incentive for them to take on the hassle, expense, and risk of offering insurance to their workers. The net result could be *less* insurance coverage among small businesses in particular.

Legislation to create Association Health Plans (AHPs) and similar employer-based risk-pooling entities have also been introduced repeatedly over the years, most recently in 2003. Supporters of AHPs hope the legislation will encourage professional and trade associations to offer health insurance plans, thereby providing an alternative source of coverage and new mechanisms for pooling health insurance risk for employers. They expect such mechanisms to prove more attractive to small employers who currently do not offer health insurance,

¹⁸ Department of the Treasury. 2004. "General Explanations of the Administration's Fiscal Year 2005 Revenue Proposals." February; <http://www.treas.gov/offices/tax-policy/library/bluebk04.pdf>.

thereby increasing the number of workers with coverage. However, legislation promoting AHPs generally includes federal exemptions from some state regulations governing existing commercial insurance products. As a consequence, the new plans would likely be more effective than existing commercial insurance products at segmenting health care risk for purposes of setting premiums. They will tend to attract relatively healthy individuals and groups, and will tend to increase premiums faced by those remaining in the residual commercial insurance market. Some (the relatively healthy) can be expected to gain from such policies, while others (the less healthy) will tend to lose. Estimates of the impact of AHPs suggest that while some employers will respond by offering coverage for the first time, others will stop offering the plans that they sponsored prior to reform. Accordingly, there would be virtually no net change in health insurance coverage.¹⁹

New tax credits to subsidize the purchase of non-group insurance policies will also tend to increase market segmentation. As is the case discussed above with regard to deductibility of high deductible policies associated with HSAs, new incentives that draw individuals out of the employer-based market and into the private non-group market as it is structured today, tend to exacerbate segmentation. This occurs by virtue of the fact that there is less risk pooling in most states' non-group markets than in employer-based markets. In addition, tax credit proposals do not usually vary the amount of the subsidy provided with the health status of the recipient; doing so is widely considered too administratively difficult for the IRS. But as discussed earlier, insurance premiums and outright access to coverage in this market do vary substantially with health status. Consequently, a tax credit that might cover a significant share of a premium for a healthy young person would most likely cover a much smaller share for someone

¹⁹ LJ Blumberg and Y Shen. 2004. *The Effects of Introducing Federally Licensed Association Health Plans in California: A Quantitative Analysis*. Report prepared for the California HealthCare Foundation. www.chcf.org.

with a current or past health problem.²⁰ Risk-pool issues may be a primary factor in the outcome of such policy proposals, with some individuals unable to access the targeted market at all, and others potentially unable to find an affordable premium/cost-sharing combination.

V. Challenges to Broad-Based Risk Pooling

Some will suggest that we can prevent the selection concerns I have outlined by providing greater choice of health insurance plans while implementing a risk adjustment system that would spread the costs associated with the high cost/high risk insureds across a particular insurance pool. As already discussed, I do not believe that spreading such costs within any particular insurance pool is sufficient. Additionally, after many years of experimentation and study, the technology available for accurately making risk adjusted payments to insurers is still not as effective as we would like.²¹ Ideally, insurers would be compensated for the excess costs of the care of their unhealthy enrollees, without compensating insurers for inefficiency in the delivery of services. As the federal experience with risk adjustment of payments to HMOs under the Medicare program has revealed, such a task is a difficult one. All empirical analyses to date have suggested that the risk adjustment formula used to determine payments to Medicare HMOs have exceeded efficient payment levels given their healthier than average enrollees. Analysts have suggested that the best risk adjustment approach would be a blend of prospective and retrospective payments.²² But even in the most ideal of situations, the maximum variation in expenditures that can be explained is roughly 20 to 25 percent.

²⁰ LJ Blumberg. 2001. "Health Insurance Tax Credits: Potential for Expanding Coverage." *Health Policy Briefs*. The Urban Institute. August; No. 1.

²¹ JP Newhouse, MB Buntin, and JD Chapman. 1997. "Risk Adjustment and Medicare: Taking a Closer Look." *Health Affairs*. 16(5): 26-43.

²² JP Newhouse, MB Buntin, and JD Chapman. 1997. "Risk Adjustment and Medicare: Taking a Closer Look." *Health Affairs*. 16(5): 26-43.

The technologies currently being used in the Medicare program which account for slightly over 10 percent of the variation are still considered inadequate, as evidenced by the dissatisfied reactions of participating plans and their continued aggressive pursuit of healthier enrollees. However, even if we could agree that the most recent approach to risk adjustment works reasonably well in the Medicare context, that does not imply that it would work sufficiently well for adjusting plans in private markets. Key differences between Medicare and private insurance are that Medicare coverage is virtually universal – the whole population of elderly are in the risk pool, and that the actuarial differences between plans are very small in Medicare. In private markets, where actuarial values of different plans can be quite large, and where people have the opportunity to opt in or out of the market, risk adjustment becomes substantially more difficult. For example, where variation in benefits is allowed – more or less of a drug benefit, mental health benefit, etc. – selection can be more targeted. In addition, when the actuarial values for plans differ substantially, it becomes much more difficult to determine what is the appropriate reference for any redistribution.

A very important issue with regard to employers and risk adjustment, however, is less technical in nature. That is -- is there a strong incentive for employers to do effective risk adjustment and maintain plan choice over time between comprehensive and high deductible policies? Although most employers want to look out for the well-being of all their workers, in a competitive environment they face incentives to keep health care premiums down while keeping their highest paid workers satisfied. If employers can keep premiums down by having a healthier risk pool or leaving more of the costs of care directly on the sick, then they will have more dollars to put toward paying higher wages, thereby making them more competitive in attracting and keeping the workers they would like to employ. HSAs may just provide employers with an effective tool for responding to these incentives, by placing a greater share of the health care financing burden directly on the sick while the most valued employees can be

compensated via the tax subsidy. This may be a real improvement over the past in the ability of employers to discriminate between the healthy and the sick, because reducing the value of employer-based packages in the past would have been potentially detrimental to all workers, and this would have hampered employers' ability to attract high wage workers. If this conjecture proves to be accurate, there may be little incentive for employers to avoid having choice of plan devolve to HSAs and high deductible policies being the only option. If no other reforms are implemented, the lower income and higher cost populations will then pay a larger share of their income toward medical care than they did previously, perhaps impeding their access to necessary services.

The most important challenge facing implementation of a broad-based approach to risk sharing, such as those that I have outlined is the financing required to implement the proposals discussed. Each of these 3 proposals – increasing funding to high risk pools and making their coverage more comprehensive; public reinsurance; and creating purchasing pools with public subsidies for both the high risk and the low income -- would require new funding in a current context of enormous federal budget deficits. However, as a first step, each proposal could be structured to limit benefits to particular groups, for example individual purchasers and/or small groups. This would limit the size of new revenues to be raised, but would also limit the benefits. In addition, each proposal should lead to some private savings, as insurance premiums go down, thereby decreasing the net costs to some extent.

In conclusion, a wise person once said, when you find that you have dug yourself into a deep hole, the first thing you should do to save yourself is to stop digging. The tools that we have been using in private insurance markets -- segmentation by health care risk, and at times, forced pooling within small enrollee populations -- have gotten us into this hole. It is time to set those shovels down (in addition to policies which provide higher subsidies for higher income people), and seriously consider an approach that would separate the excess costs of caring

for our most vulnerable neighbors from the decision to purchase health insurance.