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Health Care Reform in Transition

Incremental Insurance Reform Without an Individual Mandate

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ON JANUARY 20, 2010, SCOTT BROWN WON THE Massachusetts Senate seat held by Edward Kennedy for 46 years, ending the Democrats' filibuster-proof supermajority and stalling health care reform. Lawmakers in both parties called for bipartisan health insurance protections to supplant the more comprehensive packages, which currently include an individual purchase mandate. Piecemeal reform could impose a tax on high-cost plans, prohibit health status underwriting, require continuation coverage for individuals younger than 25 years, and fund state health insurance exchanges.¹ Although incremental reform would provide some protection for vulnerable individuals, it could have serious, unintended consequences.

Health Status Underwriting

Perhaps the most politically compelling incremental reform would bar health status underwriting (ie, excluding or charging higher rates to unhealthy applicants). Nongroup and small-group health plans almost uniformly deny coverage or charge exorbitant premiums to those with preexisting conditions—when the patient receives a diagnosis or treatment for a serious illness before plan enrollment. Therefore, a major access problem in the private insurance market is that individuals with health conditions are either excluded from purchasing coverage or have premiums priced so high they cannot afford it. In effect, individuals are denied coverage for exactly what they need, which jeopardizes their health and the financial security of their family. Because of this dramatic exclusionary policy, requiring insurers to cover individuals with preexisting conditions (in some cases only for those <19 years) has strong bipartisan support.¹

State high-risk pools operate in 34 states, offering health insurance to residents with preexisting medical conditions who cannot purchase affordable coverage. However, they comprise only 2% of the individual market and with premiums averaging 125% to 200% of standard rates, coverage is unaffordable for many.²

Risk Pools and Rate Practices

In a well-functioning private market, health insurance spreads the risk of individuals across a population to ensure that ev-

eryone can afford medical care when he or she needs it. In effect, the healthy subsidize the sick as part of a social contract, which recognizes that everyone may become ill one day. In a good society, individuals should not want for health insurance because they are already sick or too poor to afford coverage.

However, risk pools are functional only if they include enough healthy individuals to keep overall health care expenditures lower than premium costs so that high-cost individuals will be covered. The larger the population in the pool, the more predictable and stable premiums are because the high cost of a few is spread out across many. To ensure reasonably predictable and stable-expected costs, insurers attempt to maintain risk pools of individuals with health similar to or better than that of the general population.³

The extant individual health insurance market functions badly and, as a result, the poor and sick are functionally excluded. Individuals with high expected claims are often excluded or charged exorbitant premiums because if a risk pool has too many individuals in poor health, the average cost increases and those who are healthy are less likely to join. Adverse selection—whereby those with higher-than-average risk of needing health care are more likely to seek insurance—results when multiple persons of poorer-than-average health enroll in the pool.³ Countries with social insurance or single-payer systems with a standard package of benefits do not encounter problems of adverse selection because everyone, regardless of health status, is covered. However, in the United States, adverse selection increases the average risk in the insurance pool, thus driving up premiums.

Unintended Effects of Incremental Reform

Although providing greater access to health care is vitally important, in practice requiring insurers to accept more high-cost individuals without adding more healthy individuals to the pool could result in adverse selection, increased costs, and a potential financial death spiral.³ If insurers assign everyone the same rate (community rating), healthier indi-

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viduals will encounter an increase in premiums and may leave the group. However, absent community rating, if insurers adjust premiums based on the predicted costs of a group (experience rating), individuals with poor health are priced out of the market.

If there are no incentives or mandates for individuals who are healthy to purchase insurance, risk pools will become even more expensive, leading healthy individuals to leave the market and resulting in even more adverse selection, which forces insurers to continually raise premiums. This cyclical effect is deemed the adverse selection death spiral,³ leading to malfunctioning markets.

Spreading the Risk—The Return of the Mandate

Congress sought to broaden risk pools through a national individual purchase mandate. A tax penalty would be levied on individuals who do not have qualifying insurance with acceptable minimum coverage through government (eg, Medicaid and Medicare), employers, the private sector, or new health insurance exchanges. Mandates, of course, are ineffective and unfair without adequate subsidies for poor individuals and families. Premium and cost-sharing subsidies for low-income individuals and expanded Medicaid eligibility would facilitate affordable coverage and are critically important for expanding access to medical care.

A mandate counteracts adverse selection by bringing more healthy individuals into the risk pool, thereby decreasing premiums. Moreover, mandates decrease the number of uninsured, thereby lessening cost-shifting due to uncompensated care. Additional benefits include a decrease in “free riders” or individuals who forgo private insurance believing they will stay healthy or care will be available in an emergency.⁴ Many cannot afford insurance, but others choose not to purchase insurance because they are young and healthy (eg, 9.7 million individuals earning >\$75 000 annually had no coverage in 2008).⁵

Mandates, together with health status underwriting, prevent insurers from engaging in opportunistic marketing practices, such as selectively seeking young, healthy individuals while discouraging the sick and the elderly. Insurers perceive these practices as benign business decisions necessary to overcome the “take up” problem of well-off individuals being unwilling to pay for risks that seem remote.⁴ However, these practices create enormous burdens for the poor and the sick, and shift health care costs to the public or charitable sectors.

Leading up to the Massachusetts election, conservatives framed the mandate in terms of personal freedom, compulsory contracts, and transfer of money to a private party. Although nothing prevents states from implementing insurance purchase mandates (eg, Massachusetts), local lawmakers threaten to challenge the federal government’s constitutional powers to do so. Key Senate Republicans have spo-

ken out against the mandate, all but guaranteeing it stays off the table for the agreed-upon incremental reforms.

The goals of health reform are to increase access to quality affordable care, while reining in costs. Incremental reforms cannot achieve these goals. Preexisting condition coverage without a purchase mandate may benefit the sick, but ultimately may make insurance even less affordable for everyone and particularly the least well-off. Funding for state exchanges could increase access if states could keep costs down while offering guaranteed benefits packages and subsidies. However, without insurer standards and a larger participating population, exchanges have often proven ineffective and expensive.⁶ Although President Obama’s proposed discretionary spending on public programs, information technology, and health promotion is critical, it is not sufficient to increase access and equity; and it will only marginally reduce costs.

Certainly, incremental reform has expanded public programs (eg, the Children’s Health Insurance Plan) and coverage continuation (Health Insurance Portability and Accountability Act). However, piecemeal changes have done little to improve the small-group and individual market.⁷ Almost everyone agrees that the extant private market cannot ensure health care for all at an affordable cost. Comprehensive reform can bring improved health and security to the population. If this goal must be accomplished the “American way” through the private system, the simple logic of insurance has to prevail, which is to spread the risk among everyone—rich and poor, healthy and sick, young and old alike.

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