This is a sample of the instructor materials for Paul J. Feldstein, *Health Policy Issues: An Economic Perspective*, Sixth Edition.

The complete instructor materials include the following:

- Test bank
- PowerPoint slides containing the exhibits for each chapter
- PowerPoint slides with presentation content
- Course lesson plans
- Detailed instructor's manual
  - Brief overview of each chapter
  - List of the key topics covered
  - Answers to end-of-chapter discussion questions
  - Additional questions and answers for class discussion or inclusion in an exam

This sample includes the PowerPoint slides and pages from the instructor's manual for Chapter 7, "Why Are Those Who Most Need Health Insurance Least Able to Buy It?"

If you adopt this text, you will be given access to the complete materials. To obtain access, e-mail your request to hapbooks@ache.org and include the following information in your message:

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- Course level (graduate, undergraduate, or continuing education) and expected enrollment
- The use of the text (primary, supplemental, or recommended reading)
- A contact name and phone number/e-mail address we can use to verify your employment as an instructor

You will receive an e-mail containing access information after we have verified your instructor status. Thank you for your interest in this text and the accompanying instructor resources.

Digital and Alternative Formats

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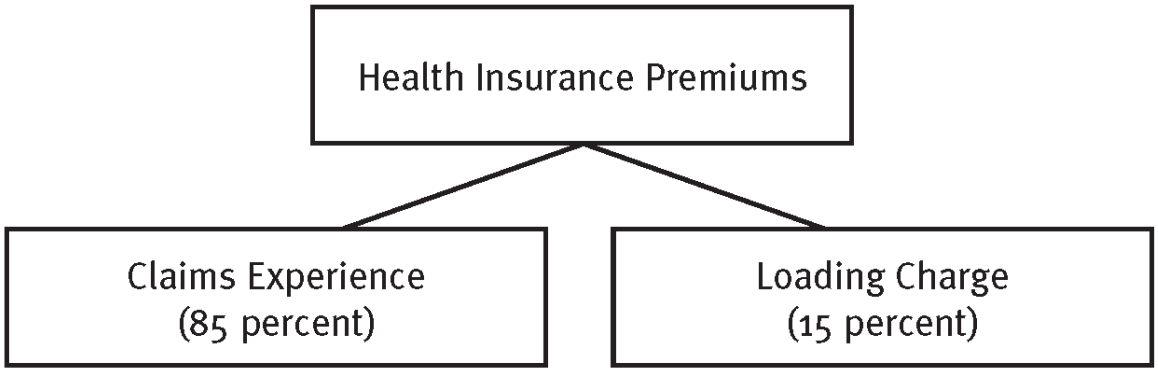
Exhibit 7.1 Sources of Health Insurance Coverage of US Nonelderly (Under Age 65 Years) Population in 2012

Market Segment	Population (Millions)	Percentage of Total
Employment-based	156.0	58.5
Individual	19.4	7.3
Medicaid	47.3	17.7
Medicare	8.8	3.3
Tricare/CHAMPVA	9.0	3.4
Uninsured	47.3	17.7

NOTE: Numbers may not add to totals because individuals may receive coverage from more than one source.
SOURCE: Data from Fronstin (2013), Figure 1.

Exhibit 7.2 Determinants of Health Insurance Premiums



Determinants of Claims Experience

Benefit coverage
State mandates
Demographic characteristics of the insured population (age, sex, and family status)
Industry
Region
Medical inflation rate
Cost-containment policies
- copayment
- deductible
- benefit design
- utilization review
- case management
- preferred provider organization

Determinants of Loading Charge

Administrative costs
Marketing costs
Reserves
Profits

Exhibit 7.3 Distribution of Health Expenditures for the US Population, by Magnitude of Expenditures, Selected Years, 1928–2010

Percent of US Population Ranked by Expenditures	1928	1963	1970	1977	1980	1987	1996	2007	2010
Top 1 percent	—	17	26	27	29	28	27	23	22
Top 2 percent	—	—	35	38	39	39	38	33	32
Top 5 percent	52	43	50	55	55	56	55	50	50
Top 10 percent	—	59	66	70	70	70	69	65	66
Top 30 percent	93	—	88	90	90	90	90	89	90
Top 50 percent	—	95	96	97	96	97	97	97	97
Bottom 50 percent	—	5	4	3	4	3	3	3	3

SOURCES: Adapted with permission from "The Concentration of Health Care Expenditures, Revisited, Exhibit 1," by M. L. Berk and A. C. Monheit, *Health Affairs*, 20(2), 2001, March/April: 12. Copyright © 2001 Project HOPE—The People-to-People Health Foundation, Inc., All Rights Reserved; 2007 and 2010 data from Yu (2010); Soni (2013); Cohen and Uberoi (2013).

Health Policy Issues

An Economic Perspective

Chapter 7

Why Are Those Who Most Need Health Insurance Least Able to Buy It?

LEARNING OUTCOME

Explain how insurance premiums are determined and how health insurance markets work

LECTURE

The Different Private Health Insurance Markets

- Exhibit 7.1

Determinants of Private Health Insurance Premiums

- Exhibit 7.2

LECTURE (CONTINUED)

How Health Insurance Markets Work

- Adverse Selection
- Preferred-Risk Selection
- Exhibit 7.3
- Pricing Health Insurance: Community Versus Experience Rating

LECTURE (CONTINUED)

The ACA's Changes to the Individual Health Insurance Market:

- State Health Insurance Exchanges
- Elimination of Preexisting-Condition Exclusion
- Medical Loss Ratios (MLRs)
- Community Rating
- Gender Rating of Premiums
- Expanded Health Insurance Benefits

continue to discussion

LECTURE (CONTINUED)

The Effect of the ACA's Rules on Premiums in the Individual Market

continue to discussion

Exhibit 7.1

Sources of Health Insurance Coverage of US Nonelderly (Under Age 65 Years) Population in 2012

Market Segment	Population (Millions)	Percentage of Total
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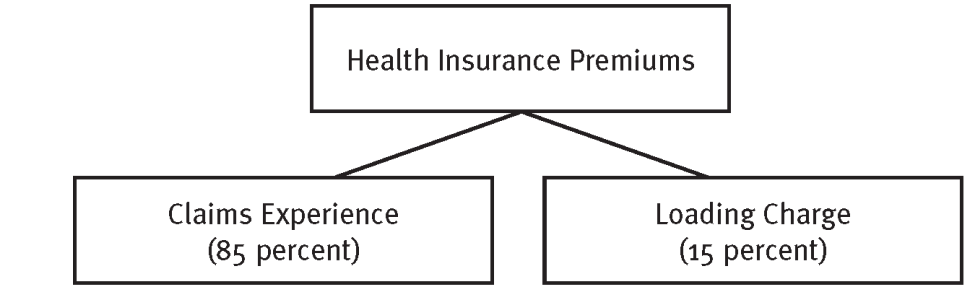
SOURCE: Data from Fronstin (2013), Figure 1.

return to lecture

Exhibit 7.2

Determinants of Health Insurance Premiums



Determinants of Claims Experience

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return to lecture

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DISCUSSION

Why is it misleading to use the medical loss ratio (MLR) as an indicator of a health plan's efficiency and quality of care? What scenarios would produce a high MLR, yet not provide high-quality care? Alternatively, when would a low MLR be aligned with high-quality care?

In your opinion, what is the best way to eliminate the problem of adverse selection? What makes it the best approach?

SUMMARY

The ACA made a number of changes affecting the insurance market, particularly the individual market:

- State health insurance exchanges were established.
- Four types of health plans are available on the exchanges.
- Federal subsidies are provided to those with low income.
- The preexisting-condition exclusion was eliminated.
- An individual mandate was imposed .
- Employees are able to switch jobs without fear that they will be denied insurance.

SUMMARY (CONTINUED)

Critics of the ACA claim that imposing a penalty for not buying insurance will increase adverse selection.

- Without young people in the risk pool, premiums will sharply rise.
- Requiring a modified form of community rating, mandated expanded benefits, and new taxes on insurers will raise premiums for the young.
- Increased premiums will reduce the demand for insurance by those who believe that paying the penalty tax is less expensive than being insured.

SUMMARY (CONTINUED)

To protect themselves from likely adverse selection, insurers are

- offering narrow provider networks;
- using less costly hospitals; and
- imposing large coinsurance rate for using non-network providers.

Mandated minimum MLRs will have unintended consequences, but the full effects of the ACA's regulations will not be known for several years.

Chapter 7

Why Are Those Who Most Need Health Insurance Least Able to Buy It?

Chapter Overview

We have all heard stories of individuals who are seriously ill but cannot find an insurance company that will sell them health insurance. Health insurance has at times seemed to be available only for those who did not need it. Should health insurance companies be required to sell insurance to those who are sick and need it most? To understand this issue, as well as what would be appropriate public policy, we must first understand how insurance premiums are determined and how health insurance markets work.

Main Topics Covered

The Different Private Health Insurance Markets
Determinants of Private Health Insurance Premiums
How Health Insurance Markets Work
- Adverse Selection
- Preferred-Risk Selection
- Pricing Health Insurance: Community Versus Experience Rating

The ACA's Changes to the Individual Health Insurance Market
- State Health Insurance Exchanges
- Elimination of Preexisting-Condition Exclusion
- Medical Loss Ratios
- Community Rating
- Gender Rating of Premiums
- Expanded Health Insurance Benefits

The Effect of the ACA's Rules on Premiums in the Individual Market

Textbook Discussion Questions

1. What are the different components of a health insurance premium? If an employer wanted to reduce its employees' premiums, which components could be changed?

   The insurance premium consists of (1) the loading charge and (2) the claims experience of the employee group.

   The loading charge represents approximately 15 percent of the premium. It reflects the insurance company's marketing costs, administrative costs for handling insurance claims, and profit.

   The claims experience of the employee group makes up the remaining 85 percent of the premium. The claims experience is the number of claims submitted by members of the group multiplied by the average cost per claim. The claims experience portion of the premium represents the total medical expenditures paid

out by the insurer on behalf of the group. This portion is also called the *pure premium*. The *medical loss ratio* is the total medical expenditure (per person) paid out by the insurer divided by the premium.

The claims experience of a group is related to the characteristics of that group, the medical benefits provided to employees and their dependents, and the cost-containment methods included in the insurance policy. Differences in premiums among employee groups, as well as the annual rise in employer health insurance premiums, result primarily from differences in claims experience, so this is the area in which employers can do the most to reduce their employees' premiums. Copays and deductibles, which may reduce employees' use of services, can help reduce premiums. Other cost-containment measures affecting demand for services are utilization review and prior authorization for specialist referrals. Medical costs can also be reduced by selecting providers according to their prices and quality of care, instituting evidence-based medicine, and employing disease management.

2. What is adverse selection, and how do insurance companies protect themselves from it? If the government prohibited insurers from protecting themselves against adverse selection, how would it affect insurance premiums?

   Adverse selection takes place when companies insure high-risk persons for premiums mistakenly based on those with low risk. This happens because some people in ill health will conceal that information so that the insurer will not know their true risk. Adverse selection is more likely to occur when individuals or small groups buy insurance. It is less likely among large employers, as the employer's premiums are averaged over a large number of employees and employees are believed to seek jobs for reasons other than just to receive immediate health insurance benefits.

   To protect themselves from adverse selection, insurance companies attempt to learn as much as the patient knows about his or her health status. Examining and testing the individual who wants to buy health insurance is a means of equalizing the information between the two parties. Another means is by stating that insurance coverage will not apply to preexisting conditions, which are medical conditions known by the patient to exist and to require treatment. Insurers might also use a delay-of-benefits clause or a waiting period, not covering obstetrical benefits, for example, until the policy has been in effect for ten months. Large deductibles will also discourage high-risk individuals because those people will realize that they have to pay a large amount of their expenses themselves.

   If the government prohibited insurers from protecting themselves from adverse selection, premiums would have to increase dramatically, and fewer people would be willing to buy insurance. Unless insurers can protect themselves from persons who withhold information and claim to be in lower-risk groups, they will bear heavy losses and eventually will be forced out of business. Lower-risk people

would either have to go without insurance or pay premiums greatly in excess of their actuarial risk group.

3. Why do insurers and HMOs have an incentive to engage in preferred-risk selection?

   As long as different groups and individuals with differing risks pay the same premium, insurers have an incentive to seek out those who have lower-than-average risks. Medical expenditures are concentrated among a small percentage of the population, and insurers can greatly increase their profits, as well as avoid losses, by trying to avoid the most costly patients. An insurer able to select enrollees from among the 50 percent of the population that incurs only 3 percent of total expenditures will profit greatly.

   To reduce the incentive for insurers to engage in preferred-risk selection, employers should pay risk-adjusted premiums. The employee's premium would reflect the employee's risk level. Insurers would then have to compete on how well they manage care and not on how well they select risk groups.

4. What are some methods by which insurers and HMOs try to achieve preferred-risk selection?

   When the premium is the same for persons with differing levels of risk, insurers will try to attract a healthier population by emphasizing services used by younger couples, such as prenatal and well-baby care, as well as wellness and sports medicine programs. Similarly, HMOs may deemphasize tertiary care facilities for heart disease and cancer treatment to send a message to enrollees who are at higher risk for those illnesses. They may also locate clinics and physicians in areas where lower-risk populations reside.

   Another method was also used in the past. When some HMOs determined that a Medicare patient required high-cost treatment, it was able to encourage the patient to disenroll by suggesting that she might benefit from more suitable treatment for the condition outside the HMO. Those on Medicare were allowed to leave an HMO with only one month's notice, and the HMO could save a great deal of money by eliminating these high-cost subscribers. However, to discourage HMOs from using this approach to maintain only the most favorable Medicare risks, the one-month notice by the aged was repealed in 2003.

5. What is the difference between experience rating and community rating, and what are some consequences of using community rating?

   With experience rating, the premium is based on the claims experience of a particular group, whereas community rating involves charging all subscribers the same premium regardless of health status or other risk factors. With community rating, the cost of higher-risk individuals is spread among all subscribers, thus

giving insurers even stronger incentives to select preferred risks. Furthermore, with uniform premiums regardless of risk status, insurers and employers no longer have an incentive to encourage risk-reducing behavior among subscribers and employees, such as promoting smoking cessation and wellness programs. Premiums for employee groups could not be reduced relative to other groups that do not invest in such cost-reducing behavior.

The community rating system raises serious equity issues because it benefits those who are at high risk and are high users of medical services and penalizes those who are at low risk and are low users of medical services. Some high users have high incomes, and many low-risk (young) individuals have low incomes. Thus, under community rating, low-risk, low-income persons have ended up subsidizing high-use, high-income persons. Many low-risk persons/low users drop their insurance under this system because their premiums increase. Further, those who engage in risky behavior are subsidized by those who attempt to lower their risks.

6. What are some reasons the ACA is likely to cause premiums in the individual health insurance market to be higher than in the past?

   The ACA's mandated "essential" benefits to be included in the health plans, together with the community-rated and gender-rated premiums and the elimination of preexisting conditions, will increase premiums.

   Many young people will decide not to buy insurance because of the higher premiums. They would rather pay a small penalty tax and buy insurance if they become sick. Insurers are anticipating that adverse selection will occur. The insured risk pool will be biased toward those who are older and have higher risks. In addition, increased taxes on insurers, pharmaceutical firms, and medical device companies to help fund the ACA will be passed on to the enrollee in the form of higher premiums.

7. What are unintended consequences of requiring insurers to have minimum MLRs?

   A regulatory limit on medical loss ratios (MLRs) will result in less insurer competition and higher premiums.

   MLRs in the individual market have generally been lower (60 to 70 percent) than the required 80 percent ratio because of higher enrollment, marketing, and administrative costs. Many smaller insurers, unable to increase their loss ratios to the higher ratio, have exited these markets, leading to less insurer competition.

   Crucial to whether an insurer can meet the 80 percent MLR in the individual market is the definition of a medical or an administrative expense. Medical expenses include payment of medical claims and quality improvement programs, such as quality reporting and chronic disease management. Administrative

expenses include cost-containment programs, such as fraud and abuse prevention activities, including medical review and provider auditing. Limiting the funds insurers spend on detecting, recovering, and litigating fraud to increase their MLR to 80 percent will result in higher, not lower, premiums. The elimination of these programs to achieve the prescribed ratios would be an unintended consequence of the legislation.

8. Why have insurers developed narrow provider networks on the state and federal insurance exchanges?

   Insurers are anticipating that adverse selection will occur. The insured risk pool will be biased toward those who are older and have higher risks because many young individuals are not expected to buy insurance. To control utilization and to lower their costs, insurer health plans are using narrow provider networks and high coinsurance to discourage enrollees from using out-of-network providers that are likely to be more expensive.

Additional Questions

1. Why is it misleading to use the medical loss ratio as an indicator of a health plan's efficiency and quality of care?

   The higher the ratio, the more of the premium dollar is paid out for medical services and the lower administrative expenses are. A health plan that merely pays out a large percentage of its premiums (high MLR) is more likely to be inefficient and lower in quality than a health plan that has a higher administrative expense ratio because it reviews the accuracy of claims submitted by providers, conducts reviews of the quality of care provided, and undertakes patient satisfaction surveys. Also, health plans that offer a variety of policies and serve small businesses will have higher administrative and marketing expenses than health plans that merely offer a single type of health plan just to large employee groups.

2. What is the best way to eliminate the problem of adverse selection?

   The best way to eliminate the problem of adverse selection is to require everyone to have health insurance. Subsidies to purchase insurance can be provided to those with low incomes and to those who are high risk in relation to their income. Under mandatory health insurance, most individuals would be good risks when they purchased health insurance and would not wait until they were ill and hence uninsurable. Everyone would have health insurance when they needed it. In the transition period of moving toward mandatory insurance, the government should establish a high-risk pool (at subsidized premiums) to cover those who are uninsurable because of preexisting conditions.