

WHY ARE THOSE WHO MOST NEED HEALTH INSURANCE LEAST ABLE TO BUY IT?

We have all heard stories of individuals who are sick and need, for example, open-heart surgery, but no insurance company would sell them health insurance. Until the Affordable Care Act (ACA) required insurers to sell health insurance to anyone willing to buy it, health insurance seemed to be available only for those who did not need it. Why did health insurance companies deny insurance coverage to those who were sick and needed it most? To understand these issues and consider what should be appropriate public policy, one must understand how insurance premiums are determined and how health insurance markets work.

The Different Private Health Insurance Markets

Most private health insurance for nonelderly Americans—66 percent in 2012 (down from 77 percent in 2000)—is purchased through the workplace. While private non-group coverage has remained relatively stable at about 7 percent, employer coverage has declined from 69 percent in 2000 to 59 percent in 2012 (Fronstin 2013, Figure 1)—see Exhibit 7.1. As previously discussed in Chapter 6, employees receive important tax advantages by having their employer purchase health insurance on their behalf. Insurance purchased

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

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

NOTE: Numbers may not add to totals because individuals may receive coverage from more than one source.

SOURCE: Data from Fronstin (2013), Figure 1.

with before-tax dollars is equivalent to a reduction in the price of insurance compared to buying insurance with after-tax dollars. This tax subsidy is not available to those buying insurance in the individual insurance market.

Those purchasing insurance in the individual market tend to be self-employed, students, retirees not yet eligible for Medicare, unemployed, individuals between jobs, and individuals who are employed but are not offered insurance through their employer (or choose not to accept it). Individual insurance was typically purchased through a broker, directly from a health plan, or on the Internet. As part of the ACA, health insurance exchanges were established in many states to primarily serve those in the individual insurance market. Exchanges are new organizations that will offer a choice of different health plans, certify plans that participate, and provide information to help consumers better understand their options. Federal subsidies are offered to those on the exchange whose income is between 133 percent and 400 percent of the federal poverty level.

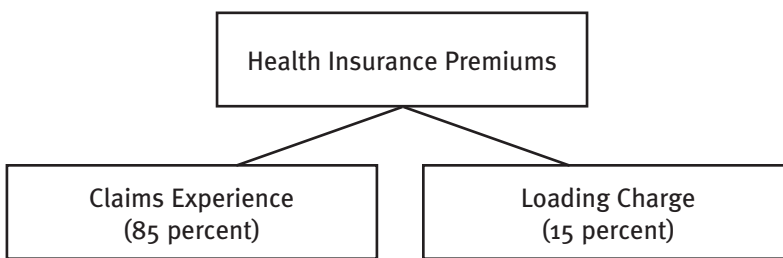
Determinants of Private Health Insurance Premiums

The insurance premium paid by an individual or an employer on behalf of its employees consists of (1) the loading charge, which represents approximately 15 percent of the premium, and (2) the claims experience of the employee group, which makes up the remaining 85 percent of the premium (see Exhibit 7.2). The loading charge reflects the insurance company's marketing costs, the administrative costs of handling the insurance claims, and profit. The claims experience of an employee group is the number of claims submitted by members of that group multiplied by the average cost per claim; this is also the medical expenditure portion of the premium, referred to as the *medical loss ratio* (medical claims expense divided by the total premium). Differences in premiums among employee groups, and the difference in annual premium increases, result primarily from differences in claims experience. An experience-rated premium is based on the claims experience of the particular group.

When a new group applies for health insurance, the insurer attempts to estimate the likely claims experience of the group. As shown in Exhibit 7.2, the insurer will consider factors that affect the group's medical expenditures, such as the following:

- Types of medical and other benefits provided to the employees and their dependents
- Types of mandates the state requires to be included in the insurance policy (e.g., hair transplants or in vitro fertilization)

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

- Average age of the group (older employees have higher medical expenditures than younger employees)
- Proportion of females (females have higher medical expenditures than do males)
- Industry in which the firm competes (e.g., physicians, nurses, accountants, and lawyers tend to be heavier users of healthcare than, say, bank tellers),
- Region of the country in which the employees are located (hospital costs and physician fees are higher on the West Coast than in the South)
- Estimate of the growth rate of medical inflation

Once an insurer has insured a group long enough to have a history of that group's claims experience, the insurance company will project that claims experience and multiply it by an estimate of the medical inflation rate.

Various approaches can be taken to reduce a group's claims experience. For example, increasing the deductible and the coinsurance rate will decrease employees' use of services; expanding insurance benefits to include lower-cost substitutes to inpatient admissions will reduce treatment costs; and requiring utilization review of hospital admissions, case management of

catastrophic cases, and use of preferred provider organizations will lower use rates and provider charges. Thus, the claims experience of a group is related to the characteristics of that group, the medical benefits covered, and the cost-containment methods included in the insurance policy.

The insurer bears the risk of incorrectly estimating the group's medical experience. If the premium charged to that group is too low, the insurer will lose money. In the past, Blue Cross and other insurance companies have lost a great deal of money by underestimating claims experience and the medical inflation rate. An insurer cannot merely increase the premiums of the group in the following period to recover its losses because the insurance market is very price competitive. If an insurer says to an employer, "We need to increase our profit this coming year because we lost money on your employees last year," the employer may switch to a competitor, switch to a health maintenance organization (HMO), or self-insure. (The employer bears the risk and uses an insurer to administer and process claims.)

Even if the claims experience of two employee groups is similar, one group may have a lower insurance premium because it has a lower loading charge. Large groups have small loading charges because the administrative and marketing costs (which are generally fixed) are spread over a great number of employees. Furthermore, insurers earn a lower profit when they insure large groups because they fear that, if their profit is too high, the groups will decide to self-insure by bearing the risk themselves. Small groups, on the other hand, are less likely to be able to bear the risk of self-insurance. If a huge claim were to occur in one year, the financial burden could be too much for a small group to bear. In a large group, large claims are likely to be offset by premiums from employees making only small or no claims in a given year. In addition to charging small groups a higher rate, an insurer is likely to maintain a high reserve in case a large claim is made, further increasing the loading charge for small groups. However, the amount of profit the insurer is able to make from a small group is still limited by competition from other insurers and HMOs.

How Health Insurance Markets Work

This brief description of how insurance premiums are determined serves as background to examine why those who are ill have found buying insurance difficult.

Adverse Selection

Assume that Person B is without health insurance and requires a heart transplant; he wants to purchase health insurance. If the insurer does not know

that he needs expensive medical treatment, his premium will be based on the claims experience of persons in a similar age (risk) group. This difference in health status information between Person B and the insurer can lead to adverse selection—that is, the insurer enrolls people whose risk level is much higher than the risk level on which their premium is based. This occurs because a person in ill health will attempt to conceal that information so that the insurer will not know of the higher risk.

For example, if 100 people were in a risk group, each with a 1 percent chance of needing a medical treatment costing \$100,000, the pure premium for each (without the loading charge) would be \$1,000 ($0.01 \times \$100,000$). Each year, one member of the group would require a \$100,000 treatment. Now, if a person who needs that particular treatment (whose risk is 100 percent) is permitted to join that group at a premium of \$1,000 (based on a mistaken risk level of 0.01), that high-risk person receives a subsidy of \$99,000, as her premium should have been \$100,000 because of her risk level. Because the \$1,000 premium was based on a risk level of 1 percent, the insurer collects insufficient premiums to pay for the second \$100,000 expense and loses \$99,000. This example does not differ from one in which a man learns that he has a terminal illness and (without revealing his condition to the insurer) decides to purchase a \$10 million life insurance policy to provide for his wife and children, or one in which a woman whose home is on fire quickly decides to buy fire insurance. Insurance enables an individual to protect against uncertainty. Once uncertainty no longer exists, however, the person is not insurable for that particular treatment or situation.

If the insurance company knew that Person B wanted health insurance to cover the costs of a heart transplant, it would charge a premium that reflected his expected claims experience—that is, Person B's premium would be equal to the cost of the heart transplant plus a loading charge.

We all favor subsidizing those who cannot afford but need an expensive treatment. Similarly, we favor subsidies to poor families. However, is it not more appropriate for the government, rather than the insurer, to provide those subsidies? When insurers are made to bear such losses, they will eventually be forced out of business unless they can protect themselves from people who withhold information and claim to be in lower-risk groups.

To protect themselves against adverse selection (insuring high-risk persons for premiums mistakenly based on those with low risks), the insurer could raise its enrollees' premiums, but then many low-risk subscribers—who would be willing to pay \$1,000 but not \$2,000 for a 1 percent risk—would drop their insurance. As more low-risk subscribers drop out, premiums for remaining subscribers would increase further, causing still more low-risk enrollees to drop out. Eventually, large numbers of low-risk people would be

uninsured, although they would be willing to pay an actuarially fair premium based on their (low) risk group.

Instead, an insurer will attempt to learn as much about the individual's health status. Examining and testing the person who wants to buy health insurance is a means of equalizing the information between the two parties. Another way insurers protect themselves against adverse selection is by stating that the person's insurance coverage will not apply to preexisting conditions—medical conditions known by the patient to exist and to require treatment. Similarly, an insurer might use a delay-of-benefits clause or a waiting period; for example, obstetric benefits may not be covered until a policy has been in effect for ten months. Large deductibles will also discourage high-risk people because they will realize that they have to pay a large amount of their expenses themselves.

Insurers are less concerned about adverse selection when selling insurance to large groups with low employee turnover. In such groups, health insurance is provided by the employer as a tax-free benefit (subsidized by the government); the total group includes all the low-risk persons as well. Typically, people join large companies more for the other attributes of the job than for health insurance coverage. Once in the employer group, employees cannot just drop the group insurance when well and buy it when ill. Thus, for insurance companies adverse selection is more of a concern when individuals or small groups (with typically higher turnover) want to buy insurance. For example, an insurer might be concerned that the owner of a small firm might hire an ill family member just so she could receive insurance benefits. Thus, employees with preexisting medical conditions will be denied coverage.

Some state and local governments have attempted to assist people with preexisting conditions by prohibiting insurers from using tests to determine, for example, whether someone is HIV positive. Rather than subsidize care for such individuals themselves, governments have tried to shift the medical costs to the insurer and its other subscribers. This is an inequitable way of subsidizing care for those with preexisting conditions. Government use of an income-related tax to provide the subsidy would be fairer. Another consequence of government regulations that shift the cost of those who are ill to insurers and their subscribers is that insurers have relied on other types of restrictions not covered by the regulations, such as delay of benefits and exclusion of certain occupations, industries, or geographic areas to protect themselves.

Healthy people may not have had health insurance for several reasons. An insurance premium that is much higher than the expected claims experience of an individual will make that insurance too expensive. For example, if an employee was not part of a large insured group, he was charged a higher insurance premium because the insurer suspected he was a higher risk. When individuals and those who are self-employed buy insurance they must do so

with after-tax dollars because tax-exempt employer-paid health insurance only applies when an employer purchases the coverage for the employee. The loading charge is also higher for the self-employed and those in small groups because the insurer's administration and marketing costs are spread over fewer employees, leading to a higher premium. Furthermore, state insurance mandates that require expensive benefits or more practitioners to be included in all insurance sold in that state result in higher insurance premiums; consequently, fewer people are willing to buy such insurance. (Large firms that self-insure are exempt from costly state mandates.) Many individuals and members of small groups also lack insurance coverage because premiums are too high relative to their income. Such persons would rather rely on Medicaid if they become ill. Others can afford to purchase insurance but choose not to; if they become ill, they become a burden on taxpayers because they cannot be refused treatment in emergency departments or by hospitals.

Medicare was concerned that adverse selection would occur in two of its voluntary programs—Part B (physician and outpatient services) and Part D (prescription drugs). Because the programs are voluntary (and 75 percent are subsidized by the government), the government was concerned that people would wait until they needed the services and then join the program; the programs would have a smaller risk pool of predominately sicker people, resulting in adverse selection to the government. To encourage all newly eligible Medicare beneficiaries to enroll in these programs, thereby increasing the risk pool, the monthly premiums were increased the longer an eligible beneficiary delayed enrolling in those programs.

The ACA decrees that the preexisting-condition exclusion could no longer be used by health insurers to deny health insurance to those willing to buy insurance. To eliminate the problem of adverse selection—namely people would buy insurance only when they became sick—the ACA requires everyone to have health insurance (an “individual mandate”) or pay a penalty. Subsidies to purchase insurance are to be provided to those with low income. Requiring an individual mandate and removing the preexisting-condition exclusion also eliminates “job lock”; employees could change jobs without fear of losing their health insurance or being denied insurance because of a preexisting condition.

Preferred-Risk Selection

Because insurers want to protect themselves against bad risks, they clearly prefer to insure individuals who are better-than-average risks. Although their risks vary, as long as different groups and individuals pay the same premium, insurers have an incentive to engage in preferred-risk selection—that is, seek out those who have lower-than-average risks.

As shown in Exhibit 7.3, in 2010, 1 percent of the population incurred 22 percent of total health expenditures (40 percent of those in the top 1 percent are aged 65 years or older). In 1963, 1 percent of the population incurred only 17 percent of total expenditures, which demonstrates the effect medical technology has had on increasing medical expenditures. Five percent of the population incurred 50 percent of total expenditures in 2010. Given this high concentration of expenditures among a small percentage of the population, an insurer could greatly increase its profits and 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 incur only 3 percent of total expenditures will greatly profit. The only way to provide insurers with an incentive to take the high-risk (hence costly) patients is to provide insurers with risk-adjusted premiums. For example, premiums for persons in older age groups should be higher than premiums for those in younger age groups. Insurers would then have an incentive to enroll these patients and manage their care to minimize their treatment cost rather than search for low-risk enrollees.

When the premium is the same for all risks, insurers attempt to enroll persons with better-than-average risks in several ways. For example, if everyone enrolling with a particular health insurer pays the same annual premium, the HMO would prefer those who have lower-than-average claims experience, are in low-risk industries, and are younger-than-average employees. To encourage younger subscribers, the HMO might emphasize services used by younger couples, such as prenatal and well-baby care. Emphasizing wellness and sports medicine programs is also likely to draw a healthier population. Similarly, de-emphasizing tertiary care facilities for heart disease and cancer

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 Uberti (2013).

treatment sends a message to those who are older and at higher risk for those illnesses. Placing clinics and physicians in areas where lower-risk populations reside also results in a favorably biased selection of subscribers.

Medicare beneficiaries can voluntarily decide to join an HMO (Medicare Advantage plan). In the past, if an elderly person decided to change her mind, she could leave the HMO with only one month's notice. (This one-month notice, which was permitted for the aged but not for those in Medicaid HMOs, reflected the greater political power of the elderly.) When some HMOs determined that a Medicare patient required high-cost treatment, they were able to encourage patients to disenroll by suggesting that they might benefit from more suitable treatment for the condition outside the HMO. By eliminating these high-cost subscribers, an HMO could save a great deal of money. To discourage some HMOs from using this approach to maintain only the most favorable Medicare risks, the one-month notice by the elderly was repealed in 2003; the elderly can change health plans only once a year during open enrollment.¹

Pricing Health Insurance: Community Versus Experience Rating

In a price-competitive health insurance market, insurers will establish their premiums based on *experience rating*. Premiums will reflect the individual's or group's risk level and will be determined as shown in Exhibit 7.2. Under experience rating, no incentive exists for insurers to engage in preferred-risk selection; insurers have an incentive to enroll and manage the care for high-risk groups, because their higher premiums will be based on their expected medical expenses. Those who have low income and cannot afford health insurance should be provided with government subsidies to buy insurance; it is not the role of insurers or their enrollees to provide subsidies to others.

An alternative approach for pricing health insurance is to require all insurers to *community rate* their subscribers—that is, charge all subscribers the same premium regardless of health status or other risk factors, such as age. The cost of high-risk individuals is spread among all subscribers. For community rating to exist, it must be mandated by the government; it cannot survive in a price-competitive insurance market. When Blue Cross started in the late 1930s, it used community rating. When commercial health insurers entered the market, it used experience rating. Because Blue Cross charged low-risk groups a premium based on the average community rate, low-risk groups moved to commercial insurers that offered them a lower experience-rated premium. As more low-risk groups switched insurers, Blue Cross's premium kept increasing and the insurer had to stop using community rating.

Community rating has serious efficiency and equity issues. It provides insurers with strong profit incentives to select preferred risks (low-risk persons) while receiving a premium based on the average for all risk groups.

Furthermore, with uniform premiums, regardless of risk status, insurers and employers no longer have an incentive to encourage risk-reducing behavior among their subscribers and employees—for example, by providing smoking cessation and wellness programs. Premiums for employee groups could not be decreased relative to other groups who do not invest in such cost-reducing behavior. Skydivers, motorcyclists, and others who engage in risky behavior are subsidized by those who attempt to lower their risks. Experience rating—with higher premiums for those who engage in high-risk activities—would provide them with an incentive to reduce such behavior and bear the full cost of their activities. Higher, community-rated premiums result in low-risk individuals dropping their coverage. The result is an increase in the number of uninsured.

When a choice exists of community-rated health plans, those who are low risk will select less costly but more restrictive plans that are less attractive to high-risk individuals. As low-risk individuals leave these more costly plans for less costly but more restrictive coverage, the more generous plans will include a greater number of high-risk individuals; this appears to have happened in New Jersey (Monheit et al. 2004). Consequently, the premiums in these more costly plans will increase, likely leading to their demise.

Community rating also has serious equity effects. A community-rated system benefits those who are high users of medical services or at high risk and penalizes those who are low users or at low risk. Low users and those at low risk pay higher premiums and those at high risk pay lower premiums than they would under an experience-rated system. Those at high risk are, in effect, subsidized by a tax on those who are low risk. Low users/low risk individuals are young and have lower income than do older, high users. Because these subsidies and taxes are based on risk rather than income, low-risk individuals who have low income end up subsidizing some high-risk, high-income people. (Not all high-risk persons are poor, and not all low-risk persons are wealthy).

The ACA's Changes to the Individual Health Insurance Market

The two approaches used in the ACA for expanding health insurance coverage to an estimated 30 million uninsured are expanding eligibility for Medicaid and providing subsidies to those who buy insurance on *state health insurance exchanges*. Although the individual health insurance market is quite small relative to the large group market, the ACA has made a number of significant changes affecting the financing and delivery of health insurance. The more significant of these changes are analyzed using previously discussed insurance concepts to determine their likely effects.

State Health Insurance Exchanges

The ACA expects each state to establish a health insurance exchange. (A federal exchange was created for those states that decided not to set up a state exchange.) These state exchanges are intended initially to serve individuals and small employer groups (up to 100 employees), but after 2017 businesses with more than 100 employees will also have access to them. The exchanges are expected to represent a market where individuals will be able to compare benefits and prices from competing insurers. Four government-standard types of health plans are to be available on the exchange, ranked from the lowest to the highest premium (Bronze, Silver, Gold, and Platinum). The Bronze plan covers 60 percent of medical expenses, while the Platinum plan covers 90 percent. Each plan limits its enrollees' out-of-pocket expenses.

Persons whose income is between 133 percent and 400 percent of the federal poverty level (\$31,721 to \$95,400 for a family of four in 2014) are eligible to receive a federal subsidy to purchase insurance (declining with higher income).

Elimination of Preexisting-Condition Exclusion

The ACA eliminated any preexisting-condition exclusions in the sale of health insurance. Insurers are required to sell health insurance to any person regardless of his health status. To ensure that adverse selection would not occur—that is, people buying health insurance just when they become ill—the ACA included an individual mandate. Those not buying insurance are penalized by having to pay a tax.

The elimination of the preexisting-condition exclusion was expected to bring into the insurance market high-cost people who were previously excluded from the market. However, as long as the individual mandate was required, insurers expected an increase in the demand for insurance by healthy individuals whose lower cost would more than offset the higher costs of those with preexisting conditions. Insurers, however, were strongly opposed to the individual mandate's penalty for not buying insurance (which is \$95 for an individual in 2014 but increasing to \$695 in 2016) versus the cost of individual insurance (which could be \$3,000 to \$5,000 per year). Many young, healthy people likely will opt to pay the penalty and buy insurance only if they become sick. Once they are treated and no longer need medical services, however, they will drop their coverage.

Eliminating the preexisting-conditions exclusion and imposing a penalty for not buying insurance will result in adverse selection for insurers. If insurers raise their rates to cover these high costs, more of their enrollees will drop their coverage. A private health insurance system cannot survive under these conditions.²

An example of how eliminating the preexisting-condition exclusion affected the health insurance market is the ACA rule (which took effect in 2010) prohibiting insurers from excluding children under age 19 years who were diagnosed with a preexisting condition. Many parents purchased child-only plans because their small employers' health insurance policies did not cover children. Concerned that they would experience adverse selection by enrolling large numbers of children with preexisting conditions (and the associated high costs), many insurers stopped selling child-only coverage while other insurers exited the market. Parents who previously enrolled their children faced much higher premiums and many disenrolled, while other parents were unable to buy child-only plans (Shaffer 2010).

Medical Loss Ratios

Health plan critics claim that insurers' profits are too high and that too little of the premium dollar goes to pay for medical expenses. These critics point to an insurance company's medical loss ratio (MLR) as an indicator of its efficiency and even the quality of care. The higher the ratio, the more of the premium dollar is paid out for medical services and the lower the administrative expenses. However, the use of the ratio as an evaluative measure is misleading. High administrative expenses (hence a low MLR) can result from a health plan (1) enrolling a great mix of small groups, which have higher marketing and administrative costs than large groups; (2) having a small enrollment base and therefore having to spread fixed administrative costs over fewer enrollees; and (3) having more insurance products, which are more costly to administer than a single product.

Additional factors are the method used to pay hospitals and physicians (by capitating providers, the administrative and claims processing expense is shifted to the provider, compared with the fee-for-service approach, in which the insurer retains those functions) and the number of cost-containment and quality review activities the insurer undertakes. For example, a health plan that merely pays out a large percentage of its premiums (high MLR) with minimal review of its claims is likely to be inefficient and lower in quality than a health plan that has a high administrative expense ratio because it reviews the accuracy of claims submitted by providers, assesses the quality of care provided, and undertakes patient satisfaction surveys.³

In a price-competitive health insurance market, a health plan cannot afford to be inefficient in its administrative functions. If it is inefficient and simply pays all claims submitted, its premiums would be higher and it would lose market share. An insurer must undertake a cost-benefit analysis to determine whether each of the administrative functions it performs either saves

money (lower claims cost) or increases purchaser satisfaction (as shown by enrollee satisfaction surveys). To do otherwise places the plan at a competitive disadvantage.⁴

The ACA established limits on MLR rather than waiting for insurer competition to determine the size of those ratios. Health plans were required to have no less than an 80 percent ratio in the individual and small group markets and a minimum ratio of 85 percent in the large group market; otherwise, the insurer must refund the difference to their enrollees. For example, if an insurer has a ratio of 70 percent in the individual market, it is required to provide the difference between 70 percent and 80 percent back to the insured individual (Kaiser Family Foundation 2013).

A regulatory limit on MLR will result in several unintended consequences. MLRs in the individual market have generally been lower (60 percent to 70 percent) than the required 80 percent ratio because of higher enrollment, marketing, and administrative costs. Many small 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 ACA. Instead of requiring minimum MLR, it would be preferable to instill greater competition among insurers to keep their profits and administrative expenses down.

Community Rating

The ACA sets rules governing how health insurers are permitted to vary their premiums. Insurers are required to use a modified form of community rating. For each type of health plan, premiums are allowed to vary by family status, geography within a state, smoking status, and age. On average, the medical costs of people in their 60s differ—compared to those in their 20s—by about 6:1. However, the ACA requires that premium differences be no greater than 3:1, much less than their actual cost differences. The effect of the ACA's community rating is the redistribution of insurance costs from the old to the young.⁵ (This age-rating rule was supported by AARP because it would lower premiums for older enrollees.)

Many of the uninsured are young. They have low income, are healthy, and don't see the need for expensive health insurance. Increasing their premiums through community rating, together with a weak penalty for being uninsured, will incentivize more of the young to remain uninsured.

Gender Rating of Premiums

Women generally use more healthcare services than do men of the same age. They visit the physician more often and take more prescription drugs. Because of their higher healthcare costs, a young woman's premium in the individual health insurance market would be 50 percent greater than for a young man. The ACA prohibits using gender rating for individuals (and employers with fewer than 100 employees). (The ACA further requires that contraception and maternity benefits be considered essential health benefits to be included in all health plans, even for single men and women past child-bearing age.)

Eliminating gender rating, when costs differ, is similar to community rating. Men subsidize women, regardless of their respective income. (In the price-competitive auto insurance industry, gender rating is not prohibited by the government; young men who have more accidents and incur higher costs pay larger premiums than do young women). The effect of the ACA's prohibition of gender rating increases the premiums for men, leading some to forgo buying insurance.

Expanded Health Insurance Benefits

The ACA requires insurers to cover a broad range of mandated "essential" benefits, the scope of which is greater than typical individual policies previously sold. For example, preventive services with no copayments must be included. (However, Russell [2009] notes that 80 percent of preventive services increase rather than decrease costs.) Insurers are required to permit parents to include their children (up to age 26 years) on their insurance policies and not be charged any more than for coverage of younger children. Also mandated to be included are behavioral health services, contraceptives, maternity care, outpatient prescription drugs, and pediatric dental and vision care; annual lifetime limits on health benefits are prohibited. The more comprehensive and generous the insurance, the more expensive it is.

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

Many young, healthy individuals are likely not to buy insurance. The many mandated essential benefits to be included—together with the community-

rated and gender-rated premiums and the elimination of preexisting-conditions exclusion—will increase premiums. In addition, taxes were increased on insurers, pharmaceutical firms, and medical device companies to help fund the ACA. These taxes will be passed on to the enrollee in the form of higher premiums. Many young people will decide not to buy insurance because of the higher premiums. They would rather pay a penalty tax and then buy insurance if they become sick. Being uninsured will be a rational choice for many young people. (Proponents of these regulations minimize these concerns by claiming that many people will receive a subsidy when buying insurance on the state insurance exchanges. To the extent this occurs, the cost of these regulations would then be borne by taxpayers.)

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, health plans are using *narrow* provider networks and high coinsurance to discourage enrollees from using out-of-network providers, which are likely to be more expensive.

Premiums on the state exchanges are higher than proponents of the ACA claimed they would be. The promise of the ACA to “bend the cost curve” is unlikely to be fulfilled.

Summary

The individual health insurance market, representing a small percentage of the overall number of the privately insured, has been the cause of much concern. Tax-exempt employer-paid health insurance is unavailable to individuals buying their own coverage, and insurers are concerned with adverse selection when individuals want to buy coverage. As a result, individual premiums are higher than those in the group insurance market and the demand for insurance is lower.

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, and an individual mandate was imposed (which should expand the insurance pool and minimize the risk to insurers of adverse selection). Employees will be able to switch jobs without fear that they will be denied insurance.

Critics of the ACA’s insurance regulations claim that imposing a penalty for not buying insurance will increase adverse selection, as many young people will wait until they are sick to buy insurance. Unless young

people join the risk pool, premiums will sharply rise for those remaining in the individual market. Requiring a modified form of community rating, mandated expanded benefits, and new taxes on insurers will raise premiums for the young. These increased premiums will reduce the demand for insurance by those who believe that paying the penalty tax is less expensive than being insured. To protect themselves from likely adverse selection resulting from fewer young people joining the exchange risk pool, insurers are offering narrow provider networks, using less costly hospitals, and imposing large coinsurance rate for using non-network providers.

Mandated minimum MLRs, as an approach for limiting insurers' profits, will have unintended consequences, such as reducing competition by having fewer insurers.

The full effects of the ACA's regulations will not be known for several years because many provisions did not become effective until 2014. Although several insurance provisions of the ACA should have beneficial effects on consumers, others will have unintended consequences on the insurance markets and on some of the insured. It remains to be seen how the private health insurance market will evolve as a result of these provisions.

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?
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?
3. Why do insurers and HMOs have an incentive to engage in preferred-risk selection?
4. What are some methods by which insurers and HMOs try to achieve preferred-risk selection?
5. What is the difference between experience rating and community rating, and what are some consequences of using community rating?
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?
7. What are unintended consequences of requiring insurers to have minimum MLRs?
8. Why have insurers developed narrow provider networks on the state and federal insurance exchanges?

Notes

1. This change was a result of the Balanced Budget Act of 1997, which sought to decrease Medicare expenditures. To compensate the aged for no longer being able to change their insurer with a 30-day notice, the aged were provided with additional preventive benefits.
2. Adverse selection is also likely to occur with the exchange's Platinum health plan, which covers 90 percent of an enrollee's medical costs. Those who are more likely to have high medical expenses will enroll in the plan that requires low copayments, while those who have low health risks will be more likely to join the cheaper Bronze plan, covering only 60 percent of their medical costs. As the Platinum plan enrolls more costly enrollees, the plan's medical costs and premiums will increase, leading those who have less costly needs to switch to plans with lower premiums, such as Silver and Bronze. This process could continue until the Platinum plan becomes too expensive and is no longer offered.
3. Robinson (1997) discusses many of these interpretive problems (and more) with MLRs and demonstrates how these ratios vary greatly within nonprofit and for-profit health plans as well as for the same health plan located in different states.
4. Expense ratios for private insurers are much larger than for Medicare. Rather than being an indication of differences in efficiency, some of the reasons for higher expense ratios among private insurers are as follows:
 - Medicare's per capita claim costs are much higher, so their administrative expenses are a smaller proportion of total costs.
 - The Center for Medicare & Medicaid Services, which performs administrative services for Medicare, is generally excluded from the calculation of Medicare's administrative costs.
 - Additional costs necessary for the operation of Medicare, such as enrollment and billing, are included in the Social Security Administration's costs. The collection of Medicare payroll taxes by the IRS is not attributed to Medicare.
 - Medicare also has lower costs because it relies on price controls and thus does not negotiate with providers or undertake cost-containment and quality improvement functions (such as medical management) or it spends too little to reduce fraud and abuse.
 - Medicare is exempt from paying state premium taxes or incurring regulatory and compliance costs that affect insurance companies.

5. Proponents of the ACA provision that overcharges the young to subsidize those who are older claim that, over time, it evens out as today's 25-year-old becomes tomorrow's 55-year-old. This argument has several problems. First, having young people overpay for their insurance (same as an excise tax) encourages more of them to remain uninsured. Second, it is inequitable to have a 25-year-old with student debts subsidize an older person with greater income and wealth. Third, considering the time value of money, on a present value basis, the young still end up incurring greater costs than if all age groups paid experience-rated premiums. Fourth, having each generation pay for the previous generation is based on the hope that succeeding generations will honor their commitment, which—as shown by Social Security and Medicare—is unlikely to occur. Few young workers believe the benefits their taxes support today will be there for them when they retire.

Additional Readings

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