S. HRG. 108–766

"EXPANDING CONSUMER CHOICE AND ADDRESSING 'ADVERSE SELECTION' CONCERNS IN HEALTH INSURANCE"

HEARING

BEFORE THE

JOINT ECONOMIC COMMITTEE
CONGRESS OF THE UNITED STATES

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"EXPANDING CONSUMER CHOICE AND ADDRESSING 'ADVERSE SELECTION' CONCERNS IN HEALTH INSURANCE"

WEDNESDAY, SEPTEMBER 22, 2004

CONGRESS OF THE UNITED STATES,
JOINT ECONOMIC COMMITTEE,
Washington, DC

The Committee met at 10 a.m. in room 628 of the Dirksen Senate Office Building, the Honorable Robert F. Bennett, chairman of the Joint Economic Committee, presiding.

Senators present: Senators Bennett and Reed.

Representatives present: Representative Ryan.

Staff present: Tom Miller, Leah Uhlmann, Nancy Marano, Mike Ashton, Colleen Healy, Wendell Primus, John McInerney.

OPENING STATEMENT OF SENATOR ROBERT F. BENNETT, CHAIRMAN, U.S. SENATOR FROM UTAH

Chairman Bennett. The Committee will come to order. I welcome you all to our hearing on Consumer Choice in Health Insurance.

The whole issue of health care, what to do with it, how to pay for it, where to take it in the future, seems to be front and center in the Presidential debate, so I think it is appropriate that we continue our series of hearings on the whole health care issue.

As those who have followed this Committee will know, we are not attempting to try to fashion any particular health care solution at the moment. What we're attempting to do is to lay out a record of the various challenges with respect to health care, with an attitude of a clean sheet of paper, that is, not what do we need to do to fix the present system, but what should we do, if we were starting from scratch, had no constraints, and could create an ideal system? What components should that ideal system really have?

That's been the overarching attitude of this Committee since we started this series of hearings, and I think we are well prepared with a variety of witnesses today, to continue to look at it in that fashion.

Now, many consumers would like to have greater choice and control of their health care and health insurance coverage. They know, from their experience with other types of goods and services, that choice and competition that matches their different tastes and preferences end up providing the best value and the greatest opportunity of choice.

Well, recent efforts to increase consumer choice in health care have included: Providing multiple health plan options with employer-sponsored coverage, and that's the kind of thing we see in the Government program; offering new consumer-driven health care arrangements such as Health Savings Accounts—now, we're seeing some experimentation with that now—reforming Medicare financing to strengthen private plan alternatives. That was originally called Medicare Plus Choice, back in 1997, but the name was changed to Medicare Advantage in last year's Medicare Modernization Act.

Then there is trying to level the playing field for those purchasers who select individual insurance market products, rather than employer group insurance coverage, trying to make that option less expensive.

Well, some of these initiatives have advanced further than the others, and, in part, that's because various plans to increase consumer choice in health insurance often face criticism that they will trigger a host of purported dangers. The one we hear the most about is called adverse selection.

That term tends to be loosely defined, but widely used, in health care debates. Its most accurate definition is when consumers know significant private information about their expected expenses that insurers do not know.

The assumption is that insurance buyers who know that their risks are greater than average will want to purchase more insurance than that which is based on average risk. You know you're going to be sicker than the company knows, you're going to want to buy more coverage than the company otherwise would sell you, in order to take advantage of your increased knowledge. That's adverse selection.

Buyers who expect their risk to be lower than average, will prefer less insurance coverage.

Now, this simple description of adverse selection projects that insurance premiums for the original coverage offered will increase more than otherwise, because low risks either switch to other types of insurance, or, in the extreme, drop coverage altogether. The end result is presumed to trigger a death spiral of rising claims costs and fewer paying customers to finance them, under the initial insurance policy, and, in the worst case scenario, the death spiral extends to the overall health insurance market, which can break down completely.

With today's hearing, we hope to examine that conclusion to see how valid it really is. It's important, because those who believe that more consumer choice in health insurance is just another risky scheme will attempt to handicap it, if not prohibit it altogether, through such policy measures as community ratings, standardized benefits, coverage mandates, and preferential subsidies.

Today's hearing will examine whether or not employers and insurers can offer better choices to consumers in practice, without producing the sort of adverse consequences that I have just described in theory.

We want to determine what really happens in insurance markets, in the pooling and pricing of risks, and sort out real problems

from imagined ones. It appears that there are natural limits on the scope and scale of potential adverse selection problems.

Employers and insurers seem to manage remaining ones rather effectively in most cases. Nevertheless, there may be policy opportunities to improve access to the care and coverage that consumers value the most.

Now, health insurance coverage, of course, as we have tried to stress over and over through these hearings, is just a means to an end. The real objective should be better health. Better health means, ultimately, lower acute care costs.

We also, of course, want better outcomes from medical treatment when the acute care is necessary, but improving the value of insurance that's available to a diverse population of consumers, is, of course, an important part of that process. Increasing choices, rather than reducing them, seems to be a fundamental starting point for upgrading the status quo.

[The prepared statement of Senator Bennett appears in the Submissions for the Record on page 29]

Chairman Bennett. Now, we usually limit opening statements to the Chairman and the Ranking Member. Mr. Stark is unable to be with us this morning, and Mr. Ryan has come over, and since we want to be ecumenical about Senate and House—this is, after all, a Joint Committee—why, we will allow Mr. Ryan to speak on behalf of the House in Mr. Stark's absence. That might send such a chill down Mr. Stark's spine that he'll rearrange his schedule to be here next time. I do not in any sense mean to criticize his absence. I know he has a very pressing conflict this morning, and we will miss him, because Mr. Stark adds a flavor to these hearings that is very valuable. Mr. Ryan, you're speaking for the People's House.

OPENING STATEMENT OF REPRESENTATIVE PAUL RYAN, U.S. REPRESENTATIVE FROM WISCONSIN

Representative Ryan. And for Mr. Stark.

[Laughter.]

Chairman Bennett. I wouldn't go that far.

Representative Ryan. I'll be brief, and thank you very much, Chairman, for your indulgence. I actually enjoy my other Committee—Ways and Means—with Mr. Stark, where we have had great conversations about this.

I'll be very brief. This is a very timely hearing. The whole adverse selection issue is really coming back up because we now have Health Savings Accounts [HSA] that are coming out in the marketplace.

We've had two amendments in the House, just in the past week, trying to prejudge this issue before any data comes out, as the Federal Employee Health Benefit Plan is now opening up its open season to a new HSA product. Those amendments were defeated, but, nevertheless, there are many who already want to make the conclusions that HSAs or consumer-directed plans encourage adverse selection.

I would argue that it's just too soon to tell, but the early data we're seeing from various sources—the companies selling HSAs,

the clearinghouse websites like e-healthinsurance, is showing, from a preliminary data standpoint, that the opposite is happening.

I would like to hear from the experts, what they are seeing, so, to me, this is a very timely hearing. I would argue that you can't make conclusions, now that we've just got new products out there that are just taking place in the marketplace. This is something that we need to watch very closely, the data, so that as each product is being sold, it is incorporated so that we can track this very well.

I think the ability to track this data is much better than it was a few years ago, so while we see a fight here, politically or ideologically, on Capitol Hill, over this issue, I think it's reasonable to conclude that neither side knows what the answer is.

That's why I think this is a very timely hearing. The end of the story is, each constituent of ours, whether they work for a big company, a small company, or are on their own, is probably facing double-digit health insurance cost increases, and answers are needed.

We have some answers that are being deployed in the marketplace. There are more things we're proposing, so I think this is a very timely hearing, and I look forward to the witness testimony. Thank you for your indulgence, Mr. Chairman.

Chairman Bennett. Thank you very much. I think we have a panel of witnesses across the spectrum of experience, background, and opinion, that can help us get a balanced view of this.

We welcome Dr. Mark Pauly, who is one of the nation's leading health economists from the Wharton School at the University of Pennsylvania, who has written extensively on the operations of health insurance markets and how public policy can shape them.

Dr. James Cardon of Brigham Young University, has examined whether consumers have private information advantages over insurers, information that could trigger adverse selection and distort health insurance markets. His most recent research focuses on the effects of the new consumer-driven health care choices like Health Savings Accounts.

Jeffrey Closs is President of BENU, a company that provides benefits choice services to mid-size employers. BENU uses risk adjustment tools to encourage insurers to compete more vigorously for a portion of an employer's business and to provide more meaningful choices for covered employees.

Then Linda Blumberg brings some direct governmental experience to the table. She is with The Urban Institute, but has been an advisor to both HHS and OMB, and has studied issues of risk selection and risk segmentation in voluntary insurance markets, particularly those involving small employers and individual consumers.

I welcome all four of you and appreciate your willingness to come and share your expertise with us. We will hear from you in the order in which I have introduced you, which means Dr. Pauly, we start with you.

STATEMENT OF MARK V. PAULY, PH.D., PROFESSOR OF HEALTH CARE SYSTEMS, BUSINESS AND PUBLIC POLICY, INSURANCE AND RISK MANAGEMENT, AND ECONOMICS, WHARTON SCHOOL, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PENNSYLVANIA

Dr. Pauly. I thank you, Mr. Chairman and Members of the Committee, for the opportunity to testify on adverse selection in health insurance, and related issues.

The world in which we live is one in which health spending risk varies before the fact, in the sense that different consumers reasonably expect to collect different amounts in benefits from a given policy, because they expect in the future, to get sick with different frequencies and severities.

Insurers can identify and measure some characteristics that they know predict above- or below-average benefits, characteristics such as age, location, and the presence of chronic conditions. Insurance markets can still function in such a world, but either premiums or purchases will be different for different people, and this makes life complicated.

What will happen depends crucially on whether insurers have and can use the same information that predicts benefits as consumers can use. If everyone has the same information, and the information does predict different risk levels, then insurance theory tells us that insurers will choose to charge below-average premiums to the lower risks, and above-average premiums to the higher risks. Someone who has four times the expected benefit from a given policy, will be charged about four times the premium.

At those premiums, insurers will be equally eager to sell to low and high risks. In insurance theory, this situation of proportional risk rating will be stable, and probably will be one in which low risks are no more or less likely to buy insurance than high risks.

A few very high risks with low incomes may find that premiums are so high and expenses are so near certain, that they are just as well off not buying insurance and paying those expenses directly, when and if they can, but that's the exception.

Insurance markets, the same theory tells us, will be very different if insurers do not have equal information that buyers have, or if insurers are not allowed to use the information they do have in setting premiums and bidding for business.

In the extreme case in which insurers cannot distinguish among risks or are not permitted to do so, they will be forced to charge the same premium to everyone who buys insurance, but if insurance purchasers know their risk levels, their willingness to buy insurance at this premium will vary.

Higher risks will be very enthusiastic about buying, since they can, on average, collect in benefits, more than they pay in premiums, but low risks may decide not to buy insurance at all, because it looks like a bad deal to them, or may at least seek to buy less generous coverage than the high risks desire.

This situation of community rating will be one in which the low risks are less likely to buy insurance than under risk rating. In the limiting case in which the low risks bail out altogether, the so-called "death spiral," the premium insurers will end up charging to the high risks who remain, will be the same ones they would have

charged under risk rating, and the effect of community rating will only be to drive all of the low risks from the insurance market, with resulting adverse effects on their access to care and financial stability.

It is in this sense that community rating can be inefficient, compared to risk rating, since it can make the low risks worse off and not make the high risks better off. In the less extreme case in which some low risks might continue to buy, the high risks could be better off, but the low risks will still be worse off than they would have been under risk rating.

There will still be inefficiency, compared to the ideal, because the low risks will choose less coverage than they would have chosen, if they had faced premiums reflective of the true cost of their coverage.

Whether there will be cream-skimming, in which insurers are more eager to sell to low risks than to high, depends on whether the adverse selection is essential in the sense of being caused by insurer inability to tell risk apart, or inessential, caused by regulation or policies which forbid insurers from using information they have, to set lower premiums for lower risks.

In the case of essential adverse selection, as in the case of risk rating, there should be no cream-skimming, because all potential purchasers look equally profitable to insurers. Insurers might want to cover only the low risk, but they cannot tell who is who.

In the less extreme case, the regulation-required community rating, insurers will try to avoid selling to high risks they can identify, on whom, as a group, they are sure to lose money, and there will be cream-skimming.

For these kinds of reasons, some insurance analysts think risk rating is better than community rating, but many policymakers and some other analysts do not look at it this way. They do note the downside of community rating in terms of squeezing out the low risks, even to the extent of a death spiral, but policymakers also find much not to like in risk rating, precisely because the higher premiums for high risks, may bite into their ability to consume other necessities of life, if they have low income, and sometimes because observing higher income, high risk paying more than higher income, low risks, still looks unfair, especially compared to a policymaker's dream world in which everybody pays a low premium.

That this is impossible in a world of competitive, but unsubsidized insurance, only margins dampens their ardor.

The most obvious way to deal with these problems is to use regulation and to require insurers to charge similar premiums or limited premiums for high risk, and forbid low risks from buying less generous policies, then require insurers to sell policies to high risks they know will be causing losses, and when there is enough political nerve, forbid insurers and the low risks from dropping out, by mandating insurance purchasing.

Measures short of this draconian one, can still lead to bad adverse selection type outcomes, especially when community rating forces insurers to ignore information they have. Then when insurers respond to community rating regulations with cream-skimming, one needs to write yet more regulations to require open enrollment and guaranteed issue.

To avoid the death spiral, we move to a regulatory spiral. As with other kinds of health care regulation, how bad or good the regulatory outcome will be, seems to vary in practice across states, depending on characteristics of their potential insureds and the form and administration of the rules.

In some states, such rules have seriously curtailed the size of insurance markets, while in others, the main effect is only discontent among the low risks and the insurers who would like to sell to them. Still, on balance, community rating seems to increase the number of uninsured.

The main novel point I want to make here is that recent research suggests that, both in theory and in practice, there are ways alternative to regulation to get closer to what policymakers want, or should want, when risk rating and adverse selection are possible.

The three kinds of solutions to which I want to draw your attention are: No. 1, guaranteed renewability at uniform premiums; No. 2, group insurance; No. 3, high risk pools. I'll speak most about the first.

The great majority of people who are high risk today, were not sicker than average at all times in their lives. Data tells us what common sense and even our bones in the morning tell us, that even people who are in excellent health, have higher medical expenses, on average, as they age, and some pick up chronic conditions.

The age effect on increasing risk is perfectly predictable. What is not predictable is the random onset of a chronic condition that makes a person high risk, not only initially, but for some time to come.

Most medical expenses for people under 65 are not related to chronic conditions; they come from the bolt-from-the-blue event of an accident, a stroke, or something that cannot be predicted well in advance, and this is precisely the kind of low-probability, high-cost event for which insurance works well.

But some events are predictable in advance, and then someone who contracts a chronic condition, gets a double financial insult. Not only will they have to pay a lot for their care in the year in which they are diagnosed, but they will probably—they may have to pay higher premiums in the future, and if insurance is perfectly risk rated, they are subject to the risk of becoming a high risk.

A protection against that in the form of guaranteed renewability exists and was quite common, even in the absence of regulatory rules. Specifically, renewability at class-average rates, requires insurers to charge the same premium to people, regardless of their experience or their risk, when that has changed after the sale of insurance. It basically means the insurers ignore new information about the level of risk, and this has the power to protect people against premium risk.

This feature is not free, of course. Policies that contain it, must have high initial premiums, front-loading, than would premiums for which the insurer retained the right to increase premiums for people who contracted a chronic illness, but it is easy to see why rational, foresighted people, would prefer the slightly more expensive mature policy.

Federal law now requires guaranteed renewability, but our research on data in a period when it was not required by Federal law

and not required in many State laws, produces the result that there is very strong empirical evidence consistent with guaranteed renewability, in that the premiums charged in the individual insurance market, which is most subject to risk rating, are much higher for lower risks than for higher risks than would be consistent with proportional rates.

Chairman Bennett. Dr. Pauly, can I ask you to summarize?

Dr. Pauly. Yes.

Chairman Bennett. This is fascinating stuff, and your whole statement will appear in the record.

Dr. Pauly. Thank you.

Group insurance can avoid adverse selection, fundamentally in two ways: The employer will limit the range of choices, which can limit the possibilities for adverse selection, but more fundamentally, in most group insurance, the employee who chooses the lower cost premium policy, or who chooses to have no insurance, will not recapture in cash, all of the money that has been saved by making that choice. In that way, people are induced not to engage in adverse selection, even if they are low risk.

My conclusion about the current functioning of insurance markets, is that adverse selection is not, in general, a severe problem, nor is its mirror image, risk rating, which causes high risks not to have coverage. To the extent that there are problems for high risks, my suggestion is that an appropriately run plan of guaranteed renewability of high risk pool, can solve that problem.

My fundamental amateur judgment on policy is that, of all of the things that are wrong with America's health care and health insurance markets—and there are many—these various risk segmentation issues so prominent in insurance theory and much policy discussion are a distraction. Not that there is no problem there, but compared to other issues like getting subsidies to people of all risk levels to help them afford insurance, if they are low-income, or making health care, if we can, cheaper and just as good, this seems to me to be a very low priority item.

[The prepared statement of Mark V. Pauly appears in the Submissions for the Record on page 30.]

Chairman Bennett. Thank you very much.

Dr. Cardon.

STATEMENT OF JAMES H. CARDON, PH.D.; ASSOCIATE PROFESSOR OF ECONOMICS, BRIGHAM YOUNG UNIVERSITY, PROVO, UTAH

Dr. Cardon. Mr. Chairman and Mr. Ryan, it is good to be here today.

Insurance is desirable because it exchanges a fixed premium for a reduction in risk. Adverse selection is caused not by imperfect information about future expenditures, but by asymmetric information. Buyers and sellers of insurance may have private information about those risks.

There is potential for adverse selection, anytime either buyers or sellers have significant informational advantages. Akerlof first illustrated the problems of private information advantages in the used car market, the market for lemons.

Seller's private information about car quality leads to an unraveling of the market in what is sometimes called a death spiral. Rothschild and Stiglitz extended the argument to the case of insurance, and identified a simple market solution of this information problem that effectively identifies and separates, high and low risks.

In this separating outcome, risk types are fully revealed, and the only deviation from the world of symmetric information is that the low risk types are forced to accept lower levels of coverage.

It is a mistake to conclude that the separating outcome defeats the purpose of insurance, since health care expenditure are unpredictable, even given detailed information about demographics and medical conditions.

As used and useful as this model is, there is something of a divergence between the theory and its application to real markets, and this has led to widespread misinterpretation of the statistical evidence.

There is a crucial difference between selection based on private information and selection based on public information, such as demographics and income. Theoretical models that lead to adverse selection are concerned with private informational advantages, and public information poses no problem for markets.

In a paper published in 2001, Igal Hendel and I built a statistical model to test for the presence and importance of asymmetric information in health care markets. The question is whether there is evidence of private information that can produce adverse selection.

The test that we used is based on the link between insurance choices and subsequent consumption of health care. Intuitively, this test is based on whether this link can be explained by mutually observable variables, or whether private information plays a significant role.

We found that the link between health insurance choices and health care consumption, is mostly explained by income and other demographics. As is normally the case, expenditures do vary predictably with income and these demographics, but most of the variation in expenditures is purely random and unpredictable.

Our research shows no evidence of private information leading to adverse selection in the health insurance market. The life insurance market is similar in many respects to the health insurance market. Cawley and Philipson find that the data are inconsistent with private information on the consumer side. Instead, the authors suggest that the insurers in this market may have the informational advantage.

Similar results have been found in the auto insurance markets. The papers cited here should cast some doubt about the presence of adverse selection. A failure to find evidence of informational advantages leading to adverse selection in a given market, does not, of course, mean that it cannot or that it does not occur; rather, it means that the problems that do exist are swamped by other factors, or that the problem has been managed by consumers or insurers in some other way.

Many cases of so-called adverse selection are due to deliberate neglect of available information.

One commonly made argument against Health Savings Accounts has been that they will lead to either increased risk segmentation and a separating outcome, or to the premium death spiral in which exit of the healthy from comprehensive plans raises premiums to the point that the market for such insurance collapses.

At a common sense level, I believe that concerns that HSAs will distort markets, are greatly exaggerated. There is evidence that informational advantages are often either small or two-sided, with both buyers and sellers having private information.

As far as risk segmentation is concerned, HSAs are similar to existing high-deductible or other plans with high levels of cost-sharing, and benefits managers know how to manage enrollment among a variety of plans by adjusting premiums and plan benefits.

After all the analysis, it's markets that will provide the final test. If HSAs work, then they will become popular. If they do not work, then they will disappear.

Traditional plans will continue to be available, and decisions are usually biased against new products. If firms find that HSAs are not a good match for their employees, they will drop them.

HSAs will likely become a useful alternative to less comprehensive insurance or managed care, and they are worth a try. Thank you.

[The prepared statement of James H. Cardon appears in the Submissions for the Record on page 39.]

Chairman Bennett. Thank you very much.

Mr. Closs.

STATEMENT OF JEFFREY M. CLOSS, PRESIDENT AND CEO, BENU, INC., SAN MATEO, CALIFORNIA

Mr. Closs. Good morning, Mr. Chairman and Members of the Committee. I'm pleased to be here today.

Our Company, BENU, offers a meaningful choice of health insurers to employees of small and mid-sized companies. We're able to offer this expanded choice by reallocating premium to health insurers to compensate for adverse selection.

We currently operate in the states of Oregon and Washington, with Kaiser Permanente Group Health Cooperative and Cigna Health Care, and beginning January 1st, BENU will be available in the Washington, DC region, with Kaiser Permanente and Cigna Health Care.

Consumer choice of health insurers doesn't exist for small and mid-sized companies. Why? Adverse risk selection.

Let me give you an example: A marketing executive for Group Health told us of their very successful program to treat diabetics. He described their sophisticated prescription system, which flags new insulin prescriptions, which then prompts a nurse to call the diabetic and offer education on monitoring and controlling blood sugar, as well as to schedule appointments with the dietician to review nutritional needs, and more testing for additional diseases.

I was impressed with the comprehensiveness and effectiveness of this care. But when I asked, why not encourage all diabetics to join Group Health, he responded, "We'd love to, but we can't. We'd go out of business."

The problem is, the premium payment will not cover the cost of treating a diabetic, no matter how efficient the care is. So, why are premiums insufficient?

Because employers pay health insurers, based on an average cost payment. Health insurers charge the same rate for all potential enrollees within a company.

The problem is that individual members have vastly different expected costs, depending on factors such as age, gender, and most importantly, the level of chronic illness they have.

We know that a person with diabetes will, on average, cost many times that of a 20-year old, yet the health plan that enrolls either of these, receives the same payment. On a pure financial basis, whom would the insurer rather enroll? Obviously, the healthy.

It's a shame that Group Health has a disincentive to promote their award-winning diabetic care program. how do we correct for this?

BENU solves this by increasing the payment to the insurer for the more costly diabetic member, while lowering the payment for the less costly healthy member, what we call risk-adjusted payments.

Employers continue to pay BENU, average cost payments, but what's transformational is that BENU pays insurers risk-adjusted payments. Insurers now get a fair payment for both the sick, as well as the healthy.

The large chart over in the corner demonstrates the amount of premium that we actually move between carriers by employer group, which we'll probably touch on later. [Chart appears in the Submissions for the Record on page 49.] The results are profound:

Health insurers now have an incentive in enrolling the chronically ill, as well as the healthy. They won't fear financial losses, if they enroll a disproportionate share of the diabetics.

Employers can now offer a choice of truly competing insurers, and provide a fixed subsidy for the lowest cost, most efficient plan.

Employees can choose to buy up to more expensive plans and pay the difference. This creates savings for the employer and controls health care inflation.

In fact, BENU has saved its customers an average of 15 percent on the total employer premium cost. In addition, consumers are significantly more satisfied.

Our customers tell us that their employees love the broad choice. Consumers can now choose from a comprehensive closed network HMO from Kaiser Group Health, an open access PPO from Cigna Health Care, or a consumer-directed plan with a Health Savings Account.

Consumers are making decisions based on their own individual financial and health needs, but, more importantly, efficiency is brought to a health care system badly in need of it. Insurers compete for the right reasons, providing high quality care to keep their members. If they don't, employees can easily move to another insurer that will satisfy their needs.

While free-market forces drive needed efficiency, the social aspect, where the chronically ill receive care at prices they can afford, is maintained.

The truth is, we expect our health insurance carriers to be more than just insurance. We expect them to be a good service plan, taking good care of the healthy and chronically ill, and we expect them to be part social program, spreading the cost of the health care evenly among all participants.

Not surprisingly, with the way insurers are being paid, they're having a hard time being either. Mr. Chairman and Members of the Committee, what's wrong with the current system is not how we fund health care, but how we pay insurers.

We fund health care by charging everyone the same premium for the same plan, no matter how sick they are, but instead of paying the insurer the average cost premium, we should adjust payments to insurers, based on the chronic illness of those enrolled.

BENU enables small and mid-sized employers to offer a competitive choice of insurers, delivery systems, health plans, and prices to their employees, and reallocates premium to insurers to compensate for the adverse selection that inevitably occurs. The result is a competitive consumer market that lowers costs, satisfies employees, and motivates insurers to provide value to the chronically ill. Thank you for your time today.

[The prepared statement of Jeffrey M. Closs appears in the Submissions for the Record on page 42.]

Chairman Bennett. Thank you very much.

Dr. Blumberg.

STATEMENT OF LINDA J. BLUMBERG, PH.D.; SENIOR RESEARCH ASSOCIATE, THE URBAN INSTITUTE, WASHINGTON, DC

Dr. Blumberg. Thank you, Mr. Chairman and distinguished Members of the Committee, for inviting me to share my views on adverse selection and health——

Chairman Bennett. Could you pull the microphone a little closer to you?

Dr. Blumberg [continuing]. For inviting me to share my views on adverse selection in health insurance, and its implications, when expanding consumer choice in private health insurance markets. 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 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 care for 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 individual's 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 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, tax deductions for the premiums of high-deductible policies associated with HSAs in the private non-group market, association health plans, and tax credits for the purchase of non-group insurance policies.

While risk segmentation increases the cost 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 closer to such a paradigm are: (1) Dramatically increasing funding for state high-risk pools, and making the coverage both more comprehensive and easier to access; (2) Having the Federal Government take on a roll as public reinsurer, particularly for the private, non-group market and for modest-sized employers; and (3) A more comprehensive strategy would allow groups to continue to purchase insurance in existing markets under existing insurance rules, while each state provides new 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 that 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 in

that experience. 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 the social welfare in the United States. 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. Thank you very much.

[The prepared statement of Linda J. Blumberg appears in the Submissions for the Record on page 49.]

Chairman Bennett. Thank you. We've been joined by Senator Reed. Senator, do you have an opening statement? We'd be happy to hear from you before we start the questioning.

OPENING STATEMENT OF SENATOR JACK REED, U.S SENATOR FROM RHODE ISLAND

Senator Reed. Thank you very much, Mr. Chairman. Just briefly, this is a very important topic, given the fact that we have legislatively committed to Health Savings Accounts for over 10 years, with a price tag of about $70 billion, so I think we have to ask the question, are we getting our money's worth in terms of broader coverage and more efficient coverage.

The issue of adverse selection is a critical component to answering that question of whether or not these Health Savings Accounts are literally allowing healthy individuals to accumulate, through the tax system, wealth, while not serving the needs of lower-income Americans and particularly very ill Americans.

Now, I think that's at the heart of this issue, and I commend the Chairman for raising the issue and for bringing together a panel of experts to do this.

Mr. Chairman, I think that sort of summarizes where we are, and I'd be happy to claim my time in questioning at the conclusion of your questioning.

[The prepared statement of Senator Reed appears in the Submissions for the Record on page 30].

Chairman Bennett. Thank you very much.

Well, you've heard each other on the panel, and what I like to do in these hearings, because they are not legislative hearings, is move more to an attitude of a panel discussion than a direct question-and-answer session. Now, we stay in the framework, in that each Member is allowed to conduct the discussion, if you will, but having heard the range of opinions here, I'd like to get a little interaction going.

Dr. Blumberg is fairly firm in her conclusion about Health Savings Accounts and how dangerous they are. I don't want to put

words in your mouth. You didn't use the word, "dangerous," but I get that sense from your testimony.

Dr. Cardon, you've done a lot of research on this. Can we have an exchange between the two of you, and then the others get into it, as to where you are on this one?

Dr. Cardon. OK.

Chairman Bennett. Bring the microphone closer to you, as well.

Dr. Cardon. Well, I don't think we know how these things are—I think Mr. Ryan said what I believe. We're not sure how these things are going to play out.

I don't think they are that dangerous, because I am skeptical about the true adverse selection. I guess we've had the range of definitions of adverse selection here.

The way I have defined it, I don't think there's a lot of it. It's driven by private information, and not by things that can be observable, including things that would be used in a risk rating system.

I think that there's some—I just don't think the dangers that are suggested with these things, are as real as might be suggested.

Chairman Bennett. Dr. Pauly, I was interested in your concluding remark that this whole debate is something of a diversion from the real structural problems that face our health care system.

I have the same feeling. I think some of the truly structural problems that we face, are being ignored in much of the debate, and at this series of hearings, we're trying to get at some of those problems.

Do you have a comment here on how important is the issue of adverse selection, and how valuable is the question of—is the opportunity of consumer choice? Is consumer choice a distraction?

Dr. Pauly. All right, actually I think that Dr. Blumberg and I both agree with you, that the more fundamental questions are ones that involve helping people afford insurance and making insurance for the average person work well.

In terms of—let me make two comments: One is whether Health Savings Accounts create adverse selection that we should be terribly worried about, and then what should we be worried about?

First of all, if low coverage policies do attract low risks, so do aggressive HMO plans. In a way, they are certainly no worse, and we've been able to deal with HMOs and tolerate them.

More importantly, if the HSA plan is offered in an individual setting, as I've already pointed out, when the individual insurance is already risk-rated, the HSA insurance would also be risk-rated, and if the insurer knows what it seems to know, which is as much as the person knows, there would be no adverse selection that would go on there. There might still be a choice by healthier people to take the HSA, but they would pay—their doing that would not cause the high-risk to pay anything more, because there is no cross-subsidization.

In the group setting, of course, it depends on what employers do. I agree with Dr. Blumberg, at least, I think, implicitly, that it would be possible for a foolish employer to set up an HSA option and then set the reward for choosing the HSA in such a way to create adverse selection.

I think that with the kind of devices that Mr. Closs talked about, or some other less formal devices, that insurers, employers, and benefits consultants know about, it's possible to control the extent of adverse selection, essentially by not offering too large a reward to the low risks for the plan that they choose, so that not to make it excessively attractive.

Then I guess the final way to look at this is, in a worst-case scenario where all the other plans disappeared and only the HSA plan was left, if that's a decent plan, which I think it is for most Americans—it may not be the best of all possible worlds, but it's not the end of the world, either—but, more generally, of course, the main adverse consequence of adverse selection is that it would wipe out choice.

I guess, to address that specific question, I think there is enormous evidence that Americans differ substantially, not only in terms of how they want their health care and what kind of health care they want, but how they want it controlled.

Some people want to control it themselves by paying out of pocket; other people are happy to have a managed care plan say no for them; still other people are happy to spend more money, because that's what it takes to be able to have full insurance coverage and whatever you want.

Of course, all of us would like cheap insurance that puts no restrictions on us, but, this side of the grave, that's not something we're going to see.

I think that offering those options to people who seem to have very different preferences in terms of how they want to see their health care financed and ultimately controlled, is part of the genius, in a way, of the American system of allowing a pluralistic arrangement where there are different strokes for different folks, makes the most sense.

Chairman Bennett. Your description of what we want is the subject of Robert Samuelson's op ed piece in this morning's Washington Post, when he says Americans want full control of choice of their doctors, full access to all services at all times, and very low premiums.

Dr. Pauly. Even grownups are still teenagers when it comes to health insurance.

[Laughter.]

Chairman Bennett. It's come to that. Mr. Closs, react to Dr. Blumberg about your experience, and then, Dr. Blumberg, react to Mr. Closs's experience in the marketplace. We've got the two professors, and now you're the practitioner here.

Mr. Closs. You know, Dr. Pauly actually set it up great for us, in that everybody has a different need, and if we try to dictate what each individual employee needs, and if it's an HMO, well, we were there once before, right, when we had everybody into an HMO, and that didn't work out so well.

I think we're potentially setting up the same thing, which is that if everybody moves into a consumer-directed plan, high-deductible HSA, by force, you're going to end up with the same situation.

The fact of the matter is, everybody has different needs. Not everybody wants to be engaged in the retail purchase of health care. They don't want to go negotiate with their doctor about how much

that visit is going to cost. Some people prefer that closed system HMO where everything is taken care of.

I think, really, our mission is to provide all of those choices in a competitive marketplace, and let free-market forces decide which of those plans provides the most value and the best efficiency at the right price for each individual.

I think that's kind of one of our fundamental business premises, that choice is good; employees want choice; they want to determine how much they're going to spend; and they want to determine how much coverage they get for that.

In terms of adverse selection, I guess I have a couple of comments: One is, there's a lot of talk about what do we do to prevent it? One of the things that happens is, I think, if we get so focused on preventing adverse selection, what ultimately happens is, we lose choice.

We lose a differentiation among products and insurers in the marketplace. Why? Because the way you minimize or mitigate adverse selection is to make everything the same, right? That's counter to what we're trying to do. We want to have differentiated choice for the individual.

If risk selection happens, adverse selection happens, kind of our philosophy is, then compensate for it. Don't spend so much time trying to prevent it, because of all the bad things that come with the prevention of adverse selection, but when it happens, the key is that the carriers need to get compensated appropriately for the risks that they get.

If they do, they now have an incentive to take care of that member. I think that's been the imbalance in this system, the connection of those two.

Chairman Bennett. Do you buy that, Dr. Blumberg?

Dr. Blumberg. What I agree with is that you expend a lot of resources to try to avoid adverse selection, and that's an efficiency loss; that's a lot of wasted time and effort.

I agree that insurers will always be better than any analyst I can think of who attempts to stop insurers from pursuing enrollment of a lower-cost risk group, using risk adjustment, regulations, or other techniques.

They are always going to be better than us at it. It's their job; they do it all the time. That's why I'm concerned about the direction of the policies that have either been implemented recently or are being seriously considered. Because although we have very limited experience with HSAs, as everyone has acknowledged, and we don't know exactly how bad the risk segmentation is going to be, all of these kinds of policies, the HSAs, the tax credits, the further deductions for high-deductible policies, the association health plans, will all have a tendency to move our market to a more segmented risk scenario.

With that, the proposals are not joined by other proposals that would compensate for this greater extent of segmentation that we're probably making. These proposals, therefore, do not acknowledge that there's no way we're going to be able to stop it from occurring, regardless of our different predictions of what the magnitude is going to be.

What I'm suggesting is that we look at proposals that are specifically designed to assist those individuals who are most vulnerable in these markets, and those are the people who incur high-cost illnesses and individuals who are of low and modest incomes.

To that extent, I agree with what Mr. Closs is saying.

Chairman Bennett. Mr. Ryan.

Representative Ryan. This is very interesting. I want to ask for a reaction on something that's happening right now, which is—I mentioned this in my opening statement, the FEHBP, the Federal Employee Health Benefit Plan. I'd like to ask each of your predictions on what you think is going to happen.

Now, this is the largest health insurance pool in the country with nine million Federal workers and their families. What OPM just did, the Office of Personnel Management, who is in charge of putting this together, this year—I think the open season starts in December—Federal employees will be able to choose HSAs.

To avoid these risks and adverse selection issues, they basically made the premium virtually identical to the other common low-deductible premiums, with all the other plans.

There has been an adjustment made by OPM, consciously, to try and avoid this, based on a big premium differential, so that's moving forward. We'll see this happening now, and from what we've been seeing from other testimony, is that the Federal Employee Health Benefit Plan is sort of a trend-setter in the large company marketplace.

We're already seeing a lot of early data coming in, that small and medium employers and the individual market, are really going toward HSAs. The adverse selection data that's coming in is splotchy. It's showing that sort of the opposite is occurring, but, again, it's too early to see.

What's your impression and your belief and your prediction on what this new policy will have? There are nine million people in this large pool, now having access to these plans. Will adverse selection occur, and, because of the premium adjustment, do you think that the bottom is going to fall out and the healthy and the wealthy employees in the Federal Government are going to flock to these and you'll have death spirals in the rest of the FEHBP? I'd just be curious to have everybody's reaction on that, and if you have studied this.

Dr. Blumberg. Well, it's an interesting issue, given that the structure, as you said, is that they're having the same premium being charged. I'm assuming that whatever extra contribution that the individual is making or the Federal Government is making into that plan, is going to go into the account, as opposed to the premium, so it still will be more attractive to individuals who have low expected health care costs. This is because they could use those dollars, not just for potential savings for retirement, which a lot of young people aren't that interested in doing, anyway, but also they can use it for discretionary types of medical care that aren't covered by traditional insurance or even by the high-deductible plans; things like eye glasses, cosmetic surgery and nonprescription drugs, those kinds of things. I think it still will be more attractive to the low cost for those reasons, and the premium savings.

Will they be able to prevent the death spiral? You know, FEHBP has some very clear experience with death spirals in the context of their Blue Cross-Blue Shield plan. Originally, they had two options, High Option and Standard Option Blue Cross-Blue Shield, with deductibles that were not that different, but there was some savings from taking the higher deductible plan.

The selection that occurred across those two plans, drove the premiums apart to the point where over time—and it did take time—the High Option Plan was no longer sustainable and was dropped a couple of years ago from FEHBP.

Do I have great confidence that they are going to be able to avoid segmentation? No, I don't have great confidence. Does it take quite a long time for death spirals to occur? It does take years. I don't think you're going to see the impact of it over a year or 2 years, but you'll start to see segmentation of the pools, if we can collect appropriate data. I don't know what OPM is doing to track what's going to be going on. It would be great if they were collecting data on the health status and the sociodemographics and the wage levels and the family status of the people that are enrolling in these different plans, so that we can really do a good assessment. But because I don't have great confidence in our ability to risk-adjust or to have a strong incentive to risk-adjust in the long run, I still have concerns.

Dr. Pauly. Well, my empirical answer to almost any question these days is no more than 15 percent, so I guess I would use that here. I think the number of Federal employees that are likely to enroll in this plan, would be no more than 15 percent.

I do think, though, it may well be, as I said in my remarks, that a high-deductible plan is the efficient plan, is the desirable plan for healthier people to use, compared to people with chronic conditions. In the best of all possible worlds, we'd like to have people have the efficient plan.

The way to—the question, though, is, will there be adverse consequences for the people who are at higher levels of risk? My answer to that is, in a sense, that's up to the Federal Government in terms of what premiums it wants to charge for the high-option plans, relative to the low-option plans.

There's no law of nature that requires it to allow the premiums for those plans to rise, relative to the HSA or to what already exists in fairly aggressive managed care plans. That can be adjusted, and if you say, as you might be thinking, "Well, what about total health care costs," then, if we don't penalize the high risks when the low risks are, in a sense, getting more than they should? The answer is, at least in economic theory, that you can adjust the money wages so that your total compensation budget stays the same.

The general philosophy—Mr. Ryan, you said the Federal employee plan is a trend-setter for plans around the country. There is one enormous difference: It offers many, many more plans than almost any private firm does. To some extent, perhaps Dr. Blumberg is right, it has more of a problem with the potential for selection, given the wide variety of plans.

But even so, with appropriate anticipation of what kind of risks will enroll in which plan, it's definitely possible to set the premium

differentials so that people end up where they should be. As I said, the kind of last resort to kind of make everything work out right, is to adjust the money wages, so that the total compensation cost stays within whatever target you set.

Mr. Closs. A couple of comments: One, I suspect that the risk selection will be a little higher in an HSA type plan. My personal opinion is that if people are sick and they know they are going to consume services, most of those services are going to happen on the other side of the deductible, all right?

So, they are going to use their cash, they're going to go past the deductible, and when they see that, they're most likely to pick a more comprehensive plan and not be exposed to that big out-of-pocket difference.

One would think that if people do have that information as they're purchasing, they may, in fact, end up with a more comprehensive plan and the more healthy will end up in a consumer-directed plan.

Again, our view is that that's fine, because we're going to compensate the carriers appropriately for that different risk, such that they are paid right.

What I want to do is talk just a little bit about the transition, and, as you said, how that moves into the large employer market, because our world is employer-sponsored.

Large employers, when they start to introduce a consumer-directed plan, they have less issues than the employer segment that we deal with, in large part because they are all self-funded. You know, the employer is the insurer, they have their own risk pool, so the risk pool is intact, no matter what people choose.

What changes is when you go into a smaller employer environment or mid-sized employer, and they buy insurance. If you have two insurance companies in that environment, that's where the dynamic occurs where the insurers won't share that business.

I think that's what we're trying to fix, is the fact that now those employers are really forced to make one choice, and that choice isn't going to fit everybody. If they go to that consumer-directed plan, it may be good for some, but it's not going to be good for all.

Really what we see is employers forced into a position today in this small and mid-sized segment, where they have to buy a single insurer, and generally they get one product. I mean, in our markets that we're in now, 80 percent of people have no choice. Only 20 percent have a choice of carriers.

I think it's important to understand the dynamic that occurs in an insurance environment, to figure out how we can make sure that we create a competitive environment where they can get all those plans and the death spiral won't happen.

Chairman Bennett. Did you say 80 percent have no choice, or 80 percent have a choice?

Mr. Closs. Eighty percent of employees in the States of Oregon and Washington, have one carrier and one plan.

Chairman Bennett. So they have no choice?

Mr. Closs. They have no choice.

Chairman Bennett. I see.

Representative Ryan. My time is up.

Chairman Bennett. Senator Reed.

Senator Reed. Well, thank you very much, Mr. Chairman, and thank you to the panel for their insights.

I was struck by Dr. Cardon's conclusion that at this point, it's hard to tell what the effect of HSAs are in terms of their impact on the health care system. That raises to me, the question of, since we're spending $70 billion already in the next 10 years, and the President is calling for $40 billion more, are we getting what we're paying for, particularly with respect to what I believe are the policy objectives, or should be the policy objectives, which are to broaden coverage and to reduce the premiums to make it more affordable, which are obviously related issues.

Dr. Pauly, do you think Health Savings Accounts are contributing in a meaningful way to increasing coverage and reducing the cost of premiums to the average person?

Dr. Pauly. Well, of course, I need to say, not yet. Nobody knows, but the potential—the primary potential advantages of Health Savings Accounts is, as I mentioned in my remarks, that by having people pay more out of pocket, they will be more prudent in their choice of health care.

That, of course, you could say, for someone who chooses an HSA, that's kind of the bargain they make. They agree to have less financial protection and more of a chance of getting a big bill that wiped out the account, but in return, on average, they'll end up being more frugal and spending less.

I think, you could just say, "Well, just let individuals choose HSAs, those who like them," but I think that from a general public policy point of view, I think there's pretty strong evidence that when the middle class chooses expensive health care, the premiums rise for everybody, and it's those rising premiums engendered by excessive insurance coverage and excessive health care purchases by people like me, that are causing health insurance to be unaffordable to lower income people.

If you ask me what's likely to be the greatest benefit of HSAs or any other cost containment feature, managed care or HMOs, I would include as, you know, the Gold Dust Twins of cost containment, and it is—the people who buy those plans can make their own decisions, but the reason why the rest of us have an interest in what those people do, who are generally not poor or near poor, is because there is this spillover or trickle down effect.

Then there has been some intriguing data from the HSA experience, which suggests that a surprisingly large fraction of people who bought those plans, were people who had formerly been uninsured. I don't have an easy explanation for that, but these days, I'm happy to hear good news, so I count that as good news.

Senator Reed. But let me return——

Dr. Pauly. But I think the main point is that their primary advantage, I think, is cost containment.

Senator Reed. Cost containment, so the other objectives, which would be essentially expansion of coverage, is probably less—not well served by HSAs?

Dr. Pauly. No. I think that's right, and that's well served by tax credits to help low-income people afford insurance.

Senator Reed. That gets to the point of tax advantages or the true nature of the tax system to relatively high-income people who have tax liabilities.

Dr. Pauly. Yes.

Senator Reed. Do you know, offhand, how many Americans don't pay taxes because they work, but they don't get to the point where they're paying income taxes?

I mean, my impression is, as I go through Rhode Island, that there are lots of people working 40 and 50 hours a week at very low-income jobs, who don't have health care, and would not be enticed to an HSA, because simply their tax liability is minimal. In fact, they pay more in payroll taxes than they do in any type of income tax.

Dr. Pauly. Well, I think that's right.

Chairman Bennett. Twenty percent of working Americans do not pay income tax.

Senator Reed. That would translate into a lot of people who would not essentially be enticed into the HSA model, because it doesn't make any real economic sense to them.

Dr. Pauly. I think that's right. Any plan whose advantage is tax deductibility, obviously only matters to people who have an income level at which that's relevant, or a tax exclusion.

In a way, what HSAs do is kind of level the playing field for those who do pay taxes, so that they will not be biased toward choosing excessively generous coverage and might decide to choose a plan that makes them somewhat more frugal, which may provide benefits to others. I guess the implication is, if you want to help the bottom 50 percent, you have to go to refundable tax credits.

Senator Reed. But the other aspect here is—and I guess I'm not talking with any quantitative data backing me up, other than my own sense of things—is that if you feel healthy, your sense of how much health care you need and how well you're going to tolerate the future, increases.

To a relatively healthy person, these HSAs are appealing, I would think. They've made a conscious decision that they don't need all the bells and whistles on a big plan, and so they say, "I'm a healthy person, I've got good genes," and it seems to me that this adverse selection issue is based not on any economic model, but just on sort of common sense or a common tendency of, if I'm healthy, I can get a tax break; I don't think I really need insurance. That might even account for those people who didn't have insurance before, and now since they have a tax break, they buy insurance.

It goes to this issue, I think, of what kind of people you're going to find in these HSA arrangements.

Dr. Pauly. Well, it is an effort to even things up. Now, if you're not healthy and you buy a very comprehensive plan, you get a big tax break, and so we're trying to be fair to the healthy and wealthy, as well as to the unhealthy and not wealthy, but I think, in terms of a factual matter, the question of who will choose HSAs and what their risk level will be, is more complicated than you think.

Of course, it depends on what the alternative plan would be that they might choose. If the alternative plan is actually the kind of

plan I have, which has a smaller deductible, a $500 deductible, but then copayment and out-of-pocket limit which is higher than the typical HSA deductible, if I were a high-risk person, I'd actually be better off in HSA/MSA plan than I would be in my current plan. They're actually compared—of course, compared to insurance that pays 100 cents on the dollar for everything, which nobody has anymore, HSAs do look more attractive to low risks, but compared to the alternative kinds of insurance that most people have, including what's in the Federal employees' plan, for the really high-risk people, the sort of stop-loss feature of most HSA plans, actually may mean they're better off than with the other.

Senator Reed. Thank you, Dr. Pauly. Thank you for your response. Dr. Cardon, and then I'll ask Dr. Blumberg. I'll do the academicians first.

Dr. Cardon. Same question?

Senator Reed. Any comment you have based on this.

Dr. Cardon. One comment I would have is, so, you're feeling good today and you think you have good genes. Well, just how sure are you? I think that there's a behavioral thing here that probably explains Dr. Pauly's 15-percent number.

People are uncomfortable with deductible plans, I mean, to some degree. I think that there is always going to be a tendency to sort of err on the side of caution and go toward the comprehensive plan, and I think that limits a lot of the selection that otherwise might occur.

There are other things, too. I mean, if I feel healthy, but I have two kids, how healthy are they? I'm not basing my selections, just on my own health, but on the sort of average health in a family, and that sort of muddies it up quite a bit.

Senator Reed. Thank you. Dr. Blumberg, your comments?

Dr. Blumberg. Thanks. First, with regard to objectives of our spending, I'd just like to say that in times when we have scarce resources, and we seem to always have scarce resources, I'd much rather see that our subsidies were being directed to those who are least likely to have health insurance in the absence of those subsidies.

I would suggest, and I think it would be hard to dispute, that the healthy and wealthy are not the ones that are least likely to have health insurance, in the absence of subsidies. While we do have some other subsidies that are upside down in our system, I would say that it doesn't make a lot of sense in terms of trying to expand health insurance coverage, to direct more subsidies to that well-off segment of the market.

In addition, I have relatively great skepticism about the potential for savings or the cost containment effect of HSAs. The reason I'm skeptical is because the bulk of dollars that are spent will still be in excess of that deductible.

Roughly 80 percent of the dollars in the health care system, will occur over those deductibles, even when you're talking about a $2,000 deductible. The share of expenses that you have at the bottom, that you're saying that people are going to spend out-of-pocket through the HSAs, is a small share of expenses.

Even if you're able to conserve a bit on that small share, what is the real extent of the savings going to be to the system? I would suggest that it would be relatively small.

I agree that time will tell, but I do feel like we're directing our energies in the wrong direction and away from the most vulnerable populations.

Senator Reed. Let me ask a followup question: My understanding—and you can clarify it if it's wrong—is that someone can have an HSA account, but as soon as they reach the age of Medicare, they can go into the Medicare system.

I would assume, since there is a certain correlation between health and age, that the real costs come at the point where we're actually picking up the tab through the Medicare system on many of the costs, so that these savings, these cost containment issues, as you point out, Dr. Blumberg, with a healthy 35 or 45 or 55-year old, are not the places where the real, the major cost are incurred in the system. Is that fair?

Dr. Blumberg. Well, I would not go quite there, because there are sizable costs associated with those under 65, and the distribution of expenditures there is just as skewed as you see among the elderly.

We do have very high-cost individuals who have not reached Medicare age, whose needs need to be addressed. But, clearly, cost containment is an issue, not just for the elderly, but the non-elderly, as well.

Senator Reed. Thank you. Mr. Closs, I was very impressed with the ingenuity and the logic of your business plan, which raises the question, why don't insurance companies do this themselves? Why do they need sort of an intermediary like yourself?

Mr. Closs. Great question. I think there are a couple of reasons: The first one is antitrust, because, you know, one of the things, when we get two insurers together, if we're going to move premium dollars around, right, we want to make sure that that is absolutely protected, such that particularly when it comes to pricing, that we want those insurers to compete aggressively for the employee in that employer group, such that we want each carrier to present prices based on that group, to try to get as many members as they can, again, trying to drive competition in there.

Two carriers together can't really coordinate that up-front effort toward the sales process and the pricing process. It's important to have an intermediary in there that protects that information, and we act as essentially a market-maker to keep that intact and to promote competition.

More importantly, after the fact, after people enroll, making sure that each carrier gets the appropriate amount of dollars. Neither carrier is going to trust each other to reallocate money to one another, so it's important to have that person behind the scenes, after the fact, to make sure that the premium dollars get to the right carrier.

Senator Reed. Thank you. Recognizing that the legitimate goal of an insurance company is to make profits for their shareholders or for their members, if it's a mutual organization, is there a distinction in the profitability of these Health Savings Accounts? I mean, have we seen that data anyplace?

Mr. Closs. I'm not aware that there's any data yet that would demonstrate that. I think it's too early.

Senator Reed. That's a quantitative issue that we haven't seen. I guess the other question I would have to the panel and to Mr. Closs, is—and this, I think, goes to the question we've been addressing all afternoon. What is the chief factor in changing the profitability of a Health Savings Account? Is it essentially making sure you pick healthy people, or is it something else?

Mr. Closs. Well, I would argue that in a risk-adjusted environment, it doesn't matter whether it's a healthy or sick person. If the carrier has an incentive to pick the healthy in the non-risk-adjusted environment, of course, there are going to be excess profits, potentially generated from taking the healthy.

But if you're actually putting an environment in place where they're competing and they know they're going to get paid appropriately for the risk, it takes that dynamic out, so if they get a sicker person in that HSA high-deductible plan, they're going to get more revenue that goes with that to take care of that person.

Senator Reed. OK, Dr. Blumberg.

Dr. Blumberg. I would just want to put a caution on what Mr. Closs said, in that I would agree with him in a perfectly risk-adjusted environment, but our technologies are not perfect for risk adjustment. In fact, the best available that's being used now, I believe, by your corporation and also by the Medicare Program, can get us to roughly half the theoretically explainable portion of the variation in expenditures.

Yes, it's true that the profitability of selecting risks goes away in a perfectly risk-adjusted environment, but nobody has that at this time.

Dr. Pauly. May I make a comment on the virtues of imperfection, which, of course, is the old maxim that you don't want to make the perfect the enemy of the good. We have got some insights into this question by interviewing the benefits managers of large firms, actually some years ago, asking them about medical savings accounts.

It was kind of interesting. They sort of fell into two camps: The slightly smaller camp were a set of people who said, "We are terribly worried about adverse selection and risk adjustment and we don't think we'll offer it, or we'll go slow."

Another group said, we tried to offer any benefit plan that a sizable fraction of our employees like. We said, "Well, aren't you worried about risk segmentation," and they said, "Well, no. For one thing, we can pretty well control that the total amount of difference in well being is pretty small, relative to our worker wages, and although the young workers might gain from the spending account in their health insurance, they're losing on the way we do pensions, without vesting the pension." In some ways, the sort of theoretical idea that you'd like to make things turn out perfectly, was trumped by the view that our primary role here in offering benefits is to offer a variety of things that our workers like, and not worry about small gains and losses, especially when they are more potential than actual.

If they turn out to be larger than small, the world—well, life is long and you can re-adjust things later.

Senator Reed. Thank you very much.

Dr. Pauly. In fact, a lot of firms do.

Senator Reed. Thank you, Doctor. Thank you, Mr. Chairman.

Chairman Bennett. Thank you very much. Having been an employer and wrestled with these challenges before I came to the Senate, I'm resonating with what you're saying, Dr. Pauly. We had a cafeteria plan in which we said to each employee, "You have $300 a month in what we called 'flex box.' You can spend them any way you want."

It was a fascinating kind of experience to discover the different situations with different employees. One employee said, "Are you nuts? I've got six kids—and Dr. Cardon, you may have only two, but I have six—I've got to have every one of those dollars in a health plan, in order to cover what might happen if a kid falls out of a tree, rides a motorcycle, whatever all else. Yeah, I'm healthy, but all that money has to go to a health plan."

The next employee comes in and says, "My husband works at Hill Air Force Base. He's covered by the Federal employee program. A health insurance program in this company would be redundant to the coverage that I already have through my husband, so can I use that money for daycare?" We said, "Sure, you know, give us the name of your daycare provider, and we will send that money every month to your daycare provider."

Next employee comes in and says, "My husband works at Kennicott, same thing, I don't need health care coverage, it would be redundant for me. My kids are all grown. Can you put that money in my 401(k)?" Yeah.

And so on. Interestingly enough, the benefit administrator who ran our plan said: "Don't offer life insurance. Life insurance is a bad investment. It's a bad mistake; don't offer it."

I said, "We're going to offer it." Well, we just told you it's a bad mistake. I said, "That's your determination. There may be employees who make a different determination, who may feel, for whatever reason, they want their benefit dollars in life insurance."

He said, "Well, they're making a mistake." I said, "I'm not going to make that decision for them; I'm going to allow them to make the decision." There was a small percentage of our employees who said, "If I have this much—these many benefit dollars to spend as I see fit, for my piece of mind, I want some life insurance."

Their determination of what amounted to peace of mind was different than the administrator's determination as to what amounted to peace of mind. I trusted the individual employee to make that decision, even though I might not have counseled them to buy life insurance.

It produced a much happier employee and a much higher level of employee morale, which is, after all, what I wanted. You know, I offer benefits in order to get people to come to work for me, and in order to make them feel like they want to stay working for me, instead of going off to work for my competitor.

I offered them a package of salary, and I offered them a package of retirement, and I offered them a package of benefits. That's what you do as employers, you compete in the pool for the best employees you can get, and then you act in ways that will hang onto them. You don't want to punish them or drive them away.

It was a very interesting experience to go through the cafeteria plan and discover how different people had different ideas, and, frankly, none of them struck me as irrational. Everyone had reasons for wanting what they wanted, and everyone came from a different situation and different circumstances.

The vast majority, of course, spent most, if not all of their benefit dollars for health care, but there were these other examples of people who said, "In our situation, it makes more sense." That experience convinced me that the old canard that the average person is incapable of making an intelligent decision with respect to health care, is just that; it's a canard; it's not the truth. I think we're smarter than many policymakers give us credit.

This has been a very helpful panel, in helping us understand the benefits, the opportunities, the challenges, and the pitfalls of expanding a degree of consumer choice with respect to health care. I thank you all for coming, and I thank you all for your contributions. Your full presentations will be in the record, and based on what we've seen at some of these other hearings, you'll be read by some very interesting people that you might not have anticipated when you made your submission to the Committee.

Again, thank you all. The Committee is adjourned.

[Whereupon, at 11:20 a.m., the hearing was adjourned.]

Submissions for the Record

PREPARED STATEMENT OF SENATOR ROBERT F. BENNETT, CHAIRMAN, U.S. SENATOR FROM UTAH

Good morning and welcome to our hearing on consumer choice in health insurance. Many consumers would like to have greater choice and control of their health care and health insurance coverage. They know from their experience with many other types of goods and services that choice and competition helps match their different tastes and preferences to those options providing the best value.

Recent efforts to increase consumer choice include:

- providing multiple health plan options with employer-sponsored coverage,
- offering new consumer-driven health care arrangements such as Health Savings Accounts,
- reforming Medicare financing to strengthen private plan alternatives in what was originally called the Medicare+Choice program back in 1997, and was changed to Medicare Advantage in last year's Medicare Modernization Act, and
- trying to level the playing field for those purchasers who select individual insurance market products rather than employer group insurance coverage.

To be fair, some of those initiatives have advanced further than other ones. In part, that's because various plans to increase consumer choice in health insurance often face criticism that they will trigger a host of purported dangers, usually starting with what's called adverse selection. That term tends to be loosely defined and widely used in health policy debates. Its most accurate definition is when consumers know significant private information about their expected expenses that their insurers do not know. In that case, it's more likely that insurance buyers who know that their risks are greater than average will want to purchase more insurance when it's priced based on average risk. Buyers who expect their risks to be lower than average will prefer less insurance coverage.

This simple description of adverse selection then projects that insurance premiums for the original coverage offered will increase more than otherwise, because low risks either switch to other types of insurance or, in the extreme, drop coverage entirely. The end result is presumed to trigger a "death spiral" of rising claims costs and fewer paying customers to finance them under the initial insurance policy. In the worst-case scenario, the death spiral extends to the overall health insurance market, which can break down completely.

Those who believe that more consumer choice in health insurance is just another risky scheme are likely to handicap it, if not prohibit it, through such policy measures as community rating, standardized benefits, coverage mandates, and preferential subsidies.

Today's hearing will examine how employers and insurers can offer better choices to consumers in practice without producing the sort of adverse consequences sometimes predicted in theory. We want to determine what really happens in insurance markets in the pooling and pricing of risks and sort out real problems from imagined ones. It appears that there are natural limits on the scope and scale of potential adverse selection problems. Employers and insurers seem to manage remaining ones rather effectively in most cases. Nevertheless, there may be policy opportunities to improve access to the care and coverage that consumers value most.

Health insurance coverage, of course, is just a means to an end. The real objective is better health and better, outcomes from medical treatment. But improving the value of insurance that's available to a diverse population of consumers is an important part of that process. Increasing their choices, rather than reducing them, seems to be a fundamental starting point for upgrading the status quo.

Our panel of witnesses today includes Dr. Mark Pauly, one of the nation's leading health economists from the Wharton School at the University of Pennsylvania. He has written extensively about the operations of health insurance markets and how public policy may shape them.

Dr. James Cardon of Brigham Young University has examined whether consumers have private information advantages over insurers that could trigger adverse selection and distort health insurance markets. His most recent research focuses on the effects of new consumer driven health care choices like Health Savings Accounts.

Jeffrey Closs is president of BENU a company that provides benefits choice center services to mid-sized employers. BENU uses risk adjustment tools to encourage insurers to compete more vigorously for portions of an employer's business and provide more meaningful choices for covered employees.

Linda Blumberg of the Urban Institute has studied issues of risk selection and risk segmentation in voluntary insurance markets, particularly those involving small employers and individual consumers.

PREPARED STATEMENT OF SENATOR JACK REED, U.S. SENATOR FROM RHODE ISLAND

Thank you, Chairman Bennett. I want to thank the Chairman for holding today's hearing on the issue of "adverse selection" in health insurance markets. This is obviously an important issue given the amount of attention that has recently been given to high-deductible health plans, such as Health Savings Accounts (HSAs).

This hearing gets to the heart of the debate over HSAs, which is whether or not they will encourage healthy and wealthy people to opt for higher-deductible plans, while less healthy people are left in increasingly expensive traditional insurance plans. Unfortunately, illness affects everyone, regardless of age, race or economic status.

Since HSAs appeal to a healthier population with fewer health care costs, they could actually have negative consequences for less-healthy people seeking insurance. The clear danger is that HSAs will divide the insurance market between healthy and less healthy people, making the health care system even more inequitable than it is today as insurers adjust pricing to reflect the risk pools in each type of insurance.

If HSAs attract the healthiest people, those Americans with traditional insurance will face higher premiums and increased cost-sharing. Higher premiums will put tremendous pressure on companies to stop offering comprehensive, traditional insurance. Companies will either pass on the higher costs to employees, make them switch to an HSA or simply drop coverage. While proponents of HSAs argue that they offer consumers more choice, those may not be terribly attractive choices to many people.

President Bush has proposed spending $41 billion on HSAs and high-deductible plans, which will at best extend health insurance to a tiny fraction of the 44 million who don't have coverage today. Clearly, this policy is not directed toward insuring the uninsured. It looks more like HSAs are another tax shelter for the wealthy—who have no trouble affording insurance or quality health care—rather than an innovative approach to expanding health care coverage.

I'm skeptical of the benefits of HSAs, which probably won't reduce costs or increase health coverage. Nevertheless, I hope today's hearing will shed some light on whether or not HSAs will make it easier for patients to get the care they need.

PREPARED STATEMENT OF MARK V. PAULY, PH.D., BENDHEIM PROFESSOR, PROFESSOR OF HEALTH CARE SYSTEMS, INSURANCE AND RISK MANAGEMENT, AND BUSINESS AND PUBLIC POLICY IN THE WHARTON SCHOOL, AND PROFESSOR OF ECONOMICS IN THE COLLEGE OF ARTS AND SCIENCES, UNIVERSITY OF PENNSYLVANIA

Thank you, Mr. Chairman, and members of the committee, for an opportunity to testify on adverse selection in health insurance and related issues.

Private health insurance would be far less controversial if we lived in a world where everyone was similar in terms of risk. Then insurers would charge similar premiums to everyone who put similar effort into shopping for a given policy, and would be equally eager to sell insurance to anyone. After the fact, those lucky enough to have low actual health expenses would have paid in more than they got back from insurance, but this redistribution from those who did not become sick to those who did would be something that everyone would agree before the fact was both fair and attractive, and all would be eager to buy insurance as long as the premium was not too much higher than expected benefits.

The world in which we do live, it is obvious, is different. It is one in which "risk" varies before the fact, in the sense that different consumers reasonably expect to collect different amounts in benefits from a given policy because they expect to get sick with different frequencies and severities. Insurers can identify and measure

some characteristics that they know predict above or below average benefits, characteristics such as age, location, and the presence of chronic conditions. Insurance markets can still function in such a world, but now either premiums or purchases will be different for different people.

What will happen depends crucially on whether insurers have and can use the same information that predicts benefits as consumers can use. If everyone has the same information, and the information does predict different risk levels, then insurance theory (Rothschild and Stiglitz, 1976) tells us that insurers will choose to charge below average premium to the lower risks and above average premiums to the higher risks. Someone who has four times the expected benefits from a given policy compared to someone else will be charged about four times the premium. At those premiums, insurers will be equally eager to sell to low and high risks. In insurance theory, this situation of *proportional risk rating* will be stable and probably will be one in which low risks are no less likely to buy insurance than high risks. (Some very high risks with low incomes may find that premiums are so high and expenses so near certain that they are just as well off not buying insurance they cannot afford and paying those expenses directly when and if they can.)

Insurance markets, the same theory also tells us, will be very different if insurers do not have equal information to what buyers have, or if insurers are not allowed to use the information they do have in setting premiums and bidding for business. In the extreme case in which insurers either cannot distinguish among risks or are not permitted to do so, they will be forced to charge the same premium to everyone who buys insurance. But if the insurance purchasers know their risk levels, their willingness to buy insurance at this premium will vary. Higher risks will be very enthusiastic about buying, since they can on average collect in benefits more than they pay in premiums. But low risks may, in the limit, decide not to buy insurance at all because it looks like a bad deal to them, or may at least seek to buy less generous coverage than the high risks desire. This situation of *community rating* will be one in which the low risks are less likely to buy insurance than under risk rating. In the limiting case in which the low risks bail out altogether, the so-called *death spiral*, the premium insurers end up charging to the high risks will be the same as they would have charged under risk rating; the effect of community rating will only be to drive out all of the low risks (which is definitely not the same as no risk) from the insurance market, with resulting adverse effects on access to care and financial stability. It is in this sense that community rating can be inefficient compared to risk rating, since it can make the low risks worse off and not make the high risks better off (Pauly, 1970). In the less extreme case in which some low risks might continue to buy, the high risks could be better off but the low risks will still be worse off than they would have been under risk rating. There will still be inefficiency compared to the ideal because the low risks will choose less coverage than they would have chosen if they had faced premiums reflective of the true cost of their coverage.

Whether there will be *cream skimming*, in which insurers are more eager to sell to low risks than to high, depends on whether the adverse selection-community rating is *essential* (caused by insurer inability to tell risks apart) or *inessential* (caused by regulations or policies which forbid insurers from using information they have to set lower premiums for lower risk and higher premiums for higher risks). In the case of essential adverse selection, as in the case of risk rating, there should be no cream skimming because all potential purchasers look equally profitable to insurers. Insurers might want to cover only the low risks, but they cannot tell who is who. In the less extreme case of regulation-required community rating, insurers will try to avoid selling to high risks they can identify, on whom (as a group) they are sure to lose money; there will be *cream skimming*.

For these kinds of reasons, some insurance analysts think risk rating is better than community rating. But many policymakers, and some other analysts, do not look at it that way. They do note the downside of community rating in terms of squeezing out the low risks, even to the extent of a death spiral in which at some point only the highest risks end up buying. (This should really be called a near-death spiral because at that point it will be profitable for some insurer to enter and offer a less generous plan at a much lower premium that can pull some of the lower risks back into the market; the market will rise, phoenix-like, only to go into another spiral.) But policymakers also find much not to like in risk rating, precisely because the higher premiums for higher risks may bite into their ability to consume other necessities for life if they have low income, and sometimes because observing higher income high risks paying more than higher income low risks still looks unfair, especially compared to a policymakers' dream world in which everyone pays a low premium. That this is impossible in a world of competitive but unsubsidized insurance markets only marginally dampens their ardor.

The most obvious way to deal with these problems is to use regulation. Require insurers to charge similar premiums (or limit premiums for high risks), but forbid low risks from buying less generous policies. Then require insurers to sell policies to high risks they know will be causing losses, and, when there is enough political nerve, forbid insurers and the low risks from dropping out by mandating insurance purchasing. Measures short of this draconian one can still lead to bad adverse-selection type outcomes, especially when community-rating rules force insurers to ignore information they have and thus lead to *inessential adverse selection*. Then, when insurers respond to community rating regulations with cream skimming, one needs to write yet more regulations to require open enrollment and guaranteed issue. To avoid the death spiral, we move to a regulatory spiral. As with other kinds of health care regulation, how bad (or good) the regulatory outcome will be seems in practice to vary across states, depending on the characteristics of their potential insureds and the form and administration of the rules. In some states such rules seriously curtail the size of the insurance markets, while in others the main effect is only discontent among the low risks and the insurers who would like to sell to them.

The main novel point I want to make here is that recent research suggests that, in both theory and practice, there are ways alternative to regulation to get closer to what policyrnakers want (or should want) when risk rating and adverse selection are possible. Compared to perfect regulation administered with perfect regulation, or even to the wise and prudent regulation that occasionally happens, these alternatives may still leave something to be desired. But compared to the kind of regulation we have had or can generally expect to have, they at least deserve equal billing and equal consideration. These alternatives may work better if some other government actions are curtailed and some modest regulation applied to encouraging the alternatives.

To be specific: one might suppose that, as is often the case, policymakers must choose between two undesirable outcomes—unfair risk rating or inefficient community rating—in order to deal reasonably well with risk variation. New developments in research (Pauly, Kunreuther, and Hirth, 1995; Cochrane, 1995) suggests that, in theory and in fact, in many circumstances realistic competitive insurance markets can avoid much of both bad situations, and that a relatively modest amount of public intervention can deal with the cases that fall through the remaining cracks. The fundamental reason for this market behavior is that potential insurance consumers also dislike the more negative aspects of either kind of behavior, and competitive insurers have developed methods to avoid them. The fundamental reason for the political behavior is that some policymakers have already developed some well-tailored solutions that leave the market intact but rein in the worst cases.

The three kinds of "solutions" to which I want to draw your attention are (1) guaranteed renewability at uniform premiums, (2) group insurance, and (3) high risk pools. Because the first is much less well understood than the other two, I will discuss it in more detail, but I will also comment on the other two devices.

The great majority of people who are high risk today were not sicker than average at all times in their lives. Data shows what common sense tells us: even people who are in excellent health have higher medical expenses on average as they age, and some pick up chronic conditions. The age-related part of increasing risk is perfectly predictable; what is not predictable is the random onset of a chronic condition that makes a person high risk not only initially but for some time to come, possibly for life.

Most medical expenses for people under 65 are not related to chronic conditions; they come from the "bolt-from-the-blue" event of an accident, a stroke, or a complication of pregnancy that we know will happen on average but whose victim we cannot (and they cannot) predict well in advance. This is precisely the kind of low probability, high cost event for which insurance works extremely well as a device for substituting a smaller certain payment for an unexpected rare but large payment. Sometimes, however, what strikes unexpectedly is a condition from which the person is unlikely to recover rapidly; such random but then chronic conditions make future medical expenses higher for people who have them. If insurance premiums were proportionately risk rated to the risk prevailing for the next year (the usual time period for health insurance), people who are well today and have no chronic conditions at the moment would face the chance of contracting such a condition with two bad financial outcomes. Not only is diagnosis usually associated with high immediate medical expenses, it would also be associated with a sudden and serious jump in premiums.

Risk averse people should want to have protection not only against high current period expenses but against the unexpected onset of a condition that might entail high lifetime premiums; they would seek protection against "the risk of becoming a high risk." In some real world health insurance markets such protection exists

and was quite common even in the absence of regulatory rules. Specifically, most health insurance policies bought on an individual basis contained a provision also common in individual term life or disability insurance: guaranteed renewability at class average premiums. With this provision, the insurer promises not to single out insureds whose risk has increased more than average for high premiums when they renew their coverage. Instead, they are to be charged the same premiums as are charged to everyone else who was in the same initial (usually low) risk class as they and bought the same type of coverage. Administering such a guarantee is easy for an insurer: it promises to base its future premiums only on whatever information it collected about risk when it initially sold the coverage; it promises not to revisit the question of risk based on new data that might be obtained from the person or even based on the claims history data that the insurer has; it promises not to "re-underwrite." This provision does not guarantee constant premiums; premiums can rise if expected medical expenses rise for everyone in the risk class (say, because of higher medical prices), and premiums may rise according to a schedule specified in advance as a function of perfectly predictable things, like growing older. But the person with coverage with this feature is protected against the bad luck of becoming riskier than average, and therefore will not pay a higher premium on becoming a high risk. This feature is not free, of course; policies that contain it must have higher initial premiums ("frontloading") than would premiums for a policy for which the insurer retained the right to increase premiums for people who contracted a chronic illness. But it is easy to see why rational, foresighted people would prefer the slightly more expensive but surer policy to the cheaper but riskier one.

Federal law now requires states to ensure guaranteed renewability for individual (but not group) insurance policies. But even before the spread of such State laws, industry observers estimated that about 80 percent of policies voluntarily (on the parts of both buyers and sellers) contained such provisions. (Pauly, Percy, and Herring, 1999) There is, however, considerable debate about how they work in practice, debate which is assisted by the absence of nationwide comprehensive data on practices in insurance markets, especially in the individual market, so that evidence tends to consist of anecdotes and problematic surmises. There certainly have been cases in which insurers were caught engaging in re-underwriting even when they were forbidden to do so, and a number of State insurance departments have said that they would prohibit risk rating at renewal even in the absence of specific State law under their general authority to limit arbitrary and excessively discriminatory premiums (Patel and Pauly, 2003). Some insurers are said to have gotten around the requirement to continue to cover high risks by raising premiums for all insureds so that all drop out of the risk class, and then selectively re-enrolling only those low risks who have not been put off by this behavior. Insurance brokers and agents insist that they pay attention to this kind of behavior and steer customers who come to them for advice away from insurers who engage in semi-shady practices. We know that this feature does not work perfectly everywhere for everyone, but how well does it work on average?

Research has provided some data that is highly consistent with guaranteed renewability generally operating as the theory and the intent of the contractual provision suggests (Pauly and Herring, 1999; Pauly and Herring, 2001). This finding is striking enough that it deserves to be emphasized even beyond the issue of guaranteed renewability. To be specific, *there is very strong empirical evidence that the premiums higher risk insureds pay are much lower than would be consistent with proportional risk rating*. Stated slightly differently, while high risks do pay higher premiums than low risks, the increase in premium with risk is much less than proportional to the increase in risk.

This result has been obtained in a large number of studies using large nationwide data sets from different time periods. Depending on the measure used of risk, the "elasticity of premiums with respect to risk" in multivariate analysis of data ranges from about 20 percent to less than 50 percent; never higher. That is a person whose risk is twice as high as average will pay a premium only 20 percent higher. Table 1 shows more intuitive evidence for this proposition. It uses data from the late 1980's before there was widespread premium regulation in the individual insurance market or requirements of guaranteed renewability, but when that feature was common nevertheless. The risk level for a person in the data set is characterized by the person's age, gender, location (to measure differences in medical cost), and pre-existing chronic conditions. Statistical models were used to relate the actual medical expenses, and the actual insurance benefits received for each person, to that person's values for these variables; the estimate of risk for that person is then the "predicted value" of their medical expenses (that is, the average medical expense for a large number of people with the same values for these characteristics as they). Those risk estimates were then used to select a sample of people with individual health insur-

ance expected to have medical expenses in the top 10 percent of possible values of risk, and another sample of people in the bottom half of those values. As the first line of the table shows, the expected expenses, the actual average expenses, and the actual average insurance benefits were much higher for the high risks than the below-average risks. The average benefits for the high risks were 11 times greater (at $2054 per person) than for the lower risks (at $187). The premiums were higher for the higher risks too, but the key point is that the premium for these very high risks (at $1150) were only 1.4 times greater than that of the low risks ($825); there was a substantial amount of averaging of risk in the premium structure.

While there are doubtless many causes for this phenomenon, one of them probably is guaranteed renewability. People with such provisions would not be paying premiums that were higher than average because they became higher risks. Of course, some people in the data were new purchasers of insurance whose premiums would be risk rated, but apparently by no means all. There is even stronger evidence. We looked at how premiums and risk varied with age for similar policies. Insurers certainly can determine a buyer's age, and they certainly can determine that, other things held constant, expected expenses and benefit payments will rise with age (especially for men). What we found, however, was that the premium paid by the average older man was only about 40 percent higher than that for the average younger man when the expected expenses differed by a factor of two to one. But this pattern of overpayment relative to expected expense for the younger people who would generally be the new buyers of insurance is exactly the frontloading that would be predicted to arise under guaranteed renewability (but that would be unstable in competitive insurance markets under proportional risk rating). We have further examined the path of premiums and benefits with age in this market and find that it corresponds rather well with the path that would be consistent with guaranteed renewability. In doing this analysis, we adjusted for the fact that people often do not keep their individual coverage from a given firm but drop it because they have taken a job that carries coverage or because they switch insurers. Because the low risks have already prepaid their contribution to the high risks, their dropping out does not cause any problems for the ability of insurers to continue to maintain protection for higher risks. Some high risks do drop out as well but, as expected, at a much lower rate.

In our analysis of individual insurance data we found that only the locational and demographic variables were consistently related to higher premiums. The person's health status when they bought insurance (measured by the presence of a pre-existing chronic condition) was not statistically related to premiums, but the scarcity of observations on people with such conditions means that our estimates are themselves necessarily imprecise (Jack Hadley and James Reschovsky, 2003) using a different risk measure (contemporaneous health status) and a more sophisticated but somewhat delicate statistical technique, did find that people in poorer health paid higher premiums, but even there the increase in premiums was much less than the increase in risk. I therefore conclude that individual insurance markets (even when they were unregulated) provided a substantial amount of protection against the adverse effects of risk rating to people who did what we want them to do—bought insurance before they became high risks, and stuck with their insurance rather than becoming uninsured.

Risk rating can only occur if insurers can determine risk levels; under perfect risk rating, there can be no adverse selection. However, in a world in which buyers of insurance may sometimes know more than sellers, it is interesting to note that guaranteed renewability provides potentially important protection against adverse selection. If people buy this coverage early in life (as they should to take advantage of the provision), they are likely to be much more similar in risk levels than they will become later on. And since it is rational for the people who remain healthy to stay in their original policy where they have already made transfers to those in their cohort who became higher risks, it is less likely that they will drop out and start a death spiral. Finally, if those who remain lower risk do drop out or are lured away, because they have already prepaid their transfer to the high risks, the insurer does not need to raise premiums to the high risks.

We have investigated some of the other reasons why higher risks pay premiums that are less than proportional to their relative risk levels. There is evidence that higher risks search more intensively to find a premium that is low relative to the expected benefits; it makes more sense to checkout many insurers (or use a broker to do so) when one is paying $400 a month for insurance, than when one is 25 and paying less than $100 a month for insurance (Pauly, Herring, and Song, 2003). And it probably is true that some risk factors, like the decision on the timing of the next child or the repair of an old football injury, is better known to the insured than to

the insurer. But this phenomenon may be partially offset by the fact that insurers actually have more accurate data on risks than typical insurance consumers do.

Another feature of insurance that can protect against uncertain jumps in premiums and adverse selection is group insurance. The great bulk of Americans obtain their health insurance as group insurance related to their employment. Probably the main reason they do so does not have to do with any risk variation factors, but rather to the substantial tax subsidy to workers (*not* to employers) present in the exclusion of compensation received as health benefits from income and payroll taxation. But group insurance probably does have some features that deter the kind of behavior theory was earlier said to predict.

Most simply (but not most obviously), group insurance offers a much better deal for your money for a given policy than does individual insurance. The difference between the premium one pays and the benefit one should expect on average to get in group insurance is lower than for individual insurance both because of economies of scale associated with group purchasing (especially lower selling and billing costs) and because of the tax subsidy. These features in effect may make insurance such a good deal for the wealthiest low risks (who get the biggest tax subsidies) that they will not be motivated to drop coverage and start a death spiral even if their premium is not properly tailored to their risk. As long as a low risk's net premium is low enough after the tax benefits are taken into account, the fact that there is some cross subsidy to higher risks may not matter.

A more complicated issue is whether or not employment-based group insurance in some sense "pools risk" more than other arrangements. For large groups, there is no explicit individual underwriting, but the cost of that function is only a tiny fraction of any insurer's administrative cost. There can be variation in premiums with risk across small groups; a firm of three 25-year-olds in good health will pay much less than a firm of three 60-year olds who are out of shape. Moreover, the requirement that one be able to work to qualify for one's own employment based insurance serves to automatically screen out the highest risks and those unable to take a job because they are caring for a dependent with high risk. But the key determinant of access to insurance and net payments for insurance is the policies employers follow with regard to this benefit:

One thing that employers are motivated to do is to try to keep as many of their employees in the insurance plan as they can, because the premium, or even the availability of group insurance, depends on the participation level of workers in the firm. Let too many of them drop out, and the group insurance may not be offered by an outside insurer. Even self-insured employers (who cover the majority of workers nowadays) want to achieve economies of scale. Thus employers should want to avoid death spirals and widespread non-participation.

Probably most importantly, workers in group insurance almost never pay an explicit total premium that is related to their precise risk levels; they almost always all pay the same employee premium if they choose the same policy for the same-sized household unit. (There *is* explicit risk rating for the higher risk associated with having more people covered under a family policy relative to an individual policy). However, economists believe that workers pay for the bulk of their group insurance not through explicit premiums but through lower wages, and generally money wages are not explicitly adjusted based on an individual employee's risk level.

The evidence does, however, strongly suggest that worker wages are adjusted to some extent to reflect the different cost of insurance as a function of risk (Pauly and Herring, 1999; Sheiner, 1994). Wages vary by seniority, and more senior workers are usually older. What we found was that, other things equal, wages increased significantly less rapidly with seniority for workers who obtained job-based insurance than for those who did not; we interpret this as the effect of higher insurance costs taking away some of what would have been the usual raise associated with more experience and seniority. Moreover, common sense tells us that an employer cannot take the typical $6000 "employer contribution" out of the wages of younger workers and still expect to compete to hire those workers with other firms that offer higher cash wages and no coverage.

There is no evidence that wages vary with health status given age and gender (though the lower wages of women could in part reflect their higher medical costs). But remember that with guaranteed renewability, premiums in individual insurance also need not vary with health status. Thus I would conclude that the amount of risk pooling in group insurance is at best only very modestly greater than in individual insurance on average. The difference would be greatest between a high risk person able to get a job at a firm that offers benefits and what that person would be charged as a new applicant for individual insurance. But the job with insurance is by no means assured to a high risk, and the typical buyer of individual insurance

is renewing, not buying new, so this difference tends to average out to a small number if it is present at all.

The main virtue of group coverage in terms of risk variation is not risk pooling per se but rather that it discourages adverse selection. It does so in several ways. Most obviously, the range of insurance choices a person has within a firm is usually much smaller than the range of choices in individual insurance, and any opportunity to choose less generous coverage (whether it is a high deductible plan or a cost constraining HMO) offers a chance for low risks to separate themselves out. The downside of this advantage is less choice, but firms and their workforces are free to make this choice not to have many choices.

Equally, if not more important, is the fact that the worker who chooses to decline group insurance while remaining in the firm almost never recaptures the full premium for that coverage. Instead the worker will get back any employee premium and (in some firms) a small bonus for refusing coverage, but that reward is almost always much less than the value of the insurance even to a low risk. We do have a problem with more workers offered employment-based coverage rejecting it, especially as the average explicit employee premium has risen, but there are almost no cases where rejecting coverage to save the employee premium would be rational behavior if the person thought that without coverage they would have to pay for all of their medical care out of pocket. (They might drop and expect to rely on family assistance or charity care, and the still tiny fraction of people offered coverage who reject it may just be the minority of any population who are irrational or unthinking.)

So there is very little total dropping out by lower risks, but do they inefficiently drop back to less generous coverage? Not necessarily, because employers can if they wish control adverse selection and risk rating. The simplest way to do this is to offer only one plan. But even when employers offer several plans, the key to controlling selection is to properly set the difference in employee premiums (or in the contribution to spending accounts) across plans (Cutler and Reber, 1998; Pauly and Herring, 2000). If employers foolishly make the premium much lower for the less generous plans, then all but the highest risk will join them, leaving the few remaining high risks in a more generous plan. But research shows employers how to calibrate the premium difference to reflect the premium cost reduction associated with the low risks (not the average and certainly not the difference in expected benefits when the low risks have already sorted into the less generous plan). So employers who want to control adverse selection can do so to a considerable extent (though not perfectly), especially if they self insure all of the plans they offer. Things are somewhat more complex if multiple outside insurers are used and those insurers are not given the data they need to estimate the risk levels of the people who will choose their plans. Risk adjustment of the total premium the insurer gets combined with appropriate setting of premium differentials will prevent adverse selection if that is an employer goal.

Research (Pauly, Percy, Rosenbloom and Shih, 2000) suggests that some employers try to limit the choice of options and set the premiums to control adverse selection, while others take the view that any redistribution away from older workers in their health plan offering is probably offset from redistribution toward such workers in their pension plan or in other benefits, and that the total amount of redistribution (and inefficiency) is small. As long as the least generous plan offered is still a decent plan even for higher risks, there probably need be little policymaker concern about adverse selection in group insurance. Personally I would only be concerned about offering a health savings account type plan to very low income workers, or offering a very restrictive HMO to workers who would react strongly to limits on access, but I would not be much concerned in general.

How does the rate of takeup of insurance vary with risk level in group and individual insurance? Are higher risks more likely to have coverage than lower risks (which would be consistent with adverse selection), are they less likely (which would be consistent with very strong risk rating), or is coverage nearly universal and independent of risk (which would be ideal)?

Research on this subject is far from definitive. Studies that have looked at people in households where someone is a full time employee (and therefore potentially eligible for group insurance if the person chooses or is able to get a job at a firm offering coverage), the strongest and most consistent finding is that the size of firm in the industry or occupation of the worker is by far the most important predictor of having coverage (along with the size of the tax subsidy and therefore income) (Pauly and Herring, 2000). People who work in industries dominated by larger firms are much more likely to end up with coverage than those who work in small firm industries. The relationship of coverage to risk, given firm size, is less well understood. What we observe seems to depend on what measure of health risk we use. If we

use chronic conditions as the measure, employed higher risks are more likely to have coverage than employed lower risks. If we use self reported health status, coverage may be less likely for high risks. Analysis of the late 1980's data showed that high risks were significantly less likely to have group coverage only if they were low-income people working in small firms, but not otherwise (Pauly and Herring, 1999). There is little evidence that employers in general have difficulty in continuing to offer coverage to people who become high risks, and no evidence at all that they have problems with people who have unexpected high expenditures.

It is much harder to determine how risk levels affect the likelihood of having coverage in the individual market because anyone can participate in that market, but most people do not do so and instead obtain group insurance. We have looked at people in households where no one is a full time employee—the household's income comes from self employment, part time work, or non-work sources. The relationship here depends even more on the measure of risk. Len Nichols and I (2002) found that if we measure risk by age, controlling for income, older people in "non-group" households were much more likely to have individual coverage, despite higher premiums, than younger people. We also found that people with chronic conditions were more likely to have coverage, although the relationship was not as strong. On the other hand, when risk is measured by self-reported health status, people who label their health as fair or poor are less likely to have individual coverage controlling for income; this is the opposite of adverse selection. One puzzle in the data is that many of those with insurance, who say that no one in their household works full time, still list themselves as having obtained group insurance coverage; there is no clean division of the population between those with access to group insurance and those who must use the individual market.

Precisely for this reason one should be very cautious in trying to draw conclusions about the comparative performance of individual and group insurance markets. If I was forced to do so, I would conclude that there may be differences in the likelihood of obtaining individual insurance coverage by people who are very high risks when they seek coverage, but that if the group market does better, the differences are small, and are limited by the fact that many very high risks do not have access to employment-based insurance. It would be nearly impossible to provide those currently without a group option access to that option on the same terms as the current users. I think the differences in the extent to which net premiums do (or could) vary with risk are small, and any stronger relationship in the individual market is attributable to its small size and marginal or add-on character. For example, a person who had group insurance, who contracts a high risk condition, loses their job and insurance, and uses up their COBRA coverage, will be recorded as a high risk trying to buy new coverage in the individual market. But one could argue that placing the person in that situation is as much the fault of the link between tax subsides and group insurance which does not provide guaranteed renwability protection to individual workers as it is the fault of individual insurance.

Fortunately, there is a device available to pick up the pieces without requiring the imputation of blame: high risk pools. I do not intend to discuss the actual working of these pools in detail. Instead I want to point out that the concept of having a subsidized, decent though limited coverage policy available to high risks unable to obtain or retain individual or group coverage makes great sense as a safety net. Since the number of high risks is by definition low, it avoids having to distort insurance markets for the great majority who are not high risks in order to make transfers to a few unlucky people. Some of the more anecdotal research shows that almost any risk can obtain individual coverage if they persist at searching long enough, but those who have already been rejected or quoted very high premiums perhaps ought to have another option than spending their time with insurance brokers. In idealized concept, a high risk pool ought to offer coverage at premiums somewhat higher than those charged for good risks but still at reasonable levels to people who have tried and failed to obtain coverage on their own. The financing of these pools should be generous enough to accommodate those who need to use them, and that financing should be raised by general revenue taxation, not by requiring insurers to contribute and thus raising premiums which drive more people out of regular insurance. The terms of coverage (premiums, type of coverage) should be only moderately attractive, because we want to preserve incentives to people to obtain voluntary coverage before they become high risk, rather than wait to pick up attractive subsidized high risk coverage when and if that happens. I am hopeful that it is possible to design a plan that walks this fine line and still preserves an opportunity for people to obtain coverage that will give them financial protection and access to care. Coordinating high risk pools with guaranteed renewability provisions would seem to be desirable.

To sum up: the important problems with private health insurance in the United States are not associated with the risk variation-risk segmentation issues that are so prominent in insurance theory and many policy discussions. Our problem is not that the insurance is expensive and unattractive for high risks; it is that in some cases it is expensive and unattractive for all risks. It is true that the largest single segment of the uninsured population is low risk healthy twenty-somethings, and some adverse selection in group and individual insurance may modestly contribute to this. But I believe that a much larger contributor is the absence of generous subsidies and the absence of marketing efforts targeted at this group; there may actually be too little effort at cream skimming those low risks who remain uninsured.

This is especially the case for people who are discriminated against by being ineligible for generous tax subsidies when they buy insurance (the non-self-employed in the individual market) and those who could have access to products with lower across-the-board administrative costs but do not currently have such access. Finally, the key background issue of what if anything we want to do when premiums are rising not because of insurance market behavior but because medical care is becoming both more costly and yet much better should really be front and center in the policy debate.

Table 1.—Expenses in Nongroup Individual Coverage, by Risk (Expected Expense)

	Bottom 50%	Top 10%
Actual benefits	$187	$2054
Premiums	825	1150
Actual expenses (total)	555	3504

Source: Pauly and Herring (1999), based on 1987 NMES data.

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PREPARED STATEMENT OF JAMES H. CARDON, PH.D. ASSOCIATE PROFESSOR OF ECONOMICS DEPARTMENT OF ECONOMICS, BRIGHAM YOUNG UNIVERSITY

Mr. Chairman and Members of the Committee:

I have been asked to comment on the problem of adverse selection, both generally and as it might apply to consumer-directed health plans, such as Health Reimbursement Arrangements (HRA), and the new Health Savings Accounts (HSA).

Adverse Selection is a term borrowed by economists from the insurance industry to describe a possible problem in the functioning of insurance markets. Insurance is valuable to people because it allows them to make a fixed premium payment in exchange for reducing risk. Adverse Selection is caused not by imperfect information about future expenditures but by *asymmetric information*: buyers or sellers of insurance may have private information about risk. There is potential for adverse selection any time either buyers or sellers have significant informational advantages.

George Akerlof (1970) first illustrated the problems of private information advantages in the used car market, the market for "Lemons." Cars are either good or bad, and only the owners—having driven them for some time—can tell the difference. Buyers cannot tell the difference, and will therefore be unwilling to pay a "Cream Puff" price for a car that might be a Lemon. Cream Puff owners are unwilling to sell at less than Cream Puff prices, but Lemon owners are. Then only Lemons are sold, and the used car market unravels in what is sometimes called a 'death spiral'. This is great economic theory because it is simple, intuitive, and seems to be supported by casual experience. Best of all, it would seem to apply to a wide range of markets. It is tempting to start seeing Adverse Selection everywhere. On the other hand, this simple, stylized model ignores important details of real markets.

Michael Rothschild and Joseph Stiglitz (1976) extended the argument to the case of insurance. In this case, consumers have private information about risk status that they withhold from insurers. High risk consumers cannot be distinguished from Low risk consumers. The authors identify a simple market solution to this information problem that effectively identifies and separates High and Low risks. The insurer offers 2 plans to all customers. One is a high cost, high coverage plan and the other is a low cost, low coverage plan. Premiums and coverage levels are carefully chosen so that High risks choose the High coverage plan and Low risks the Low coverage plan. Risk types are fully revealed, and the only deviation from a world of *symmetric information* is that the Low risk types are forced to accept less coverage.

A possible alternative outcome involves Pooling of risk types into a single plan. Both risk types receive the same coverage and pay the same premium, which reflects the average risk in the pool. Risk types are not revealed in this outcome. Low risk types subsidize High risk types and there is potential for an outside firm to engage in "cream-skimming" by offering a plan that only Low risks will prefer. In this case, the pooling outcome does not occur. Pooling outcomes can and do exist in the group market, where the possibility of cream-skimming by outside firms is limited by employer subsidies, tax subsidies, and the fact that, on average, group insurance is cheaper than non-group insurance per dollar of coverage. Factors that can limit worker mobility between firms increase the potential for a pooling outcome, and Crocker and Moran (2003) show that more generous and comprehensive coverage is feasible with decreased mobility.

The separating outcome, in which each risk type is correctly identified and rated, troubles some analysts because superficially it seems to defeat the risk-pooling function of insurance. This is a mistake, since health care expenditures are wildly unpredictable even given detailed information about demographics and medical condition. Because all risk types face substantial uncertainty about actual expenditures, insurance with premiums that accurately reflect those risks will always be desirable. The separating outcome is a possible market solution to severe informational asymmetry.

SOME LIMITATIONS OF THE MODEL

The model above assumes that consumers have the informational advantage. This might not be true. After all, insurers have data on perhaps millions of consumers as well as a reserve of medical expertise not available to the average consumer. New customers might have an advantage over insurers, but for the cost of a physical the insurer can obtain a great deal of information to reduce its disadvantage. It seems likely that both sides of the market have private information of some type.

Also, the private information consumers have might be of little practical use. To be useful the information must be specific about near-term expenditures. I believe that part of the reason that adverse selection seems obviously true is that we often mistake vague worries about family history for reliable information. We probably have less useful information than we think.

The model assumes that there is a single year of coverage and no chance for learning over time. Yet many consumers stay with the same insurance company for years, and claims data are a gold mine of information on current usage and diagnoses of acute and chronic conditions that should help insurers identify a consumer's risk type.

EVIDENCE OF ADVERSE SELECTION IN VARIOUS INSURANCE MARKETS

As used and as useful as this model is, there is something of a divergence between the theory and its application to real markets, and this has led to widespread misinterpretation of statistical evidence. There is a crucial difference between selection based on private information (unobservable information) and selection based on public information (observable information, including demographics and income). Theoretical models that lead to adverse selection are concerned with private informational advantages.

In a paper published in 2001, Igal Hendel and I built a statistical model to test for the presence and importance of asymmetric information in health care markets. The question is whether there is evidence of private information that can produce adverse selection. The test we used is based on the link between insurance choices and subsequent consumption of health care. We distinguish between mutually observable information, such as demographics and income, and information which is private to the consumer. The unobserved information links insurance choices and health care expenditures, as those consumers more likely to need health care purchase more generous insurance coverage. Intuitively, the test is based on whether the link between insurance choice and health care consumption can be explained by the observed information. If observables account for the link, then we can rule out the importance of private information in the joint insurance/health care decision.

Much to our surprise, we found that the link between health insurance choices and health care consumption is mostly explained by income and other demographics[1]. As is normally the case, expenditures do vary predictably with income and demographics, but most of the variation in expenditures is purely random and unpredictable. Our research shows no evidence of private information leading to adverse selection in the health insurance market.

Evidence from related insurance markets can be used to assess the importance of private information. Two recent studies examine adverse selection in the auto insurance market. Chiappori and Salanié find no evidence of adverse selection among new drivers in the French market (2000). Dionne, Gouriéroux, and Vanasse (1998) and find that there is no adverse selection in the Quebec market once observable demographics are controlled for.

The life insurance market is similar in many respects to the health insurance market. There is much at stake for consumers, the underlying risk is partly health-related, and there exist both group and individual submarkets. Cawley and Philipson (1999) use data on actual premiums and quantities as well as consumer perceptions about risk. They find that, contrary to predictions of the basic model, there is a negative relationship between risk and the amount of insurance purchased (people who believe they are at risk purchase less insurance). They also find evidence of bulk discounting: the cost per dollar of coverage becomes cheaper for higher coverage. Both of these findings are inconsistent with private information on the consumer side. The authors suggest that, in this case, the insurers have the information advantage:

Some studies claim to find adverse selection. My own paper cited above is sometimes cited incorrectly as having found evidence of adverse selection, when in fact the opposite is true. This classification is consistent with common but incorrect usage. The confusion in this case and in many others is the distinction between true adverse selection as it is used in theory (selection based on private information) and adverse selection as it is loosely used by policymakers in practice.

For example, an excellent recent paper by Cohen (2003) claims to find evidence of adverse selection in the Israeli auto insurance market. Cohen finds a positive re-

[1] One simple numerical measure of the private information is what we might call a "signal to noise ratio", or the ratio of the estimated variance of private information to the estimated variance of the purely random component. The higher the ratio, the more important private information is. The ratio is .27 if we artificially exclude all demographic variables and .004 if we include those variables. By this measure, the amount of true private information is trivial.

lationship between insurance coverage choices and the frequency of subsequent accidents. A peculiar feature of that market is that insurers do not use driving histories to set premiums for new customers. The so-called private information in this market is only private because insurers ignore available information that is commonly used in other countries. Even so, the insurance market still functions reasonably well.

The papers cited here should cast some doubt on the severity of the problem. A failure to find evidence of informational advantages leading to adverse selection in a given market does not mean, of course, that it cannot or does not occur; rather, it means that the problems that do exist are swamped by other factors or that the problem has been managed by consumers and insurers in some other way.

To return to the original example of adverse selection, the used car market is supposed to break down due to severe adverse selection, and yet it is clear there is a robust market for such cars. Obviously when buying a used car a consumer must consider the Lemons problem. But buyers and sellers have arranged institutions to control the problem. Warranties, inspections, seller reputation and the prospect of repeat dealing are examples of how markets deal effectively with a potentially serious problem. People are clever, and they adjust in order to make things work. So the market that inspired concerns about adverse selection is in fact a fairly good example of market success. Ebay is another example of a market that should suffer from informational problems, and yet it continues to grow. Buyer and seller reputation play an important role here.

I maintain that 'death spiral' concerns are exaggerated, and that informational advantages are often either small or two-sided, with both buyers and sellers having private information. Many cases of so-called adverse selection are due to deliberate neglect of available information. In health insurance markets, several factors mitigate the problem of residual private information. Benefits managers adjust premiums and benefits to maintain stable enrollment. There are also non-price remedies available. For example, my own benefits plan includes a low cost, higher cost-sharing option. Enrollment in this plan is for a minimum of 2 years, and this provision prevents employees from frequent switching from high to low coverage.

POTENTIAL FOR ADVERSE SELECTION IN CONSUMER-DIRECTED PLANS

Archer MSAs have been available to small businesses for several years in a very restrictive way. Health Savings Accounts (HSAs) were introduced as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. With HSAs, consumers and their employers are able to contribute pre-tax dollars into these accounts to use for out-of-pocket medical expenses. To qualify, consumers must be covered by a health plan with a relatively high deductible of between $1,000 and $5,000 for an individual and between $2,000 and $10,000 for a family. Preventive care is excluded from this restriction and can receive first-dollar coverage:

These plans offer consumers and employers greater flexibility in plan options, and there is potential to improve the delivery of health care and increase insurance enrollment by lowering costs. Part of the reason for rising health costs is that insured patients will over-consume health care because they often pay only a small portion of health expenditures. HSAs seek to reduce this inefficiency by combining higher cost-sharing with a tax-preferred saving account. Catastrophic coverage is the most important component of any insurance plan because it protects us from financial ruin. Coverage for small, predictable expenditures is largely a result of a tax code that encourages us to pay for such expenses through an insurer instead of out-of-pocket.

There is some confusion about what HSA balances represent. Accumulated balances are wealth that reasonable people will use wisely. As such, there would seem to be little concern that individuals with large balances will overspend. In general, the perceived cost of using $1 from the account will reflect the cost of replacing that $1 the following year, which depends in part on the individual's tax rate. For example, if the tax rate is 30 percent, then the cost of replacing the dollar is $.70. In effect, these plans are low cost, less-comprehensive plans with deductibles to limit risk. Unused balances can eventually be withdrawn as retirement income. Because of this provision, even very large balances will not be spent carelessly.

Concerns have been raised that these plans benefit the wealthy and offer another tax shelter. This is true, but *all* rules that allow income to be sheltered from taxes benefit the wealthy, since they face higher marginal tax rates. An employee's share of employer provided insurance is already paid using pre-tax dollars. Retirement savings receive the same tax treatment, but putting money in an HSA is preferable to putting it in an IRA because HSA offers the option of using balances for health care.

One commonly-made argument against HSAs has been that they will lead to a segmentation of health insurance markets that will exacerbate the standard adverse selection problem, leading either to increased risk segmentation in a separating outcome or to the premium 'death spiral' in which exit of the healthy from comprehensive plans raises premiums to the point that the market for such insurance collapses.

At an intuitive, common sense level, I believe concerns that HSAs will distort markets are greatly exaggerated. So far as risk segmentation is concerned, HSAs are similar to existing high-deductible or other plans with high levels of cost-sharing, and benefits managers know how to manage enrollment among a variety of plans by adjusting premiums and plan benefits.

There are two possibilities that we should consider. First, adding an HSA option to menu of plan offerings is like adding a less-comprehensive plan to the menu. This may be in addition to or in place of an existing low-coverage option. Again, this is nothing new, and should be manageable. I believe it is more likely that introducing the HSA might drive out the alternative low-coverage plan, leaving a choice between more comprehensive options and the new HSA.

Second, a firm that offers a single plan option might be replacing a traditional fee for-service plan or an HMO with an HSA. That is, the comprehensive plan in the pooling outcome is replaced with an HSA. This case might cause greater concern because this would leave employees with no alternative. However, employers can vary the generosity of the HSA by changing' premiums and the employer contribution to the account.

A move to an HSA might reflect a trend toward offering lower levels of coverage in the face of rising health care costs. Worker compensation consists of a combination of cash wages and benefits, and will be determined by worker productivity. Tax policy, regulations, and employee preferences determine the precise mix between wages and benefits. Cutting benefits makes firms less competitive in attracting and retaining workers, so firms must have a good reason for cutting benefits. The availability of new style of plan does not seem to be such a reason unless the firm believed the new plan was more efficient.

Health economics is a very challenging field, and the models and language involved tend to induce headaches. After all the analysis, markets will provide the final test: If HSAs work, then they will become popular. If they do not work, then they will disappear. After all, traditional plans will continue to be available, and decisions are usually biased against change. If firms find that HSAs are not a good match for their employees, they will drop HSAs. HSAs will likely become a useful alternative to less-comprehensive insurance or managed care, and they are worth a try.

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PREPARED STATEMENT OF JEFFREY M. CLOSS, PRESIDENT AND CEO, BENU, INC.

1. INTRODUCTION

Good morning Mr. Chairman and members of the Committee. I am Jeff Closs, President and Chief Executive Officer of BENU, Inc. I am pleased to be here today to participate in the hearing on "Expanding Consumer Choice and Addressing 'Adverse Selection' Concerns in Health Insurance". This topic is exactly what my company, BENU, addresses for small and mid-size companies today. We have a relationship with CIGNA Health Care and Kaiser Foundation Health Plan in Oregon, and

CIGNA and Group Health Cooperative in the State of Washington, to offer choice of health plan delivery systems for employers to offer to their employees, yet reallocate premium to insurers to correct for the adverse selection that inevitably occurs.

Health insurers compete aggressively for the business of the employer. What they cannot do is compete aggressively for the consumer. Let me give you an example. The marketing executive for Group Health Cooperative told us of the wonderful way they treat diabetics. He spent considerable time describing their prescription system which flags a new insulin prescription, which triggers a nurse to call the diabetic person for education on the best methods of monitoring and controlling their blood sugar, to make an appointment with a dietician to review their nutrition and to schedule follow-up appointments to screen for additional diseases. I marveled at the comprehensiveness and effectiveness of their care. But when I asked "Why not encourage all diabetics to join Group Health", he said "Of course we would love to care for all the diabetic people, however, our current payment of the average' premium will not cover the cost of treating the diabetic person no matter how efficient the care!

Our health insurance system is broken. The problem is that we expect our health insurance carriers to be more than plain old insurance. I define insurance as a financial vehicle that spreads the risk of financial calamity from rare, *un*predictable events—not *predictable* events—among a large group of people. If I tried to apply for home insurance while my house was on fire, and I was turned down, would you be surprised? Of course not. But when a woman with leukemia can't get health insurance, we find that unacceptable. We expect our health insurers to be part social program. Do we expect insurers to be paid the same rate for bad drivers as they receive for good drivers? Of course not. But to engage an insurer to compete for the diabetic as well as the healthy we need to compensate them appropriately. The truth is we expect our health insurance carriers to be part service plan, taking good care of the healthy and chronically ill alike, and part social program, spreading the cost of health care evenly among all participants. Unsurprisingly they are having a hard time being either.

Why is consumer choice so important? It is so we can create an efficient, competitive consumer market whereby insurers have the incentive to provide the service plan component. If insurers are paid appropriately, they will have the incentive to enroll the chronically ill as well as the healthy since they have the potential to make a profit. If they fail to provide high quality care, consumers can 'vote with his or her feet' and change to another insurer that will care for them appropriately. In this model, aligning insurer payment to enrolled risk creates an incentive for insurers to provide efficient, high quality health care.

What we need is an ability for consumers to make choices among competing delivery systems, to make value judgments between cost and quality when assessing their choices. If one system provides better care at an appropriate price, they should have the ability to choose that delivery system. If the diabetic feels Group Health offers superior care for their needs, they should be able to enroll with Group Health, without Group Health fearing they are going to create unsustainable losses.

But what if I told you that there was a way to fix this system, whereby we could keep the social program aspects of our system, give consumers choices they need, while at the same time engage insurers to compete for all consumers and control costs for employers? In fact, BENU does this today by reallocating premium using risk assessment tools available today.

What is wrong with the current system is not how we FUND health care, but how we PAY insurers. We FUND health care by charging everyone the same premium for the same plan, no matter how sick they are, what I call the AVERAGE COST MODEL. That's how we retain the social program part. But instead of paying the INSURER this average cost model premium, we should adjust payments to insurers based on the chronic illness of those who they enrolled, what I call the RISK-ADJUSTED MODEL. In other words, employers can still offer employees a premium-subsidy based on the AVERAGE COST MODEL, but insurers should be paid using a RISK-ADJUSTED MODEL.

2. EVIDENCE: LACK OF INSURER COMPETITION

Very few employers offer a choice of health plan, let alone choice of insurers. In 2004, 84 percent of all United States employers offered only one health plan to their employees[1]. The percentage of employers that offer more than one plan increased with employer size; however, in most cases, the additional options were simply dif-

[1]The Kaiser Family Foundation—Health Research and Educational Trust, *Employer Health Benefits Annual Survey* (Chicago and San Francisco 2004): 59.

ferent plans offered by the same insurer. For example, an employer might offer an insurer's point-of-service (POS) plan as well as their preferred provider organization (PPO) plan. Typically such plans are served by the same provider networks, so consumers are not offered competition among different delivery systems but rather different financing mechanisms for the same delivery system. Very little data exists regarding how many employers offer more than one *insurer*, but it is certainly less than 16 percent, which is the percentage of employers that offer more than one *plan*.

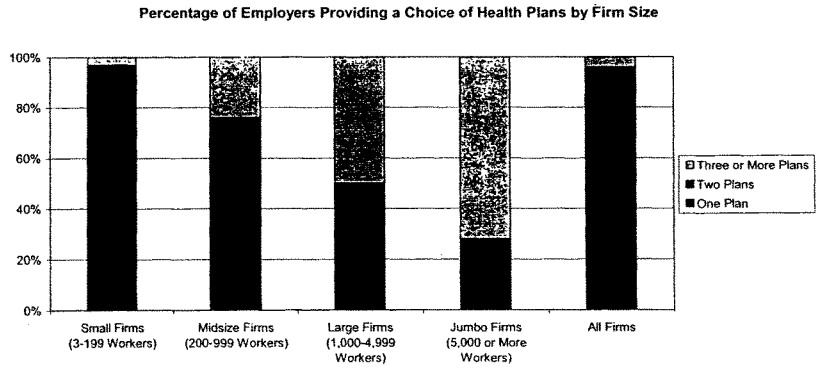

Figure 1

3. CAUSE: AVERAGE COST MODEL

Insurers charge a premium that closely matches the average member's expected cost to the insurer for the upcoming year. But individual members' expected costs vary dramatically. Someone with chronic heart failure is expected to cost much more than a healthy twenty-year-old. From a financial standpoint, the insurer prefers to enroll the healthy and not the chronically ill. Of course, this runs counter to the commonly assumed mission of insurers to cover the cost of those who need medical care. Every chronically ill member enrolled costs the plan more than his or her premium. Therefore, there is a disincentive to recruit the chronically ill, and it is this average cost model that creates the misaligned incentive[2].

4. ETIOLOGY: HOW DID WE GET HERE?

How did the health insurance industry arrive at an average cost model? Because health insurance is more than just plain old insurance. It is also a service plan and a social program, which make the current average cost payment model inefficient and costly.

First, health insurance is **insurance**: a financial vehicle that spreads the risk of financial calamity from rare, *unpredictable* events among a large pool of members. Health insurance originated in the 1930's primarily as a means of protecting individuals from unexpected hospital costs.[3] These costs were due primarily to acute conditions, and thus unpredictable. A casualty insurance model for health care financing was therefore appropriate at the time.

While the casualty model made sense in the 1930's, advances in medicine have created a new group of individuals with chronic illnesses who live much longer, requiring expensive ongoing care. For the insurer, this has meant that loss expectations include not only claims due to unpredictable events, but also some due to predictable events as well. A patient with kidney disease, who did not have a life expectancy of more than a few months in the 30's, now may live many years thanks to costly dialysis treatments. This **service plan** component of modern health insurance, in which one pre-pays for anticipated services in the coming year, does not exist in other lines of insurance. A purchaser of life insurance does not expect to die next year when he buy's term life insurance, nor does a homeowner expect that

[2] R.E. Herzlinger, *Consumer-Driven Health Care: Implications for Providers, Payers, and Policymakers* (San Francisco: Jossey-Bass Publishers, 2004); 77–83.

[3] P. Starr, *The Social Transformation of American Medicine* (New York: Basic Books, Inc. Publishers, 1982): 295–306.

her house will burn down when she buys homeowner's insurance. (If they did, it would be fraud!) But with health insurance, the insured expects to consume services and file claims in the contract year. A component of costs has become predictable.

Modern health insurance is also unique because of the expectation that the known healthy will subsidize the cost of care for the sick. A recent newspaper article described the case of an uninsured woman who was diagnosed with leukemia. The article lamented that she could not buy insurance to cover the costs of chemotherapy treatments. This sounds reasonable to us. But, by the same token, it would not seem reasonable to us for a person whose house is on fire to buy fire insurance. Why do we think differently about health insurance? Because as a society we view health insurance as part **social program.**

The social program aspect of health insurance has created the average cost model for insurer payment. It is the social program aspect of health insurance that prevents us from charging the person with cystic fibrosis his or her full expected cost in the upcoming year. Instead, the cost is spread amongst the rest of us who are fortunate enough not to have been born with the illness.

5. RESULT: SINGLE INSURER, FULL-REPLACEMENT HEALTH PLANS

The average cost model has perpetuated employers' use of a single insurer, full-replacement approach in the health insurance they offer to employees. Insurers market aggressively to employers, competing for a company's entire membership. But if an employer wishes to offer an additional insurer's health plan to their employees (called 'slice business') the original insurer resists, not just because the original insurer wants to retain the business, but because they fear enrolling the costlier portion of the group, a phenomenon called adverse selection:

Adverse selection makes it difficult, if not impossible, for insurers to compete effectively at the consumer level. Historically, insurers have pursued slice business as a means of writing more business. But this extra business is unprofitable if the new members are sicker than the group by which the average cost premium was set. As a result, most insurers will not share enrollment of the same employer group with a competing insurer.

Another way of looking at it is that adverse selection occurs when consumers are offered a choice of insurers and health plans and are exposed to significant cost differences between those plans. A consumer who does not expect to need much health care in the coming year will not see value in choosing the costlier plan. The chronically ill member, who does need a lot of care in the coming year, will likely consider that costlier plan.

When insurers allow slice business, they implement strategies to create an equal sprinkling of the healthy and the chronically ill among all of the insurers offered. They do this to create an enrollment with each insurer with an average cost potential equal to the average cost of the group. One way to achieve this is to standardize benefit designs across insurers to lessen the cost variance between insurers. Another way is to require the employer to subsidize a major portion of the cost difference between insurers.

Unfortunately for employers and employees, the mechanisms insurers use to mitigate adverse selection eliminate the reasons why employers want to offer choice in the first place: a meaningful choice of insurers and plans with meaningful price differences that allow consumers to make value assessments between cost and quality. Add to this the administrative complexity for employers of offering more than one insurer to employees, and one can see why the average cost model leads to a single insurer, full-replacement model of health insurance coverage.

6. IMPLICATION: INCREASED HEALTH CARE COSTS

In a single insurer, full-replacement model, the employer is the one choosing the insurer, not the employee. But employers are not as effective as employees in making value assessments because individual needs and preferences differ. In the late 1980's and early 1990's many employers controlled double-digit health care inflation by forcibly moving their employees into managed care. With restricted networks and tight utilization controls, managed care slowed health care inflation dramatically. While many employees did not mind this style of care, others disliked the restriction of services that used to be abundantly available. The managed care backlash led employers to negotiate with their insurers to lessen the utilization controls and to

be more inclusive in their networks. Employee satisfaction increased, but costs again skyrocketed.[4]

The single insurer, full-replacement model of health insurance coverage does not control costs. It leads instead to a demand for all-inclusive networks, forcing the insurer to include the efficient and the inefficient, and the good and the poor quality provider. These wide networks are not the cohesive provider organizations needed to efficiently take care of the chronically ill.[5]

7. SOLUTION: CONSUMER CHOICE OF COMPETING INSURERS AND PAYING INSURERS FOR RISK ENROLLED

The best way for employees to become engaged in value assessments is to have employers offer them a meaningful choice of health plans from competing insurers. Competition among insurers creates incentives to provide value to consumers and maximizes consumer satisfaction. If consumers are exposed to the true cost differences between insurers, they will have a reason to choose less expensive delivery systems or costlier options if they see value in doing so. This is called a defined-contribution approach because employers offer all employees a fixed-dollar subsidy to their health plan choice. This approach is necessary for consumers to make value assessments. It yields savings for the employer by allowing them to fund only the lowest cost plan, employees then buy-up to the options they desire.

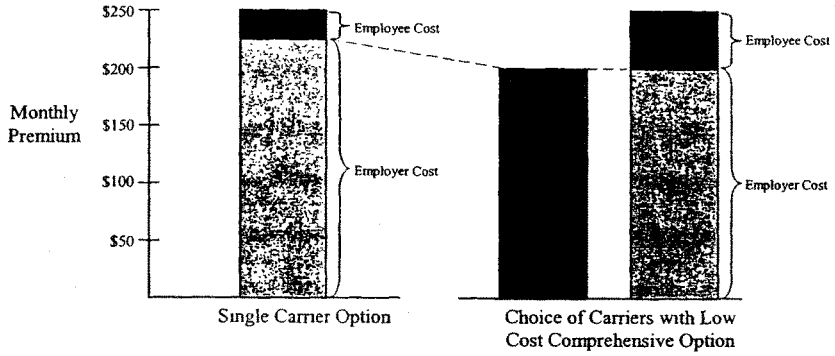

Figure 2

Figure 2 demonstrates how an employer who currently offers only one moderately priced, one-size-fits-all PPO can save significantly by introducing a lower cost, comprehensive HMO plan from a competing insurer. In the single insurer situation, the PPO plan premiums are $250 and the employer pays 90 percent of that, or $225. In the package with choice, the HMO costs $200 per month and the PPO is still $250. If the employer subsidizes $200, then it yields a $25 savings per covered employee. The employees now have a no-cost option, but they can keep the PPO if they are willing to spend $50 per month, the cost differential between the plans.

Insurers, however, need to be kept whole in this process. **While average cost payments from employers can be maintained (social program), an intermediary, such as BENU, must reallocate payments to insurers proportional to chronic illness burden, or 'risk', that enrolls (service plan).** In the example in Figure 2, healthier employees will be attracted to the low cost HMO option, raising the average per-employee-cost of those remaining in the PPO. Risk assessment tools that predict future costs based on clinical diagnoses can reallocate the average cost rates funded by employers into risk-based rates paid to insurers.

Paying insurers risk-adjusted rates allows employers to offer a choice of insurers while pursuing a defined contribution strategy that was not sustainable when the employer paid the insurer the average cost. Employers protect themselves, but employees are empowered to make the value assessments critical for efficient competitive markets.

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[4] A.C. Enthoven and S.J. Singer, "The Managed Care Backlash and the Task Force in California," *Health Affairs* 17, no. 4 (1998): 95–110.

[5] A.C. Enthoven, "Employment-Based Health Insurance Is Failing: Now What?" *Health Affairs* (Web Exclusive May 2003): 237–249.

8. ADDITIONAL BENEFIT: MORE ATTENTION TO THE CHRONICALLY ILL

When employers offer choice to employees *without risk adjusting payments to insurers*, powerful incentives are created for insurers to figure out how to enroll low cost, healthy members and not to enroll high cost, chronically ill members. One cannot blame insurers for this strategy. When employer's offer a choice of insurers in an average cost model, it creates financial calamity for insurers that actively recruit the chronically ill. Consider an HMO that may have an excellent diabetes care pathway, including an early detection system that identifies new enrollees with insulin prescriptions, an education program taught by nurses, a nutrition program in which a dietician contacts patients with nutritional advice, and a followup care program with specialists who help with co-morbid disease prevention. The HMO then markets this excellent program to an employer that will offer it to employees. But when it comes time to enroll members, there is no incentive for the insurer to enroll the diabetics. Why? Because the average premium is not sufficient to cover the costs of the diabetic, no matter how good the care is.

If employers pay insurers premiums commensurate with the chronic illness burden of enrollees, it will actively encourage these plans to compete for all members, effectively removing the underwriting profit incentive. Insurers will have the incentive to provide high quality care to the chronically ill because they represent greater revenue. If they fail to do so, the chronically ill member can vote with his or her feet and change to another insurer that will care for them appropriately. In this model, aligning insurer payment with enrolled risk creates efficient, high quality, cost effective health care.

9. SOLUTION FOR EMPLOYERS: BENU'S RISK-ADIUSTED PREMIUM PAYMENTS

BENU is currently the only independent 3rd party market-maker that allows employers to maintain average cost premiums for their employees, yet pays risk-based premiums to insurers. The key to BENU's method is to present rates to employers that the insurer would quote if each plan were to receive the entire enrollment, what BENU calls the group neutral risk level. After enrollment, BENU calculates the insurer-enrolled risk level and adjusts the premium paid to each insurer proportionately. Essentially, the rates that BENU pays the insurers are what the insurers would have quoted had they known in advance the enrollment they eventually received.

The rates BENU charges and collects from the employer for insurers differ from the rates that BENU pays the insurer, but the total premium the employer pays BENU equals the total premium paid to insurers.

Figure 3 shows how the average enrolled risk for insurers can differ from the group neutral risk.

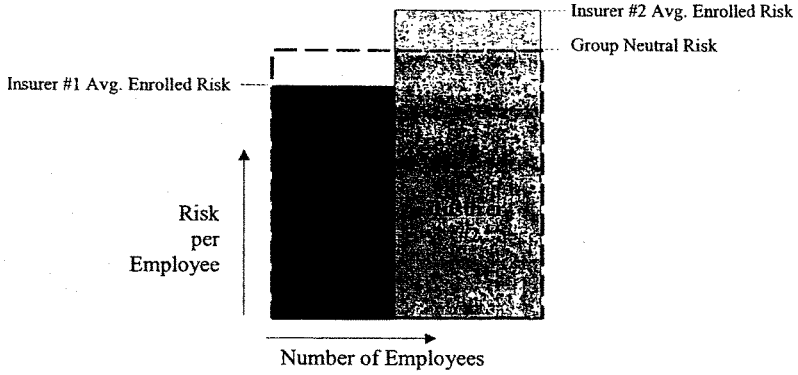

Figure 3

10. RESULTS: EXPERIENCE AT BENU

BENU currently operates in two states, Oregon and Washington. In Washington we currently offer Group Health Cooperative and CIGNA Health Care, while in Oregon we offer Kaiser Foundation Health Plan of the Northwest and CIGNA Health Care.

How does BENU assess risk? BENU uses predictive modeling tools developed over the last decade. Specifically, BENU uses DxCG software, the same company that the Medicare program currently uses in determining payment to insurers in the Medicare+Choice program. The software was developed by using claims data from a large data set of over two million members over a period of 2 years. By tracking diagnoses that are recorded for members in the first year with costs those members generate in the second year, a statistical model was created where future year costs can be predicted based on prior year diagnoses. To use the software, one simply enters the diagnoses for each member and the software will generate relative cost factors for each member. We call this a prospective risk factor.

For example, a member diagnosed with diabetes in the first year may have a prospective risk factor of 3.2. This means that next year, we can expect, on average, that this member will incur 3.2 times the cost of the average cost per member of the two million members in the original reference data set.

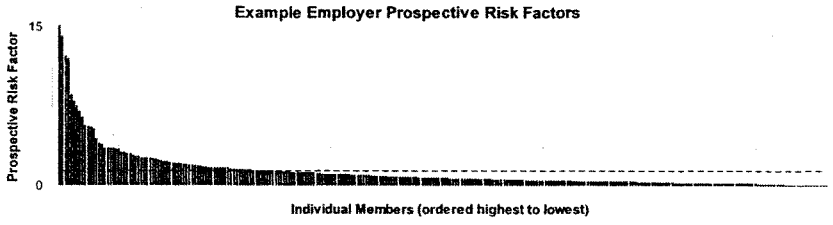

Figure 4

Figure 4 demonstrates the amount by which prospective risk factors can vary for a typical BENU employer. The graph shows prospective risk factors for each member in a 275 member group, ordered from highest to lowest. The prospective risk factor at the extreme left is 15.33, representing a member diagnosed with cancer. The factor at the extreme right is about 0.08, representing a completely healthy individual that never needed to see a physician. The most costly member in this group is expected to cost 192 times the cost of the least costly member in this group. This example demonstrates a 192-fold difference between what the costliest and least costly member is expected to cost. Yet the insurer is paid the average premium whether the member with the prospective risk factor of 15.33 or the one with 0.08 enrolls.

How much has BENU reallocated premium among insurers? Figure 5 answers this, showing the results for the first 13 employers to purchase health insurance through BENU.

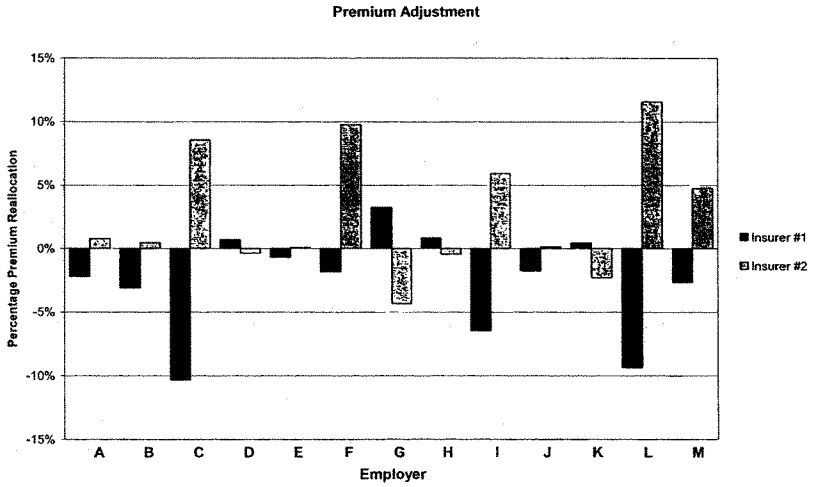

Figure 5

Notice how in several groups the adjustment altered premium more than 5 percent, which is significant because insurers operate on less than 5 percent profit margin. Adverse selection can easily turn slice business into an unprofitable venture. Without risk adjustment, the insurer that received the higher proportion of chronically ill would be forced to raise premium, making the cost share to the employee higher, further exacerbating the adverse selection, eventually making the affected insurer leave the offering—a situation called the death-spiral. Risk adjusted premiums to insurers prevent the death-spiral.

11. RISK ADJUSTMENT IN OTHER GOVERNMENT PROGRAMS

As mentioned above, BENU uses the same predictive modeling software as currently used by the Medicare program in determining payments to insurers in the Medicare+Choice program. Several Medicaid programs across the country are using similar predictive modeling tools in their programs as well. If participants in these programs have a choice of insurers, it bodes well for creating efficient health care since insurers will actively compete for all participants, the chronically ill as well as the healthy, and yet create economic pressures (i.e., loss of patients) on the most costly alternatives to innovate to contain and reduce cost. The most efficient plans gain market share and are rewarded for being economical.

12. CONCLUSION

Our current system of paying insurers perpetuates a single-insurer full-replacement model of health insurance coverage that leads to higher costs. While the current system may be an appropriate way to *fund* health care, it is not an appropriate way to *pay* insurers. BENU's risk adjustment method sensibly reallocates the funding of health care to pay insurers in a manner that creates a competitive consumer market that lowers costs for employers, satisfies employees and motivates insurers to provide value for the chronically ill.

PREPARED STATEMENT OF LINDA J. BLUMBERG, PH.D., SENIOR RESEARCH ASSOCIATE, THE URBAN INSTITUTE

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 larger 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 lookout 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 U.S. 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 U.S. 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 percent 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 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 Roth-

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[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.

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

schild 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 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 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 health insurance. In

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[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.

[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.

[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.

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 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 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 disincen-

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[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; 23(4): 167–175.

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

tive 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 toward 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), 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 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

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[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 Proceeding*. May; 93(2).

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

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

[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 Wicks, eds., Economic and Social Research Institute.

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.

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 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.

Another proposal, contained in H.R. 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.

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[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.

[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.

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, 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 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

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[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.

[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.

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.

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.

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

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