IDEAS IN ACTION

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DOLLARS WELL SPENT?: THE NEED FOR TRANSPARENCY IN THE HEALTH INSURANCE MARKET

INTRODUCTION

The health insurance crisis continues unabated. Current rate regulation laws do little or nothing to prevent private health insurers from "cherry picking": selectively choosing which individuals and small businesses to offer affordable, quality insurance, and leaving the rest - those who are older and less healthy - underinsured or entirely without coverage. While cherry picking may benefit individual insurers, it is harmful overall. It undermines health insurance's role in spreading risk, sends people into the ranks of the uninsured and underinsured, and generates costs to the health care system. Yet state regulators gather very little data about health insurer practices, keeping the public in the dark.

RISK SEGMENTATION AND CHERRY PICKING UNDERMINE THE PURPOSE OF HEALTH INSURANCE

The purpose of health insurance is to spread risk among many and make costs more predictable. Risk-spreading is based on the understanding that no one stays young or healthy forever and also reflects the widely held belief that the cost of health care is a shared responsibility. By spreading risk, everyone in the "pool" protects themselves from the extreme expenses of a health setback.

Yet avoiding risk, not spreading it, is now central to the business of health insurance. Health insurers do this through "risk segmentation" - creating separate pools into which they divide enrollees (or potential enrollees) according to how much health care the enrollees are expected to need. Through risk-segmentation, insurers restrict coverage of patients deemed undesirable, limit which services they cover for which enrollees, and charge significantly higher premiums for those who are older or less healthy. Unfortunately, risk segmentation plays a large part in defining what it means to be competitive. Consequently, rather than competing around improving health, health insurers often compete around avoiding risk.[1]

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METHODS HEALTH INSURERS USE TO SEGMENT RISK AND CHERRY PICK

Strategic Design of Benefit Packages

One way health insurers select for risk is to create many plans and strategically design them to draw in healthier individuals and discourage enrollment by those who are older or less healthy.[2] To do this, for younger and healthier people, insurers create less costly plans with "higher deductibles, higher limits on out-of-pocket liability, tighter provider networks, and caps on benefits."[3] As a result, many people wind up with health insurance that covers less than what they will need. At the same time, insurers charge much more for comprehensive plans that cover treatment that older and less healthy people need, like prescription drugs.

These benefit design practices, combined with rate manipulation, let insurers strategically drop enrollees even when this is formally prohibited. In a study of several states' individual markets, Harvard University researchers reported "a wide range of approaches adopted by some carriers to 'clean up' or 'freshen up' their books."[4] One approach - called "Whack the Mole" - involved driving up premiums to encourage healthy enrollees to move to other plans that the insurer could risk-manage better.[5]

While health insurers often defend benefit package manipulation in the name of consumer choice, the practice serves the goal of dividing up risk pools and cherry picking. State insurance law and state regulators do very little to stop this practice. On paper, approximately thirty states require health insurers to price their small group plans according to "objective differences in benefits" rather than on the health status of enrollees.[6] Yet insurers often factor in enrollees' need for health services when calculating the "objective" value of the plan. [7]

Outright Rejection

In many states, like Idaho, a carrier may reject an individual if the carrier or the state offers high-risk pool plans. However, these are often very expensive, tending to run from 125 to 150 percent higher than "street" plans, with a great range in rates depending on a person's age.[8] Health insurers actively exercise the rejection option. A recent study from Harvard University found that, in states with weaker regulation, as many as 30 to 40 percent of applicants for individual insurance were turned away. People may be rejected even for minor health conditions. As documented by one applicant, having slightly high blood pressure, jaw ache, or a neck spasm can land one among the "uninsurable."[9]

Rating Practices

In most states, health insurers may consider a number of factors - such as age, gender, and health status - when deciding how much to charge a small business or individual. Such rating flexibility constitutes an additional tool for engaging in risk segmentation. State limits on rating practices are extremely limited. The majority of states use "rating bands" in the small group or individual market. These bands permit insurers to charge more based on health status, or other factors, within a certain range.[10] In Idaho, for the small group and individual markets, that range is +/-50 percent.

However, rate bands do very little - and perhaps nothing at all - to prevent health insurers from cherry picking through rate-setting. (In Idaho, the rate band allows an insurance company to charge a range of 300 percent for similar products. So one person may be charged $450 for a policy where another person could be charged $150 for the same coverage.) By grouping rates towards the bottom of the band, insurers can double the flexibility they already have for pricing out undesirable enrollees or potential enrollees, which one observer called "a field day" for health insurers. [11]

Complicating matters further, not everyone the private health insurer covers must be placed in the same rate band. Often insurers are required only to group together individuals or small businesses with "similar case characteristics" when deciding where those enrollees will fall in the rate band. In Idaho, these case characteristics include age, gender, geography, and tobacco use, providing additional flexibility for raising rates above the 300 percent price spread.

At renewal, insurers may make baseline premium increases and add a 15 percent increase for factors such as health status, use of health care services, and length of coverage. Additionally, insurers can charge more as an enrollee grows older, reflecting a change in this case characteristic.[12]

RISK SEGMENTATION AND CHERRY PICKING WIDEN THE HEALTH GAP

Being uninsured or underinsured results in serious health and financial difficulties that draw people into a growing health gap. People without adequate coverage go without needed medical care, increasing the risk of more hospital visits and higher bills, and contributing to a higher mortality rate for the uninsured.[13] Lack of quality coverage also places people at risk of bankruptcy.[14]

Ultimately, everyone pays when insurers divide up their risk pools and create inefficiency.[15] When people are forced out of coverage, the cost appears in premiums for those of us still able to have insurance.[16] And strategic design of benefit packages drives up costs to providers, who often must contend with scores of different plans and dedicate staff and resources just to manage the billing process. This is part of why nearly one-third of U.S. health care spending goes to administrative overhead.[17]

IDAHO ALLOWS INSURERS TO VEIL RISK SEGMENTATION PRACTICES

Washington state's Office of the Insurance Commissioner (OIC) compiles rate information in the small group and individual markets and makes the information publicly available. Rates for individual policies are posted on the OIC website, as are insurer financial statements.[18] In Oregon, the legislature has passed a bill requiring health insurers to prepare reports on surplus, income, average premiums, and other financial issues. While greater transparency is still needed, these states have taken steps in the right direction.

Idaho is lagging behind. Currently, the Idaho public is denied even basic information about the health insurance industry and insurer practices. Information on how rates are developed, which would reveal much about how insurers cherry pick, is shielded as proprietary.[19] The Idaho Department of Insurance does not regularly monitor premium rates throughout the market, does not gather comprehensive information on denials of coverage, and does not track reimbursement rates to providers.[20] Aside from complying with public disclosure law on financial examinations and carrier financial statements, "the department does not undertake to disseminate insurer financial information to the public."[21]

Avoiding risk, not spreading it, is now central to the business of health insurance. Health insurers do this through "risk segmentation."

INCREASING TRANSPARENCY IS THE FIRST STEP TOWARD STOPPING RISK SEGMENTATION AND CHERRY PICKING

Some people are more expensive to insure than others, and health insurance should be designed to spread this risk among many. Are Idaho insurers manipulating the market so that the costs of health care for those who are older and sicker fall unevenly on health care providers and the state? Without adequate transparency requirements, there is no way of knowing for certain. Regulators should have the tools, funding, and mandate to investigate insurance carriers' practices and educate the public on the methods insurers use to divide their risk pools and avoid risk. This would involve requiring insurers to share full information about their rates, administrative expenses, profits, rates of denial, and other practices-in language that is comprehensible to the public. Only then will we be able to understand why consumers seem to be paying more for less when it comes to health insurance.

ACKNOWLEDGEMENTS

We are grateful for the comments of Carolyn Watts, Ph.D., of the University of Washington, on an earlier draft of this report.

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