Adverse Selection and the Individual Mandate

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Many of the reform proposals offered in Congress share a common theme: movement away from a voluntary system of obtaining health insurance through employer plans or in the health insurance market directly and toward one of expanded eligibility for Medicaid and a mandate for virtually all individuals to maintain coverage. In several markets, under these reform proposals, such coverage would have to be offered under a new system of insurance benefit and pricing requirements and restrictions. Such a move effectively requires transformation to a new paradigm for pricing, offering, purchasing, and managing health insurance.

This article will look more carefully at key underpinnings of the proposed transformation, with regard to both individual consumers and the health insurance system as a whole. While nearly everyone can agree about a goal to improve access to healthcare and health insurance, there may be unintended consequences resulting from the proposed changes and how they are constructed. These consequences should be weighed carefully to ensure that the system operates fairly and sustainably in the post-reform environment. Most importantly, if the mandate to maintain insurance coverage is not strong and effective and cannot prevent adverse selection, and if certain additional provisions or restrictions accompany a weak mandate, premium rate levels are likely to escalate significantly in the markets involved. This could create a selection spiral that potentially results in an increase in the total number of uninsureds (see the sidebar *What is adverse selection?*).

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IT STARTS WITH A COST/BENEFIT QUESTION FOR CONSUMERS

Every individual, with or without health insurance, faces the same fundamental value question: *Is the cost of health insurance justified by the benefit of having coverage?*

The question takes on a very different tenor depending on one's particular circumstances and perspective. An individual who has a medical condition (or has a family member with a condition), and may be anticipating substantial medical costs in the future, will almost certainly view the cost/benefit question very differently from someone who is young and healthy. People who work for employers that contribute significantly toward the cost of insurance face a much

WHAT IS ADVERSE SELECTION?

The purchasing or enrollment decision that an individual makes when deciding whether to obtain health insurance coverage and, if so, what plan of benefits to select, typically represents an exercise of consumer self-interest. It involves consideration of anticipated personal or family needs, price, doctors and hospitals available, other benefits or services, health plan reputation, and various other factors. Adverse selection is the natural process of individuals making insurance purchasing decisions that reflect their own personal circumstances and healthcare needs and desires. Such decisions are generally informed ones, leading to maximization of the cost/benefit tradeoff; and the decisions that maximize this tradeoff favorably for the individual consumer generally have the opposite impact on the insurance program (i.e., lead to higher costs relative to the premium level charged). In recognition of this informed consumer behavior, insurers have developed time-tested underwriting and rate-structuring techniques for mitigating and managing the resulting healthcare risks and costs.

A *selection spiral* is a worst-case result of adverse selection that can quickly make an insurance program insolvent. The dynamics of a selection spiral work like this: A health plan gets worse risks (higher-cost individuals) than it anticipated in its original rate setting, and so has to increase premium rates to provide adequate revenue to cover these higher costs. However, raising the rates changes the entire cost/benefit equation, and so the rate increase will cause some individuals to drop their coverage–and those who do drop are more likely to be the lower-cost individuals in the pool. As a result, the health plan winds up with a pool of risks even worse than the one it started with, with premiums that again need to be increased to cover the new, higher costs. This sort of spiral can quickly get out of control and lead to the collapse of the insurance pooling mechanism.

different (and, perhaps, easier) economic decision than those who do not have access to subsidized and tax-advantaged coverage.

The personal decision that an individual makes in deciding whether or not insurance is worth the cost is at the heart of consumer choice, but it also drives adverse selection in health insurance programs. People without many healthcare needs or costs—the kinds of enrollees who help keep insurance programs affordable—or those who do not have access to employer-supported or other subsidized insurance are more likely to answer *no* to the basic question of whether the cost of insurance justifies the benefit. In a voluntary market, these people can opt out of insurance, thereby acting as rational consumers; however, in so doing, they help cause insurance programs to be more expensive (on a per-person basis) than would be the case if they were enrolled.

WHAT'S SO DIFFERENT ABOUT THE WAY A NON-VOLUNTARY SYSTEM WORKS?

The proposed transformation to a new health insurance paradigm is predicated on the assumption that the entire market will shift from voluntary to non-voluntary, thereby changing basic consumer dynamics. In other words, if everyone is required to purchase insurance, insurers can operate differently in the way they manage risk and cost and still provide a viable, sustainable insurance mechanism.

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The nature of this transformation requires an understanding of how the current system operates. In our current voluntary system, insurers have developed techniques for mitigating the adverse selection that naturally occurs. These techniques often include limiting coverage to exclude certain known existing medical conditions for new applicants or an unwillingness to issue coverage altogether. Insurers also employ a process for adjusting premium rate levels to coincide with expected cost levels for individuals with differing characteristics and health histories. These types of practices have been necessary in a voluntary health insurance market in order for insurers to manage costs and risks, thereby keeping their premium rates in check. In addition, these practices achieve a general matching of expected costs to expected benefits, thereby ensuring that the price of insurance is seen as fair by the individuals purchasing the coverage.

Regardless of the philosophical reasons one may have to support or oppose moving away from a voluntary system, it is important to understand that doing so has implications. One of the obvious implications of mandated coverage is the need to have access to coverage. Another of the obvious implications is that the price to purchase such coverage needs to be reasonably within one's means. Both of these reflect the *Achilles' heel* of any health insurance system: how to provide and pay for coverage for those individuals with limited financial resources or with substantial known medical needs.

The new paradigm reflected in most reform proposals to date attempts to address the issue of adverse selection resulting from consumer choice in several ways. First, and central to this proposed new paradigm, is the notion of an individual mandate—so that all individuals are made a part of the insurance pool without regard to the cost/benefit equation described above. In order to accommodate individuals with limited means, most proposals include making health insurance premium subsidies available based on family income level (through tax rebates or otherwise). Access is assured through requirements on insurers of guaranteed issue without regard to the applicant's health status and portability of coverage under the mandate, which is a direct means of approaching the issue of access to coverage by individuals with known medical needs. This may or may not be accompanied by special funding approaches for high-risk individuals or high-cost cases.

Many of the reform proposals that have surfaced recently also include rating restrictions (e.g., limitation on recognition of health status in rates charged) and rate compression (i.e., limitation in how much rates may vary based on risk characteristics such as age or gender); some also include other restrictions such as a prohibition of the temporary exclusion from coverage of preexisting conditions when there have been gaps in coverage. These kinds of restrictions have often accompanied reform proposals that are intended to improve broad access to coverage. However, they do not directly

WHAT IS COMMUNITY RATING?

Community rating refers to a health insurance premium rating structure with limited or no variation in the premium rates among insureds. Under community rating requirements, health plans have a reduced ability to vary premium rates so as to be consistent with an individual's risk characteristics, such as age and gender. Current industry practice in the individual and small group markets is to develop premium rates commensurate with an individual's actuarially expected costs; for example, younger people have lower rates than older people. A community rating requirement would limit the degree to which a carrier can do this. Limiting the range of rates means raising the lower end and reducing the top end of the rate scale, so that rates are no longer proportionate to expected costs. This creates a cross-subsidy where younger individuals pay more for health insurance to reduce the premiums for older policyholders. The fact that community rating requirements will make insurance more expensive for younger and healthier individuals could serve to undermine the efficacy of the mandate, especially if the mandate is not highly aggressive in terms of penalties for non-compliance.

relate to, and are not a necessary part of, the basic paradigm shift to mandated coverage with guaranteed access and support for individuals with limited means. In other words, while they are often paired together, guaranteed issue is essential to the success of an individual mandate while *community rating* (see sidebar) or severely restricted rate structures are not. Additionally, since these reforms are likely to result in higher premiums for younger, healthier people, they may have the effect of enhancing the potential for adverse selection.

THE INDIVIDUAL MANDATE SEEKS TO UPEND THE COST/BENEFIT QUESTION

The dynamic just described is predicated on the ability to prevent individuals from opting out of buying health insurance. If you remove the ability to opt out, the thinking goes, you no longer need the rating and underwriting techniques that were developed to combat adverse selection. This is not to say that adverse selection entirely goes away in the proposed new paradigm. Current proposals offer several benefit thresholds. As people choose among *platinum*, *gold*, *silver*, and *bronze* plans, there will be adverse selection implications. But an individual mandate theoretically narrows the options and rules out not participating.

Theoretically is, of course, the key word. Can a mandate incentivize 100% coverage? Can it come close? If it fails to do so, what happens to the selection dynamics, and in turn, what do those selection dynamics do to the cost and availability of health insurance? The desire for changes to the way in which access to health insurance is obtained may be understandable, as is the concern about those for whom normal market-level premium rates are realistically not affordable. But if changes to the health insurance paradigm as described above are made and the individual mandate proves weak and ineffective, health insurance costs will increase.

DEFINING AN EFFECTIVE INDIVIDUAL MANDATE

Proposals for individual mandates usually incorporate an incentive (a *carrot*) to purchase coverage and a penalty (a *stick*) for not purchasing coverage.

- The *carrot* is a subsidy, voucher, or other financial mechanism to help make insurance more affordable and put uninsured people of limited means in a position where the cost/benefit decision bears a more realistic relationship to their respective income levels. This would reduce the *cost* component of the cost/benefit decision described above, and thereby encourage more people to purchase health insurance.

- The *stick* is a financial penalty of some sort on individuals who fail to purchase coverage. This changes the cost/benefit decision in that it makes the alternative to purchasing health insurance more expensive and therefore less attractive financially.

The strength or weakness in any mandate lies in the level at which these incentives and penalties are set. For example, an insufficient subsidy for healthy but lower-income individuals, even if paired with a tax penalty, may not be enough of an incentive, especially if the tax penalty doesn't create an imperative to purchase insurance.

WHERE DO HIGH-RISK INDIVIDUALS FIT IN?

As is so often the case with healthcare reform, any single reform item is dependent on any number of others. In much the same way, the success of a move to a non-voluntary market with new rating rules depends on several other factors. One key consideration is a mechanism for insuring those most at risk. The disproportionate costs incurred by the sickest individuals may results in some parts of the population creating an undue burden on the insurance pool. Some sort of high-risk pool or other safety net would likely be required to make the new non-voluntary environment operate as expected; otherwise, these individuals might make the insurance pool nonviable.

This delicate balance is overlaid with pricing considerations. If the pricing of the insurance, even after a subsidy and considering the consequences of any penalty, remains too expensive relative to an individual's perception of its value, then he or she is unlikely to buy it. For example, if too much of the cost under a legislatively restricted rating structure is shifted off of higher-risk individuals (who presumably would place great value on it) onto younger/lower-risk people (who may not), then those healthier people may be willing to suffer the consequences of a penalty rather than paying the price to buy insurance. This may be a sound, rational decision for the individuals involved, but the absence of such individuals from the insurance pool will push the pool's costs upward for others who do purchase coverage. A delicate balance must be struck.

Just what might an individual mandate look like? Such a mandate could be a carrot, a stick, or some combination of the two.

A weak coverage mandate that does little to incentivize healthy lives to buy insurance will result in adverse selection, leading to a market environment that has the same fundamental problem that exists currently. Except that, in the post-reform world, carriers will not have the tools available to them to manage this risk—and so sicker, more costly individuals will be entering the insurance pool, while the healthier and less costly people are more likely to remain uninsured. The end result if this occurs: higher health insurance costs.

IT ALL COMES BACK TO THE CONSUMER

The proposed move toward a health insurance market that does not allow the use of time-tested risk classification and management tools must be accompanied by a very strong and effective coverage mandate to manage the adverse selection risk. Absence of a strong mandate will have cost implications. If an individual mandate is not effective then the new approach to rating and underwriting will at a minimum cause costs to increase and could potentially threaten the ongoing financial viability of private health insurance. This in turn could cause the reform measures considered by Congress to have

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HOW AN INEFFECTIVE MANDATE CAN CAUSE HEALTH INSURANCE COSTS TO RISE

The idea behind a coverage mandate is to mitigate (or, ideally, totally eliminate) the effects of adverse selection on health insurance costs. If that mandate is so weak as to be ineffective, however, adverse selection will continue to be an issue and health insurance costs will increase as illustrated in the following example.

Consider a potential insurance population comprising three categories: Very Healthy, Moderately Healthy, and Unhealthy. For illustration's sake, let's say these groups have the following population sizes and expected average annual healthcare costs:

CATEGORY	POPULATION	AVERAGE PER CAPITA HEALTHCARE COST
VERY HEALTHY	800,000	$1,000
MODERATELY HEALTHY	150,000	$4,000
UNHEALTHY	50,000	$10,000

Let's also say that a strong mandate existed and all 1 million of these lives would be enrolled into the health insurance pool. In this case, the average per capita healthcare cost would be $1,900. But under a weak mandate, the Very Healthy category has less of a financial incentive to participate, and would be more likely to opt out from coverage. The Unhealthy category still has an incentive to participate because of the relatively high costs it expects to have. If, for example, a weak mandate will cause only 50% of the Very Healthy, 80% of the Moderately Healthy, and 100% of the Unhealthy to enroll, then the average per capita cost of the resulting insured population is more than $2,400–27% higher than the strong mandate scenario.

It should be apparent from this example that the relative *strength* or *weakness* of a coverage mandate could best be measured by how many of the Very Healthy potential insureds wind up actually enrolling for coverage. The more healthy lives there are in the insurance pool to help bear a share of the costs, the lower the average cost for everyone.

the opposite effect of what was intended: an increase in cost for health insurance and in the number of uninsured Americans.

On the other hand, a carefully designed reform that can effectively balance financial incentives and disincentives, cost, and pricing, along with the move toward a new consumer environment in health insurance, may help deliver better access without creating undue pressures on the cost of healthcare. Designing fundamental reform to achieve such balance is not an easy task, and it might not have street appeal in all quarters, but the consequences of poor design are likely to be severe.

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