Preceptorial on Health Insurance Reform

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Overview

- Problems
- Key features of reform proposals
- Private health insurance markets
- Public plan option
- Reform, adverse selection, and incentives for healthy behavior

Problems: cost and cost growth

- High cost of medical care

  17% of U.S. GDP

  About $8,000 per capita

  About 50% higher than next highest developed country

  Debate over quality and value (life expectancy, cancer survival, preventive, waiting time)

- Cost growth (per capita expenditure): 1997-2007

  6.1% annual growth rate

  2.4% real annual growth rate (above inflation rate)

Problems: the uninsured and access

- 47 million uninsured (population of just over 300 million)
- Access to acute care (emergency) without regard to ability to pay (many are billed)
- Adverse effects on health and longevity (magnitude uncertain)
- Characteristics of the uninsured (approximate)

  10 million non-citizens

  15 million eligible for free Medicaid coverage but have not signed up

  10 million eligible for coverage at work or through spouse but have not enrolled

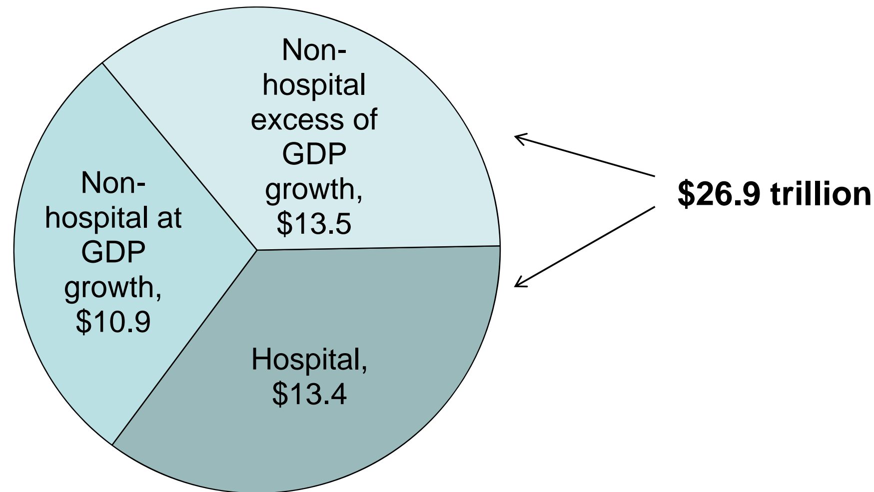
  11-12 million have incomes > 300 percent of federal poverty level

  Often uninsured for part of a year only

Problems: Federal healthcare deficit

Projected Medicare deficit (year-end 2008, 75 years)

$38.7 trillion (present-value)



What does this mean?

- $38.7 trillion (Trustees estimate)

  2.6 times 2008 GDP

  $249,000 per person aged 16-64

- $26.9 trillion (hospital and non-hosp. excess of GDP growth)

  1.9 times 2008 GDP

  $177,000 per person aged 16-64

  $4,700 per covered worker per year (75 years)

  $114,000 for new worker expecting to work 40 years

- U.S. public debt outstanding, 7/30/09

  $7.2 trillion

  50% of GDP; $47,000 per person

General features of reform proposals

- By 2013, most citizens will be required to have health insurance that meets minimum requirements specified by the federal government.
- Eligibility for the taxpayer funded Medicaid program will be expanded.
- Substantial premium subsidies will be provided to lower-to-moderate income buyers (up to 400% of FPL).
- Apart from small establishments, businesses will either have to offer health insurance to workers and contribute much of the cost, or pay some amount of tax or fine.

General features, cont.

- People not covered through employment-based coverage, Medicare, or Medicaid will buy coverage through a new "health insurance exchange" or state-level exchanges (as in Mass.)
- The government will determine standardized coverage options.
- Health insurers will have to accept all applicants regardless of health status, without excluding coverage for preexisting conditions.
- Premium rates will be allowed to vary only by geographic region and, within a restricted range, a person's age.
- Public plan option (government run health insurer)?

Paying for coverage expansion

- $900 billion to $1.2 trillion cost or more over 10 years.
- The proposals vary in how this will be paid for
  - *Taxes on high income citizens*
  - *Taxes on high cost health plans*
  - *Taxes on health insurers, pharma, device companies*
- Medicare savings / cuts
  - *Hospitals will be paid less*
  - *Payments to the Medicare Advantage program also will be cut significantly to save money and bring the program's cost in line with regular Medicare.*

Effects of reform proposals on the healthcare deficit

- Medicare spending cuts will pay part of the cost of Medicaid expansion and health insurance premium subsidies for people with low income
- Medicare deficit will decline – but total healthcare deficit won't
  - *"Budget neutral"*
  - *Health care deficit could increase beyond 10-year horizon*
- Implications
  - *Congress will have to revisit spending within a few years*
  - *Medicare will compete with expanded Medicaid and subsidized health insurance for funding*
  - *Unless something changes, a combination of significant spending cuts, tax increases, and enrollee premium increases will be needed*

Private health insurance: where the money goes – the AFL-CIO view

Health Insurance Profits Soar as Industry Mergers Create Near-Monopoly

by Mike Hall, May 27, 2009

Profits at 10 of the country's largest publicly traded health insurance companies rose 428 percent from 2000 to 2007, while consumers paid more for less coverage. One of the major reasons, according to a new study, is the growing lack of competition in the private health insurance industry that has led to near monopoly conditions in many markets.

The report says such conditions warrant a Justice Department investigation and, says Sen. Charles Schumer (D-N.Y.), provide compelling evidence of the need for a public health insurance plan option as part of the health care reform initiative President Obama and Congress are developing.

http://blog.aflcio.org/2009/05/27/health-insurance-profits-soar-as-industry-mergers-create-near-monopoly/

Competition and choice

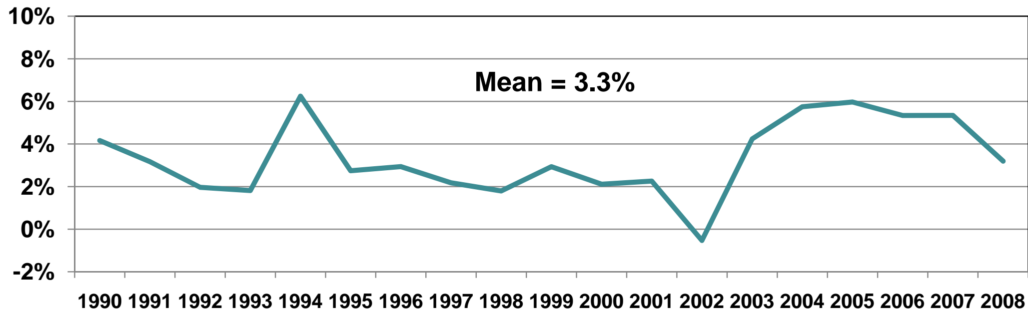
- Economies of scale
- Concentration in individual and small group markets
- Multiple choices in all states, including from non-profit insurers
- Employer-sponsored share about 85%
- Over half of employer market is self-insured
- Federal Employees Health Benefits Program illustrates competition and choice
- Antitrust exemption for the "business of insurance" if state regulates activity (bills would repeal)
  - *Price fixing is illegal*
  - *Mergers subject to normal antitrust scrutiny*
  - *Exemption has no impact on health insurance pricing*

Publicly-traded health insurers' profit margins

Fortune industry rankings: net income as % of revenues

	2005	2006	2007	2008
Net income margin	7.1%	5.8%	6.2%	2.2%
Industry rank	21	33	28	35

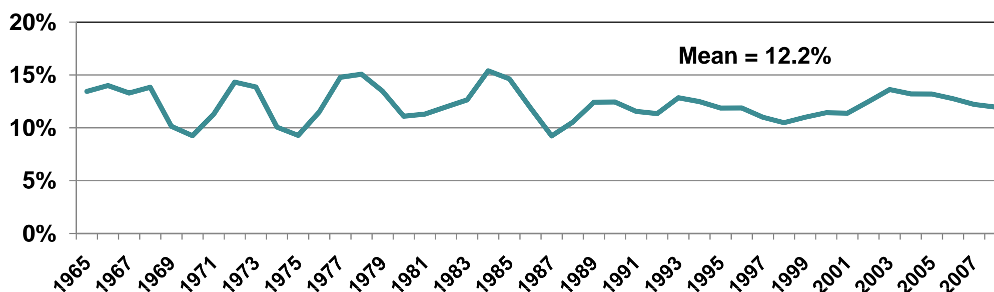
Fortune shows rankings for approximately the top 50 industries out of about 75 total industries.



Compustat, SIC 6324, hospital and medical service plans

	Public Co. (GAAP)		Non-profit Blues (SAP)	
	2008	2007	2008	2007
Premiums ($bill.)	**$251.8**	**$230.8**	**$99.5**	**$93.0**
Medical loss ratio	**82.9%**	**81.6%**	**86.5%**	**87.3%**
Admin. expense ratio	**18.0%**	**16.8%**	**11.9%**	**12.2%**
Net income / revenues	**3.1%**	**5.3%**	**1.4%**	**1.0%**

A.M. Best Co., *U.S. Health: 2008 GAAP Review*, May 4, 2009; *U.S. Health – Blue Cross Blue Shield 2008 Market Review*, August 10, 2009



http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp

CEO compensation: Graef Crystal analysis, Aug. 12, 2009

Companies with market cap above $5 bill. (trend controls for size and options/total pay)

2008 PAY:

COMPANY	CEO	TOTAL PAY (millions)	PCT ABOVE (BELOW) TRENDLINE	PCT REV.
AETNA	WILLIAMS, RONALD	$21.7	21%	0.07%
CIGNA	HANWAY, EDWARD	$12.2	-15%	0.06%
HUMANA	MCCALLISTER, MICHAEL	$5.3	-71%	0.02%
WELLPOINT	BRALY, ANGELA	$6.1	-73%	0.01%
UNITEDHEALTH GROUP	HEMSLEY, STEPHEN	$3.3	-81%	0.004%
	MEDIAN	$6.1	-71%	0.02%

2007 PAY:

COMPANY	CEO	TOTAL PAY (millions)	PCT ABOVE (BELOW) TRENDLINE	PCT REV.
CIGNA	HANWAY, EDWARD	$15.3	20%	0.09%
AETNA	WILLIAMS, RONALD	$19.9	14%	0.07%
HUMANA	MCCALLISTER, MICHAEL	$10.8	-26%	0.04%
WELLPOINT	BRALY, ANGELA	$14.2	-48%	0.02%
UNITEDHEALTH GROUP	HEMSLEY, STEPHEN	$4.6	-68%	0.006%
	MEDIAN	$14.2	-26%	0.04%

http://graefcrystal.com/images/CRYS_REP_HLTH_INS_8_12_09.pdf

Individual market offers: AHIP survey, 2006

(excludes guaranteed issue states; 1,547,247 million offers)

OFFER RATES (PERCENT OF APPLICANTS)			
Age of Individual Applicant	Medically Underwritten	Denials	Offered
Under 18	100.0%	4.0%	96.0%
18 - 24	100.0%	9.3%	90.7%
25 - 29	100.0%	10.6%	89.4%
30 - 34	100.0%	9.7%	90.3%
35 - 39	100.0%	10.0%	90.0%
40 - 44	100.0%	11.3%	88.7%
45 - 49	100.0%	13.4%	86.6%
50 - 54	100.0%	17.4%	82.6%
55 - 59	100.0%	22.3%	77.7%
60 - 64	100.0%	28.7%	71.3%
All Age Groups (non-elderly)		11.3%	88.7%

Standard premium	Higher premium	Preferred premium	Condition waiver	Waiver & higher prem.
40.2%	11.3%	48.6%	7.5%	4.2%

http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf

The President's view on rescissions

"More and more Americans pay their premiums, only to discover that their insurance company has dropped their coverage when they get sick, or won't pay the full cost of care. It happens every day."

"One man from Illinois lost his coverage in the middle of chemotherapy because his insurer found that he hadn't reported gallstones that he didn't even know about. They delayed his treatment, and he died because of it."

"Another woman from Texas was about to get a double mastectomy when her insurance company canceled her policy because she forgot to declare a case of acne. By the time she had her insurance reinstated, her breast cancer had more than doubled in size. That is heart-breaking, it is wrong, and no one should be treated that way in the United States of America. (Applause.)"

REMARKS BY THE PRESIDENT TO A JOINT SESSION OF CONGRESS ON HEALTH CARE, September 9, 2009

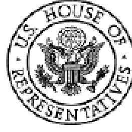
Fact-checking

The [Illinois man's] deceased's sister testified . . . her brother received a prescribed stem-cell transplant within the desired three- to four-week "window of opportunity" from "one of the most renowned doctors in the whole world on the specific routine," that the procedure "was extremely successful," and that "it extended his life nearly three and a half years."

The [Texas] woman's testimony at the June 16 hearing . . . suggests that the dermatologist's chart may have described her skin condition as precancerous, that the insurer also took issue with an apparent failure to disclose an earlier problem with an irregular heartbeat, and that she knowingly underreported her weight on the application.

These two cases are presumably among the most egregious identified by Congressional staffers' analysis of 116,000 pages of documents from three large health insurers, which identified a total of about 20,000 rescissions from millions of policies issued by the insurers over a five-year period. Company representatives testified that less than one half of one percent of policies were rescinded (less than 0.1% for one of the companies).

S. Harrington, Fact-checking the President on health insurance, *WSJ,* Sept. 14, 2009



July 27, 2009

CASE STUDIES: Examples of Health Insurance Companies Rescinding Individual Policies

Committee on Energy and Commerce

As part of a year-long investigation into business practices in the individual health insurance market, the Committee examined more than 116,000 pages of documents from three of the country's largest health insurance carriers, Assurant Health, WellPoint Inc., and UnitedHealth Group. The investigation revealed that these companies retroactively terminated, or "rescinded," nearly 20,000 policies over the past five years based on omissions in applications that the companies identified only after the policyholders became ill. These rescissions resulted in savings to the companies of more than $300 million.

- 13 cases (at least 5 reinstated)
  - *Diagnosis after application (reinstated after appeal)*
  - *Misdiagnoses / diagnosis not disclosed to patient (2)*
  - *Agent misrepresentation (2)*
  - *Misrepresentation or concealment unrelated to claim (5)*
  - *Rescission of family coverage based on applicant misrepresentation (2)*
  - *Applicant previously treated for Barrett's Esophagus who did not disclose "stomach or ulcer symptoms"*

Rescission in context

- Hundreds of years of common law, statute
  - *Contracts of "utmost good faith"*
  - *Contract invalid if <u>material</u> misrepresentation or concealment*
  - *State variations, including some that require relation to cause of the loss or claim*
- Helps encourage accurate disclosure / deter fraud
- Lowers premiums and speeds coverage
  - *Lower upfront underwriting costs*
  - *Less adverse selection*
- Discipline: (1) reputation, (2) regulation, (3) litigation
- States can take action to tighten criteria or otherwise change the rules

California Dept. of Managed Health Care: 2008 Complaint Results

- 6 plans with enrollment > 400,000
- 15.6 million members
- 3,864 complaints
- 2.47 complaints per 10,000 members

Issue	Count
Access	115
Benefits/coverage	1405
Claims/financial	1475
Enrollment	322
Care coordination	474
Plan attitude/service	319
Provider attitude/service	103

- Independent medical reviews (IMRs)
- 5 plans with enrollment > 400,000; 14.9 million members
- 1,900 IMRs resolved

Category	Withdrawn	Upheld	Overturned
Experimental/investigative	104	248	163
Medical necessity	294	477	381
ER reimbursement	120	50	63

http://www.hmohelp.ca.gov/library/reports/complaint/2008.pdf

Public Plan Option

Economic function	Exchange w/o public plan	Public plan	Effect of public plan
Risk-spreading & security	Private capital with guarantees	Off-balance sheet; tax favored	Unfair advantage
Non-claim operating expenses	< status quo	Fees to private intermediaries	Modest decrease
Claims settlement & monitoring	Private incentives	Public incentives & bureaucracy	Increased costs
Provider payment	Private contracting	Medicare A&B	Providers are squeezed; crowding out of private insurance
Innovation	< status quo	Medicare A&B	Reduced

The real action: bargaining and payment of providers

- Medicare plus 0-10% approach

  Modest or minimal provider rents

  Private payers already pay bulk of providers' fixed costs

  Result: substantial crowd-out, reduced capacity, single payer

- Public plan pays private rates

  What private rates?

  What's the point of public plan?

- Public plan negotiates rates

  Very likely will benchmark off Medicare

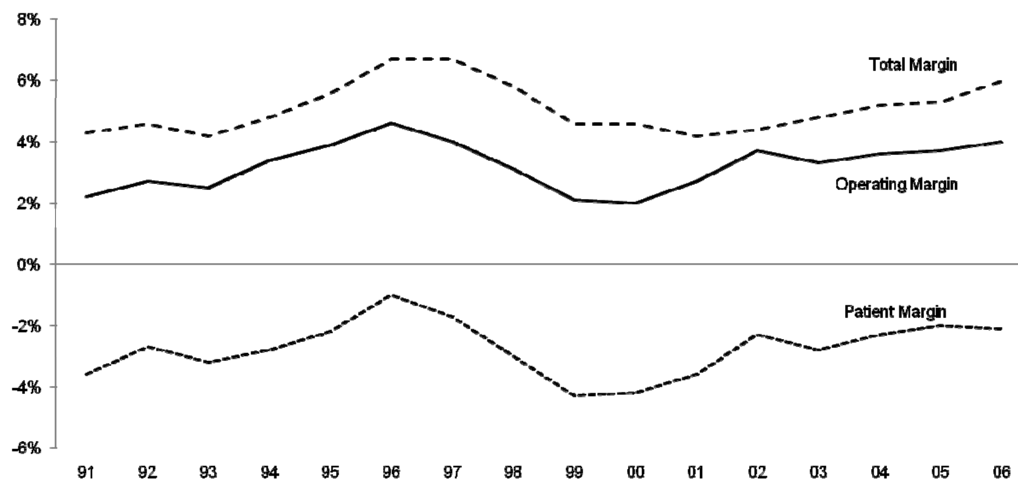
  Would require significantly higher payments than Medicare rates to avoid unjustified crowd-out

Chart 4.6: Aggregate hospital payment-to-cost ratios for private payers, Medicare, and Medicaid, 1981–2006

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2006, for community hospitals.
[1] Includes Medicaid Disproportionate Share payments.

AHA Trendwatch Chartbook, 2008

Chart 4.2: Aggregate Total Hospital Margins, [1] Operating Margins, [2] and Patient Margins,[3] 1991 – 2006



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2006, for community hospitals.
(1) Total Hospital Margin is calculated as the difference between total net revenue and total expenses divided by total net revenue.
(2) Operating Margin is calculated as the difference between operating revenue and total expenses divided by operating revenue.
(3) Patient Margin is calculated as the difference between net patient revenue and total expenses divided by net patient revenue.

AHA Trendwatch Chartbook, 2008

Health insurance and incentives

- Proposed underwriting and rating restrictions
  - *Guaranteed issue at rates that do not reflect health status*
  - *Coverage of pre-existing conditions*
  - *Limited variation for age (House vs. Senate)*
- Adverse selection and higher average premiums unless strong mandate as younger and healthier less likely to buy

Study/analysis	Projection
PWC (AHIP)	Premiums 47% higher by 2016 – does not consider premium subsidies
CBO / J. Gruber	Premiums 23% lower for comparable coverage by 2016, even without subsidies – does not consider adverse selection
Oliver Wyman (BCBS)	Avg. medical cost 50% higher after 5 years

(Un)healthy behavior externalities

1. Employee / policyholder turnover reduces incentives for employers / insurers to invest in health
2. Crude or non-existent risk-rating (ex ante moral hazard)
   - Healthy (unhealthy) behavior creates a positive (negative) externality for the risk pool
   - Too little (much) incentive for (un)healthy behavior
   - Average health of insured population declines; average cost of coverage increases
   - Insurance leads to fewer healthy people (vs. fewer healthy people buy insurance)

Internalizing the costs of unhealthy behavior

- Cost-sharing reduces externality: another argument for high deductible plans, Health Savings Accounts
- Optimal contracts would link premium payments to behavior
- Potential practical approaches

  Discounts for healthy behavior

  Discounts for "markers" of healthy behavior
- Innovation

  Discounts for participation in wellness programs; more generous coverage

  Safeway: 20% premium reduction for no tobacco, control of weight, blood pressure, cholesterol

  Lower deductibles if meet health behavior targets
- Should encourage rather than stifle this type of innovation