

FRESH Thinking
The structure of health plan competition workshop
May 3 & 4, 2007

Consensus in **BOLD**

Dr. Garber's presentation

- Key point of proposal is plan competition and not a single payer system
- There is a connection between delivery systems and health plan competition
- Plan competition isn't easy
- Administrative costs of private plans exist but are exaggerated
 - There are costs of providing goods publicly
 - Costs create behavioral distortions
 - Ordinarily accept admin costs in other settings
- Adverse selection (AS)
 - Fundamental challenge to plan competition
 - Address this partially by
 - Risk rated premium
 - Risk sharing
- Often overlooked aspect of AS is redistribution (healthy → sick)
- What do we mean by risk?
 - Mechanical definition – who is likely to have high expenditures
 - But people who have the same condition may have different expenditures
 - Should an insurer be compensated for people who want expensive care?
 - Should there be risk adjustment for that type of a characteristic?
 - There are clearly plan features that attract people who like that
- Plan competition proposal
 - Centers on risk pools/exchanges: QIX
 - Federal infrastructure to administer
 - Risk adjustment across plans in each QIX
 - Risk adjustment across different exchanges
 - Tax-advantaged savings accounts for premium payments and other health expenses
- How it works
 - Everyone pays the same premium
 - Receives subsidy on income, maybe
 - The plan gets a subsidy for high risk people (which the person does not see)
 - The plan may have to pay to other plans that have higher risk
- Data collection is important
- Not tied to a specific financing mechanism but that will be important

Dr. Enthoven

- Useful look at the 5 other countries
- Have to buy the whole package for it to work
- Dutch have done a great job
- Add to five factors
 - Universal access
 - Periodic changes
 - Open enrollment occasionally
 - Pricing by region
 - Choice of plans at individual level
 - Exchange is an impartial player
- Doesn't think high deductibles are a good idea

- Create a dynamic where you go away from individualized delivery systems, at least anecdotally there are a lot of problems
- Better alignment of incentives
- Drew a parallel to his paper in 2000
 - Different national mood at that time; the public is more willing to accept reform now
- Thinks we need a national system of exchanges

Dr. Pauly

- On selection, need to compare to other systems
 - Compare to a single payer
 - Compare to what we have for the under 65 population
- What do we gain from competition?
 - Productive efficiency → yes
 - Quality → not necessarily
 - Quality is perhaps too high for some people; don't need to increase, actually need to decrease
- Preferences
 - People have preferences for different things, hard to do under single payer
 - An improvement would facilitate better matching between people and insurance system
- With respect to thinking about selection
 - Not apparent that we necessarily have bad AS in unregulated markets
 - When we have AS in the US we may have inessential AS and not essential AS
- What would be more desirable?
 - Empirical metric for welfare cost of AS
 - Effect of selection
 - Low risk can be incentivized to join certain plans with too much benefit (preventative care)
- Medicare won't save on admin costs

Gabi Ben Nunn

- Israeli system
 - Israel has a public system
 - Crisis in 1990s with 5% uninsured and a huge budget deficit
 - 4 insurance companies collect premiums
 - 2 insurance companies with young and healthy
 - 2 others had old and sick
 - Needed a radical change
 - Key elements of reform
 - Universal coverage (obligatory)
 - Freedom of choice between the four health plans
 - Don't have too much shifting, single digit %
 - Defined benefit
 - Key components
 - Collection of premiums (based on income)
 - Resource allocation formula based on age (risk adjusted)
 - Governments commitment to fund the "cost" of the benefits package
 - First two years were crazy
 - Testing, aggressive competition
 - The capitation voucher on each new insure was greater than the additional cost
 - Too much benefits provision

- Marketing
 - Since then
 - Stabilized
 - No deficit
 - Increase of efficiency
 - Improved access (targeting minorities)
 - Budget constraint
 - Search for alternative sources of government funding – copayments, supplementary insurance
 - High satisfaction
 - As a percentage of GDP has stayed constant, slightly lower than Netherlands, much lower the USA
- Garber paper comments
 - How to solve the problem of the uninsured?
 - How do you deal with high expenditure?
 - What about administrative costs?
- Medicare is a mixed single payer with health plan competition
- Medicare for all
 - Universal coverage
 - Premium paid by tax payer
 - Basic benefits package
 - Risk adjustment payments to health plans
 - Beneficiaries can choose among qualified providers
 - Very similar to the Israeli plans

Jerry Flemming

- Practical perspective of an operator
- In healthcare individual actors behave rationally but collectively things look like a mess
- The issue of risk is a pervasive thing you think about
- Most of the costs of health care relate to chronic illness
- You don't see a lot of plans advertise to take care of that
- But you do see hospitals, because they will get paid
- Most people don't get optimal care for chronic care
- If we create a system that would reward plans for enrolling chronically ill, things will be better
- The issue of the exchanges
 - Important to KP
 - This is very attractive feature of the plan
 - Hasn't always been successful
 - PAC Advantage failed last summer
 - Understanding how the rules of the game work for these exchanges is important

Dr. McFadden

- Medicare Part D offers a good comparison
- Consumers like to be empowered with alternatives, but they dislike making choices
- By and large make good choices, relative to what they need though they hated the process
- Some people (7-13%) do make poor choices
 - A bad choice was not enrolling and leaving money on the table
- If you are going to consider a reform where consumers will have choices they won't like it and some will make mistakes
- Medicare reimbursement mechanisms are not incentive-compatible with consumer directed care

Discussion

- Flexibility
 - Need to balance variety and AS
 - Require variation in plan offerings so that individuals are more likely to get what they want
 - Flexibility facilitates evolution of plans (organizational evolution argument)
 - Innovation
 - Credit delivery market is an example where choice has been good
- **Problem of too much choice**
 - Choice costs money
 - Need to define “choice” properly
 - Some individuals will require simplification
 - Possible role for a government agency in simplifying choices
 - Tradeoff: manage how information is presented or curtail choice?
 - A choice based system may not work in the healthcare setting because there is too much specialized information
 - People will pay for choice and not necessarily utilize it (Blue Cross made money this way)
 - People don't want complexity though
 - Choice is a factor depending on when you are accessing healthcare
- Price competition
 - Everyone needs to pay the same for the same plan (platinum care costs the same)
 - Compete on offerings
 - Most consumers understand price differentials (some disagreement)
 - But paying more doesn't mean getting more
 - Two extremes
 - Everyone pays the same price for a different plans → multi-dimensional plans with price variation
- Divorcing both supply and demand side prices from their respective costs
 - Lots of confusion and discussion
 - Economists were not comfortable with this aspect of the plan, want consumers to face risk adjustment in the premium they pay, not just the plan
 - If KP does a good job treating diabetics, it can't adjust demand side price to attract diabetics
 - They can attract based upon non-price features
 - But this is distorting
- “Barebones” plans
 - Why aren't they more common?
 - Liability
 - Regulation
 - Some don't think that they actually save that much money
 - Still have the deal with the tails of critical care that drive up costs
 - **But with a health plan these costs will be mitigated because you will have better follow-up care**
- **Minimum benefits package**
 - **Critical to success**
 - **Can't be Clinton-like, with lots of pages and complexity**
 - **Has to be small**
 - Need to understand its interaction with the supplemental insurance
 - Should there be a ‘basic’ or ‘minimum benefits’?
 - Only basic sold, everything else has to be supplement insurance
 - Minimum benefits allows you to add things to the basic as a part of the insurance you offer

- May be difficult to get an accurate actuarial minimal basic package
- Supplementary insurance
 - Dutch → insurance companies underwrite supplementary with basic
 - Israel → includes many “extras” and drugs that are not a part of the basic
 - The problem will be that the supplemental system will end up swallowing the basic because the basic will be caught by a budget constraint
 - Idea of setting a budget constraint and letting an agency determine the package
 - Disagreement. Worry about creating a Canadian-like system
 - This looks a lot like Medicare Part D
 - Supplemental may drive the costs of the basic plan
- Why would you choose different plans?
 - Exchanges will be regional
 - No reason really to choose different plans
- **Information specialists**
 - **There are people who can obtain the information and discern it**
 - **They have their own motivations which need to be accounted for in any**
 - An employer can serve as an information clearinghouse for employees
 - Employers are advocates for what the employees want because their employees can go elsewhere (labor market proxy)
 - Dealing with two different animals relative to information
 - Big groups will have information specialists who will choose plans
 - Individuals and small groups will have a hard time analyzing information
- Employers
 - Large employers self-insure, they don't negotiate with insurance companies, doesn't this fact defeat the proposal
 - People disagreed
 - Why have employers be a part of this? Don't we want to get rid of them? Or is there an advantage to having them?
 - Beyond the scope of paper
 - This is at best a transition issue
 - But if employers end up offering something good, why kill it off
 - Employers innovate (Pitney Bowes example)
 - There is a cost to keeping companies in the healthcare system
 - Benefits of employers in system
 - Risk pooling
 - Innovation
 - Testing out risk adjustment between plans
 - Can employer exchanges allow non-employees?
 - They have to opt in
 - German experience is bad with closed exchanges
 - Trying to form an exchange for a small business (PAC advantage problem)
 - Small player problem
 - Solution: you get subsidy from other exchanges
 - Community rating across exchanges
 - What is the loss from taking \$500b that employers pay to having government pay?
 - Just deadweight loss?
 - Employers can prevent a plan from being offered
 - Important to remember that employers don't buy insurance, they deposit money in account
 - An exchange could market to people outside employer group
 - An insurer could offer their own exchange
 - An employer is not just a source of funds

- Could offer insurance
 - Could be exchange
 - They could offer money into an account
- Insurance companies
 - will make money by gaming risk adjustment
- Competing exchanges
 - Why have competing exchanges? Why not just have one? Voluntariness induces selection/spiral?
 - A lot of this depends on what funding mechanism this is tied to
 - If you have vouchers, no reason not to allow multiple exchanges, especially in urban areas
 - Authors are not wedded to idea of multiple exchanges everywhere
 - Not essential, but “nice” feature
 - Administrative costs won’t be too high
 - Some people thought this is an unnecessary redundancy
- Savings accounts
 - Very confusing discussion
 - No agreement between the authors
- Wrap up
 - Need a lot of infrastructure to manage this
 - Takeaway: question of how valuable choice is?
 - Not persuaded of arguments that single payer is better
 - Need to do a better job comparing alternatives as per Pauly
 - More homework on risk selection and specifying details (how exchanges will work)
 - Medicare Part D experience is important
 - The basic idea is there
 - One more: need to make clear what is essential and what is negotiable

May 4

Dr. Van de Ven

- Starting point is free competition which leads to risk-adjusted premiums and risk selection
 - This leads to poor and sick not affording insurance
- Use open enrollment as a form of regulation
- Free to set premiums
- Institute subsidies
 - Explicit
 - Assume insurers can set premiums
 - Government organizes subsidies
 - Different types
 - Premium adjusted subsidies (used in US) not optimal
 - Reduce incentives for shopping
 - Overinsurance
 - Misallocation of subsidies
 - Solution is risk adjusted subsidy – based on the risk factors that insurers
 - In practice risk adjustment is done through an insurer as a discount on premium paid on consumer
 - Are risk adjusted premiums sufficient, if not use other subsidies
 - Premium based

- Excess loss compensation
 - Form of subsidy to high risk
 - These create tradeoff between affordability and choice
 - Implicit
 - Cross subsidies enforced by premium rate restrictions
 - Community ratings, rate banding
 - This creates predictable profits and losses, and therefore selection for groups
- Effects of selection
 - Disincentive to be responsive to high risk and to contract quality care for them
 - Disincentive for providers to acquire the best reputation for treating chronic diseases
 - Selection more profitable than efficiency
 - High premiums for high risk patient
 - Instability in insurance market
- Conclusion
 - Insufficient risk equalization results in tradeoffs in affordability, efficiency, and selection
- Preferred strategy
 - Risk adjusted premium subsidies → Better results less tradeoff
- Dutch healthcare system
 - Decades of lots of government regulation
 - Core of reform is for government to step away and insurance to step in
 - Before they had a mandatory private health insurance
 - Insurers can selectively contract, open enrollment
 - Care allowances for 2/3 of the households
 - Adults pay about half to insurer and half to risk equalization fund based upon income, government contributes for 18 and under
 - Risk adjusters
 - Age gender, regions, employment, disability, and other things added
 - There are groups that create substantial predictable loss to insurers
 - This was an indication that existing system was insufficient
 - Proof of the pudding
 - Insurers advertise: chronically ill come to us
 - Critical issues
 - Community ratings are bad
 - Chronically ill need to be allowed to pay more for premiums they would become preferred risks

Dr. Enthoven

- Thought this was a great paper
- Agree that risk equalization is the best strategy
- More research on risk equalization methods
 - Electronic health records will help
- Don't need a perfect formula
- A lot difference between insurance companies and organized care delivery
- Information sharing is important
- Care providers can modify a patient's risk
 - Better disease management
- A lot that can be done to improve risk equalization
 - Primary care centers
- Commentary on positives of Dutch care are included in his written commentary
- Individual choice is good

- Competition between providers is important

Dr. Pauly

- Thought this was a really good presentation of risk adjustment
- This paper is most relevant when the contribution is nearly 100% of the premium, as in US Medicare
- But it is not the only or even best (second best) solution when the contribution is small, as in US private health insurance
- Does not know what it means in this paper to say insurance is not affordable to higher risks?
 - More needs to be said about this
- Striving for perfection and making do
 - Not correct to think that health plan efforts to select (in theory) necessarily detract from their efforts/incentives to be efficient in providing benefits to those they do attract
 - The main inefficiency that arises from selection is the possibility that attractive things plans offer to lower risks may not be worth (to individuals and society) their cost
 - Make sure that all plans are socially acceptable when taken by high risks
- Will competition harm higher risks?
 - The (wrong) intuition: plans will always try to avoid high risks
 - The right question: for any risk, plans will compare incremental revenues with incremental costs
 - So if we worry about higher risks, we may want to set a payment for them that exceeds (by a little) their expected costs
- Can this happen?
- Guaranteed renewability; an alternative approach to risk variation
 - Pauly et al and Cochrane: offer two part insurance that protects against risk of reclassification for people originally low risk. The premium in any period is based on lifetime risk for people currently good risks in that period.
 - This provides bullet proof protection in theory against outside firms selecting low risks. The transfer to high risks in any period comes from earlier prepayment by good (at that time) risks. It does not even matter if low risks leave.
 - Possible but harder to protect against insurer chiseling and changes in demand
- This works in practice as well as theory
 - Premiums for individual insurance are much less than proportional to risk in risk rating states
 - Probability that high risks have coverage is greater based on age, and only slightly less based on health state given age
 - Actual individual premiums are front loaded as theory predicts
 - And the amount of front loading is consistent with theory – it is enough to keep premiums in each period attractive

Gabi ben Nunn

- The proportion of the premium that is paid through tax influences the character of the system
- How to prevent “cream skimming” in Israel?
 - Members get to choose insurance, not the other way around
 - Revenue collection had to be distinguished from fund pooling
 - Risk adjustment formulas
- Risk adjustment formulas
 - Reduce incentives of health plan to seek out the healthiest patients
 - Fairness in resource allocation
- Financing

- 45% premiums based on income
 - 45% general tax
- Allocation of the public fund
 - Risk adjustment capitation 94%
 - Five hard diseases 5%
 - Safety net 1%
- Money to plans based on membership
- Capitation formula that works
 - Forbidding selection of members
 - Universal basic benefit package
 - No variation in premium
 - One year lock in
 - Large memberships
- Criticism
 - The formula does not reflect fairly different plan needs
- Problems
 - Lack of data
 - Privacy issues
 - Manipulation
 - Status quo

Jerry Flemming

- Went through various anecdotes of what is happening in the current healthcare system
- Risk adjustment has to be looked context of the broader health care goals of the country

Discussion

- How have the provider networks changed after implementing adjustment? Delivery system change?
 - Dutch – not much, because focus has been on insurance
 - Insurance bear a lot more risk (95%) for out patient
 - Very little for in patient (25%) which leads to a lot of government intervention
 - How much change is there as a result of the risk adjustment?
 - There are
 - Israel
 - Delivery has been impacted by how you pay the provider
 - There isn't necessarily between getting paid for old and treating old by insurance companies
- Wealth / income distinction
 - Some think you need to work off wealth not income
- Over-risk adjustment
 - Say it costs \$2000 to treat a diabetic, give \$2500 and you will incentivize care/insurance
 - Don't pay the right amount because it is unlikely that you know the cost of care precisely
 - Instead of paying extra for diabetics, wouldn't you want to compensate the plan, because of other unobservables?
 - But this encourages gaming and other tradeoffs
- Perspective
 - Are you looking at the problem though the eyes of the delivery system or the insurance company?
- Cost Effective Care
 - Need more explicit alignment with objective (cost effective care) and plan competition

- Need to be more explicit on how we are curtailing costs by being more efficient through risk equalization
 - Lot of discussion on this point
- Benchmarking
 - In a world of competition there is the benefit of benchmarking, you can tell which insurance plans treat conditions better
 - Single payer can create ratchet effects though
- Employers offering insurance
 - Cisco and other employers innovate in health care
 - But these are young and healthy people
 - Mitigate risk selection
 - But you can still have a system where bad risks embed in certain areas
 - Don't want to throw out a way to a pool people
- Marginal vs. System-wide change
 - Need a fresh ideas within current cultural framework
- **Management**
 - **Have a problem attracting good managers to health care**
 - **Don't have large companies providing healthcare (lack of prestige)**
 - **There aren't too many rewards**
 - **Need to do a better job training people, especially doctors**
- Discussion about Medicare, Medical, concierge medical service
 - None of this seemed to relate to the topic of risk adjustment
- Gaming
 - Prevent it through open enrollment
 - Have to be careful in designing supplementary insurance
 - Understand the impact of supplementary on basic basket
- Who does the risk adjustment?
 - **Idea of a risk market not well received**
 - What about creating a secondary market for selling that risk?
 - Some sort of government institute (like Dutch)
 - Companies themselves
- Regions
 - Regions will end up cross-subsidizing each other
 - Should allow for regional differentiation
 - But there might be pushback for standardization
 - Economics doesn't drive everything, other value judgments are made (i.e. equal treatment for all employees on West and East coasts)
- Agency Problems
 - Extensive literature on this topic, needs to be addressed in designing a healthcare system
- Guaranteed renewability contracts
 - Individual can leave, sign life long insurance contract.
 - Some claimed this would be as effective as the system discussed
 - If you can do it for life insurance you can do it for health
 - But individuals don't start at equal points, contract difficult to form
 - Would a company want to sign this?
 - Shifts price risk to insurance
 - Wasn't clear whether such a plan would be cheaper
 - Alternative is a contract that you can't leave
- Sum up
 - One key thing is that you can't isolate the risk adjustment piece without considering other aspects of reform
 - Incentives at insurance level filter into delivery system
 - Have some real world checks on the thinking

- Risk adjustment can be real, see Israel and Netherlands
- No consensus on how to structure the risk adjusting
 - Tradeoffs between multiple vs. single models
 - Avoiding rotten exchange
- Understand the social driving forces that would shape a system
 - In the US choice and competition
 - Non-egalitarian ethos
 - Can't replicate Israel and Netherlands