ESSAYS ON ISSUES
THE FEDERAL RESERVE BANK OF CHICAGO
MAY 2010
NUMBER 274

Chicago Fed Letter

Getting sick and paying for it

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In certain situations, Americans who become chronically ill have to pay higher rates to continue their health insurance coverage. Indeed, although the majority of Americans are insured, hardly anyone is fully protected against the risk that their next insurance policy will cost considerably more than their current one.

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Although illness can last for any period of time, a typical health insurance contract lasts for one year. This means that insurance contracts often have to be renewed while people are sick; and policyholders may be exposed to *reclassification risk*—the risk that their premiums will be increased because they are ill. In this article, I examine how and to what extent the current health insurance system in the U.S. protects individuals against such reclassification risk, and discuss some potential solutions.

The textbook solution to insuring persistent medical expenses is a lifetime health insurance contract. This would insure individuals against not only the current costs of their medical treatment, but also future changes in their premiums due to, say, a chronic health condition. However, in a voluntary health insurance system, healthy people may opt out of such contracts, leaving the insurer with only relatively sick customers. This would make the system unsustainable. In some developed countries (e.g., the UK and Italy), this problem is solved by universal mandatory participation of individuals in a nationalized health insurance system. In such a system, everyone can obtain health insurance at a risk-independent rate, i.e., a rate that does not depend on an individual's health. This type of insurance scheme relies on risk pooling. In other words, the sick are subsidized by the healthy. And the universal mandate ensures that there are always enough healthy participants in the pool.

In the U.S., the primary source of coverage for non-elderly individuals is private health insurance obtained through employers or purchased directly. Both sources of coverage have their own mechanisms to protect individuals against reclassification risk.

Employer-based insurance

About 63% of non-elderly adults in the U.S. get their insurance through either their employer or spouse's employer.[1] Employer-sponsored health insurance partially protects participants against reclassification risk because it allows all employees in a plan to buy insurance at the same basic rate regardless of their health status. This is possible because employer-based pools are usually large and have enough healthy participants to make average premiums insensitive to health fluctuations of some individuals.

The participation of healthy individuals in employer-based pools is supported by two factors. First, the major part of the health insurance premium is contributed by the employer. In 2009, employers that provided health benefits to their workers contributed, on average, 83% of the premium for single coverage and 73% for family coverage.[2] Second, employer-based health insurance premiums are

tax-deductible, while premiums on policies purchased by individuals in the private insurance market are not. This tax deductibility of employer-based insurance premiums cost the federal government $200 billion in forgone revenue in 2008.[3]

Of course, individuals can rely on risk-independent premiums only as long as they have access to employer-sponsored insurance. Such events as job loss or divorce can terminate coverage. In addition, the possibility of losing employer-sponsored health insurance creates a situation whereby some healthy individuals who cross-subsidize unhealthy participants in an employer-based pool may not get equivalent subsidies when they get sick if their coverage is terminated before they become ill.

One of the reasons behind the instability of employer-based coverage is the limited number of firms that offer health benefits to their workers. In 2009, about 60% of firms provided subsidized health insurance to their employees.[4] In order for a firm to buy into a group insurance plan that will cover all participants at the same basic rates without adjusting for health status, it has to have enough workers to obtain a sufficiently diversified risk pool. In addition, it has to pay them enough so that a wage adjustment for the employer's health insurance expenses does not leave the worker with an income below the minimum wage. As a result, large firms are more likely to offer employer-sponsored coverage and high-wage workers are more likely to be covered. In 2009, 98% of firms with 200 or more workers offered health insurance; among firms with fewer than 200 workers, the rate was only 59%.[5] In addition, in 2008 only about 19% of individuals with an annual income of less than $25,000 were covered by employer-based insurance; among those with an annual income higher than $75,000, approximately 82% had coverage.[6]

Individual private insurance

In the marketplace, profit-maximizing insurance firms charge individuals a premium that reflects their expected medical costs conditional on their current health status and their history of claims. Currently, most states allow insurance firms to medically underwrite applications for health insurance, i.e., to check the medical history and health status of applicants. To reduce individuals' exposure to reclassification risk, federal regulations require insurers to write insurance contracts with guaranteed renewability. This means that a person cannot be denied a renewal of health insurance based on a claims history. This provision was introduced at the federal level by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This federal law does not put any restrictions on premiums charged at a renewal. However, Patel and Pauly[7] found that 47 states require premiums at a renewal to be the same for all individuals within a risk class.

Guaranteed renewability with limitations on premium increases on renewal assures some protection against reclassification risk. However, this does not represent full protection, because insurance firms can legally rescind a policy at a later date. At some point after a policy has been issued and claims submitted, an insurance company may choose to conduct post-claims underwriting. This is a detailed and costly investigation, so it is usually undertaken on policies that have become very expensive for the insurer, e.g., because the insured individuals have become seriously ill. Post-claims underwriting may result in a policy being retroactively canceled, which means that not only is the coverage terminated but the insurance company is no longer responsible for the claims previously submitted. Insurers can only do this if they discover new information that would have mattered when the application for the policy was first considered. In many states, there is no requirement that the information be related to the claim that triggered the insurance company's investigation. For example, a person who is diagnosed with cancer can have his policy rescinded if the post-claims investigation discovers that he did not report some health problem that has no connection with the cancer. The total number of policies rescinded is not large relative to the number of existing policies. For instance, in Texas in 2007, fewer than 1% of the total number of policies in force were rescinded.[8] However, because rescissions are usually concentrated in policies with the most expensive claims, policy termination occurrence is higher among people who experience a health status deterioration.

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Transition from employer-based to individual coverage

Those most exposed to reclassification risk are people who have lost their employer-based insurance, usually as a result of job loss or change, and have to buy their own insurance in the marketplace. HIPAA guarantees that eligible individuals who lose their employer-based insurance (either voluntarily or involuntarily) can obtain coverage in individual markets, provided that they 1) are not eligible for another group insurance plan and 2) have exhausted the continuation coverage on their previous plan. Continuation coverage is an arrangement that allows people to maintain the same group coverage they held through their previous employer for some fixed period. At the federal level, continuation coverage is provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

While HIPAA guarantees access to insurance for workers who have lost their employer-sponsored insurance, it does not protect them against increases in their health insurance premiums; in the private insurance market, their rates will no longer be risk-independent but will be based on their current health status. Only a few states restrict the rates that people transitioning from employer-based coverage may be required to pay for health insurance in the individual market. One option available for HIPAA-eligible individuals

in many states is to buy coverage through high-risk pools. High-risk pools were originally designed to provide subsidized coverage for those who are denied coverage or face too high of a rate in the individual market. Many states also use high-risk pools to help those who lose employer-based insurance to obtain coverage. Out of 33 states that have high-risk pools, 29 of them cover HIPAA-eligible individuals.[9] The premiums in high-risk pools are higher than average standard rates in the individual market—they are typically capped at a level of 150% to 200% of the standard rates. A second disadvantage of these pools is that people with pre-existing conditions often face a waiting period after they enroll. During the waiting period, any treatment related to their pre-existing condition is not covered. Enrollment in high-risk pools is small, constituting, on average, less than 2% of individual market participants.[10]

Any interruption of health insurance coverage may lead to a situation where a new health insurance contract can be obtained only at a significantly higher rate, if at all.

Increasing protection against reclassification risk

Approaches to increasing protection against reclassification risk fall into two main categories. The first approach imposes more restrictions on the ability of insurance firms to risk-adjust premiums and deny coverage—I call this the regulatory approach. The second approach eases existing regulations and relies more on market mechanisms—I call this the free market approach.

The problem of reclassification risk arises because insurers charge people different premiums based on their health status. The key to the regulatory approach is forbidding insurers from charging prices based on health status. This type of restriction is known as community rating. The downside of community rating is that it creates an incentive for insurers to deny coverage altogether to high-risk individuals. Because of this, another regulatory restriction often proposed together with community rating is guaranteed issue, which forbids insurers from denying coverage based on the individual applicant's health status. However, community rating combined with guaranteed issue may have unintended consequences that would make the coverage more expensive for everyone. Specifically, healthy people may wait to buy insurance until their health status deteriorates, leading to increases in premiums that encourage additional healthy people to postpone the purchase of insurance. That is why the regulatory approach often favors a mandate requiring all individuals to purchase health insurance. In effect, the combination of community rating, guaranteed issue, and mandatory participation creates an enforced pooling that complements currently predominant employer-based pools. Some states have already implemented some elements discussed in the regulatory approach. Six states[11] have a combination of community rating with guaranteed issue.[12] One state, Massachusetts, has introduced mandatory participation. The health insurance reform bill approved by the U.S. House of Representatives on March 21, 2010, and signed into law by President Barack Obama on March 23 includes major elements of the regulatory approach.

The free market approach, advocated by John H. Cochrane,[13] is based on the idea that reclassification risk, like any other risk, can be insured. As proposed by Cochrane, on top of insurance against medical expenses incurred within a contract year, people could also buy health status insurance that protects them against future higher premiums should their health deteriorate.[14] That is, once an individual develops a chronic health condition, he could still get health insurance at the same rate because the increase in his premiums is paid by health status insurance.

In essence, health status insurance is a long-term contract. As such, it requires an enforcement mechanism because otherwise, individuals who turn out to be healthy will drop their health status insurance coverage. One solution proposed by Cochrane would be the creation of special health status insurance accounts that could be used only for the purpose of paying health status and medical insurance premiums.

Some of the existing regulations of the health insurance system are not highly compatible with health status insurance. First, because of preferential tax treatment, employer-sponsored insurance dominates other insurance options. An individual who expects to get an offer of employer-based coverage is not likely to commit to a long-term health status insurance contract. At the same time, people who lose employer-based coverage do not have health status insurance and thus have to face the full burden of risk-adjusted premiums in individual markets. Because of this, the leveling of the playing field between employer-based coverage and individual insurance is one of the conditions necessary for health status insurance to represent a viable approach to addressing reclassification risk. Furthermore, existing restrictions on risk adjustment of premiums in individual markets create incentives for insurers to either deny coverage altogether

ISSN 0895-0164

or provide partial coverage, e.g., excluding treatments related to pre-existing conditions. Health status insurance protects people against fluctuations in premiums, but it cannot do much in an environment where premiums are restricted from varying by a wide margin, with insurance companies denying coverage to those who are very sick.

Conclusion

The current health insurance system provides only limited protection against reclassification risk. Most people obtain their insurance at a risk-independent rate through their employer. People with continuous coverage in individual markets are mostly protected by the guaranteed renewability provision. However, any interruption of coverage may lead to a situation where a new health insurance contract can be obtained only at a significantly higher rate, if one can be obtained at all. Given that 86.7 million non-elderly Americans experienced some interruption in coverage during 2007–08,[15] reclassification risk is an important issue to address.

[1] U.S. Census Bureau, 2008, *Current Population Survey*.

[2] Kaiser Family Foundation and Health Research and Educational Trust, 2009, "Employer health benefits: 2009 summary of findings," report, September, available at http://ehbs.kff.org/pdf/2009/7937.pdf.

[3] Jason Furman, 2008, "Health reform through tax reform: A primer," *Health Affairs,* Vol. 27, No. 3, May/June, pp. 622–632.

[4] Kaiser Family Foundation and Health Research and Educational Trust (2009).

[5] Ibid.

[6] U.S. Census Bureau, 2008, *Current Population Survey, Annual Social and Economic Supplement*.

[7] Vip Patel and Mark V. Pauly, 2002, "Guaranteed renewability and the problem of risk variation in individual insurance markets," *Health Affairs*, August 28, pp. W280–W289, available at http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.280v1.

[8] Hilary Haycock, Meredith King Ledford, and Peter Harbage, 2009, "Primer on post-claims underwriting and rescission practices: Findings from Texas in the individual health insurance market," Robert Wood Johnson Foundation, report, August, available at www.rwjf.org/files/research/texascasestudyaug2009.pdf.

[9] Kaiser Family Foundation, www.statehealthfacts.org.

[10] Karen Pollitz and Eliza Bangit, 2005, "Federal aid to state high-risk pools: Promoting health insurance coverage or providing fiscal relief?," Commonwealth Fund, issue brief, November, available at www.commonwealthfund.org/usr_doc/Pollitz_highriskpools_875.pdf.

[11] These states are Maine, Massachusetts, New Jersey, New York, Vermont, and Washington.

[12] Kaiser Family Foundation, www.statehealthfacts.org.

[13] John H. Cochrane, 2009, "Health status insurance: How markets can provide health security," Policy Analysis, Cato Institute, No. 633, February 18, available at www.cato.org/pubs/pas/pa-633.pdf.

[14] While explicit health status insurance contracts are not available, Cochrane (2009) states that an insurance product with similar features has recently become available from UnitedHealth Group.

[15] Families USA, 2009, "Americans at risk: One in three uninsured," report, Washington, DC, March, available at www.familiesusa.org/assets/pdfs/americans-at-risk.pdf.