



On the Same Page *by David Guzick, M.D., Ph.D.*



Markets for Health Care: Part 2 – The Market for Health Insurance

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This is Part 2 of our newsletter on the distinction between the market for health care services and the market for health insurance. We begin by stating that competition in the health insurance market is a horse of a different color from competition in the health care services market. This is because of the differentiating features of health insurance: actuarial risk, variability in plan benefits, regulatory requirements and other considerations.

Beginning with the basics, the concept of insurance implies the spreading of risk among many individuals. As applied to health care, an individual buys insurance to cover the risk that health care services will be needed, the probability of which is unknown. If a large number of such individuals each contribute a (relatively) small premium to a financial pool, then the cost of an individual's emergency or unanticipated illness can be covered by drawing from the pooled premiums. The greater the number of individuals who contribute to the pool, and the more representative they are of a cross-section of the general population, the more efficient the system becomes.

How is the premium calculated? Across the entire insured population, some individuals will have a higher baseline risk for needing services than others, based on age, medical history and other factors. The premium is determined by taking into account the *total risk of an entire insured population* — including those who are unlikely to use health care services and those who are highly likely — and the total cost of such care. This premium will be higher if a broad array of health services are covered, and lower if the list of covered services is more restricted. The premium will also be higher if the deductible and co-pays are low, as this will increase utilization, and vice versa. It is important to note that in most insurance plans (like the ones covering UF employees and GatorCare members), the premium within a specific plan is the same for all members — i.e., the premium takes into account the average health care utilization and cost across high-risk, average-

risk and low-risk members. These plans do not charge lower premiums for healthy members and higher premiums for members with a history of medical conditions requiring expensive treatments. Similarly, premiums are currently the same for individuals who purchase a given insurance plan on ACA exchanges. These plans include a set of “essential health benefits,” no exclusion due to pre-existing conditions, and several other requirements.

The choice of a plan by consumers in the health insurance marketplace will depend on the “benefit design” of the various plans; among other things, this includes the health benefits covered, the deductible and the co-pay. Under GatorCare, for example, employees can choose between a number of plans with a variety of trade-offs between premiums, co-pays and deductibles. In the most popular plan (“Prime Plus”), the total premium paid by employer+employee is \$7,368 per year for individual-tier coverage, and \$18,480 per year for family coverage. The premium, deductible and co-pay schedule for all members of the Prime Plus plan are the same. That is, members with chronic medical conditions and/or others who are likely to use a large amount of health care services have the same premiums, deductibles and co-pays as healthy members who are likely to use very few health services.

Part of the current debate on alternative health care systems for the United States pertains to factors affecting group health insurance plans like GatorCare and the state plans for UF employees. Alternative approaches may, for example, include a different range of “essential health benefits” that all plans must cover; different rules on pre-existing conditions and lifetime caps on covered health care costs; and different rules about whether an insurance company can sell its plans across state lines.

The part of the debate receiving most attention, however, relates to the *individual* health insurance market for those who are uninsured (i.e., what is referred to as health insurance “exchanges.”) The major goal of the Affordable Care Act was to reduce the number of Americans who don’t have health insurance, which has been addressed through Medicaid expansion (in the states where this was implemented) and the “exchanges” for individuals whose income exceeds the threshold for Medicaid but who don’t have access to a group plan. Thus, the effect on the uninsured of the various new proposals has been front and center in both the House and Senate health care bills. Individuals may be uninsured because: their employers choose not to provide coverage; they are self-employed and have chosen not to buy health insurance; they are unemployed; or other reasons.

To understand why the goal of providing health insurance to the uninsured is so difficult to achieve, especially when healthy individuals choose not to be in the plan, let’s do a thought experiment in which we turn a group plan for ABC Inc. into something that approaches an individual plan. First, (using GatorCare as an example), suppose that the premium paid by the employer at ABC Inc. for individual or family coverage is instead paid to the employee. (This hypothetical example doesn’t

take into account that health insurance premiums paid by the employer aren't taxed, while such payments to employees as cash would be taxed. But let this nuance ride for the sake of the thought experiment.) Second, let's assume that the plan is in financial equilibrium such that the premiums and other expenditures that employees and employers pay into the plan are exactly offset by the cost of care provided and the cost of administering the plan. This means that the cost of care plus administration averages \$7,368 for individual employees and \$18,480 for families.

Now let's suppose that ABC Inc. designed different plans for different kinds of employees and that employees could choose plans that seem right for them, or not choose a plan at all. Thus, young, healthy employees might choose a plan with a restricted set of covered benefits, very low premiums and a high deductible (since they would anticipate using little or no health services) and pocket the difference. Or they might pocket the entire amount and not purchase insurance at all. Older individuals with known chronic medical conditions requiring frequent physician visits and expensive medications would prefer a plan with a broad range of covered benefits and a low deductible. What would happen under such a scenario?

ABC Inc. would now be able to offer very low cost plans to their young healthy employees, but this would generate a very small amount of premium revenue. To remain in financial equilibrium, the same total premium revenues that were received under the group plan would still be needed to cover the health care costs of employees with significant illnesses. Such employees would therefore have to be charged a much higher premium to make up the difference. Depending on the extent and cost of the projected health care for these employees, the premium might be two to three or more times the cash payment for health insurance received from their employer. To the extent that employees are divided into smaller and smaller subgroups according to health risk, the premiums for employees with the greatest health care costs would escalate significantly. In effect, the more refined this process becomes — in terms of subdividing employees into a large number of well-defined health risk strata — the less this looks like insurance and the more it looks like paying directly for health care. At the upper end of health care utilization and expense, few individuals would be able to afford the health insurance premiums, leading to increased demand for free emergency service.

For large employers, because such outcomes are so objectionable (and also because health care premiums are tax deductible for employers), the above thought experiment will not become reality. Large employers will continue to provide health insurance as group plans with the same set of premiums, deductibles and co-pays for all members of a given plan. However, the above thought experiment is potentially useful to understand the consequences of the different legislative proposals coming forward that attempt to address the individual market for health insurance among people who don't have access to such group plans. (Of course, there are other factors affecting this market

for health insurance: not covered here are issues such as Medicaid expansion; the grandfathering of existing high-deductible, low premium plans for healthy individuals; risk corridor payments for insurers willing to enter the market and tax benefits/subsidies applied against insurance premiums for low-income individuals.)

In summary, the market for health insurance involves a completely different set of considerations than the market for health care services. Most of the national debate pertains to the individual health insurance market. Depending on the rules established for insurers and consumers in this market, one can predict the winners and losers. Interestingly, these hotly debated rules will have little impact on the market for health care services. In the case of most health insurance plans, regardless of how the patchwork of plans unfolds, physicians and hospitals will still face the same structural factors that have historically generated a high level of utilization and cost.

The Power of Together,

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