

A Reformed Individual Market for All: Using Long-Term Health Insurance to Limit Fragmentation

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Why Do Americans Disparage Private Health Insurance?

Disparaging private health insurance often feels closer to a time-honored tradition in the U.S. than a new policy movement. There is no shortage of prominent individuals, policymakers, and constituency leaders willing to lament, if not castigate, practices and outcomes found within the industry. But accompanying and detailed conversations around the key nuances and trade-offs between the existing state of affairs and alternative healthcare financing realities are often lacking.

Thus, it is unclear what the true appetite for “Medicare for All,” or more broadly, single-payer healthcare is among a fully informed voting U.S. population. Nevertheless, the current popularity of this policy platform offers a good excuse to reflect on the potential root causes of at least some of our collective dissatisfaction with private health insurance. More specifically, we need to ask a key question seemingly absent from the contemporary debate: have we ever asked the health insurance industry for the best it has to offer?

We should begin with a few non-controversial facts about health insurance firms. Private health insurance companies in the U.S. are sitting on mounds of real-time and historical data tied to the health status and medical service utilization for individuals, families, and larger populations. These data are valuable, and these firms possess relevant technologies and specialized expertise to put the data to good use. Whether an insurance delivery system involves private companies or a government-run plan, data-driven decision-making is a necessary ingredient on the path toward better outcomes and greater efficiency in U.S. healthcare.

We likewise need to be clear about what health insurance is and is not—without doing so, we risk setting up the wrong expectations from the outset. Health insurance is not a mechanism to buy things you want with someone else's money. Among private plans, enrollees' collective premium dollars are needed to cover the total medical care spend. Among public plans such as traditional Medicare, it is a combination of beneficiary contributions and tax dollars, with the latter footing the majority of the bill in most instances. [1] In either case, we are all paying for it one way or another and are therefore exposed to the financial downsides from excessive and inefficient consumption. [2]

Health insurance is also quite different from other forms of insurance, such as auto or life policies. There is no fixed payout tied to a well-defined contingency such as accidental automobile collision or early death. Instead, health insurance shields the enrollee from a large financial burden in the event of illness. Illness can be acute or chronic, though it is the burden and mismanagement of chronic disease that is arguably our most pressing population health and spending issue of the day. [3,4,5]

The Key Problem Is Fragmented Health Insurance Delivery

The previous statements help establish an inescapable fact: personal health is a long game. A staggering number of medical issues can emerge between birth and death, and some of them can have direct and indirect consequences that span the remainder of an individual's lifetime. Thus, the potential gains from preventing disease when possible and minimizing the long-run damage when illness does occur should be clear and salient.

Ironically, and somewhat tragically, we have made a series of uncoordinated but interconnected missteps that have largely incentivized health insurance companies to focus on the short run as

opposed to the long run. Insurers typically concentrate on what a given enrollee might cost in the next year rather than the individual's projected medical spending profile over the full life course, and in particular, how much is mutable. These short-run incentives are at odds with the nature of the health and healthcare problem and are the culprit for many of our private insurance complaints.

The prevalence of insurer-enrollee fragmentation in the U.S. healthcare system suggests it is closer to the norm than the exception. The Medicaid program is notorious for churn whereby individuals and families cycle on and off a Medicaid plan as financial circumstances and eligibility criteria fluctuate. [6,7,8] This is far from an ideal model for managing the health and well-being of low-resourced populations.

In parallel, employer-sponsored health insurance, by definition, is only sustained so long as the same employer-employee relationship is intact. A new job opportunity, a change in own or family circumstances, or an economic downturn and the insurer-enrollee link is broken and the individual migrates to a new plan or no plan at all. At the same time, we intentionally subsidize employer-sponsored health insurance plans through approximately \$300 billion in forgone tax revenue per year, which makes the "favorable tax treatment of employment-based health benefits...the federal government's largest single tax expenditure." [9] Moreover, we do so in a regressive fashion whereby those in the highest tax brackets benefit the most from the federal tax code's employer-sponsored health insurance largess.

Additionally, and regardless of how one has or has not been covered prior to age 65, at that age, we abruptly graduate an individual into our current U.S. single-payer program of traditional Medicare. Whatever entity shouldered the medically related financial risk at age 64 need not worry about the downstream consequences from age 65 onward—a time when the risks of severe and costly medical events are also higher. And even within the newly reformed and enhanced individual market courtesy of the Affordable Care Act, plan contracts are for one-year intervals, with its proponents encouraging individuals to switch as often as they like. [10] In fact, among the 3.6 million who reenrolled in a health plan through the Marketplaces in 2016, 60 percent had switched from their 2015 plan selection. [11]

Taken together, we have spent decades of health policy creating a health insurance delivery system that actively subsidizes and even openly advocates for fragmentation. Rather than use

their data troves and analytic skills to prevent illness and manage chronic disease over the life course, we are inadvertently encouraging insurance companies to minimize a given enrollee's direct medical spending over the next 12 months or less, with little regard to the downstream consequences.

These problems can manifest in strategic screening of prospective enrollees, skimpy benefit designs, aggressive utilization review, and many other issues. Each of these insurer behaviors is a regular and understandable source of ire for consumers and their political representatives, but they are also predictable when the typical enrollee will be with a plan for a few months to a few years. It can further encourage misaligned contracts across insurers as well, for instance, between medical insurers and specialized third party carriers such as managed behavioral health organizations and pharmacy benefit managers.

Ideally, health insurers would internalize the gains from successful and comprehensive management of an enrollee's health across all domains of care. In the absence of a long-term relationship, however, there can be perverse incentives to rely on short-term cost-savings without a long-term perspective.

What Could Be Done? Realigning Incentives via Long-Term Health Insurance Contracting

In order to realign the incentives of health insurers with those inherent to population health management as well as encourage insurers to leverage their comparative advantages including significant data repositories and expertise, we need to move to long-term health insurance contracting. Although economists have been interested in and theoretically explored such contracts already, [12,13,14] mainstream health policy discourse has devoted little attention to it. We argue that its public hearing is overdue.

To be sure, there are technical considerations and trade-offs belonging to various implementation strategies for long-term health insurance. But long-term health insurance is possible, especially if adoption is system-wide. A necessary first step would be to move the full U.S. population into the individual market by doing away with employer-sponsored health insurance and the traditional public insurance programs—something that can benefit consumers even without long-term contracts. [15]

The federal government could then occupy two roles for which it is best suited: (1) setting the rules for market participation and (2) subsidizing the premiums for individuals and families that need it. For the first role, rule setting, the “managed competition” government activities could include setting minimum contract durations, determining qualifying events for no-cost plan switching, antitrust enforcement, and other such regulatory parameters for health insurance companies. The goal is merely to establish a contracting sandbox that applies to everyone, and then allow the companies to innovate and compete.

As for the second role, the U.S. government is already in the business of heavy subsidization for health insurance purchases. But they are not always equitable or optimal. Means-testing by financial circumstances, rather than discriminating by age in traditional Medicare or making no adjustments at all in employer-sponsored health insurance, is a clear improvement in terms of equitable design. Moreover, the federal subsidies can be dialed up or down as circumstances change without requiring a change in coverage plan or type. That is, the government would be directly supporting long-term commitments and health management, instead of health insurance fragmentation.

Intuitively, this would largely take the form of an expanded, though significantly modified, version of the individual market brought about by the Affordable Care Act. This is why we refer to it as “A Reformed Individual Market for All.”

Some might retort that population-wide traditional Medicare could accomplish much of the same. Perhaps. But relying on a government-run plan would forgo the otherwise powerful incentives for innovation in long-term health insurance design and delivery. We would have to assume that the short-termism of politics would not distort or override the long-run health and fiscal aims. History does not bode well in this regard.

Bipartisan Support: Appealing to Common Democrat and Republican Policy Objectives

Politics is the most influential factor for any health policy proposal or reform and has derailed plenty of initiatives over the years. When taking stock of some of the common, partisan health policy positions to date, however, transitioning to long-term health insurance contracts across the board has something for multiple political viewpoints, if done well. For centrist Democrats,

universal coverage and redistributive measures are embedded within the structure—not to mention the formal tying of insurance companies' profits to their long-term success in health promotion, disease prevention, and chronic disease management. For centrist Republicans, the market-oriented ingredients of private enterprise, competition, and consumer choice are all present—along with fiscal transparency and responsibility.

Thus, by embracing a competitive market place for long-term health insurance with universal participation, we can develop a policy pathway that leverages overlap in left-leaning and right-leaning objectives, as opposed to championing one while alienating the other. Making the case for it and the unavoidable transition period will not fit on a bumper sticker and may not excite the extreme partisans in either direction, but those features should not be barriers to serious consideration and honest conversations with the American public.

Looking Forward: Shift to Long-Term Health Insurance

A wholesale shift to long-term health insurance is a way to accomplish the core function of health insurance in the form of financial risk protection for consumers, while incentivizing health insurers to optimize prevention and long-run population health management for their enrollees. Our current, fragmented version of health insurance delivery is performing poorly on both fronts.

Despite the long-running frustrations with the U.S. health insurance system, it does not immediately follow that we must do away with private health insurers. Instead, we may want to rethink and reshape the implicit incentive structure we have set before them. Doing so can benefit all of us and simultaneously encourage our insurers to reconsider how they contract with healthcare providers.

The piecemeal and perverse incentives attached to the fee-for-service model would almost certainly be reduced, if not eliminated, throughout many care domains. The payment model replacements would likely be a variety of two-sided risk alternatives to help ensure that provider decision-making is taking a long-run, cost-conscious perspective. Incentive alignment between insurers, consumers, and providers is possible under a long-term health insurance framework, and importantly, all three groups can be happier with the end results. For the plurality of consumers—and hence voters—they may feel that the private health insurance industry is working with them, instead of against them, for the first time in modern U.S. healthcare history.

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