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Health reform and the individual mandate



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by Tom Snook, Principal & Consulting Actuary, Milliman Inc.



Two prominent physicians at Johns Hopkins recently [made comments](#) supporting the individual mandate provision in the healthcare reform law. Just a few days later, the 11th Circuit U.S. Court of Appeals struck down the provision, [ruling it unconstitutional](#). While the decision is seen by most as just a way station on the way to the Supreme Court, it does point to the sensitive nature of the provision.

As actuaries, we can't help but see the mandate a little differently than either physicians or judges. Regardless of our political views – and if you're wondering, mine happen to be independent, moderate and centrist – our professional expertise tells us that in the absence of underwriting and other traditional insurance risk management provisions, *something* is necessary to address adverse selection. The individual mandate may offer that something—as I indicated almost two years ago in a [paper](#) co-authored with Ron Harris. Without it, the sustainability of private health insurance is at risk.

What is meant by 'adverse selection'? Adverse selection is simply people acting in their own economic self-interest. Health insurance is [not cheap](#), especially if you don't have an employer subsidizing some or all of the cost. The purchase of health insurance is a significant financial commitment which thoughtful people will weigh carefully in light of other economic needs. (Many commentators, including the Hopkins physicians, refer to those going without health insurance as "free riders"; I find this phrase to be unfortunate, as it is simplistic and pejorative without recognizing the economic realities that families face in making this decision).

Consumers will place a value on health insurance commensurate with their perceived need for it. People with immediate healthcare needs are going to naturally place a higher value on insurance compared to those who haven't seen a need to go to the doctor in a few years. When the cost of health insurance is relatively low, such as in an employer-subsidized plan, the choice is easier: almost everyone will opt in. But when the cost of health insurance is higher, the choice is not so straightforward. Some people will opt in, while others will decide to risk it, at least for a while.

Those who opt in are going to be the ones who place the higher value on insurance. Those people are more likely to have immediate healthcare needs and hence be more expensive than the population as a whole. This is how [adverse selection drives up health insurance costs](#). The higher the costs, the higher the premium, which then circles back on the individual coverage decision – a higher premium means even more individuals will opt to go without coverage. Taken to its logical conclusion, we wind up with an insurance pool that may be unsustainable.

The traditional techniques used by insurers to mitigate this risk have included denying coverage or charging higher premiums for individuals with pre-existing health conditions, or excluding those conditions from the individual's policy – things that have been necessary to preserve the viability of health insurance programs, but also things that have been wildly unpopular with the public in recent years. These techniques are one reason why private health insurance is viewed so negatively by certain segments of the American electorate.

In response, the Patient Protection and Affordable Care Act (PPACA) takes these traditional risk management techniques away, or significantly limits them. Instead, it offers two tools to manage the adverse selection risk: coverage subsidies and the individual and employer mandates. Instead of reducing the number of unhealthy individuals entering the insurance pool, this approach tries to maximize the number of healthy lives getting coverage. The subsidies are available to lower

income Americans to help make the coverage choice easier, more like those of us who have employer-subsidized plans have. And the mandates are there to provide penalties to those who still opt out from coverage. The idea is to make it attractive to get insurance, and unattractive to go without – thereby influencing the individual coverage decision I described above.

Will it work? We'll have to see. [Some point to the efficacy of the mandate in Massachusetts](#) as proof that a nationwide individual mandate will work (for a Massachusetts-commissioned analysis, click [here](#)). Some (myself included) believe the mandates may be too weak to be effective nationwide, and that adverse selection may have a significant impact come 2014. Others dislike the subsidies because they are expensive, and the mandates because they believe they impinge on civil liberties. It is this latter point, of course, that is the subject of the lawsuits challenging the constitutionality of PPACA.

While the future of the law in general and the individual mandate in particular may rest with the courts, it's hard to dispute that *something* needs to fill the risk mitigation vacuum since PPACA takes the old techniques off the table. This is one case where the legal arguments will clearly trump the actuarial arguments, but that doesn't make the actuarial concerns go away. Market rules that turn a blind eye to adverse selection simply won't work.



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1.  [Lim Chee Beng](#) says:

[September 18, 2011 at 8:13 pm](#)

Healthcare reform is expected to happen in Malaysia too – I really hope that Malaysian Health Ministry will include expertises from the insurance industry in working committee in establishing the relevant policy. Health insurance is very different from other types of insurance, the larger the pool doesn't mean the average cost will reduce – this is what I learned previously when I was responsible to monitor the claim experience in one of my previous employer.

2.  [Tom Bakos](#) says:

[September 20, 2011 at 10:26 am](#)

Essentially, insurance is a risk sharing pool – health, life, everything else. Individuals will join such a pool and pay a premium so as to insure themselves against the financial consequences of such risk.

In a voluntary insurance pool an individual participant expects to share his or her exposure to risk with other individuals equally exposed to the same risk. True insurance is, essentially, a financial transaction – not a social or charitable compact. If risk exposures are not equal, the typical ways to address the financial fairness of insurance is to adjust premiums or benefits. When all feel they are equal participants in a financial transaction, each will be more willing to participate.

A mandate to buy insurance is only required when the person being mandated is being forced to buy something they would not buy voluntarily because it is too expensive. With respect to health insurance that means the premium such a mandated person would be expected to pay is more than the present value of the expected risk cost. A mandate is only required when the insurance principle has been violated. A mandate is a different kind of funding scheme – it is not insurance. We all know it is a form of wealth transfer.

Mandates can't work. There will never be 100% compliance – particularly when the cost of noncompliance is less than the cost of compliance. The only way “mandates” will work is if 100% participation is guaranteed by a third party who is paying the premiums and has no skin in the game – noncontributory group insurance, for example, or benefits paid for by taxes (e.g. Social Security, Medicare). I'm not suggesting that is fair financially – only that the payment for the benefits provided is sufficiently vague as to become lost in a thicker fog.

Therefore, if there is a great desire to provide an opportunity for all to get health “insurance” coverage (even those who demonstrably can't afford it) then, it seem to me, the best way to accomplish that is to subsidize (probably with tax dollars directly) the poor or unhealthies necessary risk appropriate premium payments. Imposing a mandate to buy health insurance at premium rates excessive with respect to individual risk is really a tax on the young and healthy.



3. [M Alexandra Johnson](#) says:

[September 22, 2011 at 7:40 am](#)

I agree with you that adverse selection is a big issue, but we can't ignore the huge moral hazard component of insuring such a large number of individuals. In fact, this could end up being more costly than covering individuals with imminent healthcare needs. (Not being an actuary myself, I couldn't say for sure!) The last time we provided a huge number of previously uninsured individuals with medical insurance was in 1965 when Medicare was enacted.

As I'm sure you know, healthcare costs (driven by a dramatic increase in demand for hospital and physician services) went through the roof. One would think the increase was due to people receiving much-needed care but that wasn't the entire case; greed and the American entitlement mentality took over. These mindsets are still at work as people consume more care than they may need, influenced by the medical and pharmaceutical machine, because, after all, “my insurance will cover it.” Providers continue to milk a broken system that actually rewards inefficiency and greed and we're not doing anything about that.

It would be shortsighted not to also tackle other issues that drive up costs in addition to wat you've cited: defensive medicine, over-use of technology, marketing-induced demand (in all sectors), lack of accountability and oversight... I could go on. In the last two years or so, billboards have sprung up in South Florida announcing the current waiting time at the nearest emergency room. Recently, I saw another that suggests you can “reserve” your ER spot! A long wait implies reduced acuity, relatively speaking, and calls into question the need for high-cost, high-tech emergency services. Concern about the long wait tells me the patient can probably choose a less expensive setting (urgent care center or primary care physician) the next day with no detrimental effect to his health.

I'm not in favor of the individual mandate for many reasons, but especially because it won't improve our country's morbidity and mortality indexes, it won't improve access and it won't result in more empowered, healthier patients.

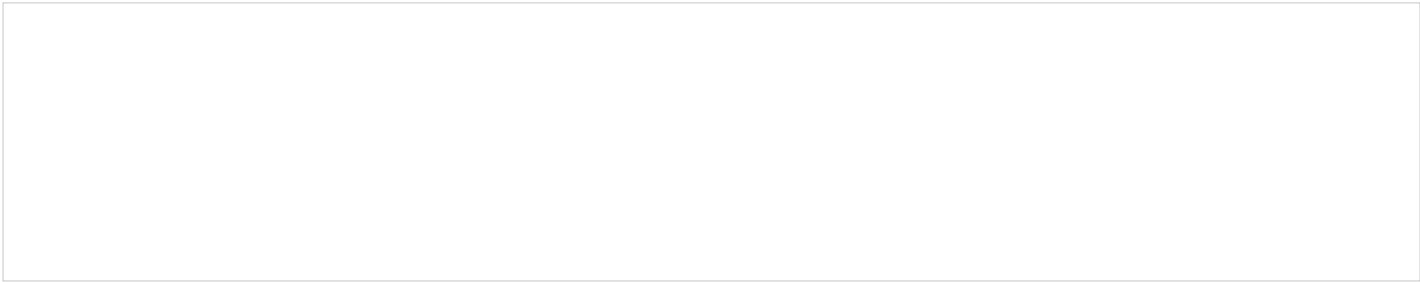
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