

Swimming Against the Tide

The Manhattan Institute Study on the Impact of Repealing Benefit Mandates,
Authorizing Age, Sex, Occupation and Health Status Underwriting, and Promoting
HSAs in New York's Individual Market

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Swimming Against the Tide

- Emerging consensus on federal healthcare reform would make U.S. insurance markets more like NY
 - Guaranteed issue
 - No health underwriting, gender, occupation
 - Individual mandate
 - Comprehensive benefits/no benefits caps
 - Exchanges
 - Affordability subsidies/Medicaid expansion
- Recent literature suggests subsidies/price reductions don't have the desired impact on uninsurance rates without an individual mandate, and downplay premium impact of eliminating mandated benefits

1. Directly Purchased Coverage in New York

“In fact, as a result of a significant increase in the cost of private-insurance(sic) coverage for individuals, the market for individual health insurance in New York has nearly disappeared, declining by 96 percent since 1994.” -- Bragdon/Parente, executive summary

Individual Purchasers of Health Insurance in New York – Three Views

| Parente/Bragdon for New York “today” | 2008 CPS ASEC For NY | UI/Partnership 4Coverage NY |
|--------------------------------------|----------------------|-----------------------------|
| 34,426 | 796,000 | 250,000 |

What’s missing?

- Variables: Non-standard direct pay; (grandfathered products, hospital only, etc.), Healthy NY Individual; Associations (Working Today/ Freelancers, NYS Bar Association, Support Service Alliance, Chambers, etc.); and sole proprietors.

2. New York, Two Deregulated Markets and Under 65 Uninsurance Rates

| New York | California | Texas |
|----------|------------|-------|
| 15.8% | 20.6% | 27.7% |

2008 CPS ASEC supplement

NY Uninsured by Income Status

➤Parente/Bragdon: 60% earn over \$25,000; 33% earn over \$50,000;

➤UHF:

| | |
|--------------------|------|
| <\$20,000: | 49% |
| \$20,000-39,999: | 26% |
| \$40,000-\$60,000: | 11% |
| \$60,000+: | 13% |
| (\$20,000 or more: | 51%) |

➤UHF analysis relies on “health insurance unit” rather than household income, as a more accurate reflection of the income available to individuals to buy coverage

➤Kaiser Statehealthfacts: 63% of NY uninsured less than 200% FPL

Technical Questions on ARCOLA model

➤ Cost savings from bare bones coverage?

- Not much, based on recent research (Monheit A/Rizzo J, "Mandated health Insurance Benefits: A Critical Review of the Literature," January 2007, NJ Department of Human Services/Rutgers Center for State Health Policy).

➤ Elasticity of Demand (How many uninsured buy coverage when price drops?)


- Parente/Bragdon: "... our model finds greater responsiveness to premium-prices changes than other micro-simulation models." (page 15)
- Table 2, a 42% change in premium causes a 2285% change in enrollment
- UHF/Gorman Actuarial Market merger report: 20 to 30% premium reduction results in 12,000 to 25,000 new members
- 4.4% of uninsured would purchase coverage with a 50% premium subsidy (Auerbach, D, "Price and the Demand for Nongroup Health Insurance," *Inquiry* 43:122-134, Summer 2006.)

The ARCOLA Model in Context

| Model | Parente/ALCORNA | Columbia/Glied | Urban/P4C |
|-------------------------|----------------------------|----------------------------|------------------------------|
| Components | Repeal CR/OE | Repeal CR/OE | Modify CR/OE |
| | Repeal Mandates | Repeal Mandates | Repeal Mandates |
| | High Risk Pool/No GI | High Risk Pool/No GI | |
| | HSA Policies | | HSA Eligible Policies |
| | Interstate Shopping | Cafeteria Plans | Subsidy for SG and DP |
| | | Short Term Policies | |
| Enrollment Gains | 810,000 | 100,00 to 130,000 | 400,000 model |

- H.R. 525/Small Business Health Fairness Act of 2005: net increase of 620,000 (CBO estimate, 4/8/2005).
- Urban Partnership for Coverage based on HIPSM; TRIM3 is not used for health policy
- S.1955/Enzi of 2006: net enrollment increase of 600,000 nationally (CBO letter to Senator Kennedy, 5/9/2006); net decline in small group enrollment in New York of 28,200 (Lewin, "The Impact of the Health Insurance Marketplace Modernization and Affordability Act, S.1955 on the Small Group Insurance Markets in Community Rated States," May 2006)

Repealing Community Rating – rates based on age, sex, health status, occupation

- Most rating rules are distributional, not a matter of added/subtracted costs for the market
- Adjusting rates by age/sex 
- Occupation/Industry underwriting +/-40%
- Maximum Variation?
- Impact on Small Group Market?

| AGE | Male | Female |
|-------|-------|--------|
| <20 | 0.450 | 0.813 |
| 20-24 | 0.450 | 0.813 |
| 25-29 | 0.433 | 0.838 |
| 30-34 | 0.576 | 1.117 |
| 35-39 | 0.812 | 1.214 |
| 40-44 | 1.041 | 1.135 |
| 45-49 | 1.150 | 1.251 |
| 50-54 | 1.302 | 1.323 |
| 55-59 | 2.115 | 1.603 |
| 60-64 | 2.620 | 2.172 |
| 65-69 | 3.311 | 2.204 |
| 70+ | 3.311 | 2.204 |

Interstate Insurance Sales

- Regulation by the states, regulation by the feds, state/federal partnership or regulation by *one* state
- Interstate insurance sales a euphemism for deregulation and a race to the bottom (e.g., incorporating in Delaware).

HSA for individuals

- Some ability for individuals to purchase HSA-eligible coverage in NY (eg., Healthy NY, Freelancers Union, sole proprietors);
- Are HSA policies still relevant?
 - Health plans make consumer-directed tools available for all policies;
 - Cost sharing broadly is leapfrogging HSA limitations. Skin in the game? How about bodyparts?
 - 40% of HSA-eligible policyholders don't have HSAs and 1/3 of employers offering coverage don't contribute, with an average contribution of \$626 to \$806 for those that do (*GAO letter to Hon. Henry Waxman, 4/18/08*);
 - More missed health care, lower consumer satisfaction, higher out-of-pocket costs (*EBRI Issue Brief No. 288, December 2005*) compared to comprehensive coverage
 - Is growth tied to enduring value of concept, or 1) desperate effort to find affordable coverage; and 2) tax benefits for middle- and upper-income policyholders?

Guaranteed Issue/High Risk Pool

- Less risk for insurers
- More risk for consumers
- If sick consumers are truly held harmless from rate increases by the rest of the market, they why bother segregating them?
- High risk pool rate of 125% standard rate not as good as it sounds (cost sharing, age/sex bands), hard to sustain (FL, CA, MN high risk pools)
- Wide variation in estimates of high risk pool enrollment (15,000 to 69,000) and new healthcare taxes needed (\$58 M to \$453 M)
- Current stop-loss subsidy (\$38 M) only covers 1/3 of eligible claims

Bare Bones Coverage

- Non-standardized direct pay coverage is available in NY
- Premium savings are negligible
- NJ Basic and Essential isn't so basic – 75% of 36,000 B&E policyholders chose plan with riders and not so inexpensive (\$282 per month, 30-year old female in Bergen County (NJ IHC Program, *2Q09 enrollment report*);
- Low take-up in many states, unless significant premium assistance is also provided (Quincy, L, “State Policies to Encourage High Deductible and Limited Benefit Health Plans: Costs, Constituents and Concerns,” “Mathematica Policy Brief, March 2009; Minnesota Department of Health, Health Economics Program, Issue Brief 2006-01, February 2006)

Bare Bones Policy Market Impact

- “In health insurance markets, choices are highly interdependent. Tradeoffs exist between flexibility (allowing wide choice), workability (achieving policy goals), and fairness (not permitting underinsurance or high cost sharing to be financed by charity care)...For example, the more benefit design is allowed to vary to meet consumer preferences...the more difficult it is to avoid and detect gaming and favorable selection.” (Fronstien P, Ross, M. *EBRI Issue Brief No.330*, June 2009)
- “The guaranteed-issue law encourages an individual without employer based coverage to wait until he or she is sick before buying individual coverage...”(Parente/Bragdon, p.4).
- The ~~guaranteed-issue law~~ **Parente/Bragdon proposal** encourages an individual without employer based coverage to wait until he or she is sick before buying ~~individual~~ **comprehensive** coverage...”
- Medicare Part B and Part D late enrollment penalties?

Conclusion

- Manhattan Institute proposal
 - Positive results for young, healthy and wealthy;
 - Mixed bag for lower-income New Yorkers;
 - Higher rates for women, older New Yorkers, sick New Yorkers, and people in certain occupations;
 - Would lead to an increase in direct pay enrollment, but a decline in ESI in the SG market;
 - Would undermine a comprehensive market for individuals, with probable implications for the Medicaid program;
 - Promotes inefficiency, increases admin costs;
 - Makes comparison shopping very difficult.