

Unhealthy exchange pool risk results from wrong assumptions of consumer behavior

Insurance premiums will quickly become unaffordable

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Executive Summary:

To be successful, the health insurance benefit exchange will need to attract healthy, premium paying individuals to protect insurers against adverse selection. If only unhealthy individuals enroll in exchange health plans, the insurance premiums will become unaffordable, and the result will be collapse of the exchange. Professional health insurance agents testify that healthy people seldom call to buy (or enroll in) health insurance: Someone must convince them to do so. Conversely, it is unhealthy people that seek out enrollers (buy) to access health insurance.

Professional Health Insurance Agents:

Professional health insurance agents founded what is now known as the National Association of Health Underwriters in 1930. NAHU now has around 200 chapters, spread across the country. Insurance agents had already been selling major medical and hospitalization insurance prior to the formation of NAHU. Agents have been insuring uninsured people for more than 80 years.

Hundreds of thousands of individuals across the country are licensed to sell health care insurance. As licensed agents, theirs is one of the most regulated industries in the country.

There is an unknown number of insurance agents that focus primarily on health insurance, but of those that do, 65 percent earn 75 percent of their income from selling health insurance.¹ It is common for professional insurance agents to hire support staff to ensure that they accurately and timely process all insurance policy information, and provide needed services to their clients.

The federal Congressional Research Service reported on the quality of service provided by professional health insurance agents.² The CRS October 2010 report indicates that of 125,651 complaints filed against the diverse entities (i.e. insurance companies, agents, vendors) whose services or products are critical to the delivery of private health insurance, less than three percent are related to the actions of insurance agents – 1,914 complaints resulted from insurance agent misrepresentation; 1,958 from agent handling of insurance transactions. The CRS reports that professional health insurance agents “rank relatively low on the list of concerns that consumers have about their insurance coverage.”³

State legislative bodies generally task the office of the state insurance commissioner as the licensing agency that licenses health insurance agents. Likewise, state legislators direct state-based offices to administer the ongoing continuing education agent requirements for insurance professionals. These CE courses and credit requirements are similar to those of other professionals – CPAs, attorneys, etc.

Nearly all health insurance agents receive their incomes from commissioned sales. The insurance companies only compensate the agent when the agent has successfully sold an individual policy or group plan, or has retained coverage for insured individuals and groups.

In order to earn an adequate living, agents must:

1. Insure the uninsured, requiring that they seek out (prospect) for new clients.
2. Keep insured individuals insured.

To accomplish these two critical tasks, agents must convince (i.e., sell) prospects and clients on the need to be insured, and agents must provide a broad range of services to retain clients. Health insurance sales are competitive, as much or more so than other direct sale products and services. Agents that fail to

convince enough potential clients to purchase insurance, or that fails to provide quality services, are soon put out of business by their competitors.

Buying and Selling Health Insurance

Today, there are two common methods by which individuals become insured:

1. They (or an employer) **buys** insurance
2. A health insurance agent **sells** insurance to an individual (or an employer)

Who **buys** insurance?

Agents report that a great majority of individuals that decide on their own to call an agent in order to **buy** insurance are those that have an immediate or potentially immediate need. This usually means they are unhealthy individuals that have become ill or injured (or moved from another location). They need health insurance as soon as possible. It is their health status that drives them to call an agent or enroller. This is similar to individuals that enroll in Medicaid or other government health plans once they become ill or injured. Without insurance, unhealthy people realize they will face large medical bills that could drive them to bankruptcy, or that will leave them financially scarred for life.

Agents are experienced at assisting unhealthy individuals that need insurance relatively quickly. They have been filling the “navigator” role for years. In Minnesota and other states that have well-established high risk pools, the agent acts as a “navigator” by helping the individual enroll in a high risk insurance plan (i.e., the Minnesota Comprehensive Health Association). Minnesota agents, acting as navigators for high risk, unhealthy individuals, are allowed to receive a one-time, \$50 fee for providing assistance to a person that **buys** this insurance coverage. Many agents never claim the \$50 fee, and voluntarily assist the individual as they enroll in MCHA.

MCHA health plans are more expensive than standard insurance. The law limits premiums rate to 125 percent of similar standard insurance plans. Fifty percent of claims cost is paid by someone else – an assessment on fully insured health plans. The reason individuals are willing to pay 120% to 125% of standard premium for an MCHA plan is that they have realized for each dollar of premium they pay, on average, they will receive back \$2.14 in paid medical benefits.⁴

The “navigator” role in the case of high risk health insurance plans like MCHA, is to enroll unhealthy individuals in a suitable health plan. Each time agents are successful, the high risk pool becomes fractionally healthier.

If an individual is *marginally* unhealthy and has a chance to receive coverage under a non-high risk health plan, the agent is diligent to search out and aggressively attempt to enroll them in such. Agents receive more than a one time, \$50 fee by enrolling individuals in a non-high risk, private insurance plan, and when successful, the newly insured individual saves 20-25% on insurance premiums.

MNCAAP Navigators

Enrollers (navigators) currently provide enrollment services in Minnesota. These “navigators” enroll eligible low-income individuals into public health plans (taxpayer subsidized) for which they are qualified. The “navigators” are registered with the Minnesota Department of Health under the Minnesota Community Application Agent Program (MCAAP). We are not aware if other states follow a similar pattern.

In 2009, 127 agencies were authorized to serve as MNCAAP “Navigators.” Of the 127 agencies, 86 have received grants ranging from \$25 to \$87,325 – the largest received by Portico Healthnet. Portico prides itself on enrolling low-income people as one of its primary missions. The total of grants paid tallied to \$397,450. Portico received 22 percent of the total grants.⁵ Of the 3,493 \$25 grants the state paid to Portico, approximately 50 percent – 1,750, for \$43,750 – were triggered by an immediate need for health care coverage for an unhealthy individual.⁶

As of this writing, at least \$336,600 \$25 enrollment fees for 13,464 applications were issued to medical providers. This is a strong indicator that the motivation to enroll these individuals was to ensure that the medical provider would receive reimbursement for services rendered.

The overwhelming number of individuals enrolled by MNCAAP “Navigators” added unhealthy risk to taxpayer subsidized health plan pools.

Navigators are suited to help unhealthy people **buy** insurance quickly, and enroll them in the plan deemed most affordable.

The navigator very well could be satisfied with a one-time fee, even \$25, or receiving a government grant to act on behalf of the exchange for this specific purpose.

Without significantly increased motivation that is unrelated to financial incentives, navigators would have no financial incentive to attempt to seek out and enroll healthy individuals.

Enrollment Institutions	Total Enrollment Fees Collected	% of Total Fees Collected	Total Number of Enrollees
Portico Healthnet (See note 6)	\$87,325	22.0% of which 11% had medical needs	3493 of which 50% had medical needs
Medical Providers	\$336,600	84.7%	13,464
All Other Enrollers	\$17,275	4.3%	691
Total	\$397,450	100%	15,898

The exchange may attempt to provide grants to professional health insurance agents to act as enrollers. The ACA, however, specifically prohibits insurance agents from receiving any compensation, directly or indirectly, from an insurance company. Curiously, it places no such specific restriction on non-agents acting as navigators who, presumably, could receive some form of compensation directly or indirectly tied to an insurance company.

Summary: Individuals that **buy** insurance in the private market generally have an immediate medical need that they expect will cost more than their premium. Receiving back more than a 100 percent return on premium would be an attractive investment for anyone. These are the individuals that will call or approach the exchange navigators for assistance in enrolling in health plans. Unfortunately, this does nothing to create a balanced risk pool, but on the contrary, will increase the proportion of unhealthy people in the pool.

Risk pools must be carefully balanced

If private insurance companies only insured people that wanted to *buy* insurance, paying their claims would drive insurance premiums upward, making coverage less affordable for everyone, unhealthy and healthy people alike. The insurance pool would be out of balance.

If the pool becomes too unbalanced with unhealthy risk, and the state or federal government disallows premium increases requested by the insurer, the insurer would quit writing health insurance, or go out of business. If the exchange risk pool attracts too many *unhealthy* people, it, too, will not be able to continue to serve its intended population. To continue to offer services, the exchange would require a progressively larger subsidy to offset the expense of insuring this unhealthy pool.

In an attempt to bring healthy risk to the pool, the federal legislation establishes a mandate that every individual *must* purchase health insurance or enroll in a public plan. There is, however, no evidence to suggest that the mandate will actually convince healthy people to enroll (see discussion below).

The insurance companies know that they must sell coverage to healthy individuals if they wish to continue to write health insurance. There must be a large number of healthy people enrolling in coverage to offset the cost of claims for a much smaller population of unhealthy people. Healthy people that enroll in insurance are willing to pay more in premium than they are likely to receive back, with the understanding someday, they may need insurance to pay medical claims. Until the healthy person becomes ill or injured, health insurance premiums seem to be a heavy financial burden.

The insurance company and the exchange face the same challenge – how to get healthy people to purchase health insurance.

Selling insurance

In 2009, the national average annual health insurance premium for individual coverage increased to \$4,824, and to \$13,375 for a family plan.⁷ These premium payments must compete with discretionary and non-discretionary spending – necessities and luxuries.

In our culture, most individuals experience the external and pressure to be insured, and fear of being uninsured. Yet, without someone convincing them to spend \$4,824 a year in premium, they are unlikely to feel so compelled so as to make the effort to go out and purchase health insurance.

The largest cohort of uninsured has historically been those who are aged 19-45, referred to sometimes as the “invincibles.” These are healthy people for whom it is difficult to justify spending \$200 to \$300 a month for health insurance in the remote possibility that they may need coverage to pay medical bills.

The federal government recognized that to have affordable health insurance for the broadest number of individuals, healthy people must be convinced to participate in the pool – i.e., to **buy** insurance. As a result, The Affordable Care Act of 2010 mandates that all United States residents must be covered under a health insurance plan, whether public or private, starting in 2014.⁸ Furthermore, the federal government realizes that an individual is more likely to own health insurance if it is provided as a benefit from his/her employer. Employer-based health insurance has been effective in bringing a high percentage of healthy individuals into the pool to offset the small number of high cost claims.

Is following the law a benefit?

Evidence indicates that when individuals are forced to make a purchase they would otherwise not make, the natural tendency is for the individual to calculate the least possible cost to them. The idea that fear of punishment, or a sense of moral obligation, will incent individuals to spend their own money to make an unwanted purchase, is not supported by evidence (see below).

To fulfill its purpose of forcing individuals to obey the mandate, the law must assess a severe and punitive penalty for healthy people to spend \$400 a month for health insurance. For those that qualify for free or nearly free health coverage under a government plan, they too will need a punitive incentive to entice them to enroll in coverage. The Minnesota Department of Health reported in 2009 that 61 percent of the uninsured population in Minnesota already qualifies for government health plans, yet they fail to enroll.⁹ It is likely that a similar proportion of uninsured all across the country fail to enroll.

The ACA defines penalties to be levied against individuals that violate the individual mandate. The penalties increase from \$95 a year in 2014, to \$695 a year in 2016, and are indexed for inflation thereafter.¹⁰

Ninety-five dollars represents two percent of the full average 2009 annual national health insurance premium. The \$695 annual penalty, without factoring in inflation in premium by 2016, represents 14.4 percent of annual premium. These very low penalty rates create a perverse incentive for healthy individuals to ignore the mandate, pay the penalty, and purchase insurance after they become unhealthy.

Beginning in 2014, the ACA forces insurers to sell insurance to anyone that applies. This creates yet another perverse incentive for individuals to ignore the mandate. The result will be that a large number of healthy individuals will refuse to enroll, leaving the risk pool out of balance between unhealthy and healthy risk.

Marginally unhealthy people that have ongoing medical expenses may also find reduced incentive to abide by the mandate. As a result, once again, the overall risk pool remains captive to unhealthy individuals.

An example: An individual on maintenance medications, for instance, may calculate a net out of pocket cost per year of \$1,000. With the penalty, the cost would increase to \$1,095. In 2016, this would increase to \$1,695, still far below the annual cost of insurance. There is a strong incentive to ignore the mandate and pay the penalty.

Exploring the effect of the mandate

In the most basic sense, it is improper to compare auto insurance mandates to health insurance mandates. However, the auto insurance mandate does provide for a background against which the health insurance mandate can be made.

Currently, 47 states mandate that anyone owning an automobile must have auto liability insurance. Unlike health insurance which is designed to protect oneself, auto liability insurance protects other people from accidents resulting from the action or inaction of the driver that causes the accident. Mandatory auto liability insurance does not cover repairs to the insured party's vehicle, if the insured party caused the accident. It protects insured people from uninsured people (lawbreakers).

The CBO reported in 2008 that about 14.6 percent of automobile drivers are uninsured, despite the mandate to purchase auto liability insurance.¹¹ Penalties range from \$0 to \$5,000 across different states that mandate coverage. In Minnesota, the penalty for driving without insurance is:

- Suspension of the driver's license
- Suspension of the vehicle registration
- Paying a traffic ticket for a no insurance violation (This is a misdemeanor in Minnesota that could result in 90 days in the workhouse and up to a \$1,000 fine.)¹²

Due in part to the high rate of those that defy the auto insurance mandate, legislators created another law that places an additional burden on those that obey the law. No-fault laws require individuals to spend additional premium dollars to cover expenses caused by lawbreakers (those who refuse the mandate to purchase coverage). Paradoxically, no-fault laws add premium expense to auto insurance purchased by law-abiding individuals. This phenomena will be evident with the health insurance mandate, but without the need for a new law. Instead, the lack of healthy individuals in the risk pool will result in higher premiums for everyone.

In 2009, the average annual individual health insurance premium in the United States was \$4,824¹³ compared to an annual Minnesota auto liability insurance premium of \$410.¹⁴ In comparison, 12 months of auto liability insurance premium is about the same as one month of health insurance premium.

Unlike auto insurance, those who will defy the health insurance mandate will do so because the cost of health insurance will greatly exceed the cost of being uninsured. Again, paradoxically, high risk individuals have more incentive to comply with the new health insurance mandate, while those that are required to own auto insurance and have a poor driving record ignore the auto insurance mandate because their cost of coverage is far greater than for those that are good drivers.

With auto insurance, good drivers predominate in the pool. With health insurance, unhealthy people will dominate the pool.

Will the penalties and incentives in the ACA be enough to convince healthy people to buy health insurance to conform to the mandate? How will that decision be affected by the ACA's other provisions that provide guarantee issue of health insurance, with no pre-existing condition exclusions? We can examine the compliance with federal IRS laws.

Although the federal Internal Revenue Service, charged with enforcing the insurance mandate, has proven itself quite able to intimidate citizens to pay their taxes, 14.7 percent of those required to file either do not file, or file fraudulent returns.¹⁵ The threat of failing to conform to IRS requirements includes assessment of interest, punitive penalty charges, and the possibility of imprisonment in a federal facility.

Good intentions: False hope

Congress included Section 1501 of the ACA for the express purpose of convincing *healthy* people to call an exchange navigator, get enrolled, and pay money into the pool to offset the claims of high cost individuals. To help convince reluctant healthy people to enroll (**buy**) coverage, the ACA establishes a broad set of federal subsidies to buy down the cost of coverage, and of out-of-pocket expense. Yet those individuals that receive a premium subsidy and who are currently uninsured, to comply with the mandate will be forced to spend money that they are not now spending. Even with a subsidy, as a result of guarantee issue and the ban on exclusion of coverage for pre-existing conditions, who will enroll? The

only individuals that will enroll (buy) in coverage are those that worry they will have more than \$4,800 in claims, or individuals that greatly fear the power of the IRS (although the ACA strips the IRS of almost all enforcement power).

The exchange will still have to find some way to **sell** coverage to healthy individuals. If the exchange is unsuccessful at convincing healthy people to enroll, it will soon find itself facing illiquidity, and with very few insurance companies willing to insure individuals, healthy or unhealthy. Unlike private entities, however, the exchange will be able to use the force of government to increase its oversight and regular power, rather than to close down its office, no matter the level by which it fails its mission.

The Exchange must decide at the start how to convince healthy people to enroll:

The exchange has at its disposal a proven strategy to sell coverage to healthy people, and avoid adverse selection. If from its inception, the exchange allows professional health insurance agents to partner with the exchange, and if the exchange provides fair compensation to agents for their services, the agents will do as they always have done – convince healthy people to enroll.

Legislators are in the process of making decisions about the future of the exchange. If legislators truly want the exchanges to succeed, they must decide how to draw healthy individuals into the pool. If the state legislators succumb to the federal pressure to launch the exchange, they should strongly encourage legislation that will include compensated health insurance agents as the primary sales force for the exchange.

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¹ Racer, D.; Dattilo, G. *National Survey Reveals Agents See a Grey Future*. Survey conducted June 2010. Freemarkethealthcare.com, St Paul, MN. July 1, 2010.

² Newsom, M. (2010) *Health Insurance Agents and Brokers in the Reformed Health Insurance Market*. Congressional Research Service, United States Congress. Oct. 1, 2010, 3.

³ Ibid.

⁴ This calculation is based on total premium paid to MCHA plans, and total claims expense of MCHA plans, average over the number of enrollees.

⁵ Kojasoy, S. (2010) "Minnesota Community Application Agent Program (MNCAA)" Data provided by email dated 11/3/2010, on an Excel spreadsheet dated 11/2/10.

⁶ Holmgren, D. (2010) Via email to Dave Racer. November 6, 2010. Holmgren is the President of Portico Healthnet.

⁷ Fritze, J. "Average family health insurance policy: \$13,375, up 5%." USA Today. Reporting on a Kaiser Family Foundation study. Sep. 16, 2009. http://www.usatoday.com/money/industries/health/2009-09-15-insurance-costs_N.htm Retrieved 10/20/2010.

⁸ The Affordable Care Act of 2010, final edition. Section 1501.

⁹ * "Health Insurance Coverage in Minnesota, Early Results from the 2009 Minnesota Health Access Survey." Minnesota Department of Health, February 2009

¹⁰ See note 7, Section 1502.

¹¹ Key Issues in Analyzing Major Health Insurance Proposals, Congressional Budget Office. Dec. 2008, P 52.

¹² 4 Auto Insurance Quotes. <https://www.4carinsurancequotes.com/States/Minnesota.html>. Retrieved on October 20, 2010.

¹³ "Average family health insurance policy: \$13,375, up 5%." USA Today. http://www.usatoday.com/money/industries/health/2009-09-15-insurance-costs_N.htm. Retrieved on Oct. 20, 2010

¹⁴ See note 12.

¹⁵ See note 11.