

# Proposals to Save the Direct Pay Market: New Life or Just Life Support?

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# UHF, EMPIRE, UHC PRESENTATIONS PRESENT A SOBERING PICTURE

- A market of premiums spiraling upward, high utilization and enrollment spiraling downward
- Unable to serve the essential purposes of an individual market in our current system – transitional insurance for some, permanent comprehensive coverage for others who do not benefit from employer-based system

# DO WE UNDERSTAND THE PROBLEM?

- That high premiums and shrinking enrollment create a vicious feedback loop of adverse selection, seems intuitively correct. The stagnation of the stop-loss pools, which fail to mitigate the effects of a concentration of sick people, is clearly a major problem.
- But other contributing market dynamics should be investigated and understood
- Sometimes, the other factors raise complicated and thorny issues that we, out of the best of intentions, elect to avert our eyes from

# OTHER POSSIBLE DYNAMICS

- UHF report: new state programs (sole proprietor, Healthy NY) peeling off enrollment
- Medicare drug benefit in 2006 – Replaces direct pay as Medigap plan for the disabled
- “Risk dumping” – purchase of private insurance for high cost enrollees -- by Medicaid, and why we avoid examining the practice (n.b.: beneficiaries may get better care, state is not as sensitive to premium increases as individuals, and this may in effect federalize some cost)
- “pooling” of products for pricing – why are profits higher on direct pay than on small group? Does our system permit subsidy to flow from the sick to the healthy?

# Questions regarding market merger

- **1. Why do UHF and Empire find similar premium reductions for Direct Pay market, but very different effects on small group?**
  - Is Empire presupposing merger of only standardized direct pay products, and not healthier less comprehensive ones (hospital only)?
  - By including premiums of lower priced products in its analysis, is UHF's estimate of the premium reductions in direct pay truly comparable to Empire's (compare rates in UHF analysis with current rates on following slide)?

# Direct Pay Premium Rates November 2008

	Suffolk County	Chemung County	Erie County	New York County	Albany County
<b>Average Individual HMO</b>	<b>\$1,074.20</b>	<b>\$964.49</b>	<b>\$967.53</b>	<b>\$974.49</b>	<b>\$994.58</b>
<b>Median Individual HMO</b>	<b>\$969.07</b>	<b>\$932.90</b>	<b>\$943.33</b>	<b>\$887.85</b>	<b>\$955.85</b>
<b>Average Family HMO</b>	<b>\$3,069.29</b>	<b>\$2,465.13</b>	<b>\$2,796.50</b>	<b>\$2,786.91</b>	<b>\$2,663.75</b>
<b>Median Family HMO</b>	<b>\$2,724.01</b>	<b>\$2,275.53</b>	<b>\$2,615.50</b>	<b>\$2,663.55</b>	<b>\$2,676.38</b>
<b>Average Individual POS</b>	<b>\$1,550.72</b>	<b>\$1,088.50</b>	<b>\$1,171.59</b>	<b>\$1,382.01</b>	<b>\$1,266.97</b>
<b>Median Individual POS</b>	<b>\$1,298.30</b>	<b>\$1,036.59</b>	<b>\$1,048.03</b>	<b>\$1,298.30</b>	<b>\$1,183.04</b>
<b>Average Family POS</b>	<b>\$4,466.71</b>	<b>\$2,798.40</b>	<b>\$3,380.94</b>	<b>\$3,989.33</b>	<b>\$3,414.05</b>
<b>Median Family POS</b>	<b>\$3,894.90</b>	<b>\$2,549.48</b>	<b>\$2,929.41</b>	<b>\$3,708.00</b>	<b>\$3,338.01</b>

# Questions regarding market merger

- **2. Are the effects of merger good enough?**
  - UHF estimates a modest 11,700 enrollment increase from premium reduction (and equal number from new product availability)
  - Empire does not estimate
  - Does this suggest that even a 30% premium reduction does not achieve “affordability”?
  - What would it take to restore the size of the market of 8 years ago?
  - Is it reasonable to use public funds to subsidize non-comprehensive products like “hospital only”?

# Questions regarding market merger

- **3. What is policy justification for using only small group market (10% of state's population) to subsidize direct pay?**
  - Will the market notice?
  - Will it erode small group coverage?
  - Are there not broader-based revenue streams available and would they not be more fair?



# Questions regarding market merger

- **4. Is mitigation for small group the best use of public funds?**
  - The only reason to merge the markets is achieve cross subsidy from small group to direct pay.
  - Why bother merging and then mitigating? If add \$128 million to current stop loss could reduce premium by \$233 pmpm. (Cf. Minn. Comp. Health Assn high risk pool - >\$140 million per year for 30,000 enrollees)
  - Or why not apply \$128 million to FHP buy-in – according to UHF Blueprint estimates, with \$128 million could enroll over 37,000 new childless adults between 150% and 200% of poverty, even more at higher incomes

# QUESTIONS REGARDING UHC PROPOSAL

- If can save 8% of premium by moving everyone to a single administrative entity, is that not an argument to move the entire system to a single payer?
- If eliminate choice among different insurers, will consumers have adequate access to care they need? Will those who now choose Empire, for example, because MSKCC is in-network, find themselves with less access to our premier cancer institute?
- If a 30% premium cut adds only 11,700 people to the rolls, how many will be added by mere 17% cut?

# QUESTIONS COMMON TO MERGER AND UHC PROPOSALS

- Both proposals espouse the benefits of opening an array of product choices to individuals. But doesn't each additional alternative increase the adverse selection in the most comprehensive products? How will you keep that product, so essential for the high proportion of chronically ill folks, affordable? Is small group enrollment in comprehensive products enough to offset this effect in a merged market? What offsets it in UHC proposal?
- Don't HSA products you would promote for this market make the adverse selection issues all the more acute? If this market now consists of the sick and the rich, and HSAs make the most sense for the rich, then won't the sick be left alone in the comprehensive product?

IN SHORT, WHAT HAPPENS LONG TERM UNDER BOTH PROPOSALS TO THE SICK PEOPLE WHO NEED THE MOST COMPREHENSIVE BENEFITS?

# LESSONS FROM THE SUBPRIME CRISIS

- In a marketplace which operates by assessing risk (commercial lenders and commercial insurers), homeowners with subprime credit, like consumers in “subprime” health, are excluded or charged more
- We as a matter of social policy encourage or mandate inclusion of subprime risks in the market
- The market is unable to spread the risks equitably on its own
- The losses from the subprime risk therefore ultimately must be socialized.
- My commentary: the solution must help Main Street (the consumer) not just Wall Street (the financier)

# Considerations Proposed In 2007 Reiterated Today

In crafting solutions, also consider past cross-subsidy failures:

- options for comprehensive coverage mean little if sicker people are isolated in those products without meaningful cross subsidy
- reducing premiums by cutting benefits does not help the sick
- the market doing the cross subsidizing must be resilient enough to bear it
- any system for transferring resources must be administratively simple

# MY TAKE

Neither proposal is the “ultimate solution” – will not, without more, make comprehensive benefits available to significant number of individuals at affordable rates for the long term. The “more” is more money than can be reasonably expected from small group market alone.

Individual coverage should be adequately funded from a broad base, through a universal coverage plan with mandatory participation similar to Massachusetts or a broad based subsidy at many times our current levels that reduces premiums substantially

Either plan, or a hybrid of the two, may have to be considered as a temporary stopgap to prevent severe dislocations from a market meltdown for the market’s current participants and those who need its protection