Chapter Six

Using Private Health Plans To Cover Everyone Will Not Work If We Can't Make Coverage Affordable

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Using private health plans to provide health coverage for most Americans will only succeed for us as a country if the coverage that is sold by the private health plans is affordable. Affordability is essential. This strategy will fail if we use private insurers to provide health coverage and the premium that is charged by the plans for their coverage is so high that people can't afford to buy the coverage.

This Strategy Will Fail If Premiums Are not Affordable

We need to make premium affordability a top priority.

So what can we do to make premiums for health insurance more affordable in this country?

Some of the necessary strategies to keep premiums affordable have been described in the prior chapters of this book. Insurers in this country need to perform several key roles relative to affordability and they need to perform each of those rules increasingly well.

For starters, if we want premiums to be affordable for Americans who buy insurance, we need our insurers to negotiate good prices with the caregivers who take care of their patients. That strategy was mentioned in two earlier chapters. Premium for health insurance is, of course, based very directly on the average cost of care for insured people. We need insurers to help bring down their needed premium levels by successfully reducing the average costs of care for the people they insure. Reductions in the fees paid to providers of care can obviously help reduce premium levels.

Cash Flow From Insurers Should Encourage Continuous Improvement

Negotiating better prices for each of the pieces of care that are being purchased by the piece is clearly an important thing for insurers to do to bring down premium costs. Those fee negotiations are actually not,

however, the very best and most useful thing that insurers can do to help bring down the cost of care for insured people.

The most useful way for insurers to bring down the cost of care is to buy care differently -- buying care, wherever possible, by the package and not by the piece. This book has explained multiple times why that approach to buying care is a good idea.

Insurers very much need to work with caregivers to create better cash flow mechanisms and more process-focused business models for care providers. The business model we use to buy care needs to free the caregivers from the rigid controls and the functionality tyranny that is created by our standard fee based approach of paying for care entirely by the piece. As earlier chapters of this book have explained several times those standard insurance company lists of approved procedures limit, inhibit, penalize, and even cripple process improvement in care delivery. Health plans can help make process improvement happen for the business units of care by using business models and payment approaches that incent and reward better processes. We need creative and enlightened payers to work with creative and collaborative care delivery entities to create better care business models. We need business models that will allow the caregivers to reengineer care and bring down operational costs without suffering revenue loss and financial damage. We can easily create a functional industrial revolution for care delivery if we do that business model redesign work well. We need that industrial revolution to happen -- and it cannot and will not happen as long as care is purchased only by the piece.

ACOs And Medical Homes Both Sell Care By the Package

The good news is that there is actually a growing list of ways we can buy care by the package. ACOs and patient-focused medical homes were both described in the last chapter of this book. Both of those care delivery approaches sell care by the package in ways that enable caregivers to do a better job of team care and a much better job of care coordination. ACO's and medical homes are high potential care delivery models. That potential will only be triggered and realized if both health

plans and government purchasers decide to support those care approaches with real cash flow. Cash flow is the key. Those steps in the right direction by the business units of care need cash flow support from key purchasers of care to survive and thrive. Caregivers can't take the steps to implement and run either ACOs or medical homes without sufficient cash flow support.

Having the purchasers of care and the providers of care working together in alignment to perform those functions makes huge sense.

The Primary Function Of Insurance -- Spread Risk

There is an obvious opportunity to use the vast river of cash that flows in our country more wisely because that massive cash flow exists now and much of it is being channeled through health plans today. Health insurers are the conduit for cash used to buy care for the majority of Americans. They will not be able to succeed in those efforts if the premiums they charge people to buy coverage are unaffordable.

Insurers Exist To Spend Risk

All of those efforts to make premium affordable will fail if we don't succeed with another major element of the business model we use to maintain and sustain the basic product sold by the health plans and insurers. That basic product is -- in a word -- insurance.

That topic is particularly relevant right now because the Affordable Care Act has made some changes in the traditional business approaches of health insurance for a major piece of the insurance market. For the individual insurance market and for the small group insurance market, the new law makes it illegal for insurers to exclude people from coverage for being ill or high risk.

Most of the insured people in this country have "group" coverage -- - with insurance purchased through employer groups. That coverage accepts all applicants inside each group and doesn't health screen anyone. But roughly 7 percent of insured people have purchased individual coverage directly from an insurer. [246] The insurers who have

sold individual coverage have been allowed to do health screens and have been able to refuse to sell individual insurance to people who are in poor health or at significant risk of being in poor health. That ability to reject people for those reasons is now gone for health insurers.

The most basic role of health plans is actually very simple and very clear. We use the plans to create "insurance." We basically pay billions of dollars to our health insurers so they can perform a very basic and fundamental cash flow function. Their basic job and their most foundational function for the bulk of their customers is to be insurers -- to spread risk and to spread care expenses among insured people.

We Buy Care With Other People's Money

Spreading risk actually is their primary reason to exist. How do the insurers spread risk? The process is pretty simple. The insurers only have one source of cash. Customers. They each collect money from their customers in premiums. The premiums are paid to the insurer by all of the people they insure. The insurers then use that money to buy care for the people they insure who actually need care. That cash reallocation process between insured people is their core function and most fundamental value. The insurers create a functional and practical cash flow mechanism that allows all of their insured people to use other people's money to pay for their care when that money is needed to buy care because the care itself is needed by that insured person.

Some people need a lot of care. When people need care that costs a lot of money, then people very clearly need access to other people's money to pay for that care. Having secure access to other people's money is a very valuable financial reality for all of the people who need that money to pay for their care. That's where risk spreading by the insurers becomes relevant. Insured people actually have access to that needed money only because their insurers have been successful in spreading risk and because the insurers have collected the money from other people and then have it on hand to pay for insured people's care.

To make that risk spreading financial model work, the insurers need to collect premium from a large number of people who aren't

currently using care so they can use the money they have collected from those people to buy care for the insured people who actually are using care at any point in time. As this book has also noted earlier in a couple of places, when we are ill, we have three ways of getting access to other people's money so we can use it to pay for our care. We can use tax money -- or we can use money collected in premiums -- or we can use money paid by our employer as part of our employee benefit package. Taxes and premiums are the two key mechanisms we have to get access to other people's money. If we are covered by one of our government programs, the other people whose money we use to buy our care are the taxpayers who pay taxes and who generate the government flow of money used to buy care. When we have private insurance, the money we use from other people to pay for our care is the money that those other people have paid in their insurance premiums to the insurer we share.

The job of each insurer is to collect enough money from all of their insured people so that there is enough money to buy care for the people they insure who need that money to pay for their care.

This book is also, obviously, recommending strongly that our health insurers now should not only spread risk -- they should now also take on multiple additional functional roles that can help improve both the quality and cost of care. As noted earlier, only insurers have the tools, the leverage and the cash flow to do important parts of that quality improvement and care redesign work. We need obviously need our insurers to do some key pieces of improved quality work and some key pieces of cost mitigation work or that work will not be done. Those are good and important roles for insurers to play -- but if we cut to the essence of the pure insurance model, that risk-spreading function is clearly the basic role that insurers must play in order for that money to be available by the insurer when it is needed to pay for people's care.

This Model Will Fail If the Risk Pools Are Destroyed

In order to spread risk, the insurers need to have a number of customers who are paying premiums but not using much care so the insurer can use their money to buy care for the people who are also

paying premiums and who do currently need that insurance cash flow money to buy their care.

In the group insurance market, everyone in each group buys the insurance -- so the risk selection issues are relatively small. In the new individual insurance market, we now have a situation where individuals who are at significant risk or who are already using expensive care can now buy individual insurance. The concern, of course, is that most of the new people who will buy individual coverage may now be very expensive users of care dollars.

At the essence of the issue, we need to recognize that the premiums that are charged to buy coverage will become either highly unaffordable or completely unavailable -- if the business model and the market reality we use to fund our health insurance premium cash flow for that individual marketplace doesn't allow each of the insurers who sell insurance to that set of people to have enough non-sick customers so that they have viable risk pools and they can pay for the care costs of their insured sick people.

Viable is a very important concept relative to risk pools. If the insurers of this country each end up with risk pools for the individual market that are made up entirely of sick people -- then those risk pools will collapse. That is a real danger. If the people who buy individual insurance are too heavily based on the subset of possible customers who are sick people, then the average cost of care for the people who are covered by each insurer to buy care for those sick people will be very high. Arithmetic becomes very relevant at that point. When the average cost of care for an insurer is high, that of course, creates premiums for each insurer that are very high. When premiums for any insurer are high, very nasty and dysfunctional things can happen to that insurer and to that insurers risk pool in any market-based insurance environment.

Why can dysfunctional things happen to those risk pools?

People Make Intelligent Choices

People are intelligent. People also tend to make decisions that meet their own self-interest. Both of those facts are relevant when the

purchase of insurance is voluntary. People who voluntarily buy health insurance are capable of making very intelligent choices relative to their own costs and expense levels. Those choices made by individual people based on their own direct costs of premium and care can sometimes potentially damage the new risk pools. That is not a new phenomenon.

When premiums go up for any given insurer, the people who buy that specific insurance react individually and personally to each price increase. People make very real choices about whether or not to cancel their insurance coverage when their premiums go up. The decisions about continuing to be insured are made at that point by each person based on each person's individual financial status and health care reality. The healthy people who have that insurance who have no immediate personal health care needs may decide that they don't want to continue to pay the higher premiums when they have no current or anticipated use of care.

So when premiums go up too much for currently insured healthy people, those low cost currently insured people may simply cancel coverage. Each insured person can make that individual choice based on their own judgment and their own circumstances. When a number of healthy people make that choice to cancel their insurance coverage, those healthy people immediately stop being part of that specific risk pool.

Insurers tend to panic when that happens. Panic is an accurate description of the insurer's reaction to a risk-pool deterioration situation. Insurers know that when the healthiest people are leaving their risk pool, that will cause the remaining risk pool of less healthy but still insured people to have an even higher average cost of care. If that higher cost of care happens for that remaining risk pool, then the premiums for that insurer also simply go up again to reflect the new average cost of care for the people who are still insured. When a next rate increase happens for that same set of people, there can be additional consequences. The usual pattern that follows additional rate increases is that more healthy people will leave the risk pool each time the rates go up. That set of consumer decisions is obviously not good for any risk pool. That sequence of events and those choices to cancel coverage by insured people can far too easily create what insurance actuaries call a "risk pool death spiral."

A risk pool death spiral very much is not a good thing for an insurance company.

The need to have a sufficient number of healthy people in each insurers risk pool is pretty clear. That is going to be particularly true for the new risk pools that will be created by the new law that allows everyone to purchase insurance, regardless of their health status.

When the opportunity to buy health insurance is fully activated for currently sick and uninsured people, it is clear that anyone who has cancer or who has diabetes and its various complications would be making a mistake not to buy that newly available insurance. The number of people with cancer who do not enroll will be fairly low. The challenge will be to get additional people who don't have cancer to also enroll.

Affordability Is The Goal And The Key To Success

Insurers, of course, understand those sets of risks very well.

Insurers very much want the premiums they charge to their customers to be affordable. Insurers have traditionally wanted premiums to be affordable not because the insurers want to charge less in premiums but because the consequences to an insurer of significant risk pool deterioration can be so grim, painful, and financially deadly.

A major business goal of the people who manage operations for voluntarily purchased health insurance premiums risk pools always needs to be affordability because actuarial death spirals can be triggered far too easily and far too quickly by unaffordability.

What does that set of financial realities tell us?

It tells us that the strategy that we have chosen as a country to use private insurers to insure people in the individual market who do not have group insurance coverage cannot succeed if the premiums charged by the insurers for those individually purchased insurance policies ends up becoming unaffordable. The premium that will be charged to people in the individual market needs to be low enough so that people who already have that insurance coverage will not cancel their coverage. It is a very circular situation. Premium affordability cannot happen if the average cost of care for any given insurance risk pool is too high. If any

given risk pool deteriorates and if all of the healthy insured people leave a risk pool, the remaining insured population in that risk pool will have a very high cost of care and premium for that set of insured people will become unaffordable.

Access To The Risk Pool Will Now Change

We are in the process of changing a significant part of the business model for health insurance in this country. Those changes are making health insurance more accessible to many people in the individual market. Those changes also are increasing the risk that the people who buy insurance and who retain insurance will be less healthy than the people who are in the current risk pools for individual coverage. This change in the law will not affect the people who now have group insurance in the U.S. As this chapter explains, we have always allowed all people with group coverage to enroll in health insurance plans regardless of their personal health status. Group coverage is a huge part of the insurance market. The group coverage model has always fundamentally included all members of each group with no health screening for any applicants and with no individuals in each group refusing to buy coverage.

But for the nongroup or individual insurance marketplace in this country, the insurance companies have always been allowed to reject individual applicants for coverage who fail each insurer's health screening criteria. The insurers used the health screening approach to keep premiums lower for the individually sold portion of their insurance business.

The Individual Market Will Now Outlaw Health Screening

We have chosen as a country to now require all health insurance companies who sell coverage to individuals to stop doing health screens for a couple of months each year and to simply accept for coverage any person who applies for health insurance coverage during that enrollment period. That represents real progress at a very important level for the

insurance marketplace in this country. Under the old approach, people who had health care problems -- who really needed other people's money to pay for their care -- could be rejected for coverage when they applied for that coverage. The old laws allowed American insurance companies to require people who applied for individual insurance coverage to fill out health history forms outlining all of their health care diagnosis and their entire history of care. The insurers then used that information about each person's care to figure out whether or not to sell health insurance to that person. That process often wasn't a good thing for sick people for obvious reasons. Most insurers tended to reject the sick and unhealthy applicants for insurance. So -- in a nutshell -- sick people who really needed insurance often could not buy that insurance.

As noted above, that business model for the individual market is changing right now for January 1, 2014. There has been an open enrollment period to start the process. Insurers cannot reject applicants during that open enrollment time frame based on their personal health statuses.

Insurers now have to accept every applicant for individual coverage, regardless of the applicant's immediate health care expenses or needs and also they will need to accept them regardless of their historical use of health care. That will be of course, a good thing for many applicants who might have been rejected for individual insurance in the past. But that process does create a possible risk for the health insurers that we all need to understand.

The Risk Pool Challenges Do Not Exist for the Group Insurance Business Model

It is important to understand that the new risk pool changes for the insurers really will only be created for the subset of the insurance market that provides non-group coverage to individual purchasers of insurance. As noted above, group health insurance coverage will not be affected by these new agendas.

The non-group insurance market is not the biggest portion of the health insurance marketplace. Under 8 percent of the people with health

insurance in this country buy that insurance now through the individual insurance marketplace.[247]

Far more people in this country get their health insurance coverage by being part of the group insurance marketplace -- usually getting their insurance from their employer.

In the much larger group insurance market that exists in this country, there will be no new danger to insurers relative to risk pool collapse. There is no new risk for the existing group insurance risk pools because in the existing group market, everyone in each group is already simply enrolled and in the group insurance marketplace everyone in each group is already insured. People with group insurance do not make individual choices about being insured. Entire groups are insured as groups. There isn't any danger from the new law for the existing group insurance coverage that provides insurance today to most Americans because there are no selection issues today inside the groups. Those issues existed to some degree at one time in the early days of group insurance, but they were resolved years ago by creating basic underwriting rules that simply enroll each group as a group with no significant individual choices.

So we will not see any new level of risk pool deterioration threat for group insurance coverage in this country because people in each group have no choices now about whether or not to keep coverage. People enrolled in those groups will have no new choices on January 1, 2014. Group insurance has a built-in risk selection safety net that exists in practical reality because the employer groups in this country typically cover all group members. Everyone in each risk pool is permanently covered as part of that insurance business model.

People Who Buy Individual Insurance Can Make Individual Decisions

That level of stability and inclusiveness is not true for the purchase of individual insurance coverage in this country. Individuals in that insurance market approach each buy or cancel their own health insurance coverage and the people who buy individual coverage make those

decisions as individuals. That is a very different business model for the health insurance companies. To survive financially in the individual portion of the health insurance market, the insurers clearly each need to have and maintain viable risk pools of individual customers.

Insurers have kept premiums lower historically by not enrolling people who are sick at the time of enrollment and by not enrolling people who had a history of being prior users of health care services. Rejecting those people for coverage was sad and very unfortunate for the rejected people, but it functionally kept the premium levels for individually purchased coverage lower for those insurance companies than the premiums would have been if people could have waited until they had cancer or a stroke and then purchased an individual insurance plan.

To understand the impact of those new rules on the individual insurance marketplace, it makes sense to consider briefly how other insurance markets might react to similar rules about not screening applicants.

Some people object very directly to the fact that the open enrollment period each year is only a couple of months. Those people would like the open enrollment period to be continuous -- allowing enrollment by any person at any time.

If anyone who wants to buy health insurance could buy insurance with no health screening at any time, it would be a little like implementing a new law for car insurance that would allow people to not buy their car accident coverage until after they had an accident. The car insurance version of that open enrollment law would allow any person who actually had a car accident to simply call their car insurer after the accident to sign up for their car insurance coverage on the spot from the site of the accident.

What would be the consequence of that model for car insurance? Figuring that impact out doesn't require an economist or an actuary.

Insuring Burning Homes Is Not Optimal

If people could wait until they had an actual accident before buying their car insurance, the premium levels for car insurance would go up.

The premium level for that insurance would need to climb to the point where the premium charged by the insurer to insure each car exactly equaled the insured cost of each accident. If people could buy car insurance after the accident, then premium for a $20,000 car accident would need to be $20,000 -- plus administrative expenses -- so the insurer could have enough money to pay the claim. That kind of post-accident enrollment in collusion coverage would be a very tough business model for car insurance. Who would buy car insurance if the premium price was that high?

Having a regulatory body of some kind use rate regulation mandates to arbitrarily cap those car insurance premiums would not help solve that problem. Arithmetic is arithmetic. Requiring a car insurance company to charge only $1,000 in premium and then require the company to pay for a $20,000 wrecked car that was already wrecked before the insurance was purchased obviously would financially destroy any car insurance companies that continued to sell that insurance.

That market would disappear very quickly if a regulator of some kind simply imposed rates on the car insurers that were less than the cost of the wrecked car. What insurance companies would sell car insurance if the premiums for that insurance were capped by the law and if the premium caps were far below the cost of paying for each wrecked car?

This is a very basic, common sense issue. If the maximum allowable premium that could be charged for insuring a $20,000 wreck would be $1,000, what sane insurer would sell $20,000 coverage for that market? Again --any insurer that would agree to take on $20,000 in expense in exchange for $1,000 in regulated premiums would have to be questioned and challenged relative to their basic math skills, their business judgment and their common sense.

Selling Life Insurance To Dead People Is A Tough Business Model

Likewise, it would be hard for fire insurance companies to survive financially if people could wait until after their homes had burned before buying fire insurance. It would actually be even harder for life insurance companies to survive as viable business entities if a law was passed

mandating that life insurance could be purchased for an individual by some family member after the person who is named on the insurance contract as the insured person had already died. The life insurance industry would be destroyed as an industry if a regulation uses magical thinking to require the life insurance companies to sell a million dollars in life insurance to dead people for $100,000 -- or some other lower number -- in order to "make life insurance affordable."

The truth is -- fire insurance works as a business because people whose houses are not burning buy fire insurance. The people whose houses are not burning pay their premiums for that insurance every month. The premiums are affordable because many people buy that insurance whose houses never burn. Their collective collected premium money is then used by the insurer to pay for the houses that do burn. People use other people's money to pay for their burned homes. If other people don't pay their premiums to fire insurers, that money isn't available to pay for the burned houses that do happen.

So obviously, those kinds of risk pool issues are very real for every kind of insurance. Health insurance isn't unique in facing those realities. To make any insurance business model work, there needs to be a sufficient number of people in each risk pool who are paying their premiums and who are not immediately using the benefits of the insurance. To protect the health insurance risk pools somewhat, the open enrollment period for health insurance is limited to two months. If car insurance had only a two-month period when people could wreck a car and still buy insurance after the fact, that rule would still cause a lot of people to buy car insurance at other times in the year to be protected against an accident in the other ten months of the year when there was no guaranteed issues of car coverage.

The new law for individual health insurance went into effect on January 1 of 2014.

We actually do not know yet whether we have inadvertently chosen to use an insurance model for individual health care insurance for this country will have on affordable average cost of care or if we have set up a business model that functions much more like a car insurance approach that will allow people to buy collision coverage after the accident.

We Want Everyone In The Risk Pool For Health Insurance

Our goal as a country is very clearly to get everyone in the risk pool for health insurance.

There is actually a penalty in the new law that says anyone who does not buy coverage must pay a fine for not having coverage. That penalty is not huge -- but it is real and it will at least draw attention to the enrollment issue for uninsured people in the individual market. The government is also setting up insurance marketplaces called insurance exchanges in every state. The new insurance exchanges will provide premiums subsidies to low income people who will be buying individual insurance. That will obviously increase insurance sales. For many low income people, those subsidies will pay most of the premium. That is an extremely important financial reality. The affordability issues that could cause risk pools to deteriorate are being softened a lot by the fact that many people's premiums will be subsidized -- health coverage will be much more affordable for many people. The exchanges, if they are run well, will also give consumers an easy way of buying individual coverage and getting access to available subsidizes. The subsidies that will be available through the exchanges will make care more affordable for significant number of low income people.

One stated goal of the exchanges is to create competition between health plans for individual insurance sales. Consumers will be able to choose between competing health plans in each exchange. Informed choices will be available in the best exchanges. The new features are all good -- but the very best feature of the exchanges relative to the issue of keeping risk pools intact and viable is that low income people will have their premium levels subsidized in the exchange.

Lower income people who buy coverage in the exchanges will have premium subsidies that are based on their personal financial situations. That should be a major positive factor that will help set a wide range of people enrolled. The new subsidies will reduce the affordability barrier hugely for many people. Experience has shown that premium affordability

is the primary reason people either do not buy health insurance or cancel health insurance. Premium subsidies obviously can mitigate that barrier.

If a significant number of healthy people who have low income levels decide to enroll in the individual market plans, then the risk pool issues for the individual insurance coverages can be significantly reduced.

If, however, only the low income people who actually have high health care needs enroll in the plans though the exchanges, then the risk pool issues that result from that process could be highly problematic and catastrophic for some organizations and markets.

We don't know today how well that process will work. We don't know how many healthy people will enroll in the new guaranteed issue insurance plans. We do know that we will need enough healthy people to enroll in those health plans and to contribute to be insured by those plans to keep the risk pools for those plans from deteriorating. If the only people who decide to buy insurance from a plan after January 1st of next year are the sick people in each market, then the average cost of care for the insured people in each existing risk pool will go up.

The math is actually pretty simple. Look at one very simple but very possible hypothetical outcome. If the people who end up buying insurance from a given insurer have care costs that are twice as high as the community average, then the premium that will be needed to pay for their care will be twice as high as the premium that would be needed to buy care for that risk pool if the people who are in the pool and who are insured actually had average costs of care.

The Risk Pools Are Viable In Europe Because Everyone Is In Them

That simple fact of arithmetic truth about the average cost of care is true everywhere on the planet. In Europe, where so many countries today use private insurance companies as the only way they insure people, the risk pools for the insurers are all viable. Why haven't those European countries seen a massive risk pool deterioration problem if the health insurers are all required to take all sick applicants for care? The risk-pool situation in Europe requires every single person to buy

insurance -- and that works for individual insurance sales in Europe just like the group coverage risk pool that covers the entire group works today in our country.

Everyone in each European country that sells private insurance is in the mega group for the country. Everyone in that mega group now chooses an insurance company. Insurance companies can cover people at affordable premium levels in those European settings because the insurers have everyone in the country absolutely insured. Those countries have a pure mandate. Coverage is not optional. Everyone in those countries must buy private insurance. Those countries do not have just sick people buying health insurance. There are no exceptions. Europe has no "free riders" when it comes to people not making their contributions to the shared risk pool.

The governments in each of those European countries understand the basic arithmetic realities of risk pools. The purchase of health insurance is simply mandated for all citizens in those countries. The Dutch, Swiss and Germans all join private health plans. That "individual mandate" keeps everyone in those countries in the risk pool and that keeps the premium levels affordable in those countries.

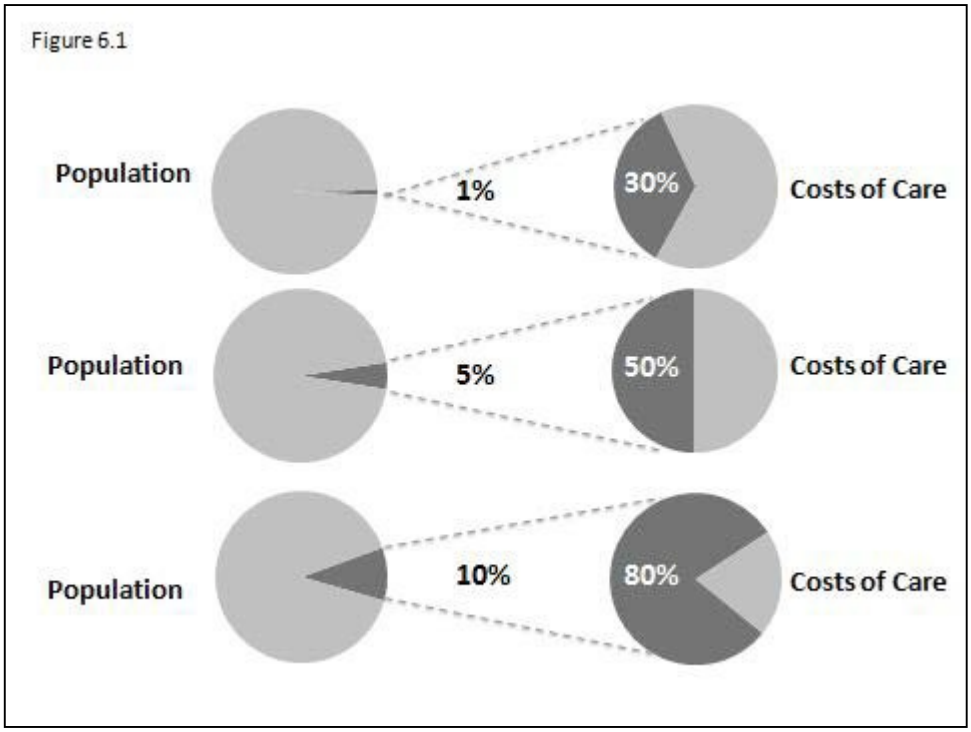
Care Costs Are Not Evenly Distributed

The people who make the laws in those European countries understand, clearly, the cost distribution realities that are shown on the next charts.

They know that care costs are not evenly distributed. Care costs are not evenly distributed in our country and they are not evenly distributed in Europe. Remember -- in any given risk pool -- about one percent of the people incur about 30 percent of the cost. Five percent of the people incur about 50 percent of the cost. And ten percent of the people incur about 70-80 percent of the cost.[248]

In every country, small numbers of people incur most of the costs. Most people incur very few costs. The eighty percent of the population who incurs very few costs are the people whose premium dollars are needed and used to buy care for the people who need care.

This is very important chart to understand.



That disproportionate distribution of costs for care across populations is true in the U.S. and it is true in every other country where data is available.

When you look at that distribution of costs from the perspective of health insurance functionality, and risk pool viability, it means that some people in each risk pool will use care and others who are in that same pool will pay their own personal premium but those people will use little or no care. The secret of success for any risk pool setting is to collect regular premiums from all of the people who are not using care so their money can be used to pay for the costs of the people who are actually using care.

The 50 percent of the population in each European country who uses no care in any given year all pay their premiums continuously in those countries so that the 1 percent of the population of Germany or Switzerland or Holland who use 30 percent of the total care dollars can have their care paid for with that premium money that was paid into the pool by everyone.

Having everyone in the risk pool obviously makes premiums much more affordable. When you calculate the average cost of care used by insured people to determine your premium, that average cost of care is a lot lower if half of the people who pay premium personally used zero care dollars.

No One Can Predict The Outcome

So what will be the final impact on individual insurance risk pools in this country from all of these changes?

No one knows.

At this point in time, that impact of all of those factors on future risk issues is both unknown and unknowable. Under the right set of circumstances, there will be more people covered next year and they will have better benefits and more financial security. Under a worst set of circumstances, the result of those changes and those resultant premium adjustments could be risk pools that deteriorate, collapse, and even melt down -- with extremely high premiums charged in a year or so to the people who still buy insurance. That scenario would leave us with even fewer people insured then we have today.

The jury is out.

The Medicaid expansion created by the new law is not affected in any way by these risk pool issues. For those states who are expanding their Medicaid coverage, the Medicaid expansion population is defined and inclusive, and Medicaid coverage under the new law in those states doesn't involve consumer choice about whether to pay premiums or to be insured.

Likewise, the Medicare future marketplace and the Medicare risk pools are not at risk from any changes made in the law.

The group insurance marketplace in this country is also not at risk. That is a very good thing. We really do not want our group health insurance marketplace to be at risk. Most people who have private health coverage in this country today get their coverage through their employer. These selection-related risk factors are not relevant to employer group coverage because everyone in each employer group is simply covered --

and the chances for people to make individual decisions that could cause group risk pools to melt down do not exist.

But for the individual insurance market -- for the type of health insurance that is purchased directly by private individuals -- we can expect that the new rating, pricing and coverage rules will trigger a whole set of potentially problematic issues -- and we will see the impact of all of those factors beginning in January of 2014 and then rolling through the next couple of years as the process unfolds.

So what do we know for sure right now?

We know that premiums will go up for some people and we know that premiums will go down for other people.

We know the rate changes for some people will be significant... and that those rates will be different for individuals.

We do not know what the total consequences of the new rule sets will be on the market for individual health insurance in America.

We will be a lot smarter 24 months from now.

The New Insurance Exchanges Can Create A New Marketplace For Coverage

The individual marketplace has been transformed as of January of 2014. In addition to the laws relating to the guaranteed sale of insurance, the current law requires every state to set up health insurance exchanges that will function as a marketplace for competing health insurance companies. As this chapter pointed out earlier, those new individual insurance market exchanges may be a wonderful and brilliant thing to do. Done well, the new exchanges could give consumers a chance to make informed choices between competing health plans and health insurers.

If the exchanges are well designed, they will facilitate informed choices, care system competition, team care, and benefit packages focused on the consumer and not the insurer or the business needs of the insurer.

The exchanges will not have an immediate impact on the people who get their coverage through larger group. The exchanges will, however, be the only place where all of the people who buy individual

coverage and who have income levels that are low enough to qualify for a government premium subsidy will their coverage.

Exchanges Could Mandate Team Care

The existence of the exchanges gives the government a wonderful opportunity to make a real difference in setting up a context for purchasing both coverage and care. Since we know that we want team care for people who need team care, the exchanges in each state could set rules that say every health insurer who sells coverage through an exchange must have products available to the consumers that that feature, support and utilize team care.

Each exchange could also mandate that participating insurers make quality data available to consumers who are choosing between health plans and providers of care. Well-structured exchanges can help significantly with the evolution of American health coverage and health care. All of the goals identified in the cash flow chapter of this book can be implemented as specifications for health plans under the exchanges. Some state exchanges are doing that kind of work now. The others could and should do that work in the future.

We Need Affordable Coverage

We need coverage to be affordable.

This model will fail if premium isn't affordable.

We need coverage linked to the care delivery models we want to encourage. We need coverage from viable insurers who will have both the risk pool stability to survive and the provider delivery competence to be both high quality and affordable.

For the business model of care to thrive, we also need the business model of coverage to thrive. We need the business model for both health coverage and health care delivery to be high performance and thriving.

The single biggest leverage point we have to make care better for the country is all the care we buy through the government.

Having the government became a better buyer of care is the topic of the next chapter.