

in directors' fees may the AHC leader retain? The Partners policy caps payments on the basis of the number of hours spent at directors' meetings and apparently does not allow compensation for preparation or committee work. An additional safeguard would be to limit the compensation that officers retain to some percentage of the AHC salary — perhaps 10%. Should there be restrictions on how leaders of AHCs may dispose of the remaining fees? Donation to the AHC or an affiliated nonprofit foundation might also be an undue incentive. Because the leader is benefiting the AHC through such donations, he or she might rationalize making decisions that benefit the company but work against some interests of the AHC. Therefore, excess compensation should be donated to nonprofit organizations that are not connected with the AHC. To allay concerns about “shadow foundations,” such donations should be disclosed to the AHC and to the public.

Fifth, is effective oversight in place at the AHC? A recent report on conflicts of interest from the Institute of Medicine (IOM), which I coauthored, recommended that such relationships be reviewed and approved by the board of

trustees of the AHC, not by the committee that oversees conflicts of interest of faculty members³ — a committee that is typically composed of physicians and staff members. It is unrealistic to expect such employees to oversee institutional leaders to whom they report in other contexts.

The new Partners policy, as well as the IOM report,³ a consensus report by the Association of American Medical Colleges and the Association of American Universities,⁵ and revised policies at other AHCs, should inspire additional academic health centers and professional societies to reconsider this and other conflict-of-interest issues, including those related to continuing medical education and the development of practice guidelines. The public grants the medical profession considerable discretion in setting its own standards because it trusts that physicians will place patients' interests ahead of their own or those of third parties. To maintain this trust, AHCs should take the lead in addressing conflicts of interest in medicine, rather than merely responding to government requirements and adverse publicity about troubling cases. Taking the initiative will promote a culture of accountabil-

ity and a commitment to professionalism.³ In their roles as clinicians and researchers, physicians tackle difficult, complex problems, clarify countervailing interests and values, make tradeoffs explicit, develop innovative approaches, and rigorously analyze the advantages and disadvantages of various options. Physicians should apply these skills to help improve conflict-of-interest policies for AHCs and professional societies.

Disclosure forms provided by the author are available with the full text of this article at [NEJM.org](http://www.nejm.org).

From the University of California, San Francisco, San Francisco.

1. Report of the Partners Commission on Interactions with Industry. Boston: Partners HealthCare, April 2009. (Accessed February 4, 2010, at http://www.partners.org/documents/CommissionReport_PartnersHealthCare2009.pdf.)
2. Wilson D. Harvard teaching hospitals cap outside pay. *New York Times*. January 3, 2010.
3. Lo B, Field MJ. Conflict of interest in medical research, education, and practice. Washington, DC: National Academies Press, 2009.
4. Dealings between directors and their corporations: conflicts of interests. In: Cox JD, Hazen TL. *Cox & Hazen on corporations*. 2nd ed. New York: Aspen, 2003:202-20.
5. AAMC-AAU Advisory Committee on Financial Conflicts of Interest in Human Subjects Research. Protecting patients, preserving integrity, advancing health: accelerating the implementation of COI policies in human subjects research. Washington, DC: American Association of Medical Colleges, February 2008.

Copyright © 2010 Massachusetts Medical Society.

Avoiding Side Effects in Implementing Health Insurance Reform

Mark V. Pauly, Ph.D.

All U.S. health insurance reform proposals currently being discussed now include changes in the way insurers treat some people with above-average health risks. In most states, insurers who sell policies directly to individuals now charge premiums

based to some extent on characteristics thought to predict the risk of high-cost conditions; insurers also exclude some or all preexisting conditions from coverage and simply refuse to cover some people. Without such “risk rating” and coverage exclusions,

insurers would be subject to substantial adverse selection — that is, consumers would seek them out primarily if and when they became ill and therefore represented higher risks to insurers — which could lead insurers needing to cover their costs to

charge premiums so high they would drive lower-risk consumers to choose minimal coverage or forgo insurance altogether. A few states, having decided that hazarding greater adverse selection is the lesser of two evils, require premiums to be the same for everyone in a given geographic area (an approach called community rating) or limit the extent to which premiums can vary with risk. Such regulation can beget the worst of both worlds — “adverse selection” when lower-risk people choose not to carry insurance and “cream skimming” when insurers avoid and mistreat high-risk people in their search for profitable lower-risk enrollees — but these adverse effects are presumably considered preferable to risk rating and exclusions. Legislation currently before Congress would extend this imperfect arrangement nationwide, though the details are as yet undetermined.

Given the tradeoffs, how should such arrangements be designed, and can they be made to work better? I would argue that both laws and regulations should make strict community rating a last resort rather than the first line of defense for people with above-average risk, and the laws and regulations should do so in ways that help to avert adverse effects.

There are two complementary ways to frame the social goal of community rating: equity and efficiency. The equity argument is that it is unfair for persons who have higher health risks to have to pay higher premiums or compromise on coverage. This sentiment is strongest in regard to people with exogenous chronic conditions and low or moderate incomes. The efficiency argument is based on the idea that risk-averse people would like to avoid

“reclassification risk” — the risk that next year they might not only have high medical expenses but also develop a chronic condition that could mean higher premiums until they reach Medicare age. They would like protection against both short-term and long-term financial risks.

Avoiding reclassification risk is a good thing. So where does community rating go wrong? The goal is for high-risk people to receive a transfer of health care funds from the community of standard- or average-risk people, but basic economics says that the money for that transfer should be raised in the fairest and least distortive (most efficient) way. Community rating in effect finances a transfer to high-risk people by raising the premiums for lower-risk people; it is like an excise tax on insurance bought by those with low risk. This mechanism causes distortions — the adverse selection and cream skimming mentioned above — and it is not especially fair, since some low-risk people also have low incomes or do not deserve to pay premiums that are high relative to the benefits they will get. It would be better to finance the transfer in a way that does not distort behavior.

The reform now being debated recognizes that adverse selection would wipe out voluntary insurance if people could wait until they contracted a medical condition to buy coverage and still obtain it at the same premiums they would have been charged had they bought it sooner — hence the mandate that all individuals obtain insurance. But the relatively modest penalties proposed for enforcing this mandate will not be enough to keep the healthy and the prudent in the insurance

pool as premiums increase to meet the expenses of people who become chronically ill. And the likelihood that lower-risk people will gravitate to more-limited coverage options means that regulators will have to restrict such cost-containing options lest they render impossible the transfers to people in need of a high volume of care. So, the simplistic selling points of community rating — that insurers will charge people premiums that do not take into account their risk level and will provide policies that do not exclude any preexisting conditions — simply cannot be realized.

I believe that the best alternative to this approach is one that is already in force in individual insurance markets. If consumers would gain by avoiding reclassification risk, they should want to pay a premium to protect against it. They can do so in the individual insurance market — indeed, this option is required by federal law and enforced by state insurance departments — under a provision termed “guaranteed renewability at class average rates.” Except for a small amount of explicitly temporary coverage, individual insurance policies must now include a promise not to impose any increase in premiums because of changes in the individual’s health or previous use of medical care. Of course, this protection is not free, and data show that individual insurance premiums sold to young people with moderate levels of risk are typically front-loaded to provide this coverage.¹

Nor is this protection bullet-proof: insurers sometimes scrupulously check for ambiguous errors in initial health information when a chronic condition crops up, some insurers have tried to

re-underwrite policy holders when they become sick, and some have “cancelled” whole rating classes, offered the lower-risk members of the class insurance at reasonable rates, and then raised premiums uniformly for the remaining, higher-risk enrollees. Nevertheless, the available data on risk levels, insurance premiums, and individuals’ ability to secure coverage indicate that these provisions provide a lot of risk protection: less than 20% of the variation in risk translates into variations in premiums, and people with a high risk may actually be more likely than those with a low risk to end up with individual coverage.^{2,3}

Unfortunately, rather than enhancing guaranteed renewability, currently debated health care reform bills will attenuate incentives for people to seek insurance while they are still healthy. If people can get insurance at an unvarying premium by waiting until they get sick and if insurers must sell coverage without exclusions, it pays to skip insurance with guaranteed renewability and just wait. Currently debated health reform legislation does appear to envision some alternative fixes. As with Medicare Part D, people who do not sign up for coverage

during enrollment periods set by insurers may be forced to wait a year for another opportunity, and premiums may be higher across the board the longer they wait. These rules will mean that more people will lack coverage than would lack it if they could simply pay higher rates to obtain it at any time during the year. It may be that, when the dust clears, people who wait to get coverage until they become high risk will end up paying higher premiums under reform just as they do now — but then “reform” will to some extent be an illusion.

There is a better approach. The objective should be to get people to obtain coverage with guaranteed renewability before they become high risk. One step in this direction would be to add guaranteed renewability for coverage of a worker’s family to small-group insurance. Another would be to implement strong incentives for obtaining coverage before one gets sick. Some of these could be carrots, such as larger subsidies for low-risk people to get them to buy in. Others could be sticks, such as increased premiums for people who decline coverage until they become high risk. The establishment of high-risk pools, adequately subsidized

by general taxes but with higher-than-standard premiums and moderately limited coverage, may be all that is needed to get nearly everyone to do the right thing. To be sure, no incentives (not even mandates) are ever universally effective. But honestly acknowledging the logical impossibility of uniform premiums with no exclusions and then working to foster the use of already tested, practical alternatives might lead to better results from either far-reaching or pared-down health care reform.

Financial and other disclosures provided by the author are available with the full text of this article at NEJM.org.

From the Health Care Management Department, the Wharton School, University of Pennsylvania, Philadelphia.

This article (10.1056/NEJMp0912181) was published on January 27, 2010, at NEJM.org.

1. Herring B, Pauly MV. Incentive-compatible guaranteed renewable health insurance premiums. *J Health Econ* 2006;25:395-417.
2. Pauly MV, Herring B. Risk pooling and regulation: policy and reality in today’s individual health insurance market. *Health Aff (Millwood)* 2007;26:770-9.
3. Bundorf MK, Herring B, Pauly MV. Health risk, income, and employment-based health insurance. NBER working paper. No. 11677. Cambridge, MA: National Bureau of Economic Research, October 2005. (Accessed January 21, 2010, at <http://www.nber.org/papers/w11677>.)

Copyright © 2010 Massachusetts Medical Society.

Risking Big Changes with Small Reforms

Stuart M. Butler, Ph.D.

As the prospects for health care reform ebb and flow by the day, one school of thought holds that making modest adjustments rather than enacting large-scale reform could help to avert controversy and command more broad support. Perhaps — but seemingly modest changes could

also unleash huge pressures that would profoundly alter the system’s future structure and function. Since perceptive lawmakers and congressional staff members recognize this fact, there may well be bitter debate over the enactment of certain apparently modest elements of a smaller re-

form package submitted to Congress.

History shows that changing even seemingly minor features of legislation or administrative decision making with regard to health care can have major — and sometimes unintended — consequences for the system’s evolu-