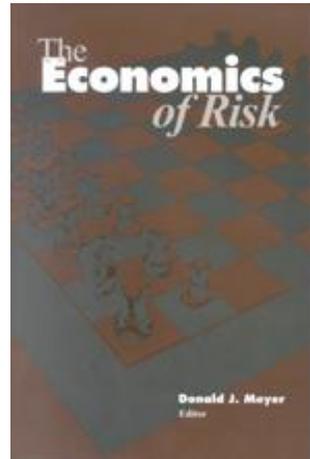

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Sharing Very High Risks

How Government Can Make Health Insurance Markets More Efficient and More Accessible

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Between 40 and 44 million Americans—one in six nonelderly—do not have any form of health insurance, according to the 2001 Census. Why they do not have health insurance involves a variety of reasons, many of which are often present in any particular person who lacks coverage. We can make two generalizations, however. First, a majority simply cannot afford to purchase health insurance unless it is heavily subsidized, which currently means subsidized by an employer that sponsors group coverage. About two-thirds of the uninsured have family incomes below \$35,000, which is generally too low to be able to afford health insurance unless an employer pays a large share of the group premium. The second generalization is that health insurance markets, especially the small group and individual (nongroup) markets, are subject to market failure. The market failure is caused by insurers' fear of adverse selection. Carriers know from experience that people who know or suspect they will have expensive health care needs in the coming year are also more likely to apply for insurance coverage than people who do not expect such expenses. Such people make up a disproportionate fraction of the people who apply for coverage every year. As a result, insurers are especially likely to either refuse to insure an applicant or set a high premium for anyone who they perceive to be likely to incur higher medical expenditures. People who fall into this category are generally over the age of 45, female, working in particular types of occupations, and have had medical problems in the past. For these people, health insurance is also either unaffordable—given the high premiums relative to their incomes—or simply unavailable.

Both of these explanations of why people lack health insurance provide rationales for government taking a role in health insurance. Medicaid and the State Children's Health Insurance Program (SCHIP) were created largely to deal with the fact that low-income people cannot afford to purchase health insurance at existing prices. Current efforts to incrementally expand eligibility for Medicaid and new, subsidized buy-in programs are similarly grounded in the tradition that we use government to redistribute resources in our society to make sure that low-income or otherwise deserving people receive goods and services deemed necessities.

When markets break down in the absence of full information (as with adverse selection), economic theory argues for government to intervene to counter the problem with the objective of making the market competitive and thereby efficient.¹ In this chapter, I develop the idea that in the case of health insurance markets, government intervention in the form of being responsible for the very highest-cost individuals every year would reduce insurers' fear of adverse selection. In turn, this would reduce inefficiency caused by insurers spending enormous effort to predict whether or not an individual will be likely to have high medical costs, and premiums ought to be lower as a result. In addition, if insurers do not need to bear the risks of very high-cost people because such risks have been shifted to government—and society at large—then accessibility to health insurance should be greater.

The plan of the chapter is as follows. In the next section, I briefly describe who lacks health insurance in the United States. In the third section, I describe how health insurance markets work and how insurers compete in the individual, nongroup market. In the fourth section, I discuss the proposal to have government shift the risk of very high-cost people from insurers to the general population and how it could increase efficiency and accessibility in individual and small group insurance markets. I also provide some examples of government taking the role of reinsurer and "backstopper" of markets so that they function. Finally, I offer some concluding comments.

WHO DOES NOT HAVE HEALTH INSURANCE?

The uninsured are a cross section of Americans—children, young adults, and middle-aged people who generally work full time but do not earn more than \$30,000 per year (in part because they have no more than a high school diploma and do not have specific skills). Because they have low incomes and no health insurance, they frequently cannot afford their share of health insurance premiums when an employer does sponsor coverage and have debts for emergency medical care that they are working to pay down. Some of the adults are widowed or divorced, with young children, so the income they earn does not enable them to pay for nongroup health insurance. Many uninsured adults are self-employed or working in small, family-run businesses that cannot afford to sponsor health insurance. About 9.2 million of the uninsured are children, and perhaps as many as 3 million of these children are eligible for Medicaid or the SCHIPs. However, parents either do not realize their children are eligible for the programs or they find the process of applying for public coverage “unpleasant” (Kaiser Commission on Medicaid and the Uninsured 2000a). A majority of uninsured are white, but African Americans and Hispanics comprise a disproportionate share of the uninsured.

The Henry J. Kaiser Family Foundation’s Commission on Medicaid and the Uninsured has conducted lengthy interviews with seven families and one 52-year-old grandmother (Kaiser Commission on Medicaid and the Uninsured 2000b). Two common threads run throughout their stories. One, the adults work hard but do not earn high incomes, so even when they have the option of obtaining health insurance through an employer, they feel that they cannot afford the employee share of the premium. Second, all of the uninsured families have incurred medical debts as a result of being uninsured. The debts are for very treatable medical problems that would not cause an insured person to think twice about seeing a physician or going to the emergency room with a sick child. But the uninsured bills for such care—running between \$1,000 and \$6,000—leave the uninsured families both strapped for cash to pay for health insurance and in daily fear of further medical bills.

When we examine demographic and socioeconomic characteristics of the uninsured, the multidimensional stories of real people are often overshadowed. Nonetheless, knowing more about the distributions of characteristics of the uninsured helps when developing public policies to increase access to health insurance. I will draw upon the March 1999 Current Population Survey (CPS) for most of what follows. The March 1999 CPS showed that there were almost 44 million nonelderly Americans without any form of health insurance. According to the March 2001 CPS, the number of uninsured declined to about 38.4 million, largely as a result of the booming economy and small increases in the number of people with employer-sponsored coverage. However, the mild recession in 2001 through early 2002, combined with the increase in unemployment, has most analysts believing that the number of uninsured in early 2003 will be closer to the number in 1999, so I will use 1999 data.

Age

The uninsured are generally young—64 percent are younger than 35—making them relatively inexpensive in terms of expected medical care use (Table 5.1). A quarter of the uninsured are children under the age of 18. The 11 million uninsured children account for 15.4 percent of all children. Two decades ago, about a third of the uninsured were children, and close to 20 percent of all children were uninsured, so the decline in the number of uninsured children is a reflection of the impact of the expanded Medicaid eligibility criteria for children. Young adults (18–24) and adults between 25 and 34 have much higher chances of being uninsured—30 percent of young adults and 24 percent of 25–34-year-olds lack coverage.

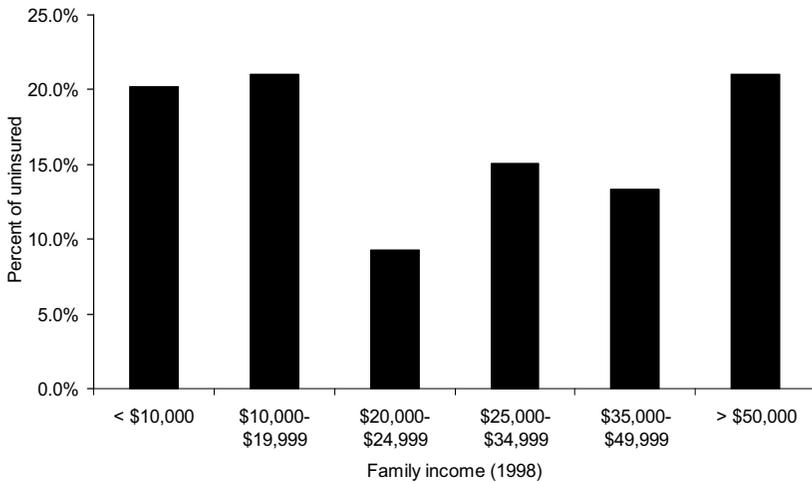
Income

Just over half of the uninsured in 1999 had family incomes in the previous year of under \$25,000 (Figure 5.1). (For comparison, in 1999 the median household income for all Americans was \$42,100.) Another 15 percent had family incomes between \$25,000 and \$35,000. Thus, two-thirds of the uninsured in 1999 had incomes below \$35,000. Another way of looking at family income is to adjust it for family size

Table 5.1 Uninsured by Age Cohort, 1999

Age cohort	Number	% of uninsured	% of age cohort
< 18	11.073	25.0	15.4
18–24	7.776	17.6	30.0
25–34	9.127	20.6	23.7
35–44	7.708	17.4	17.2
45–64	8.239	18.6	14.2
65 +	0.358	0.8	1.1
Total	44.281	100.0	16.3

SOURCE: March 1999 CPS.

Figure 5.1 Income Distribution of Nonelderly Uninsured, 1999

SOURCE: March 1999 CPS.

and compute it relative to the poverty level by family size. In data not shown here, two-thirds of the uninsured had incomes below 250 percent of the poverty level. These incomes are simply too low for people to afford to purchase health insurance unless it is heavily subsidized by an employer that sponsors group coverage. The 21 percent of the uninsured who have family incomes above \$50,000 reflects two changes in the uninsured over the 1990s. One is the growing economy and tight labor market by the end of the 1990s. This caused many people with part-time or part-year jobs (that do not include health insurance as part of the compensation) to work more hours per week and/or more weeks during the year, enabling them to earn incomes above \$50,000. This was especially true in two-earner families where each adult might have earned less than \$20,000 in weaker economic times. A second factor that explains some of the uninsured with incomes above \$50,000 is that a little more than half of these people live with family members who are not part of their “nuclear” or insurance family unit. That is, they live with parents, grown children, or siblings, and because they are all relatives, their “family” income is higher than it would be for an insurance definition of family. Nonetheless, it is worrisome that an increasing number of uninsured people have family incomes that we think of as solidly in the middle-class section of the income distribution. We do not know how much of this growth reflects people being offered health insurance where they work but declining it for themselves or their dependents because they cannot afford the employee share of the premium.

Labor Force Status of Adults

More than two-thirds of uninsured adults are in the labor force, with 60 percent of uninsured adults working and another 8 percent unemployed and looking for work. When we count all the dependents of working uninsured adults, a little more than four out of five uninsured live with someone who works (71 percent live with someone who works full time and 12 percent live with someone who works part time, according to the Urban Institute’s analysis of CPS data for the Kaiser Commission on Medicaid and the Uninsured 2000c).

Health Status

The uninsured are in relatively good health, with only 7 percent saying they are in “fair” health and another 2 percent saying they are in “poor” health. One reason more of the uninsured are not in poor health is that some of the population in poor health qualify for Medicaid or Medicare (the latter by virtue of long-term disability). Moreover, the vast majority of young people and people who work generally do not have serious medical conditions. The vignettes of the uninsured collected by the Kaiser Commission on Medicaid and the Uninsured showed people who were not in poor health in spite of the fact that they often had medical debts of \$1,000 or more. The medical bills were for treatable medical episodes that occurred in emergency rooms because the people were uninsured (e.g., strep throat, childhood asthma attacks), or events such as unexpected caesarian section deliveries.

Basic Policy Dilemma

This picture of the uninsured illuminates a basic policy dilemma. On the one hand, health insurance coverage in the United States is based on employer-sponsored coverage, and we assume that working people will obtain insurance through an employer group. Employer competition for high-skill labor has forced compensation for high-skill jobs to include higher wages and fringe benefits, including health insurance. On the other hand, we have an economy where many jobs do not require higher education and/or special skills. Such jobs generally have low wages and no health insurance. (Although low-skill jobs in large firms are more likely to provide health insurance as a fringe benefit, in 1999 a quarter of all uninsured adults worked for firms with more than 500 employees.)

The fact that the labor market for low-skill workers is not tight enough to cause employers to offer health insurance for low-skill jobs is a large part of the explanation for why 60 percent of the uninsured adults are working but uninsured. Most uninsured adults do not have more than a high school education and are not skilled enough to be in high-skill jobs. This problem is further compounded by the fact that almost half of the uninsured workers are employed by firms that have fewer than 25 employees.

As I discuss below, small firms face much higher per person premiums than do large firms, which have much larger numbers of people for pooling risks of medical expenditures. Because small firms generally have small profit margins, they cannot afford to increase the compensation of low-skill workers with the relatively high cost health insurance available to them.

Thus, unless we want to radically alter the labor market for low-skill workers and the economic conditions in which small firms operate, we need to develop two concurrent policies to expand health insurance coverage. One policy would provide heavily subsidized quasi-public coverage to people with incomes below some level, such as 250 percent of the poverty level, or \$35,000. The second would increase access to private health insurers for higher-income uninsured individuals by reducing the risk to insurers of covering people who do not have employer-sponsored coverage. Developing such a policy would provide a way for private insurers to continue to be the primary source of health insurance in the United States and cover more of the uninsured. To see why requires an understanding of how insurers view the uninsured and how they compete for business, the subject that we turn to next.

HOW HEALTH INSURANCE COMPANIES COMPETE

To understand the health insurance markets in the United States, we start with the fact that the majority of people obtain coverage through employers. Approximately 63 percent of the population (of all ages) have employer-sponsored group coverage.² Those with employer-sponsored coverage pool their individual risks of high medical care costs. Almost everyone in large employer groups participates in the employer-sponsored health insurance, so there is only a small proportion of each group who are likely to have unexpectedly high medical expenses. But people who do not have access to such pooling of risks—the uninsured and the people who obtain individual coverage—face insurance markets in which adverse selection is a major problem.

Three Interconnected Health Insurance Markets

Health insurance is sold in the United States in several interconnected markets. We can loosely distinguish between large employer group, small group, and individual (or nongroup) insurance markets. Some indemnity insurers and managed care plans (hereafter referred to collectively as carriers) actively sell coverage in all three markets, but most do not. More often, we observe large carriers selling coverage to large employer groups, and smaller carriers selling in the small group and individual markets. In addition to these three types of markets, every state regulates how insurance is sold within its borders. The states have different regulations governing facets of insurance ranging from what benefits must be covered by insurance policies to how rates are determined to requirements about financial reserves. As a result, there are 51 different submarkets within each of the three distinct markets. Many carriers, particularly smaller carriers, offer policies only in those states with similar regulations so they do not have to keep track of and respond to many regulatory changes.

One result of this is that in the individual markets in 1997, the number of carriers selling individual policies ranged from only two or three (in Delaware, Idaho, and Alaska) to more than 40 (in New York and Texas) (Chollet, Kirk, and Chow 2000). New York's relatively large number of carriers selling individual coverage is due to the requirement that all HMOs sell individual coverage. In 1997, just under 700 carriers sold individual policies in the United States; by comparison, 2,450 carriers sold policies in the large and small group markets (Chollet, Kirk, and Chow 2000). In spite of this difference, the individual and group markets are characterized by a small number of carriers having at least half of the total number of policies sold in each type of market in each state (Chollet, Kirk, and Chow 2000).

Large employers have avoided state regulations and state taxes on health insurance by self-insuring (or self-financing) their employees' health care costs. The Employees Retirement and Income Security Act of 1974 (ERISA) exempts self-insured employers from state regulations and taxes on policies sold within a state. Most self-insured employers pay a fee to a third-party administrator (almost always a carrier) to administer the claims from medical care providers, and the

employees are usually unaware that the third-party administrator is not their insurer as well.

Health coverage is sold and priced quite differently in the three types of health insurance markets (ignoring for the moment the 50 different jurisdictions' regulations). The selling practices and pricing differences largely reflect the extent to which carriers fear adverse selection in each of the markets. In the large group market, adverse selection at the group level is uncommon since almost all employees in a large company generally enroll for coverage. If an employer offers a choice of plans, then carriers may be concerned about adverse selection if they are the choice of a small proportion of the group (Buchmueller and Feldstein 1997; Cutler and Reber 1998). Employees and their dependents in large groups pay average premiums based on the total expected costs of the group; a particular person's expected medical care costs are not factored into the premium he or she pays. Usually, the employer also negotiates with several carriers as to the out-of-pocket cost sharing and benefits covered, and trade-offs between these and the premiums.

Small groups (typically, groups with less than 50 employees) and individuals face very different markets. Per policy premiums are substantially higher in these markets than in the large group market; it is not unusual to find premiums for single or family policies to be more than twice as expensive for small groups or individuals than for large groups. The primary reason for these higher premiums is that pooling of risks occurs over much smaller groups of people in the small group and individual markets. As a result, the variance on the expected costs is much larger. This creates a greater risk that actual costs will exceed expected costs by a wide margin. Carriers respond to this in two ways. First, they set higher premiums for small group and individual policies because the risk per policy is higher and they need to be compensated for bearing greater risk. Second, they try to insure only people who they expect will have lower medical costs and to avoid insuring people who they perceive to be high-cost users of medical care. Carriers go to great expense to selectively insure people who they perceive to have low risks of high medical care costs. The costs of the risk-selection mechanisms used by carriers are a large component of the higher premiums for small group and individual policies.

Information Asymmetry Shapes the Form of Competition between Carriers

Carriers cannot discern from applicant information whether an applicant will have high medical care use in the coming year. But they believe that people who apply for insurance coverage are disproportionately comprised of people who expect to have high medical care use in the near future—perhaps because they or a close relative had a medical condition in the past. The problem for carriers is that they usually cannot obtain this information; there is an asymmetry of information between what the carriers know and what the insurance applicants know. When there is asymmetric information in a market, the market cannot be competitive and inefficiency will result. In the case of health insurance markets, the carriers have the disadvantage in terms of the asymmetry of information.

Carriers' fear of adverse selection among applicants in the small group and individual markets motivates their behaviors. Carriers fear adverse selection because it causes them to underestimate premium revenues needed for expenditures and thus risk substantial financial losses. To avoid adverse selection, many carriers adopt selection mechanisms to screen out applicants whom they suspect will use expensive medical care (Swartz and Garnick 1999, 2000a,b; Chollet and Kirk 1998). Such mechanisms include medical underwriting practices,³ refusing to issue or renew a policy, excluding coverage of services for preexisting medical conditions, and differentiating their policies from their competitors' by generously covering some types of services (e.g., preventative) but limiting coverage of other services (e.g., substance abuse treatment) (Stone 1993; Frank et al. 1997).⁴

Thus, competition in insurance markets, especially the small group and individual markets, focuses on how well carriers use mechanisms to identify which firms or individuals might be high-risk versus low-risk. As Newhouse pointed out in the context of risk adjustment models, a carrier only needs to be a little better than its competitors in the use of selection mechanisms to make more of a profit (Newhouse 1994). When carriers are not constrained in their ability to set different premiums for people who they believe have different probabilities of using expensive medical care, then carriers compete in large part in terms of the accuracy of their models for predicting a person's (or

firm's) medical expenses. These models are generally known as actuarial models because they are based on actuarial tables of likelihoods of using different amounts of medical care by many different demographic and socioeconomic characteristics as well as health status and prior use of health care.⁵ Different carriers will then price their health insurance policies to people and small firms based on the individual's or firm's expenditures predicted by each carrier's actuarial model. Usually, the models are used to determine how the premiums might be underwritten for particular individuals or firms. That is, if a small firm is predicted to have a high risk of high medical expenses in the next year because several people in the group had high expenses in the last year, the carrier may agree to offer insurance only if the firm pays a substantially higher premium. The additional premium amount underwrites the basic premium for the policy.

Underwriting principles might also cause a carrier to deny coverage completely or exclude coverage for a condition to a group or person on the basis of information known by the carrier. Most states allow exclusion of coverage for a preexisting condition (such as cancer, osteoarthritis, or allergies) for a limited time period—typically 12 months. As a result, carriers more often simply deny an application if a person has had quite serious conditions, such as angina or a myocardial infarction (Chollet and Kirk 1998). In some states, underwriting of premiums is not permitted because it is viewed as a selection mechanism that discriminates against people if they are perceived to have high risks of expensive medical care. When underwriting is not permitted or its use is restricted, carriers turn to other selection mechanisms to avoid insuring high-risk people.

A frequently used mechanism for separating high- and low-risk applicants consists of differentiating the benefits (or medical services) covered by a policy. If a carrier is able to identify a health care benefit that is particularly attractive to low-risk people but not high-risk people, then it can design policies that cause people to voluntarily reveal that they are likely to be low- or high-risk people. Carriers' use of differences in benefits packages is a mechanism for getting individuals (or groups) to reveal information that separates them in terms of risk levels for nominally unpredictable expensive medical events. Thus, for example, if a person knows that cancer runs in his or her family—which the carriers do not know—the person might choose a policy that

has high upper limits on covered expenses, provides for cancer screening tests, and includes first-rate cancer centers in the list of providers. By choosing such a policy, the person is revealing information to the carrier regarding his or her risk expectations. Carriers have invested in substantial efforts to understand how differences in benefits packages can be used to attract low-risk people to some policies and high-risk people to other policies.

Carriers also have developed monopolistic market niches in the small group and individual markets as another mechanism for avoiding adverse selection (Swartz and Garnick 2000a,b). In the individual markets, for example, some carriers specialize in marketing to individuals who have left the armed services; others specialize in policies attractive to very small firms of professionals (e.g., lawyers or financial advisors) or only to individuals who are self-employed. As a result, few carriers in a state market actively compete for business among all consumers seeking individual policies, and people whom insurers perceive as high-risk have few, if any, options for obtaining health insurance (Pollitz, Sorian, and Thomas 2001; GAO 1996).

The differences in states' regulations of the insurance markets within their borders permit the greater or lesser use of these mechanisms or different combinations of the strategies to avoid insuring high-risk people. States that have attempted to block carriers' use of such preferential selection mechanisms, particularly in the small group or individual markets, have almost always set up regulations that block the use of only one or two of these mechanisms. State regulations, for example, might mandate that all policies sold in the state must cover substance abuse treatment so as to inhibit carriers' ability to avoid high-risk people who may want coverage of care for substance abuse. Some states have enacted regulations requiring carriers to accept any applicant ("guaranteed issue") so a carrier cannot turn down an applicant it views as high-risk.⁶ Of course, if a state has only one or two of these regulations in place, the carriers can use other mechanisms that are not proscribed to accomplish the same objective. A common example is when a state requires carriers to accept any applicant but does not also have a regulation governing the way in which premiums can be set, we observe what should be a totally expected outcome: high-risk people are indeed offered coverage but at an extraordinarily high premium. Similarly, when states require community rating of premiums

(say, in the small group insurance market) but do not standardize the benefits to be covered in policies sold in the market, carriers can use differences in what benefits are covered under different policies to try to separate high-risk firms from low-risk firms.

In summation, the information asymmetries in health insurance markets cause the markets, particularly the small group and individual markets, to be inefficient. Inefficiency reflects the fact that enormous efforts and expense are spent in developing and applying selection mechanisms to avoid covering people who are likely to use expensive medical care. Carriers compete with each other not in terms of producing insurance per se at the lowest possible cost, but in terms of insuring as high a proportion of low-risk people as possible in order to keep costs low. Thus, the usual competitive market forces that cause producers to seek profits by reducing their costs of production and increasing market share have been altered by the fear of adverse selection in insurance markets. In insurance, carriers seek to minimize their risk of unexpected high costs by competing to have very high shares of low-risk people among the people they insure. The competition among carriers consists of trying to do better than other carriers at selecting low-risk people, which involves efforts that do not contribute to producing insurance. The costs of creating and using selection mechanisms are a measure of the inefficiency that exists in health insurance markets.

A ROLE FOR GOVERNMENT: COVER VERY HIGH-COST PEOPLE EVERY YEAR

The market failure caused by carriers' fear of adverse selection leaves us with two outcomes. One is that risk selection activities cause premiums to be substantially higher in the small group and individual market than in the large group market, making health insurance relatively unaffordable for most people who do not have access to employer-sponsored coverage. The second outcome is that a substantial number of people do not have access to health insurance, especially in the individual market, because they have some characteristic that causes a carrier to perceive them as high-risk.

The inefficiency due to expenditures on risk selection could be substantially reduced if government were to shift responsibility from the carriers to the general population for the costs of people who, each year, have very high costs—that is, people who have health care costs in the top 1–3 percent of the distribution of medical expenditures. Currently, if a carrier has enrollees with unexpectedly high costs, those costs are borne by the other people insured by the carrier and whatever stockholders the carrier may have. If the carrier has to substantially increase premiums to recover from losses due to unexpectedly high costs of some enrollees, there is a high probability that some number of enrollees who have low costs will leave the carrier in response to the premium increase. This leaves the carrier with a risk pool that has a higher average expected cost. If the following year there are again unexpectedly high costs, the cycle will repeat itself; if it continues, we have what the insurance industry calls a “death spiral,” where the particular policy has to be closed down and abandoned or the carrier is forced out of business. This outcome places all the burden of insuring high-cost people on the individuals who have had health insurance from the carrier—and who have to pay higher premiums or drop their coverage—and the shareholders of the carrier.

If the costs of very high-cost people were shifted instead to the government—and thus to the entire population—carriers’ fears of adverse selection and a death spiral would be substantially reduced. The burden of such costs would be redistributed from the carriers that encountered adverse selection. As a result, carriers would no longer have an incentive to use and develop risk selection mechanisms, and the inefficiency present in the small group and individual insurance markets would be greatly reduced. This would also enable people to purchase health insurance policies rather than being denied coverage.

What I am suggesting is that government—most likely the federal government, but it could be state governments—take on the role of reinsurer for carriers that have insured people who have very high medical bills in a year. That is, the government could pay a portion of the costs of those individuals whose total annual medical costs exceed some threshold—say, \$30,000—or an amount that places a person’s medical expenditures above the 98th or 99th percentile of the distribution of medical expenses of the entire population. Carriers often purchase reinsurance to protect themselves from the risk that an insured’s

claims will exceed \$50,000. Instead, if the government acted as the reinsurer for the high-cost claims, the carriers would then have far less incentive to avoid insuring people they expect to have high expenditures.

Examining the distribution of medical expenditures for the U.S. population shows why this proposal would greatly reduce carriers' incentives to use selection mechanisms. According to preliminary estimates from the 1996 Medical Expenditure Panel Survey, Monheit predicts that 68 percent of the population had medical expenditures below \$1,000.⁷ He further estimates that 4.5 percent of the population had expenditures between \$5,000 and \$9,999, while just 4 percent of the population had expenditures above \$10,000. It is very difficult to predict who will have expenditures between \$5,000 and \$10,000 per year. But so long as a carrier is not responsible for costs of people with expenditures above, say, \$30,000, then it is not worth the expense for a carrier to use risk selection methods to avoid people with expenditures in the 90th to 96th or 98th percentile of the expenditures distribution. It is simply too difficult to distinguish between people who will have expenditures at the 30th percentile and those who will be in the 5–10 percentiles below the threshold for reinsurance. Moreover, while there is some correlation between a person's medical expenditures from one year to the next, that correlation falls away when a longer period of time is considered (McCall and Wai 1983; Welch 1985; Goodman et al. 1991; Gornick, McMillan, and Lubitz 1993). Thus, we should expect that different people each year would have very high medical expenditures that would qualify for the government reinsurance.

Reinsurance almost always requires the original insurer (the carrier) to bear some portion of the costs above the threshold where reinsurance picks up insuring events. This cost-sharing is built into the reinsurance structure so the original carrier will retain an incentive to manage the health care of high-cost people. It would be important to maintain this incentive if the government were to reinsure the very high medical care expenses. In addition, for any person who has health care expenditures over the reinsurance threshold level each year, the government could cover either a portion of the costs above the threshold or a portion of all of the person's costs. In either case, the share of costs that the government would cover also could vary over different levels of expenditures. For example, the government could cover 90

percent of the costs above the eligibility threshold up to two times the threshold, 80 percent of the costs from two times the threshold up to three times the threshold, and then 100 percent of the costs above that.

Having government take on the role of reinsurer would make the small group and individual insurance markets function more efficiently. This would immediately provide what economists call a “welfare” gain to everyone who purchases health insurance in the small group or individual insurance markets, since the premiums for insurance will decline in proportion to the reduction in use of selection mechanisms. Moreover, high-risk people who currently cannot obtain coverage from all carriers also would benefit because carriers would no longer deem them undesirable. High-risk people would have greater access to carriers and policies in insurance markets.

The welfare gains caused by the increased efficiency in the insurance markets are not “free,” of course. This requires government revenues to pay all or some of the medical care costs of the designated high-cost people. A political advantage of using the income tax and sources of revenues for the general revenue funds is that they do not require implementation of a new tax to pay for either a new insurance program for high-cost people or a reinsurance fund to pay carriers for high-cost claims. On the other hand, when a program is competing for general revenue funds along with high-visibility government programs—such as education, highway maintenance and construction, or homeland security—then it is vulnerable to pressures to cut the budget. This is particularly true for programs that benefit everyone, but may appear to assist only a small number of people—in this case, those individuals with high-cost claims. The argument has to be made that both of the government options for high-cost individuals increase the efficiency of insurance markets, thereby providing benefits to everyone.

Implementing an institutional structure to permit the government to take responsibility for the health care expenses of the very high-cost individuals also would require some standardization of health policies sold in the small group and individual markets. Standardizing the benefits covered by policies would make it possible to compare medical expenditure patterns of people and then to identify those people who have the very highest medical expenses. Without such standardization, it would be quite difficult to know whether a person had high expendi-

tures because of a very generous insurance policy as opposed to being quite ill.

New York State created a subsidized health insurance program for low-income individuals and small firms with low-wage workers that is very close to my proposed plan. “Healthy New York” was developed during 2000 and began enrolling individuals in February 2001. Under Healthy New York, the state pays as much as 90 percent of the costs of claims between \$30,000 and \$100,000 for people who have claims in a calendar year that exceed \$30,000 (Swartz 2001). The money for the pool of funds that pay for these costs comes from the state’s tobacco settlement funds. To ensure transparency of why people have high-cost claims, currently there is only one standardized benefits package for the Healthy New York policies. Premiums under Healthy New York for eligible low-income individuals are about 50 percent less than the premiums for individual coverage in the regular individual market; for small firms the premiums are about 15–30 percent below premiums for comparable policies in the small group market.

In sum, if government were to redistribute the risk of very high medical care costs from carriers to the broader population, efficiency would be increased in the small group and individual insurance markets, enabling more people to obtain health insurance. Premiums would be reduced because carriers would reduce their efforts to identify high-risk people whom they do not want to insure. As a result, relatively low-risk people would be more likely to obtain and retain coverage. Higher-risk people, who currently have great difficulty finding carriers willing to insure them, would have more choice of policies and carriers since there would be sharply reduced incentives for carriers to avoid higher-risk enrollees.

CONCLUSION AND POLICY IMPLICATIONS

When risk is present in markets, such as health insurance markets, market failure can be especially likely because of information asymmetry and the potential for adverse selection. Risk also can cause markets to fail to form. If government acts to take care of or remove the worst risks in such markets, the inefficiency in the markets would be

greatly reduced, and markets that otherwise could not even start up would be able to function.

There are precedents in other markets with risk where the federal government has taken responsibility for the worst risks, thereby enabling markets to function and grow. A market for reinsurance for catastrophes has developed in the United States because there has been a history (including, most recently, the response to the terrorist attacks of September 11, 2001) of the federal government stepping in to pay large fractions of the costs of catastrophes. Indeed, the creation of the Federal Emergency Management Agency in 1978 formally acknowledged the federal government's role in assisting with recovery from catastrophes. The secondary mortgage market in the United States, which enables lenders of mortgage money to replenish their capital, was established because the federal government has taken responsibility for the worst-risk mortgages since 1954. The Federal Housing Authority (FHA) and the Veterans Administration (VA) shifted the risk of default from mortgage lenders to the federal government for people who otherwise would not have qualified for mortgage loans. The FHA mortgage insurance and the VA mortgage guarantee program set minimum standards for what properties were eligible for mortgages and what types of financial information were needed from borrowers. This standardization of information permitted mortgages to be resold on a national basis because standardized information made it easier for lending institutions that were not local to perform due diligence investigations of mortgages that were offered for resale in the secondary mortgage market. In addition, very high-risk mortgages are backed by federal guarantees. It is unlikely that either the reinsurance market or the secondary mortgage market would function without the government backstopping them by covering the worst risks.

Similarly, if government were to reinsure the costs of those individuals with the highest medical expenditures each year, the risk of very high costs would be shifted from carriers to the general population. This would cause carriers in the small group and individual insurance markets to spend substantially less on efforts to avoid insuring people they perceive to be likely to have high costs. In turn, this would reduce the rates for health insurance faced by people who purchase insurance in these markets and enable a much larger set of people to obtain health coverage.

Having the government act as reinsurer, along with backstop carriers in the individual and small group markets, will help about a third of the people who currently are uninsured. The remaining uninsured do not have sufficient incomes to afford health insurance unless it is heavily subsidized. As we noted earlier, many of the low-income uninsured have medical debts for highly treatable episodes of care. Such debts would be far lower if the people had obtained medical care in settings other than hospital emergency departments. To facilitate the use of more efficient settings for medical care by the low-income uninsured, government should either create more community health care centers or extend eligibility to adults for public programs similar to the SCHIPs. Such government moves also would increase efficiency in the provision of health care to the very low-income uninsured.

Finally, the rising costs of medical care mean that health insurance premiums will also increase, along with increased cost-sharing required when people use medical care. If the past is any indication of how this will affect people's decisions to purchase insurance or take up employer-sponsored coverage, the rising costs will lead to greater numbers of uninsured as more people come to view health insurance as unaffordable. As we have seen in the last decade, the uninsured are increasingly people with lower middle-class incomes. We need to rethink both how we provide and finance health insurance if we are to avoid rising numbers of uninsured—such rethinking could begin with the government taking on the role of reinsurer for small group and individual health insurance markets. The government as reinsurer provides a mechanism for public funds to enable private health insurance markets to operate efficiently and be accessible to more people.

Notes

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1. In the case of public goods, the argument is that government should produce the goods because a market cannot be sustained.
2. Based on estimates by the Census Bureau from the March 2001 Current Population Survey. The estimates by type of coverage are not mutually exclusive because

people can be covered by more than one type of health insurance during the year, and in some cases at the same time (for example, some people have both Medicare and Medicaid coverage). See <www.census.gov/hhes/hlthins/hlthin01/fig03.gif>.

3. Medical underwriting is the process by which carriers set the premium for an applicant based on the person's expected medical care costs. Thus, if a person has poor health status, actuarial underwriting practices would yield a higher premium than that for a similar person in excellent health. The underwriting process essentially determines whether a person pays an additional amount plus the base premium for the policy.
4. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has been sometimes mistakenly assumed to restrict these selection practices in the individual insurance market. HIPAA does not prohibit carriers from applying selection practices to the great majority of individuals who seek coverage in the individual insurance markets. See Nichols and Blumberg (1998) for details.
5. Applicants in both the small group and individual markets generally have to respond to questionnaires about their health status, use of medications and medical care in the past, and health risk behaviors. It is not unheard of for small groups to be offered coverage for most but not all of the members of the group, with the rejected members being denied coverage because carriers believe they will have high medical expenditures.
6. For example, Washington State, New York, and New Jersey's individual insurance markets are required to guarantee issue of policies to any applicant regardless of the applicant's health status, age, gender, or place of residence.
7. Communication between Alan Monheit and the author, Spring 2001. Monheit and Marc Berk have analyzed the distribution and concentration of the population's medical expenditures. See, for example, Berk and Monheit (2001).

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