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Perspective

Government As Reinsurer For Very-High-Cost Persons In Nongroup Health Insurance Markets

Government already acts as a backstop for natural disasters and mortgages—why not for high health care expenditures as well?

by Katherine Swartz

ABSTRACT: Fear of adverse selection drives carriers in nongroup insurance markets to compete in their use of selection mechanisms to screen out high-risk applicants. This contributes to economic inefficiency. Government could assume the role of reinsurer, by assuming responsibility for most of the costs of people who are in the highest 2–3 percent of the national spending distribution. This would spread the burden of costs of very-high-cost persons to the broad population base and could cause premiums to fall as carriers spend less on efforts to avoid adverse selection.

Competition in nongroup health insurance markets in the fifty states should be understood as the rational response to asymmetric information: what insurance applicants know about their own health, and what carriers (indemnity insurers and managed care plans) know about the applicants. Fear of adverse selection drives the form of competition between carriers. They compete in their use of selection mechanisms to screen out applicants who they suspect will use expensive medical care—people frequently referred to as high-risk. Selection mechanisms include medical underwriting, refusal to issue or renew a policy, exclusion of coverage for preexisting medical conditions, and differentiation of a carrier’s policies from its competitors’ by generously covering some types of services (such as preventive care) but limiting coverage of other services (such as substance abuse treatment). Competition between carriers also extends to developing new methods to distinguish between high-risk and low-risk persons. These competition mechanisms differ from the standard economic model, in which perfect information is assumed to exist and producers seek lower-cost methods of production so that they can lower prices.

The use of these selection mechanisms and efforts to improve them contribute to economic inefficiency in nongroup health insurance markets. When conditions prevent a market from functioning efficiently (a situation economists label “market failure”), governmental interaction with the market is justified. In the case of nongroup health insurance markets, asymmetric information is the culprit. The primary objective of government action should be to substantially reduce carriers’ fear of adverse selection.

How To Reduce Fear Of Adverse Selection

The use of selection mechanisms is based on the assumption that once someone be-

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comes a high-cost person, he or she will remain a high-cost person. This assumption has been reinforced by the language used in the literature on risk adjustment, which commonly illustrates the problem with simple models where people are either low-risk or high-risk. In reality, longitudinal studies of people’s medical spending show little evidence that high or low medical care use persists, especially among the nonelderly. In particular, there is no evidence of someone in the highest 1–5 percent of the spending distribution remaining in that group the following year or several years running. It is impossible to predict who will be very high cost, since so much of what determines who is in the far right tail of the spending distribution depends on random, unanticipated events. Yet the expenditures in that right tail are what motivate carriers’ efforts to use selection mechanisms. If carriers’ risk of very high costs could be reduced, they would have far less incentive to use screening mechanisms to risk-select enrollees.

One way to accomplish this is to have government act as reinsurer for carriers by assuming responsibility for most of the costs of people who are in the highest 2 (or perhaps 3) percent of the national spending distribution. The actual threshold for the reinsurance would have to be determined after simulating the effects of different design specifications. As with any reinsurance policy, different levels of carrier liability would be set for different ranges of an enrollee's expenditures, so that the carrier would retain an incentive to manage every enrollee's care and its costs. For example, government reinsurance might be initiated when a person spends more than $30,000 in a given year. The reinsurance might be responsible for 90 percent of costs between $30,000 and $75,000; then 85 percent for costs between $75,000 and $125,000; and then again 90 percent of costs between $125,000 and $200,000, before finally assuming 100 percent of the costs above $200,000.

People whose costs are in the top 30 percent but not the top 2–3 percent of the spending distribution have costs for which carriers should be able to bear the risk. According to estimates by Marc Berk and Alan Monheit, nonelderly people with private health insurance who had expenditures in the top 30 percent of the distribution had average spending of $5,090 in 1996. People in the top 50 percent had average spending of $3,340. If the risk of very-high-cost claims were shifted from carriers to the government as reinsurer, carriers would have far less incentive to engage in risk-selection activities, since they are not cost-effective when applied to persons below the top 2–3 percent of the distribution.

The cost of having the government take on the role of reinsurer for nongroup markets would depend on the design of the reinsurance and the level of spending at which reinsurance would begin. It also would depend on the types of benefits that would be eligible for the reinsurance, since it would be necessary to maintain transparency that a person has high costs because of being very ill rather than having a generous insurance policy. The costs of various designs need to be estimated with sophisticated simulation models.

Increased Efficiency And Equity

If the government becomes the reinsurer in nongroup markets, these markets can operate more efficiently. The costs of producing health insurance will be lower, which will reduce premiums and ought to induce more uninsured people to purchase coverage.

Having the government assume the role of reinsurer also spreads the burden of the costs of very-high-cost people from the relatively small number of people insured by any particular carrier to the broader population base of all taxpayers. The burden of the high expenditures of a few people will be quite small for any one person. This reduces the likelihood that people who have nongroup coverage will drop...
Precedence For Government’s Bearing Risks Of Very High Costs

There is precedence for the government’s taking on the role of reinsurer in nongroup insurance markets. The government provides “backstopping” in the catastrophe reinsurance market and the secondary mortgage market. The catastrophe reinsurance market exists because there is a history of government’s stepping in to pay large fractions of the costs of catastrophes. Indeed, the creation of the Federal Emergency Management Agency (FEMA) in 1978 formally acknowledged the federal government’s role in assisting with recovery from catastrophes. Similarly, the secondary mortgage market exists because the federal government has responsibility for the worst-risk mortgages. The Federal Housing Authority and the Department of Veterans Affairs shifted the risk of default from mortgage lenders to the federal government for people who otherwise would not qualify for mortgage loans. It is unlikely that either of these markets would function without having the government cover the worst risks as a backstop. Nongroup health insurance markets similarly need the government to spread the costs of very-high-cost persons.

Current proposals to provide tax credits to subsidize the purchase of nongroup insurance by uninsured persons do not consider how the fear of adverse selection drives competition in nongroup markets. The tax credits are a well-intentioned response to the relatively high nongroup premiums, but they do not address the underlying cause of the higher premiums. The subsidies are likely to exacerbate the problem of adverse selection in the nongroup market and further drive up premiums. Subsidies for lower-income uninsured persons need to be coupled with a government role as reinsurer for very-high-cost persons if nongroup markets are to be a vehicle for reducing the numbers of uninsured Americans.

NOTES


