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Justifying Government as the Backstop in Health Insurance Markets

Katherine Swartz, Ph.D.*

Disasters—earthquakes, floods, hurricanes, forest fires, or terrorist attacks—usually bring out selfless behavior as people band together to help those in need. Disasters and our responses to them are reminders that we are in a society together. Unfortunately, for at least the last fifty years, this image of one society has faded when we have tried to work out details for implementing universal health insurance in the United States. A large part of the disagreement about how to achieve universal coverage is over the extent to which we are willing to allow government to intervene in private markets. Yet disasters provide a blueprint for what the role of government might be to help private health insurance markets work more efficiently for everyone and to enable more people to obtain coverage.

Throughout our history, philosophical arguments about the role of government in a market-oriented society have shaped many of our laws and the division of responsibilities among the federal and state governments and the private sector. In the last three decades, economists and, increasingly, politicians have argued that the free market advances economic growth and opportunity more effectively than government policies intended to achieve such goals. This view rests on the widespread belief among American economists that competitive forces yield efficiency in both the production and the allocation of goods and services. Moving from a static to a dynamic context, economists also see free market competition as a strong spur to innovation. As the view has taken hold that competition yields efficiency in markets, policy-makers have paid increasing attention to the way in which government regulation might inhibit competition and incentives for companies in a market to be

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efficient. There is now a widespread belief among economists, policy analysts, and policy-makers that government should intervene in a market only when conditions for competition are not in place, and the market fails to be efficient.

In the case of health insurance, the absence of a competitive market can arise for a variety of reasons. Within a geographic area, there are traditional concerns about monopolies. There are also more subtle concerns involving the role of information. Perfect competition requires that all market participants have perfect information on what is being bought and sold. By contrast, health insurance markets can be plagued by adverse selection—the phenomenon in which people who anticipate high medical care costs will be most likely to purchase health insurance. One consequence of the possibility of adverse selection is the extensive use of screening mechanisms by insurers to avoid high-risk (potentially high-cost) enrollees. This results in people who are perceived to be high-risk being unable to obtain coverage at affordable premiums, or denied coverage altogether. It also results in inefficiency in the health insurance markets as insurers invest in the non-productive efforts of screening to avoid high-risk people. Such efforts increase the costs of insurance for all who obtain coverage.

The role of government in dealing with disasters provides us with a blueprint for how government might reduce inefficiency in health insurance markets. Insurers almost always judge the risks of large-scale losses in the event of a disaster as too great to insure against, and they then refuse to sell coverage for such possibilities. Earthquake insurance is hard to obtain in areas that are prone to earthquakes, and it is increasingly difficult to purchase insurance for hurricane damage in coastal areas that are subject to hurricanes. But markets for property damage, casualty, and liability insurance exist and are relatively competitive. Why? The answer is that the government (primarily the federal government) has increasingly moved to provide disaster relief, thereby taking responsibility for the worst or highest risks in these markets. Government plays a backstop role in these markets by implicitly (if not explicitly) agreeing to be responsible for a large share of the costs of future disasters. This role enables insurers to cover lesser risks for property damage and liability, thereby allowing the markets for such insurance to function.

Similarly, government could take responsibility for the costs of people with the highest medical care expenses. That is, the government would shift the risk of unexpectedly very high costs from the insurers to the broad base of citizens and corporations from which it gathers general tax revenues. This would enable insurers to offer health insurance for medical
care costs below the 98th or 99th percentile of the distribution of all medical care costs, and to be efficient in providing insurance since they would not feel compelled to screen people the way they do now. By backstopping the insurers, the government would ensure that the health insurance market would be accessible to a broader set of people, and would be more efficient, thereby enhancing social welfare. Having the government backstop insurance markets so they function more efficiently is similar to government enforcement of laws regarding property rights. Without such enforcement, some markets might not function at all, and others would be markedly less efficient because payments would have to be made to middlemen to enforce a person’s rights.

In this Article, I expand on the rationale for government taking on a backstopping role in health insurance markets. I explain why health insurance markets would be more efficient and how social welfare would increase as a result. In Part I, I briefly review the two most frequently cited economic arguments for government involvement with health insurance markets. The argument that government contributes to the efficiency of insurance markets by redistributing the costs of the highest risk individuals builds on the more common argument that government should intervene in markets when they fail to be competitive. In Part II, I discuss why imperfect information creates market inefficiencies. In Part III, I describe how health insurers compete, and why the small group and individual (non-group) health insurance markets are inefficient. In Part IV, I suggest how government might spread the costs of high-risk people, and discuss why the government would reduce inefficiency in the insurance markets if it were a backstop for markets by removing the worst risks.

I. ECONOMIC JUSTIFICATIONS FOR GOVERNMENT INVOLVEMENT IN HEALTH INSURANCE

Economic theory offers two justifications for intervention in the economy. The first involves redistributing resources to assist poor or otherwise deserving groups of people who are unable to afford goods (like food or health care) that are deemed to be necessities. The second involves redressing causes of market failures—conditions of various kinds that result in a failure to achieve economic efficiency.

A. Redistribution of Resources

Economists are concerned with both economic efficiency and the distributional consequences of markets. When a market yields an allocation of its product to various consumers in such a manner as to be
judged unfair, many economists argue that a redistribution of resources should occur to make the distribution fair. Unfortunately, it is difficult to agree on what is a fair distribution, and even more difficult to agree on why one allocation is better than another. Economics and philosophy intersect when it comes to determining how we may or may not compare different individuals' levels of happiness or welfare, and how we might judge when one distribution of resources is better than another. Most economists believe that different individuals' levels of happiness cannot be compared to each other. This leaves economists in the awkward position of not having a tidy method for declaring one distribution of resources fairer than another. Instead, economists can say only that one group of people benefits or bears the burden of some policy or market outcome. We often observe a redistribution of resources when the public or policy-makers judge it to be unfair that a group within society has a disproportionate share of the benefits or burden.

Most economists argue that such resource redistributions should take place outside the market in order to leave the market's efficiency-enhancing incentives as intact as possible. This argument prefers a direct income transfer like food stamps to a policy of price controls on food. The food stamps do not alter the prices that farmers receive for their products, and they do not cause higher-income people to purchase more food as they might if all food prices were artificially low. The redistributive justification for government involvement with the economy also explains the genesis of Medicare and Medicaid. They are a response to the argument that access to health care should not depend on ability to pay, and therefore government has a responsibility to guarantee financial access to medical care. Both programs involve redistributing tax revenues from the general population to pay for medical care for people who enroll in the programs.

Although many Americans believe it is unfair that one in six people are without health insurance, there is widespread disagreement about how redistribution of resources might be accomplished so that everyone would have health coverage. There is no clear mechanism for providing health insurance to everyone without hurting the interests of some people, usually the wealthy. This has hampered advocates of expanding health insurance who have relied on the redistribution rationale for government involvement in the economy.

B. Economic Efficiency and Market Failure

The second economics justification for government intervention involves market failure. Historically, markets were said to fail when they
were inefficient—a situation that occurs when individuals bear either more or less than the full costs of resources they consume, or fail to receive the full benefits of products they produce. These conditions could arise from any of three general cases:

1. **Market Power.** A market is controlled by one or several producers who do not compete with each other and who block competition from potential new entrants. For example, a group of radiologists supply all the radiology services in a town and effectively bar any new radiologists from contracting with the town hospitals. In this case, consumers are likely to be charged more than the full cost of services consumed.

2. **Negative and Positive Externalities.** An individual’s action creates a cost (or benefit) for others for which the individual does not pay (or is not rewarded). For example, without environmental regulation, a factory would have little incentive to consider the costs its pollution imposes on others. Without a patent system, an inventive person would have little incentive to develop ideas that could be freely copied.

3. **Public Goods.** Goods like public health or national security, which, once created, can be universally consumed and cannot be restricted to only the individuals who paid for the good.

In the last thirty years, these three classical reasons for market failure have been joined by a fourth—asymmetric information. Asymmetric information was the subject of the 2001 Nobel Prize in Economics. The three prize recipients (Joseph Stiglitz, George Akerlof, and Michael Spence) made explicit another assumption of the competitive model—that people have full information about what they are buying or selling—and showed the consequences when that condition is not met. Asymmetric information is increasingly cited as a barrier to competitive markets and therefore a reason for market failure in health care and health insurance markets.

Debates about whether government should intervene in markets have almost always turned on the interpretation of evidence for and against the presence of one or more of these four causes of market failure. Government interventions in markets are generally in the form of regulations to prohibit or require certain activities, or taxes and subsidies to alter the relative prices of products. The intent of these actions is to alter the constraints and incentives that producers and consumers face in a market so the market becomes more competitive and, therefore, more efficient.
II. ASYMMETRIC INFORMATION AND HEALTH INSURANCE

The focus of this Article is how the government might address asymmetric information’s effects in health insurance markets, and therefore it is important to understand why imperfect information causes markets to fail to be efficient. In general, when consumers and producers do not have the same information, the information asymmetry favors producers because consumers have difficulty obtaining a great deal of information. For example, when consumers do not purchase a good frequently (such as a car), it is difficult to know about all the price and quality differences among cars and among car dealers. Public policies often have been designed to provide information to consumers so as to redress the information asymmetry between consumers and producers. In the case of cars, most states now require car dealers to disclose the cost of the car to the dealer and the additional mark-ups that the dealer has added.

In health insurance markets, the information asymmetry generally favors consumers. Consumers know far more about why they wish to purchase health insurance than indemnity insurers or managed care organizations (hereafter collectively referred to as carriers) can ever know. Carriers know from experience that people who know or suspect they will have expensive health care needs in the coming year are more likely to apply for insurance coverage than are those who think they are quite healthy. This creates an adverse selection problem because carriers do not have full information to correctly distinguish between low-risk and high-risk applicants. As a result, explained more fully in the next Part, the carriers compete in terms of mechanisms to screen out high-risk people. This type of competition yields inefficiency in health insurance markets because the carriers spend resources on activities that do not produce insurance per se. In addition, the selection activities limit the access to health insurance for those individuals perceived to be high-risk, as compared to their lower-risk contemporaries.

III. HEALTH INSURANCE MARKETS AND HOW CARRIERS COMPETE

In the United States, the majority of people obtain health care coverage through employers. Approximately 64% of the population (of all ages) have employer-sponsored group coverage. Those with such coverage pool their own risks of high medical care costs with other individuals covered by the same employer. Because almost everyone in large employer groups participates in the employer-sponsored health insurance plan, there is only a small proportion of each group that is 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.

Health insurance is sold in the United States in three interconnected markets. We can loosely distinguish between large employer group, small group, and individual (non-group) insurance markets. Some carriers actively sell coverage in all three markets, but most do not. More often, we observe large carriers selling coverage to large employer groups, with some of the major large carriers selling policies in the small group and individual markets. Smaller carriers sell policies almost exclusively in the small group and individual markets. In addition to these three types of markets, every state (and the District of Columbia) 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 that the carriers must hold. As a result, there are fifty-one different sub-markets 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 consequence of this is that in the individual markets in 1997, the number of carriers selling individual policies ranged from two or three (in Delaware, Idaho, and Alaska) to more than forty (in New York and Texas). 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. 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.

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 technically 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 fifty-one 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 of a large employer enroll for coverage. However, when an employer offers a choice of plans, those carriers that are the choice of a small proportion of the group may be concerned about adverse selection.11 Employees and their dependents in large group plans 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.12

Small groups (typically, groups with less than fifty employees) and individuals face very different markets. Per policy premiums are substantially higher in these markets; 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.13 Carriers’ fear of adverse selection among applicants in the small group and individual markets motivates the carriers’ behaviors. Insurers fear adverse selection because it causes them to underestimate premium revenues needed to cover expenditures and thus to risk substantial financial losses. To avoid adverse selection, many carriers adopt selection mechanisms to screen out applicants who they suspect will use expensive medical care.14 Such mechanisms include medical underwriting practices,15 refusing to issue or renew a policy, excluding coverage of services for pre-existing 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 treatment16).17

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. When carriers are permitted to set different premiums for people who the carriers predict will have different probabilities of using expensive medical care, they compete in large part in terms of the accuracy of their models for predicting a person’s (or firm’s) medical expenses.18 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 in the coming year. The additional premium amount underwrites the basic premium for the policy.

Underwriting principles might also cause a carrier to deny coverage completely or to 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 pre-existing condition (such as cancer, osteoarthritis, or allergies) for a limited time period—typically twelve months. As a result, carriers more often simply deny an application if a person has had serious conditions, such as angina or a myocardial infarction. In some states, underwriting of premiums is not permitted because it is viewed as a selection mechanism that discriminates against people who 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 voluntarily to reveal whether they are likely to be low- or high-risk. 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. 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 who carriers perceive as high-risk have few, if any, options for obtaining health insurance.
The differences in states’ regulations of the insurance markets within their borders permit 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 to inhibit carriers’ abilities to avoid people who want coverage 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. For example, carriers in the individual insurance markets in Washington, New York, and New Jersey are required to issue policies to any applicant regardless of the applicant’s health status, age, or place of residence. But, 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 an 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 employers with large fractions of high-risk employees from those with large fractions of low-risk employees.

In summation, the information asymmetries in health insurance markets, particularly the small group and individual markets, cause them to be inefficient. 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 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.
IV. GOVERNMENT AS DISTRIBUTOR OF RISK

The economy can produce more when risks in markets are reduced by actions that pool risks and/or shift risk to people who are willing to bear the risk in exchange for a payment. Insurance markets that might be formed to address risk—such as the risk of unexpectedly high medical care costs—will form and be efficient if the risk is truly random and unrelated to any observable characteristic of a person or entity seeking insurance. But as we have seen, if there are characteristics associated with higher risk, a potential insurance market is faced with an information problem that manifests itself as adverse selection. When adverse selection occurs, a market will be inefficient because of the efforts spent trying to detect the information—or a market can fail even to form. However, if the government acts to cover the costs of the worst risks, an inefficient market can become more efficient, and a non-functioning market can be stimulated to form. In particular, if the government removed the risk to carriers of very high-cost people, carriers would not have to spend as much on selection mechanisms to avoid insuring high-risk people.

The government has two options for shifting the risk of very high-cost people from carriers: (1) provide financial coverage outright; or (2) take on the role of reinsurer. Both options rely on the government’s ability to tax a broader segment of the population than just those individuals with coverage through the individual or small group markets.

A. Provide Insurance Coverage

Medicare, Medicaid, and the Veterans Administration’s health care are all examples of government-provided financial coverage of health care costs. As noted earlier, the establishment of Medicare and Medicaid was justified in part because they redistribute resources to deserving groups of people: the elderly, disabled, and very poor. Medicare was also justified because disabled and senior citizens found it virtually impossible to obtain health insurance prior to 1965 at a price they could afford. People who have served in the armed forces of the United States are covered by the health care program of the Veterans Administration (VA) for medical problems caused by their active duty. The VA was created in part to provide efficacious medical care to people who might have injuries or problems that the civilian population generally does not have. Having centers of expertise in VA hospitals is both more efficient and more effective than relying on physicians and hospitals scattered across the country with little experience with such problems. Additionally, without the presence of the VA, carriers might charge very high rates to veterans.
and/or refuse to cover medical services that might be related to injuries or medical problems incurred in the armed forces. These three government programs provide coverage to specific groups of people who have higher than average probabilities of needing high-cost medical care, and consequently would have difficulty obtaining health insurance in the private markets.

The government could provide similar health insurance programs to other identifiable groups of people who are perceived as very likely to have high expenses and therefore have trouble obtaining private coverage. Ex ante, however, it is difficult to identify other “targetable” groups of people who are likely to have high medical expenses—which is why the carriers spend an enormous amount of effort trying to avoid covering high-risk people. However, the government could target people for programs ex post, perhaps by identifying individuals with medical expenses that put them in the top 1% or 2% of the distribution of medical expenses of the entire population. Once a person was identified as being “high cost,” the government would pay all of the person’s medical expenses. Such a government sponsored “high-cost” program would drastically reduce carriers’ incentives to spend resources on selection mechanisms.

**B. Government as Reinsurer**

The other option for the government’s role in health insurance markets is to become a reinsurer for carriers that have covered high-cost people. 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 entire population’s distribution of medical expenses. Carriers often purchase reinsurance to protect themselves from the risk that an insured’s claims will exceed $50,000. Private reinsurance reduces a carrier’s exposure to the risk of high-cost enrollees; the costs of the reinsurance fall on the other individuals obtaining coverage from the carrier. These costs, in addition to the higher premiums due to high-cost enrollees, fall totally on a carrier’s enrollees—reinforcing carriers’ fears that they will lose low-cost enrollees if such costs continue to rise. Instead, if the government acted as the reinsurer for the high-cost claims, the costs of the reinsurance and the higher expenditures being reinsured would be shifted from the carrier’s enrollees. Carriers would then have far less incentive to avoid high-risk people.

Reinsurance usually requires the original insurer (the carrier) to bear some portion of the costs above the threshold so the carrier will still have an incentive to continue to manage the health care of high-cost people. It
would be important to retain this incentive if the government were to reinsure the very high medical care expenses. Moreover, the government could cover either a portion of the costs above the threshold that causes a person’s expenses to be eligible or a portion of all of the 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 80% of the costs above the eligibility threshold up to two times the threshold, and then 90% of the costs above that.

Either of the options discussed above would curtail the use of selection mechanisms to avoid high-risk enrollees and would, therefore, make the market more efficient. These changes 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 would 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 brought about by either of the government options are not “free,” of course. Both options require government revenues to pay all or some of the medical care costs of the designated high-cost people. Three major types of taxes could be used to pay these high medical costs: (1) payroll tax; (2) income tax; or, (3) head tax. Moving from a payroll to income to head tax involves an expanding subset of the population, but each tax has different impacts on the after-tax income distribution. Payroll taxes are a percent of wages and salaries, and are paid only by people who are working. Income taxes apply to all forms of income (e.g., salary, rental property income, and investment earnings) and are generally more progressive than either a payroll or head tax since higher income people are taxed at higher rates than lower income people. A head tax is independent of income and applies to every person in the country regardless of age. In addition, all of the revenue sources for the states’ and federal governments’ general revenue funds—including fines or settlement agreements paid by corporations (e.g., the tobacco settlement funds) and excise taxes not dedicated to other purposes—could be used if the general revenue funds were tapped to finance high-cost medical expenses.

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 budget-cutting pressures. 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 would also 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 expenditures because of a very generous insurance policy as opposed to being quite ill.

Finally, by providing either total coverage or reinsurance for very high medical care costs, the government would provide stability to health insurance markets. Stability contributes to efficiency in markets because people are able to make choices about purchasing insurance with less uncertainty about future premiums. When carriers find themselves in a spiral of rising costs due to adverse selection and falling enrollment of low-risk people, they often raise premiums to try to cover their anticipated losses. But rapid premium increases cause lower-risk people to drop their coverage, which further exacerbates the imbalance of costs and revenues and often leads to a death spiral for a particular policy or carrier. A market that is destabilized by rapidly rising premiums or loss of carriers will not attract lower-risk people to purchase coverage, and ultimately will fail to function. 24

Thus, if government uses its power to redistribute the risk of very high medical care costs from carriers to broader sub-groups of the population, it would increase efficiency in health insurance markets—particularly the small group and individual insurance markets. The increase in efficiency would enable more people to obtain health insurance. Premiums would be reduced because carriers would reduce their efforts to identify high-risk people who 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

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them, would have more choice of policies and carriers since there would be sharply reduced incentives for carriers to avoid higher-risk enrollees.

CONCLUSION

When markets fail, economic theory tells us that government should intervene in the market so as to increase efficiency. 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 prevent markets from forming. 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. Reinsurance for catastrophes exists because there has been a history (including the response to the terrorist attacks of September 11, 2001) of government 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. The secondary mortgage market, which enables lenders of mortgage money to replenish their capital, exists because the federal government has responsibility for the worst risk mortgages. The Federal Housing Authority (FHA) and the VA shifted the risk of default from mortgage lenders to the federal government for people who otherwise would not have qualified for mortgage loans. Moreover, 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. 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.

Health insurance markets similarly need the government to spread and redistribute the costs of those individuals with the highest medical expenditures. If the government were to take responsibility for the highest cost people, carriers in the small group and individual insurance markets would spend less on efforts to avoid enrolling these individuals. 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—all of which would increase economic welfare for the country.
References

1. Roughly speaking, efficiency is achieved in a market when no individual can be made better off unless another individual is made worse off.


3. "Social welfare is maximized by the joint pursuit of efficiency [in the production of goods and services in their allocation] and social justice." NICHOLAS BARR, THE ECONOMICS OF THE WELFARE STATE 279 (3d ed. 1998). Unfortunately, a definition of social justice is less easily agreed to by economists and others. The stumbling block is that such definitions involve value judgements.


5. The State Children’s Health Insurance Programs (SCHIPs), implemented in 1998, have a similar justification for existence.

6. Consumer Reports, published by Consumers Union, is perhaps the most widely known consumer-based magazine and newsletter that provides information about infrequently purchased items. State agencies’ web sites (particularly state agencies that oversee health insurance) often contain information for consumers about available policies and premiums.

7. U.S. CENSUS BUREAU, CURRENT POPULATION SURVEY tbl.1 (2001), available at http://www.census.gov/hhes/hlthins/hlthin00/table1.html. 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). Thus, 8% of the population have non-group private coverage, 13% have Medicare, 10% have Medicaid, 3% have military coverage (CHAMPUS/VA), and 14% are uninsured. Id.


9. Id. at 5 tbl.1.

10. Id. at 9-17.


12. Two frequently cited issues in health insurance are adverse selection and moral hazard. Adverse selection is a result of information asymmetry. Moral hazard, on the other hand, is caused by insurance itself—insurance reduces the effective price to an individual and masks the true cost of an individual’s action. Thus, a person with health insurance may engage in riskier behavior that increases health care use.
(perhaps skiing on black diamond trails when he is not an expert skier) than he would if he faced the full costs of the behavior. More commonly, when health insurance pays for most of the costs of a medical visit, people have an incentive to see a physician more often than if they paid the full cost of the visit. Such insurance-induced demand for health care causes society to spend more on medical care than would be the case if people paid the full cost of the medical care. Economists call this additional expenditure a welfare loss because it is money that is not available to be spent on other goods or services that have greater marginal value than what it costs to produce them. Moral hazard can be reduced by increasing the cost-sharing required of people when they obtain health care, particularly health care that is of a non-emergency nature.

13. Economists break an insurance premium into two parts: a person’s expected medical care costs and a “loading fee.” The loading fee encompasses marketing and administrative costs (such as processing medical claims and enrolling a person in a policy), and a payment to the insurer for bearing the risk that the person might have unexpectedly high medical care costs. In large employer-sponsored groups, the risk that any one person might have unexpectedly high medical care costs is pooled with many other people in the group. This reduces the risk faced by an insurer, so that the payment portion of the loading fee for the insurer bearing risk is reduced for large groups. Loading fees as a percent of the premium for large groups have been estimated to be about 5%. In contrast, the loading fees are estimated to be about 30% to 40% of premiums for policies sold to small groups and 60% to 80% for policies sold in the individual market. CHARLES E. PHelps, Health Economics 347 tbl.10.3 (2d ed. 1997). The much larger loading fee in these markets is due primarily to the smaller numbers of people with whom a person’s risk of having unexpectedly high medical care costs can be shared, and concern that the other people enrolled in these markets are higher-risk people.


15. Medical underwriting (sometimes called experience rating) is the process by which insurers determine as best they can each individual applicant’s expected medical care costs. The process usually entails asking questions about the applicant’s history of health care use, asking whether the applicant or a family member has any of a list of specific medical conditions, and sometimes performing a
medical exam. Thus, if a person has poor health status, actuarial underwriting practices would yield high premiums. When carriers set premiums for policy renewals, medical underwriting can yield high premiums for people who have had expensive medical care in the previous six to twelve months, or an outright denial of renewal of coverage. In contrast, community rating is when everyone—regardless of age, sex, occupation, and other characteristics—is charged the same premium for the same policy. Some states permit what is termed modified community rating, which permits different rates by factors such as geographic area of residence, age, and sex. Community rating is always for a particular type of plan—single, husband-wife, adult plus child(ren), and family.


17. Observers of insurance markets often assume that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has restricted these selection practices in the individual insurance market. In fact, HIPAA provides portability of coverage and protection from some selection practices for only a limited group of statutorily defined “eligible individuals,” people who had prior group coverage for at least eighteen months, have exhausted Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) benefits, and lack current access to group coverage or public programs. Len M. Nichols & Linda J. Blumberg, A Different Kind of “New Federalism”? The Health Insurance Portability and Accountability Act of 1996, 17 HEALTH AFF., May-June 1998, at 25, 31-32. HIPAA does not prohibit carriers from applying selection practices to the great majority of individuals who seek coverage in the individual health insurance markets. A related statute is COBRA, which required firms of twenty or more employees to offer access to the firm’s group insurance policy following a “qualifying event” for up to eighteen months for a work-related event, and thirty-six months for a family-related event. Work-related events include termination of employment; family-related events include loss of dependent coverage due to divorce or death of an insured worker. People who qualify for COBRA coverage pay a premium not to exceed 102% of the sum of the employer and employee shares of the premium. Patrice Flynn, COBRA Qualifying Events and Elections, 1987-91, 31 INQUIRY 215, 216 (1994).

18. These models are generally known as actuarial models because they are based on actuarial tables of likelihoods using different amounts of medical care by many different demographic and socio-economic characteristics as well as health status and prior use of health care. 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 (such as smoking and recreational activities). 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 of carrier fears that such people will be costly users of medical care.

19. CHOLLET & KIRK, supra note 14, at 43-44.

20. Lessons from New Jersey, supra note
14; Adverse Selection and Price Sensitivity, supra note 14.

21. Karen Pollitz et al., The Henry J. Kaiser Family Foundation, How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health? (2001). Also, in a General Accounting Office (GAO) survey of seven states' individual health insurance markets, the vast majority of the companies did not actually sell individual insurance to any applicant. Instead, these companies had a book of business of individual policies that were conversions from group policies or were restricted to people who were self-employed and belonged to associations of similarly self-employed people. GAO, Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs, GAO/HEHS-97-8 (1996), available at http://www.gao.gov/.

22. Private correspondence with confidential source (notes on file with author).

23. Welfare gain occurs when people have more choice of goods and services in the economy, more income, or goods and services are thought to be distributed more fairly. See also supra text accompanying notes 3 and 12.