WHY ARE THOSE WHO MOST NEED HEALTH INSURANCE LEAST ABLE TO BUY IT?

WE HAVE all heard stories of individuals who are sick and need, for example, open-heart surgery, but no insurance company will sell them health insurance. Health insurance seems to be available only for those who do not need it. Should health insurance companies be required to sell insurance to those who are sick and need it most?

To understand these issues, as well as what would be appropriate public policy, an understanding of how insurance premiums are determined and how health insurance markets work is necessary.

Eighty-five percent of private health insurance is purchased through the workplace. The insurance premium paid by an employer on behalf of its employees consists of the loading charge, which represents approximately 8 percent of the premium; and the claims experience of the employee group, which comprises the remaining 92 percent of the premium (see Figure 7.1). The loading charge reflects the insurance company’s marketing costs, administrative costs of handling the insurance claims, and profit for the insurance company. The claims experience of an employee group is the number of claims submitted by members of that group multiplied by the average cost per claim. The claims experience portion of the premium is the total medical expenditures paid out by the insurer on behalf of the group. Differences in premiums among employee groups, and the annual rise in employer health insurance premiums, primarily result from differences in claims experience. When the employer
is based on the claims experience of the particular group, the premium is **experience rated**.

When an employer applies for health insurance, the insurer attempts to estimate the likely claims experience of the employer. As shown in Figure 7.1, the insurer considers factors that affect the employer’s medical expenditures, such as:

- the types of medical and other benefits provided to the employees and their dependents;
- the type of mandates required by the state to be included in the insurance policy, such as hair transplants or coverage for chiropractors;
- the average age of the employees (older employees have higher medical expenditures than younger employees);
- the proportion of females (females have higher medical expenditures than males at younger ages, and less at older age levels);
- the industry in which the employer competes (doctors, nurses, accountants, and lawyers tend to be heavier users of health services, which is probably related to their educational levels, than bank tellers);

- the region of the country where the employees are located (hospital costs and physician fees are higher on the West Coast than in the South); and
- an estimate of the growth rate in medical inflation.

When an insurer has insured an employer long enough to have a history of the employer’s claims experience, the insurance company projects that claims experience and multiplies it by an estimate of the medical inflation rate.

Various approaches can be used to reduce an employer’s claims experience. For example, increasing the deductible and the coinsurance rate will decrease employees’ use of services; expanding insurance benefits to include lower-cost substitutes to inpatient admissions will lower treatment costs; and requiring utilization review of hospital admissions, case management of catastrophic cases, and use of PPO providers will lower use rates and provider charges. Thus, the claims experience of an employer is related to the characteristics of that employer, the medical benefits covered, and the cost-containment methods included in the insurance policy.

The insurer bears the risk of incorrectly estimating the employer’s medical experience. If the premium charged to that employer is too low, the insurer will lose money. Insurance companies and Blue Cross have lost a great deal of money in the past by underestimating claims experience and the medical inflation rate. An insurer cannot merely increase the premiums of the employer in the following period to recover their losses because the insurance market is price competitive. If an insurer says to an employer, “We need to increase our profit this coming year because we lost money on your employees last year,” the employer may switch to a competitor or to an HMO.

Even if the claims experience of two employers is similar, one group may have a lower insurance premium because it has a lower loading charge. Larger employers have smaller loading charges because administrative and marketing costs, which are generally fixed, are spread over a larger number of employees. Also, insurers earn a lower profit when they insure larger employers because they fear that if their profit is too high, large employers will decide to self-insure by bearing the risk themselves. Smaller employers, however, are less likely to be able to bear the risk of self-insurance. If a very large claim were to occur in one year, the financial burden may be too large for a small employer to bear. For a larger employer, large claims are likely to be offset by premiums from employees making only small or no claims in a given year. In addition to being able to charge small employers at a higher profit, an insurer is likely...
to maintain a higher reserve in case of a large claim. This further increases the loading charge for small employers. However, the amount of profit the insurer is able to charge small employers is limited by competition from other insurers and HMOs.

How Health Insurance Markets Work

With this brief description of how insurance premiums are determined, the issue of why those who are ill find it difficult to buy insurance can be explained.

Adverse Selection

Assume that an individual without health insurance requires a heart transplant and tries to purchase health insurance. If the insurer does not know that the person requires expensive medical treatment, the person's premium will be based on the claims experience of people in a similar age (risk) group. This difference in information between the individual and the insurer about the individual's health status can lead to adverse selection—a person in ill health will attempt to conceal that information from the insurer so that the insurer will not know the true risk.

For example, if 100 people are in a risk group, each with a 1 percent chance of needing a medical treatment costing $100,000, the pure premium for each (without the loading charge) would be $1,000 (0.01 x $100,000). Each year one person in the group requires a $100,000 treatment. Now assume a person (whose risk is 100 percent) who needs that particular treatment is permitted to join the group at a premium of $1,000 based on a mistaken risk level of .01. The person with the high risk receives a subsidy of $99,000 because his or her premium, based on the risk level, should have been $100,000. Because the $1,000 premium was based on a risk level of 1 percent, the insurer collected insufficient premiums to pay for the second $100,000 expense. Thus, insurer loses $99,000.

This example is the same as one in which a man learns that he has a terminal illness and, unbeknownst to the insurer, purchases a $1,000,000 life insurance policy to provide for his wife and children. It is also the same as one in which a person whose home is on fire quickly decides to buy fire insurance. Insurance enables a person to insure against uncertainty. However, when uncertainty no longer exists, the person's need for a heart transplant, for example, is not insurable.

If the insurance company knew that the person wanted health insurance to cover the costs of a heart transplant, it would charge a premium that reflected the person's expected claims experience. That is, the individual's premium would be equal to the cost of the heart transplant plus a loading charge.

Most people favor subsidizing those who need, but cannot afford, an expensive treatment. Similarly, most people favor subsidies to poor families. However, should not the government, rather than the insurer, provide those subsidies? When insurers must bear such losses, they eventually will be forced out of business unless they can protect themselves from people who withhold information and claim to be in lower-risk groups.

To protect themselves against adverse selection (i.e., insuring high-risk people for premiums mistakenly based on those with low risks), the insurer can raise everyone's premium. However, many low-risk subscribers, who would be willing to pay $1,000 but not $2,000 for a 1 percent risk, will drop their insurance. As more low-risk subscribers drop out, premiums for remaining subscribers will increase further, causing more low-risk subscribers to drop out. Eventually, large numbers of low-risk people will be uninsured, even though they would be willing to pay an actuarially fair premium, based on their low-risk group.

Instead, an insurer will attempt to learn as much about the person's health status. Examining and testing the individual who wants to buy health insurance is a means of equalizing the information between the two parties. Another means insurers use to protect themselves against adverse selection is by stating that their insurance coverage will apply to preexisting conditions, which are medical conditions known by the patient to exist and to require medical treatment. Similarly, an insurer may use a delay of benefits clause or waiting period; for example, obstetrical benefits may not be covered until a policy has been in effect ten months. Large deductibles also will discourage high-risk people because they will realize that they have to pay a large amount of their expenses themselves.

Insurers are less concerned about adverse selection when selling insurance to large employers with low employee turnover. In such groups, health insurance is provided by the employer and is a tax-free benefit (subsidized by the government); the total group includes all the low-risk people as well. Typically, individuals join large companies more for other attributes of the job than for health insurance coverage. Once in the employer group, employees cannot drop the group insurance when well and buy it when ill. Thus, for insurance companies, adverse selection is more of a concern when individuals or very small groups, with typically higher turnover, want to buy insurance. For example, an insurer may be concerned that the owner of a small firm might hire foolish workers who will be sick a lot.
become ill to receive insurance benefits. Thus, employees with preexisting medical conditions will be denied coverage because insurers will use testing and exclusions to protect themselves against adverse selection.

Some state and local governments have attempted to assist people with preexisting conditions by prohibiting insurers from using tests to determine, for example, whether an individual is HIV positive. Rather than subsidizing care for such individuals themselves, the government has tried to shift the medical costs to the insurer and their other subscribers. This is an inequitable way of subsidizing care for those with preexisting conditions because many insured but low-risk subscribers have low incomes. A more equitable way is for the government to use an income-related tax to provide the subsidy. Another consequence of these government regulations that shift the cost of those who are ill to insurers and their subscribers is that insurers will rely on other types of restrictions not covered by the regulations to protect themselves (e.g., delay of benefits, and exclusion of certain occupations, industries, or geographic areas).

Individuals, even though they are healthy, do not have health insurance for several reasons. An insurance premium that is much higher than the expected claims experience of an individual will make that insurance too expensive. For example, if employees are not part of a large insured group, they will be charged a higher insurance premium because they are suspected by the insurer of being a high risk. Also, the loading charge will be higher for the self-employed and those in small firms because the insurer’s administration and marketing costs are spread over fewer employees, leading to a higher premium. Further, state insurance mandates that require expensive benefits or more practitioners be included in all insurance sold in that state, result in higher insurance premiums. Consequently, fewer people are willing to buy such insurance. Many individuals and members of small firms also lack insurance coverage because premiums are too high relative to their incomes. Such people would rather rely on Medicaid if they become ill. Certain people can afford to purchase insurance but choose not to; if they become ill, they become a burden on the taxpayer.

The best way to eliminate the problem of adverse selection is to require everyone to have health insurance. Subsidies to purchase insurance can be provided to those with low incomes and to those who are high risk in relation to their income. Under mandatory health insurance, most people would be low risks when they purchase health insurance and would not wait until they were ill, and hence uninsurable. People would have health insurance when they needed it, and when insurance companies impose delay-of-benefit restrictions on new enrollees, those with preexisting conditions would remain with their current insurer until their medical conditions are treated.

**Preferred-Risk Selection**

Just as insurers want to protect themselves against high risks, they clearly prefer to insure individuals who are better-than-average risks. As long as different groups and individuals with varying degrees of risk pay the same premium, insurers have an incentive to seek out those who have lower-than-average risks. This is referred to as preferred-risk selection.

As shown in Table 7.1, 1 percent of the population incurs 30 percent of total health expenditures. (Fifty percent of this population are over the age of 65.) In 1963, 1 percent of the population incurred 17 percent of total expenditures, which indicates the effect that medical technology has on increasing medical expenditures. Five percent of the population incurs 58 percent of total expenditures. Given this high concentration of expenditures among a small percent of the population, an insurer can greatly increase its profits and avoid losses by avoiding the most costly patients. An insurer that is able to select enrollees among the 50 percent of the population that incurs only 3 percent of total expenditures will greatly profit. The only way to provide insurers with an incentive to take the high-risk, hence costly, patients is to provide insurers with risk-adjusted premiums (e.g., premiums for people in older age groups are higher than for those in younger age groups). Insurers would then have an incentive to minimize the cost of treating these patients, rather than searching for low-risk ones.

**Table 7.1. Distribution of Health Expenditures for the U.S. Population, by Magnitude of Expenditures, Selected Years 1928–1987**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 1 percent</td>
<td>—</td>
<td>17%</td>
<td>26%</td>
<td>27%</td>
<td>29%</td>
<td>30%</td>
</tr>
<tr>
<td>Top 2 percent</td>
<td>—</td>
<td>—</td>
<td>35%</td>
<td>38%</td>
<td>39%</td>
<td>41%</td>
</tr>
<tr>
<td>Top 5 percent</td>
<td>52%</td>
<td>43%</td>
<td>50%</td>
<td>55%</td>
<td>55%</td>
<td>58%</td>
</tr>
<tr>
<td>Top 10 percent</td>
<td>—</td>
<td>59%</td>
<td>66%</td>
<td>70%</td>
<td>70%</td>
<td>72%</td>
</tr>
<tr>
<td>Top 30 percent</td>
<td>93%</td>
<td>—</td>
<td>88%</td>
<td>90%</td>
<td>90%</td>
<td>91%</td>
</tr>
<tr>
<td>Top 50 percent</td>
<td>—</td>
<td>95%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
</tr>
<tr>
<td>Bottom 50 percent</td>
<td>5%</td>
<td>4%</td>
<td>3%</td>
<td>4%</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

Insurers attempt to enroll better-than-average risks several ways when the premium is the same for all risks. For example, if those enrolling in a particular HMO pay the same annual premium, the HMO would prefer those groups who have lower-than-average claims experience, are in low-risk industries, and are younger-than-average employees. To encourage younger subscribers, the HMO may emphasize services used by younger couples, such as prenatal and well-baby care. Emphasizing wellness and sports medicine programs also is likely to draw a healthier population. Similarly, if an HMO curtails its tertiary care facilities for heart disease and cancer treatment, this sends a message to those who are older and at higher risk for those illnesses. Locating its clinics and physicians in areas where lower-risk populations reside also results in a biased (i.e., favorable) selection of subscribers.

Those on Medicare can voluntarily join an HMO; if they change their minds, they can leave the HMO with one month's notice. When an HMO determines that a Medicare patient requires high-cost treatment, it may encourage the patient to disenroll by suggesting that he or she may benefit from more suitable treatment elsewhere for the condition. By eliminating these high-cost subscribers, an HMO can save a great deal of money. To discourage HMOs from using this approach to maintain only the most favorable Medicare risks, the one-month notice must be repealed, or the HMO must be held responsible for reimbursing the non-HMO providers when Medicare patients disenroll.

**Improving the Health Insurance Market**

Both adverse and preferred-risk selection, referred to as biased selection, are problems in the health insurance market. They occur because of differences in information on health status, consumer choice of health plans, and fixed premiums for subscribers whose expected medical expenses differ from the average cost per subscriber.

Several proposals have been made for improving the health insurance market. One is to require all insurers to community rate their subscribers. That is, charge all their subscribers the same premium, regardless of health status or other risk factors. The cost of higher-risk individuals would be spread among all subscribers. Community rating, however, provides insurers with even stronger incentives to select preferred risks. Additionally, with uniform premiums, regardless of risk status, insurers and employers no longer would have an incentive to encourage risk-reducing behavior among their subscribers and employees, such as providing smoking cessation and wellness programs. Thus, premiums for employee groups could not be reduced relative to other groups that do not invest in such cost-reducing behavior. Skydivers, motorcyclists, and other groups that engage in risky behavior are subsidized by those that attempt to lower their risks. Rather than reducing the cost of risky behavior, higher premiums for those who engage in higher-risk activities would provide them with an incentive to reduce such behavior, and to bear the full cost of their activities.

Community rating also has serious equity effects. A community-rated system benefits those who are at high risk and penalizes those who are at low risk. Those at lower risk pay higher premiums, and those at higher risk pay lower premiums, than under an experience-rated system. Those at higher risk are subsidized, in effect, by placing a tax on those who are lower risk. Because these “subsidies and taxes” are based on risk rather than income, low-risk individuals who also have low incomes will end up subsidizing higher-risk, higher-income people. Not all high risks are poor and not all low risks are wealthy.

A second, preferable, proposal to improve the health insurance market is to require insurers to offer guaranteed renewability within standard “rate bands”: upon renewal, premium increases can vary from the average increase in premiums only by plus or minus 20 percent. These proposals would make insurers sell “real” insurance. People buy insurance to decrease uncertainty. If they become ill and the insurer does not renew their insurance or charges them a very high premium, their initial purchase of insurance has not decreased their uncertainty. Unless individuals are able to renew their insurance, they will not be protected from a large, unexpected loss.

**Summary**

Both adverse and preferred-risk selection occur because individuals’ risk is not reflected in their premium. These selection problems would be minimized if premiums were related to risk group. Insurers would not need to reject high risks or search for low risks. In the case of adverse selection, the problem would be eliminated if individuals were required to have health insurance. Government regulations, such as the elimination of testing and mandating community rating for insurers, have indirect effects that may worsen equity, decrease risk-reducing employer behavior, and lead to offsetting actions by insurers.

Both adverse and preferred-risk selection affect subscribers and health insurers. To solve these problems, one must be aware of why biased selection occurs. Proposed solutions must be evaluated on the basis of
whether they encourage risk-reducing behavior, include incentives for efficient utilization of medical services, and impose a burden on those with low incomes who also may be low risk.

Health insurance reform must be directed toward eliminating uncertainty, which is what people want when they buy health insurance.

Note

1. These proposals are directed toward improving the health insurance market for small employee groups, assuming that these small groups can afford to purchase health insurance. Financing health services for the poor is discussed in later chapters, as are other aspects of health services reform, such as competitive medical systems and malpractice.

Reference


MEDICARE

In 1965, Congress enacted two different financing programs to cover two separate population groups—Medicare for the aged and Medicaid for the poor. As a result, the government’s role, particularly that of the federal government, in the financing of personal medical services increased dramatically. Currently, federal and state expenditures represent about 46 percent of total medical expenditures. Both Medicare and Medicaid have serious problems, however, Medicare’s impending financial deficits require substantial changes if the program is to survive and Medicaid must be improved if it is to serve more than one-half of those classified as poor. These two government programs are discussed in this and the following Chapter.

The Current State of Medicare

Medicare is a federal program that primarily serves the aged. People under age 65 who receive Social Security cash payments because they are disabled become eligible for Medicare after a two-year waiting period. People requiring kidney dialysis and kidney transplants, regardless of age, became eligible for Medicare in the early 1970s. As shown in Figure 8.1 Medicare covers 34 million aged and 5 million disabled beneficiaries. The number of aged covered by Medicare is expected to double over the next three decades.

Medicare comprises three parts—each offers different benefits and has a different financing mechanism. Part A provides Hospital Insurance (HI). Part B provides Supplemental Medical Insurance (SMI).