FORUM

Covering the Uninsured

Efforts to make health insurance more affordable need to address risk.

by KATHERINE SWARTZ

In any given month last year, 43 million Americans—17 percent of people under age 65—lacked either private health insurance or public coverage through Medicaid, Medicare, or the State Children's Health Insurance Program. During the entire year, closer to 60 million people were uninsured for at least a month. The flight of jobs overseas, especially manufacturing and other high-paying service jobs that have health insurance, and media coverage of employers who speak of reducing health benefits because of large increases in health-insurance premiums, are making tens of millions more people worry about losing coverage.

How to make health insurance more affordable and how to reduce the number of uninsured are two of *the* significant election issues this year. As political candidates offer strategies, it is important to judge whether these policies target the reasons people are uninsured. Prime among those reasons is the fact that it is riskier to sell insurance to individuals than it is to sell to groups of people—making premiums for individually purchased private insurance more expensive than group coverage (see "Pricing Advantages," page 38). Given our mixed system of private health insurance (whether purchased individually or as group policies sponsored by employers and unions) and the big public programs, any practicable solution must work in *both* realms. A solution is possible if the government assumes some of the risk involved in nongroup health insurance.

Lack of Affordability

In the broadest of terms, people who do not have health insurance cannot afford it. But this statement glosses over who the uninsured are and the two different reasons why they cannot afford coverage.

Most of the Uninsured Are Poor. Two-thirds of those uninsured in 2003 (the most recent year for which data are available) had incomes in 2002 that were below the U.S. median household income, then $42,400. Almost everyone in this income group who does have private health insurance has employer or union-sponsored group coverage. It is easy to understand that nongroup insurance premiums are simply not affordable for people with incomes below the median.

One option for providing access to group insurance for low-income people could be through their place of employment, underwritten by government assistance for small

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businesses or businesses with low profit margins that currently do not sponsor group coverage. Another option could involve federal-state programs that sponsor heavily subsidized health insurance, much like the State Children's Health Insurance Program. (SCHIP programs exist in every state and cover uninsured children under age 19 whose family incomes are low but too high to be eligible for Medicaid. The children's families pay a small part of the premium or copayments when they obtain medical care. As of June 2003, 3.9 million children were enrolled nationally. However, unlike Medicaid, the program is not an entitlement and state budget woes have caused a number of states to reduce their efforts to enroll or re-enroll children since last June.) A third possibility is permitting people to pay a small premium to enroll in Medicaid. Any of these will require government funds—an obvious problem in an era of government deficits—but the net *new* costs of these options may not be prohibitive: a recent study estimates that the uninsured received $35 billion of uncompensated care in 2001 that we all paid for via tax revenues and other fees. It is clear, however, that the uninsured who are poor cannot gain coverage without substantial government assistance both to create grouping options and to subsidize the premiums.

High-Cost Nongroup Insurance Is the Primary Option for Middle-Class Uninsured. People with middle-class incomes comprise the other one-third of the uninsured. Some would be counted among the poor uninsured if they did not live with relatives—for example, young adults with low salaries living with their parents, or unemployed middle-aged parents living with adult children; in such cases, the combined incomes of all adults put the household in the middle class. But a majority of the uninsured people with incomes above the median live in nuclear families. Why are they uninsured?

The primary explanation is that they do not have access to employer-sponsored insurance. They are self-employed, or their employers do not offer coverage at all, or they are not eligible for coverage (usually because they work part-time or are in temporary positions). But if these middle-class people do not have access to employer-group coverage, why don't more of them purchase nongroup insurance policies? Because, as noted, nongroup premiums are high relative to group premiums—and even with a family income above the median, many people cannot afford to pay $8,000 to $12,000 or more each year for single-person or family health coverage.

A closer look at the reasons for the high premiums reveals a subtler explanation for why anyone with a middle-class income would be uninsured: insurers that sell nongroup insurance need to avoid covering a disproportionate number of people who are more likely to use expensive medical care. Such an occurrence is known as "adverse selection." To minimize adverse selection, insurers do their best to avoid insuring too many high-risk people—those likely to have high medical expenses. The states regulate how nongroup insurers can compete. Not surprisingly, insurers employ every selection mechanism they are permitted to use in order to reduce their exposure to high-risk people—including charging high premiums.

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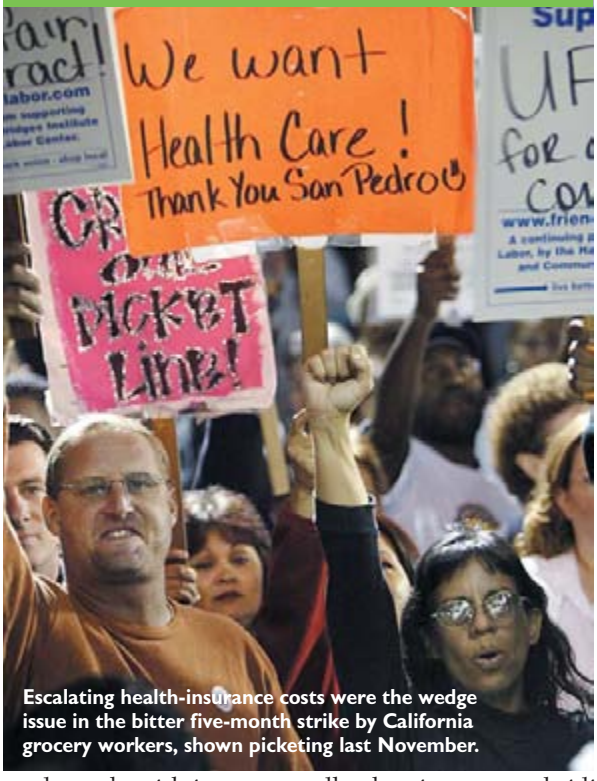

Escalating health-insurance costs were the wedge issue in the bitter five-month strike by California grocery workers, shown picketing last November.

Age and gender are the biggest demographic predictors of a person's probability of having high medical expenses. If the insurer can obtain the applicant's medical history as well, the ability to predict who is likely to have high expenses increases substantially. A large proportion of the nation's middle-class uninsured adults are over the age of 45, which makes insurers believe they are too risky to cover unless the premiums are high.

Reducing Insurer Risk

The high cost of nongroup health insurance cannot be resolved simply by offering subsidies (for example, tax credits) to middle-class people to purchase coverage. Subsidies might actually *exacerbate* the potential for adverse selection, because they would enable people who suspect they will need medical care in the near future to afford the higher-priced nongroup insurance. If such people have costly medical care in the year following enrollment, premiums for nongroup policies will rise—forcing many people covered by nongroup policies to drop their coverage. Subsidies are thus unlikely to reduce the number of uninsured individuals with middle-class incomes; subsidies will only alter who is covered by nongroup insurance and who is not.

What is needed instead is a public policy that addresses the primary reason that premiums for nongroup insurance are so high: the greater risk posed for insurers by insuring individuals. Because a major source of that risk is the potential for adverse selection, we need a new strategy. One possibility would be to make the government the *reinsurer* for nongroup health insurance policies—and thereby take over most of the medical expenses of a small number of people who incur extremely high costs in each year.

Reinsurance is insurance purchased by insurers or large corporations that wish to limit their own exposure to some risk. Health insurers typically purchase reinsurance to protect themselves from either of two possibilities: that the costs per person

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could exceed some threshold level, or the aggregate costs of all the people covered by a policy exceed some level. The companies or groups of investors who sell reinsurance charge a premium to take on the risks that expenses could be greater than expected. Rarely, however, does the reinsurer assume all of the risk. Typically, the original insurer retains responsibility for 10 percent or more of the costs if they exceed the threshold level. In the case of health, this arrangement forces the original insurer to manage the healthcare provided to very sick people.

If the federal government were to be the reinsurer for nongroup health insurance, premiums for such coverage would fall because insurers would not face all of the risk of paying claims for extremely high-cost people. Based on data from the 1996-97 federal Medical Expenditure Panel Survey, people whose total medical bills are in the top 1 percent of the U.S. population's medical expenditure distribution are responsible for about 28 percent of the country's total medical costs. People in the top 2 percent—the 98th and 99th percentiles—are responsible for about 39 percent of all medical expenses. To be in the 99th percentile in 1997 (the most recent year for which such an estimate exists), a person had to have medical expenses above $27,914.

If the federal government were responsible for most of the medical expenses of people whose costs exceeded some level—say $50,000—the risk involved in insuring people via nongroup policies would effectively be shifted to the general population. Using general revenues or revenues from a dedicated tax, the government could pay for 90 percent of expenses above $50,000, for example. Premiums for the insurance-buying public would be substantially lower as a result. (The details of the threshold level and the percent of the costs to be paid by the federal government would need to be estimated with a sophisticated simulation model. To my knowledge, this has not been done; such an effort would require a well-funded research effort by a non-partisan research organization or the Congressional Budget Office.)

The general principle of the federal government taking on risk and providing reinsurance so that markets can function is not new. The National Flood Insurance Program and, most recently, the Terrorism Risk Insurance Act of 2002, are visible examples of government programs that enable the markets for liability insurance and catastrophe reinsurance to operate—and permit people who own water-view property or are constructing tall buildings to purchase policies at reasonable rates. Similarly, because the federal government is the guarantor of the worst risks in the mortgage market, the secondary mortgage market thrives and provides more capital for loans so more Americans own their homes. Government-provided reinsurance for insurers is a central feature of New York State's Healthy New York Program, which started in 2001. The state uses some of its tobacco settlement funds to pay 90 percent of healthcare costs between $5,000 and $75,000 for anyone enrolled who has costs above $5,000. In exchange, the managed-care plans in New York set premiums for the Healthy New York (HNY) policy that are about half what the standard nongroup policies sell for. HNY is for low-income people and so far has only about 50,000 enrollees, in part because there was relatively modest publicity about it until recently and premiums are still relatively high for its targeted audience.

Framing Choices

Strategies to make health insurance more affordable and reduce the number of uninsured will succeed only if they target the reasons people are uninsured. In particular, strategies need to address the reason why risks are so much larger for insurers selling nongroup coverage than group insurance. If these risks can be substantially reduced by government policies, then nongroup insurance might be an option for many people who do not have employer-group coverage and currently cannot obtain or afford nongroup policies. The choice of which public policies to implement to reduce the uninsured numbers is ultimately a political decision, but the framing of the choices needs to focus on the different underlying factors that cause different groups of people to be uninsured. ▽

Pricing Advantages

A majority (70 percent) of nonelderly people with private health insurance obtain such coverage through their employers or union-sponsored groups. Another 6 to 8 percent of the nonelderly purchase coverage on their own; such nongroup insurance costs significantly more than group coverage, but is the only option for people without access to employer-sponsored coverage. As anyone who has tried to buy nongroup insurance knows, its premiums provoke sticker-shock. Depending on the state in which one lives and the type of policy chosen, premiums for a single-person policy range between $100 per month for someone young and healthy to more than $1,000 per month for those older than 50.

Group health insurance, especially group coverage sponsored by a large employer, has three major advantages that tend to keep premiums more affordable.

- First, there are economies of scale—administrative services, marketing, and advertising can be provided more efficiently (that is, at less cost per person) to a large group than to a small group or to individuals.
- Second, a large group of people is far less risky to insure than a single individual because average expenditures for a group are easier to predict than one individual's expenditures.
- Third, group coverage generally does not suffer from "adverse selection"—the situation that occurs when less healthy people who suspect they will need medical care are more likely than other individuals to purchase insurance. Almost everyone in a large employer group who is offered health insurance enrolls in the policy. In contrast, adverse selection is a significant concern for insurers that sell health insurance to people who are not members of employer groups. That means individuals have to be quite determined to obtain health insurance outside an employment context—creating the potential that predominantly sicker or less healthy people will apply for nongroup coverage and further increasing the risk for insurers that actual expenses will exceed expected expenses.

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