## Time and the Uninsurable: A Curious Connection

We have saved what is often considered the greatest challenge for last: the uninsurable. A *high-risk (high-cost)* individual is one whose expected future payouts are high relative to those of others. An *uninsurable* individual is one whose future payouts are certain, or virtually certain. A *high-needs* individual is one whose expected future out-of-pocket payouts are high relative to his or her ability to pay. Often, all three descriptions apply to a single individual.

Uninsurability and time are intimately tied in a way that can best be explained by considering a hypothetical person's experience from birth onward. From the birth vantage point, all of us start life alike, with sex an obvious difference. The few who could be meaningfully distinguished and identified before the moment of birth for significantly higher than average lifetime health spending prospects are rare enough that they can be ignored for purposes of the discussion here. Thus, all of us start life in a common risk pool identified by our age (here, zero year), sex, and geographic location of residence. All three determine expected payouts but are not the result of risky, harmful medical events that have already occurred.

The medical risks we face from birth onward relate to health incidents that might need to be treated in the coming insurance period (typically a year) but do not change our risk prospects thereafter, and they relate to the different risk that in the coming insurance period we might permanently enter a higher medical risk state that reclassifies us into a group that requires a lifetime of future higher medical costs. This "reclassification risk" is different from the risk of experiencing a medical event that requires care in the coming insurance period but leaves us thereafter with the same future health prospects as others for the succeeding period. At any moment in time, an individual therefore needs *two* insurance policies, one against each type of risk. Public discussion of health insurance frequently fails to explain this important distinction. How would the two kinds of health insurance work?

To see, consider a large group of male babies born at the same place on the same day. They each pay the same for a reclassification-risk insurance policy (call this policy *A*) and a standard health insurance policy (policy *B*). Policy *A* promises to pay the increase in policy *B* premiums at policy *B*'s renewal time, should the holder become reclassified during the coming year. A year passes. Some babies are treated for health events on their *B* policies and others not. In addition, some babies experience medical events that reclassify them as "group 2" boys for the second year, meaning that their expenditures for the second year are expected to be two times the average

for boys of their age. The reclassified boys should expect to pay more for their *B* health insurance in the second year, but, from their *A* policies they will receive payouts that exactly offset the higher *B* policy premiums. The net effect is that all boys, regardless of experience in the first year, pay the same total in premiums for their *A* and *B* policies that cover the second year. In fact, carrying policies *A* and *B* from birth onward *through all subsequent years of life* would imply paying the same net premiums annually as anyone else of the same age, sex, and location of residence. Guaranteed renewability of insurance at standard rates leads to the same outcome. We therefore need to consider the effects of guaranteed renewability, and why it should be a required feature of health insurance.

Presuming you have health insurance coverage of both types from birth onward, you would be covered against short-term medical risks, *and* against a change in your risk classification. Were you to have to pay a higher net total for your policies *A* and *B* in the following year, it would imply that your insurance company had reneged on its commitment. However, an insurance company cannot legally refuse to honor its obligations with respect to a covered condition once the condition has occurred. Thus, if insurance companies honor their contract, an insured population would consist of individuals who progress through life paying the same health insurance premiums as anyone else of their age, sex, and geographic location of residence. (To this list, we might add certain relevant lifestyle choices such as smoking that add to risk if they are administratively feasible and verifable.) Mandating guaranteed renewability as an insurance feature is equivalent to mandating that insurance companies honor their reclassification risk policy contracts. It implies that no one would find himself or herself paying more for insurance coverage by reason of reclassification because "reclassification" is a covered medical event.[11] Uninsurable and high-needs individuals disappear as a concern because, while there may be high-risk, high-cost individuals, they will be paying the same premiums for insurance as everyone else their age, sex, and geographic location of residence.

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[11] "If a plan guarantees to everybody a premium that corresponds to total experience but not to experience as it might be segregated by small subgroups, everybody is, in effect, insured against a change in his basic state of health which would lead to a reclassification." Arrow, 1963, p. 964.

It is important to distinguish the effects of experience rating in the presence of reclassification risk insurance where risk pools are distinguished by age, sex, and location of residence from the operation of community rating, where different age groups and sexes may be lumped together. Community rating charges all members of the community, even those in different age and sex pools, the same premiums regardless of risk. The result is that some individuals receive benefits that they did not pay for on an actuarial basis and others make payments for which they receive no benefits.

Experience-rated insurance plus reclassification risk insurance, on the other hand, starts from a situation of homogeneous risk pools of indistinguishable individuals. All individuals are charged identical premiums because they have actuarially equal expectation of future benefit payouts. With the passage of time, some individuals are reclassified, but they begin receiving income transfers equal to their higher actuarially expected benefit payouts, appropriately leaving them to pay the same (out-of-pocket) premiums in future years as others of their age, sex, and location of residence. Individuals receiving payouts on their reclassification risk policies are not receiving charity because they have paid for their benefits on an actuarially fair basis by past premiums. In a normal life cycle, we expect actuarially fair insurance costs to vary through life. Guaranteed renewability as described earlier honors this variation and leads to actuarially fair premiums. Community rating, on the other hand, ignores this variation and leads to deviation from actuarially fair insurance premiums.

When private insurance was a prominent part of the American health insurance market, 80 percent of private policies included a guaranteed renewability feature that required insurers to renew policies at standard premiums regardless of future medical status.[12] Reclassification risk is now a looming problem in American health care. The solution is to require guaranteed renewability at standard premiums, just as we legally require insurance companies to pay on claims for covered conditions once they occur. After the health insurance market is rationalized by this change, everyone will have the ability to buy insurance rated for his or her age, sex, and location of residence. Risk adjustment by itself is no longer a problem if everyone has insurance coverage from birth that includes reclassification risk coverage. In fact, efficiency *requires* that premiums reflect the demographics (age, sex, and location) of the individuals who are a part of the

[12] "Federal law now requires states to ensure guaranteed renewability for individual (but not group) insurance policies. But even before the spread of such state laws, industry observers estimated that about 80 percent of policies voluntarily (on the parts of both buyers and sellers) contained such provisions (Pauly, Percy, and Herring, 1999)." Pauly, 2004, p. 8.

risk pool. It will still be the case that *high-needs* individuals may be present, but dealing with high-needs individuals is a separate problem that can be handled separately from the problem of *uninsurable* individuals. We discuss in Chapter 8 how to resolve the problems of high-needs individuals without impairing the effectiveness of the insurance market. They include (1) the problem of individuals whose premium payments exceed their ability to pay, (2) the problem of transitioning from our current system to one with efficient insurance, and (3) the problem of how people can move back and forth among plans.

### 7.3. Summary and Evaluative Discussion

Americans rely on a health insurance system that would never have been deliberately created. Health insurance began as a means of providing a predictable revenue stream for hospitals. Employers used it to attract and retain workers during times of labor shortage. Ultimately, an employer-based system became the dominant way most Americans received coverage because of political decisions to grant special tax subsidies, amounting to over $200 billion in 2004, or approximately $1,400 for every member of the work-force.[13]

Conventional coverage, the kind that most insured Americans have, does not make much economic sense at all. The income tax subsidy encourages the system to provide more insurance than rational risk aversion would prescribe. Coupled with the employer contribution (on average, about 75 percent of the premium), the arrangement creates the illusion that insurance is less expensive than it actually is. Most workers would be better off if their pay were not reduced because of their employer's contributions and they were free to choose coverage in a competitive insurance market on an equal tax basis, accessing market experts that would be better informed than many of their employers now are. By collecting premiums for the expense of routine medical bills, conventional insurance forces excess spending. Many find insurance unaffordable and its purchase a poor use of money.

The employer-based insurance system has other unintended consequences. There is evidence that it reduces labor mobility[14] and crowds out other pooling arrangements that do not qualify for the employer-based subsidy. Interestingly, the arrangement does provide a partial way of dealing with reclassification risk. Premiums in employer-based systems tend to rise with the age of the insured, but not in proportion to the rise in

[13] Sheils and Haught, 2004.
[14] Gruber, 2000; Adams, 2004.