January 27, 2003

Shannon:

Your article in the most recent issue of *The Atlantic*, "The Overtreated American", is the most recent in a long series of articles agonizing over what we can and should do to make health care available and affordable for all of our citizens. I have some comments and what I think is the answer to the problem.

You write about the "uninsured" and "health insurance". It is critical that we recognize that virtually nobody has health "insurance". Insurance is a contractual arrangement in which one party – the insurer – accepts a contingent, non-quantified financial risk in any amount up to the limit specified in the policy in exchange for a fixed payment – the premium – paid by the insured (an individual or, perhaps, an employer on behalf of its employees). Insurance, therefore, involves a transfer of financial risk. The amount of the premium, of course, is based on an actuarial analysis of likelihood and magnitude of the risk to be covered.

In the context of providing assurance of payment for health expenses, the likelihood of claims and the minimum (let alone the potential maximum) cost is so high that premiums become unrealistic very quickly. Put another way, the minimum premium has to be at least the minimum amount of health care expenses that will be incurred by the insured during the policy period. Since these expenses are, as a practical matter, more of a certainty than a contingency (virtually every insured will have some health care expense), the insurer is basically betting with the insured as to the amount of an essentially known claim. (Note that this analysis is vastly different for other types of insurance where potential claims are truly contingent and the cost of actual claims can be spread over a large number of insureds. Not everybody has an auto accident or a house fire, and the expenses of those who do can be shared with those who do not.)

Since the information available to the insurer is imperfect, the insurer will be conservative and over-price the risk. Certainly the insured – who has better information than the insurer, although this information is still imperfect – will perceive the premium as excessive (particularly since the premium is essentially an estimate of the amount of the loss that the insured is paying in advance). So, for most insureds, the benefit of transferring to the insurer risk of expenses significantly greater than the premium amount is not worth the cost – the amount by which the insurer's estimate of likely cost (the premium) exceeds that of the insured.

Notice that there is no mention of profit for the insurer in the discussion of premium. This is because, with rare exceptions, insurers in a competitive market are not able to realize an underwriting profit. Commonly, costs of paying claims exceed premium income by a slight amount. Insurance companies make money from earnings on invested premiums.

Individuals who desire health care coverage might as well pay out-of-pocket rather than pay the cost of risk transfer. Employers find this to be the case as well. So, that is what they do. The role of insurance companies in the health industry is not to accept transfer of the risks of health care expenses, but to serve as agents of employers, unions, private associations and other large groups of beneficiaries in administering claims. The health care benefit provider (employer, union, etc.)

reimburses the insurance company for actual costs plus an administrative fee. The insurance company's profits come from the administrative fee.

The benefits for the health care benefit provider are health care costs that, even including the administrative fee, are lower than the costs that would be incurred by the health care benefit provided paying directly because of the expertise of the insurance company in claims handling and volume discounts that the insurance company is able to negotiate on behalf of all of its customers. [One clarification: True risk transfer insurance is available at very high levels, and employers commonly purchase so-called "stop loss" policies to protect them from catastrophic losses. Such policies might, for example, cover claims by an individual in excess of $250,000 or aggregate claims of all employees in excess of $2,000,000.]

There is one risk that the insurance companies providing health care benefit services take on and that is credit risk, the risk of the insolvency of the health care benefit provider. In the case of employers, this risk is backstopped by the government under ERISA.

As for individuals or small employers, "insurance" is simply unavailable. They need true risk transfer, which simply is not possible for risks (like health care) that essentially are not contingent. The premium in such cases must be an amount in excess of what the costs of claims are certain to be, plus an amount for uncertainty.

Employees need to realize that their health care expenses are being paid dollar for dollar by their employers and that there is no "Daddy Warbucks" insurance company paying in exchange for fixed premiums.

The continued references to "insurance" and the lack of understanding by the insured that there is no "insurance" contributes significantly to the problem of excess utilization and lack of correlation between cost and outcome that you identify in your article.

But the real problem is a basic economic phenomenon known as the "tragedy of the commons". Neither providers nor consumers of health care have any direct interest in the cost (Just as, in Colonial Williamsburg, no citizen with sheep to graze had any direct interest in the cost of maintaining the town commons, so they were always overgrazed.). Employee consumers pay "co-pays" and "premiums", both in fixed amounts. Their incentive is to maximize the benefits they receive in exchange for these amounts, not to minimize expense to the "insurance" company (really, the employer). Every employee has an incentive to maximize the use of the available resources without regard to ultimate cost. So, additional supply will inevitably lead to additional demand.

There is nothing that government policy-making can do about this problem that will not lead to rationing or other adverse, unintended consequences.

The answer to the problem requires an understanding of how we got into this mess in the first place. Health insurance and other "perks" were industry's response to wage and price controls enacted during World War II. Unable to compete for employees by offering better wages, employers instead offered "benefits".

Initially, doctors feared health insurance and refused to accept assignment of benefits. Consumers had to pay the health care provider and then seek

reimbursement from the insurance company. This provided some check on cost as providers could not charge amounts that consumers had inadequate liquidity to pay, and consumers bore the risk that their claims for reimbursement would be denied as excessive. Eventually, health care providers realized that if they accepted assignment of benefits their charges would not be limited by consumer liquidity. Once assignment of benefits became common, the consumer no longer had any real interest in the cost of health care.

The IRS has exacerbated this problem by allowing employers to deduct the cost of health care benefits without requiring that the consumers include those costs in taxable income.

The answer to the problem, then, is simple. Health care benefits should be taxable to the consumer. To avoid obvious hardship in cases of serious illness, amounts of benefits in excess of 7.5% of income could be excluded, just as costs in excess of 7.5% of income are currently deductible. The cost to a low-income worker with a low marginal tax rate would be nominal (as would their incentives to keep costs down). But, there are enough people with higher levels of income with marginal rates of 20% or more who would begin to care about health care cost. Moreover, accepting as accurate your report of $1.2 trillion in annual health care expense, the revenue gain to the Treasury would be substantial, probably enough to provide health care coverage to those who do not currently have it and, perhaps, to help "save Social Security" as well.

The problem, of course, is that this proposal is politically untenable, at least currently. Since consumers now have essentially no interest in containing health care cost, any proposal that would impose such an interest on them will be unacceptable.

Regards,

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