Statement
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Oversight and Government Reform Committee

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"Between You and Your Doctor: the Private Health Insurance Bureaucracy"

Mr. Chairman, members of the subcommittee, thank you for this opportunity to present my perspective on providing secure health insurance to American consumers.

The Marvel of Voluntary Health Insurance Markets

Every year in the United States, thousands upon thousands of Americans walk or are carried into hospitals. Some are in extreme pain. Some are close to death. Using the tools of modern medicine, doctors routinely heal their pain and save their lives.

No less marvelous, however, is the fact that the bill is often paid, voluntarily, by complete strangers. These benefactors do not know the patient. They do not know her illness. They may not practice the same religion or speak the same language. Were they to meet the patient, they might not even like her. And yet, without anyone pressuring or forcing them to do so, these people repeatedly purchase lifesaving medical care for complete strangers. Indeed, they play a role every bit as important as the doctors and hospitals. By some marvel, this wonderful phenomenon occurs every day in the United States.

That marvel is health insurance. When individuals choose to purchase health insurance, they make an agreement to pay for the medical expenses of those in the insurance pool who become sick or injured. They uphold that agreement by paying a periodic premium to an insurance company. To be sure, it is not compassion for others but self-interest that motivates most insurance purchasers: each wants to have her own medical bills paid in the event of a catastrophe. Yet that only makes health insurance all the more marvelous. Health insurance harnesses the self-interest of millions of strangers to produce an unquestionably compassionate result.

Of course, such generosity inevitably invites opportunistic behavior. If the insurance pool paid for all their medical care, some patients would consume more medical care than they need. And why not – those other people in the pool are just strangers. Health care providers could try to sell those patients more medical care than they need. If individuals can tap the pool members' generosity whenever they chose, many would not contribute to the pool until they became sick. By the time they join the pool, their medical expenses would well exceed their contributions. Before long, premiums would spiral out of control, and no one would want to participate. For these reasons, members of the insurance pool hire someone to protect them from opportunistic behavior.

Health insurance companies are essentially intermediaries between members of the pool. Insurers charge higher premiums to enrollees who purchase more extensive coverage, because those members will draw more money from the pool. Insurers require members to pay part of the cost of their own medical care (through deductibles, coinsurance, and copayments) to ensure that members aren't careless with other members' money. Insurers look over physicians' shoulders (with managed-care tools like capitation payment, preauthorization, and utilization review) to ensure physicians are being careful with their members' money. Insurers also calibrate each new member's premium to her expected claims. If an individual waits until she is sick to join the pool, her premiums will therefore be much higher than if she joined while healthy. Risk-based premiums thus *promote* compassionate behavior, because they encourage individuals to contribute to the pool while they are still healthy—so their premiums can help save the lives of strangers. Once in the pool, however, insurers don't increase members' premiums when they become ill.

Insurers compete and innovate to see who can best manage these features, and provide members the protection they desire at the lowest possible premium. That competition is the market's way of navigating what economists call "the Samaritan's dilemma," or the human tendency to take advantage of other people's compassion.[2]

Do Health Insurance Markets Fail?

Critics claim that unregulated insurance markets do not provide secure access to medical care; that risk-based premiums are unfair; that insurance companies drop people when they get sick; that markets will not provide health insurance to everyone; and that government must create pooling arrangements that correct these alleged market failures.

Evaluating the performance of unregulated health insurance markets is complicated by the fact that most Americans obtain health insurance in markets heavily regulated or distorted by government.

- Nearly all seniors obtain health insurance from government through the federal Medicare program.[3]

- Due to large tax preferences for employer-sponsored insurance, about 90 percent of nonelderly Americans with health insurance obtain it through an employer.[4]

- Only 10 percent of the nonelderly insured (about 16 million people) obtain insurance directly from an insurance company, i.e., through the "individual" market.

In addition, many states impose significant regulations on their individual health insurance markets. Even if a state does not, administrative costs and premiums in that market will be higher than necessary because government diverts most consumers into the employment-based market.

Researchers examining America's badly hampered individual health insurance markets nevertheless have found considerable evidence that unregulated markets provide consumers with reliable long-term protection from the cost of illness. For example, University of Pennsylvania economist Mark Pauly and colleagues find:

- "Actual premiums paid for individual insurance are much less than proportional to risk, and risk levels have a small effect on obtaining coverage."[5]

- "Premiums do rise with risk, but the increase in premiums is only about 15 percent of the increase in risk. Premiums for individual insurance vary widely, but that variation is not very strongly related to the level of risk."[6]

- "Guaranteed renewable" policies, which are intended to protect against premium increases if the enrollee becomes sick, "appear to be effective in providing protection against reclassification risks in individual health insurance markets."[7] The vast majority of insurance products (75 percent) provided guaranteed renewability before they were required to do so by government.[8]

- High-cost individuals who are covered by small employers are nearly twice as likely to end up uninsured as high-cost individuals covered in the individual market.[9]

- "On average, guaranteed renewability works in practice as it should in theory and provides a substantial amount of protection against high premiums to those high-risk individuals who bought insurance before their risk levels changed. The implication is that, although there are some anecdotes about individual insurers trying to avoid covering people who become high risk (for example, by canceling coverage for a whole class of purchasers), the data on actual premium-risk relationships strongly suggest that such attempts to limit risk pooling are the exception rather than the rule."[10]

Similarly, RAND economist Susan Marquis and colleagues find that the individual market protects enrollees with expensive conditions and that risk-based premiums are not as harsh as critics imply:

- "Purchasers derive value from having the range of choices that the individual market offers."[11]

- In the individual market, "a large number of people with health problems do obtain coverage."[12]

- "We also find that there is substantial pooling in the individual market and that it increases over time because people who become sick can continue coverage without new underwriting."[13]

- Regarding enrollees who purchase insurance and later become sick, "in practice they are not placed in a new underwriting class."[14]

- "Our analysis confirms earlier studies' findings that there is considerable risk pooling in the individual market and that high risks are not charged premiums that fully reflect their higher risk."[15]

Recent experience in California shows that insurance companies will sometimes rescind coverage when enrollees provide inaccurate information about pre-existing conditions—and perhaps even when enrollees have not done so. California insurers have since reinstated coverage for many enrollees, often under the threat of breach-of-contract suits. As one California attorney told *The Washington Post*, "These cases are very, very good in front of a jury…I wish I could tell you the amount of money they throw at us just to make it go away and keep quiet."[16]

That episode demonstrates that government enforcement of insurance contracts can prevent individuals from defrauding strangers and prevent insurers from breaching their commitments to care for the sick; that media scrutiny is an important market mechanism; and that both types of consumer protection can spur insurers to change their behavior. All told, free markets provide considerably better health coverage than critics suggest.

Should Markets Provide Universal Coverage?

Critics are correct that markets will not provide health insurance to everyone. Voluntary insurance pools often will not cover medical conditions that are known to exist at the time an individual enrolls.

Health insurance markets are completely justified in not covering pre-existing conditions – and it is crucial that government not force them to do so. Were government to force insurers to cover pre-existing conditions, few would purchase insurance until

they had an expensive medical condition, and the pool would unravel. Thus, there is a very good reason why markets will not deliver universal coverage.

That still leaves a problem. Risk-based premiums will encourage most people to purchase insurance before they become ill. Yet there will always be some people who either did not join a pool while they were still healthy or never had the opportunity because they are indigent or because their high-cost condition has been with them since birth.

Assuming they cannot afford medical care, individuals with expensive pre-existing conditions require *subsidies*, which is not to say they need *insurance*. Insurance is merely one way—and a very expensive way—of subsidizing pre-existing conditions. More than other types of subsidies, insurance resembles a blank check. In general, strangers do not voluntarily give blank checks to other strangers, again with good reason: strangers are difficult to monitor, and the beneficiaries (encouraged by their health care providers) may take more than they need. Other ways of subsidizing the needy include limited amounts of cash, vouchers, or in-kind subsidies from providers, private charities, or government. Compared with the alternatives, the added costs of subsidizing pre-existing conditions with insurance outweigh the added benefits.

Exclusions for pre-existing conditions do not indicate a lack of compassion by insurance companies or consumers. They are the consumers' way of telling us that consumers do not want to subsidize people with pre-existing conditions *through insurance*. They do not preclude other options for subsidizing the needy, both public and private.[17]

Does Compulsion Improve the Picture?

Introducing compulsion into the mix disrupts the market process and thereby reduces the ability of consumers to meet each others' needs. Congress is currently considering the introduction of three principal forms of compulsion into health insurance markets: imposing price controls on health insurance premiums; making health insurance compulsory for most or all U.S. residents; and compelling taxpayers to fund, at a minimum, the start-up costs of a new government-run health insurance scheme.

Price Controls

Compelling insurers to charge all consumers the same premium is a form of price control. According to National Economic Council chairman Larry Summers, "Price and exchange controls inevitably create harmful economic distortions. Both the distortions and the economic damage get worse with time."[18]

In a free market, insurers innovate and compete to provide high-quality health insurance to everyone at the lowest possible price. If Congress demands that insurers sell $50,000 policies and $5,000 policies for $10,000, however, insurers will compete to

attract only those customers that represent a $5,000 profit and to avoid customers that represent a $40,000 loss.

Congress cannot police the thousands of subtle ways that insurers would respond to price controls by courting the healthy and avoiding the sick. Health economist Alain Enthoven notes: "A good way to avoid enrolling diabetics is to have no endocrinologists on staff in the county. A good way to avoid cancer patients is to have a poor oncology department."[19]

Price controls punish insurers who provide quality coverage to the sick. In 2008, an Aetna plan in the price-controlled Federal Employees Health Benefits Program dropped coverage for the 12-hour-a-day nursing care on which spinal muscular dystrophy patients like 11-year-old Shelby Rogers depend. An Aetna spokesman explained the company dropped the benefit because other insurers do not offer it, which caused the $50,000 patients to gravitate to Aetna's plan.[20]

In the end, price controls will eliminate the plans that sick people find most attractive. President Obama's economic advisor David Cutler finds that the price controls in Harvard University's health insurance exchange reduced choice by eliminating comprehensive insurance.[21]

Compulsory Health Insurance

The $5,000 of profit that insurers would receive from low-cost patients is in fact a $5,000 tax on the healthy. To prevent the healthy from avoiding that tax, President Obama and others propose to make health insurance compulsory for most or all Americans, either through an "individual mandate," an "employer mandate," or both.[22]

The Massachusetts experience demonstrates that at a national level, compulsory health insurance would effectively prohibit low-cost health plans and force tens of millions of already insured Americans to purchase more expensive coverage.

Massachusetts belies the claim that making health insurance compulsory will bring down health care costs. Federal, state, and private-sector health care spending have all increased under compulsory health insurance. Private health insurance premiums are growing 21 percent to 46 percent faster than the national average.[23] A report funded by the BlueCross BlueShield Foundation of Massachusetts indicates that overall public and private spending on health insurance has grown 66 percent faster than it would have otherwise.[24]

In 2009, Massachusetts' compulsory health insurance scheme covered previously uninsured families of four at a cost of at least $20,000, which is 50 percent greater than the nationwide average cost of employer-sponsored family coverage.[25] That estimate should be considered conservative, because it does not include the cost of the additional coverage that Massachusetts requires already insured residents to purchase. It is even more exorbitant considering that 86 percent of uninsured Massachusetts adults were in

"good, very good, or excellent" health[26] and therefore should have cost *less* to insure than the average person.

Summers writes, "If policymakers fail to recognize the costs of mandated benefits because they do not appear in the government budget, then mandated benefit programs could lead to excessive spending on social programs."[27] Massachusetts offers a perfect illustration.

Finally, compelling Americans to purchase private insurance would give incumbent insurers a guaranteed customer base and would protect incumbent insurers from competition by standardizing product design.

Government Programs

Congress is also contemplating a new government health insurance program as an option for some or all U.S. residents under the age of 65. For my thoughts on those proposals, I refer the committee to the attached study I recently authored for the Cato Institute.[28]

To the argument I make in that study, I would merely add: It can be difficult to make private insurers to keep their commitments to provide care to the sick. Yet making government honor its commitments to the sick may be more difficult, because government wields the sole, legal, and unilateral power to breach its commitments without compensating those it harms.[29]

Conclusion

Whatever our disagreements about government health insurance programs, however, I hope we can agree that private insurers do not deserve the sort of massive bailout represented by proposals to make private health insurance compulsory.

Thank you for holding this important hearing. I look forward to discussing with the subcommittee how to provide secure health insurance to American consumers.

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[2] See, for example, Michael F. Cannon, "Medicaid and SCHIP," *Cato Handbook for Policymakers*, 7th edition, chp. 13, p. 133, http://www.cato.org/pubs/handbook/hb111/hb111-13.pdf.

[3] See Michael F. Cannon, "Medicare," *Cato Handbook for Policymakers*, 7th edition, chp. 12, p. 125, http://www.cato.org/pubs/handbook/hb111/hb111-12.pdf.

[4] See Michael F. Cannon, "Large Health Savings Accounts: A Step toward Tax Neutrality for Health Care," Forum for Health Economics & Policy, Vol. 11, issue 2 (Health Care Reform), Article 3 (2008), http://www.bepress.com/fhep/11/2/3/.

[5] Mark V. Pauly and Bradley Herring, "Risk Pooling and Regulation: Policy and Reality in Today's Individual Health Insurance Market," *Health Affairs* 26, no. 3 (May/June 2007): 770–79, http://content.healthaffairs.org/cgi/content/abstract/26/3/770.

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[7] Bradley Herring and Mark V. Pauly, "Incentive-Compatible Guaranteed Renewable Health Insurance Premiums," *Journal of Health Economics*, vol. 25, no. 3, May 2006, pp. 395-417.

[8] Mark Pauly and Bradley Herring, *Pooling Health Insurance Risks* (Washington: American Enterprise Institute, 1999), p. 18.

[9] Mark V. Pauly and Robert D. Lieberthal, "How Risky Is Individual Health Insurance?" *Health Affairs* Web Exclusive, May 6, 2008, http://content.healthaffairs.org/cgi/reprint/hlthaff.27.3.w242v1.pdf.

[10] Mark V. Pauly, "How Private Health Insurance Pools Risk," NBER Reporter Research Summary, Summer 2005, http://www.nber.org/reporter/summer05/pauly.html.

[11] M. Susan Marquis et al., "Consumer Decision Making In The Individual Health Insurance Market," *Health Affairs* Web Exclusive, 25, no. 3 (May 2, 2006): w226-w234, http://content.healthaffairs.org/cgi/reprint/25/3/w226.pdf.

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[13] M. Susan Marquis et al., "Consumer Decision Making In The Individual Health Insurance Market," *Health Affairs* Web Exclusive, 25, no. 3 (May 2, 2006): w226-w234, http://content.healthaffairs.org/cgi/reprint/25/3/w226.pdf.

[14] M. Susan Marquis et al., "Consumer Decision Making In The Individual Health Insurance Market," *Health Affairs* Web Exclusive, 25, no. 3 (May 2, 2006): w226-w234, http://content.healthaffairs.org/cgi/reprint/25/3/w226.pdf.

[15] M. Susan Marquis et al., "Consumer Decision Making In The Individual Health Insurance Market," *Health Affairs* Web Exclusive, 25, no. 3 (May 2, 2006): w226-w234, http://content.healthaffairs.org/cgi/reprint/25/3/w226.pdf.

[16] Karl Vick, "When Your Insurer Says You're No Longer Covered," *Washington Post*, September 8, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/09/07/AR2009090702455.html.

[17] See Michael F. Cannon, "Medicaid and SCHIP," *Cato Handbook for Policymakers*, 7th edition, chp. 13, p. 133, http://www.cato.org/pubs/handbook/hb111/hb111-13.pdf.

[18] U.S. Department of the Treasury, "No Short-cuts to Development," remarks by Lawrence H. Summers Deputy Secretary of the Treasury To the IDB Conference on Development Thinking and Practice, September 4, 1996, http://www.ustreas.gov/press/releases/rr1247.htm.

[19] Alain Enthoven, "The History and Principles of Managed Competition," *Health Affairs* 12, supplemental (1993): 35, http://content.healthaffairs.org/cgi/reprint/12/suppl_1/24.pdf.

[20] Joe Davidson, "Caught by a Change in Health Care," *The Washington Post*, November 27, 2008, http://www.washingtonpost.com/wp-dyn/content/article/2008/11/26/AR2008112604131.html.

[21] See Thomas C. Buchmueller, "Consumer Demand for Health Insurance," *NBER Reporter*, Summer 2006, http://www.nber.org/reporter/summer06/buchmueller.html.

[22] In his recent address to Congress on health care reform, President Obama said, "And unless everybody does their part, many of the insurance reforms we seek - especially requiring insurance companies to cover pre-existing conditions - just can't be achieved. That's why under my plan, individuals will be required to carry basic health insurance." Transcript of Obama's Address to Congress, MSNBC.com, September 9, 2009, http://www.msnbc.msn.com/id/32765453/ns/politics-health_care_reform/.

[23] Cathy Schoen, Jennifer L. Nicholslson, and Sheila D. Rustgi, "Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes," The Commonwealth Fund, August 2009, p. 8, http://www.commonwealthfund.org/~/media/Files/Publications/Data%20Brief/2009/Aug/1313_Schoen_paying_the_price_db_v3_resorted_tables.pdf; and author's calculations.

[24] Robert Seifert and Paul Swoboda, "Shared Responsibility: Government, Business, and Individuals: Who Pays What for Health Reform?" Blue Cross Blue Shield of Massachusetts Foundation, March 2009, http://bluecrossfoundation.org/~/media/Files/Policy/Policy%20Publications/090406SharedResponsibilityFINAL.pdf.

[25] Author's calculations based on Alan G. Raymond, "Massachusetts Health Reform: The Myth of Uncontrolled Costs," Massachusetts Taxpayers Foundation, May 2009, http://www.masstaxpayers.org/files/Health care-NT.pdf; personal correspondence with Massachusetts Taxpayers Foundation president Michael J. Widmer, July 20, 2009 (available on request); and Cathy Schoen, Jennifer L. Nicholslson, and Sheila D. Rustgi, "Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes," The Commonwealth Fund, August 2009, p. 8, http://www.commonwealthfund.org/~/media/Files/Publications/Data%20Brief/2009/Aug/1313_Schoen_paying_the_price_db_v3_resorted_tables.pdf.

[26] Sharon K. Long, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year," *Health Affairs* Web Exclusive, June 3, 2008, p. w281, http://content.healthaffairs.org/cgi/reprint/27/4/w270.pdf.

[27] Lawrence Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review* 79, no. 2 (May 1989): 177–83, http://www3.amherst.edu/~jwreyes/econ77reading/Summers.pdf.

[28] See Michael F. Cannon, "Fannie Med? Why a 'Public Option' Is Hazardous to Your Health," Cato Institute Policy Analysis no. 642, July 27, 2009, http://www.cato.org/pubs/pas/pa642.pdf.

[29] *Flemming v. Nestor*, 363 U.S. 603 (1960). See also U.S. Social Security Administration, "Supreme Court Case: Flemming vs. Nestor," http://www.ssa.gov/history/nestor.html. ("There has been a temptation throughout the [Social Security] program's history for some people to suppose that their FICA payroll taxes entitle them to a benefit in a legal, contractual sense…Under this reasoning, benefits under Social Security could probably only be increased, never decreased…Congress clearly had no such limitation in mind when crafting the law.")