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PROTECTION AGAINST HIGHER PREMIUMS BASED ON CHANGES IN HEALTH STATUS: IS THERE A MARKET-BASED SOLUTION?

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P R O C E E D I N G S

MR. MILLER: Good morning everybody. I'm Tom Miller, Director of Health Policy Studies at the Cato Institute.

Are you feeling healthy today?

But do you know whether or not you will be in good health a year from now or further out in the future? This uncertainty about the future concerns not only your health, but also the likelihood that you will be able to find, afford and retain satisfactory health insurance coverage. Inadequate protection against health risk redefinition and sudden unexpected jumps in one's health insurance premiums related directly or indirectly to one's health status is often highlighted as an example of market failure in various segments of our private health insurance system.

Now, in the past we've coped with this problem in various incomplete ways. Reliance on a predominately employer-sponsored group insurance coverage system presumed that most workers would remain tied to a particular firm for an extended period of time for reasons largely unrelated to health status. Those stable employer pools would maintain a sustainable stream of premium cross-subsidies from their many low-risk workers to a few high-risk workers -- in other words, from the

healthy to the sick -- when all those parties are covered by the insurance plan.

But our private health insurance system has generally failed to offer contracts that fully insure against long-term illnesses. Health insurance contracts in most cases are on an annual basis. For employer groups, the variation in premiums is still largely experience rated each year, but it is just at the group rather than the individual worker level.

Now, some regulatory band-aids to deal with health risk variation have included various doses of community rating, rating bands, guaranteed issue requirements, for some if not all segments of the private health insurance market.

More recently we had the 1996 HIPAA legislation that imposed portability rules for employer group insurance plans that limited somewhat the length and application of preexisting condition exclusions and it also required combinations of guaranteed issue, guaranteed renewal, and non-discrimination against individual worker's health status. All this to the extent that those protections were not already largely provided in the voluntary private insurance market.

Now, leaving aside for the moment whether or not those regulations made much of a difference in the traditional employer group market, the problems of inadequate long-term protection against health risk redefinition appeared to remain more

difficult in the individual insurance market. And as we look ahead to the possible evolution of the private insurance market, we see some possible erosion of those stable employer-sponsored insurance pools as a foundation of health risk transfers.

So, some contributing factors might include: the various degrees of newer defined contribution health benefit plan options, increased cost sharing by employees, greater worker mobility and lesser commitment to a single employer, reduced insurance take-up by employees that are younger, healthier and/or more income constrained, employee demand for more choice and flexibility in health benefits options, and increased costs in regulatory burdens on smaller employers that reduce the likelihood of their offering group insurance at all, or at least increase their desire to find alternative insurance pooling and purchasing mechanisms, like association health plans and health marts.

Looking ahead even further to additional unbundling of more standardized group health insurance arrangements we might include future reform of the Medicare program, in either a premium support or more individualized defined contribution manner, and the further customization of health benefits and health care in the wake of individualized genetic information that would become more predictive of future health risks and treatment options.

So, today's discussion is in part aimed at determining whether private insurance markets can come up with better ways to handle possibly greater fragmentation of the traditional employer group-based model and to provide deeper, more sustainable protection against the uncertainties of change in health status across one's life cycle.

Now, can we do that and also provide sufficient choice of insurers and insured benefits? Can we structure commitments to insurance pools that are mutually beneficial and mutually binding? Will our legal and political system allow more time consistent long-term insurance contracts to be enforced? Do we need less regulation, more regulation, or, hard as it is for me to imagine this occurring, smarter regulation?

Or does a good bit of our current mix of private insurance arrangements handle some of this task already in less obviously observed ways? Is our traditional employer-based insurance system up to the task? How much of an expanded role might the individual insurance market take on?

What about expansion and improvement of past efforts to structure voluntary pooling mechanisms for groups of small employers or private association members? Would a more refined use of health risk rating help or hurt the availability and affordability of private insurance coverage?

Well, sit back and listen while our panel rolls up its sleeves. I can ask the questions -- the answers are a little harder -- but we have assembled some of the most thoughtful and innovative people around to wrestle with at least some of these topics and to navigate relatively uncharted health policy waters today. And I might even say something later on.

Leading off today's discussion is the health policy tag team of Mark Pauly and Bradley Herring. Mark is the Bendheim Professor and Chair of the Department of Health Care Systems at the Wharton School of Business. He is also a Professor of Health Care Systems, Insurance and Risk Management, and Public Policy and Management at the Wharton school. And he is a Professor of Economics in the School of Arts and Science at the University of Pennsylvania.

Mark's prolific writing and teaching about the market-based economics of health care provides support for both sides of the human cloning debate. Maybe we really can get by with having only one Mark Pauly to handle the wide range of issues he addresses so well, but it is tempting to consider producing several duplicate originals to give him a break now and then.

Just this month Mark has published a superb overview article, with Wynne Nichols, in Health Affairs, about what we know and what we don't know and what we will disagree about for

nonfactual reasons about the individual insurance market. He is also co-author of two National Bureau for Economic Research studies, with former students, about the affordability of health insurance for the uninsured and about the possible effects of electronic Internet-based insurance information exchanges on search costs and the resulting level and dispersion of premiums paid for individual health insurance.

And he is one of a handful of hardy souls who have dared to explore how market-based, guaranteed renewable insurance policies might be structured to provide longer-term protection against variations in one's health risk profile. His persistence in this task has been time consistent, if not incentive compatible, with past articles in 1995 and 1998 in the Journal of Risk and Uncertainty.

Joining Mark today in his most innovative look at multi-period incentive-compatible guaranteed renewable health insurance premiums is Bradley Herring. Brad is Assistant Professor in the Department of Health Policy and Management at the Rollins School of Public Health at Emory University in Atlanta. He previously was the Robert Wood Johnson Foundation Scholar in health Policy at Yale's Institution for Social and Policy Studies.

He received his doctorate degree in economics from the Wharton School, where his dissertation examined the impact of

access to charity care on the demand for private health insurance, a subject on which Brad spoke at a Cato Forum last year. Brad also has co-authored several recent articles on medical savings accounts, the individual health insurance market and tax credits, with Mark Pauly, in Health Affairs and the Journal of Health Economics. And they have co-authored probably the most thorough demystifying look at the workings of the individual insurance market, in a 1999 AEI book called "Pooling Health Insurance Risks."

Mark is going to start things off in framing the issue and demonstrating a solution to this chronic insurance problem that can work in theory. Then he'll hand things off to Brad, to provide some estimates on how it actually could work in practice.

Mark Pauly.

MARK PAULY,

UNIVERSITY OF PENNSYLVANIA

DR. PAULY: Thank you Tom.

My assignment is to provide a kind of frame for the empirical work that we want to report on here that we are excited about, and that Brad is primarily going to discuss. Then I get to come on at the tail end to do the sort of denouement on what all of this might mean for policy.

I did want to describe, before I talk about the social objectives and the policy problem, the way economists are trained to think about the particular issue that is involved here, and IT has to do with adverse selection, information asymmetry, and a whole host of Excedrin headache topics in insurance. We are trained to first appreciate the beauties of the competitive market, which are certainly worth appreciating, but then to look for potential sources of market failure -- something Tom mentioned.

And the two that had been around, at least since Alfred Marshall and probably before, were externalities and imperfect information. And the third category is generically labeled asymmetric information, where a person on one side of the transaction has better information than the person on the other side of the transaction. And that has led to the discussion of adverse selection of health insurance and the lemons problem in the used car market.

If you don't see the parallel there, you can read some of the discussion of the reasons for awarding the Nobel Prize to George Ackerlof, Joe Stiglitz and Mike Spence to explain why those two are really the same thing.

One important difference, though, between the first two kinds of market imperfection and this kind is the first two kinds, we actually have a pretty good idea of some fairly simple

correctives that governments could implement and at least still allow for some market to remain. In the cases of externalities, it is either attacks on a smoking chimney or a subsidy on a facade of a house that needs historical preservation.

For imperfect information, the government may, in principle, step in and either provide that information or provide vouchers for people to go out and get their own information. The problem with adverse selection and imperfect risk adjust is that the government solutions, short of taking over the whole industry and deciding for everyone what they shall have, are not very obvious.

And so, to some extent, my interest in this, and I dragged Brad into this when he was a Ph.D. student and now he has kind of stuck to it, my interest in this topic has been to ask the question: Well, if there is inefficiency going on here, is there some market-based solution to it? So, that is sort of the setup. And to some extent, I am embarrassed by the story I'll tell you here, but I've got tenure so I don't really have to worry about that.

First of all, let me talk about the social objectives that I think we want our society to pursue when it comes to health insurance, and especially for individual health insurance is this an issue. Although, for reasons Tom mentioned, it also provides kind of a rationale and maybe an excuse for group

insurance. One is that a person not only wants to insure against having unusually high medical expenses in the current year, but also, in theory, to insure against having unusually high life-time medical expenses.

The problem is that if insurance is based on expected medical expenses that a person has as would occur in a competitive market each year by year, and if it is sold on a year-by-year basis, you are potentially subject to a risk that not only will you have a chronic condition, which is bad enough news but, in addition, sort of the Jobe syndrome, your insurance premiums are going to quadruple or maybe it will even go away.

So, protecting against large and unexpected jumps in premiums is something that we think people would want to have, ought to have. Gradual and expected changes in premiums are okay, but it is the large ones and the unexpected ones.

Also, though, it would be desirable to offer incentives to consumers to become insured when low risk and remain insured. It is not a good idea to only fix the roof when it is raining, and then you can't do it or at least not at a high expense. People should be insured all the time. And finally, at least we think -- I think; I am not sure whether Brad agrees -- but I think that, other things equal, one would want to limit public subsidies and regulation to the minimum necessary.

So, the options for doing this -- just a brief run-through -- and focusing specifically on the first goal of protecting people against jumps and risks. The most common option that is unsubsidized is community rating, where, through regulation, insurers are required to charge people who become high risks essentially the same premium they would charge if they were low risks, and, effectively, average the charge across everybody in at least the insurance community. That is usually not the whole community. So, that is one possible solution.

The second solution, which is the one we focus on here, is guaranteed renewability at group-average premiums. And the fundamental idea there is that the insurer promises that, first, if you want to, the health insurance policy you bought this year, they will sell it to you next year. And, second, if you happen to become a high risk, they won't raise your health insurance premiums for that reason. They may raise them for other reasons, like medical costs rose or the product was woefully underpriced in the first period, or whatever it might be, but there is a promise not to raise them for any individual for the specific reason that that individual had a worse experience than average or is anticipated to have a worse experience than average in the subsequent period. So, that is guaranteed renewability.

So, it doesn't mean premiums are literally guaranteed; it means you are guaranteed not to have to pay anything more than the people who originally bought the insurance policy with you.

Those are the unsubsidized solutions to this problem. There are subsidized solutions to the problem of people who become high risk. One, of course, is a high-risk pool, where insurance is made available to high risks at a premium usually above the standard risks, but well below its costs, and then, effectively, with an excise tax usually on other insureds that is paid for, or the alternative is risk-rated credits or subsidies. The idea would be that insurers, in a world where people were subsidized to buy insurance through vouchers or credits, those credits would be bigger for people who are higher risks and were charged higher premiums.

And the good thing, or at least we think a neat thing, about guaranteed renewability -- this is a little doctrinaire and I will probably back off if challenged -- but, roughly speaking, only guaranteed renewability provides an incentive to do all the three things up above -- to continue to have insurance and to buy insurance when you are low risk and to be protected from jumps in premiums, and to do so without enormous public subsidy or regulation, although some subsidy, in my view, is always needed for relatively low-income people.

So, that is what guaranteed renewability is. And it is a solution to the problem of risk variation in insurance. I kind of reversed the order of things in the handout, and I ought to tell you why. I'm a little embarrassed. In 1995, along with Rich Roth and Howard Kunreuther, I wrote a paper that offered a way, in theory, to solve the problem of variation risk over time, a way to provide a guarantee and yet keep people in the insurance pool, and not do the obvious thing like make people settle on their health insurance when they are 21 and then they are stuck with it the rest of their lives.

John Cochran, at Chicago, who has won the Samuelson Prize in Financial Markets, has a similar kind of argument. And that is basically what we are talking about here -- incentive compatible guaranteed renewable insurance. And partly as a result of the paper on the individual markets that we did some years ago, we discovered, much to our surprise, and, to some extent, embarrassment, the thing that we thought we had done the world a great favor by inventing, although you have to be able to read technical economics to discover it, had actually been in existence in real-world insurance markets for many years -- even in health insurance markets.

And so, at least as I understand the institutional structure here, roughly speaking, about 80 percent of people who had health insurance even before there was extensive State or

Federal regulation of guaranteed renewability had guaranteed renewable insurance. In the absence of any regulation, virtually all term-life insurance has guaranteed renewability, and long-term care insurance does, too. So, it was a pleasure but a little bit of an embarrassment to discover that the market was already doing something like this.

But of course what has happened from a policy point of view to this question of guaranteed renewability is that -- and somewhat to our surprise -- it has become a fairly warm at least, if not hot, policy topic, in part because the HIPAA law -- a less well-drafted law would be hard to imagine at least in this dimension -- requires guaranteed renewability but does not define it very well at all. States do define it in various ways and forbid reunderwriting, but the current state of what the States really will let you do or will not do, I think it is only charitable to say, is in somewhat disarray, largely because the laws that the States interpret as prohibiting reunderwriting are often fairly general and untested in the courts.

So, that is sort of the policy frame. The main theoretical question I have already described. We asked ourselves, we the three musketeers, back in 1995, asked ourselves: Can we think of a way, without having people to make a lifetime decision on their insurance, to pay your insurance premium year by year and still provide yourself with protection

against the possibility that you would become a high risk, and also protection against the possibility that if some people discovered they were low risks, they could wreck the insurance pool?

And the idea of this can be made very complicated, but the general idea is fairly simple. The notion is, say -- I am going to be picking on some 25-year-old -- it could potentially be one in my family who I always have to make sure that she has health insurance -- who is thinking about buying insurance for the next year. The way to think about the kind of insurance that is guaranteed renewable is that there is a single insurance premium but it actually has two parts.

One part goes to pay for whatever medical expenses she might incur in that year. The other part goes to pay for the contingency that, should she contract a chronic condition or a condition that would raise her expected expense if not for lifetime at least for some subsequent periods, that extra premium would pay to bring the premium in subsequent years down to the level that would be paid by good risks.

So, in a sense, you are buying a sort of two-part insurance policy. One is an insurance policy to cover your medical costs this year. The other is an insurance policy to protect you against the thought that your premium might jump if you became a chronic high risk.

So, that is the general theoretical idea and the work that we are going to report on here is an attempt to add some empirical content to the question of what would the premium schedule that satisfies these properties look like. And one of the issues that has been raised about this notion is, well, if people are, in a sense, paying up front for risks that may be with them their whole lifetime, if you just tell me that, it sounds like young people are going to be asked to pay a very high insurance premium because the second part will be large even if the first part is small. And can they afford it?

So, what we wanted to do -- although nobody quite knows what affordability means although I am trying to define it -- what we wanted to do was to get some idea of what the lifetime path of premiums would look like with guaranteed renewability, see how it would compare with the lifetime path without guaranteed renewability, and see, in a sense, if the extra GR premium would be affordable.

And so that is basically the question. So, the fundamental embarrassing issue here is, first, that we discovered something that already existed, and the second source of embarrassment, to some extent, our work here is the answer to the question: Sure, it works in practice, but can it work in theory? And the answer to that turns out be affirmative.

So, the basic questions I will pose -- and the little picture at the bottom of page 2 of the handout is supposed to help you keep track of them -- we first just wanted to know what the lifetime profile of GR premiums would look like. And I will describe this in a moment, but the GR schedule we most focus on is what I call there the automatic GR schedule, represented by the little dots. And the solid line is the low-risk premium.

And basically, the message is that you do pay a little bit more for GR when you are young compared to not buying that protection at all and being lucky enough to stay a low risk all your life, but it is not very large, it turns out, and is not so large that it would involve you paying a higher premium when you are 25 than when you are 55. In fact, your premiums will still be low when you are young and not earning as much and somewhat higher when, hopefully, even if you are older, you will be earning more. So, the GR premium schedule slopes upward with age as well.

Second, would this still be attractive to people? The answer, I have already given. The dotted line compared to the solid line shows how these two premiums would work. And this automatic schedule involves an insurer just calculating the actuarial expected value of the future medical expenses associated with chronic conditions and just imposing that as the GR premium.

Can people afford this kind of insurance when they are young? The punch line here basically is partly, as I already said, the premium is still relatively low when you are young and higher when your old, when you can afford it better. It is also, as you will see, not particularly higher than even just having the luck of staying healthy. It is only about 1 percentage more of a person's income, or a few hundred dollars more, to buy this. So, it doesn't seem to be a serious problem.

We also explore whether it might be possible to tilt this premium a little bit. Because, after all, it should be worth something to even depress the GR premium a little bit below the automatic level when young -- of course, you have to pay a little bit more when old -- and it turns out it is possible to do that.

So, I will turn things over now to Brad, who will explain and show you some numbers to show how this actually works. Then I will come back on to summarize.

BRADLEY HERRING,

EMORY UNIVERSITY

DR. HERRING: Thank you for having me. Thanks Mark.

So, basically I think it is pretty clear what the rest of the talk will do. We want to essentially look at some data

and come up with what these premiums would actually look like based on the theory outlined from a decade ago.

I am not sure if you have heard about this Emory professor. About a week ago he resigned, because he essentially was faking data, coming up with numbers looking at gun ownership in the late 1700's, early 1800's. I was kind of surprised that anybody even cared about that, but I am sure that a lot of people don't even care about health insurance premiums.

So, like him, I am essentially going to present some numbers from premiums that are made up. Well, I am actually looking at some pretty good data on medical expenditures, medical claims, to construct what these hypothetical premiums are. So, I think we are based in some good, solid ground, and hopefully it is nothing I will have to resign over.

So, what is this data? Well, it is the Medical Expenditure Panel Survey data. It is a nationally representative survey of about 25,000 individuals a year. I pooled together three years of them, from 1996, 1997 and 1998. As the title suggests, there is medical expenditure data, which is very useful to us, but also there is really detailed data on chronic conditions.

There is a set of 12 chronic conditions, such as cancer, diabetes, and high blood pressure but, moreover, the data also includes the date that those conditions were discovered.

So, we do some complicated statistical techniques that some of you are interested in, and probably most of you aren't, so I will just kind of leave it at that. But essentially, we do some sophisticated kind of stuff to come up with an individual's expected medical expense based on their age, based on their gender, and based on their health status of whether or not they have these 12 chronic conditions and how long ago those conditions might have been discovered.

So, from there, we do two things. We consider two regimes. One is to take these expected expenses and assume that the individual health insurance market is setting premiums proportional to what an individual's expected expense is. Or, on the other hand, let's construct what this hypothetical GR premium would like. Hopefully, it is pretty clear at this point. Essentially, the GR premium at any point is going to equal the expected expenses of the low-risk individuals, plus the excess expected expense for people who are going to become high risk during that year.

So, for example, the premium that you would want to charge people who are age 64 is simply the expected expense of all the healthy people at age 64. The premium you are going to want to charge the 63-year-olds is the expected expense of the healthy 63-year-olds, plus the excess expense of all the people who are going to become sick during age 63, to cover their excess

claims in age 64 over what the low-risk people's claims are going to be.

So, you keep doing this on and back to age 18, and you essentially create these premiums, where we are going to cover all the cost but we are going to cover all the costs with premiums that are front-loaded. And then people who are younger are paying more to cover their future claims.

So, essentially, with the data of this Medical Expenditure Panel Survey, we just have to put everyone's expected expenses in the right hole and sum them all up.

And as Mark eluded to earlier, if you start thinking about these front-loaded premiums, you might have to get the expenses for all the young folks really, really large to cover all the people in their older ages. And actually, I think we find three mitigating factors which kind of suggest, and we show a little later, that the amount of this front-loading isn't necessarily as large as a lot of people would suspect.

Maybe you could refer to Tables 2 and 3, which I have morphed together from the paper and they are on this handout. The first observation is people who become high risk when they are young are either going to recover or they are going to die. For example, if you start with the standardized population of males, 100 males at age 18, 40.9 percent will be high risk by the time they are 64. But since a lot of them are actually going to

die, we only really have to pay for 32.1 of them at age 64. So, that mitigates it just a little bit. And to handle the recovering bit, we split our expected expenses based on whether or not the condition was discovered before or later than 5 years ago.

A second mitigating factor is the proportion of people who are becoming high risk increases as individuals become older. For example, 18 year olds have a less than .5 percent chance of becoming high-risk in any given year. But that ramps up to a point of about 2.5 percent when you are in your 60's. So, that is another effect that people aren't becoming high risk until they are getting to their middle and older ages.

A final effect that we uncover that mitigates this amount of premium payment necessary is that even for individuals who are in perfect health, their expected expenses still increase with age. For example, males at age 18, if they are completely low-risk, their expected expenses are about $580, whereas males at age 64, are $3,200.

So, if you run this program and get this "break-even" auto-pilot GR premium schedule, we find that the excess amount that has to be collected per year is actually kind of moderate, and it is lower for the youngest folks than it is for middle-aged folks. It is about $200 for people when they are really young,

between $400 and $500 in their middle ages, and then, as defined, that excess falls down to zero as you approach age 64.

So, as a check, you can see that the low-risk premium and the GR premium are exactly the same at age 64. The sum of these things are identical, the average premiums and the GR premiums but, as should be clear by now, the slope is a lot less steep for the GR premium. But I think we can kind of conclude that it is not really that excessive.

If you look at the next page, I have actually graphed these things out. The light diamond defines what the low-risk premium would be. The light triangle represents the average risk. So, if you were to include all the people who are high-risk -- and then concentrate on this premium schedule noted by the X's -- as you can see, it is a lot less steeper than the average premium gradient and it is about this 2 to 500 above the lowest premium but tapers back down to nothing at age 64. And so there it is graphed out.

The next thing we want to do is we have some access to some data for actual premiums from the community tracking study. They are included on the graph, but the key does not show them there. They are the circles. And the circles are the ones that bounce around a lot, and they are actual non-group premiums.

I guess two things are pretty striking. And I should say that we didn't really do any adjustment based on what kind of

plans these people held or anything. So, there are a lot of alternative explanations for what could be going on here. But I think two things are rather consistent with the fact that maybe premiums are having this GR feature. One is that the slope is a lot steeper than the average expense for individuals. And there is this pretty noticeable tapering off over the last 10 years as you approach Medicare eligibility.

So, the final thing we want to do -- and Mark will talk about the implications of this a little bit more -- but we wanted to attach some kind of valuation for this GR feature. And so the fact that people are risk averse and they would prefer to avoid having uncertain fluctuations in premiums they face over time, there should be some kind of valuation they have to avoid uncertainty in the future.

Economists have different ways to examine this, based on how much people avoid this and to get a dollar value of this. And that is one thing we do. So, if that is a benefit of this GR feature, a potential cost of this GR feature as well, as Mark said before, there are essentially two portions of the premium you are paying. One is your current expenses and one is the future premiums that you are going to encounter should you become high risk. And people might not be able to afford to pay for these things in the future.

As an individual, I am indifferent between, for example, having a dollar today and 95 cents in a year. So, it may be the case that individuals value their consumption more in the present. And there is going to be some sort of cost. We call this capital constraint cost, because individuals presumably can't borrow in a perfectly efficient market to cover these premiums. So, we try and attach some value to that by assuming different discount rates for the insurer versus the individual. We try and do this mostly not as a clear indication of what this actual utility value is, but more or less bringing it up and starting to consider this thing.

There are two main results. If you look at the valuation of the benefit related to the uncertainty reduction, which is these squares, it is pretty small for younger individuals, and it ramps up considerably for older individuals. And so this is kind of like the other side of this double-edged sword.

Well, younger individuals have this really low probability of becoming high-risk when they are young, and so that means this GR premium you have to collect is pretty low. But at the same time, since it is a relatively low-probability event, they are willing to pay a little bit less for this reduction in uncertainty, whereas, as you get older, this is somewhat more common -- I mean it is still rare, it is about

still about 2 percent a year, but it is a little more realistic and so there is a higher valuation.

The valuation of this capital constraint is pretty level, but obviously it tapers off as you get to age 65. I guess the main thing to think about this is if you just consider this break-even GR automatic pilot premium schedule, it may be the case that it is undesirable for younger individuals simply because the benefit of the risk reduction is outweighed by the cost.

So, if you just consider this break-even premium schedule, there might be problems, but who says we have to adhere this break-even premium schedule? If you think of looking at the total utility gain across all ages, older individuals are willing to pay a lot for this GR feature and so you should be able to, in principle, take a lot of that money, shuffle it around, and have the old subsidize the young a little more, and things would probably work out.

We do another thing in the paper, where we look at the proportion of premiums of total income over the lifetime cycle and, more or less, trying to see if this is suggestive of a bigger thing of evening life-time consumption, presumably because that is the underlying reason for wanting to look at this. And it does appear that the GR premiums as a proportion of income do

seem to be more level compared to the average premiums or the alternative schedules that are out there.

So, let me turn it back to Mark to make some sense of all this.

Thank you.

DR. PAULY: The main message from this empirical research is that a schedule of guaranteed renewable premiums that insurers can feasibly offer is one in which premiums still are low for young people and higher for older people. Probably what is more important is that it looks like a premium schedule compared to the one without this protection, most people, at least if they were rational and risk averse -- and not even economists or actuaries were urged to think about it -- would prefer paying a little bit extra for this feature as opposed to buying an insurance policy that lacked the GR feature, but running the risk that if you come down with diabetes or leukemia or M.S. or something like that, your premium either goes to the sky or the insurance disappears.

The extra premium is relatively moderate, a few hundred dollars a year, and is moderate relative to the income that people have at various ages.

Again, to kind of continue with the embarrassment -- so, we discovered this would actually work. When we looked at actual premiums, they are not that different. Maybe the market

has already figured this out. In one sense, that is good news for an economists. It is nice to know that all those stories about the market and the invisible hand really works. On the other hand, it is bad news. It means you can't get as much consulting work. But I guess I would go for the former rather than the latter. And there are still some tweaks that we think -- and they may be a little more than tweaks -- that could improve the attractiveness, compared to the automatic pilot version in any case.

So, that is sort of the punch line from the research. There are a couple of comments I wanted to make about the policy relevance to all of this. The main message I think for policy is guaranteed renewability does seem like something worth thinking about as a way of providing this protection against jumps in premiums and also as a way of providing for the social objective that at least some people have that just people who get sick, whatever the consumers thought, shouldn't be required to pay higher than average premiums either. This sort of achieves both of those objectives.

There are two primary threats to this that I will conclude by just discussing and arguing that they may not be so bad as they seem. The first one, at least in theory, isn't a problem. It is a red herring. Although in practice it could be. This is the behavior that I think is sometimes called churning.

The idea is that the insurer raises the premium for everybody once people get locked into this contract after a few years, raises the premium for everyone above the level that would keep the low-risks in. That causes the low-risks to drop out. And the insurer then says to them, well, since I see you are still a magnificent physical specimen, I will sell you insurance at a premium lower than what I was charging you for the GR thing. And then the poor high-risks are left in the GR plan. But even if the plan charges the same premium to everybody, it is really quite a high premium potentially.

The reason why that shouldn't be a problem at least in theory -- it is always hard of course to make this work in practice -- is, first, there should be reputational deterrent to it. Who would want to buy from an insurer that was going to go through this routine of if you are unlucky they are going to raise your premiums and if you are lucky they won't? And if you fell for the, "Oh, you are lucky now, we will give you a new better deal," why should you think that you might not be on the short end of the stick the next time around?

So, that does seem like something nobody in their right mind really ought to want to do. Of course, what is needed to make the market work in that way is for there to be information available to people about what the insurer's policies are.

And Keith and I in our group were talking about this in the green room -- at least for people who believe in markets, it almost seems like information would be sufficient. There is no necessary reason to prevent an insurer from offering a policy with reunderwriting as long as you know it was printed in big red ink something that says "Do not take this policy home," or something like that on it, or "Dangerous." But if someone wanted to buy it, they could. But according to the theory we've elucidated, and for the most part, people wouldn't want to -- at least not if they thought seriously about it.

And then finally, it does seem to me potentially as a substitute for information, where it is expensive or where most people wouldn't want this anyway, you could have some regulation that limited the ability of insurers to reunderwrite. In this situation, it probably wouldn't being doing much harm other than the cost of regulation itself and it might be doing some good.

The other thing that is a potential threat -- and this is actually a little more serious -- is turnover. The model that we talk about, or at least we have in the back of our minds, imagines you pick one individual insurance policy and you stick with it the rest of your life. That is not what most people do. They only, on average, go about four years.

You might say, well, that means if I think I am the average person, why would I pay this high double premium? But of

course, if most people don't stick with it for very long, the extra premium for renewability doesn't have to be all that high. So, it would still prove attractive to the average person.

If people have different knowledge about when they are likely to leave the individual policy and go somewhere else, on to Medicare or on to an employment-based policy or whatever, the ideal solution would be to offer a guaranteed renewable feature that specified the number of years. So, you could buy GR from your current age until you go on Medicare at 65. Or if you thought, because you're in graduate school or something and in five years you are going to have a really terrific job with group benefits, you could buy only a five-year policy. That would be a lot cheaper than the indeterminate duration policy, and that would be the way to solve the problem.

The main dilemma would be if it was too complicated to run that sort of situation. Then the people who expected to need GR for only a few years would find it overpriced and they might not choose to pay the GR premium. In a way it's adverse selection all over again. These are low-risks, and if they can't get a premium or an offer that is based on their being low-risks, the market won't work.

But generally -- I guess this is the punch line, this is not exactly a big finish, but I think it is the appropriate

thing to say about individual health insurance and guaranteed renewability -- generally, it should work pretty well.

TOM MILLER: Thank you, Mark and Brad.

Up next in the dark trunks of the traditional employer group insurance system is the healthy policy tag team of Keith Crocker and John Moran.

Keith is the Waldo O. Hildebrand Professor of Risk Management and Insurance, and he is also Professor of Business, Economics and Public Policy at the University of Michigan Business School. Keith Crocker has also taught economics at Penn State and at the University of Virginia. He received his Ph.D. in economics from Carnegie-Melon University.

Keith is Associate Editor for the Journal of Risk and Insurance and for the Geneva Papers on Risk and Insurance Theory. His research has included such topics as insurance risk classification, long-term contracting, and insurance markets with asymmetric information. One of his recent working papers, which you have, with John Moran, looks at "Contracting with Limited Commitment: Evidence From Employment-Based Health Insurance Contracts."

John Moran is an Assistant Professor in the Department of Economics at Syracuse University, where he is also a Senior Research Associate at the University Center for Policy Research. John previously was a Research Fellow and Robert Wood Johnson

Foundation Scholar at the University of Michigan, and he was an instructor in Penn State's Department of Economics. His doctorate in economics is from Penn State.

John's recent work includes an article on preference diversity and the breadth of employee health insurance options. That was published last year in Health Services Research.

Keith and John are going to split up their presentation of their recent findings that impediments to worker mobility work as a de facto commitment mechanism that holds together employer-sponsored insurance pools, and it may improve the quantity of health insurance provided to workers by their employers.

John will start us off in their salute to the unappreciated side of job lock and an examination of the limits to long term contracting for health insurance.

JOHN MORAN,

SYRACUSE UNIVERSITY

JOHN MORAN: First of all, I would like to thank Tom Miller for inviting me to participate in this very interesting forum. Unlike Mark Pauly, I am not tenured, so I am not going the reveal any professional embarrassments that I might have suffered over time.

In the time allotted to me here, what I would like to do is briefly discuss the question of whether the employment-based health insurance system in some way solves the problem of individual risk rating. That is, premiums that vary based upon fluctuations in individual health status.

Now, on the surface, the answer would appear to be yes. It is very few employment-based policies that are risk rated at the individual level. However, even within an employer group, it has to be remembered that insurers still have to confront the same underlying commitment problem that gives rise to risk rating in the non-group markets. Specifically, the fact that insured individuals cannot credibly pre-commit to remain with a particular insurer at a pre-specified premium in the event that they turn out to be healthier than average.

Now, in some of the work I've done with Keith Crocker that was eluded to a second ago, we argue that when there are transaction costs to switching employers due to things like the specialized nature of employment, job-specific training, or just the cost of changing jobs due to search frictions or things like that, that tying health insurance to employment provides a mechanism for keeping the low-risk individuals in the insurance pool.

Now, of course, the amount of job attachment that is conferred by these switching costs is not absolute. In fact, it

varies considerably across employers. As a result, insurers still have to structure group insurance policies in a manner which makes them attractive to low-risk individuals.

So, within employer groups, this can be done in one of two ways depending on the number of plans that are offered by the employer. So, in firms that offer a single health insurance policy to all their workers, low-risks can be retained by reducing coverage below what it might otherwise have been -- below the optimal level so to speak -- and, in turn, lowering the group premium. That's a trade-off -- less coverage at a lower cost that will be differentially valued by the lower-risk members of the pool, and it provides a mechanism for keeping them interested in sticking around.

Now, the main insight for my paper with Keith is that the extent to which that has to be done depends upon the amount of job attachment within the firm. The more locked in workers are based on the switching costs I alluded to a minute ago, the less coverage has to be reduced in order to keep the low-risks interested in remaining in the pool.

Now, by contrast, in firms that offer more than one health plan, there is also less of a need to reduce coverage, because workers sorting across plans based upon health status, in part at least, is going to result in different premiums being charged to high- and low-risks. And this offsets the need to

directly and overtly reduce the amount of coverage specified in the plans.

So, from an empirical standpoint, the two key questions are then: How large are the coverage reductions in single-plan firms that are necessitated by incomplete commitment on the part of workers? And, two: To what extent does worker sorting in multiple-plan firms result in health related differences in premiums? Which is also something that, at the beginning of time, when you are 18 years old, you would like to insure against.

Now, in our work, we didn't address the second question, but we can provide some evidence on the first. In the handout you were given -- I think actually our paper itself was distributed -- but there is also a handout, called "Table 1, Effective Job Attachment on the Amount of Insurance Available Through Employment Based Groups," this handout illustrates how increases in job attachment affect two measures of insurance coverage in single-plan firms. That is, in firms that offer only a single insurance plan. And the two measures are the lifetime limit on benefits and the annual stop-loss amount. Both of these are measured in 1987 dollars.

In the first column to the left, we have a measure of the average amount of job attachment in each firm in our sample. It is an index variable that we have created, and it based

essentially on a measure of how much specialized training is required of workers in that firm. And you can see in the table, as this job attachment index varies over its sample range, from a low of about 3 to a high of about 6.8, the predicted lifetime benefit and the predicted annual stop-loss change dramatically.

So, in going from the sample minimum, for example, to the sample maximum, we see that the predicted lifetime benefit almost doubles -- it is actually somewhat less than doubling -- and the predicted annual stop-loss falls by something just short of a half.

Now, that is actually kind of an extreme thought experiment. So, what might be more appropriate is to compare a firm that is in the 25th percentile, in terms of how locked in their workers are, to a firm that is in 75th percentile, in terms of how locked in their workforce is. And even there you can see that in terms of the predicted lifetime benefit, we see roughly an 18 percent increase in the lifetime benefit. And doing that same movement, going from the 25th to the 75th percentile in job attachment, we see about a 15 percent decline in the annual stop-loss amount.

It is important to remember that the lower the stop-loss is, the more insurance protection you have. So, these things naturally go in the opposite direction as you are moving towards more insurance coverage.

Now, I am a little short on time so I can't really go into a great deal of detail on exactly how we generated these numbers. Suffice it to say it comes from a standard regression methodology, where we hold all of our other exploratory variables at their mean values and then conduct a simulation, which is illustrated in the table.

If anyone is interested in the details, I was going to refer you to my Web site, where a copy of the paper is available, but apparently it has been distributed if anybody wants to take a look at it.

So, what I would like to do then before handing things off to Keith Crocker is briefly sum up the conclusions that I take away from the work that we did on the employment-based market. The first conclusion is that limited commitment is an important impediment to the provision of long-term health insurance even in employer groups. Moreover, it is a problem that must be confronted in any insurance setting where risk types are changing over time.

Second, employer sponsorship of health insurance provides only a partial solution to the commitment problem. As we saw, individual risk rating is eliminated but at the cost of less overall insurance protection. In single-plan firms, as we saw a second ago in the table, this comes in the form of lower lifetime limits on benefits and higher annual stop-loss amounts.

In multiple-plan firms, which we didn't look at directly, it presumably comes in the form of some degree of segregation of high- and low-risk individuals into different plans. And this leads me to my third conclusion, which is that given that the employment-based health insurance system doesn't completely solve the commitment problem, that certainly leaves open the possibility that some alternative approach, such as guaranteed renewable policies sold directly to individuals, may be able to improve upon matters.

In closing, I should just mention that finding such an arrangement could become even more important over time if the overall amount of job stability in the U.S. labor market were to decline. And there is some early and tentative evidence that that may in fact be happening.

So, what I would like to do now is turn things over to my co-author, Keith Crocker, who will offer some observations on the desirability and viability of guaranteed renewable policies.

KEITH CROCKER,

UNIVERSITY OF MICHIGAN

DR. CROCKER: Thank you, John. John sort of has worn the health care hat amongst the two of us here today, and I have on my insurance/contracting economist hat here today.

I would like to just start by just saying that what Brad and Mark have done here is a really, really neat exercise. I mean, even if it turns out that these guaranteed renewabilities don't catch on and Mark and Brad don't make millions of dollars in royalties off of this idea ideas as a consequence, I still think they have really done a valuable exercise for us here today and I would like to see what happens with the market test.

Although I am a little bit humbled because, in my experience, firms in competitive markets usually do a pretty good job of figuring these things out before a bunch of economists like us come along and tell them how to do it. So, the only exception to that rule that I can think of off the cuff is the Black Scholes Option Pricing Formula, where we actually thought of it as a group of economists, not me in particular, but somebody else first.

Generally, though, we are sort of following along behind the people in the market who get these things cornered. And as Mark indicated, there may be a little bit of this going on here, too. But, nonetheless, I think this is a really important piece of work that they have put together.

Now, I have, effectively, three comments that I would like to make. First, with respect to the market test here, who are the targets might one expect for these guaranteed renewable policies? Well, I think right off the bat there is going to be a

tendency to think the currently uninsured are probably the people that might benefit from this. And I'm not too sure of that. Because a big chunk of the currently uninsured are, quite frankly, uninsured because they made the choice to be.

And we can fight about how big that group is but, for example, the young, a lot of the young, don't even buy current policies that aren't GR policies that would be cheaper because they don't find it worth their while. And maybe they are uninformed, I don't know, but it is unlikely that folks like that, who don't want to buy the current policies, are likely to buy these.

Another possibility is that maybe these guaranteed renewable policies might peel off some folks who currently have some employer-sponsored coverage that they are unhappy with. That certainly is a possibility and it does lead me into my second observation. And that is that guaranteed renewability does have the nasty result of sort of locking you into a particular insurance company. And I don't know about you, but when I eat dinner at a restaurant tonight, I want the fellow cooking my dinner to know that if it is a crummy dinner I can take a hike and I don't have to eat there tomorrow night. So this lock-in is a bit troublesome.

And maybe reputation will have something to do in terms of keeping people from moving in with an insurer that already has

a reputation as a bad actor. But if you are already there, that reputation isn't going to help you a whole lot if you are already locked in.

The one advantage that a group policy with an employer has is that you are locked to the group, not to a particular insurance company, and the employer can shop that group around if a particular insurance provider ends up being undesirable for whatever reason. But, having said that, I would like to see how this works in the market test, and we'll see how it goes.

Now, the third observation that I would like to make really has me with my contracting hat on here. The question that I would like to ask just rhetorically, because I think I have some answers here is, what conclusions can we draw from Herring and Pauly's work here today for the individual market?

Now, I want to emphasize that I have absolutely no beef with the calculations they have made in this paper. What they have done is they have taken the current complexion of health care costs and they have used that to forecast out what future health care costs are likely to be, and then use that to develop these premium trends that you have seen in their paper.

And this would I think be not only a neat exercise, but really relevant if we were in a stable world. I think health coverage, though, is a pretty complex animal, and especially over the extended time horizons that we are talking about here in this

discussion. So, what I am worried about here is the incomplete contracting problem and the ability to actually contract in a credible kind of way with insurance providers over an environment where things are going to change a lot.

Now, I have heard in the setting here today, and others, parallels with life insurance. And I really think that this is a little bit of a stretch for a couple of reasons. If you think about whole life, we do have the front loading that locks you in, but that is a product that has fallen into a little bit of disrepute over the last 20 years or so.

I think people have figured out that the implied interest rates on those policies isn't real good. And, not surprisingly, a big chunk of the people who buy whole life policies are 65 years old and facing their day of reckoning with the inheritance tax. And the nice thing about a whole life policy, if you buy when you are 65, you can move your estate into untaxed life insurance proceeds and there is a big tax wedge there. It will be real interesting to see how whole life does as the inheritance tax winds down over the next 10 years.

With term policies, you do have the guaranteed renewability. That is really, I think, the closest parallels here. But with term policies, we have a lot of people who drop out routinely. Even for a boring business school professor like myself who is a safe risk, by the time I get into my mid-fifties

it is pretty prohibitive. And so I expect I won't be having term life insurance by the time I'm 60 years old.

Finally, the triggering event with life insurance is something pretty easy -- death. Is he dead or not? Sometimes we get people faking their deaths, but generally that is pretty easy to determine. And the insurance financial obligations in the event of that triggering event are pretty clear. In addition, actuarial trends are on the side of the insurance company, because people are living longer, and that is good for the insurance company.

So, I was thinking a little bit when I was coming down on the plane this morning -- I had to get up at 4 in the morning so I had lots of time to think; and I'm flying on Northwest and that's an interesting market experience being in the Detroit hub -- I hope there is nobody here from Northwest, but sometimes they're late and there is not a whole lot of competition on that route -- but I was thinking about, suppose in 1972, when old Keith Crocker was 18 years old and just graduating from high school, a low risk, and signed up for a policy. And what would I have signed up for? What would that policy have looked like to treat me now, 48 years old, 30 years later? And certainly costs change, and that's not a big deal.

I think Mark and Brad's approach can probably take care of that okay. But the real thing is that treatments change. And

the thing is that, with health insurance, you have diagnoses and the diagnoses change all the time -- they can diagnose things now they didn't know existed when I was in high school -- that initiates a treatment that triggers costs. And the real problem here, I think, is the incomplete contracts that we are going to have to see as a consequence over these long-term time horizons. I think this is ultimately going to be the toughest nut to crack here in these settings. And I, for one, don't want to leave it up to the good graces of the insurance company to decide, 50 years out, what treatment I should in fact get.

But I think that the work that Mark and Brad have done here has been absolutely critical in furthering how we think about insurance policies. They have pointed out that the capital constraint and the front-loading issue that was viewed as sort of the final nail in the coffin for these GR policies maybe isn't that big a deal after all.

And so, again, even if they don't make a lot of money off of royalties off of this idea, maybe even if it doesn't catch on, maybe what this will do is help up, as policymakers and as academicians, think seriously about, well, if it is not the front loading, what is it about the individual market that doesn't make things work? And again, my candidate here today is going to be the contractual incompleteness problem over these long, long horizons.

I would just like to say one final thing and then I promise I will sit down, Tom. And that is that there is only one thing in the paper that I disagree with. And that is on page 14 of the paper. They almost got away without drawing an issue from me on this. And this is where they say in the last paragraph regarding insurance companies, "but what is less clear is whether they are aware of the need to tailor that front loading to the desires of the low-risks who need to be kept in the pool."

Well, I think, quite frankly, insurance companies do understand this. And I will draw as evidence of this an incident that occurred back in the spring regarding a small life insurance company from Wisconsin that was engaging in reunderwriting of life insurance policies. And I am not commenting on reunderwriting per se -- and maybe we can talk about that later -- but, effectively, there was a wonderful article on the front page of the Wall Street Journal, above the fold, on this matter. And a representative of this company was quoted in black and white as saying that the reason that we have to reunderwrite is we have to keep the low-risk people in the pool.

Now, you may not agree with reunderwriting as the way to do it, but that's evidence to me that insurance companies certainly understand that this is an issue. Anyway, Mark, Brad, nice job.

Thank you.

TOM MILLER: Thank you, John and Keith, for a nice job as well.

Providing some comments on the previous presentations is Rick Curtis. He is President of the Institute for Health Policy Solutions. It is an independent, non-profit institute. It was founded about a decade ago to develop creative and workable solutions to health system problems related to access, costs and quality. Among the Institute's areas of expertise and interests are assisting purchasing pool development, to give small firms, employees and their families a meaningful choice of competing health plans as well as developing approaches to cover uninsured workers and children.

We also, though, hope to hear Rick's thoughts on whether any of the previous discussion might suggest better ways to structure the next round of those alternative purchasing pool options.

Rick previously has been Director of the Department of Policy Development and Research for the Health Insurance Association of America. He was founding Executive Director of the National Academy for State Health Policy and Director of Health Policy Studies for the National Governor's Association.

Rick Curtis.

RICK CURTIS,

INSTITUTE FOR HEALTH POLICY SOLUTIONS

MR. CURTIS: Hi there. As is my penchant, I am largely winging it here.

I think it is symbolically appropriately that just as the health care market changes profoundly over time, my assignment has evolved a bit. At first -- and I wasn't sure quite what Tom meant when he was inviting me -- and he didn't use the term -- but basically as the contrarian I believe. And I indicated that actually, long term contracting, I've always thought might have some promise, although I am not sure in some respects how it would work. And then it sort of evolved into this approach of well, gee, why don't you talk a little bit about this experience with these purchasing pools to try to parlay the advantages of employment-based risk spreading with individual choice.

I wasn't quite sure what he meant on the contrarian front until I heard him speak at Len Nichols conference. I think most people in this audience were at that conference last week. And I think the term you used -- this was your strawman -- the adverse selection bogeyman. And much of this talk was that we obsess too much about this problem. And I came to realize that I was invited as the adverse selection bogeyman incarnate.

(Laughter.)

MR. CURTIS: First of all, I would just like to say that for the first time since graduate school when the people in my program tried to get me to stick around for a Ph.D., I wish I had stuck around so that I could understand all the formulas in these papers, but I didn't, so I'm not even going pretend to. But I would point you to, on page 4, a footnote by Crocker and Moran. And in his presentation he alluded to some of these points.

In footnote 5 he lays out why things are more complex -- some dimensions of why things are more complex when it comes to health insurance vis-à-vis, life insurance. And he actually did a better job of laying those things out than I could have. But I would add a couple more dimensions. These are a bit less arcane and a little bit more common sense.

I remember -- and this is a true story -- some years ago, and I can't remember precisely how many, when people were talking about choice very seriously for the first time, and there was a high-ranking senior researcher who had recently come from academia and now with the Federal Government. And she was talking about how wonderful it is that through FEHBP they have choice, and what a terrible experience she had had with her carrier the previous year. She was sick and tired of changing, and she was going to pick a plan that would be there in the long

run, so she was going to pick "a piece of the rock." This is a true story. And the day before in the business section of the Wall Street Journal had been the announcement that Pru was getting out of the group business. A couple of people in the audience raised their hands and said, sorry, you won't have that choice.

So, beyond these issues of a carrier maybe not serving a consumer well over time or meeting their particular needs over time, there is the issue of AETNA becomes US HealthCare, becomes AETNA again. ALMOST is bought by WellPoint but then brings in senior WellPoint operatives and now functions like WellPoint.

Beyond Prudential, I will mention a couple of other small company names -- MetLife and Travelers. And then, beyond that, I think Mark is right -- I did major in econ as an undergrad -- the informed consumer wouldn't logically pick a carrier who doesn't have a good long-term reputation, especially if they're signing into a long-term contract. But there are a number of consumers in a number of States who have bought plans where not only is there no deep pocket, there is no pocket there at all. There is just a hole -- the Cayman Island-based fly-by-nighters.

And that is the extreme example and it is relatively rare, but this is of course a very complex market and for consumers this is tough stuff. So, unless the market is well

structured and the kinds of consumer information that Mark talked about is there in readily understandable ways, I wouldn't rely on that.

A further complication -- and this is not an area where I claim to be expert -- but this has to do with Dr. Helm's point that he brings to any meeting -- there is no such thing as a free lunch. I see Gary Claxton is in the audience, and he knows about this sort of thing. He has regulated insurance in the past. In the individual market it's not just a matter of a carrier offering a plan over time. They have things they call policy forms -- I think of it as a product -- and they open and close them.

Some carriers tend to really try to keep them open as long as they can. And what that simply means is that if we all signed up right now with a given policy form and it is guaranteed renewable, but they start experiencing escalating costs -- they weren't so good at predicting what these people were going to cost -- and the costs start escalating back beyond what they predicted, they have some bad choices. They can close the policy forms.

Some carriers do this sort of thing on purpose; others are reluctant to do it, I understand. But they can close that policy form, and then the people who are better risks, who can go get another guaranteed renewable policy, will leave, because what

they have to do is increase the price. Or they can keep it open, but they have to increase the price some and they are not going to be attracting good risks. So, there are those kinds of real-world problems with taking, as Mark said, an academic model and assuming it translates immediately to how the real world will work.

Let me just point out some of the lessons I think with these consumer choice purchasing pools. There are a couple of them that still are around. The one in Connecticut and the one in California I would point to.

Number one, there is no such thing as the magic bullet. And these ideas -- consumer choice and employer purchasing pools -- are not panaceas. The first point would be this issue of adverse selection in insurance markets is real, real, real, real. It's the first thing, the last thing and the middle thing you hear from health plans as they talk about whether they will participate or continue to participate in these organizations.

And one thing I would point out is there is not one example of a success with this kind of a program going up with the kinds of rating practices within a group that employers have in a market that has health rating and surviving. There are some States that tried that sort of thing and there are some States that authorized private organizations to try that sort of thing.

There were people like me saying that will never work. It didn't work. Everyone of those efforts failed.

Number two -- and this is something Tom was pointing out over the phone when we were talking before the presentation, and he is absolutely right -- there is a tradeoff between having the choice of competing plans and having the choice of substantial variation in product and in benefit.

In fact, when these things were invented they were on the Enthoven model of the purchaser prescribes the benefits, you have a level playing fields, and these things would have a couple of different benefit levels, and then point-of-service or PPO options on each of the benefit levels, and then a number of competing plans. And that was so people could easily compare value and all. You guys know the theory from that. It was also to help avoid risk selection.

Well, that became pragmatically the concern. Because even though health plans are resistant to standardized benefits, they refused to participate in these things unless there was that kind of a level playing field in the past, because they were so apprehensive about adverse selection as a result of benefit design. That is evolving. And obviously as we get better at this thing called risk adjustment, that can hopefully be solved. But it is a constraint. It is a constraint.

Another interesting observation here that most people are not aware of is these organizations generally passed through age rating to not only the small employer on a composite basis, but to individual employees depending on what the employer's contribution policies were. So, it ended up being modified community rating within the group.

Now, normally the employer would contribute a high percentage and would be paying most of the difference for the workers themselves based on age. But age rating, of course, is very, very, very simple compared to health rating. It is formulaic. You can show people what their prices are going to be for any of the competing plans and products depending on their age. If you start getting into health rating, it is never-never land. None of these ever did go to the point of having individual plans health rate.

But, going back to my first point, as these kinds of pools tried to survive in underwritten markets they were faced with bad choices. One is the least common denominator underwriting approach that you try to apply uniformly -- so you have relative prices set for the competing plans so that the consumers can see it, and then you have one underwriting apparatus, so you basically have a multiplier factor that would apply to the people in a given group. And where that sort of thing was tried, like in Illinois, the simple fact of the matter

is a pool is never going to be as good at that across carrier that have to all agree on the approach as an individual carrier who is particularly adroit at health underwriting and health selection.

I think there are lessons there. Maybe now that you are funded by Robert Wood Johnson on an ongoing basis, maybe they would let you spend some time mining that database. But there are some real lessons, if a researcher looks at I think, on what happens to choice as employer contributions vary between defined contribution -- and a number of them did do that. They would essentially peg a plan that looked like a high-value plan, pay a percent of that, and that was their contribution rate vis-à-vis others.

My next point would be, again, selection, selection, selection, selection. The most recent one of these to go down was in Colorado. And it happened because they were offering four plans. Pacific Care was losing money nationally. They withdrew from this, and any place else where they couldn't do as good a job at controlling. Then they were down to three.

AETNA as you all know was closing its book in any market where they were losing money. They were losing money in Colorado. They got out of the choice plan first because they couldn't control selection as well as in the open market.

That left two -- Anthem and Kaiser. Anthem announced they were losing money because of selection problems where there was individual choice. They wanted out; they went out. And then Kaiser, who likes choice, looked across the table at this purchasing pool, and they said to each other, well, this is supposed to be a choice purchasing pool and there is no choice; shall we close the doors? And they did. And that is only two years on the hill of tremendous growth in that particular purchasing pool.

I still would like to think that the long-term contract idea has some merit. Tom laid out a very interesting idea of taking a FEHBP-like private organization -- if I am paraphrasing correctly -- make them available to people with long-term contracts. There are a whole level of more complex issues here. At least it wouldn't suffer the problem of some guy being stuck with a plan that wasn't what they bought to begin with because they were acquired by somebody else or their corporate culture changed or they're losing money this year and they're anything they can do to save money, or what ever it is. So, it is very attractive.

Of course, it is the plans that bear risk, not the pools. So, how you make that work is a question. As people like Eric Claxton would ask, okay, what happens if the person decides to leave? Liquidated damages wouldn't be worth very much then.

So, unless there is a law laying out what the penalty is, it wouldn't work well.

But what I can tell you about FEHBP models, if you took FEHBP and just made it available in an existing small group market, with health underwriting as it now operates, or an individual market, it would be FEHBC, with the last letter C standing for "creamed." This is a big problem.

I am very quick at this stuff, but not so quick that your additional charge at the end of your introduction -- okay, how do we design these for the future?

I will say he mentioned to begin with that most of this is presenting about looking forward to uncharted waters. I'm sort of looking backward at what happened when we traversed waters under very different climatic conditions. And this stuff is very, very multidimensional. Ad how to design a choice purchasing pool that can work relates very, very importantly to are there subsidies. Are there subsidies for only people in the pool?

If you do that -- and he knows that I think this; he has read the Inquiry article before -- if you did that, if you had tax credits that are applicable only to choice pools, you could make this stuff work, I am pretty sure. If you said our individual market or a small group market is going to be choice

pools, then you could make this stuff work. You could make a lot of things work.

If you don't do one of those two things, what can work is for more constrained.

MR. MILLER: Thank you Rick.

I was thinking of how to square the circle of mandating choice in a libertarian manner -- but I'll come up something.

John Moran didn't carry the water for me on asymmetrical information, and some studies in that regard would suggest that the customers aren't the ones taking the insurers to the cleaners if the insurers are able to charge the customers what the ex ante costs of their policies or risks would be. And when people object to adverse selection, they really mean they object to insurers actually charging people what it costs to underwrite them. And that is a different version of adverse selection, which is probably what is carried out.

But the first rule of thumb in commenting on any paper by Mark Pauly is to say, "Nice job, Mark," and talk about something else.

(Laughter.)

MR. MILLER: I do think, though, that Brad and Mark have provided a great advance in thinking about the structure of incentive-compatible, longer-term guaranteed renewable policies, and some creative use of the data to show how it could be done

and to place some limits of health risks variation over one's lifetime in perspective. I think also moving away from the earlier thoughts of about having lifetime level premiums was a particularly significant advance.

Now, on the Crocker and Moran limited commitment and health insurance contracts, the unanswered question is: If commitment is such a key, what do we do and what can we expect in terms of relying on commitment for smaller employers, which is where the leakage is in terms of the health insurance market?

They can't get that commitment. So, how do we develop some other means of creating commitment to a pool that we might be able to attempt, aside from tying it to a single job with a single employer?

There is an opportunity here -- and I know it's consulting contracts away -- to consider some further institutional reforms to deal with the evolution of the private insurance market, and to consider whether we might be able to craft some deeper, more innovative way in which private markets could handle some of the problems that are suggested better than the camouflaged command-and-control cross-subsidies of the past.

In part, what we are trying to talk about, and I think Rick alluded to, is something that is neither an individual market or an employer group market but a hybrid, where you are having individuals coming together to bind themselves into a

sustainable group. And that has been hard to work out in practice, but it is that type of hybrid approach which might possibly offer a way to bring down some of the loading and administrative costs we are seeing in the individual market. If that doesn't take off in terms of it suddenly being a much larger group of policyholders, can we find some other way to, in effect, make that way of bringing together some insurance choices more cheaper than currently is there in the marketplace?

We still need to come up with some mechanisms to allow people to switch among insurers in whatever type of pool is going to be structured there. The first stage may really involve, as we are seeing to some extent with what I think Vivius is doing with its own networks, which is you have to pair with a particular insurer, guarantee them all the customers, then the insurer offers the variety of products and the choice, knowing that they are, in effect, keeping the stable base of customers there, as opposed to switching back and forth among competing insurers. Then we get to the second stage a little later on.

But also, what will it take to allow and create a role for a third-party broker, intermediary, market organizer, just basically an honest broker who will set up those types of choices in these pools that I'm at least imagining for the future?

The other complication, which has been alluded to by the speakers before, is that health insurance is not just kind of

a financial item. It's a service contract. It's adjustable to variations over time in quality and its effectiveness. And dissatisfied customers have to be able to have the option to exit, albeit at some type of penalty when they do so.

Insurance is not a generic term, despite the best efforts of Alan Enthoven in setting up some kind of managed competition. But we don't know how we are going to accommodate the fact that it could vary greatly in its scope, its quantity and quality if we are going to create some type of choice alternative.

The other side of this is on the customer end. Just how altruistic and generous are individual customers going to be, or have they exercised that behavior in the past? Is there really a market demand for what we might think is a good long-term product? But maybe people want to play the lottery in terms of what they think is their short-term advantage in their health risk as opposed to what might be a wiser set of long-range alternatives.

Looking back on the work about a decade ago by a couple of my heroes, Brian Dowd and Roger Feldman, in trying to think of some of way to have these type of voluntary multi-period pooling mechanisms, they pointed out that consumers may not want to be locked into one insurer for a long period of time when health plan choices have significant ongoing service consequences.

Now, we are a little bit away from managed care with the tighter networks -- that is a component. Even claims administration, contract administration, that is going to vary from insurer to insurer. Also, some consumers will need contractual flexibility to change insurers in the event that they later obtain a job that would offer better employer-paid insurance coverage as opposed to what might be that individual coverage in the pool.

Finally, many consumers, frankly, are unwilling to risk redistributing their income when they are younger and healthier through premium subsidies to others in a voluntary pool when they can instead be picked off as good risks by other insurers and then pay lower premiums.

So, when we think about how to construct some other as yet unseen pooling mechanism -- but the imagination stretches pretty far -- let's think about a couple of other issues we are going to have to confront. This is more from David Cutler's work, in terms of the failure to have long-term contracts in insurance. Can we index, benchmark or create some type of even a derivative product which would deal with future increases in health care costs? Some of that is tied to technology and greater treatments, but it is a bit of a random walk as to where it is going. Or maybe it isn't if we, in effect, can match it to something.

Cutler, in his work, talked about the variability of average costs over time is greater than cross-section heterogeneity in the use of services. Some of that is due to unforeseen technologies. As Mark Pauly said, in the past, no one seems to want to buy last year's health care at last year's prices. Maybe we need to find a way to offer that as an option.

A different way to deal with that -- and this is Cutler's stab at the long-term care insurance approach -- is the difference between an indemnity contract, which is basically saying this is how much money you are getting for a particular item, as opposed to a service contract, where we are just taking a guess as to what that might cost way down road in the future -- and that is why we have capped policies for long-term care.

Now, that is a little bit inadequate, but perhaps if you are thinking of a health insurance system in which you are insuring more of a fixed, defined contribution in the future -- and maybe that can be baselined to a particular index as opposed to an open-ended defined benefit in a set of services -- and then you would supplement that with an additional financial services savings and investment related component to deal with what you can't predict but you know you are going to need some money for as well. In effect, a two-tiered type of benefit, or even a baselined benefit with an optional supplement which you may not be able to have that long-term protection for but you have pay

for if you want to, in effect, go up a level and fly in first-class 10 years from now.

Cutler talked about inter-temporal risks, but, remember, he also talked about a lot of uncertainty being due to public sector actions. So, let's try to control the volatility of regulatory risks before we overemphasize the controls on market risks.

Now, I've tried a couple of suggestions in some papers that I've left out there -- and they are certainly far short of perfect. One way is paralleling Rick but not as mandatory. If you have a new tax credit option, you could tie the availability of these type of pooling alternatives to the folks who use that tax credit option, but you wouldn't require them to do it. It would just be a new incentive to try do it and they would have greater regulatory freedom in that regard.

Some other possibilities would be better voluntary pooling if you allowed some experienced rating, or limited underrating, for the first couple of year of people's entry into whatever this pool is. That is not how these various type of purchasing networks have operated in the States that have been put together. They generally are community rating coming in, except for some age adjustments, and you don't allow, in effect, some of the early durational effects to wear off. After a couple of years, you would know that someone has been fairly priced

initially. And then the guaranteed renewable features such as Mark is talking about for individual insurance would kick in, in return for agreeing to some binding constraints in being in that pool.

And that involves exit disincentives. It has been tough in the past to have our courts, the political system, actually enforce those types of contracts if you put that in, but it says that if you want to play in this league and you want to have some of these protections, you are going to have to leave some money behind on the table if you suddenly decide to bail out for some strategic possibilities. So, they are not initially community rated and you leave money behind if in fact you thought you had a better opportunity elsewhere.

Also what remains is the relative tradeoff between choice versus security guarantees. But we see this throughout all types of health insurance alternatives.

A different way to deal with not getting all the insurers together to agree upon risk ratings -- this didn't succeeded in an early startup in defined contribution, but I think it still remains a promising idea -- is to have, in effect, a third-party cutout as a risk aggregator, who would be using market-based means to determine for the folks in the pools what they think their actual individual insurance premium might be if they were facing risk-rated premiums on the other side. And, in

effect, get a sensitive market-based evaluator of risk to do the risk adjustment rather than try to do some type of centralized brittle formula.

Again, though, as we move away from comprehensive insurance and toward more of a focus upon insurance for catastrophic care -- and there may be some signs of that with discretionary account spin-offs -- it may not be quite as hard to deal with this variation in underwriting risk if in fact people are buying more of a generic insurance product and having to deal with other means to finance their discretionary health care items through, in effect, the convergence financial service products and more limited health insurance products.

Well, these are all concepts, but I am going to leave you with a couple of quotes from my most favorite health policy guru, which usually solves it most of all, Yogi Berra. The first is: The future isn't what it used to be, so don't get stuck in the past. Also, in terms of straining too much to make these markets work so well: If the world were perfect, it wouldn't be.

Finally, not speaking directly on the subject of insurance but in general Yogi said: I don't know what the best type is, but I know none is bad.

Let's have some questions.

MR. LEE: Jason Lee, with Academy Health

And I spend part of my time on the changes in the health care financing organization program which received this proposal for this work. And I read it many times, and had the pleasure of doing so. Frankly, some of the questions that I had initially, I still have. And so in making a gesture of trying to be helpful, let me ask a couple of questions and encourage you to think about them and respond to them.

You've said that this a guaranteed renewability product has been shown empirically. You have shown empirically that it can work. But what I wonder is, for one thing, would it work behaviorally? In particular, would the young people -- young males in particular -- commit to a long-term contract when they know -- you know, if you look at your chart, whether its males or females, and males even more so -- they know that at a young age, if they were to purchase insurance on an annual basis that their low-risk rated premium is going to be less, and it is going to be less for a number of years, than what they would have to commit to if they purchased this GR product.

We know that folks are very sensitive to price. And so I am wondering, if you build it if they will come, in that respect. We know cycling is a problem both in the individual and small group markets. And that, too, seems to be a problem, as you acknowledged I believe. And we know that people have sort of a lack of a long-term perspective. We don't save. We don't buy

long-term insurance when we can at the level that we should. Does this fascinating and I think important thinking out of the box model assume rational behavior that may not be there?

DR. PAULY: Yes. This is not the answer to everything. And it is certainly not the answer to irrational behavior. On the other hand, even if not everybody is rational, a lot of people are. And one piece of evidence for that is -- and I think I probably didn't say this clearly enough -- we are not proposing guaranteed renewability as something new that people ought to start doing; it's something that has been there. And even before it was required by regulation, 80 percent of contracts had it as a feature and people presumably chose those contracts voluntarily.

Now, what I don't know, and I guess you raise a good point, Jason, is whether young people back in those days -- unfortunately, the data is probably not available anymore -- were more likely to choose a contract without GR compared to older people. And that would be a reasonable question. It is certainly true that some people think they are immortal.

So, there is obviously an issue of how to deal with people who do not think rationally about what their future is going to be. Whenever I was a young man and I came to my dad with a problem, he always offered me the same advice, "You should have thought of that beforehand," but not everybody does that.

But this can certainly be, for people who are concerned about the fluctuation in premiums should they take sick, this can certainly be a device to deal with that, which, even if not perfect, is, like democracy, may be better than all the other alternatives, like community rating and even ersatz groups that have other problems as well.

So, I think I wouldn't offer this as the answer to the uninsured or the answer to the problem of some people are grasshoppers and some people are ants, but I think for those people who are concerned about getting this kind of protection, which was maybe 80 percent of buyers when we had a market test, this is a kind of protection that ought to be recognized and, at a minimum, not destroyed by substituting less perfect alternatives for it as if it wasn't there in the first place.

So, in some ways this sort of makes us less than the usual crusader and maybe even as able to do well while doing good because we are not really proposing something new here. We are proposing the recognition of something that has been around for awhile.

I do personally believe it can be improved, essentially by casting the spotlight of information on it in all sorts of ways, including scaring 25-year-olds to death that they are not immortal. And we'll see how far that goes. But I think it's

worth knowing that we have a device already that could be the foundation for dealing with these problems.

And I might say -- as well as Rick said, well, it's selection, selection, selection -- there is a selection problem with guaranteed renewable insurance. At age 25, if you are already high-risk, there is still a problem of adverse selection. Fortunately, that is a tiny fraction of the population at that age. But once you buy the GR policy, then you never have to worry your pretty little head, nor do the policymakers anymore, about selection, assuming that the insurer runs the policy correctly and correctly sets the premium so that it continues to be attractive to the people who remain good risks.

So, it is not going to solve -- I think Professor Berra probably commented on this being less than the most perfect of all possible worlds as well -- it is not going to solve that problem, but it can be an improvement over doing nothing or some of the other remedies which have other kinds of side effects.

MR. MILLER: Yes, a question here.

MR. CLAXTON: Gary Claxton, from the Kaiser Family Foundation.

This is to Mark again. I would like to hear sort of a response to the problem of the incomplete contract, is that the right term?

DR. PAULY: That will do.

MR. CLAXTON: Our style of insurance has sort of changed quite a bit over time. And the notion of guaranteed renewability is that a policyholder and the insurer are supposed to know what is going to happen from year to year for quite a few years. And it seems to me there is something of a challenge here in developing a contract that both parties would agree 10 years from now that this is what they meant but still allows enough flexibility so that you could move in and out of managed care and maybe move into health savings accounts and out of health savings accounts and whatever is going to come next and after that.

My second question has to do with open and closed blocks of business. It is not really a churning question in insurers doing a bad thing. It is what happens if they get the prices wrong at some point. They need to close the block in order to open a new one to get the prices right for new entrants. How do you put that all together so that someone who is unfortunate enough to have bought into a wrongly priced block of business and got sick doesn't end up as one of three people when they are 65 in a very small risk pool?

I know the Academy of Actuaries has been working about four years trying to figure out how to deal with pooling of closed blocks of business. It is a hard question, and I think it probably needs to be addressed as part of this issue.

DR. PAULY: Yes. And I don't have a very good answer the second question, although I have some opinions on it.

As to the first question, what is the incompleteness here? I need to say, I still have the same Blue Cross/Blue Shield policy that I took out when I was 25, so I'm not the person probably to ask about the need to jump from one insurance form to the other.

MR. CLAXTON: How many endorsements have been added onto that policy?

DR. PAULY: Well, there is obviously nothing to prohibit, and probably a lot of reasons to have, provisions that would allow for modification of the terms of the policy. You don't necessarily have to buy into a straightjacket. There need to be some rules for how those decisions will be made. But even refer them to the Institute of Medicine. I could buy the contract like that and that would be something.

But I think the main point is that at least some of the things that you would like to contract against, or about -- the rate of growth of future technology -- well, GR can't contract about that, but nothing can, or at least not very well, because that is not independent. When technology improves, it improves for all of us. So, there is no real way to guarantee what your premium will be without knowing in advance what future technology will be and what the cost/benefit ratio is. I mean, you could

sort of hedge it by buying drug company stocks. And then, if your health premium goes up, you will at least collect extra on the profits. But that is the part that I think can't be guaranteed by any form of insurance, and that is just one of the uncertainties of life.

But it does raise the issue for me, I think, that in a way guaranteed renewability -- and I think Keith was saying something like this -- would make the most sense when the kind of insurance policy you buy is already a pretty flexible one. So, if it was to take the simplest form, not that I'm advocating this, but just a simple catastrophic policy, if that is your best policy when you are 25, unless all of a sudden you become terribly risk averse, there is no reason why you should change. Even if it's an indemnity policy with 20 percent co-insurance, then your out-of-pocket payments sort of ride along with the rise in health care cost.

It would be more of a problem if you were thinking of an insurer that was very specific in terms of how they manage care. So, I think it doesn't fit as well with the managed care model as it does with the other one. Although, again, I come back to what my dad said -- in all these things, you basically should think beforehand what is likely to happen.

MR. CLAXTON: [Off microphone.]

DR. PAULY: Well, I'm not sure what's changing here, the person's preferences or --

MR. CLAXTON: [Off microphone.]

DR. PAULY: Well, then that's a matter of how much pre-commitment the insurer is willing to make as to the nature of their network.

DR. HERRING: Can I say something? We've kind of modeled a real static population, but the fact that it's dynamic actually should improve things, in that, okay, you are concerned about a middle-aged, near elderly person being locked into the plan that they chose 20 years ago. Well, that plan still has to attract new people to their plan, and presumably those new people are going to be making that choice based on how they are treating their older people.

The other thing is that if you're concerned about cost changing, well, we have somewhat modeled this as a pre-funded situation, but there is no reason why it can't be a pay-as-you-go system, in that the younger folks who are currently insured in the plan are paying for the older folks.

DR. PAULY: Let me just comment on the second question as well. Again, thinking of the two parts of the premium, if the rate of growth of health care spending ends up being higher than was anticipated, that is really not a problem because the premium in this GR policy is allowed to increase. And an insurer that

said, well, we charged to little -- let's call it CIGNA -- we charged too little that last year and now we want to charge a whole lot, well, I guess you shouldn't have chosen that insurance in the first place.

But the part that is somewhat difficult, I will admit, is what the insurer is supposed to do is collect enough for the second premium to cover the future runout of the chronically ill people. And that seems to me to be the most daunting part. And again, I think what is going to have to happen is that it can't be perfect, you can't absolutely guarantee, but you should be able to do a reasonable job at it. You could sign up with an insurer that charges a much higher second premium but will have enough money there to pay even if the bad event occurs and people discover ways to keep chronically ill people alive for a lot of long years. Or you could take a chance on it and have a less well-reserved policy. It really depends on what level of reserving, in effect, the consumer has a demand for.

MR. MILLER: Keith has a comment and then we are going to go on to another question from Carl.

MR. CROCKER: Just an anecdote for incompleteness. Suppose I had signed up for a health insurance policy when I was 18, before the ravages of middle age and an unhealthy lifestyle had taken its toll. One of those things that might have been reserved against in that policy was the probability that I might

have my gallbladder removed. And of course the process back then was to open me up from my chin to my belly button, take it out, and I lay around home for six weeks afterwards recovering.

Now, it is 2002. I have to have it done. But the preferred way to do it now is merely poke a couple of holes in me, they pop it out. I'm back to work next week. But is cost the insurance company three times what it costs to do it the old way. Now, which one or they going to have me do? That's where I'm concerned about the incompleteness.

It is clearly in the insurance company's interest, if I am trapped with them, to give me the diagnosis and the treatment that triggers the lower-cost expenditure for their indemnification. So, my concern is really with the new diagnoses and the new processes generating incompleteness in that regard.

DR. PAULY: Of course laparoscopic surgery would be cheaper. But I guess the way to prevent that from happening is don't sign up with an insurer that you give the power to determine what treatment. Whereas if you have an indemnity insurance, in the worst-case scenario, you pay a little more and get what you want.

MR. MILLER: And I think we are vastly overestimating the difficulty of projecting future costs of health care. Len Nichols just left, but he was on the technical advisory committee. He told us that it was only going to go up 1 percent

real all the way into the future, so it must be pretty predictable in that regard for Medicare costs. Actually, what costs will go up is as much as we can pay for them, but not more.

A question from Carl Poser, in front.

MR. POSER: I'm CARL Poser, with the Employee Benefit Research Institute, and I do some independent work myself.

This is not a brilliant question, but it seems to me that to get at this issue of the long-term contract, we have been talking about renewability, but I thought it was the law of the land under HIPAA that we have that. And there are issues of interpretation. What you're really talking about is a longer-term contract. Wouldn't that simplify it? You are talking about a loner than one-year contract.

DR. PAULY: No. I am talking about what HIPAA requires. All I am saying that's new is -- well, for one thing, it works, but the other thing is this is better than community rating as a way of protecting people against changes in risk over time.

MR. POSER: But why couldn't you right it as a five year-or an infinite-year contract, with a rating process inside it, and call it that?

DR. PAULY: You could, as I said.

MR. POSER: And then the next question is, given all the added uncertainty and the moral hazard involved in insatiable

demand, et cetera, involved in health insurance, how do the insurer's costs go up, how do the regulatory costs go up, the reserving costs? How much more difficult is it to get reinsurance for the insurer? Do you build those cost into the contract as the number of years goes up?

DR. PAULY: Well, at the moment, at least as I understand it, it effectively is an infinite-year contract, or at least until you go on Medicare. Guaranteed renewability, the company has to promise to behave that way for an indefinite period of time as long as you keep wanting to renew with them.

As I said in my remarks, I could see a rationale for allowing people to choose fixed time periods. And I think you made a good suggestion that if it is necessary to re-base this at some point in the future, kind of having various periods of term and allowing for some -- they would still have to be specified in advance -- but some set of adjustments at that point might solve some of these problems of what if the future turns out to be very different than what we thought it was going to be in the first place.

MR. MILLER: We are going to take one more question from Walt Francis in the back and then we will break for lunch upstairs.

MR. FRANCIS: Actually, it is not so much a question as a comment. I sell information to consumers on what health

insurance plan to buy, so I try to overcome some of these market imperfections on knowledge in the context of the Federal employee system.

Since it has been mentioned several times, I thought I'd tell you all something -- two interesting things that are happening right. First, just this week Stan Dorn has published a paper on using the FEHBP as a model for the private sector. It is a 100 pages of 150 footnotes. And I haven't had a chance to read it because I just put my Web site and my book to bed, but I just mention to people that it is probably of interest to everyone in this group.

Secondly, another interesting development is that there is now an MSA plan in the Federal employee system. I've just finished rating it, and people who buy my product will find out how I rate it. But I will tell you I rate it very highly, not just for the young and healthy but also for the old and sick, and indeed for a target group they didn't even really intend it to be good for -- as a Medigap plan for people with Medicare Parts A and B.

Anyway, it is a very interesting national experiment. We are talking here about 4 million individual contracts, 9 million people, and they now all have an MSA choice next year. My prediction is that the company that is offering this, which is one of the postal unions, currently has about a 2 percent market

share. I think they will double their market share. Which is in one sense a huge change and, in another sense, yawn, ho-hum; 98 percent of the people still aren't in an MSA.

And I think this then relates to my more general comment which is that this is a program which, from an Allen Enthoven point of view, is a managed competition program with about 1 percent of the amount of management it ought to have by the employer sponsor. It is totally unmanaged from the point of view of risk, and there are all kinds of things they could do. And I don't want to go into it. And there is risk segmentation in the program, no doubt about it -- desirable risk segmentation, many of us would argue. The point is that it works.

Now, the Colorado program apparently didn't work. Other programs have not worked that involved multiple-plan competition. One of the reasons it works is real simple -- and I think it is very important in this tax credit sort of context which I guess is sort of lurking in the background here -- is that when you subsidize everyone's premium, the system gains a whole lot, depending on how it's done. The design details become very important, but it is possible to have a system that is really quite stable, in which it pays young people to be in the risk pool with the older people and so on, because they are getting the subsidy.

And I think you can over-intellectualize all the sort of difficult problems and so on. Clearly, there will remain major problems in the individual market no matter what happens as long as it is truly a fragmented market. But that doesn't mean it can't be significantly improved over what it is now. And the last time I looked, it did not look like it was dead. End of comment.

MR. MILLER: Okay, a couple of concluding thoughts. I have no doubt that traditional health policy researchers and analysts will once again find a way to go postal on an MSA option despite its benefits. And from thoroughly modern Millie, I think we have learned today that everything old is new again.

Let's thank our speakers very much for I think extending the territory quite a bit today.

(Applause.)

MR. MILLER: I will join you upstairs for lunch.

[Whereupon, the Cato Institute Policy Forum was concluded.]