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Health-Status Insurance

How Markets Can Provide Health Security

by John H. Cochrane

Executive Summary

None of us has health insurance, really. If you develop a long-term condition such as heart disease or cancer, and if you then lose your job or are divorced, you can lose your health insurance. You now have a preexisting condition, and insurance will be enormously expensive—if it's available at all.

Free markets *can* solve this problem, and provide life-long, portable health security, while enhancing consumer choice and competition. "Heath-status insurance" is the key. If you are diagnosed with a long-term, expensive condition, a health-status insurance policy will give you the resources to pay higher medical insurance premiums. Health-status insurance covers the risk of premium reclassification, just as medical insurance covers the risk of medical expenses. With health-status insurance, you can always obtain medical insurance, no matter how sick you get, with no change in out-of-pocket costs.

With health-status insurance, medical insurers would be allowed to charge sick people more than healthy people, and to compete intensely for all customers. People would have complete freedom to change jobs, move, or change medical insurers. Rigorous competition would allow us to obtain better medical care at lower cost.

Most regulations and policy proposals aimed at improving long-term insurance—including those advanced in Barack Obama's presidential campaign—limit competition and consumer choice by banning risk-based premiums, forcing insurers to take all comers, strengthening employer-based or other forced pooling mechanisms, or introducing national health insurance.

The individual health insurance market is already moving in the direction of health-status insurance. To let health-status insurance emerge fully, we must remove the legal and regulatory pressure to provide employer-based group insurance over individual insurance and remove regulations limiting risk-based pricing and competition among health insurers.

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The Problem of Long-Term Insurance

None of us has health insurance, really. Most Americans have coverage through their employer, or the employer of a parent or spouse. But suppose you get cancer, heart disease, HIV, have a stroke, discover a genetic defect, or develop any other long-term expensive health problem—and then lose your job, divorce, outgrow your parents' plan, or your employer or insurer goes out of business. You lose your health coverage. You now have a preexisting condition, and insurance will be enormously expensive—if it's available at all. This happens to real people. A significant and expensive health problem is a common root cause of catastrophic economic descents in the United States. Many people stick with bad jobs or bad marriages just to keep their health insurance.

The lack of secure, long-term, portable health insurance is the greatest single problem with our current health care system. Solving this problem is a central goal of every health care reform proposal from all parts of the political spectrum. There are plenty of other problems with our health sector: the uninsured, hospitals' hotel-minibar pricing policies, poor information, the drudgery of useless paperwork, cost recovery of new medicines, optimal copayment levels, and so on. But all of these are fairly clear problems, each limited in its reach, with fairly clear remedies. The lack of long-term insurance, by contrast, seems a harder nut to crack. And unlike, say, the plight of the uninsured, it is a problem that faces each of us directly.

Free and competitive markets are the best way to spur innovation, provide better service, and reduce costs. So far, however, many people have thought that competition undermines long-term insurance, leading to the extensively regulated market we now face and to proposals for further regulation. Health-status insurance lets us break out of this dilemma. Health-status insurance can give us both completely portable, lifetime health insurance *and* great individual freedom of choice in a deregulated, competitive—and hence—efficient and innovative market.

Unsurprisingly, health-status insurance requires a thoughtful deregulation of insurance markets, starting with an end to the strong tax and regulatory preference for employer-provided group coverage. It does not need a new layer of regulation. The small individual insurance market is already starting to feel its way toward health-status insurance. The deregulatory path will allow this effort to blossom fully.

Health-Status Insurance

Market-based lifetime health insurance has two components: medical insurance and health-status insurance.[1] Medical insurance covers your medical expenses in the current year, minus deductibles and copayments. Health-status insurance covers the risk that your medical insurance premiums will rise. If you get a long-term condition that moves you into a more expensive medical insurance premium category, health-status insurance pays you a lump sum large enough to cover your higher medical insurance premiums, with no change in out-of-pocket expenses.

Why can't medical insurers just charge everyone the same premium? In a competitive market, medical insurers must charge sick people higher premiums, and charge healthy people lower premiums. If an insurer charged everyone the same price, then a competitor could woo away healthy low-cost customers, and the original insurer would go out of business. Furthermore, the main reason insurance companies refuse coverage, deny coverage for preexisting conditions, or more subtly avoid or mistreat people with long-term expensive conditions, is that they cannot charge those people enough to cover their costs. If medical insurers can charge enough, they will compete for the business of every customer, even the sickest. Freely risk-rated, competitive medical insurance gives everyone access, albeit at a cost. It leaves people vulnerable to the financial risk of

large premium increases, but health-status insurance would fill that gap.

The combination of health-status insurance and competitive, freely priced medical insurance solves the central problem of our current health insurance market: the lack of real, long-term, portable health security. With health-status insurance, you can always get medical insurance, no matter if you get sick, change or lose jobs, move, divorce, take some time out of the labor force, or even let your medical insurance lapse. The lump-sum payment from the health-status insurer means you can always pay your medical insurance premiums.

Health-status insurance would also give each of us much greater freedom and choice. No matter how sick you become, you would always be free to change medical insurers. You could always afford the higher premiums a new medical insurer will demand, just as you could afford the higher premiums your current insurer will require. You would not depend on the good treatment of one insurer, the vagaries of one group, the link to one employer, or the bureaucratic decisions of one government-provided plan.

Best of all, when every consumer is free to switch insurers at any time, medical insurance companies will compete for everyone's business. They will compete for the business of expensive, high-risk customers, rather than try to get rid of them or "contain their costs." They can also compete for the business of people who are currently healthy, as such competition will not undermine the implicit cross-subsidy to people with preexisting conditions. Constant competition for every consumer will have the same dramatic effects on cost, quality, and innovation in health care as it does in every other industry.

In sum, health-status insurance can simultaneously give us complete and portable long-term insurance, great individual choice, and cost-containment beyond the dreams of any health policy planner. And, as I show below, it doesn't cost consumers anything. The combined health-status and medical insurance premiums are the same as those of a lifetime individual insurance contract, and the same in present value terms as those of a (hypothetical) successful group or pooling program, even before we factor in cost savings from greater competition.

An Illustration

Suppose that a healthy 25-year-old male will incur $2,000 worth of medical expenses in a year, on average. A competitive medical insurance market will offer him insurance with a $2,000 premium, plus administrative costs and profit.

Suppose that, along with potential short-term illnesses, he has a 1 percent chance of developing a chronic condition that will raise his average medical expenses to $10,000 per year. If he develops this condition, a competitive medical insurance market will still cover him in following years, but his annual medical insurance premium must rise to $10,000, plus costs and profit. This is a large financial setback.

To be covered over the long term, then, he needs a lump-sum payment large enough to cover $8,000 per year in additional medical insurance premiums. At a 5 percent interest rate, that sum is $148,370.[2] The premium for health-status insurance is 1 percent of that value, $1,483.70, plus administrative costs and profit. In sum, he pays $2,000 for one year of medical insurance, plus $1,483.70 for health-status insurance, for a total of $3,483.70 in out-of-pocket expenses in the first year. Now he is completely covered, for short-term and for chronic medical expenses. If he gets sick, he is also still free to change medical insurers, with no change in out-of-pocket expenses.

This example is simplistic, of course. Bradley Herring and Mark Pauly use data on the incidence of a long list of chronic diseases to provide a realistic estimate of the sum of medical and health-status insurance premiums.[3] Their estimate of annual medical insurance premiums for a low-risk male rises from $800 at age 25 to $3,038 at age 55, while a high-risk male pays $2,300 at age 25 and rises to $10,023 at age 55. Clearly, jumping from the low-risk to the high-risk category implies a large finan-

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cial penalty. They estimate that the combined medical and health-status premium starts at $1,487 at age 25 and rises to $3,936 at age 55. Subtracting, health-status premiums are $687 at age 25, and rise to $898 at age 55. Total premiums for younger people are lower than for older people, unlike in my example. That fact reassures us that young healthy people, who typically have lower incomes than older people, will not shy away from purchasing insurance.

Health-Status Insurance Accounts

Lump-sum payments from health-status insurers should go into a special "health-status insurance account" that can only be used to pay medical insurance premiums or medical expenses. This contractual requirement solves many problems associated with large lump-sum payments, and it makes health-status insurance less expensive, for three reasons. First, large lump sums are a temptation to fraud—get a fake diagnosis, take the money, and disappear. That's much less tempting if all you can do with the money is buy medical insurance. Second, people who receive a large lump-sum payment may choose to spend it on other things and then show up in the emergency room, unable to pay their bills. It is in both consumers' and insurers' interest to precommit against this option. Third, this provision makes it feasible to require that you return the lump sum if your medical insurance premiums decline because you become unexpectedly healthier. In this circumstance, you no longer need the lump sum, so promising its return does not hurt you. Returning the unneeded lump sum lowers costs and thus reduces premiums for everyone. Of course, if your health status deteriorates again, you will receive another lump sum.

Health-status insurance accounts are not the same as health savings accounts. Health savings accounts are tax-preferred savings vehicles. You choose when to put money into a health savings account, you can withdraw money for nonmedical purposes (with a penalty), and you can pass the assets on to your heirs. Health-status insurance accounts are funded by payments from an insurance company, they can only be used for medical insurance premiums, and they should not be inheritable. Legally, health-status insurance accounts would be set up like a trust account.

However, health savings accounts are a great first step, as they establish a legal and regulatory framework for accounts that are limited in some ways to health-related uses. Now, markets only need to create (and regulators need to allow) a variant of something that already exists, rather than something completely new.

Calculating Payments

Calculating present values of premiums sounds complicated. However, in the real world we don't insure people down to the last dollar, so it is not necessary to key health-status payments precisely to the exact present value of each person's premium for a given plan's premium schedule. Home insurance markets work, even though the payment is never equal to the exact value of the home.

Health-status insurance companies could offer three or four levels of coverage, keyed to surveys of the costs of three or four standard levels of medical coverage. Similarly, medical insurers would probably have a short number of classifications, say a 1–10 scale of "low risk" to "high risk," rather than publish a premium schedule for every conceivable disease history. This would make their job and the health-status insurer's job much easier at a small cost.

A health-status insurance contract could then be very simple. For example, the policy could say "pays $50,000 if you are reclassified from category 3 to category 5." A simple table could advise people in a given medical insurance plan that this is the right level of coverage.

Interruptions

Health-status insurance can provide long-term security through interruptions or changes in medical insurance.

As soon as you stop making premium payments with a conventional insurance contract, you lose any right to low premiums and to con-

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tinued coverage of your (now preexisting) medical conditions. This happens. People who lose their jobs often can continue their health insurance under COBRA—if they pay the entire premium, including what used to be the employer's portion. But this privilege doesn't last forever, and people who just lost their jobs often have trouble paying premiums, especially if the job loss coincides with an expensive illness.[4] People who take time off from work to raise a family, or lose their connection to health insurance through divorce, don't have any right to continue coverage in the first place.

By contrast, anyone with a health-status insurance account can switch to a lower-cost medical plan, or miss some period of medical coverage entirely in a time of economic misfortune, and retain protection against the costs of their long-term illnesses. When they're ready to reestablish medical insurance, or move to a more expensive medical insurance plan, the health-status account is there and waiting. If they maintain health-status insurance, even without medical insurance, they can be protected against any new long-term illness.

Changing Tastes and Quality

Suppose you purchase an economical medical plan and health-status insurance. You contract a high-cost condition. What if you then decide you want to move to a more expensive medical plan?

Insurance can cover misfortune, but it can't cover changing tastes. If you want to move to a more expensive plan, you're going to have to pay more. However, insurance companies could sell, and you could buy, economical medical insurance together with health-status insurance that covers changes in a more expensive medical plan's premiums. In the above example, you could opt for a policy that pays $70,000 rather than $50,000 if you are reclassified from category 3 to category 5. That would cost a little bit more, but if you get sick, a larger sum will be deposited in your health-status insurance account. This option would be attractive for young people or people in temporarily reduced circumstances. Home and car insurers will not let you be "overinsured," declaring a $100,000 value for a $20,000 car, for obvious reasons. But since you can't do anything but buy medical insurance with the payouts, there is no such worry with health-status insurance.

What about People Who Are Already Sick?

Private insurance cannot cover events that have already happened. You can't tell an insurance company, "My house just burned down. How about some insurance?"

Many people feel that government should insure events that have already happened, especially when no insurance was available and the unfortunate are in some sense blameless. Health-status insurance accounts offer a good way to help people who are already sick. The government could simply deposit money in an individual's health-status insurance account and then get out of the way. Private charities could help people in the same way. This is much more straightforward, flexible, and less distortionary of markets than directly running a government-sponsored health insurance plan, or forcing private insurers to take such patients and treat them well.

The problem of people who have preexisting conditions is most critical at startup, when people will not yet have had a chance to buy health status insurance. Once health-status insurance is widely available, people will be able to insure against more events than one might think. Parents could buy family insurance that provides health-status insurance accounts for their children. Then, children who develop rare long-term diseases would be covered for life without government intervention. Health-status insurance could even apply to unborn children, and thus insure against genetic defects from birth.

Having the government set up such accounts for people with preexisting conditions might also be useful in getting the whole process going. This step would establish the legal and regulatory framework for health-status insurance accounts, and it could be done at the same time government deregulates premiums: regulators and legislators would be

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more willing to allow free risk-rating if they knew that the most vulnerable populations could afford the extra payments.

Other Implementations

The contracts I have described, combining competitive one-year medical insurance policies with health-status insurance payments held in a custodial account, show most clearly how free-market long-term insurance can work. However, markets may devise many other implementations that may be more attractive to consumers, insurers, and regulators—even if they don't seem as elegant to economists.

Consumers could purchase health-status insurance and medical insurance from different companies. Since health-status insurance is largely a financial transaction, a financial services company might be able to handle it better than a medical insurance company. On the other hand, consumers may prefer to have the two forms of insurance bundled as "long-term health insurance" and not worry about two separate contracts.

Simple long-term insurance policies are undermined by competition, and if you get sick, nobody else will take you. Health-status insurance is the natural remedy.

The health-status insurance account need not be settled up every year. For example, you could have a long-term medical insurance policy in which health-status payments occur only when you leave. On the other hand, with insurance—as in all social endeavors, there is less chance of a dispute if long-term debts are settled up more frequently and in smaller chunks, rather than in one large chunk after one party has already decided to leave.

Rather than an account with a dollar figure in it, your health-status insurer could simply promise to pay any increases in medical insurance premiums. The exact kinds of payment would have to be spelled out in some detail, either by specifying the qualifying plans or by specifying how much extra will be paid out for various risk conditions, but that's fairly straightforward in practice. In this implementation, we wouldn't have to worry about the insurer retrieving lump-sum payments if a person gets healthier. You would still be dependent on a long-term contract, but it is much more reliable to receive an annuity from a financial services company than it is to rely on a long-term promise from a medical insurance company. Plus, you would still have the right to choose any medical insurer you want.

You could just have a transferability right rather than a health-status insurance account. Your current insurer could agree that, when you want to leave, it will pay a lump sum to any new insurer, such that the new insurer will now be willing to take you in a plan of similar quality with no change in your out-of-pocket expenses. The lump sum could be the same amount that your current insurer charges to take on a new customer of your age and health status. Transferability obviously would not give consumers quite as much freedom as a health-status insurance account with real money in it, but it might work almost as well in practice and might be simpler for consumers to understand.

Choice and Security

Why not just mandate that premiums cannot rise when you get sick? As it happens, federal law already requires that individually purchased medical insurance be "guaranteed renewable," meaning that the insurance company cannot drop you or increase your premiums if you get sick.

There are two problems with this arrangement. First, as with all pooling arrangements, simple long-term insurance policies are undermined by competition. Second, if you get sick you depend on the good graces of one company, for the rest of your life, as nobody else will take you. It is possible to fix the first problem, and markets are heading in that direction already. The second problem remains, and health-status insurance is the natural remedy.

To see the first problem, return to the above illustration, in which there is a 1 percent probability that a person's expected medical expenses would transition from $2,000 per year to $10,000 per year in the first year of an insurance contract. The average medical costs for all individuals would be

$$(0.99 \times \$2{,}000) + (0.01 \times \$10{,}000) = \$2{,}080.$$

It seems the insurer could break even by offer-

ing guaranteed-renewable policies for $2,080 per year. However, if there is any competition, this arrangement will fall apart after the first year. Another insurer charging just $2,000 per year could woo away all the healthy people. The same competitive pressures unravel forced-pooling arrangements, as discussed below.

Fortunately, markets can solve this problem by front-loading the premiums.[5] If each person pays $3,483.70 in the first year and $2,000 in subsequent years, the insurer will still break even, but healthy people will no longer have an incentive to leave. Even if another insurer lures them away, the additional first-year premiums would cover the long-term costs of the people who got sick. Bradley Herring and Mark Pauly call this an "incentive-compatible" guaranteed-renewable contract.[6]

Notice that the premiums and calculations of an incentive-compatible guaranteed-renewable insurance policy are exactly equal to the combined premiums of a medical insurance policy plus a health-status insurance policy, and the present value of both is the same as those of a $2,080-per-year pooling arrangement, if the latter could be made to work. More importantly, a health-status plus medical insurance policy is exactly equivalent to an incentive-compatible guaranteed-renewable policy, in which the insurance company periodically "marks to market" its long-term obligations to the customer, or the two parties occasionally settle up the long-term debt implied by the promise to treat the expensive customer. At the end of the first year, the insurance company selling guaranteed-renewable coverage should look at each patient who developed a long-term illness and say, "This person is going to cost us (say) $8,000 per year. We should write down the company's value by $148,370"—the present value of $8,000 per year in my example. In the health-status insurance model, the insurer would pay out $148,370. The company would then have no more long-term obligations and the consumer would have no long-term contract to enforce.

The implications of periodically settling up a long-term contract are profound, and they solve the second problem of long-term individual contracts. Sick people must stay with their original insurer forever in a guaranteed-renewable contract, whereas a health-status insurance payment frees them to choose another insurer. People value choice. As Thomas Buchmueller and colleagues write:

> People do not want to be locked into the same health insurance plan year after year. When new medical services are developed, people want access to those services. . . . If people move, they want to be covered by new providers, not the providers in the town they moved from. Under guaranteed-renewable policies, only those who remain healthy can hope to switch coverage.[7]

If people are bound to one insurance carrier, furthermore, the original insurer doesn't have any incentive to treat sick people well. Yes, reputation and court enforcement of contracts can help to prevent insurers from treating sick people badly. But the freedom to leave is a much more effective force to keep insurers and providers on their toes. Competition for people with long-term diseases will also induce the whole medical industry to improve treatment of those diseases.

Finally, insurance companies don't last forever. They can go bankrupt, change owners, change policies, and so forth. Periodically retrieving the present value of long-term promises adds to the safety of any contract.

We do not have to have a policy debate between guaranteed-renewable and health-status insurance, however. Market participants can decide how often it is optimal to settle up, as long as both options are permitted by law and regulation. Guaranteed-renewable individual insurance is also a great start, because it provides a natural stepping stone to health-status insurance without requiring major policy shifts.

What about Adverse Selection?

People who know they are sick and can hide it tend to buy more insurance, which the-

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oretically can cause insurance markets to unravel. Realistically, however, "adverse selection" is not a serious problem for long-term health insurance markets. True adverse selection refers to things patients know that the insurer cannot know—what economists call "asymmetric information." But does a patient who knows his or her aches and pains really know more than an insurer can learn by looking at his or her entire medical history and a careful health exam? (Hiding one's history is fraud, and can invalidate a contract.)

If we observe adverse selection in today's marketplace, it is because government *artificially* forbids insurers from using information they do posses to charge more for people whom everyone knows are going to be more expensive. This fact does not represent a fundamental information problem that would stop a less-regulated market from working.

Adverse selection is exactly the same issue for health-status insurance as it is for long-term insurance with a single company. The portability engineered by lump-sum payments doesn't make adverse selection any better or worse. So at a minimum, this isn't a special issue for health-status insurance.

What Needs to Be Done

What policy steps should be taken instead to allow health-status insurance to emerge? The basic message is "get out of the way," but we need to describe a set of steps that nervous regulators and politicians could actually take.

First, we should eliminate the tax and regulatory preferences for employer-provided group health insurance. Employers can still pay for insurance, or even provide medical insurance. We could even retain the tax-advantaged status of health insurance payments by companies or individuals. Those features cause many distortions, but those distortions don't harm long-term insurance. It is crucial that the employee owns any health-status insurance account, just as he or she owns defined-contribution retirement accounts and health savings accounts. That way, if the employee gets sick and leaves, he or she always has the resources to purchase a medical insurance policy. If long-term health insurance is bundled with medical insurance, it is important that this is an individual, portable policy—no matter who pays for it.

Second, we need to allow and encourage insurers to adjust medical insurance premiums freely, so that anyone can get coverage, albeit at a price, and so that healthy people will not flee the market. Finally, we should lift the many other competitive restraints on insurers.[8]

We do not need a carefully planned and choreographed deregulation. Once we remove the tax and regulatory preferences for employer-based group insurance, much of the rest will follow naturally. We will first see much more individual insurance emerge, and that insurance is already incentive compatible, guaranteed renewable, and portable. Competition and consumer demand for the freedom to change insurers will push insurers toward the incentive-compatible front-loaded premium structure with periodic settling-up clauses. Health-status insurance accounts will follow quickly if you think about how the insurance contracts are written. As health-status insurance develops, there will be no reason not to allow insurers to fully risk-rate medical insurance policies and compete ruthlessly. Each step can coexist with the last and can happen as quickly or slowly as regulators are willing to let go.

Regulators could help, too. They could encourage medical insurers to publish explicit premium schedules based on health risk, so that health-status payments can be more easily calculated. Insurers may rightly fear that publication of such a premium schedule now would draw all sorts of political and regulatory ire. Hearing the opposite would help.

Markets Are Showing the Way

It is encouraging that even in our highly regulated environment, the individual market is already moving in the direction of health-status

insurance. Three-quarters of private medical insurance policies were guaranteed renewable even before this feature was mandated in 1996.[9] Bradley Herring and Mark Pauly find evidence that individual health insurance premiums are beginning to reflect the front-loaded "incentive-compatible" structure,[10] which exactly mimics medical plus health-status insurance premiums. Most encouraging of all, the UnitedHealth Group, one of the nation's largest health insurers, just announced a product that gives customers the right to buy medical insurance in the future. The future premium will be based on the customer's *current* health status, even if their health worsens in the interim. The *New York Times* reports:

> "What this product is designed to do, for a very modest premium, is to essentially protect your insurability for the future," said Richard A. Collins, the president of UnitedHealth's individual insurance unit, who says he is the first policy holder. His monthly fee is $50.[11]

This product only gives customers the right to buy a UnitedHealth policy, rather than a policy from any insurance company. But it is clearly a big step toward full health-status insurance. Further steps may be forthcoming. The *Times* continues:

> Private insurers are increasingly interested in coming up with new plans that offer coverage even to those individuals with pre-existing conditions, said Bob Vineyard, an insurance broker in Atlanta. He said he expected such plans to be introduced next year.[12]

Markets *can* provide long-term, portable insurance—but only if we allow them to do so.

Competition and Regulation

Why then do we have such a regulated system? If deregulation would quickly solve our most pressing health insurance problem, why haven't we deregulated it already? There is in fact a clear story for how we got stuck where we are. Understanding this story can give us confidence that the deregulatory path outlined above will work, and it shows us why further regulation will not cure the health insurance system.

Employer-provided group insurance is the dominant form of medical insurance in the United States, encouraged by a strong tax advantage and regulatory pressure. The tax advantage emerged in WWII, as a way for firms to attract workers in the face of federal wage and price controls,[13] not from any careful study of long-term health insurance.

Group insurance is a long-term pooling arrangement. The premiums of healthy people cross-subsidize the expenses of those with long-term illnesses over long periods. Competition undermines long-term pools. A competitive insurer can woo the healthy away with a lower premium, leaving the original insurer with only sick people.[14] And people with long-term illnesses who lose their job or other tie to the pool won't be able to join another pool in a competitive market.

However, these problems were not evident when health insurance markets first emerged and health expenses were largely temporary. There wasn't much one could do about the chronic conditions for which we now have expensive treatments. The long-term insurance problem emerged as expensive treatments for long-term conditions became available.

A lot of health insurance regulation makes some sense when viewed as a patchwork aimed at trying to prohibit competitive forces from undermining long-term pools. The federal tax exemption for employment-based group insurance does not allow healthy workers to direct their employer's pre-tax premium contributions, or their own pre-tax dollars, to an individual plan. This fact forces healthy workers to stay in their employer's plan and to cross-subsidize the sick. Additional regulations to encourage employer-sponsored group insurance help workers with illnesses to get

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coverage at a new job if they leave their old one. Regulations that limit risk-rating and exclusions for preexisting conditions or that mandate coverage of certain conditions try to force the individual market to be a catch-all for people who have lost group coverage. Restrictions on competition attempt to keep insurers from poaching each other's healthy customers.

Most policy proposals aimed at providing better long-term health insurance try to further limit competition and expand forced pooling. They strengthen incentives for employer-provided group insurance, create pools based on geography (e.g., the Clinton administration's 1993 proposal), force insurers to take all comers at the same price, assign high risks to insurers, prohibit competition for healthy customers, force (or "mandate") healthy people to buy high-priced insurance, mandate payment levels and treatments for expensive diseases, and so forth.

Alas, each of these steps reduces competition, and reduces people's freedom to choose the insurers and providers that best serve their needs. That reduction begets poor service, higher costs, and less innovation. Reducing competition and choice is not an unfortunate side effect of the regulatory approach to long-term insurance—it is the *point* of that approach. Competition undermines forced pooling arrangements, so to strengthen forced pooling, you have to reduce competition.

Even these sterner measures will not be enough, so long as people have any need or freedom to change pools. National health insurance—a single, mandatory pool—is the only way to provide ironclad long-term insurance following this logic. But national health insurance completely eliminates consumer choice and insurer competition.

We seem to face an unpalatable tradeoff between competition and choice on one hand and better long-term insurance on the other. Health-status insurance removes this unpleasant tradeoff. With health-status insurance, a completely deregulated market with complete freedom and competition can also provide lifetime portable health insurance.

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The Obama Plan

As I write, the most relevant health care reform proposal is the one presented by President Barack Obama's campaign. It is a good specific example of these general points.

The Obama campaign plan promised to bring "portability and choice" to health insurance. It promised that Americans "will be able to move from job to job without changing or jeopardizing their health care coverage." It called for "stable premiums that will not depend on how healthy you are," and promised that "no American will be turned away from any insurance plan because of illness or preexisting conditions."[15] Those goals are exactly what health-status insurance can accomplish.

Unfortunately, the Obama campaign proposals go in the standard direction of reduced competition, forced pooling, and mandates. For example, the Obama campaign plan proposes a "National Health Insurance Exchange" through which the federal government would ban pre-existing condition clauses and force insurance companies to take everyone at the same price. The campaign plan proposes to mandate coverage for children and most workers. It foresees, and indeed promises, the inevitable result of a nationalized health-insurance system:

> Obama will make available a new national health plan . . . The plan will cover all essential medical services, including preventive, maternity, and mental health care. . . . Individuals and families who . . . need financial assistance will receive an income-related federal subsidy to buy into the new public plan.[16]

Clearly, President Obama and his health policy advisers are genuinely concerned about long-term insurance, and they recognize that choice, competition, and lower costs are desirable in health care. They are neither for nor against health-status insurance in any meaningful sense. They simply have never heard of

it. They advocate more regulation and nationalized health insurance simply because they, like most people, think they have to choose between long-term insurance and competition. They do not know that a market alternative that delivers both is possible. If they knew about it, there is no reason they should not embrace it.

Conclusion

With health-status insurance, a completely private, less-regulated, and competitive insurance market can solve the central problem of health insurance in America: the lack of secure long-term portable protection from health risks. We need not choose between freedom and competition on one hand, and long-term health security on the other. Markets can deliver both.

Getting there requires us to move in exactly the opposite direction of current regulation and most policy proposals. We need to end the tax and regulatory preference for employer-provided group insurance over portable individual insurance, not strengthen that pressure. We need to allow medical insurers to compete—to charge more for people with long-term expensive conditions and less for healthy people—not prohibit them from doing so. We need to allow health-status insurance to emerge so that people can be insured against higher costs.

Any good policymaker looks for market failure before regulating something. Where is the market failure behind bans on risk-based premiums, medical insurance competition, or tax preferences favoring employer-provided group health insurance? No one has seriously documented natural monopoly, missing property rights, adverse selection, asymmetric information, or any conventional source of market failure motivating these interventions, or preventing the emergence of private long-term health insurance. Those regulations emerged as a patchwork response to the historical accident of employer-provided group insurance, not as a coherent regulatory program to address market failure. However, we have not so far had a vision of how a completely free market could provide long-term and fully portable health insurance. Without that vision, one could have a nagging sense that there is some hidden market failure.

At a minimum, the possibility of health-status insurance gives us that vision, reassuring us that there are no such failures, and that these are needless regulations. Free-market economists no longer need to hem and haw, saying, "Well you have a point there, but do we have to make the regulation quite so intrusive?" We can instead say with confidence, "We *can* have long-term insurance with a less-regulated health insurance market, and here's how."

Of course, I also hope that it actually happens: that our government takes the simple steps necessary to let long-term health insurance emerge in place of highly regulated long-term pooling systems. We could then watch with delight as the resulting competition does its usual magic of raising quality, lowering costs, and spurring innovation in both health care delivery and finance.

Notes

The author thanks Joe Feldman, Mark Pauly, and especially Michael Cannon for helpful comments.

1. The contracts in this article are described more fully in John H. Cochrane, "Time-Consistent Health Insurance," *Journal of Political Economy* 103 (June 1995): 445–73.

2. To keep the math simple, I assume that he wants medical insurance only until age 65, when he will transition to Medicare, and that he is certain to live that long. A realistic calculation should include the actuarial probability of death at each age, and can therefore handle the absence of Medicare. Of course, Medicare would be unnecessary with an effective long-term health insurance market.

3. Bradley Herring and Mark V. Pauly, "Incentive-Compatible Guaranteed-Renewable Health Insurance Premiums," *Journal of Health Economics* 25 (2005): 395–417. As I explain below, the "GR" or guaranteed-renewable premiums shown in their Figure 3 and Table 3 are identical to the combina-

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tion of health and health-status insurance payments described here.

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

5. Mark V. Pauly, Howard Kunreuther, and Richard Hirth, "Guaranteed Renewability in Insurance," *Journal of Risk and Uncertainty* 10 (1995) 143–56; Mark Pauly, Andreas Nickel and Howard Kunreuther, "Guaranteed Renewability with Group Insurance," *Journal of Risk and Uncertainty* 16 (1998): 211–21.

6. Herring and Pauly, pp. 395–417.

7. Thomas Buchmueller, Sherry A. Glied, Anne Royalty, and Katherine Swartz, "Cost and Coverage Implications of the McCain Plan to Restructure Health Insurance," *Health Affairs* 27, no. 6 (September 16, 2008), web exclusive, http://content.healthaffairs.org/cgi/reprint/hlthaff.27.6.w472v1.pdf.

8. See, e.g., Henry Butler and Larry Ribstein, "The Single-License Solution," *Regulation* 31, no. 4 (Winter 2008–2009): 36–42.

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

10. Herring and Pauly, pp. 395–417.

11. Reed Abelson, "UnitedHealth to Insure the Right to Insurance," *New York Times*, December 2, 2008, http://www.nytimes.com/2008/12/03/business/03insure.html

12. Ibid.

13. See, e.g., Robert Helms, "The Tax Treatment of Health Insurance," in *Empowering Health Care Consumers through Tax Reform*, ed. Grace-Marie Arnett, ed. (Ann Arbor, MI: University of Michigan Press, 1999), pp. 1–25.

14. Tom Daschle, Scott S. Greenberger, and Jeanne M. Lambrew give a splendid description of how competition for healthy people undermined the Blue Cross/Blue Shield "community rating" (i.e., pool) system of the 1940s, helping to create "the flawed system we are saddled with today." See Tom Daschle, Scott S. Greenberger, and Jeanne M. Lambrew, *Critical: What We Can Do about the Health-Care Crisis* (New York: Thomas Dunne Books, 2008), pp. 56–57.

15. All quotes are from Obama '08, "Barack Obama's Plan for a Healthy America: Lowering Health Care Costs and Ensuring Affordable, High-Quality Health Care for All," p. 7, http://www.barackobama.com/pdf/HealthPlanFull.pdf.

16. Ibid.

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