**Frequently Asked Questions (FAQ) – Replacing ACA**

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**Section A - Affordability - How to Cover**

**QA1. Where are the principal concerns for health coverage affordability today?**

There are two very big ones today – the rapidly growing cost of healthcare in a family’s budget and the extra burden if someone has a serious pre-existing condition.

The overall cost and rising health insurance burden has not been effectively addressed in the Affordable Care Act (ACA). Tort reform could be a major cost saver in the future. Defensive medicine is estimated to be as much as ten percent of today’s costs. Some states already have a partial handle on it. Federal tort reform is a non-starter, because there is no constitutional authority for it.

Cost-saving measures in ACA are mostly in the form of price controls, which amounts to a deterrent on growing the number of medical practitioners.

Milton Friedman suggested that insureds get more involved on individual price decisions. A vigorous individual policy market with higher deductibles and the same tax deduction as work-based policies would help.

Pre-existing conditions (PEC) are possibly the next major concern, and any new measure needs to deal with the underlying dynamics of handling this issue.

Other concerns have easier solutions:

* Removing lifetime limits on policies is actually an easy solution, by states (not the federal government). They can enact legislation for insurers to have a price for it quoted in their rate manuals. It is not very expensive, but insureds need to know what it costs, and some insurers need to line up reinsurance for it.
* Similarly, portability has a simple solution via more insurers for individual health insurance policies like we have in auto insurance. Tax deductibility for such is the simple fix at the federal level.
* Guaranteed access to insurance coverage is another concern and again easily fixed with assigned risk plans by state, just as in auto insurance.
* Removing fear of cancellation after a claim or after discovering a pre-existing condition is also on the public’s list of concerns. Again the availability of assigned risk plans by state, plus guaranteed renewable contracts are a simple solution here, except for the pre-existing condition part.

In summary, for all but the need to handle pre-existing conditions better, there are relatively easy ways to improve the old health insurance system, without resorting to a complex, inefficient federal solution offered in the ACA. Even for pre-existing conditions, there are far better ways to deal with this than the ACA.

**QA2. How well has the system of employer-based policies dealt with pre-existing conditions?**

It was a partial solution which hid the amount of subsidy. After a waiting period, you generally had coverage for PEC. If you needed a knee replacement costing $30,000, it was covered in your employer policy, which was mostly experience-rated, so your fellow employees really paid for your PEC procedure.

If you lost your job, and ultimately found another job, you would go through a similar waiting period before getting PEC coverage. Some employers, possibly smaller ones, might have had further restrictions if the PEC was going to be very costly and impact the bottom line of the company.

In between jobs, you generally had a COBRA policy (very expensive and generally without PEC coverage). The Consolidated Omnibus Budget Reconciliation Act created this in 1985 to provide continuation of heaIth insurance for a time after leaving an employer. If the original employer went out of business, you could also lose your COBRA coverage, and have to rely on a state residual market program, again very expensive.

**QA3. Is ObamaCare a good way to subsidize pre-existing conditions?**

ObamaCare is an extremely poor way of funding PEC. It hides the subsidies in overpriced coverage for the young and the healthy. First, we don’t even know now what the current PEC costs are because they are hidden in today’s subsidies. Next, the nation needs to decide overtly how much we can afford to pay, or want to pay, for those subsidies. They could be very large, possibly $100 billion or more a year.

Furthermore, growing an entitlement program such as Obamacare means another unfunded burden, adding substantially to the current burden of more than $70 trillion present value. Recall that the formal national debt is a mere $18 trillion! We have made additional promises to our populace where the U.S. government needs an extra $70 trillion in the bank now, earning interest (not actually done). We would possibly need an extra $100 trillion if Obamacare is added to the mix.

In addition, the hidden nature of the PEC subsidies makes it impossible for a free market individual policy insurance system to function properly. Thus, the really bad way to handle PEC would be to ban measuring it and to make insurers cover it without any extra revenue to pay for it.

Even worse would be to compel insurers to write anyone who applies for insurance, with no right of underwriting. This was tried in Massachusetts automobile insurance in the late 1970s with an absolute disaster. The government’s promise to make the insurers whole by redistributing funds after the fact did not work, and 80% of the insurers left the market, and virtually all of the large ones – leaving a few small insurers at the mercy of the government to make them whole.

This abandonment of fundamental actuarial principles was flawed from the start, and would doom the naïve ideas of any who would try it again at the national level by federal law. Any state that tried it, after ObamaCare repeal, would be welcome to another trial, but might soon find a similar result of the demise of a free market insurance system, fomented by the heavy hand of government dictates.

**QA4. After repealing ACA, could a High** **Risk Pool be used to cover PEC?**

This is an improvement on the current system. Employers could continue to offer group policies that pool this PEC risk via experience rating a large number of employees that share this risk. Much smaller employers could form mutual pools to emulate that approach. Lastly, individual policyholders could easily buy PEC exclusion policies on the free market or in an assigned risk pool, and handle the PEC separately with a state subsidy source.

The straightforward way to separately handle PEC is to set up a high-risk pool in a state (or combine several states via mutual cooperation) to cover it. Thus a large number of individual policy insurers can price and offer coverage competitively, knowing that PEC is automatically covered in the state catastrophic pool.

The separate PEC coverage would be written and funded in the state pool. The costs would be shared by all the health insurers licensed and writing in that state. Non-licensed, out-of-state insurers, if allowed to write policies in that state, would somehow have to contribute to funding the pool. To work best, the pool would have access to block grants from Medicaid to partially subsidize the cost of individuals in the pool, using some sort of means test, so a rich person might pay the full cost of that coverage without others subsidizing him. The rating system for various types of PEC could reflect some relative cost of coverage, but there would not need to be a full cost-based pricing system.

**QA5. Could new specialty insurers handle PEC on an individual policy basis?**

This actually is a better way. PEC specialty insurers could form to offer coverage at an actuarially appropriate rate. The insurance regulator would have the chance to review the actuarial pricing method. The subsidies to actual insureds would be from a state agency reviewing the affordability of the coverage to the applicant and how much the subsidy would be. The subsidy fund would come from block grants back to each state from monies at the federal level usually earmarked for Medicaid.

If the subsidy did not cover the entire cost, then the insured might have to make up the difference. The state might even cover some of the shortfall from state tax revenues.

Recall that this new system does not purport to cover every need of the public by federal fiat. There are still basic needs in the public (shelter, clothing and food) that are not guaranteed to be supplied by the federal government or the Constitution.

The advantage of the specialty insurer approach is a classic case of identifying true risk so that risk control may be a better answer than just risk financing. Specialty insurers could well identify characteristics that could mitigate the risk (e.g. medical devices or life style changes) that mean lower premiums and more chance that the insured will ultimately pay a lower price.

Admittedly there is a sentiment that some of the problem may be DNA or inherited traits that the insured can’t control outright. But that does not mean society can’t encourage ways to reduce the overall costs without bankrupting the individual.

**QA6. Is there another way to provide PEC coverage (and added access to insurance) via HMOs?**

HMOs could be a third way to do it, as they have an added value in using a longer-term view of loss control and loss payment. The theory is that doctors in an HMO have an incentive to use a more holistic approach. By investing in preventive measures early on, they will save on lower treatment costs later. The HMO is then responsible for later more costly treatment, so they are incented to do much more in the way of early detection and early risk management. It is also a long-range commitment for the coverage, instead of encouraging insureds to try shopping around for the lowest initial premium.

After repeal of the ACA, it would be good for some states to experiment with HMO formation and expansion of this concept. In those experiments, they must deal with another countervailing risk management technique, namely having insureds participate more in the cost of trivial claims to avoid overutilization.

PEC coverage would have to be handled in these HMOs initially, but the longer term nature of the contracts and the insured’s commitment make for better handling of PECs as well.

**QA7. Is it better or worse to have an overt subsidy for pre-existing conditions instead of how it was handled in employer-based policies?**

Transparency is always better. If an employee had advice to have knee replacement at a cost of $30,000, his firm used to pay for that. They then would charge it to the general employees’ account, if the plan were large enough to be experience-rated (a common situation). So the other employees would essentially be paying for it, without knowing how much extra they were paying for this generous benefit, that might have been handled by the employee who could really afford to pay for it on his own.

After ACA repeal, an employer-based plan might work the same way as before, if the employer arranged and partially subsidized health insurance for all its employees. The tax-deductible portion would only be above a high deductible threshold.

If the employer merely gave a tax-deductible credit to buy guaranteed basic coverage on the open market, the employee would have to disclose the PEC to prospective insurers and pay almost all the extra costs for that PEC if he failed a means test.

If the condition were as simple as needing specific knee surgery from a prior injury or even knee replacement, he would likely have to budget for paying the cost of knee replacement at an appropriate convenient time in the future to plan for it. The good news is that his fellow employees would no longer be subsidizing him for the cost. He therefore may have to dip into savings or else borrow on his home equity loan and pay back over time the cost of that procedure.

He may, however, try to bargain with the surgeon and the hospital about the costs, as he is personally paying for it, not some faceless insurance company that has lots of cash assets. He may even check with other surgeons in the area to lend a sense of competition, as it is not an emergency situation (which would be covered under his new policy), but a true pre-existing condition.

**QA8. If the PEC were something like diabetes, would the overt subsidy method work?**

Yes, and it would have the added advantage of identifying where risk control might even lower costs.

A situation like diabetes usually means much higher likelihood of future medical treatments, but not a certainty, so it is inherently more insurable. There are recommended life style and diet changes that can keep the costs lower. However, it is true that a health insurance policy for a diabetic could well be two to three times the annual cost of a non-diabetic. So the extra premiums per year of perhaps $8,000 to $12,000 must be dealt with.

If employed by a large company with a generous heath plan, he would have “free” coverage, as generally large employers don’t charge extra for a PEC condition.

If no group policy at work, the diabetic’s first source of premium support would be a new state program for those needing PEC policies. The federal block grants back to the states would be providing some $50 billion or more previously not available. A state review of the individual’s financial resources would then grant some level of premium support, and perhaps complete support if the income and asset level were much below average.

However, if the individual had sufficient income and/or family assets to allow paying for the extra costs without state aid, that person may have to shoulder the extra costs on his own. If so, he would be especially cognizant of the specialty insurer’s recommendations on how to save on premiums by lifestyle and diet changes to keep the risks lower, under the general risk management guidelines rule of risk control versus risk transfer.

If a given state had extra Medicaid block grant funds due to favorable other conditions (like tort reform and competitive rating laws), there may be more funds available for premium support than in other states without those favorable conditions.

**QA9. How would the allow exclusion of PEC in regular policies and having a separate PEC policy affect the competitive market?**

It would improve competition by having more regular insurers and allow better focus on the PECs themselves.

Separating PEC coverage would maximize the competitive market size and help keep service up and prices down. Specialty insurers could handle PEC better, with more intensive knowledge of the conditions, and with the availability of subsidies on an overt basis. This would also allow the public policy makers to be able to quantify the total cost of PEC and make recommendations on how the country would pay for this situation. Also those who can afford the coverage would not be subtracting funds from the subsidy pool, to allow more to qualify for extra funding.

**QA10. What about PECs that are not known at the time of initial application to an individual insurer? Are they automatically excluded?**

The short answer is NO! Only known conditions need to be disclosed to a prospective insurer in order to price it actuarially. If the condition is minor, there might be only a small surcharge, e.g. for a past knee injury from an athletic event, where a future arthroscopic procedure might be called for. If there is a new injury, that would be covered as it is a new event.

If the applicant reveals that he has already been advised to need a knee replacement, that is a condition that can’t be covered actuarially with no extra cost contemplated. That might be a true PEC not covered in the new policy. The insured would then have to consider a long-term funding plan to pay for a procedure that might cost, for example, $30,000. He could apply for that specific PEC coverage in the state residual market program, but would be subject to a means test,

He may even be rejected in that state PEC pool payment process, because he already has an identifiable procedure with a known cost – a virtual certainty of a loss, not a risk of a loss. It’s like not getting a binder for fire insurance on a building that is already on fire.

Contrast that to a person with a diagnosis of diabetes. That is a condition that brings the risk of more cost but not a certainty – which is an eminently insurable condition, but just at a higher premium. There are many things that such an insured can do to lower the future risk – via diet and exercise. The new PEC insurer may even offer substantial discounts for such committed activities, if verifiable.

Hence the advantage of an overt insurer for this PEC, instead of just throwing them in a pool and paying whatever the extra cost, and billing the state or the federal government for the extra costs. Managing the individual risk is always better than papering over the cost via a disinterested outside third party.

**QA11. Do PEC subsidies need a national pool to administer it, or merely to fund it?**

The pool to administer the subsidies does not have to be federal, because there is not a big difference from state to state in PEC risk, as there is in property catastrophe risk.

There is, however, a need for a large-scale overall funding source at the federal level which could be allocated very equitably across states. Each year the Ways and Means Committee in Congress could allocate some of the Medicaid funding in block grants back to the states. By taking a uniform portion of the taxes supplied from each state, it could target back those funds to each state to provide PEC subsidies. The states would then administer the subsidies using a means test, so that the needier get the most relief. If the whole added risk is not funded, but only substantially ameliorated, that would still be a very good thing.

Congress could also incent better programs by state by allocating a higher percentage for better programs, e.g. tort reform and more actuarially sound pricing procedures, such as better risk measurement, and no “community rating” price controls.

We could even have a debate whether the public wanted more affluent PEC policyholders to get extra funding, but that would likely have a lower chance of getting full funding. In contrast, the ObamaCare approach to PEC gives even the wealthy full PEC coverage. Perhaps those funds could be better allocated.

But by treating PEC separately, we would in the future at least know what the needs were, and could consider other solutions. By hiding the costs in hidden subsidies, we lose that option.

Also, as experiments in auto insurance have shown, in blind pools with no real scrutiny of individual claims, the opportunity for more fraud exists. The results are usually much worse than if individual insurers are accountable for claim settlement.

**QA12. Why would a competitive market fall apart with an approach like ACA currently does on hiding the costs of PEC?**

Yes. Consider the analogy of you and your cousin each owning a GM car dealership in adjoining counties. You have both Chevys and Cadillacs in good supply at your showroom, designed to sell at $20,000 for the Chevys and $40,000 for the Cadillacs. Your cousin has mostly Chevys.

The overall regulator of prices decides you have to charge the same price for all vehicles sold from now on, regardless of your cost from the manufacturer. You are to sell initially at an average price of $30,000 per car. Your cousin gets the mandate to sell his cars for $25,000 each as he has fewer Cadillacs.

Almost every customer in your shop opts for the Cadillacs at $30,000 each and you sell few Chevys. You lose a fortune the first year. Your cousin gets most of the Chevy buyers, and few Cadillac buyers (he had only a few of them to sell) and he makes a lot of profit the first year.

You then apply for reinsurance and rate relief. You get to raise your prices closer to your costs, and next year your uniform car price is $35,000. The regulator then taxes your cousin for his excess profits, and gives you some of his profit. His next year price is $22,000 per car.

Next year’s customers still behave rationally and you continue to lose money, while he still makes an extra profit. Again the regulator redistributes the wealth. And so it continues.

When people come in for trade-ins, the same pattern of price controls exist and you never recover, and have to close down. Your lucky cousin continues, unless some new dealer goes after his mispriced inventory and starts him down the death spiral of price controls and mispricing that the overlord regulator never really can keep up with.

By the way, after a few years, like in ObamaCare, the formal redistribution of wealth scheme ends anyway, so you are both on your own to try to compete with this massive mispricing scheme attempting to function in an ostensibly free market. So many car dealers leave the market that eventually the government takes over the profit and loss system, and only pays the showrooms to sell whatever the government decides to charge and the dealers make their profits purely from commissions.

**QA13. Could insurance approach, within state regulation, work by precluding the use of PEC in underwriting or pricing new health insurance plans by state?**

That is usually a fatal flaw, as well. Another analogy within insurance is worth noting. Suppose the state legislature (or regulator) decided in Florida that it is not in the public interest to use geography as a rating variable in homeowners insurance. So any application for coverage was not allowed to reflect that the insured lives on the coast (with its much higher pre-existing condition for vulnerability to hurricane.

If every insurer wound up with the exact same proportion of coastal risks, it may even work initially, as the risk would have been “spread around” evenly. But suppose insurer Y got too many coastal risks initially. It of course would have lost the first year, as its rates contemplated an average distribution.

The next year its rates would have been allowed to rise to reflect the worse anticipated future risk. And its competitive posture would deteriorate as other companies had lower rates going forward. So it would lose some of its customers at the lower end of the risk profile. Its coastal customers would of course hang on, as they are being subsidized.

And the state would have to have rigid rules imposed, and monitored, so that insurers don’t dare try to non-renew these heavily underpriced risks on the coast.

The result can become what people have referred to as a “death spiral” as the disadvantaged insurers keep getting deeper and deeper into red ink, until they finally withdraw from the state.

This is what happened in Massachusetts auto insurance, when even the state’s wealth distribution program did not prevent the “death spiral”. The wealth distribution system tried to tax the advantaged insurers to reimburse the disadvantaged ones.

**QA14**. **What is the effect of taking the wrong approach on covering PEC?**

At the state level, if it fails, it can more easily be replaced. If it succeeds, then other states can learn how to accomplish this very difficult task. If a federally mandated approach fails, the consequences are much more dire.

If a state wanted to try to replicate the system of ignoring a major risk delineator and trying to have a free market insurance system function, it will have to overcome the above economic realities. Perhaps some states might even try to do it again, as the goal of subsidizing high risks, high for the most part though no fault of their own, is a noble one. Having the free market function, with its efficiency and low costs and innovation, is the hard part.

The real risk is that these sentiments, ignoring the extra costs, are perhaps expressed without knowing how a private insurance system really works. They can have the unintended consequence of destroying the private insurance system.

Some cynics believe that the real purpose of ObamaCare was to do exactly that, so the ultimate result would be a total federal takeover of health care, as single-payer system.

If there are skeptics to this cynical view, they are invited to actually read the full text of ObamaCare. The only conclusion to reach is that this tremendously complex law, almost unintelligible, had no possible chance for success, so the ultimate outcome would be simply be replacement by a federal takeover. After five or ten years under its unworkability, the easy out for the voters would be giving up and let’s have single payer, and rely on the government, just as Medicare and Social Security have done for seniors.

**Section B – Availability - Ways to Implement Mandatory Access – Different from ACA**

**QB1. How would state assigned risk plans (ARPs) work?**

It would work well to provide guaranteed access to basic coverage, just as it has done in auto insurance for six decades.The ARP in each state would generally not need a separate subsidy because, as in auto insurance, the system itself has a practical method for affordable subsidy. For example, ARP rates approved would likely be higher than voluntary market rates by amounts such as a 20% to reflect the higher risk.

If the actual costs to insure ARs were higher than allowed in the premiums, the insurers themselves would be allowed to charge that extra cost back to its voluntary insureds. For example, the ARP risks may be 40% worse than voluntary risks. In that case, the excess cost of say 20% (over the charged rates already 20% higher than voluntary) would be subsidized by an extra charge of 1% to all its insureds, presuming only 5% of the risks need ARP coverage.

The reason this works in the competitive marketplace is that the needed extra charge of 1% likely falls fairly uniformly on all insurers in the state, so no extra redistribution of costs is needed to be overseen by the state regulator. And the public would be informed that their surcharge is likely only about 1% to make allowances for guaranteed access to all who apply for ARP coverage. Thus this subsidy would be transparent, as the state regulator would disclose the totality of extra charges applied for by the voluntary insurance carriers.

**QB2. If an assigned risk insured left a state, would there be the opportunity to get into a similar assigned risk plan in the new state?**

There should be, with some slight changes is state laws, and possibly a back-up fund federally to cover a few temporary gaps.

First, that person might be able to find a voluntary policy in the new state. Three voluntary turndowns is the usual requirement to apply to an ARP. Next, every state should have an assigned risk plan for health insurance to qualify for Medicaid block grants. If a state has not yet done so, there might be a provision for continuation of the old state policy on a fee-for-service basis until a new ARP is available, or until the insured tries and succeeds in getting a voluntary policy.

**QB3. Could Assigned Risk Plans be used to cover PEC?**

This is not a recommended way to handle that high risk, where are several better ways.

The first instinct for states might be try to cover PEC in their assigned risk plan (ARP) without allowing insurers to contractually exclude it from their basic policies. Recall that a basic ARP could easily handle risk variability (but not catastrophic level). It does this by guaranteeing coverage for those not easily finding a policy in the open market, through the ARP.

A basic policy would be guaranteed in the ARP at a modest surcharge, say 10% to 20% over the generally good open market rates. As is the case with auto insurance ARPs, the real costs are usually larger than the 20% surcharge allowed, maybe even 20% worse than that. What happens is that the insurers are allowed to pay for that cost by “taxing” the regular market insureds an extra 1% or so to pay for it. If 5% of your risks are ARPs, and you lose 20% or each, you can recover the cost by a 1% surcharge on the rest. And every insurer has basically the same situation, as the ARP risks are collectively not a catastrophic risk. So there are no insurers competitively at a disadvantage. They are made whole without some need for the state to intervene to move funds around to take from the lucky and give to the unlucky to keep them interested in staying a licensed insurer in that state.

Contrast that with the hurricane catastrophe risk for Homeowners insurers. In Florida, living on the Atlantic coast is like having a pre-existing condition. In some areas the risk is ten times other coastal areas, and perhaps twenty times an inland town risk. To try to randomly allocate PEC coastal risks among insurers would require an elaborate measurement of relative losses and a backwards redistribution of funds to keep insurers from fleeing the state, afraid of a very bad and inequitable treatment of large losses.

Instead the state allows selling policies ex-wind, and treating the very volatile wind risk in a separate fashion. Thus insurers can freely compete for homes on the coast for all the other perils covered on a homeowners policy, knowing there is not a contingent catastrophic outcome facing them, with little means of paying for it.

The state (and other states) has a separate pool and a separate policy to cover catastrophic wind (hurricane mostly, but some tornadoes are spawned by tropical storms). Those losses are pooled in one entity, and funded separately (some with assessments of regular policyholders inland and even other non- homeowners policyholders). Within the pool itself, there are different premiums for greater risk areas of hurricane, to try to make the sources of extra risk pay a good portion of the extra hazard presented. Those living in Miami Beach did not create the extra risk themselves; it is just that nature has dealt them this extra hazard.

Florida regulators and legislators have tried to create a more national pooling method of sharing the extra catastrophe hazard, but with not much success. Maybe California might be interested in sharing its Earthquake extra hazard, but North Dakota has no interest in such. Trading away their relatively smaller tornado risk is no bargain, when considering a very big Florida hurricane could exceed $50 billion costs or even higher.

The good news is that Florida could find funding for very big storms using international reinsurance capacity, but those on the coast enjoying ocean views might have to more than double their premiums. And there is no sympathy for federal relief special to Florida versus other states.

**QB4. Instead of an assigned risk plan, could a state just have a pool for the risks not written voluntarily by the free market?**

It has not worked in auto insurance.

The pool approach for an auto insurance residual market has been tried in a few states and usually abandoned as unsuccessful after a few years. The most notable was New Jersey where the chief problem was that a pool means no one is in charge who is really accountable for results. Claims just get paid by an enormous bureaucracy and the bad results are just charged back to others who have no choice but having to pay for it.

An assigned risk system works well because the individual insured is actually a customer of the insurer and the insurer is responsible for collecting the right premium and adjudicating the claims just as they do on their other customers. Also the insurer then has the right to court that customer as a desired one eventually when they get to know each other better.

Nevertheless after repeal of the ACA, if a state wanted to try a new version of a state pool trying to fix the aforementioned obstacles, the system of state innovation and experimentation would be the best place to try it. If other states had better results, or saw a new way to fix an observed problem in another state, they could be free to adopt the successes and fix the failures.

The problem with a federal mandate is that the failures are a lot harder to fix and/or abandon.

**QB5. Could an availability solution start with allowing low cost insurers from other states to write policies in every other state?**

Some variation of that solution could work to provide more competition, with some added protections for the consumer that are not now in the state regulatory system.

Competition from many insurers is great to inspire lower cost and better service. The current system of state regulation of insurance (and its national body of collective wisdom and advisors, the National Association of Insurance Commissioners, i.e., the NAIC) has expressed some concerns on how to deal with out of state insurers, who are not covered by each state’s insurance insolvency fund. The latter pays claims to insureds who had a policy with a newly defunct or insolvent insurer. One of the ways to prevent insolvency is by the regulator’s scrutiny or examination (periodic) of financial books, records and plans of insurers licensed in that state.

There is a procedure right now to allow unlicensed insurers to write in a state, when there is a shortage of suppliers for a given particular line of business. It involves a so-called Excess and Surplus lines provision under a state’s insurance code. In that case, the buyer of insurance acknowledges that they know the insolvency fund does not apply and the usual pre-scrutiny does not exist on the outsider insurance company. Hence a “buyer beware” label is put on the product, as it were.

For a policy covering basic health insurance, there may be a way to expand those rules to allow possibly a bit more commentary by the domiciled insurance department on why the new coverage has not been approved in the state, because the filer insurer either got rejected for a license, or else did not even apply for a license.

It would be good to add this outside insurer as a potential source, provided it is licensed for that coverage in one or more other states, to put pressure on the new state as to why it is not available on a regular basis in other states. If the main reason for not allowing that insurer in the state is the belief that the coverage is too basic, that could be one factor. But then some states are too rigid on what they believe a consumer can handle. Possibly there can be exceptions via customer acknowledgement that it is a minimum policy.

Also the new state has less ability to monitor the rate reasonableness of the outside insurer. It does have access to the NAIC profitability reports on all insurers for all lines for all states. So it could see if that insurer had perceived excess profits or excess losses in its home state of domicile.

**Section C – How to Pay for New Programs**

**QC1. How can the federal government help the states pay for a much expanded health insurance system with subsidizing PEC and guaranteeing basic coverage to all?**

The federal budget approval process would give block grants back to each state and vary the amounts to help make the subsidies for preexisting conditions (PEC) more effective.

First, a block grant should not be made until a state establishes an appropriate assigned risk plan (ARP) or equivalent way to provide guaranteed access to basic health insurance. The ideal would be guaranteed coverage for non-PEC in an ARP priced at a slight margin above the voluntary market (perhaps 20% above for someone who got rejected three times in applying for regular coverage).

The actual experience in the ARP should generally set its premium level. However, to help in affordability, the state regulator could insist there be a certain level of rate inadequacy that can be handled in another way. For example, if the shortfall is modest enough (20% or so), then the state regulator could keep the ARP rates at a basic level, say at 20% above voluntary rates. The regulator could then observe that the normal providers could charge the shortfall to their regular market policyholders with 1% surcharge, if only 5% of the total insureds were in the ARP (5% X 20% = 1%).

If 10% of the market were in the ARP, a shortfall of 20% in rate need would only translate into a 2% surcharge on every voluntary policy – an amount that the public might easily be expected to support.

Next, in for a state to achieve a higher block grant, states should have rating laws promoting competition, e.g., laws that do not require elaborate advance permission for an insurer to change premium rates. Those rates would be valid unless the state intervenes for a good reason.

Recall that each state also has at its disposal a vigorous monitoring system on profitability by line of insurance by insurer. If the insurer does not exceed a certain margin of profitability over a period of time, that is prima facie evidence that the rates are reasonable. If subsequent monitoring of profitability of an insurer shows “excessive return” for a period of time, the state regulator can do interim examinations of the insurer to make sure the ultimate rate standard of “adequate, not excessive and not unfairly discriminatory” is upheld.

Also a vigorous competitive market ensures that excess profits are not made, because other insurers can steal business from a too high-priced competitor.

Another incentive for a higher block grant would be the absence of price controls for rating policies. Some states have “community rating laws” on the books under the misguided belief that certain rating variables should be banned, e.g. age, to create hidden subsidies of other risks. In the example, the legislature may have believed that younger, generally healthier people should be overcharged to pay for older, sicker people. These types of price controls generally cause other perverse conditions, such as lack of availability, and should be discouraged.

Even rating by medical condition should be allowed, because an overt subsidy can be given for high priced PEC policies for those with lower income.

If a person moves to a new state that has lower block grants, he can apply, for a period of time, for extra subsidy in the new state. Ultimately it is hoped that states move in the direction of more competitive rating laws (without price controls) and better tort reform.

**QC2. What happens to current ACA subsidy payments to individuals?**

They can be continued for a time, at the federal budgeting process, until the states have enacted appropriate replacements to the ACA.

The current subsidies are in several forms. Low-income people get a refund on their federal tax returns if they earn less than four times the federally defined poverty rate. The good news is the new system would not likely, in the first place, be charging a low-income young person a very high premium to subsidize older Americans. So those people would likely not need the income tax credit.

They also would not be impelled to buy a high priced policy for extra benefits they don’t need or want. Instead they would be encouraged to buy a very high deductible policy (like in a Health Savings Account) that is low cost and handles catastrophic events. Hospitals would be happy to see this as today, many young persons have no insurance coverage, and $100,000 procedures are being performed in emergency care outside of insurance reimbursement. In the future, a low cost catastrophe policy would likely be in place for a young “invincible” so the hospital does not have to surcharge other patients to make up the difference. States could either mandate that financial responsibility on its populace (with some exceptions), or else the very existence of low cost high deductible affordable policies would motive young adults to buy one to prevent them from being bankrupted by a serious injury.

Older low income people, but not with a PEC, if not eligible for Medicaid, would lose their ACA subsidy, but could apply for premium support from the state fund created by block grants from national Medicaid, on a case by case basis with a state authority.

Other people being subsidized in ACA include pre-existing conditions (PEC). There could be in every state a mechanism to continue a direct subsidy. However, unlike under ACA, that subsidy would only go to those who need it. A more affluent insured is not intended to get the PEC subsidy.

Older insureds under ACA are getting subsidies but they are hidden, as medical condition is not recognized and age is not fully utilized in setting rates. But older insured generally have more income than younger ones and can more likely afford to pay the true cost of their coverage. Furthermore they would also to have the option to buy a catastrophe policy (e.g. an HSA), and would not have to include the “extras” mandated by ACA if they don’t want it (e.g. abortion coverage or contraceptive device availability). Insureds in ACA who are subsidized by coverage mandates, such as the “extras” described above, would lose that subsidy and have to pay for that service separately just as they did before ACA.

If a state has not yet introduced its ARP or PEC program, there may be a need for a transition program to allow Medicaid relief for hardship cases from the state's own Medicaid program.

**QC3. Since the federal government does not have the authority to mandate insurance coverage, but the states individually do, what can Congress do to strongly encourage states to act to replace the federally enacted ACA, when it is repealed?**

First, and foremost, it can quickly extend tax deductibility to individual health insurance policies to level the playing field with employer-based policies. It should also restrict that deductibility to the more basic policy costs, to encourage the concept of Health Savings Accounts.

Next, it should strongly encourage states to allow cross-border sale of basic health insurance policies. It can do this by creating a national fund to supplement state insurance insolvency funds for state licensed insurers that become insolvent to pay the basic claims of insureds who are disadvantaged by such insolvencies. The cross-border sales fund should recognize that the insurer must qualify as state licensed for those type policies in at least one other state.

Third, it should specify minimum standards for Medicaid block grants to be increased only for states that establish adequate assigned risk plans (or effective alternatives) guaranteeing access to a basic form of health insurance for families.

At the same time, it could outline the other standards that would qualify a state for extra or diminished block grants in the area of medical tort reform laws, or restrictions on competitive rating laws under the federally enacted McCarran Ferguson Act of 1945.

Referring to that same law, it should specify that it expects the NAIC, through NCOIL, to prepare model laws mandating an adequate statistical reporting and sharing methods. These are designed to allow better pricing of basic health insurance policies, with access by new insurer entrants to enhance competition. If those model laws are not devised within two years, specify that Congress will contract out to have an independent party research and develop such model law wording.

Finally, Congress could separately fund, for a defined period of time, any ACA insured who had “free” PEC coverage beginning in 2015, when medical condition was banned as a distinction in offering coverage. The length of time may vary on when new state laws and procedures pick up the funding of this extra PEC risk. Congress should also impose a means test on this fund to help those with a PEC.

**Section D – Specific Features of New Plans**

**QD1. Would employers continue to offer coverage, even as individual policies would be equally or more competitive?**

Some might continue the provision of adequate cover at work, and some may offer alternatives to fund that need for health insurance.

Employers could continue to offer health insurance coverage paid via payroll deduction. Some may convert to an allowance (e.g. $5,000 per employee) to buy from a pre-arranged insurer or set of insurers who market at the workplace. Getting employers off the responsibility of designing health insurance plans for their employees would allow them to concentrate more on their core business skills.

Tax deductibility at work for health insurance as well as individual policies could then be converted to only higher deductible policies (such as the eligibility for Health Savings Accounts). This would restore the insured as being involved in minor procedure decisions, instead of the syndrome of “what do you care, someone else is paying for it.” The latter tends to drive up total expenditures by overutilization.

**QD2. Why should the tax-deductible status of employer-based health insurance be expanded to individual policies?**

It is outmoded from its original purpose, and now prevents individual policies from thriving as an alternative. Even the ACA did not address this anomaly.

It was introduced during World War II to get around wage controls at employers. It is now an anachronism, and should be fixed, according to an article written by Nobel Prize winning economist Milton Friedman over ten years ago.

Individual policies should be treated the same as group policies, with a tax deduction for a basic level of coverage only. Furthermore, individual policies are much more portable.

The full tax deductibility at work, moreover, discourages the use of Health Savings Accounts, with their higher deductibles to control overutilization.

**QD3. Under a new system, what happens to portability if a person moves to another state?**

Portability of group policies is not very good today. COBRA policies may help but they are quite expensive, might not be tax deductible, and only stay in force if the original employer stays in business.

Individual policies are very portable, as many insurers are licensed across states, especially neighboring states, so the basic coverage could continue seamlessly. Doctor networks arranged by the same insurer may change, but there would be similar types of networks.

To handle the situation when the original insurer happens not to be licensed in the new state, state laws can be amended so that grandfathering takes place on coverage provisions. If the original state had a guaranteed coverage in case of insolvency, then some sharing of the reimbursement should be arranged.

**QD4. What happens to policies that are subsidized, if one moves to another state?**

That can be easily covered.

If a subsidy was involved in the original state (such as for pre-existing conditions), that should continue in the new state. If the new state has much less in the way of block grant from Medicaid to help pay for such subsidy, an expansion of the Medicaid block grant could be arranged to fill in the difference. Recall that the formula for Medicaid block grant to a state is based on proportional census numbers, but modified for better tort reform and no pricing restrictions such as “community rating laws”.

**QD5. How would guaranteed renewal policies work to reduce risk for insureds?**

This new feature to protect consumers could be easily handled.

First, the usual rules would apply to allow insurers not to renew if an insured failed to pay premiums or misrepresented material information on application details. Absent those rules, insurers would generally have to offer renewal to each customer each year, so they can reliably predict they will not lose coverage as long as they stay with the insurer.

The next level of security could be for an insured to buy price protection on renewal contracts so that any material change in condition did not raise the premium beyond a specified amount. This is especially important if a new condition arises, e.g. contracting diabetes, which might normally raise the premium due. For an extra premium each year, e.g. 1%, the insured would be guaranteed that his premium would not rise more than 10% over the normal premium he was paying, due to a reunderwriting process arising from a major new condition.

Insurers easily offer this price protection because they know the probabilities of new conditions arising and can fund for it. It is possible that the insurer may ask about family history in pricing the guarantee, so that a family with a history of developing adult onset diabetes may pay a little extra for that price guarantee. It is also true that many with a family history do not ever get the disease that other family members have had in the past.

**QD6. What type of tort reform would help to reduce overall costs?**

California has a good system that can be emulated.

A meaningful cap on “pain and suffering” awards, such as the $250,000 one in California’s MICRA passed in 1975, possibly indexed for inflation, would go a long way to prevent unnecessary lawsuits. MICRA stands for Medical Injury Compensation Reform Act. Its existence in California has helped keep physicians in practice there without the huge rise in their professional liability insurance rates that other states have experienced. Those high and unnecessary extra insurance rates in other states have raised the prices to patients as well as discouraged some practitioners from even continuing in those states.

**QD7. How would any new plan work within the current system of state regulation of insurance?**

The current system of insurance regulation by state could work well with new plans by state to replace the ACA.

For a new plan to work well, it is also important that state regulation of health insurance rates not be overly bureaucratic. For example, no artificial price controls should be established such as exist in so-called “community rating laws” which are really misguided attempts to hide subsidies. By precluding or restricting rating by age, those legislatures were really trying to have young people subside older ones in a hidden fashion. In auto insurance and life insurance, rating by age is an accepted and effective risk assessment variable. Besides older insureds generally have higher income than young ones to be able to afford the higher cost policies. Price controls, in general, have never really worked in a free enterprise system that deals with supply and demand.

Rating laws by state can be very effective even if prior approval of detailed rate applications are not required. Insurance is not like a utility where there is only one supplier in a monopoly environment for a needed product. Dozens of suppliers competing for customers help to keep prices and service competitive. Encourage state health insurance regulation on a “file and use” basis, where carriers can implement changes quickly and easily, with an after the fact review by the regulator. This has worked well in auto insurance by state for decades.

The state regulator even has the ultimate trump card once profitability is revealed by insurer by state. If an insurer somehow has earned what is perceived as extraordinary profits compared to competitors, an immediate interim examination of that carrier can be initiated by the domiciliary insurance department, aided by regulators in other states for which that carrier is licensed. This would be in addition to the regularly scheduled periodic examination of insurers on a three or five-year cycle. This method of state regulation of insurance has thrived for decades ever since state regulation of insurance began in its current form after the federal law, the McCarran-Ferguson Act, was passed in1945. Monitoring and publishing profitability of insurers by state for key lines of insurance has been in existence since the 1970s when computers facilitated the quick dissemination of such detail.

Also recall that state regulatory review of fiscal responsibility has also been part of the formula. There is a fiduciary responsibility of insurers to be available to pay claims when premiums are paid in advance. The product quality is not complete until the last claim is paid under the policy to indemnify the insured for their risk which is transferred to the insurer.

Insurers have functioned well under a vigorous state insurance regulatory system where policy forms and rates and financial solidity are under varying degrees of state regulatory scrutiny to protect the public. The fact of relatively few insurer insolvencies over the past 60 years is a direct function of the existing authority levels of state regulators with cooperation from related states where the insurer was also licensed. State licensing also provides the means to recompense those who happen to be insured by a company that failed.

The National Association of Insurance Commissioners (NAIC) is also a well-established mechanism for joint cooperation on standards and best practices among state regulators on common problems with a means to fund needed mechanisms of scrutiny and enforcement. Among its goals are: protecting the public interest, promoting competitive markets, facilitating fair and equitable treatment of insurance consumers, promoting reliability, solvency and financial solidity of insurers. It was founded in 1871 and initially helped in making financial reporting to regulators and to the public meaningful and uniform among insurers across the U.S.

There is also a joint venture for possible common legislative solutions by state in the form of the National Conference of Insurance Legislators (NCOIL).

**QD8. What new insurance companies would surface to offer individual policies?**

There are plenty quality insurers that could enter this new market of individual health insurance policies to create more competition, better service and lower insurance rates.

The current employer-based health insurance system is dominated by relatively few large specialists: United Health Care, Wellpoint, Kaiser, Humana, Blue Cross, Aetna, Healthcare Services, American Family and Highmark. And often there are only two or three active in any one state.

In auto insurance, the largest insurers are: State Farm, Berkshire Hathaway (GEICO), Allstate, Progressive, Farmers, USAA, Liberty Mutual, Nationwide, American Family, Travelers, Hartford, with typically a total of 80 or more licensed insurers by state. The competition for insureds is intense. And so the profit margins are low (4% or less), and the incentives for good service are high because it is easy to fire your current insurer and replace it with another willing insurer.

The size of the individual health insurance market is even greater than for auto insurance (possibly a trillion dollar market), so the competition should be intense to attract customers.

Auto insurers already have a presence in each state with an agency force that can give advice and service beyond just auto and homeowners insurance. Some have exclusive agents, such as State Farm and Nationwide, and some deal through independent agents, such as Travelers and Hartford. Some have a multi channel agency force, such as Allstate, Progressive and Liberty Mutual. Insurers such as GEICO and USAA can also function and thrive dealing directly with customers. All have large capabilities in medical and health insurance today, as no fault auto insurance coverage has direct medical claim requirements stemming from auto accidents.

The largest life insurers are: Metropolitan, Northwestern Mutual, New York Life, Lincoln National, State Farm, Massachusetts Mutual, American General, Prudential, Minnesota Life, Pacific Life, Hancock and Transamerica. Life insurers, such as Prudential and Metropolitan and others, have auto insurance and health insurance experience from past ventures. They similarly might want to give additional products to service their life insurance clients through their agent marketing system.

There may even be new insurance entities formed, from a consortium of medical providers such as hospitals and doctor groups, that would apply to be a licensed insurer in a given state.

The point is that a new trillion dollar insurance market would attract sufficient players to make the new individual insurance policy market very competitive.

**QD9. How popular is today’s system of networks set up by group insurers?**

The network system today is not the ideal situation from a consumer standpoint; there is a lot of resentment.

Today’s employer group insurers guarantee customers to medical providers and elicit “discounts” for steering their insureds to those providers. This by nature creates a two-tier system. If you are in, you get the lower rate. If you are out, you pay the higher price, for example, an insured going “out of network.”

In the extreme, if you don’t have any insurer, you may be faced with a ridiculously high quoted price from a hospital, at their so-call “rack rate”, like a hotel that isn’t dealing with pre-arranged discount group (brokered convention, AARP or AAA customer).

Is this the free market of competition setting prices resembling true costs with a reasonable markup for profit and contingencies, even considering marginal cost pricing issues?

**QD10. Will the new insurers offering individual policies be willing and able to set up appropriate networks to make the process work better?**

Under a new, more competitive system, there could be innovations in networks for a more reasonable price structure, without some of the prior disadvantages of prearranged group pricing.

For many insureds, there will be a self-insured deductible in place, so the individual will be asking for competitive prices because he or she will be actually paying for the procedure. There should be no more cases where the medical provider’s billing person says: “what do you care what the price is; you are not paying for it.”

Nevertheless, there could be some advantage in prescreening a good set of providers. Therefore, new entrants will still want to create medical provider lists, at a discount, for people residing in a local community. For insurers without that skill of identifying better medical providers, they can outsource that process by hiring specialty firms to compile the lists and an arrangement of advance discounts.

**Section E – General Issues**

**QE1. Can these reforms really be implemented with only one new federal law?**

Yes. Repealing ACA is the first step. With that done, only needed in law is the tax deductibility extension to individual policies. The tax deduction should be only for a basic policy, e.g. a level to qualify for a Health Savings Account (high deductible). The deductibility level should be made to employer-based insurance to make insureds more involved with personal health decisions. The basic policy could include coverage for a low deductible annual check-up with a doctor.

This will pave the way for individual policies to thrive, where the policy is portable when someone changes jobs or loses a job, just like auto insurance stays in force independent of work.

**QE2. Is there a likelihood of a single solution to replacing the ACA?**

Differences are likely to exist by state, depending on popular preferences.

Some may want to mandate some sort of basic coverage, so that every person showing up at a hospital emergency room has at least a catastrophe policy to handle the very large costs of a serious injury.

Pre-existing conditions (PEC) can be more fully insured if a state wants to kick in more of its own funding, above the Medicaid block grants back from the U.S. Treasury.

Some states may handle PEC coverage via a pool, while others may encourage specialty insurers to help identify the real costs of that coverage, and with innovative risk control incentives. Those needing premium help can apply for relief from a state source using federally supplied block grants. Some states may innovate with expanded HMOs supplemented by new public health clinics.

If the federal relief is insufficient to offset all the extra costs, states have other options, e.g. add their own relief paid for by their own tax system.

In the final analysis, no one is suggesting that government can solve all financial problems of lack of total resources. The goal of using the private insurance system is to have the efficiency and effectiveness of competition to solve a lot of it, instead of another delegation to the federal bureaucracy. The latter has not shown its ability to deliver major products and services better than the free market.

The U.S. medical system is the envy of the world in many respects, so why ruin it with socialized medicine. Its high costs can be dealt with, by realizing the current system of employer-based coverage almost exclusively has left out huge opportunities for cost savings.

Furthermore the wasteful practice of ”defensive medicine” can also be cured with more meaningful tort reform, that already exists in some states as a role model.

**QE3. Why are state solutions better than a federally mandated one?**

Mistakes at the federal level can be catastrophic.

If someone had the one definitive answer to the complex goal of guaranteed access to affordable health care for everyone who needs it now in the U.S., they would have revealed it by now. And it would have been cited in the preamble to the ACA, with universal agreement by all concerned. Instead the ACA was passed with virtually no Congress person having read it. And no Republican was allowed to offer suggestions on what to include, as the Bill was rammed through on a totally partisan basis – unheard of before on federal entitlement legislation (Social Security or Medicare).

It is better to have individual states try solutions. Others can adopt the successes, and avoid the failures.

**QE4. Didn’t Massachusetts have a healthcare insurance solution similar to ObamaCare?**

There were similarities but with several major differences.

First, its experiment was limited to the state of Massachusetts. There were no federal bailouts if the costs got so high that its citizens couldn’t afford it. If very high, at least its taxpayers would have a chance to vote on providing the extra subsidies.

Secondly, states do have the power to mandate coverage. Auto liability insurance is a virtual mandate in almost every state The form may be financial responsibility to pay a claim if a driver causes harm while driving on public roads. The federal government has no ability to mandate coverage. It is not an enumerated power envisioned by Article I, Section 8 of the U.S. Constitution and the Tenth Amendment. Let the states innovate, and if there are good ideas shown through actual experience, other states can adopt those successes and avoid the failures.

Massachusetts actually innovated with an automobile insurance system in the late 1970s, but it turned out to be a failure. If the U.S. had mandated that solution in every state before evaluating its consequences, it would be much harder to undo.

**QE5. Why did the Massachusetts experiment in auto insurance alternative pricing scheme fail?**

Overreaching and complex, intrusive government regulation is often not successful in trying to beat the free market’s efficiency and effectiveness.

First, Massachusetts has a rather unique rating law, different from every other state. It allows the insurance commissioner to actually *promulgate* auto insurance rates that must be charged by free market insurers there. Every other state *allows* the insurance regulator to *approve or disapprove* rates and rating plans submitted by private insurers. The regulators in all other states then follow the general rule that the submissions are presumed valid unless they violate a standard that the rates shall be adequate, not excessive and not unfairly discriminatory.

Using that unique power in Massachusetts to promulgate, an innovative insurance commissioner decided in 1977 that traditional actuarial principles can be suspended to try a new way of handling affordability and availability problems for auto insurance in Massachusetts.

Actuarially indicated rates in Boston were very high, as were rates for teen-age male owners or principal operators of cars. He then set the rates that were *no longer* those actuarially indicated rates. He also told insurers that they *must accept* all applicants, without underwriting them, and charge them less than the heretofore-actuarial rates.

The market place then went into turmoil to avoid mispriced risks. The state set up a reinsurance pool whereby the regulatory system tried to rearrange the wealth. If insurers got stuck writing too many Boston drivers at too low a rate, they could be subsidized by insurers who had extra profits from insuring a lot of overpriced drivers in Springfield. And similarly if an insurer had too many underpriced teens, they could get help from insurers that had too many overpriced adults.

Eventually the mainstream insurers with prominent offices in Boston (like State Farm, Allstate, and Nationwide) with large and prominent sales offices, wound up losing too much and having to subsidize the system from surplus. They couldn’t try to recoup from other states, because of competition (overcharging there would make them uncompetitive) and by actuarial law and principles (as you can only charge for true costs of the risk transfer; you can’t charge for a loss in another state).

The result was that after 20 years or so of this experiment, only the smaller, specialty insurers were left in the state. They stayed because they were still able to game the system and make money, as long as the big prominent companies were patsies for the mispricing anomalies. When the big professional insurers abandoned the state, the smaller ones could not pick up the slack. Also, the smaller Massachusetts specialty ones had no surplus from business outside the state to fund the subsidies. They had already made their profits from gaming the system, and were not about to give back what they had already gained.

So the legislature had to end this experiment in utopian avoidance of actuarial principles and use of state mandated cross-subsidies. Massachusetts went back to the old system of assigned risk plans to provide subsidized coverage for availability and affordability, like most other states has used for the past 60 years.

Other states tried innovations (avoiding actuarial principles) to achieve some perceived goals of low rates for all drivers, and ignoring actuarial principles. For example, New Jersey tried a pool system in the 1980s that resulted in a $3 billion loss for the state in only seven years (larger than the GDP of 90% of the world’s nations). This debt from the state pool in this failed experiment had to be paid for, as states must ultimately pay for their debts, and can’t rely on a federal bailout from future generations. New Jersey then returned to the assigned risk system that they had before and that virtually every other state has used successfully to solve affordability and availability problems in auto insurance.

**QE6. Why should a new plan not offer insurance as the only solution to every health need?**

Some things can’t be insured effectively, which is why there is whole body of wisdom on the concept of insurability.

Insurance is the transfer of risk of loss for a certain payment called a premium. If a house is already on fire, insurance doesn’t work. People who are already in need of immediate medical treatment should have another recourse – Medicaid or clinics or hospitals. Other premium payers should not have to subsidize those already sick. Possibly the state could, but not other insureds in the state.

Also, people who are poor can’t react to traditional insurance devices to control costs such as high deductibles and high co-pays. Medicaid exists for those purposes. Trying to make a single system, such as the ACA, to handle all medical needs will fail because it creates too many inequitable situations for a private insurance market to survive. Those who wind up paying disproportionately for the needed subsidies don’t know how much the subsidies are.

There is a real role for traditional insurance for health coverage, as there is for auto and homeowners insurance, that provides efficiency and equitable treatment of the costs. If society wants to provide extra relief to a portion of its citizens, that is what a tax system is for, so that a subset of individuals is not unknowingly overly burdened with the extra costs.

**QE7. Is there any downside to always trying to subsidize high risks in insurance to help with affordability?**

Yes, it can preclude key elements of risk management: risk identification, risk control and risk and cost reduction.

In the Massachusetts experiment mentioned above, there was a risk management downside to trying an exclusive financing solution to high risk. For example, for teenage male drivers, the highest rates are for those who are owners or principal operators of cars. If the son only uses the family car with parental permission for truly needed trips, the rates are much lower. By subsidizing the higher rated driver, it might be construed as encouraging more driving in the higher risk situation. Parents, who would have to pay fully for the total use of a car by a teenage son, might choose the lower cost alternative of restricting his droving to the family car under much more supervision. This would undoubtedly lead to fewer accidents and lower overall costs.

So it is nice for politicians to curry favor with teenagers by subsidizing their driving insurance costs, but this generosity has consequences not always thought of at the time of inventing new rating schemes. As recommended by Stanford Research Institute (now SRI International), in a Study of Risk Assessment, it is not good to legislate against the use of knowledge in a free market. Insurers don’t create high risks; they can serve society by identifying them via risk assessment. Then it is sometimes better to handle the problem with risk control, e.g. risk reduction, rather than merely financing the high risk.