

Auto Insurance Principles Should Apply to Health Insurance

MANY AMERICANS RELY ON THEIR AUTOMOBILES TO GET TO WORK. No automobile means no job, no rent or mortgage money, no food. A single parent, struggling to make ends meet in the suburbs with 100,000 miles on the odometer, would presumably welcome the guaranteed opportunity for low-priced insurance that would take care of every possible repair on her auto until the day it reaches 200,000 miles or falls apart, whichever comes first. Especially if the insurance is valid regardless of whether she even changes the oil in the interim.

So why aren't the auto insurance companies writing such coverage, either directly or through used-auto dealers? And given the importance of reliable transportation, why isn't the public demanding such coverage? The answer is that both auto insurers and the public know that such insurance can't be written for a premium the insured can afford, while still allowing the insurers to stay solvent and make a profit. As a society, we intuitively understand that the costs associated with taking care of every mechanical need of an old automobile, particularly in the absence of regular maintenance, aren't insurable. Yet we don't seem to have these same intuitions with respect to health insurance.

If we pull the emotions out of health insurance, which is admittedly hard to do even for this author, and look at health insurance from the economic perspective, there are several insights from auto insurance that can illuminate the design, risk selection, and rating of health insurance.

Auto insurance comes in two forms: the traditional insurance you buy from your agent or direct from an insurance company, and warranties that are purchased from auto manufacturers and dealers. Both are risk transfer and sharing devices, and I'll generically refer to both as insurance. Because auto third-party liability insurance has no equivalent in health insurance, I'll examine only collision and comprehensive insurance—insurance covering the vehicle—and not third-party liability insurance.

Bumper to Bumper

The following are some commonly accepted principles from auto insurance:

- *Bad maintenance voids certain insurance.* If an automobile owner never changes the oil, the auto's powertrain warranty is void. In fact, not only does the oil need to be changed; the change needs to be performed by a certified



mechanic and documented. Collision insurance doesn't cover cars purposefully driven over a cliff.

- *The best insurance is offered for new models.* Bumper-to-bumper warranties are offered only on new cars. As they roll off the assembly line, automobiles have a low and relatively consistent risk profile, satisfying the actuarial test for insurance pricing. Furthermore, auto manufacturers usually wrap at least some coverage into the price of the new auto in order to encourage an ongoing relationship with the owner.

- *Limited insurance is offered for old-model autos.* Increasingly, limited insurance is offered for old-model autos. The bumper-to-bumper warranty expires, the powertrain warranty eventually expires, and the amount of collision and comprehensive insurance steadily decreases based on the market value of the auto.

- *Certain older autos qualify for additional insurance,* either in terms of warranties for used autos or increased collision and comprehensive insurance for vintage autos. But such insurance is offered only after a careful inspection of the automobile itself.

- *No insurance is offered for normal wear and tear.* Wiper blades need replacement, brake pads wear out, and bumpers get dings. These aren't insurable events. To the extent that a new-car dealer will sometimes cover some of these costs, we intuitively understand that we're "paying for it" in the cost of the automobile and that it's "not really" insurance.

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■ *Accidents are the only insurable event for the oldest automobiles.* Accidents are generally insurable events even for the oldest autos; with few exceptions, service work isn't.

■ *Insurance doesn't restore all vehicles to pre-accident condition.* Auto insurance is limited. If the damage to the auto at any age exceeds the value of the auto, the insurer then pays only the value of the auto. With the exception of vintage autos, the value assigned to the auto goes down over time. So whereas accidents are insurable at any vehicle age, the amount of the accident insurance is limited as the auto ages.

■ *Insurance is priced to the risk.* Insurance is priced based on the risk profile of both the automobile and the driver. The auto insurer carefully examines both when setting rates.

■ *We pay for our own insurance.* And with few exceptions, automobile insurance isn't tax deductible. As a result, the fear of increasing insurance rates due to traffic violations and/or accidents changes our driving behavior, and we sometimes select our automobiles based on their insurability.

Each of the above principles is supported by solid actuarial theory. Although most Americans can't describe the underlying actuarial theories, most everyone understands the above principles of auto insurance at the intuitive level. For sure, as indispensable as automobiles are to our lifestyles, there is no loud national movement, accompanied by moral outrage, to change these principles.

Unsustainable Market

In contrast, similar principles are routinely violated in health insurance. To demonstrate this, let's return to the same suburban mother from the opening paragraph. She's busy working, driving to and from work, and driving her kids to school and activities. She ends each day exhausted, sitting on the couch with fast food. She's obese, with a sedentary life and a bad diet, and hasn't taken the time to go to the doctor in years. After a simple injury doesn't heal for weeks, she turns up at the emergency room and learns she has type II diabetes. Although type II diabetes is controllable, changing diet and exercise habits and properly tracking her condition take time and effort, and she's never quite successful in implementing the necessary lifestyle changes.

So the initial emergency room visit is only the first of a long list of health care related to non-controlled diabetes and other problems associated with obesity. Whether she has individual or group insurance, her insurance pays for each episode of care, without singling her out for a premium increase and without charging her any more cost sharing than is charged to the healthiest and most medically diligent insureds. Her coverage continues until she voluntarily changes insurance companies and/or employers or she becomes eligible for Medicare. If she's covered under group insurance, she may not even pay any premium. Her insurance continues unabated, even though the disease was caused by neglecting her body and she maintains her poor lifestyle even after the disease becomes known.

This just wouldn't happen in auto insurance. This scenario is the auto insurance equivalent of guaranteed access to low-priced auto insurance that takes care of every possible repair, including damage already done, until the day the car falls apart so completely it's unsalvageable (death) or reaches 200,000 miles (Medicare), regardless of whether she even changes the oil (takes care of herself) in the interim.

As a society, we don't expect this in private-market auto insurance, but we expect it in private-market health insurance. Furthermore, there's a chorus of national and state interests, which continuously pushes us further away from the auto insurance principles.

The current private health insurance market isn't sustainable. Prices have been consistently increasing faster than inflation for decades. Each year, insureds use more health care than ever before, and more people have no insurance at all. Most actuaries and other people in the private health insurance market don't want national health insurance with its bureaucracy and one-size-fits-all benefits. Yet, we're trying to sustain a private insurance system that violates the very principles we know are necessary for private insurance markets.

Yes, health insurance involves the sacredness of human life and is therefore different from auto insurance. But if we're to sustain a private-market solution to

health insurance, actuaries need to explain to the larger society, in terms that society understands, the rationale for the following principles:

■ As sacred as health care is, it's still an economic transaction that has to be balanced by individuals and societies, against other economic choices. It can't be unlimited. Sometimes it will be secondary to other choices. On a given day, for example, the mother in our scenario may value her car more than her health.

■ Insurance premiums should be paid by the individual and tied to controllable risk factors. This will provide the best incentive for their control.

■ Although it's hard to draw the line between abuse, neglect, and ignorance, self-abuse shouldn't be insured, and we need to draw that line somewhere.

■ The private market can't provide unlimited, self-directed health insurance.

■ Routine care and ongoing treatments of chronic conditions can be pre-funded, can even be subsidized, but they don't constitute "insurable events."

■ Insurance can't be expected to keep every human body in pristine condition. No amount of health care will prevent everyone's ultimate death.

■ Comprehensive, unlimited, non-subsidized private-market coverage isn't possible for people with severely impaired health.

■ The private health market can provide limited non-subsidized health insurance, such as protection from accidents, to even health-impaired individuals.

■ Individuals who can afford to do so and who take good care of themselves should be able to "buy up" to better coverage. People have the option of buying up for everything else in life.

Discussion of these principles is lacking from most of the current health insurance debate. If society can intuitively understand how similar principles apply to health insurance, then it should be able to understand the principles in the health insurance context. We need to initiate the debate. ●

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