

> Body Shop

wanted to respond to Tia Goss Sawhney's article "Auto Insurance Principles Should Apply To Health Insurance" (January/February 2007).

Ms. Sawhney's comments and insights are indeed innovative and thought-provoking. The analogy, however, isn't necessarily straightforward, and there are several unstated assumptions that are likely invalid to a greater or lesser degree.

A key actuarial difference is that the distribution of losses is much wider for health insurance than for auto insurance. The physical damage in auto insurance as defined in the article is going to be a function of the car's original cost new and the cost of claims that fluctuates within a relatively narrow band. Health care costs are a function of many different variables and fluctuate within a much wider range.

A second key actuarial difference is



that the average car price also depreciates significantly and steadily from purchase onward. Yet the average person's health care costs are rather high at birth, decrease for many years, and then increase significantly at advanced ages. Rather than trying to make health care costs fit the model of car prices, it would seem more reasonable to create different products for different age groups.


Another difference is that it's harder to

diagnose and treat a person's health care needs than a car's mechanical problems. A skilled auto "surgeon" can probably narrow down the cause of a problem pretty quickly, while a true surgeon may need multiple tests and a second opinion to diagnose a client.




Yet another key difference is that most auto repairs are actually replacements. It's easier and often cheaper for an auto repair shop to replace a defective part than to fix it. It's unlikely, however, that a doctor would ask for an organ transplant for a sore throat.

No matter how sentimental, most consumers view their cars dispassionately, and insurers are more likely to declare a total loss if needed. The same is dramatically untrue when health care needs strike a loved one.

Finally, there are ethical and moral issues, and reasons of compassion, that enter into health care decisions. How does



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one insure people who have a genetic predisposition to heart disease, for example?

A more appropriate model might be between health insurance and workers' compensation insurance. I would look forward to Ms. Sawhney's dissection of that analogy.

As a disclaimer, the above represents my personal view and not necessarily that of my employer.

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➤ Hard Choices

I much enjoyed both Holly Kwiatkowski's November/December 2006 article ("Taking America's Pulse on Health Care Reform") and Dwight Bartlett's March/April 2007 article ("The Hard Choices of Health Care Reform"). I'd like to address one area for which I don't believe the choices are all that hard.

Mr. Bartlett mentions that "individual medical expense policies are the most egregious example of our excessively expensive health insurance plans." In particular, he cites the NAIC guideline that anticipated loss ratios for individual medical policies must be less than 50 percent for the premiums to be considered unreasonable. While I don't take issue with Mr. Bartlett's assertion, I believe the egregiousness of individual medical expense policies extends far beyond concerns over

the proportion of the premium dollar used to provide for medical expenses.

As an unfortunate hostage of the individual medical expense industry for the past five or six years, I have a very personal distaste for my treatment and the treatment of so many others by health care companies. While I'm currently one of the fortunate ones that can still obtain an individual family policy at standard rates, I can never rest easy as my future treatment lies in the hands of actuaries and companies that are constantly testing new ways to isolate or dispense with any individual policyholder who is no longer a select risk.

For example, upon receiving my latest 40 percent rate increase last year, I contacted the health care plan to understand my options. I was offered the following:

- I could increase my \$5,000 / \$10,000 individual/family deductible to \$10,000 / \$20,000. Fair enough.

- I could apply for the re-underwriting of my current policy to reduce my current premiums by 20 percent or so. Not fair!

- I could apply for a replacement policy since my current plan design was now a closed block. The replacement policy would have virtually the same benefits as my current plan, but of course would require that my family be re-underwritten. This is one of the tricks that should cause the industry and complicit actuaries to hide their collective heads in shame. That is, the issuing of slight policy revisions and the closing out of existing policies.

Of course, the intent and ultimate fate of almost all those relegated to the individual health insurance market is to be isolated with medical conditions in a closed block with ever-increasing rates until one's policy is no longer affordable. NOT FAIR!

What I elected to do was change insurers. But I have no assurance that I won't receive the same or worse treatment from my new insurer.

An even more egregious practice is to rescind, for questionable reasons, individual medical policies during the first one or two years for those incurring high-cost

claims, without regard as to whether the insureds (and I use the term loosely) completed their application accurately and completely to the best of their knowledge. Insurance departments and attorneys are now focusing on this abusive practice, and companies are being forced to drop it.

How can anyone feel that they have health care insurance when the day you truly may need care is the day the individual medical insurance industry is hell bent on isolating you or getting you out of the system altogether?

While I welcome responses from the individual medical insurance industry, I would hope that those responses won't focus on their hands being tied due to the free marketplace. If this were really the primary concern, the industry should get together and proactively address these obviously obscene practices.

It is my strong opinion that a relatively simple approach to many of the current abuses (but not the 50 percent loss ratio issue) is to require that companies provide creditable coverage to anyone covered over some defined period. That is, no continuous re-underwriting, even across companies, to let the marketplace work. I do realize that there is no such thing as a simple solution once the lawyers, regulators, and actuaries get together and look forward to some, I hope, constructive dialogue.

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➤ Orwellness

Dwight K. Bartlett's Commentary ("The Hard Choices of Health Care Reform," March/April 2007) gives his views on the ailments of and possible cures for the U.S. health care/health insurance systems. Some of the views seem well-founded and unquestionable: "Our health care systems need to focus less on crisis care and more on health maintenance." But the comments that attempt to justify some form of central control over health care are highly questionable.

For example, it's not appropriate to



compare a loss ratio of 50 percent for individual health insurance with administrative expenses of less than 2 percent for Medicare—Parts A and B—and imply that a government-controlled system would be less expensive than the present system. As the article states, Medicare and Medicaid already pay for nearly one-half of all medical care in the United States. Yet that hasn't resulted in a low-cost system; many would maintain that it has caused our high-cost system.

Similarly, it's not a credible argument in favor of a government-controlled system to state: "The argument that increased competition will help to control costs, while appealing in concept, has yet to be proven."

The author concludes with this chilling, Orwellian statement: "In summary, I do believe, regrettably, that successful health care reform is going to require some rebalancing of our national values with some resulting loss of personal control—I hope limited—over what kind of health care we get and how it's paid for."

President Ronald Reagan said—in a slightly different context—in his first inaugural address on Jan. 20, 1981: "We've been tempted to believe. . . that government by an elite group is superior to government for, by, and of the people. Well, if no one among us is capable of governing himself, then who among us has the capacity to govern someone else?"

If I become ill, I hope I get treated in the U.S.A., where I still have some "personal control," rather than in any of the other Western nations that have "broad public support for their health care systems."

If, as the commentary suggests, "actuaries, working largely through the Academy and its various health-oriented committees, will have an opportunity to influence the desperately needed reform of health care and health insurance in the United States," I hope they will consider carefully the philosophy upon which their advice is based.

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➤ Closer to Home

As Hank Cox suggests ("Reverse Image: Australian vs. U.S. Fiscal Policy," March/April 2007), it is indeed imperative for the United States to recognize its predicament and look to the examples set by other advanced nations. Australia is one good example, but, as Mr. Cox noted, there are some significant differences between Australia and the United States. Among the differences are the two countries' retirement systems. Fortunately, there is another advanced nation that has a retirement system similar to that of the United States, and it's not on the other side of the globe.

The Canada Pension Plan is a defined benefit plan funded by employer/employee contributions fixed at 9.9 percent of covered pensionable earnings. The latest actuarial report verifies that the CPP will provide the promised benefits without further contribution increase until 2075. This is partly thanks to an investment fund that was established in the mid-1990s to invest current excess contributions in such things as foreign stocks, bonds, and private equity. The investment fund now stands at \$110 billion. On the usual 10-for-1 ratio used to compare Canada to the United States, this would be equivalent to the U.S. Social Security system having available a real asset fund of \$1 trillion.

How did the CPP achieve this? In 1994, the Canadian liberal government battened down the hatches and turned an annual federal government deficit

into a nine-year (and counting) surplus. Although Canada is not out of debt, it has reduced its federal debt to less than 40 percent of gross domestic product. As a part of this fiscal discipline and the political realization of the importance of a sane approach to all financial matters, the CPP changes were made.

U.S. politicians could do the American people a great service by looking to the Canadian example, not only in pension issues but in a few other service and finance areas as well, such as the aging population and medical costs.

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➤ Kicked Upstairs

I enjoyed the article on math proficiency and generations ("First Date With Math," July/August 2006). My offspring don't seem very numerate, so there may be something to the theory [of math ability skipping a generation]. It was interesting that the people you queried had their awakenings around the middle of grammar school. My own epiphany came in the fourth grade when they administered the Iowa achievement tests. I realized that the solution to one of the problems had to be a negative number. I'd never heard of a negative number, so I invented it on the spot. They promptly shoved me into the fifth grade.

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