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What If~
The ACA Applied to Auto Insurance Instead of Health Insurance?

By David Leo, President of WMI® Mutual Insurance Company & WMI TPA®

As part of candidate Donald Trump's promise to "Make America Great Again," he firmly set his sights on the Affordable Care Act (the ACA or Obamacare), President Obama's signature legislation that was aimed at reforming the health insurance market and ensuring that health care would be affordable for all Americans. Now that Mr. Trump has become President, he and the Republican Congress are like the dog that finally caught the car.

For years, Republicans have toed the party line and repeated the mantra "Repeal and Replace." So far, however, their plan has been heavy on repeal, and empty on replace. If and when the Republicans develop enough consensus to design and reveal a replacement plan, it is anyone's guess what that plan will look like, but there are a few key areas that are crucial to the success of any replacement program and of utmost importance in the court of public opinion. Among those are: **(1)** the coverage mandate; **(2)** the prohibition on pre-existing condition exclusions; **(3)** the requirement that ACA metal plans be community rated; and **(4)** the extension of coverage to dependent children up to age 26.

For years, we've been saturated with information and mediaspeak about the ACA. Rather than rehash the same old stuff, I'm going to take a brief look at those four specific topics under a different pair of glasses: **AUTO INSURANCE**. Removing the emotion and subjectivity that inevitably accompanies a person's health will allow us to look at those issues more clearly, empirically, and dispassionately. I hope that eliminating some of our inherent bias will help us analyze the ACA in a more legitimate and unprejudiced way, and will allow us to view those elements in light of well-established insurance principles rather than political talking points. My intention is not to try to persuade anyone to see the ACA as I do, but simply to understand it and assess it for what it truly is, not what we've come to believe it is.

COVERAGE MANDATE – All states (except for New Hampshire) mandate that you maintain automobile liability insurance before you can legally drive a car. Few people would argue against requiring motorists to carry a minimum level of coverage before taking to the roadways, because it protects us all if we are injured by someone who can't afford to pay for the damage they have caused. One important distinction exists, however, between mandating automobile insurance and mandating health insurance: automobile insurance protects *others* from your negligence behind the wheel; whereas health insurance protects *you* from financial devastation due to your personal illness or injury. To be sure, you can purchase first-party automobile insurance that protects you in the event of an accident (*e.g.*, medical no fault or personal injury protection (PIP), uninsured motorist coverage, underinsured motorist coverage), but these coverages are generally optional, and are only available after you have purchased liability coverage that protects others from your actions.

Whether it's good public policy to make people purchase *health* insurance like we require them to purchase *auto* insurance is up to the individual reader to decide, but one thing is clear: it's not possible to provide affordable health insurance and universal health care if people are allowed to game the system by waiting until they develop a need for health insurance before they buy it. In other words, if we're going to make people purchase health insurance to cover their first-party medical needs, which is a valid and legitimate exercise of Congressional authority (the U.S. Supreme Court has said so), there must be meaningful consequences if an individual doesn't purchase insurance and decides to "go bare." Otherwise, as evidenced by the failure of the overwhelming majority of the ACA co-ops, the system will collapse.

PREEXISTING CONDITIONS – The coverage mandate issue provides a nice segue into the second big issue: whether health insurance should be allowed to exclude or limit coverage for pre-existing conditions (PECs). This issue is one of the most popular and important addressed in the ACA, but it is also one of the most controversial and expensive since it allows people to game the system with very limited consequences. Moreover, it incentivizes people to wait to purchase health insurance until the need has already arisen. Consider a situation where an uninsured motorist is involved in a fender-bender. He takes his car to the body shop, but after he gets a repair estimate, he tells the body shop owner he'll have to bring his car back in a few days because he needs to purchase auto insurance so the auto insurance company can pay for the preexisting damage to his car.

Allowing someone to purchase car insurance to cover automobile damage that has already occurred, or to purchase fire insurance to insure a building that has already burnt down sounds absurd, but that is precisely what the ACA allows (indeed, encourages)

people to do with health insurance. Many sick people have signed up for ACA coverage and have gotten their new insurance companies to pay for their preexisting conditions. While covering preexisting conditions may sound altruistic, it makes for poor insurance underwriting, and it raises costs for everyone. I'm not advocating that we should forever exclude someone from the health insurance system if they went without health insurance and gambled wrongly, but I believe there should be meaningful consequences (either financially or through coverage limitations) if they are going to jump into the health insurance market *ex post facto*. (Oh, and if you don't believe this happens, check out this story in Pennsylvania's Altoona Mirror newspaper: *Man Accused of Buying Auto Insurance From Scene of Car Wreck* (March 5, 2015).

COMMUNITY RATING – The ACA divided the health insurance world into two segments: (1) large employer groups with 51 or more employees; and (2) individuals and small employer groups with 50 or fewer employees. The ACA still allows insurance companies to rate large employer groups based on their specific demographics and claims experience, but individuals that are covered by an ACA metal plan, whether under an individual policy or a small employer policy, must be offered the same rate, regardless of health status, claim history, or other underwriting factors. There are a few things that can be used to adjust rates in the small employer and individual markets (*e.g.*, age, tobacco use, plan design, deductible amounts, etc.), but otherwise, rates are the same for everyone.

On the surface, it may seem that community rating is the fairest way to set health insurance premiums. What could be more fair than everyone paying the same rate regardless of health status? However, if we look at that principle through our auto insurance glasses, it doesn't take long to see the flaws in such a "socialist" rating system. For example, if the principles of community rating were applied to auto insurance, a 25-year old male with multiple speeding tickets, several accidents, and a criminal charge for driving under the influence (DUI/DWI) would pay the same premium rate as a 25-year old female with a spotless driving record. The male in this scenario who gets much cheaper insurance than he deserves might think the result is fair, but the female with the good driving record who would end up subsidizing the irresponsible male driver, would undoubtedly disagree.

As fair and equitable as we all strive to be, we just can't escape the reality that some medical conditions are entirely random and should probably be borne by society as a whole, and some medical conditions are brought about because of poor health habits, unhealthy lifestyles, and dangerous or risky pursuits. The "80/20 rule," (*i.e.*, the principle that 80% of all health care dollars are used by 20% of individuals) is alive and well in the health insurance world. (In fact, when analyzing health care spending, you might be surprised to learn there's a well-proven 50/5 rule whereby 50% of all health care dollars are spent by 5% of the population!) When medical claims and expensive health conditions are truly random, most of us would say, "That's what insurance is for." However, when expensive medical claims are the result of risky behavior or poor health management (*e.g.*, smoking, obesity, bad eating habits, sedentary lifestyle, etc.), we aren't quite as tolerant. In those instances, most people would argue the high utilizer should pay a more fair share of the cost, even if it's higher than the average.

EXTENDED COVERAGE OF DEPENDENT CHILDREN – If there's a major component of the ACA that makes good sense and is relatively affordable, it's the extension of coverage to dependent children under their parent's health insurance policy until they turn age 26. Many states already required this before the ACA was passed, and it has gone a long way to help address the problem of "young invincible" twenty-somethings who go uninsured because they can't afford health insurance on their own. Although I support the extension of coverage to dependents until age 26, I believe the ACA went too far. Unlike auto insurance, where coverage of dependents is generally limited to those who reside in the insured's home or share a car with their parents, the ACA doesn't limit coverage to those who truly depend on their parents for support.

I would argue it's good public policy to extend coverage to a 25-year old dependent child who is living at home, continuing her studies or is between jobs, and who can't otherwise afford health insurance on her own. However, I would also argue that it's poor public policy to require a health insurance company to insure a 25-year old daughter (often for no additional premium) who is married with her own children, whose 30-year old husband has access to family health insurance through his own employer, and who can easily afford to be added to her husband's insurance policy with the rest of her family. Unfortunately, the latter scenario is what the ACA requires!

Time will tell what Obamacare will look like under President Trump's administration, but I can only hope the end product will be a well-thought-out surgically revised plan rather than a wholesale hatchet-wielding repeal that smacks of Washington D.C. politics. Some positive things about Obamacare should be retained in the Trump reform effort, but many parts need to be overhauled. At the end of the day, my sincere hope is that the Trump administration and Republican Congress will inject various reforms into the ACA that will produce a better law that addresses the health care crisis in our country in a fair and meaningful way. Who knows, if we're really lucky, the reform movement may include some medical and prescription drug cost controls, which I've always maintained are critical to achieving true health care reform.

If you have questions about this article or would like to discuss your company's health insurance progam, feel free to contact me at ***(801) 263-8000*** or ***davidleo@wmimutual.com.***