

Preliminary

Extending the Theory to Meet the Practice of Insurance

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December 2003

We are grateful to Anda Bordean and Anna Joo for research assistance, and to Dan Gilbert for helpful conversations.

Doth not the wise merchant in every adventure of danger give part to have the rest assured?
Nicholas Bacon, to the Opening of Parliament, 1559

Formal insurance arrangements date back at least to ancient Greece. Marine loans in that era advanced money on a ship or cargo. It would be repaid with substantial interest if the voyage succeeded, but forfeited if the ship was lost, much like the structure of contemporary catastrophe bonds. The interest rate covered both the cost of capital and risk of loss.¹ Direct insurance of sea risks, using premiums, probably started around 1300 in Belgium. The first known life insurance policy was written in 1583. By the end of the 17th century, sea risk insurance had evolved to a competitive process between underwriters evaluating risks and meeting at Lloyd's coffee house, the precursor to Lloyds of London.

Today, insurance is a major industry established throughout the world. It moves progressively into new fields. For example, health insurance was virtually unknown in the United States prior to 1929 and now pays for more than 10 percent of the US GDP. Risks ranging from a Camcorder breaking down to being sued for sexual harassment are all insurable events.

In recent decades, economic attention has caught up with the remarkable burgeoning of the insurance industry. This is largely attributable to the explosion in

¹ Such arrangements are known as bottomry or respondentia bonds. Early insurance arrangements reflected poor understanding of insurance theory. For example, in 1692, England offered life annuities for sale at a fixed price, independent of age. Not surprisingly, healthy young people bought the policies, and the treasury lost heavily. Mortality tables had not yet been conceived. Indeed, Edmond Halley (from Halley's Comet) produced the first life table in response to this event. Still, many of the modern problems had been anticipated. Understanding of moral hazard dates back to second century Roman Palestine. For more on this, and a detailed description of insurance as understood 100 years ago, see the famed 11th edition of *The Encyclopedia Britannica* (1910).

attention to information in economics. Indeed, insurance so well fits this attention that it is a major topic of introductory discussions about the role of information in economics. Moreover, the core insurance topics of moral hazard and adverse selection have been transplanted to fields like labor economics and finance.

This sounds like a happy confluence of theory and practice growing up alongside one another: theory improves by studying practice, and practice draws on the results of theory. A principal theme of this essay is that perception is fundamentally wrong. We believe that there is an increasing divergence between the theory of insurance and insurance practice. Consider the following quiz about optimal insurance.

1. Suppose that a risk goes from negligible to possible -- for example, the increased probability of a terrorist accident on US soil after September 11, 2001. Would you expect the private market to provide (a) more insurance; or (b) less insurance?
2. A 70 year-old unmarried woman has three children, all of whom are comfortably middle class. Would you expect her to be more likely to hold (a) an annuity; or (b) life insurance?
3. A consumer buys a \$620 camcorder and is offered insurance in case it breaks. The insurance is for three years and costs \$120, supplementing the 1 year parts and labor that comes with the camcorder. The probability of a camcorder needing a repair over three years is 8 percent (mostly in the first

year), with average repair costs of \$125. Would you expect the person to (a) decline the insurance; or (b) accept the insurance.²

In each case, optimal insurance principles suggest that (a) is the right answer. But (b) is the answer we often see in the world. Coverage for terrorism risk plummeted after the attacks in September 2001, despite the greater demand for care. About seven times more elderly people have life insurance than annuities, in spite the fact that incomes of children are rising over time. And insurance against small cost consumer durables is among the most profitable items sold by commercial electronics stores. For almost all products, one in five of the customers purchase it; for some it is four in five.

We argue in this paper that these examples are not minor anomalies, but reflect a systematic tendency for insurance in practice to differ from insurance in theory. We discuss and grade a number of insurance settings: mortality, health, and property risk for individuals; and property, liability, environmental, and terrorism risk for businesses. In the vast majority of cases, we argue that insurance in practice diverges from insurance in theory.

The divergence is of two forms. First, insurance is often purchased – sometimes at excessive prices -- when theory would suggest it should not, and many significant risks that should be insured are not. The case of life insurance among the elderly, or insurance for minor consumer durables, is an example of the former. The lack of coverage for terrorism insurance is an example of the latter. Second, there are significant mismatches between parties who should bear risk and those who actually do. Risks can be borne by

² Repair costs and frequencies from *Consumer Reports* (1998).

public entities, private (for profit and not-for-profit) firms, and through financial markets. In practice, the allocation of risk across these entities seems suboptimal. Governments insure risks that the private sector might better bear, and financial markets, with their vast resources and wide participation, are not the risk bearer for many large private risks.

The divergence between theory and practice is not a result of moral hazard or adverse selection. In many settings with failures, information is as close to symmetric as it is possible to be, and moral hazard is extremely implausible. Rather, we argue that the divergence of insurance theory and practice is a result of three phenomena, the first on the supply side, the second on the demand side, and the third a true joint product.

The first is highly incomplete diversification on the part of insurers. This outcome, we believe, arises due to contracting problems on the supply side of insurance. Investors in insurance companies may be nearly risk neutral for virtually all insurance decisions, but managers of insurance companies are not. Risks that are hard to predict, or are correlated across insureds, may result in the insurance company losing significant amounts of money, with some people being blamed and losing their jobs. We argue that this is an important reason why large but nontraditional risks, e.g., terrorism or long-term health care, are not insured.

Contracting difficulties also help explain why financial markets, with assets in the trillions, as opposed to billions for insurance companies, have not played a more significant role in insurance. One challenge is to secure collateral from investors – the ideal source to cover claims – in case a claim arises. Catastrophe bonds are a small step in this direction, but there is no reason to use as collateral only fixed-income investments. In time, we expect, individuals will be able to participate in insurance pools by pledging

such assets as stocks and real estate. A second challenge is to marry insurance expertise with ready pools of capital. Such marriages have been highly successful in such areas as venture capital and hedge funds.³ The standard financial arrangement for such contracts (a management fee and a share of profits) may not be sufficient, though, since profits on insurance may be large until an adverse event occurs. Still, there is plenty of money to write insurance, and ample expertise to write the insurance effectively, even if bringing the two together will require innovative institutions and creative contracts.

The demand side contributes its share to the poor performance of insurance relative to theoretical par. The central problem is that people have severe difficulties making decisions where small probabilities and significant stakes are involved. These difficulties have been discussed in the burgeoning literature on behavioral economics and behavioral decision-making, which was pioneered by Amos Tversky and Daniel Kahneman, and for which Kahneman shared the 2002 Nobel Memorial Prize in Economics. People seem (irrationally) fearful of uninsured losses. They overly project their unhappiness and regret were a bad event to occur, and they misjudge probabilities. As a result, people often insure when theory would say they shouldn't; they insure against small risks; they take deductibles that are way too small; and they insure against events that though tragic do not change the marginal utility of income.

The third problem is what we refer to as probability monopoly. It arises when sellers of insurance know risks much better than buyers, and when there is limited competition. Sellers then set prices well above actuarial and administrative cost so as to

³ We judge by money raised, not investment results.

capitalize on potential buyers' misestimates. Buyers that overestimate the risk of breakdown purchase insurance, at a profit for the insurer.

In the remainder of the paper, we develop these themes about the operation of insurance markets in theory and practice. We introduce areas where we think the theory of insurance should be extended if it is to explain practice, such as understanding what benefits actual purchasers believe they get when they purchase insurance. We start with some basics on when we expect insurance to be widespread, and then turn to an evaluation of insurance markets in practice.

We note at the outset that this is a thought piece. Thus, it tries to present neither rigorous theory nor detailed empirical analysis. It draws data from many sources and arenas to illustrate its themes. And it is speculative in part to be provocative. Thus, for example, we provide our own grades for the functioning of insurance markets across many areas.

I. Insurance in Theory

In many arenas insurance does work well. We begin by examining what we might think of as par performance for insurance markets, and then grade various insurance areas on how they do on these criteria.

A. Insurance in Theory

The principal goal of insurance, as assessed by economists, is to transfer resources from low marginal utility of income states to those where the marginal utility of income

is high. If insurance is actuarially fair, this process will continue until the marginal utility of money is constant across states. When unfair, insurance will be partial, and greater the greater is risk aversion.

Insurance is most effective when losses are common enough to be of concern but not frequent enough to be routine. Neither asteroid strikes nor car scratches make for good insurable events. Insurance for routine events requires repeated administrative expense that makes the insurance less valuable; the risk spreading benefits are also low. Insuring extremely rare risks also involves reasonable expense, with little compensating gain.

Similarly, transactions costs make it important that risks be relatively well defined, and assessable once they happen. Otherwise, claims assessment and litigation can be exceedingly expensive. For most familiar risks, e.g., a house burning down, we would think this condition would be met. However, the recent experience with the one-or-two incident World Trade Center catastrophe makes it clear that there are important exceptions, even with burning buildings. Such ambiguities are more likely where new classes of risk come into play.

Effective insurance also requires that unobservable actions, i.e., moral hazard, not be too significant. Fortunately, major aspects of non-monetary, uncovered loss often assure that this is the case. Thus, for example, rational drivers are not likely to drive at too high speeds because they are insured, and people are unlikely to smoke because they know that if they get cancer, they will receive treatment. The potential for death and disability in these cases counts at least as heavily as covered losses. Monitorable actions

(e.g., determining whether a building is kept in safe condition), and risks due to an external source (e.g., earthquakes) also diminish the moral hazard problem.

These important attributes for effective coverage are generally associated with the demand for insurance. The supply side of insurance also determines significantly how well it works. Two critical questions are how diversifiable the risk is, and whether there is an entity that is capable of bearing it. Most familiar insured risks, e.g., the risk of death, are readily diversified cross-sectionally, since the experiences of members of large pools of insureds are effectively independent. There are, however, many critical risks – e.g., the costs of long-term care – where expected costs for different individuals are strongly correlated; they are so-called aggregate risks. Cross-sectional diversification is not possible with these risks, and other risk-sharing arrangements need to be made.

Concerns about the supply-side may seem misplaced in an industry like insurance, where there are many firms and barriers to entry seem relatively modest. Still, competition in insurance seems far from perfect. As one demonstration of this, consider a fundamental attribute of perfectly competitive markets: the law of one price. In a competitive market, the same good should sell at the same price everywhere.

Table 1 shows the price of “Medigap” insurance for seniors – supplemental insurance coverage that pays for the cost sharing required by Medicare – in Colorado. Medigap is an interesting market to study because the policies that can be offered are absolutely standardized, being set by law. Thus, there are no hidden provisions to account for. Still, the price for insurance varies by a factor of four across companies.⁴ Even more unusual is the obvious difference in pricing strategies that firms follow.

⁴ Mitchell, Poterba, Warshawsky, and Brown (1999) show a large divergence in the price of annuities across companies.

AARP has a uniform price by age, while none of the other insurers do. In a situation where consumer shopped around regularly, this would not occur.

Even businesses find it hard, or seem reluctant, to shop for the best insurance deal. Warren Buffett, one of America's shrewder insurance purveyors, announces periodically in his Berkshire-Hathaway report that he will not be writing various types of business coverage this year because the rates are too low.⁵ Buffett suggests that despite expected losses, his competitors are writing insurance to keep their old customers, expecting these customers to stick with them when prices rise.⁶ His competitors at least think cross-elasticity of demand is low for insurance.

We consider a large number of potential individual and business risks, and evaluate them on these criteria, effectively seeing how well they are likely to be spread. Table 2 shows our assessment. In each case that we consider, there is a disparity in marginal utility across states of nature. This is why insurance is valuable, at least from an economic standpoint. The other criteria differ in applicability across the risks.

B. Consumer Risks

We analyze three major consumer risks. The first is mortality. Though death is certain, its timing is not. Family-oriented breadwinners would like to insure against early departure. Thus, we expect term life insurance to be a common asset in non-retirement

⁵ The insurance price cycle is one of the many divergences between theory and practice that must await future study.

⁶ Quotation from BERKSHIRE HATHAWAY annual report forthcoming.

years. Once retired, the demand should tip to annuities that guard against outliving one's assets.

Mortality risk is a classic case where we expect insurance to perform well. On the individual side, the event is obviously infrequent, so that administrative costs are not too high. The loss is also well defined, and moral hazard is contained.⁷ On the supply-side, it is relatively easy to diversify mortality risk across people, since aggregate death rates are generally fairly stable.

The second risk is to health – more specifically the danger of incurring conditions that are expensive to treat. We divide health risks into two categories. The first is short-term health risks. People have variable health needs in the current years, which conventional health insurance covers. Health risk is somewhat less conducive to insurance than is mortality risk. In part, the need for health care is less ideal. While some health needs are truly random, others are routine, such as an annual physical or well-baby care. The costs of running payments for such services through insurance may be high. In addition, moral hazard is an issue in health care. People may (or may not) take much worse care of themselves when they have health insurance – termed *ex ante* moral hazard – but they certainly use more care when insured than when uninsured (*ex post* moral hazard), e.g., come in for minor aches and pains. Health insurance is not run like a contingent claims market. Whatever your health condition, the more you spend, the greater the cost you impose on the insurer.⁸

⁷ Some have speculated that people live longer because they have an annuity, though we suspect this is relatively minor in aggregate.

⁸ Medicare payments, fixed payments to providers dependent on condition, are an exception.

Some health risks are also long-term. Long-term care expenses provide a salient case. About one-third of the elderly will use nursing home care on a sustained basis, and this care can be expensive – costing upwards of \$40,000 per year (National Center for Health Statistics, 2003). Because a lot of the gains from long-term care insurance involve pooling people who die without using a nursing home with those who do, this care needs to be purchased before significant morbidity sets in. Risk about future health type is related to long-term care risk. Health insurance for individuals, or the groups they purchase with, is usually experience rated. Should an individual's health decline, or the health of the average member of the group decline, the premium increases. Thus, one might expect people to want insurance against the risk of becoming high cost in the future (Pauly, Kunreuther, and Hirth, 1995; Cochrane, 1995; Cutler, 1996).⁹

Adverse long-term health events are sufficiently infrequent, but not too much so, that insurance makes a good deal of sense, at least in theory. But these risks challenge conventional insurance in three other ways. As with short-term health insurance, moral hazard is likely to be an issue in long-term insurance: if insured, move grandma to the nursing home. In addition, the loss is poorly defined. When does a person need long-term care, and when is she capable of functioning on her own? What does the appearance of a health event today signal about potential future spending? These information problems undermine the viability of long-term insurance. On the supply-side, there is a substantial concern about diversifying these risks. When future medical costs increase for some people – e.g., because expensive new medical technologies become available – they will increase for others as well. Similarly, if new medical knowledge extends

⁹ Indeed, since health declines lead earnings expectations to diminish, and earnings cannot be insured, long-term health insurance is that much more valuable.

survival at older ages, it will yield such benefits to millions. The unhappy side effect is that a much greater percentage of the population will spend a fair amount of time in nursing homes. Such properties of long-term health risks imply that cross-sectional diversification will not be entirely possible.

The final individual risk that we address is property and casualty risk. People own homes, cars, and consumer durables that may burn, crash or break. Consequently, they may want to insure them. Property and casualty insurance has many attributes that are favorable to insurance coverage. The major exception is moral hazard. One might imagine that people drive faster when they are insured, or take less good care of their house or other durables. Some evidence suggests that this is the case (see Cohen and Dehejia, 2003, for a summary), though the evidence is far weaker than for moral hazard in medical care utilization.

While mortality, health, and property/casualty risk are the major individual risks that we consider, it is important to note that there are other risks we are not discussing. Most people owe money on a house, and face a choice between an ostensibly risky debt payment (an adjustable-rate mortgage) versus a fixed, insured payment (a fixed rate mortgage). However, it is not obvious which form should be preferred, i.e., whether the borrower should protect the bank against interest rate movement, or vice versa. We might analyze this financial choice in the same way as other forms of insurance. People might also like insurance for their human capital, for example to guard against depreciation of their skills – think travel agents -- or prolonged unemployment. There is public insurance for some of these risks, via unemployment insurance, workers' compensation, and disability insurance. But many risks, e.g., lost productivity, are

insured by no one. Moral hazard is clearly a substantial issue for many of these risks. In the interest of brevity, however, we do not consider the entire range of risks that individuals face.

C. Business Risks

Many business risks are similar to individual risks. Businesses own property, for example, and there is uncertainty associated with damage to that property. Businesses are also liable for damages if someone is injured on their premises, if they are found to cause health harms, or if their employees are mistreated. As with health risks for individuals, we divide property and casualty risks for businesses into two groups. Short-term risks are the most common type of business risk. They encompass most damage to property, and litigation exposure. Most of these risks involve relatively infrequent events (but not too infrequent) and generally have well-defined losses (the World Trade Center being a notable exception). There may be some moral hazard in these actions, but we suspect it is not too large.

Most, but not all, short-term business risks can be diversified cross-sectionally. The most prominent exception is terrorism risk, where the potential losses are so large that even having a substantial insurance pool does not drive the variability of losses particularly low. As a result, we note ease of diversification as being either favorable or adverse.

Long-term property and casualty risks are those risks that will not be realized for some time. Firms may discover only years later that the chemicals in their product increase cancer risk. In the same fashion, obstetricians may be sued years after a birth for

complications that were only realized later. One can think of the liability revolution in the 1970s and 1980s as a bad realization of a long-tailed risk. Once again, this long-tailed risk makes diversification difficult, since new knowledge increasing claims against one business are often correlated with increases in claims against another. Difficulties with diversification are a major problem in many litigation risks.

Firms also face risk about employment decisions. Firms may be sued for sexual harassment, unjust dismissal, or unfair hiring practices. This risk has many of the attributes of long-term property and casualty risk. The event is not very frequent and is well-defined, but may not be diversifiable cross-sectionally. The same legal changes that make liability for pollution or medical harms greater than are thought also increase the potential losses from employment issues.

Finally, businesses have risky obligations for the pensions and health care of retired workers. Many large firms have defined benefit pension plans – plans that obligate them to a specific payment based on the age of the retiree and number of years of service. Retiree health insurance payments may work the same way. If pension costs rise more rapidly than expected, or a firm's earnings fall substantially, the firm may be unable to meet its pension obligations. Moral hazard is of clear importance in this risk. Firms that are doing poorly will underfund their pensions, knowing that if the firm fails it will not have sufficient assets to pay out its pension liabilities.¹⁰ Diversification issues

¹⁰ In a related situation, one of the authors worked for Equitable Life in the early 1960s. One task was to determine when a company had incurred a catastrophe in an accident. Excess losses would be written off, lest dividends never be paid in the future. Our naïf inquired: “Why don't our policies indicate that there will not be a payoff in case of nuclear war?” The answer was basically: “It does not matter what we say. Given a war, our losses will be too great, and our asset base significantly destroyed. We will not pay.” Our second story is at a less monumental scale, and in keeping with the early winter of 2003-04. The author's roommate created a company in high school to shovel snow for a flat fee for the winter, thus offering insurance to its customers. There was a big snowstorm early in December. The company announced it was going out of business and returned the money.

are also important, since pension and health costs tend to rise jointly across firms. For this and other reasons (perhaps the political imperative of caring for penurious retirees), pension obligations are generally insured through the public rather than private sector.

As with individuals, there are other financial risks that businesses might like to insure. Using sophisticated financial instruments, businesses can often do this.

Companies selling abroad can hedge exchange rate risk, and businesses can insure interest rate risk through appropriate derivative securities. To keep our analysis manageable, we avoid consideration of these financial risks.

D. Bundling Insurance and Other Services or Attributes

Many products that are officially sold or presented as insurance provide more than just financial protection; they bundle other services with the risk benefits. These additional benefits are important to account for in evaluating the insurance policy.

In some arenas, insurance products have integrated backwards into purchasing services, or at least procuring them. This enables insurers to purchase products at substantially reduced rates. Health insurance is the most prominent example.¹¹ When insurance is coupled with provision, the combination may have significant advantages in exerting leverage as a buyer. This should not be thought of as exclusively or even predominantly as an insurance product, i.e., as a risk-spreading device.

¹¹ Differences in bargaining power produce significant results. Altman, Cutler and Zeckhauser (2003) find that for a common pool of insureds (government employees in Massachusetts), the indemnity plan pays prices 35 percent more than HMOs for the same procedure. The gap with uninsured individuals would surely be much greater. Health plans frequently pay less than half as much for prescriptions from the same pharmacy as uninsured customers. If anything, the administrative costs for insured patients would be higher, since two parties have to be charged.

Many insurance products couple insurance with a tax shield. The buildup in whole life insurance is not taxed, for example, making that product an excellent vehicle for saving. Health insurance that pays for routine care costs is also a tax dodge, saving the taxation that would be associated with wage and salary payments. The primary motivation for such policies is not the financial risk *per se*, but the combination of risk reduction and tax rewards.

Still other insurance programs, especially in the public sector, have a strong redistributive element. Government “insurance” programs, such as Social Security and unemployment insurance, almost always have an intended redistributive role. That is, judged *ex ante*, some participants are hurt and others helped. But even in the private sphere, we see redistribution at play. Thus, young workers usually subsidize older workers in employer-provided health insurance.

Alas, there is no way to discuss insurance without referring to instruments that work as buyers cooperatives, and insurance that significantly redistributes income. These instruments are not strictly insurance. This caveat should inform our discussion below.

III. Insurance in Practice – Consumer Risks

In this section, we evaluate how insurance for consumer risks fare in practice. Because we consider a number of risks, our analysis is necessarily impressionistic. We rely on conclusions of detailed research studies where possible, and analysis of aggregate data in many cases. For many types of risk, we conclude that insurance performs substantially less well than is anticipated by theory. Table 3 shows our summary.

A. Mortality

As Yaari (1965) first noted, life insurance and annuities cater to mutually exclusive circumstances – living too long and living too short; one would not expect the same person to want both in force at the same time.¹²

In practice, life insurance is very common, and annuitization is very rare. The 2001 Survey of Consumer Finances estimates that two-thirds of families have life insurance, including as many as 90 percent of two-adult families. In total, families have \$16 trillion of assets in life insurance (American Council of Life Insurers, 2003). Annuities, by contrast, are owned by only a small share of the population, usually as one option in a retirement plan, e.g., with an IRA rollover. Only 8 percent of the population aged 70 and older has an annuity, compared to 78 percent of that group that has life insurance (Brown, 1999). Annuity reserves total less than \$2 trillion.

Without knowing individuals' preferences exactly, despite knowing their assets, earnings and family and health status, we cannot tell what insurance arrangement is optimal for them. A married worker might skip life insurance if he does not value highly the consumption of his non-working spouse. Similarly, a couple may not want an annuity in old age if it is penurious relative to assets, or can deal with a declining consumption stream. Still, one suspects that such cases are rare, and that large consumption changes individuals might experience due to lives cut short or stretched long are not intended. The research literature takes this perspective in evaluating the adequacy of annuitization and life insurance: it has examined whether these products are purchased in sufficient

¹² Davidoff, Brown, and Diamond (2003) extend this analysis to the case of incomplete markets, with relatively similar results.

quantity to minimize consumption changes in the event that bad outcomes are realized. Because of the centrality of life insurance and annuities to debates about social security reform, their use has been considered in detail.

Life Insurance. The spread of life insurance is expected and valuable, and important as a source of savings as well as security. Still, two aspects of life insurance have drawn attention as being sub-optimal. The first is the substantial rate of life insurance holdings among the elderly (see Brown, 1999, for a review). Some of the elderly, a group whose children are presumably independent, would rationally want life insurance protection (if pensions depend on the survival of one spouse, for example) but three-quarters is a very high share, and even many elderly without dependents have life insurance.

Some work has focused on the high rate of life insurance coverage among the elderly. One proposed explanation is that social security provides too much annuitization, and people offset that by purchasing life insurance. Brown (1999) finds evidence that this is not the case, however; term life insurance is not more likely to be held by people with larger social security payments. He suggests that other explanations are more important: tax policy that allows for tax-free buildup in whole life insurance or tax-free payment of burial costs; and inertia from purchasing life insurance earlier in life. The exact share attributable to each is not entirely known, but the non-tax explanations such as status quo bias (Samuelson and Zeckhauser, 1988) are surely important.

The extent of life insurance during the working years seems broadly appropriate, though concerns linger. In particular, some authors have worried about whether people in their working years are sufficiently insured. Recent studies suggest that too few

families have life insurance, and many families that have insurance are underinsured. Bernheim, Forni, Gokhale, and Kotlikoff (1999) use data on family income, assets, and demographic characteristics for people aged 51 to 61 (from the Health and Retirement Survey) to examine the consumption consequences should they die. They estimate that 30 percent of wives, and 11 percent of husbands, would suffer a consumption decline of 20 percent or more if their spouse passed away, a large enough reduction to rule out the explanation of rational preferences, apart from the joint explanation of little concern for and insufficient bargaining power of the dependent spouse. The shortfall in insurance coverage is more surprising given government tax subsidy to employer-paid premiums, and to investment earnings during the life of a policy.

The extent of underinsurance varies with socioeconomic characteristics. After correcting for income and assets, underinsurance is more common among lower income families, and among couples with very asymmetric earnings (for example, one-earner couples). In the latter families, the death of the higher earning spouse would often pose severe hardships for the surviving spouse. Indeed, work by Bernheim, Carman, Gokhale, and Kotlikoff (2001) suggests that two-thirds of poverty among surviving women and one-third of poverty among surviving men results from a failure to purchase sufficient life insurance.

Adverse selection could explain the underpurchase of insurance among some families, but the literature does not suggest that this is important in life insurance. Cawley and Philipson (1999) document that prices decrease with additional purchases, where adverse selection would imply the reverse. They also find that individual forecasts of mortality probabilities do not help predict purchase of life insurance. Life insurance is

also estimated to have very low administrative expense. More likely is that these families are simply not planning adequately for adverse events that may occur: they do not forecast the extent of consumption declines should death occur; life insurance never becomes a conscious decision the family makes; or the male decision-maker does not weigh the utility of his spouse very highly.

Annuitization. The central question about annuities is why so few people purchase them. As noted, less than 10 percent of people aged 70 and older have any private annuity, though essentially all elderly have social security and many elderly have defined benefit pension plans.

The administrative load in annuities provides a partial explanation. Mitchell, Poterba, Warshawsky, and Brown (1999) estimate that the load on annuities is about 15 to 20 percent. About half of that is a result of adverse selection; the remainder is marketing costs, processing costs, and insurer profit.

Still, it does not seem possible to explain the low rate of annuitization, even with these administrative costs. First, the investment returns in annuities are strongly tax favored. Second, risk spreading concerns make annuities worthwhile. In a utility-based simulation model of the annuitization decision, Mitchell et al. estimate that people should be willing to pay an administrative fee of 25 percent to annuitize their assets. That is far above the cost that we see in practice. Conceivably, strong bequest motives could explain low rates of purchase.¹³ But annuities would be one way to insure the size of the bequest. The literature has not explored the degree or nature of bequest motivation that

¹³ But that leaves the puzzle for big asset holders as to why so little is given away during the lifetime. Such gifts cut the estate tax by a third, since the gift tax – which comes out of the estate – escapes taxation.

could help explain these results. We expect that few could stand up to rational economic scrutiny.

The literature speculates more about ‘behavioral’ explanations for the low rate of annuitization. Anecdotal evidence suggests that many elderly may not be aware of or understand annuities, and many fewer have priced them (further undercutting the high administrative cost explanation for modest use). Other potential customers may fear paying money to an insurance company only to die shortly thereafter without much return. Along the latter lines is the seemingly inexplicable preference some people have for annuities that guarantee a payment for a certain number of years, even if the annuitant dies before that time.

Summary. As a means of keeping track of the evidence, we provide our net assessment of the various insurance markets we consider. To keep the analysis simple, we use a three-point scale: good, fair, or poor. We recognize that this assessment is highly subjective; readers may take issue with particular values, or even the scale that we use. On the basis of the evidence, we grade life insurance as fair and annuities as poor. Life insurance earns a higher grade because it functions well for many people. But in both cases, there is some underinsurance, and in the case of life insurance some overinsurance as well.

B. Health

Health risk is the second major type of risk for individuals. We divide health risks into two categories: short-term risks, and long-term risks.

Short-term health risks. Most people have health insurance for current medical care needs. About 85 percent of people have some form of health insurance in the United States. Coverage rates are greater in most other major developed nations, usually because of government involvement.

As with mortality risk, there has been substantial analysis of the optimality of private health insurance contracts. The fact that not everyone has private insurance has generated policy debate and research attention. There are three typical explanations for lack of coverage. The first is administrative expense. In any market with administrative costs, we would expect coverage to be less than full. Administrative costs are only about 15 percent of health insurance, however, so most analysts discount this explanation.

Indeed, the true rate of administrative expense in health insurance is likely smaller, perhaps net negative in many instances when buyer leverage is figured in. Health insurers – with their strong bargaining power in a high fixed-cost industry – purchase specific health care goods and services much more cheaply than do individuals. Such discounts likely more than make up for administrative costs.¹⁴

Adverse selection provides a second explanation. Insurance priced for the average enrolled person can lead to an equilibrium where the healthy do not enroll. We know of no simulations about the importance of this phenomenon, but we suspect that this explanation is right for some people. Many of the uninsured are young and relatively healthy. The value of insurance priced at average rates would not be very high for this group. One concern about this explanation, though, is that insurance can vary along the intensive margin as well. Deductibles, services covered, and access to particular

¹⁴ See footnote 11.

providers all vary across policies, and we might expect more of the healthy to segregate into less generous policies than go without coverage entirely.

The third explanation is crowdout by government insurance programs (for example Medicaid) and charitable programs, e.g., hospital free care. In this theory, people do not purchase private coverage because they know that they can receive care even if uninsured. Naturally, there is a loss. Being uninsured is associated with less, and less appealing, access to medical care providers, less use of preventive and acute care services, and worse health outcomes (Institute of Medicine, 2003). But it also saves money. For some people, the savings may be worth it.

Empirical evidence shows that crowd-out is a factor in explaining insurance coverage. Increases in the generosity of public insurance (Cutler and Gruber, 1996), and in uncompensated care (Rask and Rask, 2000; Herring, 2001) lead more people to go uninsured. The type of analysis necessary to explain how much of the total number of uninsured this accounts for has not been undertaken, however.

Even were the level of health insurance appropriate, one might question the mix of provision between public and private. Insurance has a surprising mixture of such provision, in a pattern hardly in line with notions of comparative advantage across sectors. In the case of health insurance, some argue for public insurance, on the grounds that administrative costs are lower in public programs than in private policies (Woolhandler and Himmelstein, 1989). Others argue for private insurance, for the usual reasons of competition and concern over bureaucracy. And within the private sector, there are arguments for both for-profit and not-for-profit entities. The US has a mixture

of both public and private, often in the same narrow sector, with adverse interactions between the two (as witnessed by the crowd-out literature).

Among people who have insurance, economists' greatest concern has not been over inadequate coverage, but rather over the generosity of coverage people have for small medical risks. Cost sharing in traditional indemnity insurance policies is relatively low. A typical policy has a deductible of about \$300, with 20 percent coinsurance up to a stop-loss of perhaps \$1,500 (Kaiser Family Foundation and Health Research and Education Trust, 2003). For much of the health spending distribution, cost sharing will be very slight; this makes moral hazard a significant concern.

A lengthy literature has explored whether this structure of cost sharing is optimal or too small (see Cutler and Zeckhauser, 2000, for a review). Generally, the literature concludes that current insurance is too generous, leaving people with too little risk for medical expenses, particularly smaller expenses. The most comprehensive analysis is from Blomqvist (1997), who finds that optimal insurance should have a declining coinsurance rate ranging from 27 percent at \$1,000 of spending (compared to 20 percent in most plans) down to 5 percent at \$30,000 of spending (compared to zero in most plans).

The traditional explanation for the low rate of cost sharing is the tax subsidy to health insurance (Feldstein and Friedman, 1977; Pauly, 1986). As with life insurance, employer payments for health insurance are not taxed as income to workers, while wage and salary payments are. Thus, there are incentives for people to run more medical payments through employer-paid health insurance than is optimal. This includes having lower cost-sharing than would otherwise be desirable. Empirical work shows that this

explanation is important in practice (Cutler and Zeckhauser, 2000). What other factors contribute to low cost sharing is not known, however.

Behavioral explanations, which we explore at length subsequently, also merit study for low cost sharing. Fuchs (19xx), for example, argues that cost sharing is low in part because people do not want to make decisions about whether additional medical care is worth the money. We argue below that prospect-theoretic preferences for outcomes, e.g., loss aversion and risk seeking on losses, make individuals eager to avoid small losses.

We note that these types of behavioral explanations make normative analysis difficult. Say that loss aversion affected behavior, implying that even small per-visit charges strongly discourage use. Would such copayments represent an effective rationing tool, or would it be imposing noticeable pain without collecting much revenue? Fortunately, our analysis has a descriptive, not normative, purpose.

Finally, given HMOs strong penetration of the private insurance market and their firm supply-side restrictions, we note that it is hard to assess what appropriate cost sharing should be for their members.

Long-term health-care insurance. Health also has a long-term risk component. People may have health needs in the future, which they would like to insure today. Most important here is long-term care expenses; the magnitude of these expenses was noted earlier.

A large part of the return to long-term care insurance is related to early mortality among the elderly. Nearly 20 percent of people over age 85 are in a nursing home,

compared to about 1 percent of the population aged 65 to 74. For long-term care insurance to be effective, people have to purchase before they reach advanced ages. Yet, most elderly do not have such coverage. Only about 10 percent of the elderly possess long-term care insurance. The bulk of long-term care expenses are paid for out-of-pocket or by Medicaid.

Risk about future health type is related to long-term care risk. Health insurance for individuals or the groups they buy as part of is usually experience rated. Should health decline, a person's (or their company's) premium increases. Thus, one might expect people to purchase insurance against the risk of becoming high cost in the future (Pauly, Kunreuther, and Hirth, 1995; Cochrane, 1995; Cutler, 1996). In practice, however, we see virtually no insurance against the risk of becoming sick and facing higher annual premiums in the future.¹⁵

Adverse selection and moral hazard no doubt contribute to the failure of this market, but we believe the theoretical elegance of these subjects has led economists to give them too much weight. Risk aversion certainly differs across people, and that is not so correlated with health status (many of the worried well want to purchase insurance, in addition to the currently sick). *Ex ante* moral hazard is also somewhat deterred because health declines, even if treated, lead to much worse states, for which compensating payments are not forthcoming.

¹⁵ There is some informal insurance for this risk, but it is imperfect. Many large employers, for example, prohibit insurers from experience rating at the individual level, providing a form of intertemporal insurance *if* one stays at the same company. Most states prohibit some forms of experience rating for small groups of people, but these prohibitions are often very limited (see Cutler, 2002, for a review). Overall, insurance against the risk of becoming high cost in the future is very limited.

Attention has instead focused on two alternatives. The first is crowd-out of private long-term care insurance by the public sector. The Medicaid program covers long-term care expenses for people with no private insurance who have exhausted their income and assets paying for long-term care services. People may thus rely on Medicaid, if it comes to that, or give away assets to qualify for Medicaid, rather than purchase private insurance (Pauly, 1990). Recent simulation work suggests that this explanation can explain a significant fraction of the lack of purchase of private nursing home insurance (Brown and Finkelstein, 2003). As with short-term health insurance, there seems to be an inefficient interaction between public and private insurance.

The second explanation for low insurance coverage is that these risks are non-diversifiable, and thus shunned by insurance companies (Cutler, 1996). The dominant driver of changes in long-term care costs over time is technology that allows people to live longer or higher quality lives, but at high cost. This technology is common across people, and thus cannot be diversified cross-sectionally. We explore how this might affect the supply of long-term insurance below.

Summary. We rate coverage of short-term health risks as fair and coverage of long-term risks as poor. Short-term risks are covered for most people, but as with mortality risk there is both underprotection (those without coverage) and overprotection (too generous insurance in indemnity policies). Coverage for long-term health risks is poor, since private insurance is rare and the public sector has substantial inefficiencies.

C. Property

The third major type of individual risk is for property damage for personal physical assets. People insure their home, car, and consumer durables against various types of damages. In at least the first two cases, essentially everyone has coverage. Homeowners insurance is generally required by mortgage lenders, and all states require auto insurance. Fewer people have coverage for consumer durables, but the costs of these durables are far smaller, hence insurance is far less valuable.

The major issue in property insurance is the degree of cost sharing. Most people have relatively low deductibles for home and auto damage. The question is whether these deductibles are too low, from the standpoint of the individual and the standpoint of efficiency. (Efficiency requires avoiding little claims where administrative costs are large relative to any loss or payment.) There is speculation about this in the literature, but no formal analysis that we are aware of.

As with any evaluation dependent on the parameters of the utility function, we cannot say for certain whether consumers should or should not purchase more generous coverage. But we can evaluate what set of preferences are required to justify current purchases. Suppose that the probability of a loss is p . The loss may be damage to a car or house. For the simple algebra here, we assume the loss probability is independent of the details of the insurance policy.¹⁶

People face a menu of insurance deductibles and premiums, where lower deductible plans command higher premiums (more is covered, and moral hazard is

¹⁶ Allowing for moral hazard would only strengthen the conclusions, as the high deductible policy would look even more attractive.

exacerbated). Denoting the insurance premium as π and the deductible as d , the period utility that an individual receives from choosing an insurance policy is:¹⁷

$$V = p U(Y - \pi - d) + (1-p) U(Y - \pi).$$

where Y is income, assumed to be constant.¹⁸

With the specification of a utility function, we can evaluate which of several possible insurance policies would maximize utility. Considering the calculation another way, we can evaluate what risk aversion parameter would be required to explain the decisions that people make. We suppose that individuals have constant relative risk aversion utility:

$$U(C) = \frac{C^{1-\beta}}{1-\beta}$$

where β is the coefficient of relative risk aversion.

There are no national data sets of insurance premiums and coverage choices. To learn about these issues, we determined the menu of deductibles and premiums that an individual faces by examining the policies offered by some of the largest home and auto insurance companies. Table 4 shows auto insurance offers in two cities (Boston, MA, and Miami, FL), and homeowners insurance offers in two others (Philadelphia, PA, and Orlando, FL). The most common policy for both risks, chosen by an estimated 60 to 90 percent of people, has a \$500 deductible.

¹⁷ We assume that the utility of money is the same with or without a loss. This seems appropriate in the case of property damage, where the individual is less likely to be permanently harmed.

¹⁸ This model assumes no savings. That is empirically close to correct; most people have little savings outside of a house and consume relatively close to their income. We discount borrowing on the house for these purposes. Our simulations assume after-tax income of \$20,000.

If we consider increasing the deductible to \$1,000, the premium savings range from \$34 to \$91 for auto insurance and \$220 to \$270 for homeowners insurance. This is a significant share of the deductible: 7 to 18 percent for auto insurance and 44 to 54 percent for homeowners insurance. Empirically, the probability of an accident¹⁹ is far smaller than this. For auto insurance, the accident rate is estimated to be 4.1 percent (Insurance Research Council, 2002), and for homeowners insurance the rate is estimated to be 9.3 percent (Insurance Information Institute, 2003). A risk-neutral individual would thus buy the high deductible policy over the low deductible policy.

With risk aversion, it is possible that people will find the lower deductible optimal. But the levels of risk aversion needed are not plausible. In each of the four cases (two cities for auto insurance and homeowners insurance), the required β to rationalize the purchase of the low deductible policy is over 10. To put this in perspective, economists are used to working with models of log utility ($\beta=1$) or perhaps somewhat higher ($\beta=2$).²⁰

Carveouts. Homeowners insurance does not cover all of the property risks that a typical home owner faces. Two particular risks are generally excluded: damage from floods; and from earthquakes. At one time, coverage for floods was included in homeowners insurance. In the 1960s, however, increasing claims from floods, coupled with Federal government subsidies to areas affected by floods, led private insurers to pull out of the market (United States General Accounting Office, 2003). This is the first

¹⁹ More accurately, the share of people who file a claim. Small damages may not be reported to the insurance company, but this would be true under less generous insurance as well.

²⁰ As a more intuitive reference, a person with a coefficient of relative risk aversion of 10 would not take a gamble over a \$1,000 gain or loss unless the odds of winning were nearly two-thirds.

example we shall encounter of a regular problem: when beliefs about the extent of risk increase, and demand for insurance correspondingly rises, insurers often pull out of the market. Today, flood insurance is provided with substantial Federal *ex ante* subsidies, and often with *ex post* Federal subsidies, e.g., when disaster areas receive assistance.

The consumer durable insurance puzzle. Bizarre levels of excessive insurance are found most acutely with consumer durables. Table 5 shows the menu of warranties a typical consumer faces when purchasing consumer durables. For a number of electronic items, we present the typical manufacturer's warranty, the extra protection offered to consumers, the cost of that extra protection, and an estimate of the share of customers who purchase that protection.

At face value, the purchase of this insurance seems hard to justify. A typical electronic item has a probability of needing repairs of about 10 to 25 percent (10 percent for a CD player; 25 percent for a Camcorder or VCR). The cost of a repair is perhaps \$100. Thus, the expected value of the warranty is perhaps \$15. Since most problems show up very quickly, and are thus covered by the manufacturer's warranty, or after many years, when the warranty runs out, the actuarial value of these additional warranties is even lower. A guess is \$5 to \$10. The premium for the insurance, in contrast, is several times that amount, generally averaging \$70 to \$100.²¹ Indeed, even this calculation overstates the value of the warranty for many insured items, since the prices of electronic goods are falling rapidly – over 20 percent a year in many cases – and their capabilities are increasing. Hence, the net benefit of repairing an item when it breaks is falling substantially over time.

²¹ This is roughly the equivalent of the plans priced as a share of purchase cost as well.

Despite this fact, purchase of comprehensive protection for consumer durables is widespread. An estimated 20 to 80 percent of people purchase extended protection for consumer durables, and they are widely perceived as being money makers (CITE FORTHCOMING).

Summary. The major types of property insurance are widespread, either by government mandate (auto insurance), or by lenders requiring collateral (homeowners insurance). Underpurchase is generally not a problem in this market. But overinsurance is. Many people have deductibles that seem far too small given price differentials, the size of the risk, and common beliefs about the extent of risk aversion in normal circumstances. For this reason, we rate coverage of home and auto insurance as fair. The magnitude of consumer durable insurance is more problematic, since almost no utility function would justify purchase of insurance for minor durables. We assess the function of this market as poor.

III. Insurance in Practice – Business Risks

Some markets for business risks seem to work well. Businesses own property, for example, and most businesses insure at least some portions of that property. There is not very good data on the extent of this insurance, but studies of the industry suggest that this insurance is generally believed to work well. This is not surprising, since large businesses have individuals who specialize in the purchase of insurance, and even small businesses usually have some financial expertise. Predominantly on a secondary reference basis, we rate this insurance as good on our scale.

Businesses also have general liabilities associated with damages they may incur in the cost of doing business (people falling in the store, for example, or doctors being sued over health harms they cause). The performance of this insurance varies by industry. If we take account of both drama and policy import, the situation is particularly problematic in medical malpractice. There have been three medical malpractice crises in the past 25 years: one in the mid-1970s, another in the mid-1980s, and a third in just the past two years (Mello and Studdert, 2003). Each crisis was precipitated by claims paid increasing more rapidly than premium increases. The cause was changes in the social climate, not in any upswing in adverse medical incidents. Lawsuits filed increased more rapidly than expected, and liability judgments awarded were greater than expected.

As a result, insurers lost money. In response, premiums rose precipitously, many insurers dropped out of the market, many physicians found insurance difficult to obtain, and some physicians changed their practices (e.g., some OBGYNs quit doing obstetrics). Only after a few years did the market return to reasonable function, with insurance again available – albeit at higher price. This type of availability crisis, though often with no return to normalcy, is a common theme of many types of business insurance.

Risks with residual variability: environment and terrorism. In theory, as we noted above, insurance is best equipped to deal with small to moderate probability, high loss risks, for there is where it does the most good. However, it is for precisely those risks where business insurance has failed most recently. Environmental liability was the classic issue here (General Accounting Office, 1986; 1988; Huber, 1988; Zagaski, 1992); terrorism losses have recently joined it. In each case, private markets turned out to work

much less well than anticipated, once the risks eventuated. We discuss these two risks in turn.

Prior to the mid-1980s, environmental coverage insured firms indefinitely for events that occurred during the policy year (termed an occurrence-based policy). Long-term risk was thought to be small. Total claims in the 1962, for example, were less than \$XXX. Events in the 1970s and 1980s, however, highlighted the “long-tailed” nature of risk. Asbestos claims in the 1970s, for example, dealt with exposure to asbestos in the 1940s and 1950s. Added to this was the perception that legal interpretations were seen as changing the provisions of insurance policies. It was frequently asserted that courts ignored restrictions in policies to “sudden and accidental” environmental damage. Moreover, the courts, usually on the basis of jury decisions, imposed liabilities well beyond those the policy was intended to cover.²² The result was increased uncertainty about the liability of environmental insurers.

In theory, an increase in risk should increase demand for insurance, increase the price of insurance, and result in greater overall coverage at higher prices. This was not the outcome with environmental risk, however, as it was not with medical malpractice insurance. Rather, the policies themselves changed in a way that made them *less* generous. For example, the occurrence-based policy was dropped in favor of a claims-made policy, which covers damages only if the claim is filed within a certain period of time.²³ Effectively, this eliminates insurance coverage for long-tail risk, placing that risk

²² A notorious case involves a BMW car that was damaged but repainted. The owner was awarded \$4,000 in compensatory damages and \$4 million in punitive damages.

²³ Similar changes happened in medical malpractice insurance in the 1970s and professional liability insurance in the 1980s. The stated reasons for the change were similar to those for environmental coverage.

instead on the insuring firm, in the form of increases in premiums as the extent of damages is realized. Indeed, the reduction in insurance coverage was not limited to primary insurance markets. In 1984, international reinsurance markets began denying coverage for pollution liability reinsurance.

Insurers also imposed aggregate dollar limits on payouts for environmental damage, to limit their overall risk exposure. Of course, this is denying protection precisely where it is needed most, for high losses.²⁴ These changes limited the aggregate risk born by the insurer, with the consequence that more of the risk was retained by the firms at risk. Even two decades after the liability revolution and the initial cutbacks in insurance coverage, the market for environment insurance is substantially less generous than it was.²⁵

The 'crisis' in terrorism insurance burst onto the scene on September 11, 2001. The attacks that day drastically changed expectations about the likelihood and magnitude of terrorism losses in the future. Unlike nature's extreme blows, e.g., Hurricane Andrew, which can increase perceived future losses by say 100%, the man-made loss of 9/11 increased future expected terror losses at least by a factor of 10, perhaps much more. The immediate result was a crisis in insurance availability. Insurers claimed that terrorism was 'uninsurable', and stopped writing coverage for it. About one-quarter of policies written in 2002, an even larger share for large firms, excluded terrorist acts.

²⁴ There may be a moral hazard justification for limiting coverage for large losses. Insureds may have some control over the size of loss, trading off probability and magnitude. Thus, a toxic waste release on the ground may be allowed to sit untreated, avoiding a medium loss, but risking a much larger loss should it leach into the groundwater.

²⁵ Note also that an implicit part of many insurance coverages was lost, namely the idea that if you insure today you will be guaranteed coverage tomorrow.

Though the most dire predictions about the consequences of lost insurance did not come true -- buildings got built and buildings traded hands -- the potential for severe economic disruption was judged to be high. After several months, the Federal government stepped in to stabilize the market. The Terrorism Risk Insurance Act of November 2002 provides for coverage related to international terrorism, with the Federal contribution rising with the magnitude of loss up through \$100 billion of insured losses. Beyond that, the Congress decides what additional payments it wants to make.²⁶ In exchange for taking the back-end risk (without coinsurance), the Act requires insurers to write coverage for smaller terrorist losses. The Act sunsets at the end of 2005, and it is not clear what will happen in the market beyond that point.

Employment practice insurance. Many businesses also have insurance for employment liability resulting from claims such as sexual harassment and race or gender lawsuits. As the potential liability from employment issues has become more widespread, the cost of this insurance has increased. As Table 6 shows, a business with 20 full-time employees and 20 part-time employees, for example, would pay a premium of \$5,000 per year and have a 10 percent coinsurance rate.²⁷ There is also a limit on *insurer* liability, generally at \$1,000,000. We do not know of general assessments of this line of insurance, however, so we omit it from the table.

²⁶ Thus, businesses are protected against attacks that knock things down, which are highly unlikely to exceed the losses of 9/11. However, they are not protected against other risks such as dirty bombs, which make major parts of a city uninhabitable for a sustained period.

²⁷ As with auto insurance, the change in premiums for a change in deductible is highly non-linear. Moving from a \$5,000 deductible to a \$2,500 deductible raises the premium by only \$26. Raising the deductible to \$10,000, in contrast, lowers the premium by over \$1,000. We suspect adverse selection is behind these rate differences.

Pension obligations. One of the more important long-term risks that firms face is over their obligations to retirees. Many firms, particularly large manufacturers, have substantial defined benefit pension obligations. Firms also have obligations for retiree health insurance. These obligations are risky because retirement experience and the earnings on pension assets are both uncertain.

Insurance for these risks is affected by a substantial degree of moral hazard. Firms that are doing poorly have the option of declaring bankruptcy and defaulting on their pension liabilities, rather than continuing to pay them. As a result of this moral hazard, pension risk is insured by the government. The Pension Benefit Guarantee Corporation (PBGC) requires firms to contribute an annual premium based partly on the number of retirees and partly on the degree of pension underfunding.

Like many government programs, the PBGC has difficulty changing prices to guarantee solvency. This is particularly difficult since pension default is a long-tailed risk: premiums taken in today need to be saved for potentially high use in the future. Boyce and Ippolito (2002) estimate that premiums charged by the PBGC are 50 percent below what equivalent private insurance rates would be, with unfunded liabilities currently over \$100 billion. For these reasons, the General Accounting office rated the PBGC as high-risk.

Because participation in the PBGC is mandatory, we lose the yardstick of what private insurance would charge for equivalent coverage. And because it is effectively subsidized, there is little complaint. For these reasons, we rate the operation of pension insurance as poor.

Summary. Businesses are much more sophisticated than individuals about the purchase of insurance, with professionals handling the task in large firms. For traditional risks, insurance works well. Recent years, however, have witnessed the rise of risks due to purposeful human activity, e.g., the liability revolution or terrorism. These risks are larger than older risks, are correlated across insuring firms, and are often not resolved for many years. For such risks, insurance markets tend to work poorly.

V. Explanations for Poor Performance

Insurance in practice differs substantially from insurance in theory. Despite rating many insurance markets as likely to work well in theory, only one of the actual markets we evaluate draws a ‘good’ rating – homeowners insurance. Four markets get a fair rating (life insurance, short-term health insurance, auto insurance, and general business property and casualty insurance). The remaining six risks (annuities, long-term health risks, consumer durable insurance, and business environmental, terrorism and pension coverage) all rate poorly. While some may quibble with our ratings in particular cases, we suspect that none would disagree with our overall assessment of substantial underperformance in actual insurance markets.

The discrepancy between theory and practice is of two types. The first is a mismatch between expected coverage and actual coverage. Some risks that we expect to be covered, such as terrorism risk, long-term health risk, longevity risk, or environmental liability risk, are covered not at all, or at best poorly. Even risks that are covered well, such as life insurance, are not purchased by everyone who seems like they could benefit

from them. In contrast, many risks that theory would predict to be uncovered, such as small losses for automobiles, houses, and consumer durables, are covered by individuals voluntarily purchasing insurance. Assuming rational decision, only excessively high degrees of risk aversion could explain the pattern of property coverage that we observe. Further, many elderly seem overinsured against unexpected death (life insurance) even as they are underinsured against beyond-average survival (annuitization).

In addition, there is little rhyme or reason to the mix between public and private coverage. To be sure, many of the largest risks, such as terrorism, have made their way into the public sector, as one might expect. But smaller risks are covered publicly as well (flood insurance, for example), and many large risks are left to private insurers (environmental damage).

A common but troubling phenomenon is severe underpricing of risk coverage by the public sector, often because premiums are insufficiently responsive to risk differentials. Savings and loan insurance prior to the multi hundred billion dollar bailout is a good example. When politics and political pressures intrude, it is often impossible to impose significant differential rates for insurance. Often government just sets a risk standard to be met if one wants to insure. Such standards are often ambiguous, and government denial of insurance is often too much of a nuclear weapon.²⁸ The interactions between public and private insurance seem unhelpful at best, harmful at worst.²⁹

²⁸ Witness the 2003 struggles of the PBGC with US Airways, which argued that its pension fund was underfunded when it wanted to emerge from bankruptcy, but adequately funded later on MORE COMING.

²⁹ On pricing, the “sliver solution” deserves attention. With it, a private insurer writes coverage for a small part of a risk. The government insures the rest, at a premium proportional to the private insurance. This inserts private market discipline into the price. Government terrorism reinsurance does this to some extent, charging insurance companies roughly 10 percent of their premiums.

There a number of complementary explanations for the mismatch between insurance theory and insurance markets in practice. We explore them in the next sections.

A. Information-Based Explanations

The explanation favored by most economists (casual polls suggest) is asymmetric information. Insurers may not offer particular products because they worry that it will affect the behavior of insureds (moral hazard), or because they fear that the product will be selected by people who have a high likelihood of suffering a loss (adverse selection). Such “bad behavior” cannot be monitored.

These explanations contribute, but we suspect that they are far from sufficient. For many of the risks that are uncovered, such as long-term environmental exposure by firms or the need for long-term care, evidence of moral hazard is at best tenuous. Where we are certain there is moral hazard is for use at a point in time, short-term health care for instance. This risk is covered, if anything, too well.

Nor is adverse selection much of an explanation. Evidence to date suggests no adverse selection in long-term care insurance purchases, for example (Finkelstein and McGarry, 2003). While adverse selection has dominated the theoretical literature, the actual experience of an insurer – what we think of as ‘adverse experience’ – depends on many factors beyond perceived risk. Risk aversion is important: the worried well purchase insurance just as much as the high risk. As a side benefit, this keeps premiums low for those on the margin of purchase.³⁰ Indeed, risk aversion may be inversely

³⁰ Market power on the part of insurers cuts in the opposite direction. Prices above marginal cost encourage low risk people to drop out of the market.

correlated with risk levels, if risk averse people take better care to avoid putting themselves in risky situations.

Ignorance is also a blessing here. If potential insureds do not know their risk levels, there will be no correlation between risk and the insurance decision. More generally, non-rational behavior helps deter adverse selection. It introduces many new elements that encourage people to insure, without necessarily being correlated with risk.³¹

In many situations, we might expect that insurers would know *more* about risks than individuals. This is likely the case with consumer durable warranties, and possibly health insurance as well. Variation in price by risk status limit adverse selection, though they may be inefficient in other ways (denying people insurance over their risk level).

The limited explanatory power of asymmetric information-based explanations show up most clearly in the analysis of terrorism insurance. By all assessments, there is little to no differential information about the likelihood of terrorists striking any particular object (adverse selection) nor is it plausible that firms would substantially lower their guard against terrorist attack (moral hazard) just because they are insured. (The uncompensable losses, including one's own loss of life, are just too great.) Insurance coverage dried up for other reasons.

Our more general hypothesis is that in many markets where we might speculate that adverse selection would exert a powerful undertow on the market, it proves to be more mild current than sweeping tide. We propose three alternative reasons why the theory and practice of insurance diverge in the early 21st century.

³¹ From the welfare perspective, the variation introduced by behavioral decision, unlike that generated by varying levels of risk aversion, does not assure that those who do buy insurance are the ones who need it most.

B. Incomplete diversification, supply-side contracting difficulties.

The first explanation is insufficient diversification of insurance companies.

People may want insurance against a risk, but insurers have to be willing to provide that risk, even at rates far above the best estimates of actuarial cost. If insurers – or more accurately insurance executives -- are worried about their capitalization, they may be unwilling to write policies for some risks, even if both price and demand are high. The prospect of severe losses, or even bankruptcy with its limited liability, may not scare the diversified investors in an insurance company, who would be happy to write unusual insurance for robust premiums. But insurance executives have to worry that they may be considered to have misestimated risks and premiums, with consequent career collapse.³²

In the standard theory of insurance, risks are minimally correlated across insureds. A few people will experience a loss in a period, but the vast majority will not. Insurers use the premiums from those who do not suffer a loss to compensate those who do. Many risks, however, have an aggregate component, many people incur a loss at the same time. Nuclear wars represented the ultimate aggregate risk for many years. Today's aggregate risks include new liability revolutions (as with environmental damage), significant increases in prices (say for medical care), and major terrorist attacks. Even good developments have their aggregate risk component. Thus, rapid rises in longevity would impose heavy aggregate costs on pensions and other annuities. Long-term care insurance well represents an aggregate risk: When the expected costs increase for one person, say because a longevity jump makes nursing home stays, particularly

³² The behavior of Warren Buffett, by contrast, shows what happens when an executive has no such concerns.

Alzheimer stays, more expensive, this factor applies to many insureds. As a result, the traditional method of risk diversification, pooling independent risks across people, fails.

Risk neutral insurers will not care about this aggregate risk. The owners of insurance company assets can diversify the risk posed by diversifying their portfolio. But managers and workers in those insurance companies may care. Their jobs may be lost if the company goes bankrupt, or if that line of business loses gobs of money. Thus, the insurance company itself may behave as if risk averse.

A moderately risk-averse insurance company will still sell insurance, but will impose a higher administrative charge to do so. Administrative loads in long-term care insurance, which has a large contingent of aggregate risk, are 35 percent at minimum, and reach 50 to 70 percent for some groups (Cutler, 1996; Brown and Finkelstein, 2003). In comparison, administrative costs in short-term health insurance are only about 15 percent (United States General Accounting Office, 1984), roughly their level for annuities (Mitchell, Poterba, Warshawsky, and Brown, 1999).

An insurer that is more risk averse than potential insureds will refuse to write insurance altogether. We often see this in the nature of risk exposure that is written. When they do write policies, long-term care insurers limit their exposure to a fixed dollar amount per day of nursing home care; one cannot buy coverage for the actual cost of care received (in contrast to annual health insurance). Similarly, environmental insurers and medical malpractice insurers refuse to cover all claims that result from operations today; instead, they put a time limit on when the claim must be filed.

The cycle of insurance crises shows clearly this problem. When risks increase more than expected – e.g., the liability revolution, knowledge of particular chemical

harms, terrorist action – insurers respond at first by refusing to write new risk. That is understandable, as markets digest the new information. Over time, prices rise. That too is predictable. But even after the market ‘settles down’, insurance frequently becomes less generous than it was formerly, and stays that way indefinitely. That is the part that is economically unpredicted.

While the practice may appear to be irrational economically, the idea of severely curtailing company risk is standard advice given in the insurance industry. According to A.M. Best (1991), a leading analyst of the insurance industry, insurers should keep the risk of any line of business small. “[T]o provide stability and safety, an insurer should limit its maximum loss exposure on a single risk (or group of related risks) to a small percentage of its policyholders' surplus, normally less than 2 percent” (p. xiii). With aggregate risks, insurers face the Scylla and Charybdis of not knowing their market, or having too heavy exposure. The outcome is that the insurance industry does not write certain classes of risk.

For some risks the government may step in, as it has with terrorism risk. But that is a short-term (three-year) solution, it is as an adjunct to other private-sector insurance, and it is in an area where the government could be deemed to have responsibility for controlling the risk. Government as reinsurer is not a likely solution for many troubling aggregate risks, such as long-term environment or health-care risks.

Fortunately, there is a far greater pool of resources that could conceivably absorb such risks. It is found in financial markets. Risks that are large even for the world’s insurance pool – estimated to be on the order of \$1 trillion in the United States and \$2 trillion worldwide (Insurance Information Institute, 2003) – are small relative to financial

markets. For example, the value of equity markets in the US alone is more than \$10 trillion. One great advantage of financial markets as insurance instruments, apart from their volume, is that they effectively bring together tens of millions of investors, none of whom would have to hold too much of an aggregate risk.

There has been recent use of financial markets to diversify aggregate insurance risks. Most prominent have been catastrophe bonds, used to reinsure weather-related housing risks. Interest in these bonds rose with Hurricane Andrew in 1992, the Northridge earthquake in 1994, and the Kobe, Japan earthquake in 1995, all involving losses that were massive relative to historical experience. The market for catastrophe bonds has been relatively small, but it is perceived to be successful (United States General Accounting Office, 2002). One measure of success is the prices charged. Famed investor Warren Buffett underwrote earthquake reinsurance in California for four years in the early 1990s, earning an 11 percent premium for an estimated 1 percent risk. Buffett recognized what other insurers must have missed: This risk, though unusual, brought neither adverse selection nor moral hazard. Over time, the advantage of this investment became known and premiums fell. “The influx of ‘investor’ money into catastrophe bonds – which may well live up to their name – has caused super-cat prices to deteriorate materially. Therefore, we will write less business in 1998”, Buffett wrote.

Use of these new instruments is not without problems. Participation of insurance companies is likely to be important, since these companies have expertise in assessing risk that is vital. Possibly, insurance companies will underwrite the risks initially, to provide their assessment expertise for a fee, and investors will then take their share.

Reinsurance is already common in the insurance industry, though it is typically done by specialized companies rather than broader financial markets.

Perhaps more importantly, the nature of the payment needs to be determined. Investment managers are currently paid for assuming risk. The common arrangement is for the general partner to charge an annual management fee, say 1 percent, and to receive 20 percent of the profits or excess profits.

With insurance, equivalent arrangements would be hard to structure, since risks are discrete and it is hard to know whether a policy issued has been profitable in expectation thus far. If there is a 3 percent chance of a calamitous event, for example, but otherwise no losses, a general partner paid on the basis of annual “profits” would be expected to do quite well for a period before the odds brought down the house. Further compounding the difficulty, prior management and incentive fees would probably be unrecoverable in the event of a bad loss. Many of the names at Lloyds of London experienced just such a string – many small successes followed by a mammoth loss – when the liability revolution hit.

One way around this problem would be to have the portfolio of risks be highly diversified. But such diversification blunts the value of specialized expertise on the market being insured. Other types of contracts may be needed.

With additional time, we expect that financial instruments will continue to evolve and allow further investors into the market. It is possible – perhaps likely – that the first problem we identify has a solution forthcoming.

C. Non-standard behavior on the demand side

Theory and practice diverge in the insurance industry for a second reason: potential insureds engage in non-standard economic behavior. In traditional decision theory, people have concave utility functions defined over consumption. Risk averse people will want to insure against all risks, assuming fair actuarial pricing. They temper this because of moral hazard and administrative costs, which lead prices to exceed expected payouts. In response, people will choose to cover large risks, at least substantially, and leave small risks unprotected.

Such preferences may not correspond to reality, however, as the prevalence of insurance coverage for small risks suggests. Several alternatives to standard preferences have been proposed that may explain this type of coverage.

Prospect theory. A leading possibility is loss aversion – the idea that people significantly dislike any loss, even small ones (Kahneman and Tversky, 1979). Hence, people will pay far above actuarial value to protect against small losses, such as those when a stereo breaks.³³

It seems plausible that this phenomenon could explain some of the anomalous behavior we documented above, especially the purchase of insurance for small risks. To see how readily this explanation might work, we modify our analysis to allow for simple loss aversion. Suppose that utility consequence of incurring any deductible is $1 + \theta$,

³³ Kahneman and Tversky hypothesized that people were concave in both gains *and* losses about the certainty point. Additions to wealth were valued with concave utility, as were losses to wealth: small losses had a greater marginal cost than did large losses.

where θ represents the additional utility cost of having to make a cash outlay. With this set of preferences, expected utility is given by:

$$V = p U(Y - \pi - d \cdot (1 + \theta)) + (1-p) U(Y - \pi).$$

If we assume a particular utility function, we can use the menu of choices that people face to determine what value of θ is required to explain insurance decisions. Assuming that utility is logarithmic in consumption ($\beta=1$), the θ required to explain a preference for a low automobile deductible over a high deductible ranges from 0.5 to 2.5, depending on the policy and the degree of risk aversion. For homeowners insurance, the equivalent value of θ ranges between about 3 and 4. Thus, preferences of this sort can perhaps contribute to the overinsurance policy, but cannot explain it all.

Affective Forecasting. Recent work by Gilbert, Kahneman and others has demonstrated that people significantly overestimate the magnitude of the negative experience from a loss. Gilbert et al (2002), for example, attribute this to a durability bias, a belief that the negative aspects of the loss will last much longer than they do, and to a significant overestimate of the regret they will feel after a loss. People who believe their utility will change permanently with a loss will want to purchase more insurance coverage than people who recognize that losses will be readily accommodated. It is not surprising that such people will be interested in very generous insurance.

Anxiety and regret. Consider a significant loss, one that would drive down utility considerably, but that does not affect marginal utility of income. For example, one might have a painting of one's departed grandmother, which is worth a great deal sentimentally

but little monetarily. The death of a non-earning loved one would be the same.

Rationality-loving economists would say not to insure. But many people do.³⁴ One reason for this is that insurance reduces anxiety, acting as a form of reassurance for many people. In the heirloom gets stolen, people reason that at least they will receive some money if the painting is damaged.³⁵

Regret is similar to anxiety, though looking backwards rather than forwards. A person who has rationally chosen not to purchase insurance may suffer lower utility if the bad state of nature arises, both because the risk occurred and because the person did not purchase insurance for the risk. Imagine, for example, that a person buys a new Camcorder, rationally chooses not to choose supplemental insurance, but then finds that the Camcorder breaks in the first week of use. The person will regret not having purchased the insurance. Knowing the possibility of regret later on, the person in the store may choose to buy Camcorder insurance.

Purchasing insurance as a means to reduce anxiety or stave off regret is not difficult to reconcile with the standard neoclassical framework. We show the situation for anxiety, though regret is similar. Suppose that an individual is faced with a lottery L , defined by $L = [-d, p; 0, 1-p]$, where $d > 0$ is the loss and p is the probability of loss. An individual determines that her utility for outcomes $V(L) = V(C)$, where $C = [-e, 1]$; i.e., e is the certainty equivalent. If insurance is offered at price $f > e$, the person will decline, since for lottery $D = [-f, 1]$, $V(L) = V(C) > V(D)$.

³⁴ Witness the number of people who have life insurance on their children (EVIDENCE FORTHCOMING).

³⁵ It may also be that people do not realize their marginal utility will not change, perhaps because they are bad at forecasting their utility in different states of nature.

Now allow for a time dimension to the lottery. Utility has two dimensions: the lottery L , and time t ($t=0$ is the present). Unresolved risk creates anxiety. We model this as $U(L,t) = V(L) - A(L,t)$. Our interest is in the form of $A(L,t)$. First consider the nature of the lottery. If the lottery is over good states ($d < 0$), there might be ‘joy along the way’ ($A(L,t) < 0$), and people will not purchase insurance. If, as with insurance situations, the outcome is significantly adverse ($d > 0$), anxiety is likely to arise. If L involves only a certainty outcome, C , we normalize to no anxiety.³⁶ The time dimension is also important. Without significant dispute (we suspect), we assume that $A(L,0) = 0$ and $\partial A / \partial t > 0$.

Assume that the insurance purchase is for a year, and that the lottery is resolved at the end. Our potential insured experiences anxiety. Then, we might have:

$$U(L,0) = V(L) > V(D),$$

but $U(L,1) = V(L) - A(L,1) < U(D,1) = V(D) - A(D,1) = V(D)$.

This can happen since $A(L,1)$ is positive and $A(D,1)$ is 0. Thus, she may reject the insurance if the lottery is resolved immediately, but accept it if resolution is delayed sufficiently.

Saliency. Many insurance policies pay double if someone dies in an accident as opposed to natural causes. Many individuals, particularly young individuals, asked whether to purchase such coverage say yes. Insurance theory would say the individual should insure for the same amount, no matter how he dies. (If anything, dying in an accident is likely to be cheaper, than say from cancer.) But the accident becomes salient

³⁶ People might get anxious about a bad event they know will occur (a borrowed car must be returned), but we abstract away from this.

as a way to die, and individuals purchase such insurance. We suspect a form of ‘availability heuristic’ is likely playing a role here (Tversky and Kahneman, 1974). We see this in other contexts as well, such as Kunreuther’s (1979) finding that people purchase flood insurance after there is a flood, and the frequent purchase of additional insurance when one takes an airplane trip.

Hyperbolic discounting. Some insurance that we think should be purchased, such as annuities when elderly, are not bought. One possibility is hyperbolic discounting – people value today more than proportionately over the future. A hyperbolic discounter knows that purchasing an annuity is a good idea, but always wants to delay the purchase to next year – either because consumption is particularly valuable today, or because it is easier to delay decision-making until tomorrow. Empirically, people who are forced to make financial decisions by a specified date choose to save more than people who are free to make such decisions at any time (Choi et al., 2002).

Summary. Almost certainly, one theory is not right for all the phenomena we seek to explain. As a starting point for future research, we provide some of our own speculation about theories of likely importance on the consumer side of the market, shown in the table below. Future research will be needed to test these theories more completely, and possibly develop others.

Phenomenon	Insurance against small risks	Insurance against risks that do not affect marginal utility	Insurance against salient risks	Lack of insurance for big risks
Examples	Appliance insurance; Low deductible insurance	Single elderly with life insurance; Family heirlooms	Purchase of flood insurance after flood	Underpurchase of annuities, life insurance
Possible explanations	Prospect theory; Regret avoidance	Affective forecasting; Regret avoidance; Anxiety	Saliency; Anxiety	Hyperbolic discounting

We have principally been interested in improving descriptive theory. Usually when economists, including the authors, find divergences between normative theory and practice, they proselytized for the former. However, studying insurance is a sobering prospect. Unlike our standard models, most insurance decisions involve future contemplation and backward reflection. Thus, for example, given the importance that consumers attach to minimizing regret and anxiety, there is strong argument that such concepts should be given a role in our normative theories, a task for future efforts.

C. Probability Monopoly

There is considerable market power for some forms of insurance. At the high end, only the electronics store can realistically sell you an extended warranty at the time you purchase a camcorder or DVD player. Much life insurance is sold by salesmen calling on buyers, rather than vice versa. Even standardized Medigap insurance shows considerable price variability, a sign of market power.

Given market power, the sale of insurance introduces an element of monopoly pricing. People have some idea of expected loss probabilities, but this information is not complete.³⁷ Indeed, the loss probability might be aided by salespeople (once the device had been safely purchased, so as not to imply its quality was low).³⁸ Potential insurers can thus price above marginal cost, knowing that those with low risk assessments will choose to forgo coverage, while those with high assessments will buy. The markup on the population with high loss probabilities can make this a profitable strategy. We refer to this situation as probabilistic monopoly, and believe it helps explain the purchase of vastly overpriced insurance in a range of situations.

Consider a specific example: a store faces risk neutral consumers with different probabilities of needing repairs. The likelihood distribution is triangular, with density of $8-32y$ for probability y ranging between 0 and 25 percent. The implied mean breakdown probability is 8.33 percent. The store knows that the true likelihood is 2 percent, the same for all customers.

The store will set a price of insurance that maximizes expected profits, knowing the distribution of perceived risks. Normalizing the price to 1, the solution to this is the

value x that maximizes $\int_x^{.25} (8 - 32y)(x - .02) dy$. The optimal price is .097, or nearly 10

³⁷ Unlike the situation with adverse selection, it is possible that people have differences in their perceived loss probabilities that are not true in reality. A person might think himself clumsy with electronic devices, but not know that the devices are designed with clumsy people in mind.

³⁸ High-priced extended warranties undermine a product's presumed reliability. Thus, we now have many auto companies offering extremely long warranties. Electronics stores only offer extended warranties once a sale seems firm, and it is the electronics store, not the manufacturer, that is offering them. Such bundling with a sale has the additional advantage of rolling the two costs into one price. Raising the cost of a \$620 item to \$690 is more likely to get a sale than setting a new \$70 price for the warranty, e.g., of a camcorder.

percent of the purchase price. This is nearly five times above actuarial value, and well above the mean value in the population.

Monopoly pricing will not work if the buyers draw appropriate inferences from the situation. People who ask why the store is willing to sell insurance will conclude that it is only because the warranty makes money, and will decline the offer – a situation related to the familiar Winner’s Curse. Fortunately for electronics stores, even relatively sophisticated people are poor at drawing appropriate inferences.

Monopoly pricing will also not work if people underestimate the risk probability. We suspect this occurs in some situations where insurance is not sold. But as we learn from prospect theory, most people overestimate the risk of small probability events.

D. Summary

We posit three explanations for the poor performance of insurance markets beyond the traditional explanations surrounding moral hazard and adverse selection. They are contracting difficulties on the supply side, leading to incomplete diversification; non-standard behavior on the demand side; and probability monopoly. Given the vast divergence between the received theory of insurance and actual practice, students of insurance must extend current theory, often in unfamiliar directions. We believe these are promising paths for the future.

V. Conclusion

The United States government recently enacted the largest expansion in health insurance coverage in a generation. In November 2003, the Medicare program, set up in the 1960s and largely the same today as then, was enriched by the addition of an outpatient prescription drug benefit.³⁹

In many ways, adding prescription drugs to Medicare represented a triumph of economic reasoning. The fundamental principle of insurance demand is that coverage becomes more valuable as the variability of potential outcomes grows. In the 1960s, prescription drug costs were low, and there was little risk associated with buying medications. It made little sense to include prescription drugs in coverage. By 2003, the risks for the elderly were much greater. Even though the costs to the government of the new benefit were high, the potential risk-spreading value made it worthwhile.

Alas, effective risk sharing was not fully enshrined in the new legislation. Indeed, the cost sharing in the new legislation is, by economic considerations, somewhat bizarre. Elderly enrolling in the new program face a \$250 deductible. After that, the government pays 25 percent of the bill up to \$2,250 in total spending. The government then ceases payment until total spending reaches \$5,100 (\$3,600 of individual costs). Above that amount, the government pays 95 percent and the individual 5 percent. There is no upper limit on individual spending.

³⁹ Prescription medications used on an inpatient basis are already covered in Medicare hospital payments. For simplicity, we refer to the new benefit as prescription drug coverage, leaving implicit the restriction to medications taken on an outpatient basis.

From a risk-spreading perspective, a far more valuable insurance policy would have individuals cover more of the up-front costs, and leave the government to take more of the back-end liability. Politics no doubt helps to explain the benefits structure, probably derived from the type of utility anomalies discussed above. A certainty equivalent benefit of \$110, where the actual monies go to 10 percent of the elderly population may be politically less effective than a certainty equivalent benefit of \$100 where a large share of the money is spent among the vast part of the population.

The new legislation also considers the issue of public and private insurance, but here too the answer seems strange. Why didn't the private sector ever offer insurance for prescription drugs if that coverage is so valuable? The answer is that drug benefits are almost a poster child for adverse selection. The elderly with high drug needs know who they are, and they would raise the cost of private drug coverage beyond what the vast majority of elderly would consider paying.⁴⁰ Given sufficient skewness in expenditure, the market unravels.

Still, the new legislation envisions the majority of the elderly obtaining coverage through private insurance companies offering stand-alone pharmaceutical coverage. The classic economic solution to adverse selection – single payer health insurance – was explicitly rejected as being too regulatory a solution. To partly offset the selection incentives induced, the legislation includes a substantial sum to give to employers already providing drug coverage – 28 percent of costs between \$250 and \$5,000 per person. It is

⁴⁰ There is substantial evidence of adverse selection for prescription drug coverage in the 'Medigap' insurance market, which sells supplements to the standard Medicare package (see Atherly, 2002). Pauly and Zeng (2003) simulate a private market for prescription drug coverage allowing for reasonable degrees of adverse selection and conclude that such a market would not be feasible.

not known if this subsidy will prevent crowdout any more than previous subsidies to the poor through Medicaid.

Unfortunately (for economists), the seeming anomalies in the Medicare drug benefit are more common than we would care to admit. Exploring a number of insurance policies in practice, we argue that the conventional theory of insurance misses reality in two respects. First, it assumes near risk neutrality on the supply-side of the market, when in fact strong risk aversion is more appropriate, particularly given agency concerns of insurance decision makers. Second, we show that many attributes of insurance equilibrium can best be explained if people's behavior diverges from the rational model. They have non-standard preferences – e.g., they care about even tiny losses; they seek to equate utility across states not marginal utility; they disproportionately buy coverage for risks that are “available”.

We also identify possible solutions. Encouraging greater risk spreading beyond the narrow confines of primary insurance and reinsurance is a central one. Sometimes, government and private firms collaborate in this venture, as in terrorism insurance, where the government is a reinsurer. More generally, financial markets represent an enormous pool of largely-untapped potential insurance dollars.

The future, we are confident, will confront significant new risks, and will develop new mechanisms for spreading them. Alas, neither the invisible hand nor sophisticated theories of insurance will assure that the right entities write the right coverage for the right insureds. Our theories of insurance must be elaborated to capture realities on the ground, including the factors that motivate entities to insure. Insurance practice should be adjusted to meet realistic expectations of how risks can be spread effectively. This

ongoing minuet of adjustments, perhaps a dance over decades, should allow the theory and practice of insurance to reunite.

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Table 1: Medigap Monthly Premiums for Plan C in Denver,
Colorado

Firm	Age 65	Age 70	Age 75	Age 80
AARP	\$129	\$129	\$129	\$129
Equitable Life	96	113	123	134
5 Star Life	52	78	58	88
Union Banker	204	230	271	326

Source: www.centuraseniors.org.

Table 2: Assessment of Insurance Possibilities

Risk		Criteria for Insurance				
		Disparity in marginal utility	Frequency of event	Well-defined loss	Importance of moral hazard	Ease of diversification
<i>Individual Risks</i>						
Survival	Life, annuities	+	+	+	+	+
Health	Short-term	+	-	+	-	+
	Long-term	+	+	-	-	-
Property and casualty	House, auto, consumer durables	+	+	+	0	+
<i>Business Risks</i>						
Property and casualty	Short-term	+	+	+	0	+/-
	Long-term (pollution)	+	+	+	+	-
Employment	Harassment, unfair hiring	+	+	+	+	-
Obligations	Pensions	+	+	+	-	-

Note: A + indicates that the risks is in the direction favorable for insurance. An - indicates that it is unfavorable for insurance. A 0 indicates that it is neutral for insurance or unknown. The assessments are provided by the authors. See text for more discussion.

Table 3: Evaluation of Insurance Markets

Risk		Issues Noted	Other factors	Overall evaluation
<i>Individual Risks</i>				
Mortality	Life	Underinsurance of widows Overinsurance of elderly	Tax-free buildup	Fair
Health	Annuities	Too little purchase		Poor
	Short-term	Too much coverage for small risks	Tax subsidy	Fair
Property and casualty	Long-term	Too little coverage for large risks		Poor
	House	Too much coverage for small risks		Good
	Auto	Too much coverage for small risks		Fair
	Consumer durables	Why do people buy?		Poor
<i>Business Risks</i>				
	General	Good for most industries (major exception is medical malpractice)		Fair
Property and casualty	Long-term risk (pollution)	Inadequate coverage of large risks Market dries up with new knowledge		Poor
	Terrorism	Inadequate coverage of large risks Market dries up with new knowledge		Poor
Obligations	Pensions	Underfunding of pensions	PBGC reinsurance	Poor

Note: The assessment is based on the authors' beliefs. See text for details.

Table 4: Auto and Homeowners Insurance Policies

Policy	Deductible	Policy 1		Policy 2	
		Premium	Cost relative to common policy	Premium	Cost relative to common policy
Auto	\$300	\$684	-\$4	\$829	-\$47
	500**	680	0	762	0
	1,000	644	34	671	91
	2,000	634	44	643	119
House	\$250	\$3,630	-\$130	---	---
	500**	3,500	0	\$1,670	\$0
	1,000	3,230	270	1,450	220
	1,500	3,100	400	---	---

Note: For auto insurance, policy 1 is Amica insurance in Boston, Massachusetts and policy 2 is State Farm Insurance in Miami, Florida. In each case, the policy is for a 35 year old male driving 2004 Toyota Camry with a clean driving record, good credit, living less than 10 miles from work, with coverage of \$25,000 per person / \$50,000 per accident and \$20,000 / \$40,000 for an uninsured motorist. The coverage in market 2 is the same, with the exception that the lowest deductible is \$250, not \$500, and the limits for uninsured motorist coverage are \$10,000 / \$20,000. For homeowners insurance, policy 1 is a \$500,000 home in Philadelphia, Pennsylvania, built of brick structure within 5 miles of a fire station and 500 feet of a fire hydrant, with personal property reimbursement included. Policy 2 is a \$300,000 home in Orlando, Florida, built in 1990 of stone structure within 5 miles of a fire station and 500 feet of a fire hydrant, with a 2 percent hurricane deductible and personal property reimbursement included. Both quotations are from AllState.

** Most common policy, with an estimated market share of 60 to 95 percent.

Table 5: Common Insurance for Consumer Durables

Product	Typical warranty	Extended Product Protection or Replacement Plans*	% of customers who purchase**	Frequency of repairs***	Typical repair cost***
Camcorders	1 yr parts & labor	extended product protection \$70 / 2 yrs, \$120 / 3 yrs, \$300 / 5 yrs	30	25% within 5 yrs; 8% within 3 yrs	\$125
VCRs	1 yrs parts; 90 days labor	product replacement plan at 15% of cost / 2 yrs	70	24% within 5 yrs	\$75
DVD players (single)	1 yr parts & labor	product replacement plan at 15% of cost / 2 yrs	50		\$100
DVD players (home theatre system)	1 yr parts & labor	extended product protection \$30 / 2 yrs, \$175 / 5 yrs	50		
CD players	1 yr parts; 90 days labor	product replacement plan at 15% of cost / 2 yrs	80	10% within 5 yrs	\$80
MP3 players	90 days parts & labor	product replacement plan at 15% of cost / 2 yrs	70		\$100
TV sets (item cost \$80-\$180)	2 yrs picture tube; 1 yr parts; 90 days labor	product replacement plan at 15% of cost / 2 yrs	30	7% during lifetime	\$90
TV sets (item cost \$180+)	2 yrs picture tube; 1 yr parts; 90 days labor	extended product protection depending on item cost; range: \$150 / 3 yrs, \$2,000 / 5 yrs	45	20% during lifetime	\$175
Boomboxes	1 yr labor; 90 days parts	product replacement plan at 15% of cost / 2 yrs	60		
Microwaves	1 yr parts & labor ; 10 yrs magnetron	extended product protection \$70 / 3 yrs, \$100 / 5 yrs	5		\$150
Dishwashers	1 yr parts & labor	extended product protection \$90 / 3 yrs, \$140 / 5 yrs	35	19% within 5 yrs; 8 % within 3 yrs	\$250 (major); \$95 (minor)
Washers	1 yr parts & labor ; 5 yrs transmission	extended product protection \$100 / 3 yrs, \$170 / 5 yrs	20	23% within 5 yrs	\$300 (major); \$100 (minor)
Dryers	1 yr parts & labor	extended product protection \$70 / 3 yrs, \$140 / 5 yrs	20	14% within 5 yrs	\$150 (major); \$80 (minor)
Refrigerators	1 yr parts & labor; 5 yrs compressor	extended product protection \$110 / 3 yrs, \$170 / 5 yrs	30	8% within 3 yrs	\$300

Table 5 (continued)

Product	Typical warranty	Extended Product Protection or Replacement Plans*	% of customers who purchase**	Frequency of repairs***	Typical repair cost***
Vacuums	1 yr parts & labor	extended product protection \$40 / 2 yrs, \$70 / 5 yrs	40	34% within 5 yrs	\$50
Electric Ranges	1 yr parts & labor	extended product protection \$90 / 3 yrs, \$140 / 5 yrs	30	14% within 5 yrs; 8 % within 3 yrs	\$300 (major); \$100 (minor)
Digital Cameras	1 yr parts; 90 days labor	product replacement plan at 15% of cost / 2 yrs			
Treadmills	1 yr parts; 2 yrs labor; 3 yrs motor	extended product protection \$140 / 3 yrs	10		
Laptops	1 yr limited	extended product protection \$190 / 2 yrs, \$280 / yrs		19% within 5 yrs	\$100

*Common plans offered at SEARS and other retailers.

**Estimates from sales clerks at SEARS in Boston, MA.

***Sources: Consumerreports.org and sales clerks in Boston, MA.

Table 6: Premium for Employment Practices
Liability Insurance

Deductible	Premium	Difference
\$2,500	\$5,357	-\$26
5,000	5,331	0
10,000	4,283	1,074
25,000	4,021	1,336

Note: The premium is for a policy in Massachusetts with a \$1 million limit, CAP of \$50,000, and coinsurance of 5 percent. The firm has 20 full-time and 20 part-time employees.