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## Long-Term Health Insurance: Theory Meets Evidence

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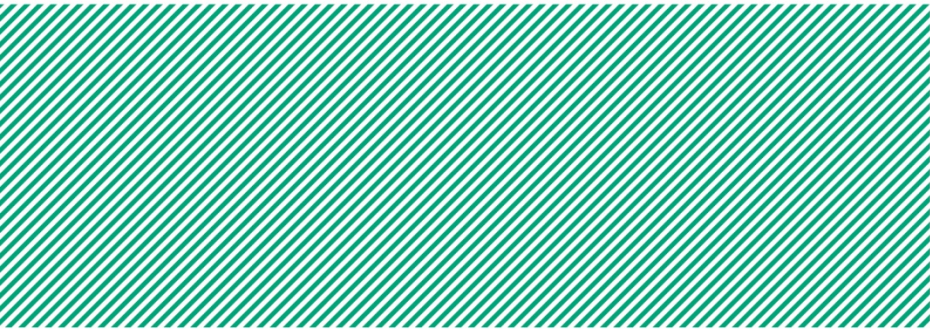
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#2020/01

Juan Pablo Atal, Hanming Fang, Martin Karlsson, and  
Nicolas R. Ziebarth

## **Long-Term Health Insurance:** Theory Meets Evidence

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Juan Pablo Atal, Hanming Fang, Martin Karlsson, and Nicolas R. Ziebarth

## **Long-Term Health Insurance:** Theory Meets Evidence



Juan Pablo Atal<sup>\*</sup>, Hanming Fang<sup>†</sup>, Martin Karlsson<sup>‡</sup>, and Nicolas R. Ziebarth<sup>§</sup>

## Long-Term Health Insurance: Theory Meets Evidence<sup>\*\*</sup>

### Abstract

*To insure policyholders against contemporaneous health expenditure shocks and future reclassification risk, long-term health insurance constitutes an alternative to community-rated short-term contracts with an individual mandate. Relying on unique claims panel data from a large private insurer in Germany, we study a real-world long-term health insurance application with a life-cycle perspective. We show that German long-term health insurance (GLTHI) achieves substantial welfare gains compared to a series of risk-rated short-term contracts. Although, by its simple design, the premium setting of GLTHI contract departs significantly from the optimal dynamic contract, surprisingly we only find modest welfare differences between the two. Finally, we conduct counterfactual policy experiments to illustrate the welfare consequences of integrating GLTHI into a system with a “Medicare-like” public insurance that covers people above 65.*

**Keywords:** Long-Term Health Insurance, Individual Private Health Insurance, Health Care Reform

**JEL classification:** G22; I11; I18

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# 1 Introduction

For decades, academics and policymakers alike have been studying options to regulate (short-term) private health insurance markets. Such policy options strive to avoid outcomes that are considered undesirable, such as a high uninsurance rate, unaffordable premiums for sick individuals or large premium fluctuations following changes in health status (Claxton et al., 2017). However, standard regulatory tools to address these issues, e.g. community-rated premiums and guaranteed issuance, involve cross-subsidization from the healthy towards the sick, and therefore typically imply a trade-off with other unintended consequences such as adverse selection (cf. Akerlof, 1970).

A fundamental alternative to regulated cross-subsidization is an individual *long-term* health insurance contract. Instead of relying on transfers across individuals with different health statuses, long-term contracts leverage individuals' private intertemporal incentives over their lifecycle. Under long-term contracts, sick individuals pay relatively low premiums and compensate by paying relatively high premiums in healthy times of their life. In theory, a carefully designed long-term contract can reduce the risk of premium fluctuations due to health shocks ("reclassification risk"), while ensuring participation and eliminating adverse selection (cf. Pauly et al., 1999; Patel and Pauly, 2002; Pauly and Lieberthal, 2008).

In this paper, we study the largest and oldest individual private long-term health insurance market in the world. In Germany, ten percent of the population (or 8.8 million individuals) hold individual long-term health insurance policies sold by private insurance companies. After an initial risk-rating, the policies are guaranteed renewable until death (without an expiration date or enrollment period) and future premium changes have to be community rated; that is, premium changes over the lifecycle are independent of changes in the policyholder's health status.<sup>1</sup>

The simple design of the German long-term health insurance contract (henceforth GLTHI) differs substantially from the welfare-maximizing contract derived by Ghili et al. (2019) (henceforth GHHW). The German contract foresees the payment of constant real premiums over the lifecycle, regardless of the evolution of an individual's income and health status. As a consequence, the GLTHI contract almost entirely eliminates reclassification risk—at the expense of relatively high premiums during the early life years ("frontloading"). In contrast, the optimal dynamic contract involves a premium path that is income-dependent, and that changes over the lifecycle after the realization of health shocks. The optimal contract considers the individual's lifecycle income profile to find the welfare-maximizing balance between insurance against reclassification risk and consumption

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<sup>1</sup>Germany has no public insurance specifically for people above the age of 65, like Medicare in the United States.

smoothing over the lifecycle.<sup>2</sup>

This paper first presents and discusses the main principles and functioning of GLTHI. It is a market that, despite its stable existence for decades, has received very little attention outside Germany. We formulate the theoretical foundations of GLTHI and contrast them with GHHW. Next, we leverage a unique panel of claims data from one of the largest German private insurers. In total, our data include 620 thousand unique enrollees over 7 years, spanning all age groups and all German states. For example, the oldest policyholder is 99 years and the most loyal client has been insured for 86 years. We then make use of the German version of the John Hopkins ACG<sup>©</sup> software, and propose a novel risk classification method which allows us to categorize the expected health risk and study health transitions over time. Because lifecycle income profiles play a crucial role when assessing the welfare effects of GLTHI, we leverage more than three decades of lifecycle income panel data from the representative German Socio-Economic Panel Study (SOEP). For this purpose, we rely on household income measures that consider all income streams, including social insurance benefits and consider within-household redistribution.<sup>3</sup>

We find that the simple GLTHI design generates only small welfare losses compared to the optimal contract of GHHW. Under various parameterizations and scenarios, replacing the GLTHI contract with the optimal contract would increase welfare by between zero and seven percent. Within a plausible range of parameter values, we find that the welfare gains are smaller than four percent. When delving deeper into an understanding the surprisingly small welfare loss of GLTHI relative to the optimal contract, we find that, compared to the optimal contract, the GLTHI contract entails less consumption smoothing over the lifecycle, but also less reclassification risk. On balance, compared to the optimal contract, the welfare loss due to less consumption smoothing is almost entirely offset by better reclassification risk insurance in the GLTHI contract. These results are robust to the incorporation of private savings, to a wide range of degrees of risk aversion, and to non-time-separable recursive preferences à la Epstein and Zin (1989).

We also investigate the potential implications of our findings for U.S. health insurance reform. We argue that the U.S. health insurance system, prior to the Affordable Care Act at least, could be approximated by a hybrid system of private health insurance contracts for the working-age population up to age 64 and payroll tax financed Medicare insurance for age 65 and higher; in addition,

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<sup>2</sup>The contract derived by Ghili et al. (2019) is optimal under one-sided commitment and no-borrowing constraints. This paper also maintains those assumptions. The first-best contract corresponds to a constant consumption profile over an individual's lifecycle but is unattainable under these assumptions.

<sup>3</sup>We also show that the findings are robust to using more than three decades of lifecycle income data from the U.S. Panel Study of Income Dynamics (PSID).



the market for private health insurance contracts is to a first order approximation a 60/40 mixture of long-term contracts (employer-sponsored health insurance) and short-term contracts. We implement the U.S. system using our estimates from the German data, and show that switching all short-term contracts to long-term contracts (either in the form of GLTHI or the GHHW optimal contracts) could result in substantial welfare gains. However, we also find that such a hybrid system of private insurance contracts and Medicare achieves lower welfare than a system in which private long-term insurance contracts cover individuals throughout their entire lifecycle (as in the GLTHI system).

This paper contributes to the literature on dynamic contracts for which vast theoretical work but relatively little empirical evidence exists. Pauly et al. (1995) propose a “guaranteed-renewable” contract with a pre-specified path of premiums that fully eliminates adverse selection and reclassification risk. Similarly, Cochrane (1995) proposes a scheme of severance payments, made after the realization of health shocks, which provides full insurance against reclassification risks. Hendel and Lizzeri (2003) and Ghili et al. (2019) show that the optimal contract only partially insures reclassification risk, because fully eliminating reclassification risks requires large frontloaded payments, preventing consumption smoothing over the lifecycle. These results are mostly theoretical, and the proposed contracts typically have complex designs that have high informational requirements to implement. The main contribution of our paper is to provide a systematic welfare analysis of an existing, simple real-world alternative long-term contract with a distinct advantage of *low information requirements* for implementation. We show that, even though the GLTHI contracts are theoretically not optimal, they provide a close approximation in terms of welfare to the optimal GHHW contracts by providing better reclassification risk insurance at the cost of less intertemporal consumption smoothing.

Several papers, including Hendel and Lizzeri (2003), Herring and Pauly (2006), Finkelstein et al. (2005), and Atal (2019), investigated empirically the workings of long-term contracts in different contexts. Our paper also contributes to this empirical literature by introducing in Section 5.1 a method of discrete classification of health risks. We base our method on the properties of *homogeneity* and *separation* in the actuarial science literature (see Finger, 2006). Our proposed method is, in our view, a more informative way of discrete classification of health risks than the mostly *ad hoc* method used in the existing literature.

Our paper is also related to a few papers that have previously studied the Germany long-term health insurance market. Hofmann and Browne (2013) describe GLTHI contracts and show that switching behavior in the market is consistent with its incentive structure. Christiansen et al. (2016) empirically study determinants of lapsing and switching behavior. Baumann et al. (2008) and Eekhoff

et al. (2006) discuss the potential effects of higher switching rates on market competition if the capital accumulated through frontloaded payments were to be made portable across insurers. While these two papers discuss a hypothetical reform, Atal et al. (2019) theoretically and empirically study the effects of the actual 2009 portability reform on switching behavior.

The rest of the paper is organized as follows. In Section 2, we provide the institutional details of the GLTHI market; in Section 3, we derive the theoretical life-cycle premiums under the GLTHI framework and contrast them with the premiums of the optimal contract as derived in Ghili et al. (2019); in Section 4, we describe our data sets and provide summary statistics; in Section 5, we model the health risk and income dynamics over the lifecycle. In Section 6, we make use of the theoretical and the empirical inputs to simulate the economy quantify various welfare under different contracts, and present implications of our findings on the U.S. health reform; in Section 7, we discuss the robustness of our main results to different values of risk aversion, and to Epstein and Zin (1989)'s recursive preferences; finally, in Section 8, we conclude.

## 2 Institutional Details

Germany has a two-tier health insurance system where a statutory health insurance (SHI) and an individual private health insurance market co-exist. SHI is a public insurance program that covers ninety percent of the population. SHI enrollees pay income-dependent contribution rates for a standardized benefit package with very little cost-sharing, and they are enrolled in one of the 109 non-profit sickness funds (Schmitz and Ziebarth, 2017; Bünnings et al., 2019; Bundesministerium für Gesundheit, 2020). However, for historical reasons, select population subgroups (see below for details) have the right to leave the public SHI system *permanently* and fully insure their health risks on a private market. By opting out of the SHI, individuals no longer need to pay SHI taxes, but they are mandated to purchase long-term private health insurance. In the private market, individuals can choose among thousands of individual *long-term* plans. Karlsson et al. (2016) provide more details on the general structure of the German health insurance market. Hofmann and Browne (2013) and Atal et al. (2019) provide additional specific details on the individual private market. The uninsurance rate in Germany is around 0.1 percent (German Statistical Office, 2016).

Besides Chile (cf. Atal, 2019), Germany is the only country in the world with an existing private long-term health insurance market. About 8.8 million enrollees in Germany are long-term insured on this market (Association of German Private Healthcare Insurers, 2019b). For historical reasons,

GLTHI covers three main population subgroups: (a) the self-employed; (b) high-income earners with gross labor incomes above a politically defined federal threshold (in 2020, the threshold is € 62,550, or about \$68,800 per annum); and (c) civil servants. These population subgroups have the option to leave the public SHI system and insure their health risks privately with a long-term contract (Nuscheler and Knaus, 2005; Hulleger and Klein, 2010; Polyakova, 2016; Panthöfer, 2016). This decision to enter the private market is essentially a lifetime decision. Switching back to SHI is strictly limited, so as to prevent individuals from strategically switching back and forth and gaming the system; the basic principle is “once privately insured, always privately insured” (Schencking, 1999; Innungskrankenkasse Berlin Brandenburg, 2018). We discuss the institutional specifics of this rule, as well as the empirical evidence on the difficulty of switching from GLTHI back to SHI in Appendix A1.

The GLTHI market consists of 48 private insurers that sell *comprehensive* as well as *supplemental* insurance coverage (Association of German Private Healthcare Insurers, 2019c). The focus of this paper is the comprehensive or “substitutive” (to SHI) insurance, which is solely sold as individual policies. Besides not paying the SHI taxes, other advantages for consumers to opt out of SHI and getting private GLTHI coverage include that the GLTHI offers a lot of choice as well as actuarially fair premiums in a lifecycle perspective (as we discuss in more detail below). Compared to the post-ACA era in the U.S., the GLTHI market is less regulated. Applicants can freely choose their level of coverage in terms of benefits and cost-sharing amounts, within some lax limits. This results in thousands of different health plans among the 8.8 million policyholders, most of which are sold across state lines and nationwide. The majority of private insurers operate nationwide and are open to all applicants who opt out of SHI.

**Provider Networks.** Provider networks and “Managed Care” are unknown in the public and private system in Germany; that is, people can freely choose their providers in either system. Moreover, in both the public and private system, reimbursement rates are centrally determined and do not vary by insurers or health plans. While the fees for inpatient services are identical across the public and private market, the fees for outpatient services are structurally higher in the private market, which is why wait times for outpatient services, especially those of the specialists, are shorter for the privately insured (Werbeck et al., 2019). Because they do not negotiate rates or build provider networks, the main job of private insurers is to customize health plans and process, scrutinize, and deny claims. Thus, different from the private insurance plans in the United States, the GLTHI contract primarily

constitutes a *pure financial contract*. This feature of the German health insurance system significantly simplifies our welfare analysis of GLTHI versus the optimal contract and other alternative arrangements.

**Guaranteed Renewability and One-Sided Commitment.** While an individual applies for a private health insurance, the insurer can initially deny coverage to applicants with bad risks, however, the insurers cannot terminate ongoing contracts. Contracts are not yearly contracts like in the U.S., but permanent lifetime contracts without an end date. In other words, the GLTHI contracts are guaranteed lifetime renewable.<sup>4</sup> Because enrollees can cancel their permanent contracts but insurers cannot, the GLTHI is a market with a one-sided commitment. However, it is relatively common that enrollees remain insured with their carrier until they die (recall that Medicare does not exist in Germany).<sup>5</sup> In addition, whereas the initial premium is risk-rated, all subsequent premium increases are community-rated at the plan level, such that the contract provides insurance against reclassification risk.

**Premium Calculation and Old Age Provisions.** The initial GLTHI premium is individually underwritten.<sup>6</sup> Premiums consist of several components whose exact calculations are regulated by the *Kalkulationsverordnung (KalV)*. The insurers' actuaries carry out the specific actuarial calculations which have to be approved by a federal financial regulatory agency (the *Bundesanstalt für Finanzdienstleistungsaufsicht, BaFin*). Specifically, Chapter 1 of the *KalV* specifies that premiums have to be a function of the expected per capita health care claims or *Kopfschäden* (which depend on the plan chosen, age, gender, health risks),<sup>7</sup> the assumed guaranteed interest rate (*Rechnungszins*), the probability to lapse (*Stornowahrscheinlichkeit*), and the life expectancy (*Sterbewahrscheinlichkeit*).

One important and distinct characteristic of the GLTHI market is the legal obligation of insurers to build up *old-age provisions*, typically until age 60 of the policyholder. The *old-age provision* accumu-

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<sup>4</sup>In fact, because there is no enrollment period and end date, contracts are permanent and do not have to be renewed.

<sup>5</sup>In our sample, the policyholders' average age is 46 years and policyholders have been with the insurer for an average of 13 years; the oldest client is 99 years old and the most loyal client has been with the insurer for 86 years, see Table A1 (Appendix).

<sup>6</sup>The only exception is the "Basic Plan" (*Basistarif*). The Basic Plan must be offered by all carriers and is structured after the SHI with the same essential benefits and actuarial values. For the Basic Plan, guaranteed issue exists for people above 55 and those who joined the GLTHI after 2009. The maximum premium is capped at the maximum SHI contribution (in 2020, it is €935.94 per month). The legislature mandated the Basic Plan to provide an "affordable" private option for GLTHI enrollees who cannot switch back to SHI, are uninsured, would have to pay excessive premiums, or would be denied coverage. However, the demand for the Basic Plan has been negligible; thus henceforth, we will abstain from it. In 2018, in the entire GLTHI, only 32 thousand people, or 0.4 percent, were enrolled in the Basic Plan (Association of German Private Healthcare Insurers, 2019c). In our data, only 1,006 enrollees chose the basic plan in 2010.

<sup>7</sup>Gender rating was allowed until December 21, 2012. After this date, for new contracts, all insurers in the European Union (EU) have to provide unisex premiums as the EU Court of Justice banned gender rating as discriminatory (Schmeiser et al., 2016)

lated early in the lifecycle serves as capital to cover higher health expenditures later in the lifecycle. Premiums are calculated under the basic principle of a constant premium over the lifecycle that is enough to cover expenses over the enrollee’s lifecycle (we provide a formal treatment of this principle in Section 3.1). Thus, in young ages, premiums exceed the expected claims; while in old ages, premiums are lower than the expected claims —a phenomenon known as ‘*front-loading*’ in long-term insurance contracts (Nell and Rosenbrock, 2007, 2009).<sup>8</sup>

Figure 1 provides an illustration of the front-loading for four combinations of age at initial enrollment and health risk: high and low health risk, and initial enrollment at either age 30 or 50. In this illustration, we assume the health risk types to be constant over the lifecycle.<sup>9</sup> The low health risk type corresponds to a hypothetical individual with no pre-existing conditions, and the expected health expenditures by age conditional on survival is denoted by  $E(m|surv, low)$  in Figure 1; the high health risk type corresponds to a hypothetical individual who has 50 percent higher expected health care costs at each age, denoted by  $E(m|surv, high)$  in Figure 1. In Figure 1,  $P_{30,low}$  (and respectively,  $P_{30,high}$ ) is the premiums under the GLTHI if a low (respectively, high) risk type starts its enrollment into the long-term contract at age 30; similarly,  $P_{50,low}$  and  $P_{50,high}$  are the premiums under the GLTHI if the two types start their enrollment into the contract at age 50.

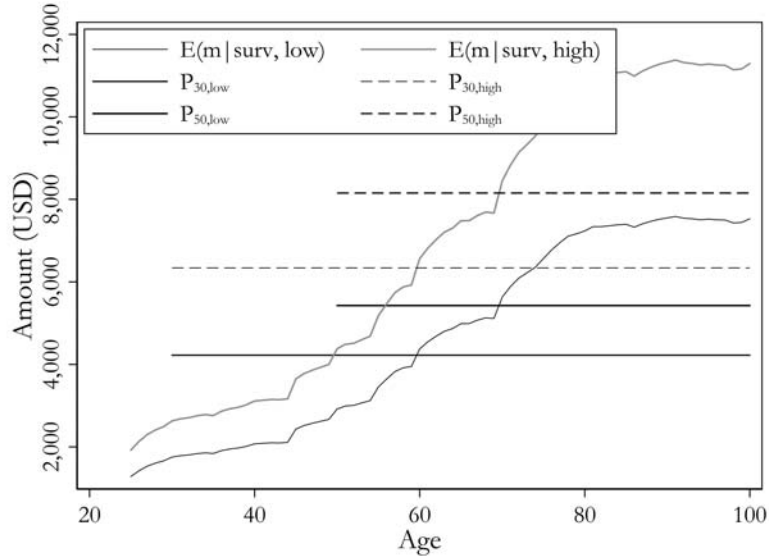
Figure 1 has the following important features. In principle, premiums remain stable over enrollees’ life cycles. Front-loaded premiums allow to dampen increases in premiums via the capital stock built through old-age provisions – the cumulative difference between the premium payments and the expected claims in addition to the investment returns from these front-loaded payments.<sup>10</sup> Second, premiums are higher for enrollees who joined the GLTHI later in their life, as the expected yearly future expenditures increase with age.<sup>11</sup> Third, because of the initial risk rating, high-risk types (the “sick”) pay higher premiums throughout their lives, relative to the low-risk types (the

<sup>8</sup> Such front-loading creates a ‘lock-in’ effect, in addition to the lock-in induced by guaranteed renewability (Nell and Rosenbrock, 2008; Atal, 2019). To strengthen consumer power and reduce this lock-in, the German legislature made a standardized portion of these old-age provisions portable across carriers for contracts signed after Jan 1, 2009; see Atal et al. (2019) for an evaluation of this reform. For existing contracts, Atal et al. (2019) do not find a significant impact on external switching rates. However, they find a one-time increase in internal plan switching during the limited six months period from January to June 2009 where portability was granted for existing contracts.

<sup>9</sup> Although the case with permanent health risk allows to illustrate the basic front-loading principle, allowing for a stochastic health status is fundamental to the analysis: First, it allows to show that front-loading can dampen the reclassification risk. Second, an evolving health status means that individuals who start unhealthy may lapse their contract, which introduces (downwards) reclassification risk even if premiums are constant within a given contract. Also, lapsation needs to be taken into account when calculating the premium level. We treat the case with evolving health status extensively in Section 3.1 and in the rest of the paper.

<sup>10</sup> In 2018, the capital stock built through old-age provisions amounted to € 260 billion (\$286 billion) for 8,736,400 policies, or to € 29,760 (\$32,737) per policy (Association of German Private Healthcare Insurers, 2019c).

<sup>11</sup> This is not necessarily true when health risk may change over time. With a stochastic health status, the initial premium may start to decrease at very high ages as, over time, the need to front-load for future negative shocks to health status decreases (see Section 6.1.)



**Figure 1:** Premiums and Health Expenditures over the Lifecycle in the GLTHI

Source: German Panel Claims Data (see Section 4.1), own calculations, own illustration.

“healthy”).<sup>12</sup>

While, theoretically, the premium of a contract is constant over an individual’s lifecycle, in reality nominal and also real premiums do increase. The main factors that trigger such premium adjustments (*Beitragsanpassungen*) are the following: (i) structural changes in life expectancy; (ii) structural changes in health care consumption; (iii) structural changes in health care prices mostly due to medical change, e.g. new expensive drugs;<sup>13</sup> (iv) structural changes of the economic environment, e.g. through capital markets or new financial regulation. An example of (iv) is the structural and unexpected shift of central banks to a super-low interest rate environment over the past decade. Such a structural shift implies a strong decrease in returns to risk-free capital investment. Because GLTHI insurers (like life insurers) are heavily invested in the bond market, structural premium adjustments have been the consequence.<sup>14</sup>

Premium adjustments are not only allowed in some cases, but also *required* by the regulatory financial oversight agency *BaFin* to ensure financial stability within the regulatory framework in the

<sup>12</sup>Again, this is not necessarily true when health risk may change over time.

<sup>13</sup>The Health Care Reform 2000 (*GKV-Gesundheitsreformgesetz 2000*) introduced a mandatory 10 percent premium surcharge up to age 60 to dampen structural increases in health care spending due to medical progress. This surcharge only applies to GLTHI contracts signed after January 1, 2000 (see article 14 of *GKV-Gesundheitsreformgesetz (2000)*).

<sup>14</sup>The *KaIV* has traditionally capped the assumed return on equity, the so called “guaranteed interest rate” (*Rechnungszins*) for the premium calculation at 3.5 percent. This has been the case for five decades. However, in 2016 for the first time, the average net return on investment has dropped below 3.5 percent, which is why the *German Actuary Association* has issued a new guideline to calculate the new insurer-specific “maximum allowed interest rate” (*Höchstrechnungszins*), see *Deutsche Aktuarvereinigung (DAV) (2019)*.

*Versicherungsvertragsgesetz (VVG)*, the *Versicherungsaufsichtsgesetz (VAG)*, and the *KaIV*.<sup>15</sup> Most insurers have to follow the *Solvency II* reporting requirements. Each year, insurers have to test whether their underlying assumptions for their premium and old age provision calculations for each health plan are still accurate. If they deviate by a certain amount, they have to adjust the premiums, which can result in two-digit premium increases, bad press, and lawsuits (Krankenkassen-Zentrale (KKZ), 2020).<sup>16</sup> However, on average, nominal premium increases have been moderate—in 2018 at 1.8% and from 2009 to 2019 at an average nominal rate of 2.8% (Association of German Private Healthcare Insurers, 2019a). Most important for our analysis is that the premium adjustments of GLTHI after the initial purchase are not allowed to depend on the enrollee’s possibly evolving health status.

### 3 Premium Settings and Welfare Measures

#### 3.1 Lifecycle Premiums in the German Long-Term Health Insurance (GLTHI)

We start by formalizing the calculation of GLTHI premiums over the lifecycle. Then we compare them to the lifecycle premium profile of the optimal dynamic contract as derived by Ghili et al. (2019) (GHHW).

Let  $P_t(\xi_t)$  be the premium offered when signing a GLTHI contract in period  $t$ .  $P_t(\xi_t)$  depends on the individual’s health risk in year  $t$ ,  $\xi_t$ , as GLTHI contracts are individually underwritten at inception (see Section 2). We assume that  $\xi_t \in \Xi$  where  $\Xi$  is a finite set of health states to be described below. In subsequent periods, each contract is guaranteed-renewable. As such, individuals who sign a contract in period  $t$  can renew the contract for the same premium,  $P_t(\xi_t)$ , in all periods between  $t + 1$  and  $T$ , regardless of the evolution of their health status.

As discussed in Section 2, the contract breaks even in equilibrium, given premium  $P_t(\xi_t)$ . Consequently, we express  $P_t(\xi_t)$  as the solution to a fixed-point problem in which  $P_t(\xi_t)$  covers exactly the expected claims of enrollees who stay in the contract at premium  $P_t(\xi_t)$ . We solve for  $P_t(\xi_t)$  recursively, starting from the last period,  $t = T$ . In  $T$ , there is no uncertainty regarding future health shocks and future lapsation. Let  $m_t$  denote health care expenditures in year  $t$ . Assuming full coverage, it follows that  $P_T(\xi_T) = \mathbb{E}(m_T | \xi_T)$ .

<sup>15</sup>Effective January 1, 2016 the *KaIV* has been replaced by the *Krankenversicherungsaufsichtsverordnung (KVAV)*.

<sup>16</sup> All premium adjustments have to be legally checked and approved by 16 independent actuaries who are appointed by the *BaFin*. However, some plaintiffs in lawsuits argue that some of these actuaries would not be sufficiently independent. Other reasons of courts to declare a premium increase as “not justified” were insufficient explanations by the insurers or a deliberate initial underpricing of premiums in the first year to attract enrollees (Krankenkassen-Zentrale (KKZ), 2020).

To calculate the equilibrium premium in  $t < T$ , we need to consider *endogenous lapsation*. Enrollees will lapse their current contract if, given the evolution of their health status, they can obtain a lower premium if they apply for a new policy in the market than their current guaranteed-renewable premium. Formally, lapsing a contract signed in  $t < T$  at the risk-rated premium  $P_t(\xi_t)$  occurs at the first  $\tau > t$  under health status  $\xi_\tau$  if  $P_\tau(\xi_\tau) < P_t(\xi_t)$ , where  $P_\tau(\xi_\tau)$  is the premium that the individual can get time  $\tau > t$  when his/her health status is  $\xi_\tau$  from a new long-term policy.<sup>17</sup>

**Remark 1** *Note that the lapsation decision under GLTHI is only driven by a comparison between one's current guaranteed premium  $P_t(\xi_t)$  and the premium that he/she could obtain from a new contract  $P_\tau(\xi_\tau)$ . Neither risk aversion nor income shocks play any role in the lapsation decision under GLTHI; also as we mentioned previously, GLTHI is a pure financial contract, thus the lapsation decision is not driven by any differentiation in provider networks associated with the policies.*

For a given  $t < T$  and  $\tau > t$ , we denote  $\mathbf{P}_{t+1}^\tau \equiv \{P_{t+1}(\cdot), \dots, P_\tau(\cdot)\}$  as the set of guaranteed premiums from  $t + 1$  to  $t + \tau$ . We can then recursively write the break-even GLTHI lifecycle premium for time- $t$  new enrollees applying for GLTHI with health state  $\xi_t$ , which we denote by  $P_t(\xi_t)$ , as follows:

$$P_t(\xi_t) = \frac{\mathbb{E}(m_t|\xi_t) + \sum_{\tau>t} \sum_{z \in \Xi} \delta^{\tau-t} \mathbb{E}(m_\tau|z) \times q_\tau(z|\xi_t, \mathbf{P}_{t+1}^\tau, P_t(\xi_t))}{1 + \sum_{\tau>t} \sum_{z \in \Xi} \delta^{\tau-t} \times q_\tau(z|\xi_t, \mathbf{P}_{t+1}^\tau, P_t(\xi_t))}, \quad (1)$$

where the first element of the numerator,  $\mathbb{E}(m_t|\xi_t)$ , is expected health care costs in period  $t$ , given  $\xi_t$ ; the second element of the numerator is the sum of the expected future health care costs over all remaining life years from  $t$  to  $T$ , which are discounted with rate  $\delta$ , with the spending at a future time  $\tau$  weighted by  $q_\tau(z|\xi_t, \mathbf{P}_{t+1}^\tau, P_t(\xi_t))$ , the probability that (1)  $\xi_\tau = z$ , and (2) the individual does not lapse (or die) between periods  $t$  and  $\tau$ , given the subsequent equilibrium premiums  $\mathbf{P}_{t+1}^\tau$ . These expected lifecycle health care claims are then normalized by the expected number of non-lapsing years in the contract in the denominator.<sup>18</sup> In other words, in the GLTHI market, the lifecycle premium  $P_t(\xi_t)$  equals the average of today's expected health care spending and all expected future health care spending, given the health risk today and in the future, weighted by the likelihood of non-lapse in any of the future time periods until death.

<sup>17</sup>Note that we abstain from horizontal differentiation across plans, and from switching costs.

<sup>18</sup>Of course,  $q_\tau(z|\xi_t, \mathbf{P}_{t+1}^\tau, P_t(\xi_t))$  depends on the evolution of the health status  $\xi_{t+1}, \dots, \xi_\tau$  and death, conditional on current health status  $\xi_t$ . We describe how we model the health risk process in Section 5.



Equation (1) implicitly determines the constant GLTHI equilibrium lifecycle premium for a contract signed in period  $t$ . Note that the break-even constraint determines the GLTHI lifecycle premium in any period for different health statuses, considering the likelihood to lapse in future periods. These lifecycle premiums do not maximize any *ex ante* consumer objective functions; conceptually, they are *not* designed to maximize any welfare criterion.

**Remark 2** Note that the equilibrium premiums of the GLTHI recursively determined by Equation 1 do not depend on the utility function, and the income profiles. Therefore, the GLTHI premiums do not depend on educational achievement of the applicants even though the income profiles differ substantially across education groups.

### 3.2 Lifecycle Premiums in the Optimal Dynamic Health Insurance Contract (GHHW)

In contrast, Ghili et al. (2019) study the optimal dynamic health insurance contract that maximizes consumer welfare, subject to break-even, no lapsation, and no borrowing constraints, in an environment where individuals have *time-separable* and *risk averse* preferences subject to stochastic health expenditure shocks. Ghili et al. (2019) show that the optimal dynamic insurance contract provides a *consumption guarantee*  $\bar{c}_t(\xi_t, \mathbf{y}_t^T)$  that is a function of enrollees' current health risk as well as the vector of current and future income  $\mathbf{y}_t^T \equiv \{y_t, y_{t+1}, \dots, y_T\}$ . The optimal dynamic insurance contract establishes that the individual will start consuming  $\bar{c}_1(\xi_1, \mathbf{y}_1^T)$ . Over time, the consumption of an individual holding a guarantee  $\bar{c}$  is bumped up in every period  $t$  such that a competing firm can offer a higher guarantee  $\bar{c}_t(\xi_t, \mathbf{y}_t^T) > \bar{c}$  and still break-even in expectation.

Analogous to the GLTHI lifecycle premium calculation,  $\bar{c}_t(\xi_t, \mathbf{y}_t^T)$  is solved by backwards induction. Specifically, the consumption guarantee in period  $T$  is given by  $\bar{c}_T(\xi_T, y_T) = y_T - \mathbb{E}(m_T | \xi_T)$ . For any  $t < T$  and  $\tau > t$ , denote the set of future equilibrium consumption guarantees  $\bar{\mathbf{c}}_{t+1}^\tau \equiv \{\bar{c}_{t+1}^\tau(\cdot), \dots, \bar{c}_\tau(\cdot)\}$ . Then an algebraic reformulation of the consumption guarantee in Ghili et al. (2019) shows that the equilibrium break-even consumption guarantee under the optimal dynamic contract for an individual purchasing a long-term optimal contract at time  $t$  under health status  $\xi_t$  is recursively determined by:

$$\bar{c}_t(\xi_t, \mathbf{y}_t^T) = \frac{y_t - \mathbb{E}(m_t | \xi_t) + \sum_{\tau > t} \sum_{z \in \Xi} \delta^{\tau-t} (y_\tau - \mathbb{E}(m_\tau | z)) \times q_\tau(z | \xi_t, \bar{\mathbf{c}}_{t+1}^\tau, \bar{c}_t(\xi_t, \mathbf{y}_t^T))}{1 + \sum_{\tau > t} \sum_{z \in \Xi} \delta^{\tau-t} \times q_\tau(z | \xi_t, \bar{\mathbf{c}}_{t+1}^\tau, \bar{c}_t(\xi_t, \mathbf{y}_t^T))}, \quad (2)$$

where  $q_\tau(z | \xi_t, \bar{\mathbf{c}}_{t+1}^\tau, \bar{c}_t(\xi_t, \mathbf{y}_t^T))$  is, with some slight abuse of notation, the probability that (1)  $\xi_\tau =$

$z$ , and (2) the individual does not lapse (or die) between periods  $t$  and  $\tau$ , given the set of future equilibrium consumption guarantees  $\bar{c}_{t+1}^\tau$ . Again, as above, Equation (2) implicitly determines the equilibrium consumption guarantee in period  $t$  under health status  $\zeta_t$ . As noted in Ghili et al. (2019), these consumption guarantees can be re-interpreted as a series of contracts with guaranteed premium paths  $P_\tau(\zeta_\tau, y_\tau) = y_\tau - \bar{c}_t(\zeta_t, \mathbf{y}_t^T)$  for  $\tau \geq t$ ; and the consumer would lapse at a time  $\tau > t$  under health status  $\zeta_\tau$  whenever  $\bar{c}_\tau(\zeta_\tau, \mathbf{y}_\tau^T) > \bar{c}_t(\zeta_t, \mathbf{y}_t^T)$ . That is, a consumer who chose an optimal long-term contract at time  $t$  under health status  $\zeta_t$  will lapse at a future time  $\tau$  under health status  $\zeta_\tau$  if he/she is able to obtain a new long-term contract from the market that provides higher consumption guarantees.

**Remark 3** *The consumption guarantees under GHHW's optimal long-term contracts, recursively characterized by Equation 2, do not depend on the utility function. What is important for the theoretical derivations of the optimal contract is that the consumers' preferences are time separable and exhibit risk aversion. The time-separability assumption is violated when we examine the Epstein-Zin recursive preferences in Section 7.*

**Remark 4** *The consumption guarantees under GHHW's optimal long-term contracts, recursively characterized by Equation 2, do depend on income profiles. This implies that the corresponding guaranteed premium paths  $P_\tau(\zeta_\tau, y_\tau) = y_\tau - \bar{c}_t(\zeta_t, \mathbf{y}_t^T)$  also depend on the income profiles. Since income profiles differ by education group, the GHHW premiums differ by education group. This differs from the GLTHI premiums (see Remark 2).*

### 3.3 GLTHI vs. GHHW from a Welfare Perspective

The design of the GLTHI contract differs substantially from the welfare-maximizing GHHW contract, leading to different consumption profiles.<sup>19</sup> On the one hand, GLTHI implies the payment of a constant premium regardless of policyholders' income and the evolution of their health (with the exception of those who become healthy enough to switch to a contract with lower premiums; as shown later, this is a rare occurrence). As a consequence, the GLTHI contract almost completely eliminates the reclassification risk. However, the elimination of reclassification risk comes at the expense of large premium payments at early ages to prevent future premium hikes. These large upfront premiums have negative welfare implications when income is low and the marginal utility of consumption is high at early ages. On the other hand, the optimal dynamic contract involves a path of consumption

<sup>19</sup>In the special case of flat income over the lifecycle, i.e.,  $y_t = y^0$  for all  $t$ , then  $y^0 - P_t(\zeta_t) = \bar{c}_t(\zeta_t)$ , cf. Equations (1) and (2). That is, when income is flat over the lifecycle, then the guaranteed premium in GLTHI coincides with the implicit guaranteed premium paths in GHHW.

guarantees (and therefore, a path of premiums) that is income-dependent, and that changes over the lifecycle after health shocks. The reason is that the optimal contract penalizes high premiums when the marginal utility of consumption is high.

We quantify the welfare consequences under each contract from the perspective of lifetime utility  $U$  defined as:

$$U = \mathbb{E} \left( \sum_{t=t_0}^T S_t \delta^{t-t_0} u(c_t) \right)$$

where  $S_t$  is an indicator of survival until period  $t$ , and  $c_t$  is the consumption in period  $t$  that is specified by the contract, which may depend on the full history of health realizations up to  $t$  as well as the individual's full lifecycle income profile. Expectation is taken over the individual's lifetime health history  $(\xi_1, \xi_2, \dots, \xi_t)$  and survival.<sup>20</sup> With a parametric assumption for flow utility  $u(\cdot)$ , and knowing income  $y_t$ , we can summarize welfare with the “certainty income equivalent”, denoted  $CE$ , such that:

$$u(CE) = \frac{\mathbb{E} \left( \sum_{t=t_0}^T S_t \delta^{(t-t_0)} u(c_t) \right)}{\mathbb{E} \left( \sum_{t=t_0}^T S_t \delta^{t-t_0} \right)}$$

This simple expression captures the main trade-offs in health insurance design for lifetime welfare. Lifetime utility is higher when consumption is smoothed across health states and across periods. In particular, the *first-best* consumption level is equal to the present discounted value of “net income”  $y_t - \mathbb{E}(m_t)$ , taking into account mortality risk. This constant optimal consumption level  $C^*$  is given by:

$$C^* = \frac{\mathbb{E} \left( \sum_{t=t_0}^T S_t \delta^{t-t_0} (y_t - \mathbb{E}(m_t)) \right)}{\mathbb{E} \left( \sum_{t=t_0}^T S_t \delta^{t-t_0} \right)} \quad (3)$$

In contrast, under a series of actuarially fair *short-term* contracts, the premium at time  $t$  and health status  $\xi_t$  will simply be  $\mathbb{E}(m_t)$  and the consumption will thus be  $c_t = y_t - \mathbb{E}(m_t | \xi_t)$ , the certainty equivalent  $CE$  becomes:

$$u(CE_{ST}) = \frac{\mathbb{E} \left( \sum_{t=t_0}^T S_t \delta^{t-t_0} u(y_t - \mathbb{E}(m_t | \xi_t)) \right)}{\mathbb{E} \left( \sum_{t=t_0}^T S_t \delta^{t-t_0} \right)} \quad (4)$$

## 4 Claims and Survey Panel Data from Germany

This section describes the claims panel dataset and the survey panel dataset used in this paper. The main working samples focus on the privately insured in the GLTHI market. We use the claims

<sup>20</sup>We assume that there are no annuity markets, so mortality risk is still considered.

panel data primarily to estimate individual health transitions and related medical expenditures over the lifecycle. In contrast, we use the survey panel data primarily to estimate individual income dynamics over the lifecycle.

#### 4.1 GLTHI Claims Panel Data

The claims panel data are administrative records for the universe of contracts and claims between 2005 and 2011 from one of the largest private health insurers in Germany. In total, our data include more than 2.6 million enrollee-year observations from 620 thousand unique policyholders along with detailed information on plan parameters such as premiums, claims, and diagnoses. Atal et al. (2019) provide more details about the dataset. The claims data also contain the *age* and *gender* of all policyholders as well as their occupational group and the age when they first signed a contract with the insurer. We converted all monetary values to 2016 U.S. dollars (USD).

**Sample Selection.** We focus on primary policyholders. In other words, we disregard children insured by their primary caregivers and those who are younger than 25 years (555,690 enrollee-year observations).<sup>21</sup> Moreover, due to the 2009 portability reform (see footnote 8), we disregard inflows after 2008 (253,325 enrollee-year observations).<sup>22</sup> Hence, the final sample consists of 1,867,465 enrollee-year observations from 362,783 individuals.

**Descriptive Statistics.** Table A1 (Appendix) presents the descriptive statistics. The mean age of the sample is 45.5 years and the oldest enrollee is 99 years old. 34 percent of the sample are high-income employees, 49 percent are self-employed and 13 percent are civil servants. The majority of policyholders (72 percent) are male, because women are underrepresented among the self-employed and high-income earners in Germany. On average, policyholders have been clients of the insurer for 13 years and have been enrolled in their current health plan for 7 years. 10 percent of all policyholders have been with the insurer for more than 28 years and one policyholder has been with the insurer for as long as 86 years, illustrating the existence of a real-world private long-term health insurance system.<sup>23</sup> The distribution of policyholders' age when joining the company is shown in Figure B2.

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<sup>21</sup>Children obtain their own individual risk-rated policies. However, if parents purchase the policy within two months of birth, no risk-rating applies. Under the age of 21, insurers do not have to budget and charge for old-age provisions.

<sup>22</sup>Below we show that the composition of enrollees has remained stable between 2006 and 2011.

<sup>23</sup>Our insurer doubled the number of clients between the 1980s and 1990s and has thus a relatively young enrollee population, compared to all GLTHI enrollees. Gotthold and Gräber (2015) report that a quarter of all GLTHI enrollees are either retirees or pensioners.

The mass of individuals signs their first GLTHI contract around the age of 30, at a time when most Germans have fully entered the labor market but are still healthy and face reasonable premiums.

Table A1 shows that the average *annual premium* is \$4,749 and slightly lower than the average premium for a single plan in the U.S. group market at the time (Kaiser Family Foundation, 2019). Note that the *annual premium* is the total premium—including employer contributions for privately insured high-income earners.<sup>24</sup> The average *deductible* is \$675 per year.

In terms of benefits covered, we simplify the rich data and focus on three plan-generosity indicators provided by the insurer. These classify plans into *TOP*, *PLUS*, and *ECO* plans. *ECO* plans lack coverage for services such as single rooms in hospitals and treatments by a leading senior M.D. For *ECO* and *PLUS* plans, a 20 percent coinsurance rate applies if enrollees see a specialist without referral from their primary care physician. About 38 percent of all policyholders have a *TOP* plan, 34 percent a *PLUS* plan, and 29 percent an *ECO* plan. Because these plan characteristics have mechanical effects on claim sizes and correlate with policyholders' age, we control for them in our estimation of health care costs in Section 5.

## 4.2 Socio-Economic Panel Study

The German Socio-Economic Panel Study (SOEP) is a representative longitudinal survey that started in 1984. It collects annual information at the household and individual level from individuals above the age of 17. Currently, the SOEP surveys more than 20,000 respondents from more than 10,000 households per year (Wagner et al., 2007). We use SOEPlong (SOEP, 2018), and all existing waves as of this writing, from 1984 to 2016, in order to fully exploit the lifecycle dimension of this panel survey.<sup>25</sup> Table A2 (Appendix) provides summary statistics for our SOEP sample. Again, all monetary values are in 2016 USD.

**Sample Selection.** We leave the representative sample as unrestricted as possible, but exclude observations with missings on core variables such as age, gender, employment status or the insurance status. Other than that, we only exclude respondents below the age of 25 as many Germans have not entered the labor market before that age.

**Income Measures.** Our main income measure, *equivalized post-tax post-transfer annual income* accounts for redistribution within households and controls for economies of scale by assigning each

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<sup>24</sup>Employers cover roughly one half of the total premium and the self-employed pay the full premium.

<sup>25</sup>Prior to 1990, the SOEP was not in the field in East Germany but started covering East Germans right after the reunification in 1990 (Wagner et al., 2007).

individual a needs-adjusted income measure. Specially, *equivalized post-tax post-transfer annual income* sums over all post-tax monetary income flows at the household level, such as income from labor, capital, public and private retirement accounts, or social insurance programs.<sup>26</sup> Then, the total annual post-tax household income is divided by the number of household members, where we use the modified OECD equivalence scale.<sup>27</sup> As Table A2 shows, from 1984 to 2016, the average annual income per household member was \$26,433. Note that this measure has positive values for *all* respondents, including those who are not active in the labor market.

For completeness, Table A2 also shows statistics for two additional income measures: *monthly gross wage* and *monthly net wage*. These measures have positive values for all working people with labor earnings (58 percent of observations in Table A2). The SOEP Group generates and provides these individual-level income measures to guarantee consistency over time. As seen in Table A2, the average *monthly gross wage* was \$2,940 and the average *monthly net wage* was \$1,921 between 1984 and 2016.

**Socio-Demographics.** Table A2 also provides the summary statistics of all other socio-demographic variables. In the SOEP sample, the average age is 47, and 52 percent are female. About 27 percent are white collar workers, 6 percent are self-employed, and 4 percent are civil servants. 42 percent work full-time and 14 percent part-time.

Below, we differentiate the lifecycle income processes by educational status. We do this because, after age 25, schooling degrees are largely time-invariant and determine lifecycle income substantially. Germany has a three-tier education system: *Ed 13* is one for individuals with the highest schooling degree after 13 years of schooling. *Ed 10* is one for individuals with an intermediate degree after 10 years of schooling. *Ed 8* is one for individuals who earned a degree after 8 or 9 years of schooling.

## 5 Modeling Health Risk and Income over the Lifecycle

### 5.1 Risk Classification

Risk classification is a key ingredient for calculating the prices of and the welfare from the short- and long-term insurance contracts. The risk classification variable represents the observed risk type

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<sup>26</sup> The SOEP group also generates and provides these single components in a time-consistent manner.

<sup>27</sup> The modified OECD equivalence scale assigns a value of 1 to the household head, 0.5 to other adults, and 0.3 to children up to 14 years of age.

of an individual at the beginning of each year. In this section we introduce a procedure that borrows insights from actuarial science, to produce an “efficient” classification. We consider our procedure to be a significant improvement over the approach used in the state-of-the art literature of dynamic contracts.

Following the literature (e.g. Einav et al., 2013; Handel et al., 2015; Ghili et al., 2019), we construct the risk classification variable using the (German version of) the John Hopkins ACG<sup>©</sup> software, which is routinely used by commercial insurers for underwriting purposes. The ACG<sup>©</sup> software provides a continuous *risk score*  $\lambda_t^*$ . The commonly-used approach to risk classification would use an ad-hoc criterion to partition the domain of  $\lambda_t^*$  into different risk classes.<sup>28</sup> We depart from the common approach in two key ways: First, we allow the risk class to be a function of current and lagged values of  $\lambda_t^*$ ;  $\Lambda_t^*(n) \equiv \{\lambda_t^*, \lambda_{t-1}^*, \dots, \lambda_{t-n-1}^*\}$ , where  $n$  is determined within our procedure. Our procedure can therefore allow for higher-order dependencies in the health dynamics in a parsimonious way. Second, we propose and implement a method to discretize the vector of scores  $\Lambda_t^*(n)$ . Our method maximizes an efficiency criterion from the actuarial science literature, that we discuss in detail later (cf. Finger, 2001).

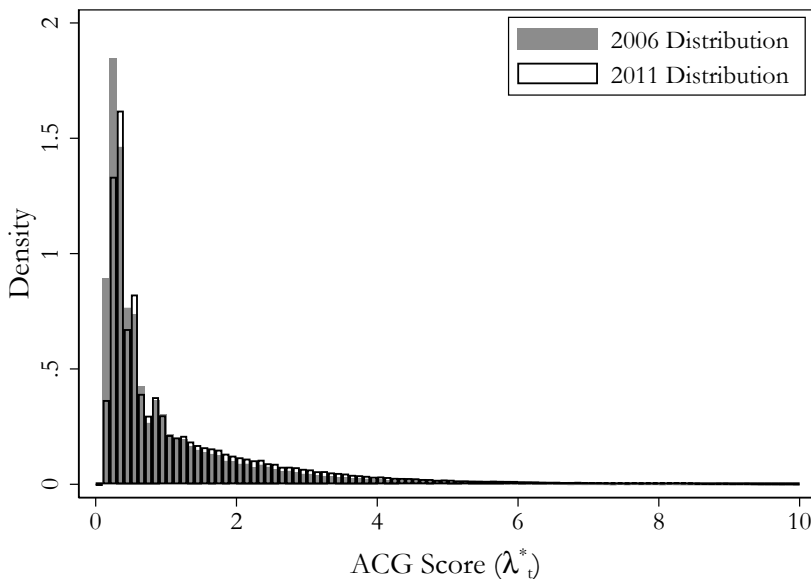
In the first step, we calculate the continuous score  $\lambda_t^*$ , which is the *unscaled total cost predicted risk* variable provided by ACG<sup>©</sup>. It is based on a) diagnosis codes (pre-existing conditions and claim diagnoses), b) costs of treatments and c) treatment episode dates.  $\lambda_t^*$  is meant to represent the *expected costs* in year  $t$ . In the reference population of publicly insured individuals in Germany, it has a mean of 1.

Figure 2 shows the empirical distributions of  $\lambda_t^*$  for our working sample in 2006 (the first year) and 2011 (the last year). Both distributions are approximately unimodal, and they appear stable over time.<sup>29</sup> Figure 2 also illustrates that the distribution of  $\lambda_t^*$  is heavily skewed and has a long right tail (consistent with stylized facts regarding the distribution of health expenditures, see French and Kelly, 2016). For example, the top percentile of the  $\lambda^*$  distribution has expected health expenditures  $\mathbb{E}(m|\lambda^* \geq \mathbb{P}_{99}) = \$63,422$ ; the second highest percentile has  $\mathbb{E}(m|\mathbb{P}_{98} \leq \lambda^* < \mathbb{P}_{99}) = \$30,027$ ; and the following three percentiles have  $\mathbb{E}(m|\mathbb{P}_{95} \leq \lambda^* < \mathbb{P}_{98}) = \$19,253$ , where  $\mathbb{P}_k$  denotes the  $k$ -th percentile of the distribution of  $\lambda^*$  plotted in Figure 2.

Next we combine the continuous score  $\lambda_t^*$  and its  $n - 1$  lags into the vector of scores  $\Lambda_t^*(n)$ , that we map into  $K$  different *risk categories*. These categories will be ultimately combined with the

<sup>28</sup>For example, Ghili et al. (2019) partition the health statuses measured by  $\lambda_t^*$  into seven mutually exclusive and exhaustive bins, where each bin contain one-seventh of the overall sample.

<sup>29</sup>This suggests that excluding inflows in 2010 and 2011 due to the portability reform, see Section 2, poses no major issue.



**Figure 2:** Distribution of  $\lambda_t^*$  in 2006 and 2011

*Source:* GLTHI claims data, ACG<sup>©</sup>, own calculation, own illustration. The distribution of  $\lambda_t^*$  is truncated at 10; but 0.7 percent of the analysis sample have  $\lambda_t^* > 10$ .

individual's age for the construction of discrete health types. Modeling risk types as a discrete state serves two specific purposes. First, we allow the contract premiums to depend on the risk type. Hence, the granularity in our model should capture the granularity of the information needed by the underwriters, both in the actual environment and in counterfactual scenarios. Second, the model should be parsimonious enough to allow for modeling health dynamics with a reasonable number of parameters.

The considerable skewness in Figure 2 implies that the amount of reclassification risk will strongly depend on the granularity allowed for in the risk classification. We split the task of constructing the risk categories into two sequential problems: (1) For a given number of classes  $K$ , and the  $n$  most recent values of  $\lambda_t^*$ , define the efficient partitioning of the scores vector  $\Lambda_t^*(n)$  into  $K$  discrete categories; (2) Find the values of  $K$  and  $n$  that lead to the best performance of the classification system. We explain the details of each step below.

**Efficient Classification.** According to the actuarial science literature (cf. Finger, 2001), an efficient risk classification system has two properties: *homogeneity*—meaning that individuals in one risk category are similar in terms of risk, and *separation*—meaning that categories are sufficiently different in



terms of expected loss to warrant their specification as being a distinct category.<sup>30</sup>

For any given number of risk categories ( $K$ ) and number of current and lagged values of  $\lambda_t^*(n)$ , we define a *risk classification* as a surjective function  $f_K : \mathfrak{R}_+^n \rightarrow \{\lambda \in \mathbb{Z} : 1 \leq \lambda \leq K\}$ , where  $\mathfrak{R}_+^n$  is the state space (i.e.  $\lambda_t^*$  and its  $n - 1$  lags). Denote this classification function  $\lambda_t = f_K(\Lambda_t^*(n))$  where  $\Lambda_t^*(n)$  is the vector of the  $n$  most recent ACG<sup>©</sup> scores available for an individual, and  $\lambda_t \in \{1, \dots, K\}$  is the risk category assigned to a person with those ACG<sup>©</sup> scores. According to Finger (2001), the *efficient* risk classification  $f_K$  maximizes the “structure variance” defined as

$$SV(f_K) = \text{Var}(m_t) - \sum_{k=1}^K \Pr(\lambda_t = k) \text{Var}(m_t | \lambda_t = k), \quad (5)$$

where  $m_t$  is individual annual health expenditure. The structure variance  $SV(f_K)$  is thus the total variance less the weighted sum of within-class variances of health expenditures. Put differently, the efficient classification maximizes the variance of mean expenditure across groups. Applying the law of total variance to both terms in Equation (5), we can write the structure variance as:<sup>31</sup>

$$SV(f_K) = \text{Var}(\mathbb{E}(m_t | \Lambda_t^*(n))) - \sum_{k=1}^K \Pr(\lambda_t = k) \text{Var}(\mathbb{E}(m_t | \Lambda_t^*(n)) | \lambda_t = k). \quad (6)$$

Note that the first term in Equation (6) is independent of the classification (as it is independent of the classes  $\lambda_t$ ); thus for a given  $K$ , finding the efficient classification system is equivalent to finding the classes  $\lambda_t$  that *minimize* the heterogeneity in expected expenditure within risk classes:  $\sum_{k=1}^K \Pr(\lambda_t = k) \text{Var}(\mathbb{E}(m_t | \Lambda_t^*(n)) | \lambda_t = k)$ .

Three things are worth noting about Equation (6). First, only the mean expenditure conditional on ACG<sup>©</sup> scores  $\mathbb{E}(m_t | \Lambda_t^*(n))$  matter for the classification system, whereas the dispersion of  $m_t$  around this mean is inconsequential. Second, minimizing heterogeneity within classes is incidentally what the k-means clustering method does (Lloyd, 1982; Athey and Imbens, 2019). Thus, we will apply k-means clustering of  $\mathbb{E}(m_t | \Lambda_t^*(n))$  to determine the efficient classification system. Third, this implies that the efficient classification also maximizes the coefficient of determination ( $R^2$ ) in a regression of expenditure on risk class indicators (Kriegel et al., 2017).

Next, we determine the number of risk classes  $K$  and the history  $n$  (number of lags) of ACG<sup>©</sup>

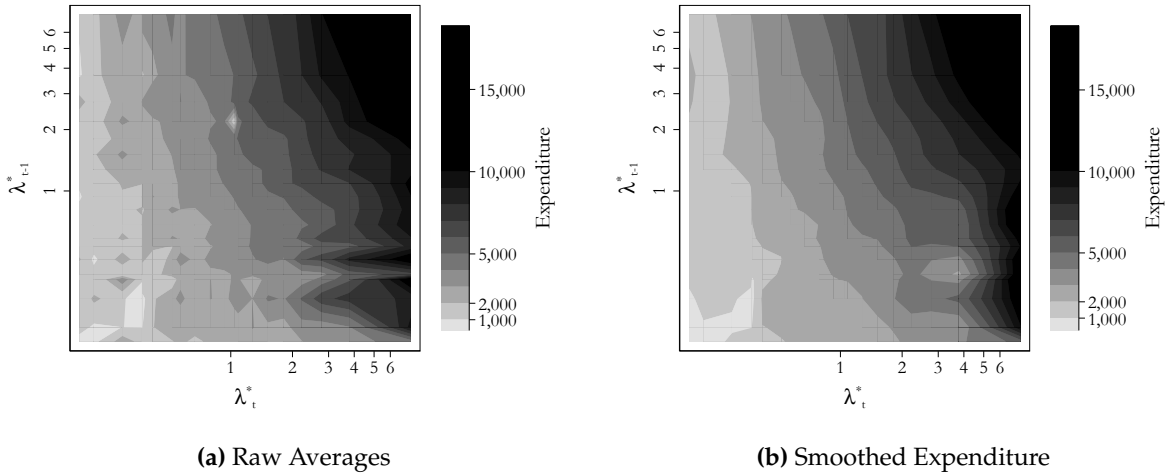
<sup>30</sup>For instance, given the distribution of  $\lambda_t^*$  in Figure 2, it is easy to see that equally-sized categories are unlikely to be optimal as they would assign similar individuals in terms of  $\lambda^*$  into different categories in the left tail of the distribution, failing the *separation* principle. In addition, it would assign individuals with substantial  $\lambda^*$  differences into identical categories in the right tail of the distribution, failing the *homogeneity* principle.

<sup>31</sup>The law of total variance implies  $\text{Var}(m_t) = \mathbb{E}(\text{Var}(m_t | \Lambda_t^*(n))) + \text{Var}(\mathbb{E}(m_t | \Lambda_t^*(n)))$  and  $\text{Var}(m_t | \lambda_t = k) = \mathbb{E}(\text{Var}(m_t | \Lambda_t^*(n)) | \lambda_t = k) + \text{Var}(\mathbb{E}(m_t | \Lambda_t^*(n)) | \lambda_t = k)$ .

scores when computing  $\mathbb{E}(m_t | \Lambda_t^*(n))$ .

**Model selection.** The last step of the risk classification system is to perform model selection, i.e., select values for the parameters  $K$  and  $n$  that determine, respectively, the number of risk classes and how many  $\text{ACG}^\odot$  scores lags should be included in  $\Lambda_t^*(n)$ .<sup>32</sup> k-means clustering is an unsupervised learning method; therefore, choosing the correct number of clusters is difficult (Athey and Imbens, 2019). We proceed assuming that the objective  $SV(\cdot)$  applies also when determining these parameters. As noted above, this means we can use  $R^2$  as our criterion for model selection.

If  $n = 1$  so that  $\Lambda_t^*(n) = \lambda_t^*$ , the clustering algorithm can be applied to  $\lambda_t^*$  since  $\mathbb{E}(m_t | \lambda_t^*) = \mu \lambda_t^*$  (where  $\mu$  is the global mean expenditure). If, however, previous  $\text{ACG}^\odot$  scores have explanatory power,  $\mathbb{E}(m_t | \Lambda_t^*(n))$  needs to be estimated. In order to get predictions that are accurate along the entire distribution, including the tails, we use cubic regression splines. Figure 3 provides a comparison of mean expenditure by  $\Lambda_t^*(n)$  before and after smoothing for  $n = 2$ .



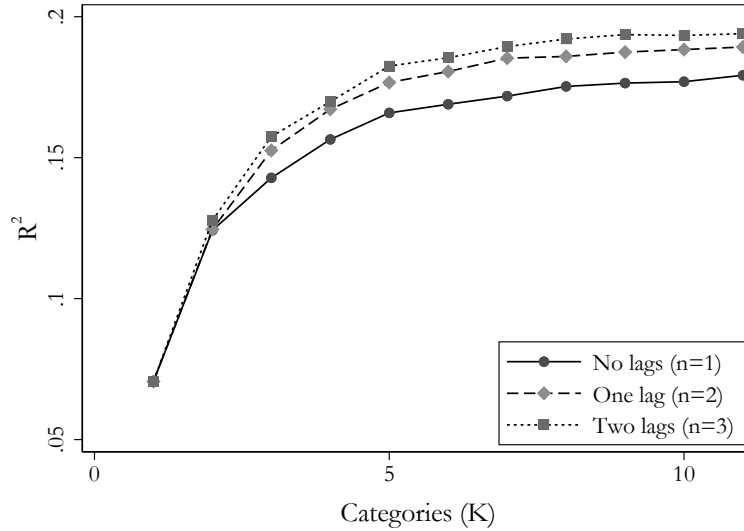
**Figure 3: Mean Expenditure by  $\Lambda_t^*$ .**

*Note:* The left figure is based on average expenditure within each of 400 cells (ventiles in  $\lambda_t^*$  and  $\lambda_{t-1}^*$ ). The right figure uses predicted values from a cubic spline regression. Source: German Claims Panel Data.

Once  $\mathbb{E}(m_t | \Lambda_t^*(n))$  has been estimated for all  $n > 1$ , we can conduct the k-means clustering in order to maximize the objective function (6). Figure 4 shows how the performance depends on parameters  $K$  and  $n$ . For all values of  $n$ , there is initially a rapid improvement in the predictive power when we increase the number of categories  $K$ ; however, this improvement levels out at quite low levels. Moreover, starting from a classification scheme that uses only the previous year's claims ( $n = 1$ ), there is distinct improvement when we add the previous year ( $n = 2$ ). However, adding a

<sup>32</sup>Including lagged  $\text{ACG}^\odot$  scores is consistent with an underwriting process often covering a relatively long medical history of the applicant (e.g., all diseases of the past 5 years and all surgeries of the past 10 years in case of our insurer).

second lag of the ACG<sup>©</sup> scores brings only marginal improvement in the predictive accuracy. Figure 4 shows that including at least one lag and 7 distinct classes attains the best performance; increasing  $K$  or  $n$  further yields negligible improvement in performance.<sup>33</sup>



**Figure 4:** Performance of Alternative Risk Classifications.

*Note:* Each specification includes 21 age times gender fixed effects, year fixed effects and 79 plan fixed effects. Source: German Claims Panel Data.

Appendix C1 presents a number of robustness checks regarding the efficient classification system. First, we analyze the extent to which results are driven by *outliers* in  $m_t$ . It is of course desirable that the classification considers outliers, given their disproportionate contributions to means and variances; however, if the performance of the classification were widely different when they are not considered, it would cast doubt on how well the scheme performs with regard to less extreme risks. Figure C1 (Appendix) plots the performance of different classification systems when using winsorized expenditures. As expected, the topcoding of outliers improves the predictive power of all schemes; however, their relative performance is unaffected by this change.

Second, we compare two different ways of including a longer history of claims. Instead of expanding the information set  $\Lambda_t^*(n)$  before discretizing, we consider an alternative based on  $\Lambda_t^*(n) = \lambda_t^*$  but where we consider the predictive power of the classification scheme interacted with its lags (i.e. a classification based on  $K^2$  classes). Figure C2 (Appendix) provides the results. It shows that our preferred classification with  $K$  classes performs only slightly worse than the corresponding interacted classification with  $K^2$  classes.

<sup>33</sup>We consistently report *unadjusted*  $R^2$ . All results are robust to using *adjusted*  $R^2$  instead.

Third, we acknowledge that increasing  $n$  also changes the sample used for estimation. In Figure C3 (Appendix) we compare the performance over different  $n$  within the same sample. It shows that our main result is robust to the sample used.

## 5.2 Estimation of Expenditure Risk

Next, we estimate the transition rates between different discrete risk categories  $\lambda_t$ , as well as the mean expenditure by risk categories. We posit that the risk type of individual  $i$  at age  $t$ ,  $\zeta_{it}$ , depends on the combination of the contemporaneous risk category  $\lambda_{it}$  and age at  $t$  (in 5-year bins). That is,  $\zeta_{it} \equiv (A_{it}, \lambda_{it})$ , where  $A_{it}$  is an indicator for one of the eleven age groups (five-year bands from age 25 to age 75 and 75+). It is important to note that the ACG<sup>®</sup> scores are based on an individual's age, so that, in principle, a risk category  $\lambda_{it}$  that uses ACG<sup>®</sup> scores as input should contain all the information needed to predict mean expenditures. However, ACG<sup>®</sup> scores are not designed to predict transitions so, in principle transition matrices, may depend on age even after conditioning on  $\lambda_{it}$ . As discussed below, our results confirm these predictions.

Considering that the clustering method generates a set of risk classes of very different sizes, a completely non-parametric estimation for the transition matrices  $g(\zeta_{it}|\zeta_{i,t-1})$  and mean expenditures  $\mathbb{E}(m_{it}|\zeta_{it})$  is not possible. Instead, we resort to a parametric, yet flexible model. To estimate the transition matrices, we estimate a multinomial logit model for health dynamics specified as:

$$\eta_{it}^j = A_{it}\beta_j + L_{it}\gamma_j + h(A_{it}, L_{it}; \theta_j) + \epsilon_{it}^j \quad (7)$$

where  $\eta_{it}^j$  represents the log odds for  $\lambda_{i,t+1} = j$ , for  $j \in \{2, \dots, 8\}$ . The category  $\lambda_{i,t+1} = 1$  is the reference category and  $\lambda_{i,t+1} = 8$  represents death.  $A_{it}$  represents  $i$ 's age groups, and  $L_{i,t}$  is a set of indicators for the categories of  $\lambda_{i,t}$ . In addition, Equation (7) includes  $h(A_{it}, L_{it}; \theta_j)$  which consists of pairwise interactions of  $A_{it}$  and  $L_{it}$  with the associated parameter vector  $\theta_j$ .<sup>34</sup>

To model the expected claims based on risk type, we follow a similar approach, but use the predicted values of claims from an OLS regression. In addition to the controls in Equation (7), we also control for a vector of dummies  $Q_{it}$  representing health plan generosity  $q \in \{ECO, PLUS, TOP\}$ . The base specification is:

$$m_{it} = A_{it}\beta + L_{it}\gamma + Q_{it}\delta + h(A_{it}, L_{it}, Q_{it}; \theta) + \epsilon_{it} \quad (8)$$

<sup>34</sup>We selected the interacted terms sequentially: in each iteration, we include the interaction term with the strongest association with transition rates (based on a  $\chi^2$  test), until none of the remaining interaction terms is statistically significant.

In an iterative process, we add pairwise interaction terms between  $A_{it}$ ,  $L_{it}$ , and  $Q_{it}$  (represented by  $h(A_{it}, L_{it}, Q_{it}; \theta)$ ) to Equation (8) until no remaining term is statistically significant.<sup>35</sup> Hence, we include age groups indicators  $A_{it}$  also in the estimation of expected expenditure. As noted above, we should expect that age per-se does not have predictive power in the model for expected expenditures if our risk classification based on ACG<sup>©</sup> scores is rich and flexible enough.

**Descriptive Statistics.** Table 1 shows the summary statistics of total claims  $m$  by age group. Following Ghili et al. (2019), we decompose the variation of  $m$  into two components: the part that is explained by  $\lambda$ , i.e., S.D. of  $\mathbb{E}(m | \lambda)$ ;<sup>36</sup> and the residual variation around the predicted value, i.e., S.D. around  $\mathbb{E}(m | \lambda)$ .

As expected, mean claims strongly increase in age: they almost double from \$1,996 in age group 25 to 30, to \$3,719 in age group 45 to 50, almost double again to \$7,151 in age group 65 to 70. For enrollees above 75 years, the average amount of claims is \$10,020 (all values are in 2016 U.S. dollars). This age gradient is, however, accounted for by our risk classification. Even though a few age-related parameters in Equation (8) turn out statistically significant, the deviations from mean expenditure within each risk class are economically insignificant. Figure A1 (Appendix) illustrates this point. We interpret it as evidence that our preferred risk classification is rich enough.

**Table 1:** Health Expenditure Claims  $m$  by Age Group

Ages	Mean	S.D.	S.D.(\mathbb{E}(m   \lambda))	S.D.(m - \mathbb{E}(m   \lambda))
All	4,109	9,451	3,494	8,806
25-	1,996	5,529	1,782	5,234
30-	2,619	6,050	1,938	5,731
35-	2,840	6,312	2,086	5,957
40-	3,119	7,153	2,411	6,734
45-	3,719	8,444	2,946	7,913
50-	4,880	9,866	3,544	9,208
55-	6,517	12,679	4,573	11,825
60-	7,635	18,608	4,299	18,104
65-	7,151	12,753	4,421	11,963
70-	8,355	13,837	5,026	12,892
75-	10,020	13,485	4,490	12,715

Source: German Claims Panel Data. Sample includes all age groups and uses the ACG<sup>©</sup> scores to construct risk categories  $\lambda$  as explained in Section 5.1.

<sup>35</sup>The estimation of conditional expenditure given  $\lambda_t$  is based on a subsample of clients with moderately-sized deductibles. The reason is that clients with large deductibles may decide not to submit their claims, which leads to a downward bias in the estimates. This is less of a concern for the risk classification  $\lambda_t^*$ , which is based on a much broader set of information on the clients and on treatment episodes. In Appendix section C2 we provide some descriptives for this subsample, which generally confirm that this assumption is reasonable.

<sup>36</sup>This statistic also corresponds closely to the maximand of the risk classification algorithm, cf. Section 5.1 above.

Table 2 shows how different age groups are distributed across risk categories  $\lambda$ , and it shows a clear age gradient in health expenditure risk. The probability of being in the lowest risk category, i.e.,  $\lambda = 1$ , declines progressively with age, whereas the share of enrollees in the five highest categories increases in age; the pattern is particularly pronounced for categories  $\lambda = 4$  and  $\lambda = 5$ . Only 1.7 percent of enrollees between 25 and 30 years are in categories  $\lambda = 4$  and  $\lambda = 5$ . This share almost quadruples to 6.2 percent in age group 45 to 50, and then more than quadruples again to 28.6 percent in age group 65 to 70. It is 61 percent for enrollees above 75 years. On the other hand, risk category  $\lambda = 7$  clearly represents catastrophic costs and covers at most 0.3 percent of the population in any age group.

**Table 2:** Health Risk Categories  $\lambda$  by Age Group

Age	1 (Healthiest)	2	3	4	5	6	7 (Sickest)
25-30	0.789	0.154	0.039	0.013	0.004	0.001	0.000
30-35	0.740	0.178	0.054	0.020	0.006	0.001	0.000
35-40	0.652	0.225	0.085	0.027	0.009	0.002	0.000
40-45	0.622	0.227	0.103	0.034	0.012	0.003	0.000
45-50	0.539	0.258	0.136	0.046	0.016	0.004	0.001
50-55	0.463	0.263	0.174	0.068	0.024	0.007	0.001
55-60	0.291	0.319	0.232	0.108	0.036	0.011	0.002
60-65	0.184	0.313	0.269	0.155	0.058	0.019	0.003
65-70	0.069	0.291	0.337	0.217	0.069	0.014	0.002
70-75	0.019	0.203	0.347	0.309	0.105	0.015	0.002
75+	0.000	0.092	0.267	0.422	0.188	0.029	0.003

Source: German Claims Panel Data. Sample includes all age groups and uses the ACG<sup>©</sup> scores to construct risk categories  $\lambda$  as explained in Section 5.1.

**Transitions between States.** Table 3 displays one-year transition rates between health risk categories for all age groups; the numbers are predicted probabilities based on Equation (7). Two facts emerge from Table 3. First, we find strong persistence in health risk. For instance, an individual with  $\lambda_t = 1$  has an 83 percent probability of  $\lambda_{t+1} = 1$ . The likelihood of staying in the same category between two consecutive years decreases over risk categories but, still, 45 percent of individuals in category 7 remain in category 7 in the next year. Second, despite the high persistence, the likelihood of a severe health shock (and thus the reclassification risk) is non-trivial even when just considering two calendar years. For example, the probability of ending up in risk category 4 in  $t + 1$  is 3.6 percent after being category 2 in year  $t$ .

The transition rates are highly dependent on age. Tables C1 and C2 (Appendix) show transition matrices for each of the 11 age groups. For example, the probability of remaining in state 1 decreases

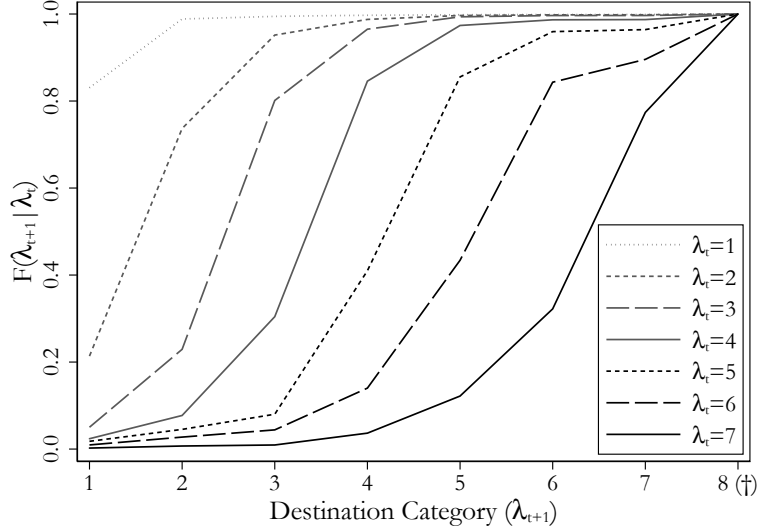
**Table 3: Health Risk Category Transitions**

$\lambda_t$	$\lambda_{t+1}$							
	1	2	3	4	5	6	7	8 (+)
1	0.831	0.158	0.006	0.003	0.001	0.001	0.000	0.001
2	0.214	0.523	0.215	0.036	0.009	0.001	0.000	0.002
3	0.050	0.179	0.572	0.164	0.029	0.003	0.000	0.003
4	0.024	0.053	0.227	0.541	0.128	0.013	0.001	0.013
5	0.018	0.027	0.035	0.330	0.445	0.104	0.005	0.036
6	0.010	0.018	0.017	0.096	0.294	0.409	0.052	0.104
7	0.002	0.005	0.002	0.027	0.085	0.200	0.452	0.226

Source: German Claims Panel Data. Sample includes all years, all age groups, and uses the ACG<sup>©</sup> scores to construct risk categories  $\lambda$  as explained in Section 5.1.

from 89 percent among 25-year-olds to 18 percent among individuals above 75. Also the probability of recovering, i.e. transitioning from a higher to a lower risk class, is declining in age. Moreover, the mortality rates increase rapidly with age – in particular for states below 7. All these differences are statistically significant. Therefore, allowing for age-dependent transition rates is necessary even though, as noted above, expected expenditure conditional on risk class is constant in age.

**Stochastic Dominance.** In their characterization of the optimal contract, Ghili et al. (2019) invoke an assumption of stochastic dominance. It requires that transition rates between risk categories—which are represented by the cumulative distribution function  $F(\lambda_{t+1} | \lambda_t)$ —satisfy first-order stochastic dominance in the following sense: if  $\lambda'_t > \lambda_t$ , then  $F(\lambda_{t+1} | \lambda'_t) \succ_{FSD} F(\lambda_{t+1} | \lambda_t)$ . In Figure 5 we show that this property holds for all pairwise combinations of  $(\lambda_t, \lambda'_t)$  such that  $\lambda'_t > \lambda_t$ .



**Figure 5:** Stochastic Dominance.

### 5.3 Lifecycle Income Paths

Next, we estimate the lifecycle income paths using 33 years of SOEP panel data. Because individuals may enroll in GLTHI contracts during their entire lifetime, we consider all sources of income beyond wages. Our main income measure is the *equivalized post-tax post-transfer annual income*, which sums over all post-tax income flows at the household level, and then normalizes by the number of household members (see Section 4.2). Using this income measure, we estimate the following individual fixed effects model:

$$\log(y_{it}) = \theta_i + f(\text{age}_{it}) + \epsilon_{it} \quad (9)$$

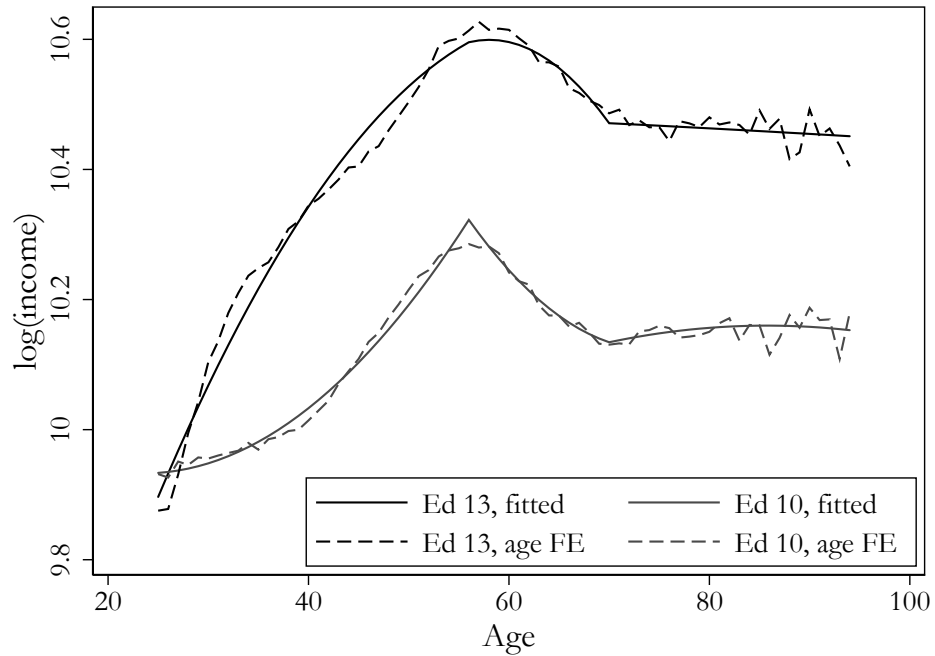
where  $y_{it}$  stands for our income measure in 2016 U.S. dollars in year  $t$  for individual  $i$ ; and  $\theta_i$  are individual fixed effects which net out all persistent individual time-invariant income determinants, such as gender, preferences, or work productivity. The flexible function  $f(\text{age}_{it})$  represents a series of age fixed effects and identifies the main coefficients of interest. They capture the main features of the German lifecycle income profiles from 1984 to 2016.

We estimate this income process separately by educational status for the two following groups: (a) individuals with the highest schooling degree after 13 years of schooling (*Ed 13*), and (b) individuals with an intermediate degree after 10 years of schooling (*Ed 10*).<sup>37</sup> We estimate separate income processes by education groups because lifecycle profiles differ substantially by educational degree

<sup>37</sup>Germany has three different schooling tracks where the majority of students complete school after 10 years and then start a three-year apprenticeship (cf. Dustmann et al., 2017).



(Becker and Chiswick, 1966). As mentioned, the steepness of these lifecycle income profiles will determine the welfare consequences of long-term health insurance to a large extent.



**Figure 6:** Lifecycle Income Paths Germany, Nonparametric and Fitted.

*Note:* Source: SOEP (2018), years 1984 to 2016. All values in 2016 USD.

The solid black lines in Figure 6 show the estimated coefficients of  $f(age_{it})$  for the two groups. Income rises sharply between age 25 and age 57. Then it decreases substantially until around age 70, from which point it remains relatively flat until death. It is also easy to observe a level difference in income paths between the two educational groups over the entire lifecycle.

Several factors can explain the lifecycle income pattern in Figure 6. First, the labor market entry and subsequent careers significantly increase post-tax income between the main working ages 25 and 55. Second, our income measure includes social insurance benefits, and the German welfare state is known for its generosity. Third, it may be surprising that equivalized household income starts to decrease after age 57 until around age 70. However, especially in the 1980s and 1990s and also today, many Germans retire early (Börsch-Supan and Jürges, 2012); others reduce their working hours, for example, to take care of their grandchildren or provide long-term care for their parents (Schmitz and Westphal, 2017). Finally, the stable permanent income stream from age 70 until death may be explained by the fact that our income measure includes primarily statutory pensions, employer-based pensions and private pensions (Geyer and Steiner, 2014; Kluth and Gasche, 2016; Engels et al.,

2017).

We accommodate these lifecycle income pattern by fitting  $f(age_{it})$  as a piece-wise squared polynomial of age, where we allow the parameters of age and age<sup>2</sup> to differ across three different age bins: [25,56], [56,70] and 70+. This is illustrated by the two gray solid lines in Figure 6. It is noteworthy that the piece-wise squared polynomials fit the empirical lifecycle profiles very well.

## 6 Main Results

### 6.1 Equilibrium Lifecycle GLTHI Premiums

After estimating the health risk process, we can calculate the equilibrium GLTHI lifecycle premiums by solving Equation (1) using backwards induction. Note that  $P_t(\xi_t)$  in Equation (1) is the guaranteed-renewable premium that an individual with health  $\xi_t$  would be offered if she entered a contract in period  $t$  in the GLTHI market. Therefore, the equilibrium GLTHI premiums correspond to 490 values: premiums depend on enrollee's current health category  $\lambda_t \in \{1, 2, \dots, 7\}$ , as well as age  $t \in \{25, \dots, 94\}$ . We use a discount factor  $\delta = 0.966$  (corresponding to a discount rate of 3.5 percent).

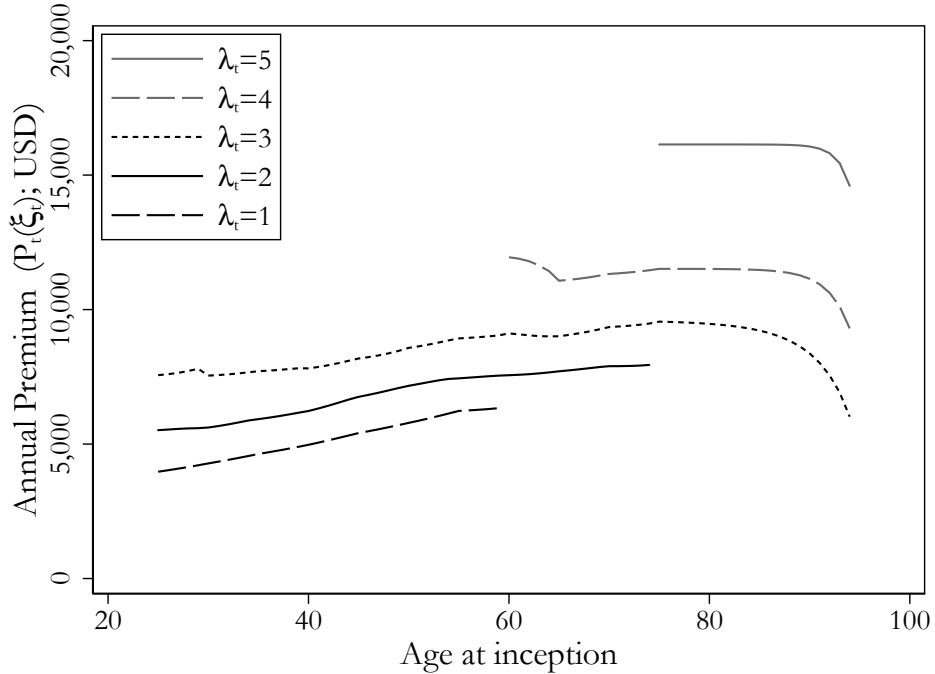
Figure 7 plots the resulting premiums for a handful of the most relevant combinations:  $\lambda_t = 1$  and  $t \in [25..59]$ ;  $\lambda_t = 2$  and  $t \in \{25, \dots, 74\}$ ;  $\lambda_t = 3$  and  $t \in \{65, \dots, 94\}$ ;  $\lambda_t = 4$  and  $t \in \{60, \dots, 74\}$ ;  $\lambda_t = 5$  and  $t \in [75..94]$ . These combinations represent the three most common states for each corresponding age interval.

Three forces are at play that determine the lifecycle profile of  $P_t(\xi_t)$  in Figure 7. First,  $P_t(\xi_t)$  is an increasing function of  $\xi_t$ . This is because, for any age, a higher health risk classification is associated with higher current and future health claims (both through their effect on current claims and their effect on health transitions).

Second, starting premiums increase with age for most age ranges. This is because expected health care claims and health transitions depend on age (through the  $A_t$  component of  $\xi_t$ ). As a consequence, the annualized net present value of health care claims of an individual with a given  $\xi_t$  increases with age for most of the age ranges.

Third, however, when individuals enter the contract later in their lives, the need to front-load premiums to fund future negative health shocks *decreases* over the lifecycle. This force explains why  $P_t(\xi_t)$  decreases with  $t$  when  $t$  is sufficiently large.

In Figure D1a and D1b (Appendix), we compare the calibrated and the observed premiums by age at inception. First, we observe positively sloped starting premiums by age over the entire age



**Figure 7:** Calibrated Starting Premiums  $P_t(\xi_t)$  in the GLTHI

*Note:* Source: German Claims Panel Data. Own calibration, own illustration.

range, both for the calibrated and the observed premiums. Second, there are clear level differences by health risk such that the starting premiums are a clear function of  $\lambda_t$ —sicker applicants have to pay higher premiums. This rank ordering persists over the entire lifecycle. Third, although the premium levels for sicker individuals are slightly larger in the calibrated than the observed case, the two Figures D1a and D1b show very similar starting premiums by age and health risk.

## 6.2 Comparison with the Optimal Dynamic Contract

The optimal dynamic contract as derived by Ghili et al. (2019) implies evolving consumption guarantees over the lifecycle. These consumption guarantees depend on lifecycle income profiles (see Equation (2) and Remark 4).

We illustrate the differences between the optimal and the GLTHI contract by comparing the contract terms at age 25. Panel (a) of Table 4 shows the GLTHI premium and front-loading amounts for a 25 year old by the health status  $\lambda_{25} \in \{1, \dots, 7\}$ . Specifically, if an individual's health status is  $\lambda_{25} = 1$ , she pays a premium of \$3,973, which is \$2,499 in excess of expected claims. Individuals with higher  $\lambda$ 's pay higher premiums, but the amount of front-loading decreases. For example, for  $\lambda_{25} = 3$  the premium is \$7,563 which includes \$1,545 in front-loading. The amount of front-loading decreases

**Table 4:** Contract Terms at Inception

$\lambda_{25}$	1	2	3	4	5	6	7
Expected claims	1,473	3,559	6,019	9,302	14,600	24,554	54,930
(a) GLTHI							
Premium	3,973	5,517	7,563	10,363	15,291	24,561	54,930
front-loading	2,499	1,957	1,545	1,062	691	7	0
(b) GHHW <i>Ed 13</i>							
Premium	1,895	4,578	6,988	10,103	15,187	24,554	54,930
front-loading	421	1,019	970	801	586	0	0
(c) GHHW <i>Ed 10</i>							
Premium	2,571	5,366	7,489	10,307	15,273	24,554	54,930
front-loading	1,097	1,807	1,471	1,006	673	0	0

Source: German Claims Panel Data, SOEP data. Table shows expected health care claims, starting premiums, and the amount of front-loading by health risk category at age 25,  $\lambda_{25} \in \{1, \dots, 7\}$ . All values in 2016 USD.

the worse the current health status is, because the likelihood of a further health deterioration also decreases the worse the current health status is. Also, note that the GLTHI premiums are *not* contingent on the lifecycle income paths (see Remark 2).

Panel (b) of Table 4 shows the premium and front-loading amounts under the optimal dynamic contract for an individual with the highest schooling degree (*Ed 13*). For almost all health states, the initial premium and front-loading is lower and thus consumption higher when compared to the GLTHI contract. However, the differences in premiums between GLTHI and GHHW converge, the worse the health risk classification. For example, for  $\lambda_{25} = 1$  the GHHW premium is \$1,895 (vs. \$3,973 for GLTHI) but for  $\lambda_{25} = 4$ , the GHHW premium is \$10,103 (vs. \$10,363 for GLTHI). The optimal contract entails less front-loading because a higher front-loading increases the marginal utility of consumption; in addition, if the current health status is very poor, there is a lesser need for front-loading because the likelihood of future health status getting worse is smaller. As such, in the optimal contract, the amount of front-loading depends not only on the implications of the current health state for future health states, but also on its implications for the marginal utility of consumption.

Panel (c) of Table 4 shows the optimal contract for an individual with a schooling degree after 10 years of schooling (*Ed 10*). This individual has a flatter income profile over her lifecycle (see Figure 6), which is why the optimal contract entails a *higher* degree of front-loading, especially for healthy individuals. In general, the premium and front-loading amounts for the education group *ED 10* with  $\lambda_{25} \in \{1, \dots, 5\}$  are in between the premiums and front-loading levels of GHHW for *Ed 13* and the GLTHI. For example, for enrollees with  $\lambda_{25} = 1$ , the optimal premium is \$2,571 for an individual with

*Ed 10*, which is in between the optimal premium of 1,895 for individuals with *Ed 13* and the GLTHI premium of 3,973. Similar to Panels (a) and (b), for *Ed 10* group enrollees, the front-loading amount is lower, the sicker the individual is at inception. This is because, the likelihood of a further health shock decreases and it is very rare that health substantially improves over the lifecycle for very sick individuals.

Finally, comparing Panels (a)-(c), we see that the premium amounts under GLTHI, GHHW (*Ed 13*) and GHHW (*Ed 10*) converge for individuals whose health status at inception is  $\lambda_{25} \in \{5, 6, 7\}$ , the three sickest states. Specifically, for  $\lambda_{25} = 5$ , all three premiums are around \$15K; for  $\lambda_{25} = 6$ , all three premiums are around \$24.5K; and for  $\lambda_{25} = 7$ , all three premiums are exactly at \$54,930.

### 6.3 Welfare Results

We now calculate welfare under the different contracts as defined in Section 3.3. We calculate welfare by simulating the economy for a lifecycle of 70 years, from age 25 to age 94 for  $N = 500,000$  individuals. Note that, up to now, we did not need to specify the utility function because, as we pointed out in Remarks 1 and 3, neither the GLTHI premiums nor the premiums under the GHHW optimal contracts hinge on the specific utility function. However, for welfare comparisons, we need to assume some utility function. For the baseline results, we follow Ghili et al. (2019) and use a constant absolute risk aversion (CARA) utility function of the form:<sup>38</sup>

$$u(c) = -\frac{1}{\gamma}e^{-\gamma c}. \quad (10)$$

In our main results, following Ghili et al. (2019), we use a risk aversion parameter  $\gamma = 0.0004$ . In Section 7, we will explore the robustness of the welfare results with respect to  $\gamma$ , and also under non-time-separable Epstein-Zin preferences.

We provide nine sets of results, corresponding to different assumptions regarding the probability simplex that determines the initial state,  $\Delta_0 \in \Delta^7$ . Panels (a) to (g) of Table 5 show the results assuming that individuals start in each of the seven possible health states. For instance, Panel (a) assumes that everyone starts in the healthiest state, such that  $\Delta_0 = \frac{1}{100}[100, 0, 0, 0, 0, 0, 0]$ . Panel (h) assumes that  $\lambda_{25}$  is drawn from the distribution implied by the transition matrix at age 25, given  $\lambda_{24} = 1$  (see Table C1, Appendix). By doing so, we accurately replicate the distribution of  $\zeta$  among the 25-

<sup>38</sup>The CARA utility function has the convenience of allowing for negative consumption, which occurs when income is lower than the required premium payments, for example, but it also implies that the consumption equivalent may be negative under some contracts, as we will see in Table 5.

to 30-year old. Finally, Panel (i) replicates Panel (h) but does not allow individuals to start in the worst possible health state. We simulate Panel (i) because Panel (h) shows that even though only 0.01 percent of the population are in the worst health state, this group dominates welfare calculations for all contract types considered. As discussed in Section 5.3, we stratify the findings by two different education-dependent lifecycle income paths.

Column (1) calculates the welfare for the first-best as described by Equation (3); Column (2) calculates welfare under a series of short-term contracts,  $C_{ST}$  (Equation (4)); Column (3) shows the results under the GLTHI contracts,  $C_{GLTHI}$ ; Column (4) calculates the welfare under the optimal dynamic contract as described by GHHW,  $C_{GHHW}$ . Columns (5) and (6) show the welfare difference between the GLTHI and  $C_{ST}$ , and that between  $C_{GHHW}$  and  $C_{GLTHI}$ , respectively.

**Table 5: Welfare Under Various Contracts**

	$C^*$ (1)	$C_{ST}$ (2)	$C_{GLTHI}$ (3)	$C_{GHHW}$ (4)	$\frac{C_{GLTHI}-C_{ST}}{C^*-C_{ST}}$ (5)	$\frac{C_{GHHW}-C_{GLTHI}}{C_{GHHW}}$ (6)
Panel (a): $\Delta_0 = \frac{1}{100}[100, 0, 0, 0, 0, 0, 0]$						
Ed 10	23,082	-10,153	21,484	22,587	0.952	0.049
Ed 13	34,857	-1,954	26,125	28,115	0.763	0.071
Panel (b): $\Delta_0 = \frac{1}{100}[0, 100, 0, 0, 0, 0, 0]$						
Ed 10	22,712	-10,777	20,915	21,563	0.946	0.030
Ed 13	34,485	-3,704	25,193	25,970	0.757	0.030
Panel (c): $\Delta_0 = \frac{1}{100}[0, 0, 100, 0, 0, 0, 0]$						
Ed 10	22,417	-10,683	20,039	20,435	0.928	0.019
Ed 13	34,187	-1,957	23,644	24,032	0.708	0.016
Panel (d): $\Delta_0 = \frac{1}{100}[0, 0, 0, 100, 0, 0, 0]$						
Ed 10	22,128	-10,795	18,548	18,752	0.891	0.011
Ed 13	33,898	-2,007	21,356	21,530	0.651	0.008
Panel (e): $\Delta_0 = \frac{1}{100}[0, 0, 0, 0, 100, 0, 0]$						
Ed 10	21,765	-10,871	15,083	15,132	0.795	0.003
Ed 13	33,534	-1.993	17,039	17,092	0.536	0.003
Panel (f): $\Delta_0 = \frac{1}{100}[0, 0, 0, 0, 0, 100, 0]$						
Ed 10	21,055	-11,209	6,414	6,416	0.546	0.000
Ed 13	32,820	-2,401	8,021	8,027	0.296	0.001
Panel (g): $\Delta_0 = \frac{1}{100}[0, 0, 0, 0, 0, 0, 100]$						
Ed 10	13,261	-26,690	-26,673	-26,673	0.000	0.000
Ed 13	24,631	-24,214	-24,212	-24,212	0.000	0.000
Panel (h): $\Delta_0 = \frac{1}{100}[89.10, 10.25, 0.47, 0.11, 0.04, 0.03, 0.01]$						
Ed 10	22,980	-10,179	-912	-912	22.117	0.000
Ed 13	34,150	-2,759	1,344	1,344	27.865	0.000
Panel (i): $\Delta_0 = \frac{1}{100}[89.11, 10.25, 0.47, 0.11, 0.04, 0.03, 0]$						
Ed 10	22,980	-10,119	21,168	21,945	0.945	0.035
Ed 13	34,159	-2,223	25,088	26,093	0.751	0.039

Source: German Claims Panel Data, SOEP data. Table shows welfare measured by the consumption certainty equivalents in 2016 USD dollars, per capita, per year, separately for two income profiles (see Figure 6). Panels (a) to (g) differentiate by initial health status  $\lambda_{25} \in \{1, \dots, 7\}$ . In Panel (h), we use the actual population distribution across health states in our data and in Panel (i), we do not allow 25 year olds to be in the worst health risk category. Columns (1) to (4) show welfare according to the (1) first-best, (2) a series of short-term contracts, (3) the GLTHI, and (4) the GHHW. Column (5) shows how much of the welfare gap between (2) and (1) is closed by GLTHI. Column (6) shows the percentage of welfare loss under GLTHI relative to GHHW.

Overall, Table 5 shows the following: First, not surprisingly, Column (1) shows that welfare in the first-best scenario is always lower for the lower education (*Ed 10*) and decreases with health at inception. For example, for individuals with the highest schooling degree who are in the healthiest

risk category at age 25, the consumption certainty equivalent is \$34,857 per year. This decreases to \$24,631 for those 25 year olds who are in the sickest risk category.

Second, Column (2) shows that a series of short-term contracts  $C_{ST}$  produces large welfare losses compared to the first-best. For all initial health states at age 25 and for both lifecycle income profiles, the consumption certainty equivalents are always negative.<sup>39</sup>

Third, the GLTHI produces substantial welfare gains compared to short-term contracts. Consider the case when  $\lambda_{25} = 1$  with probability 1, which is described in Panel (a) for  $\Delta_0 = \frac{1}{100}[100, 0, 0, 0, 0, 0, 0]$ . Column (3) shows that, under the GLTHI, the consumption certainty equivalent is \$21,484 for *Ed 10* and \$26,125 for *Ed 13*, respectively. Column (5) shows that the GLTHI closes 95 and 76 percent of the welfare gap between a series of short-term contracts and the first best for *Ed 10* and *Ed 13* individuals, respectively. Column (4) presents the welfare under the theoretically optimal GHHW contract, which shows that indeed the GHHW contracts achieve higher welfare than that from GLTHI for both *Ed 10* and *Ed 13* education groups, with their consumption equivalents equal to \$22,587 and \$28,115, respectively. However, Column (6) shows that the welfare gains from the GHHW contracts relative to those achieved under the GLTHI contracts are quite small, at only 4.9 and 7.1 percent, respectively, for *Ed 10* and *Ed 13* education groups.

Fourth, when evaluating welfare under different distributions over the initial health states, the findings discussed above turn out to be systematic. The welfare differences between the GLTHI and the GHHW contracts for initial health states  $\lambda_{25} \in \{2, 3, 4\}$  are reported in Panels (b)-(d), respectively. Column (6) in these panels show that the welfare differences are only between 0.8 to 3 percent, for lifecycle income profiles of both *Ed 10* and *Ed 13* education groups. For very bad initial health states,  $\lambda_{25} \in \{5, 6, 7\}$ , the results are reported in Panels (e)-(g). Column (6) for these panels reveal that the welfare between the GHHW and the GLTHI contracts is almost identical for both *Ed 10* and *Ed 13* education groups. However, it should be noted that starting in the sickest state  $\lambda_{25} = 7$  produces negative welfare even under GHHW (see also Ghili et al., 2019) and also under GLTHI. In Panels (h) and (i) where the initial health distributions corresponds to the observed empirical distribution for age-25 enrollees in our sample, we find that the welfare loss under the GLTHI contracts relative to the optimal GHHW contracts is at most 3.9 percent.

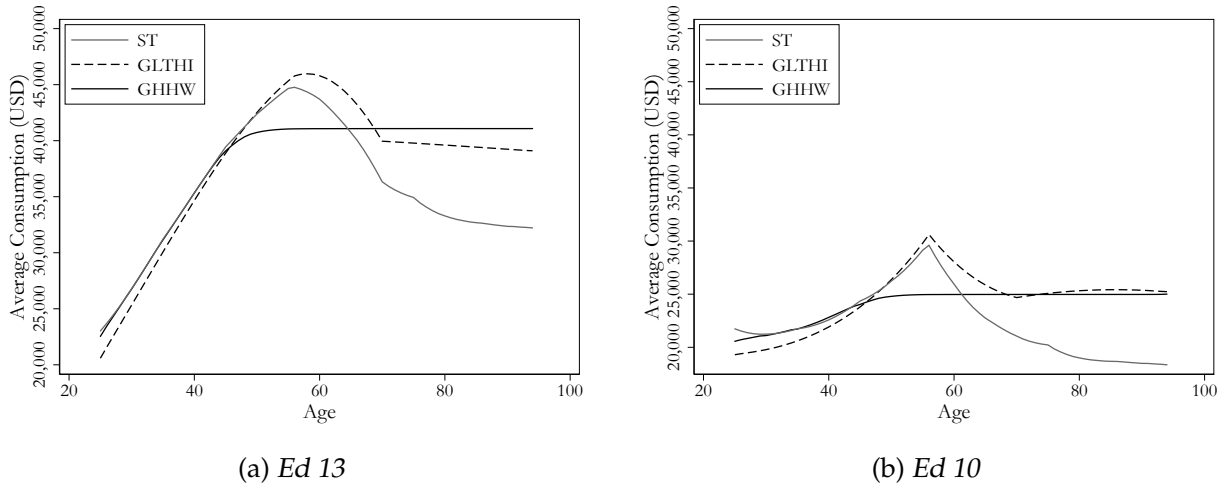
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<sup>39</sup>Recall that the CARA utility function as specified by Equation (10) allows for negative consumption.



## 6.4 Understanding the Welfare Comparisons

In order to understand the welfare results discussed in the previous section, we now delve deeper into how the short-term contracts, the GLTHI contracts, and the GHHW contracts affect both individuals' *intertemporal consumption smoothing* and the *consumption volatility* over their lifecycle. Figure 8 plots the *average* consumption over the lifecycle for (i) a series of short-term contracts, (ii) GHHW, and (iii) GLTHI, separately for *Ed 10* (Figure 8a), and *Ed 13* (Figure 8b). The figures illustrate the driving forces behind the welfare differences in Table 5.



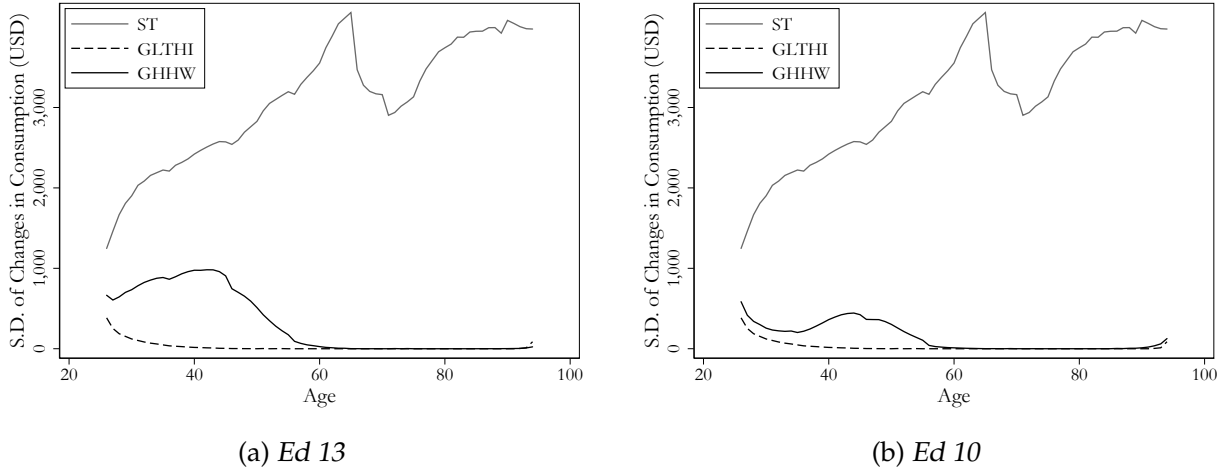
**Figure 8:** Expected Consumption over the Lifecycle by Education

Note: Source: German Claims Panel Data, SOEP data.

As shown by the thin solid lines, the average consumption under a series of short-term contracts is simply equal to the income (Figure 6) minus the expected medical spending (see Equation 4). The average consumption profile under short-term contracts is therefore hump-shaped over the lifecycle for both education groups. As shown by the dashed lines, average consumption under the GLTHI has a similar shape, but starts at a lower level and is higher at older ages. This reflects the heavy front-loading of GLTHI up to the early 50s. As shown by the thicker solid lines, average consumption under the optimal GHHW contract is designed to account for the utility effects from not only *reducing the reclassification risk*, but also from the *smoothing of consumption over the lifecycle*. Hence, the optimal contract implies a much smaller degree of front-loading than the GLTHI contract (Table 4). Thus, the average consumption under GHHW contracts starts at a higher level, particularly for the highly educated who have steeper income profiles and for whom front-loading is costlier. As individuals approach their middle ages, the optimal contract allows to fully smooth consumption, which

is illustrated by the straight flat consumption line after around age 40.<sup>40</sup>

However, relative to GLTHI, the optimal contract achieves better consumption smoothing at the expense of *more* reclassification risk. To illustrate the degree of *reclassification risk* over the lifecycle, Figure 9 displays the *standard deviations* of consumption *changes* over the lifecycle. (That is, Figure 9 plots for each  $t$  the standard deviation of  $\Delta C_{i,t} \equiv C_{i,t+1} - C_{i,t}$ .)



**Figure 9:** Simulated Standard Deviation of Consumption Changes

Note: Source: German Claims Panel Data, SOEP data.

As seen, the GLTHI contract imposes very little reclassification risk as most individuals lock  $P_{25}(\cdot)$  in the first period. The few individuals who switch are those who start with  $\lambda_{25} > 1$  and become sufficiently healthier over the lifecycle (such that  $P_t(\xi_t) > P_{25}(\xi_{25})$  for some  $t$ ) to be offered a cheaper contract. However, this is a rare event, especially after age 40. On the other hand, the optimal GHHW contract specifies consumption bumps early in the lifecycle. For instance, the consumption guarantee under GHHW increases for individuals who start at  $\lambda_{25} = 1$  and remain at  $\lambda_{26} = 1$  in the following year. The reason is that a competing insurer can take into account the “good news” regarding future health, contained in the event “ $\lambda_{25} = 1$  and  $\lambda_{26} = 1$ ,” and offer the individual a higher consumption guarantee, and still break even in expectation. Finally, the standard deviation of consumption changes increases strongly between age 25 and 60 for a series of short-term contracts, then decreases slightly up to age 70 and then increases again until death.

Figure 10 compares the average lapsation rates under each contract, where lapsing under GHHW

<sup>40</sup>Furthermore, as we will show in Figure 11 below, with a risk aversion parameter of  $\gamma = 4 * 10^{-4}$ , the welfare differences between GLTHI and GHHW contracts due to differences in the *expected* consumption profiles over the lifecycle are meaningful. Barring differences in reclassification risk across contracts, the lifecycle consumption under the GHHW contracts produces welfare gains of approximately US 2,600 per year.

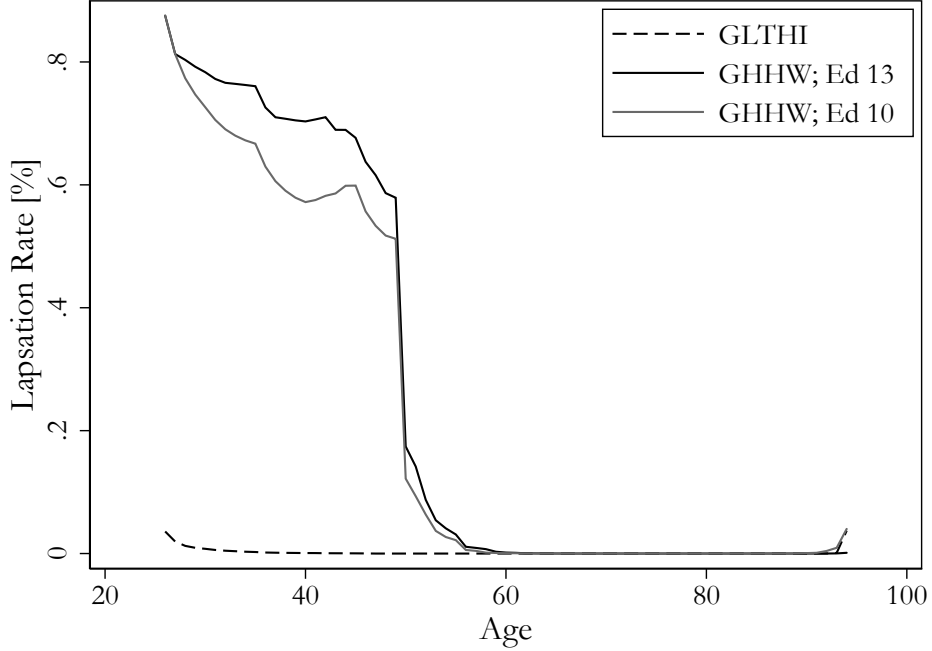
is defined as an increase in the consumption guarantees.<sup>41</sup> As expected, lapsation from GLTHI is very low over the entire lifecycle. In contrast, when expected future health improves, GHHW leads to a higher consumption for the healthiest types (and therefore for almost everyone) in the early periods. Still, lapsation under GHHW decreases substantially in the late 40s. At this point, most individuals have achieved their consumption plateau. Subsequently, consumption remains constant in order to transfer resources intertemporally and to save for old age.

Figures 8-9 illustrate the fundamental trade-offs between the GLTHI and the GHHW. The GHHW requires less front-loading by tolerating more consumption volatility (and reclassification risks); because consumers' income profiles for both *ED 10* and *ED 13* education groups tend to rise in early ages, less front-loading required by the GHHW contracts implies that GHHW contracts engender a better intertemporal consumption smoothing than the GLTHI, as illustrated by Figure 8. However, the extra front-loading of the GLTHI contracts does result in lower standard deviations of consumption changes (and much lower lapsation rates) than the GHHW contracts. Of course, by design, the GHHW contracts optimally balance the above-mentioned trade-offs; thus the GHHW contracts always, in environments that satisfy the conditions required for Ghili et al. (2019)'s theoretical characterization, achieve a higher welfare than the GLTHI contracts. The results we reported in Table 5, however, suggest that the GLTHI contracts, despite their simplicity, are able to achieve welfare similar to the optimal GHHW contracts.

The trade-offs between the GLTHI and the GHHW contracts, therefore, are intertemporal consumption smoothing vs. consumption volatility. The welfare effect of intertemporal consumption smoothing depends on the *intertemporal elasticity of substitution* (IES), and the welfare effect of consumption volatility depends on *risk aversion*. The time-separable preference hypothesized so far in our analysis, similar to that in Ghili et al. (2019), imposes that the IES and risk aversion are parametrically linked. In Section 7, we will break the parametric link between IES and risk aversion, and conduct welfare comparisons between different contracts under the Epstein and Zin (1989)'s recursive preferences.

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<sup>41</sup>As noted by Ghili et al. (2019), optimal contracts impose a "no-lapsation constraint", so that the consumer will always stay in the same contract. However, an increase in the consumption guarantee specified within a contract can be also interpreted as a lapsation from an equivalent set of guaranteed premium paths. Figure 10 uses this interpretation of lapsing.



**Figure 10:** Lapsation Rates by Type of Contract and Education

*Note:* Source: German Claims Panel Data, SOEP data.

## 6.5 Savings and the Welfare Comparisons

Our main welfare calculations assume that individuals cannot save. This assumption may substantially underestimate the welfare under short-term contracts, and under the GLTHI. As noted above, the GLTHI contracts result in a consumption profile that closely tracks the hump-shaped life-cycle income profile. Moreover, under short-term contracts, individuals experience large premium shocks that could be smoothed with precautionary savings. Hence, this section allows for precautionary savings. We do so by solving a dynamic programming problem of optimal savings with mortality risk as in Yaari (1965). Individuals solve the following maximization problem:

$$\begin{aligned}
 \max_{c_t} \quad & \mathbb{E} \left( \sum_{t=t_0}^T S_t \delta^t u(c_t) \right) \\
 \text{s.t.} \quad & a_{t_0} = 0 \\
 & a_t \geq 0 \quad \forall t \\
 & a_{t+1} = (1+r)a_t + y_t - c_t - P(\Xi_t)
 \end{aligned}$$

where  $P(\Xi_t)$  is the premium in period  $t$  as a function of an individual's medical history  $\Xi_t \equiv (\xi_1, \xi_2, \dots, \xi_t)$ , and  $a_t$  is the level of assets.

Different contracts result in different mappings between an individual's medical history up to period  $t$  and an individual's premium in  $t$ . Under a series of short-term contracts, only an individual's current health status matters since  $P(\Xi_t) = \mathbb{E}(m_t|\Xi_t) = \mathbb{E}(m_t|\xi_t)$ . In contrast, for a GLTHI contract, the entire medical history matters. Due to guaranteed-renewability,  $P(\Xi_t)$  is defined recursively: In the first period,  $\Xi_1 = \xi_1$  and  $P(\Xi_1) = P_1(\xi_1)$ , where Equation (1) defines  $P_t(\xi_t)$ . In any period  $t > 1$ ,  $P(\Xi_t) = \min\{P(\Xi_{t-1}), P_t(\xi_t)\}$ .<sup>42</sup> (Note that, in this optimal consumption problem with savings, there is uncertainty regarding net income  $y_t - P(\Xi_t)$  and mortality risk.<sup>43</sup>)

For a given lifecycle income profile, the dynamic program provides an optimal consumption policy  $C_t^*(\xi_t, a_t)$  where  $a_t$  is the level of assets carried into period  $t$ . The certainty equivalent (CE) of the dynamic problem is equal to:

$$u(C_{SAV}) = \frac{\mathbb{E}\left(\sum_{t=t_0}^T S_t \delta^{t-t_0} u(C_t^*(\xi_t, a_t))\right)}{\mathbb{E}\left(\sum_{t=t_0}^T S_t \delta^{t-t_0}\right)} \quad (11)$$

**Table 6:** Welfare by Type of Contract with Savings

	$C_{GHHW}$	$CE_{GLTHI,SAV}$	$CE_{ST,SAV}$
Ed 10	21,945	21,177	741
Ed 13	26,093	25,088	4,879

Source: German Claims Panel Data, SOEP data. The distribution of initial health states at age 25 used in this table corresponds to that in Panel (i) of Table 5. All consumption certainty equivalents (welfare) are in 2016 USD per capita, per year.

Table 6 shows the welfare results when allowing for savings, assuming  $r = 1/\delta - 1$ . Allowing for precautionary savings substantially improves welfare under the series of short-term contracts. Consider the distribution of initial health state  $\Delta_0 = \frac{1}{100}[89.11, 10.25, 0.47, 0.11, 0.04, 0.03, 0]$  as considered in Panel (i) of Table 5. The consumption certainty equivalent increases from  $CE_{ST} = -10,119$  to  $CE_{ST,SAV} = \$741$  for *Ed 10* individuals, and from  $CE_{ST} = \$ - 2,223$  to  $CE_{ST,SAV} = \$4,879$  for *Ed 13* individuals. On the other hand, savings do not significantly improve welfare under the GLTHI. Intuitively, the GLTHI contract already achieves substantial savings through highly front-loaded premiums. Moreover, as shown in Ghili et al. (2019), under GHHW, individuals have no incentives to

<sup>42</sup>The state variable in the dynamic program under GLTHI is the guaranteed-renewable premium; its law of motion is given by the probability of qualifying for a lower premium.

<sup>43</sup>Mortality risk implies that individuals may die with positive assets. Therefore, the expected net present value of consumption with optimal savings will be lower than the net present value of resources. Our calculations implicitly assume that individuals do not derive value from bequests.

engage in additional savings. Thus, introducing savings does not affect welfare under the optimal contract.

## 6.6 Implications for Reforms to the U.S. Health Insurance System

So far, we have contrasted welfare under the GLTHI, the optimal dynamic contracts of Ghili et al. (2019), and under a series of short term contracts. In each case, we assumed that policyholders would keep each contract for their entire lives. This assumption is realistic for the GLTHI, because Germany has no special insurance program for retirees.

We argue, however, our findings also have implications for U.S. health system reforms. The U.S. has a mixture of public and private health insurance. Among the working age population younger than 65, about 60 percent have employer-sponsored health insurance (ESHI) and about 40 percent have either short-term private health insurance or are uninsured (Claxton et al., 2017); Medicare covers people above 65 (and the disabled), financed by payroll taxes. This is of course drastically different from the German health insurance system, as we described in Section 2. The ESHI in the U.S. are community rated, and essentially long-term provided that the employer and employee do not separate; thus it resembles the GLTHI. The individual private health insurance market also closely resembled the individually risk-rated short-term contract, as we described in Section 3.3, prior to the Affordable Care Act (ACA) reform of 2010.<sup>44</sup> Thus, as a first order approximation, the pre-ACA U.S. health insurance system can be thought of as a mixture of 60 percent GLTHI and 40 percent of short-term health insurance for workers up to age 65; followed by a Medicare for those 65 or older.

The questions we would like to ask in this section are: if we were to reform the current U.S. health insurance system, as approximated above, by mandating that all private health insurance for the working age population has to be long-term contracts, either implemented as the GLTHI contracts or as the GHHW contracts, followed by the Medicare for those 65 and older, how much can we improve the welfare? How would such a *hybrid system*, with long-term private insurance (the GLTHI or the GHHW) for the working age and public Medicare system for the elderly, compare with a system where individuals purchase the long-term insurance contracts that also provide coverage after 65 till they die (i.e., our baseline scenario with lifetime coverage)?

**Implementing the Pre-ACA U.S. Health Care System.** To implement the pre-ACA U.S. health care system in the German context, we consider a social insurance program where, at age 65, individuals

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<sup>44</sup>However, the individual private insurance after the ACA is community rated – though ACA still allows insurers to charge older people and smokers more – thus differs from the short-term contracts described in our paper.

qualify for free health insurance that is financed by a proportional tax on income. Although this is a simplified version of the U.S. Medicare program, its structure captures the main effect of Medicare in the context of long-term contracts. The Medicare tax acts as an additional, front-loaded premium during working ages to fund free health insurance for all people above 65, regardless of their health status.

For each education group  $Ed \in Ed\ 10, Ed\ 13$  separately, we assume that the proportional Medicare payroll tax  $\tau_e^*$  collected from individuals in the education group covers all expenses of members in their education group during the Medicare period (age 65 and above), such that

$$\tau_{Ed}^* \mathbb{E} \left( \sum_{t=25}^{64} S_t \delta^{t-24} y_t | Ed \right) = \mathbb{E} \left( \sum_{t=65}^{94} S_t \delta^{t-24} m_t \right) \quad (12)$$

where  $S_t$  is an indicator of survival until period  $t$ ,  $y_t$  is income,  $m_t$  medical spending, and  $\delta$  is the discount rate. In conducting this exercise separately for  $Ed\ 10$  and  $Ed\ 13$ , we do not allow for cross-subsidization and redistribution between high and low-income earners. By doing so, we can compare the hybrid system to our baseline scenario for the same net present value of resources. Consequently, all welfare consequences are due to intertemporal substitution and reclassification risk, and not due to transfers across individuals of different income levels.

To evaluate the welfare under the hybrid system, we separately compute a new set of GLTHI premiums, and the consumption guarantees under GHHW, *assuming that the terminal period is  $T = 64$* .<sup>45</sup>

The consumption certainty equivalent is the constant consumption level that provides the same lifetime utility as those achieved under the hybrid system. Panel (a) of Table 7 shows the welfare results under the hybrid system, separately for  $Ed\ 10$  and  $Ed\ 13$  lifecycle income profiles. Panel (b) of Table 7 replicates the baseline results without Medicare (and thus the corresponding contracts apply over the entire lifecycle). For illustration purpose, the distribution of initial health states used in the calculations is the same as that of Panel (i) in Table 5, namely,  $\Delta_0 = \frac{1}{100} [89.11, 10.25, 0.47, 0.11, 0.04, 0.03, 0]$ .

Top row of Panel (a) shows that the Medicare tax up to 64 that are necessary to finance the Medicare system for those aged 65 or above. As we explained, we calculate two separate tax rates according to Equation 12 for education groups  $Ed\ 10$  and  $Ed\ 13$  separately. The payroll tax rates are

<sup>45</sup>For GLTHI, the Medicare payroll tax rates  $\tau_{Ed}^*$  do not impact the calculation of the equilibrium premiums when  $T = 64$  (see Equation 1). The GHHW premiums, however, depend on the income paths (see Equation 2); we assume that incomes of individuals in education group  $Ed\ 10$  and  $Ed\ 13$  are taxed at the respective rate  $\tau_{Ed}^*$  calculated by Equation 12.

**Table 7:** The Welfare Impact of a Hybrid System of Private Contracts plus a “Medicare-Like” Public Insurance Program

	<i>Ed 10</i>	<i>Ed 13</i>
Panel (a): Medicare Tax up to 64 + Medicare from 65		
Payroll Tax Rate (%)	4.36	3.12
$CE_{GLTHI}$	20,371	24,350
$CE_{GHHW}$	20,765	24,973
$CE_{ST}$	-11,080	-3,417
Panel (b): Baseline: Panel (i) in Table 5		
$CE_{GLTHI}$	21,168	25,088
$CE_{GHHW}$	21,945	26,093
$CE_{ST}$	-10,119	-2,223
Panel (c): Social Insurance Program		
$CE_{w/o \text{ cross-subsidies}}$	22,608	28,536
$CE_{w/ \text{ cross-subsidies}}$	23,168	27,838

Source: German Claims Panel Data, SOEP data. The distribution of initial health states used in the calculations is the same as that of Panel (i) in Table 5, namely,  $\Delta_0 = \frac{1}{100} [89.11, 10.25, 0.47, 0.11, 0.04, 0.03, 0]$ . All consumption certainty equivalents (welfare) are in 2016 USD per capita, per year.

4.36% and 3.12% respectively for *Ed 10* and *Ed 13*. The next three rows show the consumption certainty equivalents under three arrangements of the private health insurance for individuals younger than 65:  $CE_{GLTHI}$  is the certainty equivalent when individuals are assumed to purchase the GLTHI contracts from age 25 till 64;  $CE_{GHHW}$  is the certainty equivalent when individuals are assumed to purchase the GHHW contracts from age 25 till 64; and finally,  $CE_{ST}$  is the certainty equivalent when individuals purchase short term contracts from age 25 till 64.

As we argued, the current U.S. system could be considered a 60/40 combination of  $CE_{GLTHI}$  and  $CE_{ST}$ , with welfare as reported in the top panel of Table 7. Hence, transforming the current private U.S. system by converting the 40 percent with  $CE_{ST}$  to  $CE_{GLTHI}$  would substantially improve the welfare of the whole population. Converting all individuals’ current private insurance to the GHHW contracts would be even better, though consistent with our previous findings, the difference in the welfare gains from converting to GLTHI and to GHHW contracts is relatively small.

It is also instructive to consider whether having a hybrid system, as implemented above, with a system where individuals purchase the long-term insurance contracts that also provide coverage after 65 till they die (i.e., our baseline scenario with lifetime coverage). Interestingly, theoretically it is *ambiguous* whether the hybrid system or the private system achieves higher welfare. The reason is that Medicare is a mandatory public system, and as such it does not suffer from the one-sided commitment problem that the GLTHI and the GHHW contracts need to address.



The baseline results are reported in Panel (b) of Table 7. Comparing Panels (a) and (b) reveals that the welfare under the hybrid system is always lower than the baseline scenario with the corresponding type of private insurance contracts. The reason is as follows. Compared to the optimal contract, the Medicare program reduces consumption at earlier ages (because of the payroll tax), with no substantial changes in the reclassification risk. As seen in Figure 9, the optimal GHHW contract involves virtually no reclassification risk after age 65. For similar reasons, the Medicare program does not improve welfare when combined with the GLTHI contract. GLTHI has already *too much* front-loading and *too little* reclassification risk relative to GHHW.

What is more surprising is that the hybrid system also achieves a lower welfare when the private health insurance is in the form of short-term contracts. Because the Medicare provision in the hybrid system substantially decreases consumption volatility at old ages, in principle, introducing a Medicare-like program could increase welfare in an economy with short-term contracts. However, the Medicare tax decreases consumption at early ages, when the marginal utility of consumption is high. As Table 7 shows, the latter effect dominates for both income groups. In both cases, introducing Medicare is also welfare decreasing in an economy with short term contracts.

Finally, Panel (c) explores the welfare under a “Social Insurance Program”. In this scenario, individuals are taxed during working ages with a linear tax and, in exchange, they receive free care during their entire lifetime. The first row of Panel (c) shows the certainty equivalent of each education group when each group is taxed separately, i.e., there is no cross-subsidization across income groups. The second row of Panel (c) shows the certainty equivalent of each education group when there is a unique tax rate applied to both groups, i.e., there is cross-subsidization from the high earners to the low earners.<sup>46</sup> We find that this program achieves higher welfare than both the long-term contracts and the hybrid programs. Although a linear tax on income does not achieve the optimal consumption smoothing over the lifecycle, this program fully eliminates reclassification risk. As we assume that taxes are fully enforceable, this program achieves welfare that is unfeasible with the participation restrictions embedded in the optimal contract.<sup>47</sup>

<sup>46</sup>Without cross-subsidization, the tax for high-income earners and low-income earners would be 12.2% and 17.1%, respectively. With cross-subsidization, assuming a share of high-income earners relative to low-income earners consistent with Table A2, the uniform tax rate would be 14.8%. For comparison, consider that the tax rate in the German statutory SHI (which we briefly describe in Section 2) is 16% when combining both the employee and employer contributions.

<sup>47</sup>This direct comparison of welfare under the social insurance program and the private contracts does not take into account any possible efficiency costs from taxation. However, a back-of-the-envelope calculation suggests that the social insurance program is still preferable even after accounting for the excess burden of taxation: Let  $R$  be the net present value of the total tax revenue collected for an individual (which, by definition, is equal to the net present value of health expenditures). An “equivalent yearly tax burden” can be calculated as the constant dollar amount  $r$  such that the net present value of paying  $r$  every year is equal to  $R$ . We find  $r = \$4,022$ . Applying a marginal excess burden per dollar of tax revenue of 0.195 from Saez et al. (2012), we find that the tax of the social insurance program imposes a yearly cost of

**Robustness of the Findings.** The results in Table 7 assume that the Medicare payroll tax during working ages fully covers all medical expenses for the population above 65. In reality, however, Medicare Part B beneficiaries do pay a (subsidized) premium.<sup>48</sup> Premium-free Medicare coverage at old-age increases the tax rate needed to fund the entire program. Therefore, the degree of front-loading increases further. Because our simplified version of Medicare imposes *too much* front-loading, it is instructive to investigate the effect of introducing a *Medicare premium with a corresponding decrease in the tax rate*.

In Appendix D1, we illustrate the trade-off between charging a higher Medicare payroll tax for future beneficiaries vs. a higher Medicare premium for current beneficiaries. In conclusion, we find that a higher premium for current beneficiaries increases welfare because it increases consumption at early ages. However, even a very high Medicare premium (such that the Medicare tax is close to zero), combined with either the optimal contract or the GLTHI contract, would *not* achieve the same level of welfare as the optimal GHHW contract.

We also test the robustness of the results in Table 7 by allowing for *savings* in the Medicare environment. In this economy, individuals are offered the GLTHI premium profile up to age 65, and free Medicare coverage starting at age 65. Such an insurance structure creates incentives to save. As in Section 6.5, we calculate welfare under an optimal level of savings and find a certainty equivalent of \$20,672 (*Ed 10*) and \$24,656 (*Ed 13*) (detailed results available upon request). This level of welfare is higher than welfare without savings (see Table 7), but still lower than welfare under either a lifetime GLTHI contract or a lifetime GHHW contract.

## 7 Robustness

In this section, we investigate the robustness of our main findings in two dimensions. First, we investigate whether our results are robust to degree of risk aversion, i.e., the parameter  $\gamma$  in the CARA utility function specified by (10); second, we investigate whether our results are robust to Epstein and Zin (1989)'s recursive preferences where risk aversion and intertemporal elasticity of substitution are separately parameterized.

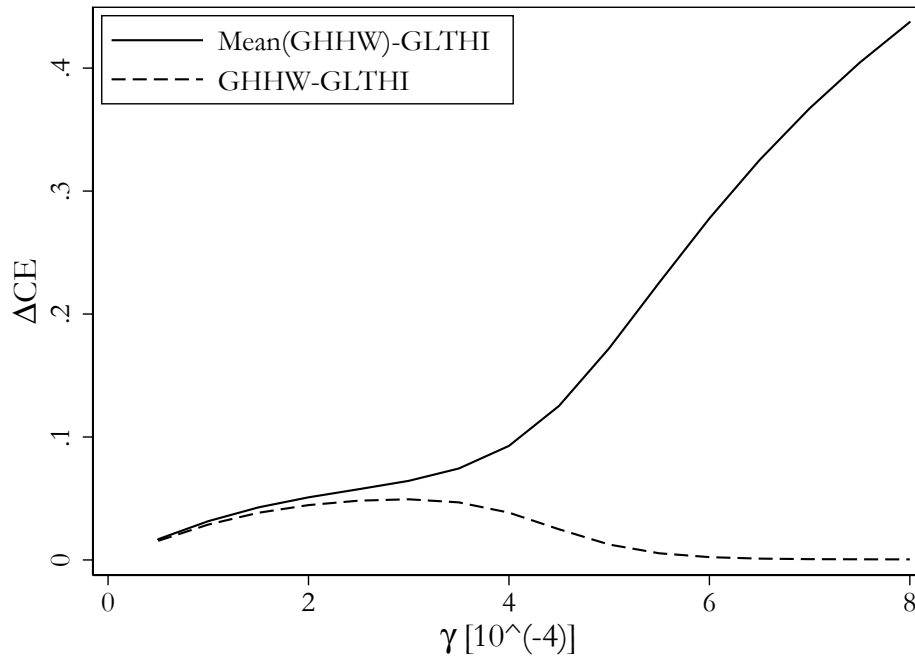
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\$784. This deadweight loss of taxation is lower than the extra welfare of the social insurance program. Note also that the GHHW contract could in principle result in efficiency losses since premiums are tied to income.

<sup>48</sup>In addition, Medicare Part A imposes substantial cost-sharing, from which we have abstracted throughout in the paper.

## 7.1 The Degree of Risk Aversion

Under our parametric assumptions on preferences, the GLTHI contracts entail a small welfare loss relative to the optimal dynamic GHHW contracts as characterized by Ghili et al. (2019). Almost entirely eliminating reclassification risk basically compensates the welfare loss from heavier front-loading in the GLTHI. Following Ghili et al. (2019), our main results assume a level of risk-aversion of  $\gamma = 4 \times 10^{-4}$ . With this level of risk aversion, an individual would be indifferent between (a) a gamble where she wins \$1,000 with a 50 percent chance and loses \$713 with a 50 percent chance and (b) no gamble, i.e., the status quo. This subsection investigates the robustness of our findings with respect to different levels of  $\gamma$ .



**Figure 11:** Difference in CE (GHLTI vs. GHHW) by Risk Aversion

*Note:* Source: German Claims Panel Data, SOEP data. The x-axis shows the level of risk aversion  $\gamma$ . The y-axis shows differences in consumption certainty equivalents (CE) between GHHW and GLTHI as a fraction of total GHHW welfare, in other words, the welfare loss of GLTHI relative to GHHW. The dashed line shows total welfare differences, and the solid line shows only welfare differences due to differences in consumption.

Figure 11 shows the results graphically, where the x-axis spans values of  $\gamma \in [5 \times 10^{-5}, 8 \times 10^{-4}]$ . For each  $\gamma$ , the y-axis shows the corresponding difference in certainty equivalents as a fraction of the welfare under GHHW. The dashed line plots total welfare differences between GLTHI and GHHW. As seen, the difference is small when  $\gamma$  is either very low or very high. That is, our main qualitative finding—the simple GLTHI contract can basically achieve similar welfare as the optimal dynamic

GHHW contract—is robust to the degree of risk aversion,  $\gamma$ .

To investigate the underlying reason for the robustness of the findings with respect to  $\gamma$ , the solid line plots the percentage point differences in welfare when we only focus on *differences in consumption* across the lifecycle. In other words, we eliminate the welfare differences that are due to differences in reclassification risk. As seen, we then find that GHHW is superior to GLTHI and that the difference is increasing in  $\gamma$ .<sup>49</sup>

In summary, varying the levels of risk aversion affect the differences between GLTHI and GHHW via two underlying channels. The first is due to differences in lifecycle consumption, which clearly favors GHHW, and even more so the larger  $\gamma$ ; the second is due to differences in reclassification risk, which clearly favors GLTHI, and even more so the larger  $\gamma$ . As we vary  $\gamma$ , these two opposing forces almost completely cancel out.

When risk aversion is close to 0, GLTHI and GHHW contracts coincide. In the extreme case of risk neutrality, the volatility of premiums and the lifecycle shape of expected consumption are irrelevant. For low levels of  $\gamma$ , the lifecycle path of expected consumption is the most relevant factor determining the welfare differences between the two contracts. However, when  $\gamma$  becomes large enough, the higher degree of reclassification risk in GHHW becomes increasingly relevant. Even though individuals with large  $\gamma$  strongly prefer the smoother consumption under GHHW, they also dislike the higher associated reclassification risk.

The dashed curve in Figure 11 shows total welfare differences between GLTHI and GHHW. The maximal welfare difference between the two contracts across all values of  $\gamma$  is 5 percent. This difference arises when  $\gamma = 3 \times 10^{-4}$  and amounts to equals about ten percent of the welfare under GHHW.<sup>50</sup>

## 7.2 Epstein-Zin Recursive Preferences

When a single parameter governs both risk aversion and the intertemporal elasticity of substitution, the welfare differences between the GLTHI and the GHHW contract are small. In this section, we investigate the robustness of this result when breaking the parametric link between risk aversion,  $\gamma$ , and the intertemporal elasticity of substitution,  $\psi$ . In particular, we evaluate both contracts under

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<sup>49</sup>In practice, the line represents the *CE* of consumption after replacing the actual consumption under GHHW with the expected consumption at each age under GHHW, thus eliminating the reclassification risk component of the optimal contract. By contrast, the reclassification risk component of GLTHI is negligible.

<sup>50</sup>Under this level of risk aversion, an individual would be indifferent between (a) a gamble where she wins \$1,000 with a 50 percent chance or loses \$768 with a 50 percent chance, and (b) no gamble.

Epstein-Zin (EZ) preferences (Epstein and Zin, 1989). Preferences are defined recursively as:

$$V_t = F(c_t, R_t(V_{t+1})),$$

with

$$R_t(V_{t+1}) = G^{-1}(\mathbb{E}_t G(V_{t+1}))$$

As in Epstein and Zin (1989), will consider the CES aggregator

$$F(c, z) = \left( (1 - \delta)c^{1-1/\psi} + \delta z^{1-1/\psi} \right)^{\frac{1}{1-1/\psi}}$$

We embed the same CARA specification used in our main analysis into the EZ preferences by assuming  $G(c) = u(c) = \frac{1}{\gamma}e^{-\gamma c}$ . In Appendix C2, we show that the consumption certainty equivalent can be expressed as:

$$c = \left( \frac{\left( \frac{G^{-1}(\mathbb{E}_0(G(V_{t_0}(\xi_{t_0}))))}{1-\delta} \right)^{1-1/\psi}}{\sum_{j=t_0}^T \delta^{t-t_0} S_{t_0}^j} \right)^{\frac{1}{1-1/\psi}}. \quad (13)$$

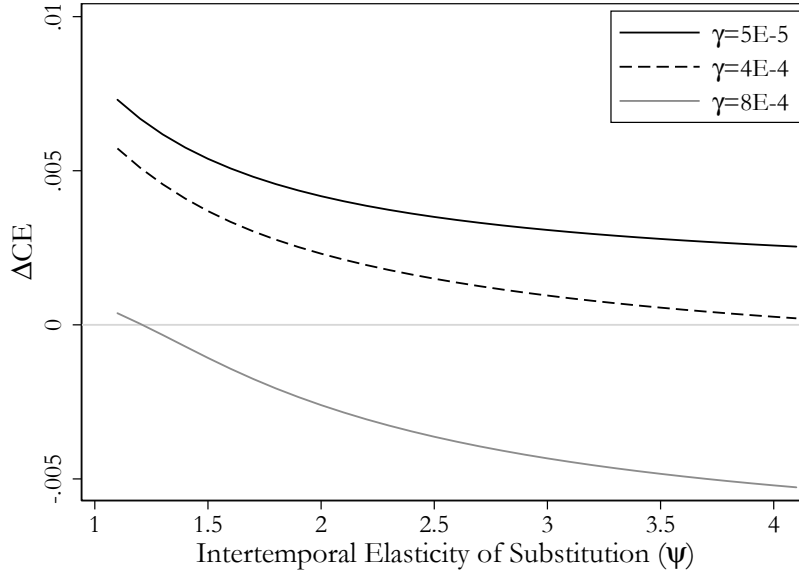
where  $\mathbb{E}_0(\cdot)$  takes expectations with respect to the “birth” state,  $\xi_{t_0}$  and  $S_t^j$  is the survival probability from  $t$  to  $j$ .

For each contract, we compute  $V_{t_0}(\xi_{t_0})$  numerically *via* backwards induction.

Varying  $\gamma$  and  $\psi$ , Figure 12 shows differences in certainty equivalents between GLTHI and GHHW as a fraction of the welfare under GHHW. As seen, the welfare differences between the two contracts are small over all the entire range of parameter values considered. Notice that in Figure 12, when the risk aversion parameter  $\gamma = 8E - 4$ , the certainty equivalent of GHHW can be lower than that of GLTHI, when the intertemporal elasticity of substitution is relatively high. This can occur because the GHHW contract is not necessary optimal contracts under recursive preferences – recall that Ghili et al. (2019)’s theoretical characterization requires that preferences are *time separable*, which Epstein and Zin (1989)’s recursive preferences do not satisfy.

### 7.3 Income Profiles

Finally, to test the robustness of our results with respect to the income profile, we also estimate the lifecycle income pattern for the United States. To this end, we use the Cross National Equivalence Files (CNEF) of the Panel Study of Income Dynamics (PSID). The PSID is the oldest and longest-



**Figure 12:** Difference in CE (GHLTI vs. GHHW) by Intertemporal Elasticity of Substitution

*Note:* Source: German Claims Panel Data, SOEP data. The x-axis shows the level of intertemporal elasticity of substitution  $\psi$ . The y-axis shows differences in certainty equivalents (CE) between GHHW and GLTHI as a fraction of total GHHW welfare.

running panel survey in the world. It has been surveying U.S. families annually since 1968 and, since 1997, biannually (Panel Study of Income Dynamics, 2018). The CNEF harmonizes survey measures across countries and over time (Frick et al., 2007). We use the cleaned and generated variables of the CNEF-PSID project, which allows us to generate the exact same income concept (in 2016 USD) and implement the same estimation process as that for Germany. That is, we exclude respondents under 25, focus on the years 1984 to 2015, and estimate Equation (9). Figure A2 (Appendix) shows an increase in the post-tax equivalized income that is very close to the one observed in Germany between ages 25 and 60. However, the decrease in lifecycle income after age 60 is much steeper in the U.S. than in Germany, for both educational groups. Our calculations show that the main findings are robust to the US income profiles: compared to the GHHW contract, we find that the GLTHI contracts are able to achieve welfare that is only 5.8 and 3.5 percent lower for Americans with high school and college degrees, respectively.<sup>51</sup>

<sup>51</sup>The detailed results are available from the authors upon request.

## 8 Conclusion

Pricing regulation in health insurance markets has to trade off reclassification risk, adverse selection, moral hazard as well as consumption smoothing over the lifecycle. Very few countries in the world have organized their health insurance based on private markets—e.g., the U.S., Chile, Switzerland and Germany. The U.S. and Switzerland have traditionally organized them in the form of short-term annual contracts and tight pricing regulation with a focus on community rating to insure against reclassification risk of all citizens. A fundamental alternative is private individual *long-term health insurance* which has the power to leverage individual, intertemporal lifecycle incentives to eliminate reclassification risk for most citizens. In this paper, we present, discuss and evaluate the basic principles of such a real-world market that has been largely overlooked as a fundamental alternative to community-rated short-term health insurance or government-run single payer markets: the German individual private long-term health insurance market (GLTHI).

First, we present the basic principles of the market and derive the theoretical lifecycle premiums and welfare effects of the market. We show that GLTHI almost fully eliminates health reclassification risk over the lifecycle. However, the low reclassification risk comes at the expense of high premium frontloading and limited intertemporal consumption smoothing.

Second, we benchmark the welfare effects of GLTHI contracts against the optimal dynamic contract as derived by Ghili et al. (2019), using a unique database of one of the largest German private insurers.

Overall, we find that GLTHI contracts generate substantial welfare gains relative to short-term contracts. More importantly, the German-style long-term contracts achieve almost the same welfare as the optimal dynamic contract as derived by Ghili et al. (2019). We show that the elimination of reclassification risk almost fully compensates the welfare loss due to more frontloading relative to the optimal contract. We also show that this finding is robust to alternative degrees of risk aversion, and welfare under the GLTHI contract converges to the welfare under the optimal contract for very low and high degrees of risk aversion. Moreover, the findings are also robust to different degrees of intertemporal elasticities of substitution and Epstein-Zin preferences, as well as using income profiles derived from U.S. surveys

On the other hand, the German contract is shown to provide large welfare gains relative to the *status-quo* system in the United States. We also address the interaction of long-term contracts with Medicare and show that combining long-term contracts during working ages with Medicare is a

superior alternative to the *status quo*, but inferior to long-term contracts for the entire lifetime.

Compared to the optimal contract, an unquantified advantage of the German long-term contract is its simple design, combined with low information requirements. Moreover, the market has been stable and providing insurance for millions of people for decades. We believe that our findings, coupled with these facts, strengthen the case of the German design as an appealing policy option.

We finish by acknowledging two important caveats of long term contracts, in general. First, our results show that neither the German design nor the optimal dynamic contract may be a desirable alternative for some population subgroups. In fact, as already pointed out by Ghili et al. (2019), long term contracts may be highly undesirable for people who are very sick in young ages. From a policy perspective, this result implies that societies implementing long-term contracts must provide an alternative—like the co-existing public insurance in the case of Germany—for those individuals.

Second, our theory abstracts from a couple of key features that may have relevant implications for welfare under long term contracts. First, our model assumes time-consistent individuals, but frontloading may render the long-term contracts to be highly undesirable from the perspective of a present-biased consumer (particularly in the case of the German contract when frontloading is high).<sup>52</sup> In addition, our model abstracts from moral hazard. In the presence of moral hazard, using long-term contracts to decrease reclassification risk could induce inefficiencies in spending, which reduces the desirability of long-term contracts. Quantifying the role of moral hazard in long-term contracts is an important avenue for future research.

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<sup>52</sup>Still, Gottlieb and Zhang (2019) show that with a sufficiently large number of periods, the inefficiencies arising from time inconsistency vanish, and time-inconsistent agents achieve the same level of welfare as time-consistent agents with the long-term contract that emerges in the equilibrium with time-inconsistent agents.



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# Online Appendix: Not Intended for Publication

## Appendix A

### A1 Descriptive Statistics

**Table A1:** Summary Statistics: German Claims Panel Data

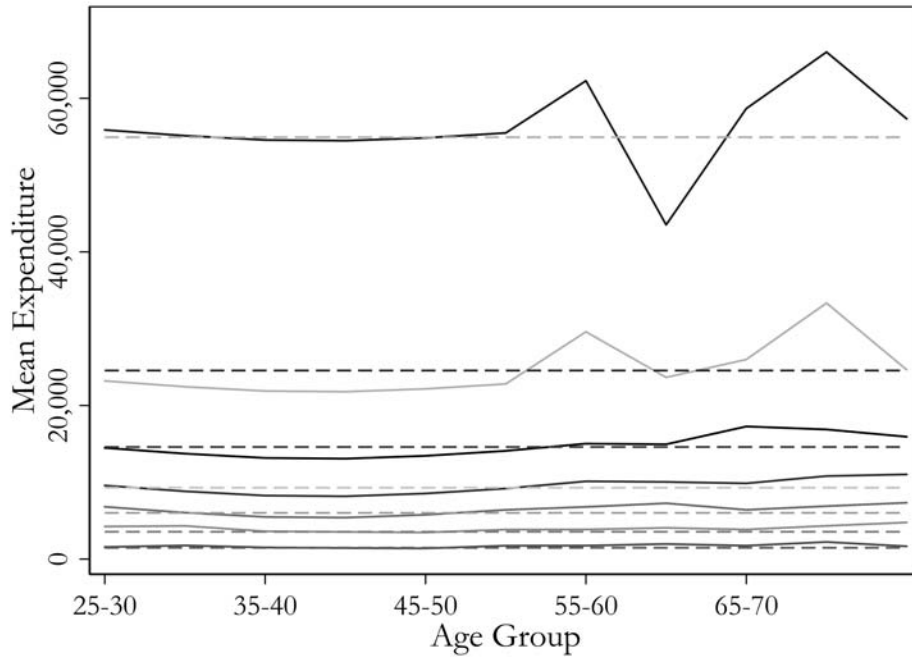
	Mean	SD	Min	Max	N
<b>Socio-Demographics</b>					
Age (in years)	45.5	11.4	25.0	99.0	1,867,465
Female	0.276	0.447	0.0	1.0	1,867,465
Policyholder since (years)	6.5	5.0	1.0	40.0	1,867,465
Client since (years)	12.8	11.0	1.0	86.0	1,867,465
Employee	0.336	0.473	0.0	1.0	1,867,465
Self-Employed	0.486	0.500	0.0	1.0	1,867,465
Civil Servant	0.132	0.338	0.0	1.0	1,867,465
Health Risk Penalty	0.358	0.480	0.0	1.0	1,867,465
Pre-Existing Condition Exempt	0.016	0.126	0.0	1.0	1,867,465
<b>Health Plan Parameters</b>					
TOP Plan	0.377	0.485	0.0	1.0	1,867,465
PLUS Plan	0.338	0.473	0.0	1.0	1,867,465
ECO Plan	0.285	0.451	0.0	1.0	1,867,465
Annual premium (USD)	4,749	2,157	0	33,037	1,867,318
Annual risk penalty (USD)	157	453	0	21,752	1,867,465
Deductible(USD)	675	659	0	3,224	1,867,465
Total Claims (USD)	3,289	8,577	0	2,345,126	1,867,465

Source: German Claims Panel Data. *Policyholder since* is the number of years since the client has enrolled in the current plan; *Client since* is the number of years since the client joined the company. *Employee* and *Self-Employed* are dummies for the policyholders' current occupation. *Health Risk Penalty* is a dummy that is one if the initial underwriting led to a health-related risk penalty on top of the factors age, gender, and type of plan; *Pre-Existing Conditions Exempt* is a dummy that is one if the initial underwriting led to exclusions of pre-existing conditions. The mutually exclusive dummies *TOP Plan*, *PLUS Plan* and *ECO Plan* capture the generosity of the plan. *Annual premium* is the annual premium, and *Annual Risk Penalty* is the amount of the health risk penalty charged. *Deductible* is the deductible and *Total Claims* the sum all claims in a calendar year. See Section 4.1 for further details.

**Table A2: Summary Statistics: German Socio-Economic Panel Study**

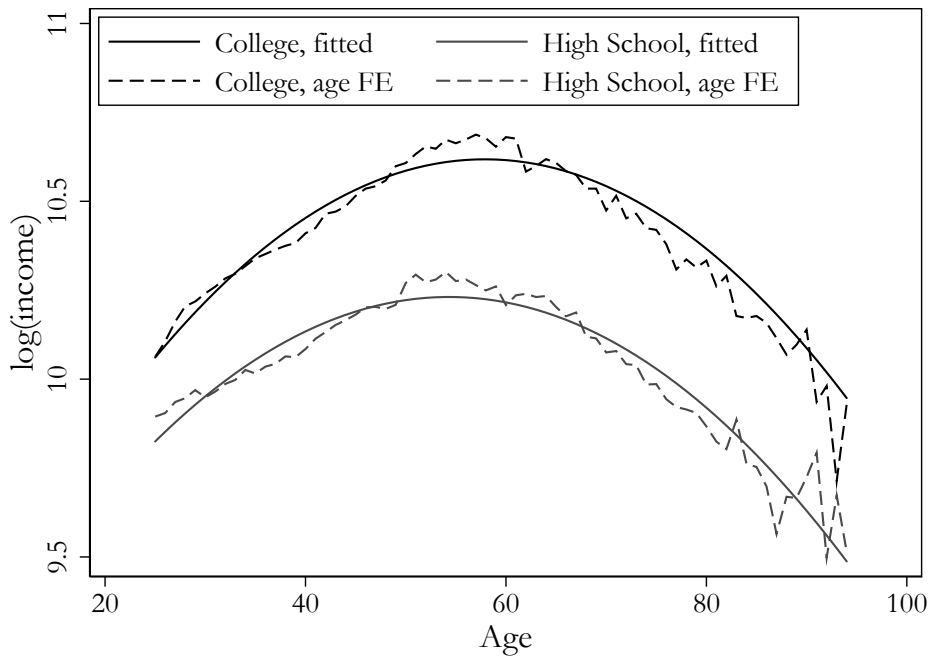
	Mean	SD	Min	Max	N
<b>Socio-Demographics</b>					
Female	0.5217	0.4995	0	1	530,228
Age	46.9119	17.4922	17	105	530,228
No degree yet	0.058	0.2338	0	1	530,228
Dropout of high school	0.0378	0.1908	0	1	530,228
Degree after 8/9 years of schooling (Ed 8)	0.3619	0.4805	0	1	530,228
Degree after 10 years of schooling (Ed 10)	0.2737	0.4459	0	1	530,228
Degree after 13 years of schooling (Ed 13)	0.1746	0.3796	0	1	530,228
<b>Employment</b>					
Civil servant	0.0393	0.1943	0	1	530,228
Self-employed	0.0624	0.2419	0	1	530,228
White collar	0.2736	0.4458	0	1	530,228
Full-time employed	0.4152	0.4928	0	1	530,228
Part-time employed	0.1402	0.3471	0	1	530,228
<b>Income Measures in 2016 USD</b>					
Monthly gross wage	2,940	2,506	0	215,093	310,460
Monthly net wage	1,921	1,527	0	134,511.5	310,460
Individual annual total income	20,361	24,434	0	2,580,000	530,228
Equivalized post-tax post-transfer annual income	26,433	18,731	0	2,155,394	530,228
<b>Insurance and Utilization</b>					
Hospital nights in past calendar year	1.6652	8.3794	0	365	530,228
Doctor visits in past 3 months	2.4941	4.1436	0	99	461,971
Privately insured	1	0	1	1	57,558

Source: SOEP (2018), the long version from 1984 to 2016. Whenever the number of person-year observations is less than 530,228 the question was not asked in all years from 1984 to 2016. For example, *Doctor visits in past 3 months* has only been routinely asked since 1995. *Privately insured* indicates that 57,558/530,228=10.8% of all observations are by people who are insured on the GLTHI market. All income measures have been consistently generated and cleaned by the SOEP team; e.g., *Monthly gross wage* is labeled *labgro* and *Monthly net wage* is labeled *labnet* in SOEP (2018). See Section 4.2 for a detailed discussion of the variables.



**Figure A1: Predicted Health Expenditure.**

*Note:* Solid curves represent mean expenditure by age for each risk category  $\lambda_t$ , estimated according to equation (8) in Section 5.2. The dashed lines represent the corresponding predictions assuming expenditure does not depend on age.



**Figure A2: Lifecycle Income Paths for the United States, Nonparametric and Fitted.**

*Note:* Source: Panel Study of Income Dynamics (2018); Frick et al. (2007), years 1984 to 2015. All values in 2016 USD.

## Appendix B

### Switching from GLTHI to SHI

As mentioned in Section 2, the decision to enter the private market is essentially a “lifetime decision.” The basic social insurance principle is: “Once private, always private[ly insured].” Below, we discuss the specific and very limited institutional exemptions for GLTHI enrollees to return to the public SHI system. We also provide empirical evidence on the switching rates.

First, for people above the age of 55, switching back to the public system is essentially impossible, even when their income decreases substantially or when they become unemployed. One of the few options for people above 55 would be to exit the labor force and enroll under the public family insurance of the spouse, if available. Rules for switching back to SHI have been very strict for older employees to avoid strategic switching to the private system when individuals are young and healthy and switching back to the public system when they are old, sick and have little income (and thus low income-dependent contribution rates).

Second, people below the age of 55 can only return to the public system if they become unemployed (and receive UI benefits), or if their gross wage from dependent employment permanently drops below the income threshold. However, assuming an average annual premium of €3,900 (as observed in our data), for an equally high SHI premium (15.5% of the gross wage), annual labor income would need to be as low as €25,000 which does not make sense from a stratical point of view for the overwhelming majority of cases. Moreover, switching to SHI entails loosing the entire old-age provisions which averaged about \$33K per policyholder in 2018 (Association of German Private Healthcare Insurers, 2019c). Moreover, switching back to GLTHI in the future would imply risk reclassification.

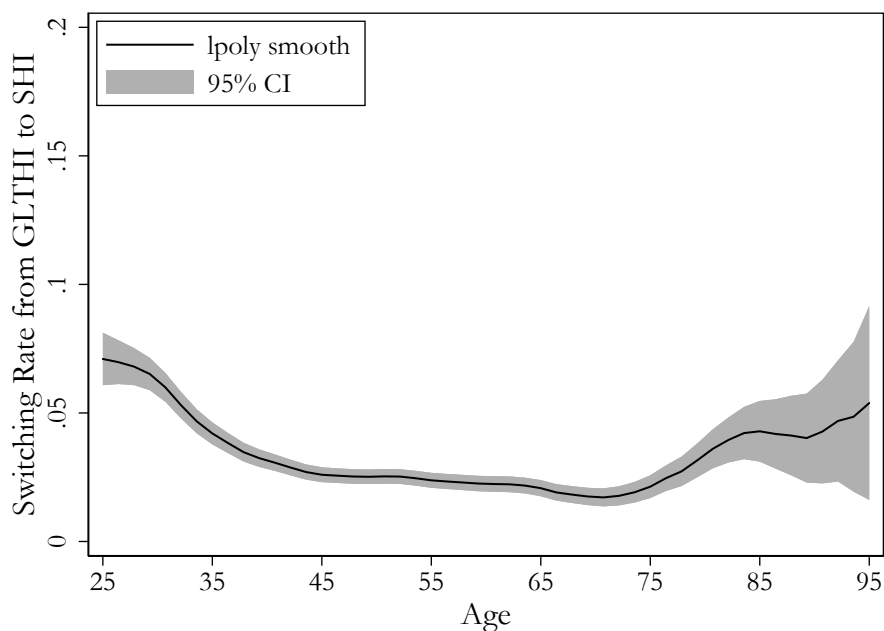
Third, the self-employed below 55 can only switch to SHI if they give up their business and become an employee with a gross salary below the income threshold (see Social Code Book V, Para. 6 for details of the law, Büser, 2012; Cecu, 2018).

Official statistics show that the absolute number of people who switched from the private to the public system has been relatively stable at around 130,000 since the beginning of the 1990s, which corresponds to around 1.5 percent of the GLTHI market per year.<sup>53</sup> Figure B1 below uses SOEP

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<sup>53</sup>As the total number of GLTHI enrollees has steadily increased over the last decades, this implies declining switching rates over time. Several reforms in the last decades are likely to be the cause of these declining switching rates over time: The *Gesundheitsreformgesetz* of December 20, 1988 substantially tightened the possibility of switching for pensioners; the *Gesundheitsstrukturgesetz*, passed on December 21, 1992, also likely affected switching between the systems as it introduced the free choice of SHI sickness funds, along with other provisions about the regulation of private insurers. Likely due to these and other reforms (e.g. the *GKV-Wettbewerbsstärkungsgesetz* of 2007), the rate as a share of all privately insured has declined in the last decades.





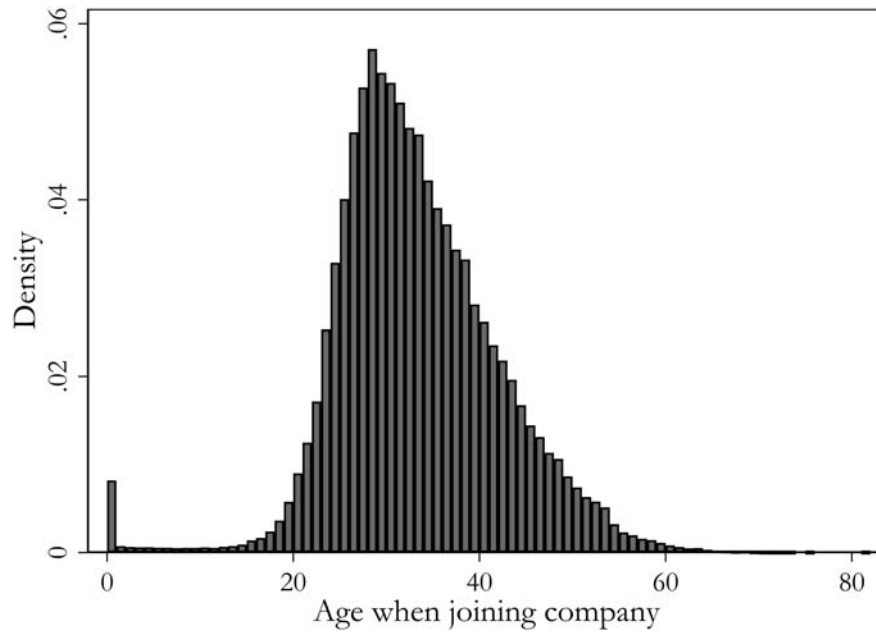
**Figure B1:** Likelihood to Return to SHI by Age

Note: Epanechnikov kernel, degree 0, bandwidth 2.6. Source: SOEP (2018), the long version from 1984 to 2016.

data to plot switching rates by age. As seen, the likelihood to return to SHI decreases substantially between the age of 25 and 35. We conjecture that this is mostly because people who were privately insured as students enter the labor market and have to enroll in SHI if their gross salaries are below the income threshold. Switching rates remain stable at a low level between age 40 and age 75, and then slightly increase again. Using a fixed effects regression for the probability of switching to SHI among the universe of Germans who were at least once policyholder of a comprehensive private plan, we find very few significant determinants of switching back from the private to the public system. In particular, health care utilization measures (number of hospital nights and doctor visits) are not significant determinants and neither is the equivalized household income. The results of this analysis are available upon request.

Finally, we would like to point out that the historically grown institutional features of the German system induce advantageous selection into the GLTHI. This is almost the case by construction as private insurers have the right to deny coverage (or impose pre-existing condition clauses) to the sick. Hence, the sick basically remain publicly insured with SHI (Nuscheler and Knaus, 2005; Hulleger and Klein, 2010; Polyakova, 2016; Panthöfer, 2016).<sup>54</sup> While the main purpose of our paper is to

<sup>54</sup> When children of privately insured parents are also privately insured by their parents, under a family plan or a separately private plan, parents have to pay premiums for each child. These are typically relatively modest as no old-age provisions are built for children. Moreover, if parents sign a private GLTHI contract for their child within two months after birth, risk rating is prohibited. In addition, some insurers offer a relatively unknown “option insurance” (*Optionstarif*) which

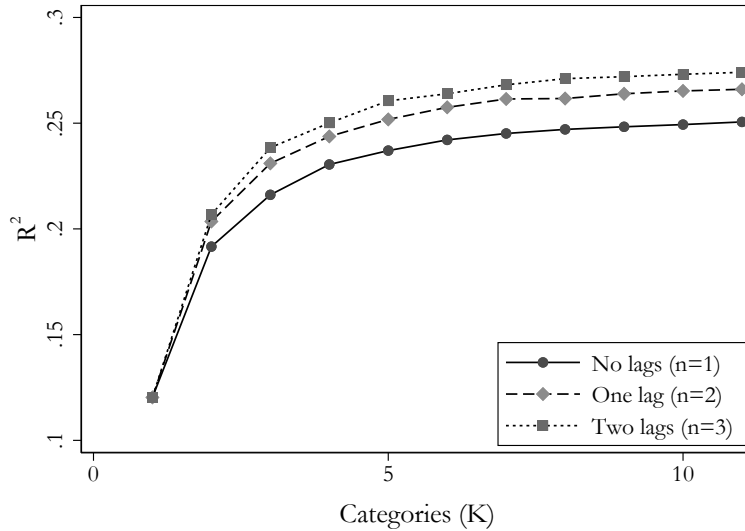


**Figure B2:** Age Distribution of Initial Plan Inception

*Note:* Source: German Claims Panel Data.

present, discuss and evaluate the basic principles of the GLTHI market, it is a real-world possibility for sick people to have a public option in Germany. Confirmed by the welfare analysis, it is clear that GLHI only maximizes welfare when people are relatively healthy at the time of their application. This insight has policy implications, which we discuss in Section 8. If other countries would design a market after the GLTHI and allow insurers to deny coverage (or impose guaranteed issue at all stages but allow risk-rated premiums), then a public option (either direct provision of insurance or premium subsidies) for those who are sick in young ages is necessary to avoid uninsurance and underinsurance. Note that the uninsurance rate in Germany is around 0.1 percent—in 2015, only 69 thousand individuals were without health insurance coverage (German Statistical Office, 2016).

is mostly sold in combination with supplemental (to SHI basic coverage) private hospital, dental, or travel insurance for which insurers carry out risk ratings. This initial risk rating then purchases the policyholder the option to purchase a GLTHI contract with that specific insurer without another risk rating within 6 to 10 years (and once one becomes eligible to opt out). No official numbers on the practical relevance of this option insurance are available. However, Google Trends yields zero hits, Google Scholar only 17 total hits, and a keyword search in the German *Handelsblatt* (similar to the *Wall Street Journal*) yields only one single hit for the *Optionstarif*, whereas it yielded 152 for the *Basistarif* which covers 0.4% of privately insured (see footnote 6). As a very last point, a more widespread and commonly known option is to put the existing GLTHI contract on hold for a monthly fee (*Anwartschaftsversicherung*), for example, when temporarily moving abroad. When returning to Germany, people with that option can simply re-activate their contract under the old conditions (§ 204 VVG).



**Figure C1:** Performance of Alternative Risk Classifications: Winsorized Expenditure.

Note: Each specification includes 21 age times gender fixed effects, 5 year fixed effects and 79 plan fixed effects. Source: German Claims Panel Data.

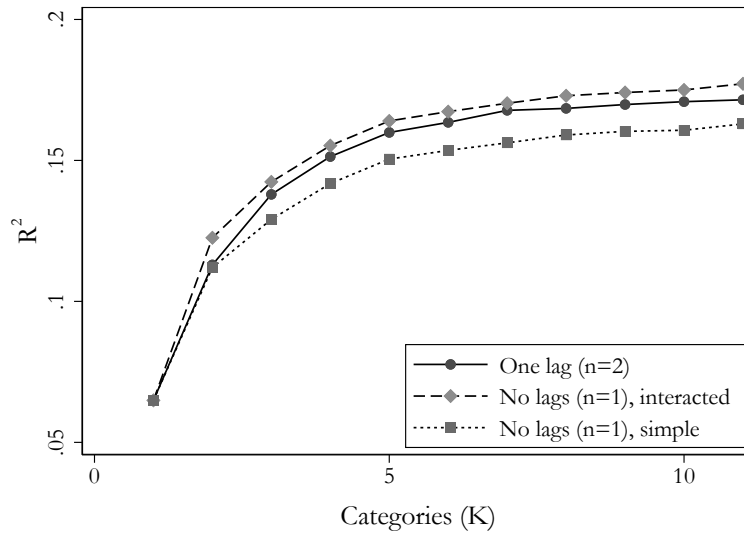
## Appendix C

### C1 Risk Classification: Robustness Checks

We expose the risk classification scheme derived in Section 5.1 to a number of robustness checks.

**Winsorizing.** First, we analyse the extent to which results are driven by outliers in  $m_{it}$ . It is of course desirable that outliers are considered in the classification, given their disproportionate contributions to means and variances; however, if the performance of the classification were widely different when they are not considered, it would cast doubt on how well the scheme performs with regard to less extreme risks. Therefore, we compared the performance of different classification schemes after the top percentile of expenditure had been winsorized. Results are provided in Figure C1. As expected, the topcoding of outliers improves the predictive power of all schemes; however, their relative performance is unaffected by this change.

**Lags of classes.** Second, we compare two different ways of including a longer history of claims. Instead of expanding on the information set  $\Lambda_t$  before discretising, we consider an alternative based on  $\Lambda_t^* = \lambda_t^*$  but where we consider the predictive power of the classification scheme interacted with its lags (i.e. a classification based on  $K^2$  classes). Results are provided in Figure C2. It compares the two alternatives  $q = 0$  and  $q = 1$  from above, and in addition an interacted version, where the classification is based on  $q = 0$  but this classification scheme is interacted with its lags in the regressions (leading effectively to  $K^2$  classes). Clearly, this alternative has similar, actually even better,

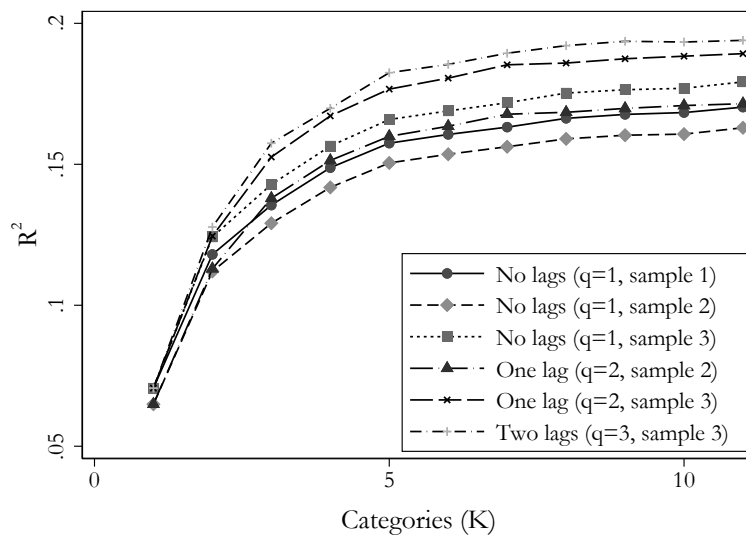


**Figure C2:** Performance of Alternative Risk Classifications: lags of classification.

*Note:* Each specification includes 21 age times gender fixed effects, year fixed effects and 79 plan fixed effects. Source: German Claims Panel Data.

predictive power than  $q = 1$ . However, the variant with  $q = 1$  thus achieves similar performance with a much smaller number of classes.

**Sample selection.** The results in Figure 4 are based on a sample of individuals who are observed over 4 years, since three lags are needed in  $\Lambda_{it}^*$ . In figure C3 we check how robust the finding is to varying the observation window required for sample selection. Sample 1 requires only that  $m_i$  and  $\lambda_t^*$  are observed, sample 2, also that  $\lambda_{t-1}^*$  is observed, and sample 3 in addition that  $\lambda_{t-2}^*$  is observed. The results provided in Figure C3 show that the predictive performance is sensitive to the sample used; however, the relative performance between schemes is the same regardless of the sample considered.



**Figure C3:** Performance of Alternative Risk Classifications: Different Samples.

*Note:* Each specification includes 21 age times gender fixed effects, year fixed effects and 79 plan fixed effects. Source: German Claims Panel Data.

**Table C1:  $\lambda$  Risk Category Transitions by Age Group – Ages 25–54**

Age	$\lambda_t$	$\lambda_{t+1}$							
		1	2	3	4	5	6	7	8 (+)
25-29	1	0.8907	0.1024	0.0047	0.0011	0.0004	0.0003	0.0001	0.0004
	2	0.3197	0.4257	0.2020	0.0432	0.0077	0.0011	0.0003	0.0003
	3	0.1242	0.2829	0.4104	0.1404	0.0378	0.0043	0.0000	0.0000
	4	0.0892	0.1688	0.2484	0.3917	0.0860	0.0159	0.0000	0.0000
	5	0.0938	0.1250	0.0625	0.3750	0.2917	0.0521	0.0000	0.0000
	6	0.0909	0.0000	0.0455	0.2273	0.3182	0.3182	0.0000	0.0000
	7	0.0000	0.0000	0.0002	0.0045	0.0240	0.1447	0.7619	0.0647
30-34	1	0.8767	0.1145	0.0055	0.0018	0.0009	0.0002	0.0001	0.0003
	2	0.3212	0.4347	0.1909	0.0438	0.0080	0.0006	0.0001	0.0007
	3	0.1241	0.3015	0.4080	0.1409	0.0229	0.0016	0.0000	0.0011
	4	0.1039	0.1640	0.2407	0.3739	0.1032	0.0115	0.0007	0.0021
	5	0.0734	0.0911	0.0506	0.2911	0.3747	0.1089	0.0025	0.0076
	6	0.0422	0.0438	0.0529	0.1678	0.3628	0.2450	0.0525	0.0329
	7	0.0128	0.0115	0.0083	0.0574	0.1545	0.1663	0.4524	0.1368
35-39	1	0.8427	0.1480	0.0055	0.0022	0.0009	0.0002	0.0001	0.0004
	2	0.2798	0.4635	0.2113	0.0360	0.0076	0.0013	0.0000	0.0005
	3	0.1177	0.2379	0.4850	0.1288	0.0275	0.0028	0.0001	0.0002
	4	0.0719	0.0967	0.3055	0.4085	0.0999	0.0158	0.0003	0.0014
	5	0.0743	0.0493	0.0691	0.3402	0.3629	0.0958	0.0039	0.0045
	6	0.0415	0.0331	0.0340	0.1180	0.2958	0.4009	0.0455	0.0312
	7	0.0127	0.0088	0.0054	0.0409	0.1276	0.2757	0.3975	0.1313
40-44	1	0.8514	0.1392	0.0050	0.0024	0.0010	0.0003	0.0001	0.0006
	2	0.2862	0.4666	0.2050	0.0329	0.0075	0.0014	0.0001	0.0003
	3	0.1137	0.2229	0.5134	0.1225	0.0241	0.0022	0.0001	0.0011
	4	0.0790	0.0769	0.2936	0.4213	0.1113	0.0157	0.0003	0.0018
	5	0.0640	0.0392	0.0759	0.3281	0.3763	0.1055	0.0038	0.0072
	6	0.0295	0.0382	0.0342	0.1605	0.2773	0.3613	0.0539	0.0450
	7	0.0081	0.0091	0.0049	0.0502	0.1079	0.2240	0.4247	0.1710
45-49	1	0.8148	0.1736	0.0059	0.0028	0.0012	0.0006	0.0002	0.0009
	2	0.2267	0.5059	0.2229	0.0329	0.0093	0.0013	0.0001	0.0010
	3	0.0653	0.2027	0.5708	0.1309	0.0258	0.0031	0.0001	0.0012
	4	0.0427	0.0712	0.2877	0.4655	0.1153	0.0140	0.0005	0.0029
	5	0.0303	0.0438	0.0475	0.3570	0.3964	0.1101	0.0058	0.0090
	6	0.0153	0.0266	0.0211	0.1118	0.2919	0.4163	0.0607	0.0563
	7	0.0038	0.0057	0.0027	0.0314	0.1021	0.2321	0.4298	0.1923
50-54	1	0.8117	0.1740	0.0056	0.0035	0.0020	0.0008	0.0004	0.0020
	2	0.2283	0.4979	0.2228	0.0377	0.0101	0.0016	0.0002	0.0015
	3	0.0602	0.1799	0.5727	0.1509	0.0317	0.0027	0.0001	0.0018
	4	0.0398	0.0648	0.2660	0.4930	0.1160	0.0155	0.0007	0.0041
	5	0.0274	0.0387	0.0426	0.3666	0.3866	0.1182	0.0075	0.0124
	6	0.0130	0.0222	0.0179	0.1084	0.2688	0.4220	0.0746	0.0732
	7	0.0028	0.0042	0.0020	0.0265	0.0819	0.2049	0.4600	0.2176

Source: German Claims Panel Data. Sample includes all years, 25-30 year old enrollees, and uses the ACG<sup>©</sup> score as  $\lambda$ .

**Table C2:  $\lambda$  Risk Category Transitions by Age Group – Ages 55+**

Age	$\lambda_t$	$\lambda_{t+1}$							
		1	2	3	4	5	6	7	8 (+)
55-59	1	0.7261	0.2537	0.0101	0.0037	0.0020	0.0013	0.0004	0.0027
	2	0.0932	0.6432	0.2123	0.0357	0.0110	0.0018	0.0004	0.0025
	3	0.0002	0.1739	0.6167	0.1690	0.0335	0.0044	0.0001	0.0024
	4	0.0001	0.0637	0.2426	0.5404	0.1287	0.0180	0.0007	0.0058
	5	0.0001	0.0356	0.0363	0.3758	0.4009	0.1282	0.0069	0.0163
	6	0.0000	0.0195	0.0145	0.1061	0.2662	0.4370	0.0650	0.0917
	7	0.0000	0.0037	0.0016	0.0260	0.0813	0.2126	0.4016	0.2732
60-64	1	0.7558	0.2147	0.0145	0.0044	0.0042	0.0019	0.0011	0.0033
	2	0.1023	0.6414	0.1981	0.0387	0.0120	0.0031	0.0004	0.0040
	3	0.0002	0.1612	0.6076	0.1836	0.0394	0.0053	0.0001	0.0028
	4	0.0001	0.0555	0.2243	0.5507	0.1419	0.0204	0.0008	0.0063
	5	0.0001	0.0292	0.0317	0.3610	0.4168	0.1370	0.0075	0.0168
	6	0.0000	0.0153	0.0122	0.0980	0.2660	0.4489	0.0686	0.0910
	7	0.0000	0.0028	0.0013	0.0235	0.0794	0.2136	0.4143	0.2651
65-69	1	0.3707	0.5949	0.0172	0.0076	0.0030	0.0015	0.0009	0.0042
	2	0.0624	0.6492	0.2407	0.0352	0.0065	0.0012	0.0004	0.0045
	3	0.0008	0.1058	0.6561	0.2082	0.0223	0.0013	0.0000	0.0056
	4	0.0002	0.0335	0.2013	0.6242	0.1261	0.0052	0.0005	0.0090
	5	0.0000	0.0128	0.0159	0.3546	0.4985	0.0763	0.0019	0.0400
	6	0.0000	0.0000	0.0107	0.0551	0.4067	0.3517	0.0195	0.1563
	7	0.0006	0.0066	0.0029	0.0264	0.0553	0.1690	0.5289	0.2103
70-74	1	0.3848	0.5793	0.0225	0.0060	0.0011	0.0003	0.0014	0.0048
	2	0.0070	0.6771	0.2554	0.0406	0.0105	0.0012	0.0000	0.0082
	3	0.0001	0.0810	0.6277	0.2599	0.0230	0.0014	0.0001	0.0068
	4	0.0002	0.0115	0.1625	0.6579	0.1404	0.0080	0.0002	0.0195
	5	0.0000	0.0015	0.0184	0.2829	0.5654	0.0736	0.0010	0.0572
	6	0.0000	0.0000	0.0000	0.0327	0.3039	0.4052	0.0065	0.2516
	7	0.0005	0.0056	0.0033	0.0184	0.0172	0.0263	0.7192	0.2094
75+	1	0.1770	0.5900	0.0442	0.0995	0.0598	0.0063	0.0083	0.0150
	2	0.0006	0.6237	0.2903	0.0471	0.0094	0.0012	0.0000	0.0277
	3	0.0000	0.0525	0.5876	0.2988	0.0254	0.0012	0.0000	0.0344
	4	0.0000	0.0029	0.1012	0.6668	0.1623	0.0055	0.0008	0.0605
	5	0.0000	0.0000	0.0060	0.2262	0.5581	0.0837	0.0028	0.1232
	6	0.0000	0.0000	0.0019	0.0206	0.3127	0.4064	0.0225	0.2360
	7	0.0000	0.0000	0.0000	0.0000	0.1111	0.1481	0.4630	0.2778

Source: German Claims Panel Data. Sample includes all years, 25-30 year old enrollees, and uses the ACG<sup>©</sup> score as  $\lambda$ .

## C2 Sample Selection: Robustness Checks

This robustness section focuses on plans with low deductibles. We consider a stricter sample selection rule, where we only include plans with deductibles below \$400.<sup>55</sup> These plans have approximately full coverage and thus more reliable information on the universe of health care expenditures. Summary statistics for this subsample are provided in Table C3. A comparison with the numbers in Table A1 makes clear that the two samples are very similar in terms of age, gender and history with the company. On the other hand, the restricted sample has a greater share of employees and civil servants, but a smaller share of self-employed. The plan characteristics are also similar to a great extent – with the obvious exceptions of deductible size and average claims.

**Table C3: Summary Statistics: Low-Deductible Plans**

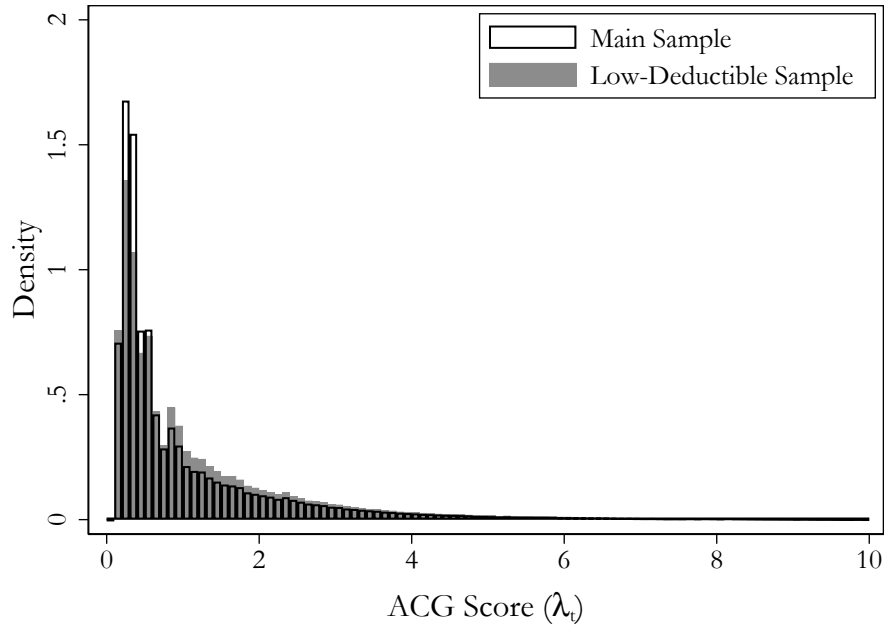
	Mean	SD	Min	Max	N
<b>Socio-Demographics</b>					
Age (in years)	44.8	11.8	25.0	99.0	879,468
Female	0.256	0.437	0.0	1.0	879,468
Policyholder since (years)	7.7	5.3	1.0	40.0	879,468
Client since (years)	13.9	11.7	1.0	84.0	879,468
Employee	0.414	0.493	0.0	1.0	879,468
Self-Employed	0.281	0.449	0.0	1.0	879,468
Civil Servant	0.280	0.449	0.0	1.0	879,468
Health Risk Penalty	0.338	0.473	0.0	1.0	879,468
Pre-Existing Condition Exempt	0.015	0.121	0.0	1.0	879,468
<b>Health Plan Parameters</b>					
TOP Plan	0.342	0.475	0.0	1.0	879,468
PLUS Plan	0.397	0.489	0.0	1.0	879,468
ECO Plan	0.261	0.439	0.0	1.0	879,468
Annual premium (USD)	5,208	2,005	0	33,037	879,374
Annual risk penalty (USD)	133	347	0	21,214	879,468
Deductible(USD)	154	164	0	395	879,468
Total Claims (USD)	3,868	9,064	0	2,345,126	879,468

Source: German Claims Panel Data. *Policyholder since* is the number of years since the client has enrolled in the current plan; *Client since* is the number of years since the client joined the company. *Employee* and *Self-Employed* are dummies for the policyholders' current occupation. *Health Risk Penalty* is a dummy that is one if the initial underwriting led to a health-related risk add-on premium on top of the factors age, gender, and plan; *Pre-Existing Conditions Exempt* is a dummy which equals one if the initial underwriting led to a coverage exclusion of services for some conditions. The mutually exclusive dummies *TOP Plan*, *PLUS Plan* and *ECO Plan* capture the generosity of the plan. *Annual premium* is the annual premium, and *Annual Risk Penalty* is the amount of the health risk penalty charged. *Deductible* is the deductible and *Total Claims* the sum all claims in a calendar year. See Section 4.1 for further details.

<sup>55</sup>This is the lowest cutoff for the deductible which gives us a sufficient number of observations to analyse health risk transitions within each age group.



Figure C4 compares the distributions of  $\lambda^*$  in the two samples. As expected, the zero-deductible plans have higher ACG<sup>©</sup> scores in general.



**Figure C4:** Distribution of  $\lambda^*$  for Main Sample vs. Low-Deductible Plans.

Table C4 shows how clients distribute over different risk categories by age in the low-deductible sample. A comparison with Table 2 confirms that the individuals in the low-deductible sample are in slightly worse health.

**Table C4:** Health Risk Categories  $\lambda$  by Age Group: Low-Deductible Sample

Age	1 (Healthiest)	2	3	4	5	6	7 (Sickest)
25-30	0.739	0.190	0.049	0.016	0.006	0.001	0.000
30-35	0.672	0.225	0.069	0.025	0.007	0.002	0.000
35-40	0.559	0.282	0.112	0.034	0.011	0.003	0.000
40-45	0.507	0.291	0.141	0.043	0.015	0.003	0.000
45-50	0.406	0.317	0.190	0.060	0.021	0.005	0.001
50-55	0.316	0.311	0.244	0.090	0.030	0.008	0.001
55-60	0.172	0.309	0.320	0.139	0.045	0.013	0.002
60-65	0.093	0.263	0.361	0.190	0.069	0.022	0.003
65-70	0.038	0.200	0.423	0.252	0.072	0.014	0.002
70-75	0.011	0.131	0.403	0.333	0.107	0.015	0.001
75+	0.000	0.055	0.286	0.453	0.179	0.024	0.003

Source: German Claims Panel Data. Sample includes all age groups and uses the ACG<sup>©</sup> score for the classification.

Table C5 shows the transition probabilities between different health states in the low-deductible sample. The probabilities are very similar to those reported in Table 3.

**Table C5: Health Risk Category Transitions: Low-Deductible Sample**

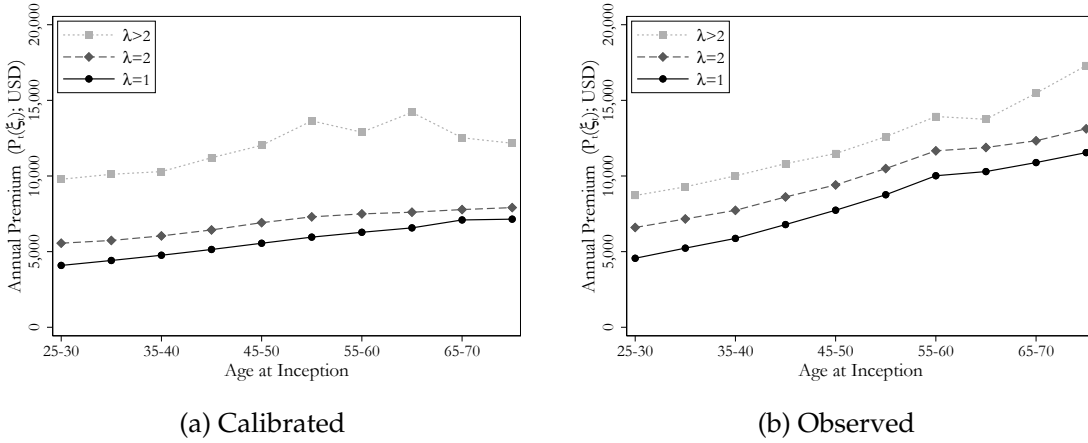
$\lambda_t$	$\lambda_{t+1}$							
	1	2	3	4	5	6	7	8 (+)
1	0.797	0.192	0.007	0.002	0.001	0.000	0.000	0.001
2	0.186	0.536	0.234	0.033	0.008	0.001	0.000	0.001
3	0.038	0.167	0.602	0.160	0.026	0.003	0.000	0.003
4	0.015	0.041	0.237	0.555	0.126	0.012	0.000	0.014
5	0.014	0.018	0.034	0.339	0.453	0.103	0.004	0.035
6	0.007	0.012	0.016	0.104	0.311	0.401	0.051	0.097
7	0.000	0.000	0.003	0.028	0.113	0.228	0.423	0.204

Source: German Claims Panel Data. Sample includes all years, all age groups, and uses the ACG<sup>©</sup> score for the classification.

# Appendix D

## D1 German LTHI Premium Profiles

Figure D1 compares the (a) calibrated and (b) observed premium profiles for individuals entering their plan at different ages. In both figures, the highest category ( $\lambda_t > 2$ ) is a weighted average calculated according to the actual distribution of  $\lambda_t$  in the different age groups.



**Figure D1:** Calibrated vs. Actual Starting Premiums  $P_t(\xi_t)$  by Age at Inception

Note: Source: German Claims Panel Data. In Figure D1 (b), the sample includes all years and all health plans, and clients who have been in their contract for 2 to 5 years. We adjusted premiums for the three benefit categories *TOP*, *PLUS*, *ECO* and deductible size.

## Appendix E

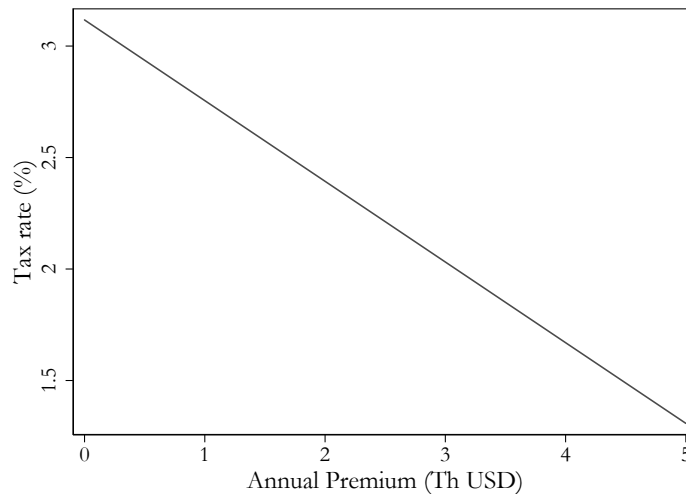
### E1 Trading Off the Medicare Payroll Tax and Medicare Premiums

In this section, we evaluate the welfare consequence of changing the timing of payments into Medicare. Our baseline scenario assumes that Medicare coverage is completely free without any premium. However, the actual Medicare program in the US entails a premium (Part B) and cost-sharing provisions (Part A and B). In the context of our lifecycle model, premiums and cost-sharing provisions backload Medicare expenses by reducing the Medicare tax rate required to fund Medicare.

As a first approach, we maintain the assumption of no cost-sharing, but vary the level of premiums charged during retirement. Specifically, we assume a Medicare premium  $p$  has to be paid, starting at age 65. The associated Medicare tax rate  $\tau(p)$  is such that the revenue neutrality condition holds

$$\tau(p) \mathbb{E} \left( \sum_{25}^{64} S_t \delta^{t-24} y_t \right) = \mathbb{E} \left( \sum_{65}^{94} S_t \delta^{t-24} (m_t - p) \right)$$

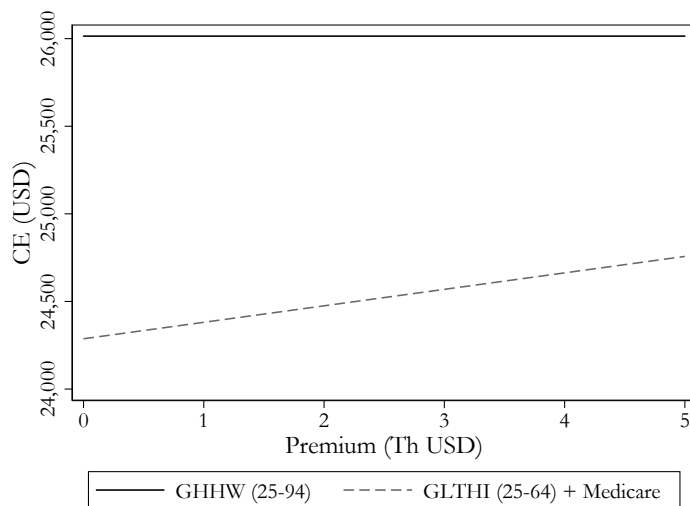
It is clear from this equation that a higher premium at old age is compensated by a lower tax rate at younger ages. Figure E1 shows this trade-off, where the x-axis depicts the tax rate that is needed for each premium level depicted on the y-axis.



**Figure E1:** Tax Rate and Medicare Premium

Figure E2 shows welfare for the combined GLTHI + Medicare case, and when charging a Medicare premium in addition to the Medicare tax. The x-axis shows different premium levels, and the y axis shows the welfare consequences.

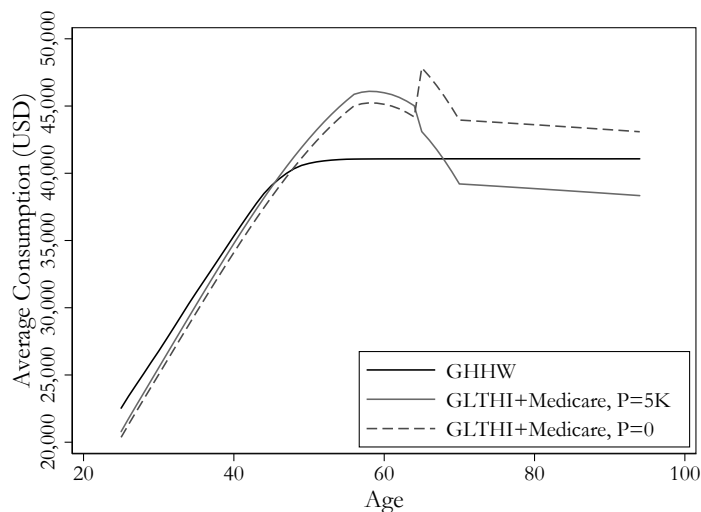
Three findings emerge from Figure E2: (1) a higher Medicare premium (and thus lower tax rate) is



**Figure E2:** Welfare of GHHW and Medicare with different Premiums

desirable from a welfare perspective, and (2) at any premium level, GHHW does better than GLTHI.

To understand the intuition behind the welfare result in Figure E2, Figure E3 shows the expected lifecycle consumption profiles under (a) GHHW over the entire lifecycle, (b) GLTHI + Medicare with a zero premium and the corresponding tax rate in Figure E1, (c) GLTHI + Medicare with a premium of \$5K and the corresponding tax rate in Figure E1.



**Figure E3:** Expected Consumption Profile

Figure E3 illustrates that a higher Medicare premium increases consumption in early ages (because it decreases the tax rate). Under the GLTHI + free Medicare scenario, one observes a sharp increase in consumption at retirement, because individuals stop paying GLTHI premiums and stop

paying Medicare taxes. Under the GLTHI + Medicare with a \$5K premium scenario, one observes a reduction in consumption at retirement because the Medicare premiums exceeds the GLTHI premium. Figure E3 also illustrates that even a very large Medicare premium (and almost zero Medicare tax) does not outperform GHHW because it fails to achieve the same level of consumption at early ages. Compared with the optimal contract, it still has too much frontloading.

## Appendix F

We provide the derivation for the formula of the certainty consumption equivalent for Epstein-Zin preferences, provided in Equation (13). Preferences are defined recursively as

$$V_t = F(c_t, R_t(V_{t+1})),$$

with  $R_t(V_{t+1}) = G^{-1}(\mathbb{E}_t G(V_{t+1}))$ . As mentioned in the main text, we use the CES aggregator for  $F(c, z) = ((1 - \delta)c^{1-1/\psi} + \delta z^{1-1/\psi})^{\frac{1}{1-1/\psi}}$ , and incorporate the CARA utility function as  $G(c) = u(c) = \frac{1}{\gamma} e^{-\gamma c}$ .

Throughout we have assumed that utility is zero if the individual is dead. We can re-interpret  $V_t$  as the value of being alive in period  $t$ . Under that interpretation, one can write preferences recursively as:

$$V_t = \left( (1 - \delta) c_t^{1-1/\psi} + s_t \delta R_t(V_{t+1})^{1-1/\psi} \right)^{\frac{1}{1-1/\psi}} \quad (14)$$

where  $s_t$  is the probability of survival between  $t$  and  $t + 1$ .

We now derive an expression for the certainty equivalent consumption  $c$  for any given value  $V_t$  under recursive preferences. Consider the situation in which consumption (while alive) is constant and equal to  $c$ . This means that  $R_t(V_{t+1}) = V_{t+1}$ , and therefore we can re-write

$$V_t = \left( (1 - \delta) c^{1-1/\psi} + s_t \delta (V_{t+1})^{1-1/\psi} \right)^{\frac{1}{1-1/\psi}} \quad (15)$$

Replacing the  $V_{t+1}$  in Equation (15) as a function of  $V_{t+2}$  yields

$$\begin{aligned} V_t &= \left( (1 - \delta) c^{1-1/\psi} + s_t \delta \left( (1 - \delta) c^{1-1/\psi} + \delta s_{t+1} (V_{t+2})^{1-1/\psi} \right) \right)^{\frac{1}{1-1/\psi}} \\ &= \left( (1 - \delta) c^{1-1/\psi} + s_t \delta (1 - \delta) c^{1-1/\psi} + s_t s_{t+1} \delta^2 V_{t+1}^{1-1/\psi} \right)^{\frac{1}{1-1/\psi}} \end{aligned}$$

Iterating forward we can show that

$$\frac{V_t^{1-1/\psi}}{1-\delta} = \sum_{j=t}^T c^{1-1/\psi} \delta^{j-t} S_t^j$$

where  $S_t^j \equiv \prod_{k=t}^j s_k$  is the survival probability from  $t$  to  $j$ . Solving for  $c$ , we get an expression defining the certainty equivalent:

$$c = \left( \frac{\frac{V_t^{1-1/\psi}}{1-\delta}}{\sum_{j=t}^T \delta^{j-t} S_t^j} \right)^{\frac{1}{1-1/\psi}} \quad (16)$$

Equation (16) provides the certainty equivalent consumption to a program that provides value  $V_t$ .

We are interested in the certainty equivalent taking into account the uncertainty regarding the “birth state”  $\zeta_{t_0}$ . Denote the value of this lottery  $V_b$ . It can be expressed as a function of  $V_{t_0}$  (the value at age 25):

$$V_b = G^{-1}(\mathbb{E}_0(G(V_{t_0}(\zeta_{t_0})))) \quad (17)$$

where  $\mathbb{E}_0(\cdot)$  takes expectations with respect to the uncertain “birth” state,  $\zeta_{t_0}$ .

For each contract, we can compute the value  $V_{t_0}(\zeta_{t_0})$ , for each state  $\zeta_{t_0}$ , *via* backwards induction. Plugging Equation (17) into Equation (16), applied to the initial period  $t_0$  we get the expression in the text.

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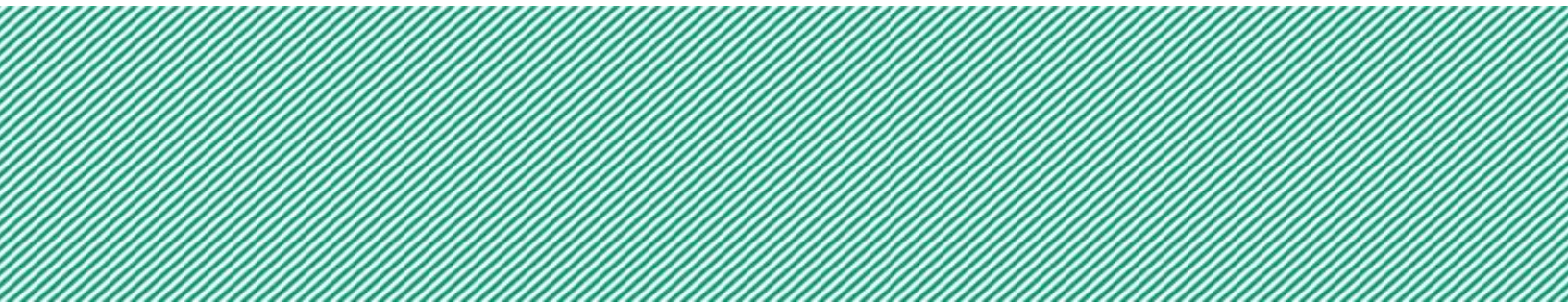


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