Has Community Rating Produced Optimal Results?

Taurayi Chinowona

Momentum Group.

The prohibition of premium rating in the medical scheme environment, also known as 'Community Rating', since the enactment of the Medical Schemes Act of 1998 ('the Act') has been the cornerstone of the Department of Health's ('DOH') philosophy of social equity in the medical schemes industry.

An oft-stated concern of the DOH is the low proportion of the population that belongs to medical schemes. The absolute number of medical scheme beneficiaries has been stagnant at around 7 million lives for the past decade.

This paper poses the question: Has community rating produced optimal results? 'Optimal' here means various things:

- Has it resulted in the greatest number of people possible belonging to medical schemes?
- Is the status quo economically efficient, in particular, is it Pareto optimal?

The answer to each of these questions is probably NO.

I will show that welfare would increase were full or limited premium rating on the basis of age to be allowed.

I will also demonstrate that it is likely that age rated premiums can potentially increase the membership of medical schemes.

Finally I will argue that, in the first place, the notion that community rating reduces social inequities is misguided and that, even if it could, it is an inappropriate tool to achieve this end.

1. Introduction

We live in a world in which the prices of identical goods are generally uniform. We are so accustomed to this that it never occurs to us that this state of affairs may be economically sub-optimal. In a market with a single price there are potential economic exchanges that would increase the welfare of both parties involved that are never consummated. These are transactions for which the cost of supply is lower than the price the buyer is prepared to pay but for which both amounts are below the market price.

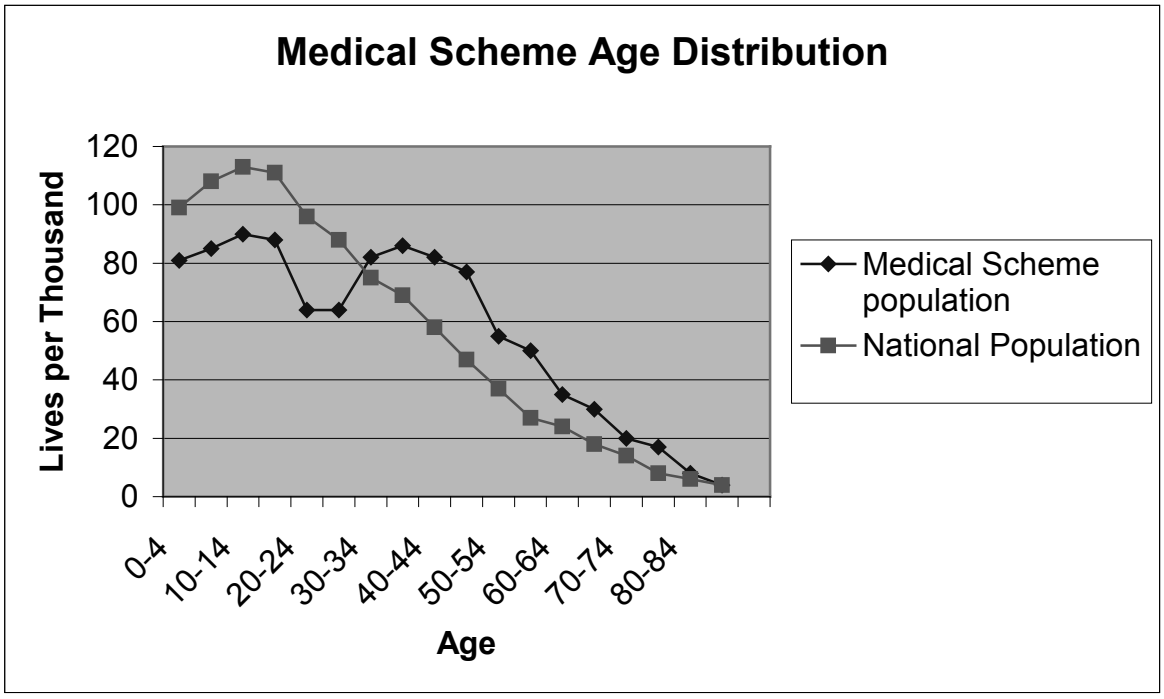
In reality we see a uniform price landscape all around us because there exist obstacles to price discrimination. In the first place, for most goods the only factor that causes variations in cost of supply is geographical location, either of the buyer, the seller or both. Even in the absence of differences in supply costs, there are normally wide variations in the prices buyers are prepared to pay. Under such circumstances price discrimination would be more efficient than uniform pricing. However, the existence of secondary markets, or merely the possibility of one emerging, renders this impractical. Such markets would arbitrage away the price differences.

Services are much less prone to secondary market arbitrage. The same can be said of intangible goods such as financial contracts, of which insurance contracts are a class. Not only is insurance immune to secondary market arbitrage but also the cost of supplying it does differ from one group of buyers to another for reasons other than geographical location. Hence, the prevalence of price discrimination in this market. In South Africa price uniformity in the health insurance market has been imposed by legislation.

2. Age Profile of Medical Scheme Members

A comparison of the age distribution of medical scheme members to that of the national population suggests that those in the 20-35 age group are less willing to pay the current price for medical scheme membership than are older members of the population. This may be because community rating imposes a price on them that is way above the cost of supply, which is closely related to their perceived value of the benefits. Their perception of the value of benefits determines their demand for this good.

The age distribution of medical scheme members in South Africa is bi-modal. It rises steadily, in tandem with the national age distribution but falls sharply in the early 20s. It reaches a low in the 25 to 30 age group and then starts rising again until it reaches another peak in the 35 to 40 age bracket. This distribution is compared to the age distribution of the national population in the graph below.



Sources: the Council for Medical Schemes Annual report 2006-7and Statistics South Africa

Given the strong positive correlation between age and average claims, were the medical scheme population representative of the national population with respect to age, average premiums would most probably be lower. The lopsidedness of the medical scheme population with respect to age would probably be worse were it not for the fact that a sizeable proportion of employers make medical scheme membership a condition of employment. What the graph does not show is that the younger members tend to have lower coverage levels than the older members. A number of these young members would probably not bother to be insured were it not for the fact that they are compelled to do so by their employers. The premium-weighted average age of scheme members is therefore older than the national average age to a greater extent than might be suggested by the graph.

3. Data and its key features

A sample of a number of medical scheme membership databases was used for this research. In total this sample consisted of about 3 000 lives. The fields of interest were as follows:

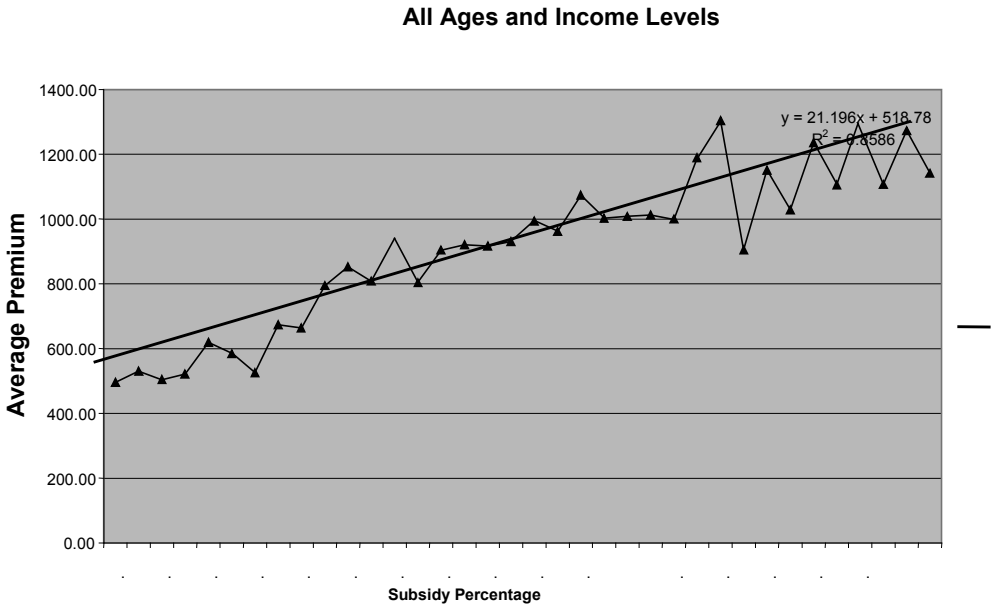
- premium level,
- income in respect of some individuals,
- age,
- the portion of the premium that the employer subsidises

I used the data relating to single lives only. The main reason I disregarded all other data is that it gives no indication of the age of the dependants.

Three key features of the data are worth mentioning at this stage.

Firstly there is some correlation between average premium (and therefore level of cover) and subsidy percentage. The graph below illustrates this.

GRAPH 1



There is also some positive correlation between average premium (and therefore level of cover) and age. The correlation co-efficient is 11%. Lastly, there is also a correlation between average premium and income for those for whom income data was available. The correlation co-efficient from our sample is 21%. The correlation between the subsidy level and the average premium is the key to resolving the questions raised in this paper. As will be explained in later sections this relationship provides us with an analytical tool, but only to the extent that it represents a causal relationship. Because of similar positive correlations between average premium and age on the one hand and average premium and income, and the fact that both age and income may, in turn, be positively correlated to subsidy level, the relationship shown in the graph above may be less causal than it may first appear.

4. The Model

The key to answering the questions posed in this paper is the price elasticity of medical insurance. The data show that demand is positively correlated with both age and income. It is likely that price elasticity is also a function of these two variables. Further, it is likely that price elasticity also varies with price itself. I therefore modelled price elasticity as a function of all three variables.

Price elasticity is key because the demographic profile of insured lives is a function of the vector of age-dependent premiums [Px] where x denotes age. In fact one could theoretically create any age profile one desired by choosing an appropriate set of age-dependent premiums.

Let Di, x, p be the demand for healthcare insurance as a function of income, age and price. An inspection of the data suggests that this function has the following characteristics

$$\frac{\partial Di, x, p}{\partial p} \leq 0 \text{ as can be expected} \qquad (1)$$

$\frac{\partial Di, x, p}{\partial p}$ is proportional to the price elasticity of demand (on the elasticity definition adopted in this paper)

but also that

$$\frac{\partial Di, x, p}{\partial i} \geq 0 \qquad (2)$$

and

$$\frac{\partial Di, x, p}{\partial x} \geq 0 \qquad (3)$$

The definition of price elasticity used in this paper is the change in absolute number of lives, as a proportion of the total number of lives in the population, per unit change in price. The conventional definition is the percentage change in demand for each percentage change in price. I have not used the conventional definition because the former definition is easier to model in this particular instance.

Some employers subsidise the medical scheme premiums of their current and retired employees. These subsidies are typically expressed as percentages of the premium charged. Because these percentages vary from employer to employer, the prices individuals bear for the same level of cover is not necessarily the same. For a given age and income level, the proportion of members with a given amount of coverage gives us an indication of the demand for that level of coverage at that price. In this case the price is the premium less the employer subsidies. I estimated the variation of this demand by price, by calculating it for different employer groups who offer different levels of subsidies.

It is the set of price elasticities thus derived that I used to predict the change in the proportion of lives covered at each age group as a result of a change from the current community-rated premiums to an arbitrary set of age-rated premiums.

I extrapolated these elasticities to premiums below the current minimums available in the market in order to estimate the number of new lives that were likely to enrol in the event of these arbitrary premium reductions. Ideally one should estimate the price elasticity of the decision to enrol on a medical scheme. However, I did not have data relating to non-medical scheme employees. An implicit assumption underlying the method by which we derive enrolment elasticity estimates in this paper is that individuals are rigid about the price that they are prepared to pay for medical insurance. In other words, that if the lowest available market prices are only marginally above what a given individual is prepared to pay, then that individual will opt not to belong to a medical scheme. In reality the cost of being unisured can be deemed so high that the demand for medical insurance products that are priced just below the lowest available prices in the market may already be reflected in the membership of medical schemes at the lowest end of the market.

Suppose that the prohibition against age rating were to be lifted. Then if all medical schemes were to impose an arbitrary set of age-related premiums [Px] in respect of their entry-level options, and also offer no other options, the demographic profiles of medical schemes would probably change. Some of those who would experience premium increases would cease membership or reduce coverage. Conversely, some of those who would experience premium reductions would increase coverage or enrol if they were not already members.

Then:

$$\Delta Ni, x = -\int_{\Pr ate}^{Px} E(i, x, p).dp \qquad (4)$$

And

$$\Delta Wi,x = -\int_{\Pr ate}^{Px} E(i,x,p) \times p.dp - Cx \times \Delta Ni,x \quad (5)$$

Where:

$\Delta Ni,x$ is the increase in the number of insured lives as a percentage of the population at income i and age x

$\Delta Wi,x$ is the increase in welfare at income i and age x

E(i,x,p) is the price elasticity at income i, age x and price p

P*rate* is the community rate premium

Px is the age-dependant price of a set of benefits for beneficiaries aged x

Cx is the average claims cost at age with an allowance for non-healthcare costs

Summing over all ages and incomes gives us

$$\Delta N = \iint_{i,x} \Delta Ni,x.di.dx \quad (6)$$

And

$$\Delta W = \iint_{i,x} \Delta Wi,x.di.dx \quad (7)$$

The solution to Equation (6) is the answer to the first question, which is "Is it possible to increase the number of lives covered by moving to an age rated premium basis?"

Equation (7) attempts to answer the second question, which is "Is it possible to increase economic welfare by moving to an age-rated premium basis?"

This welfare increase is a result of, firstly, younger members who place a greater value on medical insurance than it costs them under the new price regime enrolling on medical schemes. The second mechanism by which welfare is increased is the phenomenon of older members dropping out of schemes. (In real life members could also respond to premium changes by increasing or reducing their cover.) These individuals will tend to be those who do not place as much value on medical insurance as it now costs them. Some people may have great difficulty in accepting that a premium increase for a section of the insured population, and, as a result, that some of them having to do with lower coverage levels or none at all can be said to represent an increase in economic efficiency. This is more so when this segment of the population is made up of individuals that society regards as 'vulnerable'. This view may be justified from a normative point of view. However, we must not lose sight of the fact that the question of whether or not welfare is optimised is a purely positive one.

Given that some people may regard this measure as callous, I have constructed an alternative measure of the inferiority, in economic efficiency terms, of community rating. I have termed this measure the Kaldor-Hicks underwriting result. It is based on a less onerous form of Pareto efficiency known as Kaldor-Hicks efficiency. The Kaldor-Hicks criterion does not require that no-one be made worse off by a change for that change to be regarded as a Pareto efficiency improvement. All it requires is that the increase in welfare accruing to the gainers be more than is required to fully compensate the losers.

I have defined the Kaldor-Hicks underwriting result thus:

$$KHU = \sum_{x} Px \times Nx,p - \sum Cx \times Nx,p \geq 0 \quad (8)$$

Provided

$$\forall Px \leq \Pr ate \quad (9)$$

Where:

Px is the premium at age x
Nx,p is the number of lives at age x and at price p
P*crate* is the community rate
Cx is the average claims cost at age with an allowance for non-healthcare costs

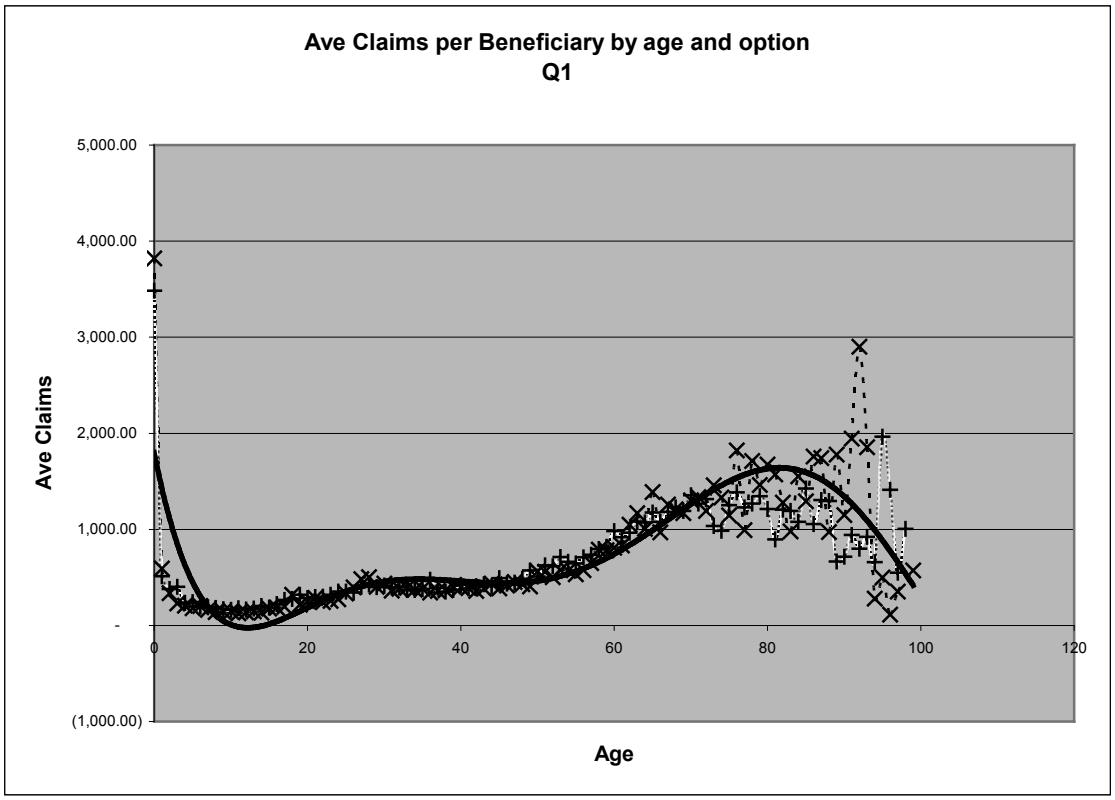
In simple terms, this means we are looking for a set of age-dependent premiums, [Px], such that none of these premiums is greater than the current community rate, that will not result in an underwriting deficit. All that is required to demonstrate that community rating under the current environment may not be Kaldor-Hicks efficient is to show that U exists, whatever its value. If it exists at all it is likely that the solution to [Px] will not be unique. There will be distinct sets of values that will result in U. The maximum size of U will be a measure of the extent of the economic inefficiency of the status quo.

There are two distinct ways in which the younger members of the population can increase their participation in medical schemes. The most obvious is the enrolment of those previously not on medical schemes. The other is the migration of those already participating to richer benefit options. Premium reductions will produce both effects. Our model only deals with te first phenomenon.

The variation of average claims by age in this country takes the shape in the graph below.

This variation is more pronounced for certain types of benefits than for others. Cases in points are chronic medicines and hospital benefits. Therefore this variation will take on different shapes from one product to the next, although the general form will not vary that much. The graph below is not based on an actual set of claims data but is illustrative of the variation of claims with age.

GRAPH 2



The variation of claims with age, together with the variation of demand with age, as well as the variation of price elasticity with age that will be shown in the next section conjures up the following circular relationship. Premiums affect the membership age profile, which in turn affects the claim profile, which in turn affects the premiums. It is this relationship that raises the possibility that economic efficiency in this industry is a function of premium structure.

5. A survey of related literature

A number of studies on price elasticity have been carried out in the last two decades. However, most of these are not ideal benchmarks for the price elasticities referred to in this paper because they are actually estimates of the price sensitivity of a particular insurer's prices when its competitors' prices remain constant. The elasticity values thus obtained will be greater than the ones that are of interest to us. I will discuss a few of the results obtained in these studies below.

Buchmueller (2003) investigated the price elasticity regarding choice of plan in respect of retirees. The sample of data consisted of retirees that were in receipt of different levels of subsidies. This study did not suffer from the defect I have alluded to in the previous paragraph. Because policyholders with different subsidy levels were distributed uniformly across plans, plan specific characteristics did not bias the results. There is a possibility that the level of subsidy may be correlated with age, thereby introducing some bias. This link arises from the fact that the subsidy differentials arise from the fact that in sometime in the 90s employers started slashing the subsidy amount of successive generations of retirees. As a consequence, the older retires are more likely to be in receipt of bigger subsidies than their younger counterparts. His estimates in respect of single lives lay in the range –0.26 to –0.34. In respect of all retirees the corresponding range was –0.21 to -0.37. [2]

Van Dijk et al, at the Netherlands Bureau for Economic Policy Analysis examined the propensity to switch between plans due to price differentials. Their population was the entire insured Dutch population between the years 1993 and 2002. They looked at the price differences between every pair of insurers in the dataset and compared this with the flows of policyholder between them during this period. Their estimates ranged from –0.1 to –0.38. Crucially the elasticity values were greater at the lower ages. [3]

Abraham, Vogt and Gaynor in the United States estimated households' price elasticities in respect of employer-based insurance. Their results for single-income households lie between –0.1 and –1.54. [1]

6. Estimated Parameter Values

Using multiple linear regression, the crude estimated elasticities per certain arbitrary price changes, at sample ages, and across all incomes are tabulated below. In the end I ignored income as the income data turned out to be too sparse.

TABLE 1

Age	**R800-R1,200**	**R1,200-R1,600**	**R1,600-R2,000**
Price reduction	**R200**	**R300**	**R400**
25	-5%	-16%	-9%
30	-7%	-14%	-12%
35	-5%	-10%	-11%
40	-2%	-10%	-9%
45	-1%	-9%	-9%
50	-1%	-12%	-8%

The confidence intervals of these estimates are rather wide. However, when transformed to the conventional definition of elasticity these values are of a similar order of magnitude to the estimates referred to in Section 5.These results indicate that elasticity decreases with increasing age. This is in agreement with the findings of Van Dijk et al.

7. Credibility of Price Elasticity Estimates

At this stage questions ought to be raised as to the credibility of these results.

The most critical one has to do with the degree to which the sample is representative of the medical schemes industry in South Africa. A common method of ensuring representativity is to create the sample by selecting its elements randomly from the underlying population. Obviously this was not possible in this exercise. To minimise the bias in the sample I ensured that the lives were sourced from 8 employer groups from various sectors of the economy. Nevertheless 8 employer groups may still not be large enough number to ensure representativity.

Having said that, I did test the degree to which the sample was representative of the national medical scheme population in respect of those characteristics that are known about that population. I calculated the sample age distribution, its average family size and gender mix and found no significant differences between these values and the corresponding values in respect of the underlying population. In light of this, it is not unreasonable to assume that the sample is also representative of the population with respect to price elasticity.

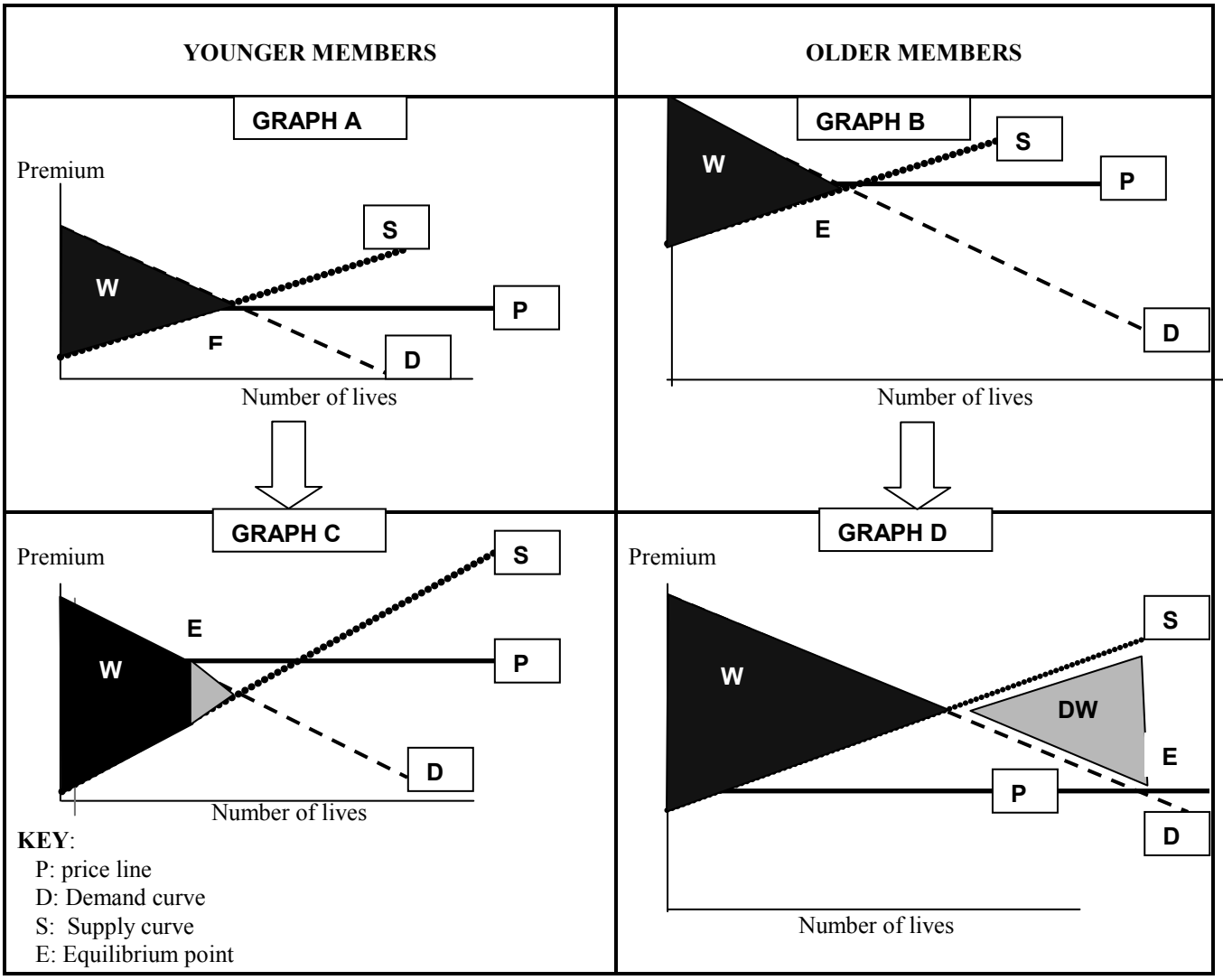
A second problem is one of spurious correlations. The principal hypothesis put forward in this paper, and on whose validity the conclusions reached rely, is that there is a causal link between the level of medical scheme contribution subsidy and demand. The correlation between these two quantities is assumed to arise from this causal link. However, it could be that both quantities are linked causally to a third variable and there may actually be no causal link between the two of them. For instance, our sample shows a positive correlationship between age and demand, as well as between age and subsidy level. The possibility exists therefore, that there is no causal link between subsidy level and demand at all. However, I dispelled these doubts by controlling for age in the regression analysis between subsidy level and premium. A similar problem arises regarding income. Unfortunately the data did not enable me to control for income. Part of the variation of demand by subsidy level may actually be due to income variations. The only question that remains open is how much.

The elasticity values that should be of interest to us are those relating to the decision to enrol on medical schemes. Due to lack of data relating to non-medical scheme members I estimated the elasticity values relating to the level of cover. I then extrapolated these estimates to ages below those currently available in the market. The critical assumption is that these interpolated values are good estimates of elasticity relating to the decision to enrol. The validity of this assumption is open to question.

A final criticism that may be levelled is that, even if we assume that these estimates are unbiased and are an accurate reflection of the true underlying elasticity, they relate to single members of schemes only. The elasticity values of the other members may be very different. To be sure, the age profile of single members is different from that of the larger sample of members from which they were extracted. The important thing is that single members represent a significant proportion of the medical scheme population and their elasticity values can be expected to have a material bearing on the corresponding values for the entire population.

8. Graphical Demonstration of Economic Inefficiency of Community Rating

It is trivial to demonstrate that community rating is economically inefficient, irrespective of the price elasticity of demand. I will use a graphical argument to illustrate the loss in welfare that results from a move from an age-rated regime to a community rated one.



The graphs shown above are Demand-Supply curves for medical insurance. I have divided the membership of medical schemes into "Younger members" and "Older members". The cut-off age is arbitrarily chosen but ideally it is the age at which average claims are equal to the community rate premium.

Suppose we are in a regime in which the older members are charged a higher premium than the younger ones. The applicable Demand-Supply curves are represented by Graphs A and B. If a common premium rate is then imposed on both groups it will cause the following changes. Graph A, representing the situation for younger members transitions to Graph C. Graph B, representing the situation for older members transitions to Graph D. The points at which the curves intersect represent the equilibrium premium rate and membership size. The areas shaded black and labelled "W" represent the welfare.

The move from Graph A to C shifts the equilibrium point (E) to the new intersection of the price line P and the demand curve D, thereby shifting demand to the left. Similarly the move from Graph B to D shifts the equilibrium point to the right. The first change causes the area represented by the triangles labelled W in Graph A, representing the welfare, to shrink by an amount equal to the area shaded grey. In respect of the transition from Graph B to D an area of negative welfare, also shaded grey and labelled DW emerges. These grey areas represent deadweight. In the case of the younger

members it is due to the fact that some members who were prepared to pay premiums greater than what medical schemes were prepared to charge them have given up medical insurance. In the case of older members it is because some members, who were only prepared to pay a premium that is lower than what medical schemes are prepared to charge them have enrolled.

9. Simulated responses to premium changes

The previous section demonstrates that, irrespective of the strength of the relationship between demand and prices, a community rate regime is not efficient in the classical sense of the term. However, it does not follow that such a regime is Kaldor-Hicks inefficient nor that it is not conducive to an optimal membership size.

In order to test the efficiency of the regime on these latter two measures, I applied the results of the price elasticity estimates to a model of a medical scheme.

I created a hypothetical scheme that consists of the entire membership of the industry (and is therefore a monopoly). Each and every individual in this scheme is a principal member. The claims vary with age in the same manner as a PMB package of benefits. I have also added an arbitrary allowance for non-healthcare expenses of R70 per month. The community rate premium is equal to the average claims. I will refer to this situation as State 1. I tested the effects of uniform arbitrary premium reductions on the scheme-a premium reduction will send the scheme into another state, State 2. A premium reduction will have two effects. The obvious one is a fall in average contributions. A second effect is a change in average claims as the demographic profile will most likely change as a result. It is not unreasonable for this change to be greater at the younger ages, given that the price elasticity (as defined in this paper) is higher at the lower ages. The test result is positive if the percentage decrease in the average claims is greater than the percentage reduction in contributions, because that means that this change would be unlikely to adversely affect the underwriting position of the scheme.

State 2 will therefore be more efficient than State 1. It can be shown mathematically that a set of premiums that increase with age, and that all lie below the original premium level, and give rise to a better underwriting result than State 2 must exist. This state, State 3 meets the Kaldor-Hicks criterion as no one's premiums are above the original premiums in State 1 and the membership of the scheme is greater. Moreover, because the underwriting position is no worse, this is an equilibrium state. The results of various test reductions are tabulated below.

TABLE 2

	Change in average claims
Premium reduction	
10%	3%
20%	10%
30%	14%

These test results indicate that it is unlikely that a uniform premium reduction would result in greater efficiency.

However, this is a severe test. A less severe test is for the premium reductions that take the scheme into State 2 to be confined to those below an arbitrary age. That way we can ensure that the number of lives does not increase at the higher ages. We can thus enhance the positive impact on the age profile. I chose a cut-off age of 40. The results are tabulated below.

TABLE 3

	Change in average premium	Change in average claims
Premium reduction		
10%	6.5%	7%
20%	13.0%	18%
30%	19.5%	22%

This test meets the Kaldor-Hicks criterion. The test is satisfied because, over the age range ang premium range over which the reductions are simulated, the aggregate value (on the conventional definition) has a magnitude greater than

one. Premiums that increase with age up to the current community rate will not result in an underwriting loss. This change will therefore be Kaldor-Hicks efficient with respect to the community rate regime.

However, such a premium structure willl not be an equilibrium state unless it is enforced by legislation. In a free market the only equilibrium state of affairs is one in which each age group is charged a premium that corresponds to the expected value of their average claims.

10. Interpretation of results

We have already demonstrated in Section 8 that community rating is economically sub-optimal, irrespective of the price elasticity of the demand for medical insurance. Based on the elasticity estimates obtained in this paper, it is likely (though far from certain) that there exists a set of age-related premiums that result in greater Kaldor-Hicks economic efficiency than the existing community rated set.

However, the actual extent to which younger members will respond to premium reductions may be less than is suggested by the elasticity estimates. I say this for several reasons:

The shortcomings of the data used for the estimation are highlighted in Section 7 of this paper. These defects cast serious doubts on the values of these estimates. However, similar studies as laid out in Section 5, seem to be in general agreement with these values. Reasonable doubt is also cast on the results by the possibility that medical scheme membership may already be above its "natural" level due to the fact that many employment contracts compel enrolment.

Income has also not been taken into account in the determination of the elasticity estimates. Unemployment, which is particularly acute at the lower ages, means many individuals may be immune to premium reductions.

However, we have only considered the demographic profile with respect to age only. State of health is the more relevant variable of interest and age is merely its proxy. At any given age it is not unreasonable to expect that demand for medical insurance is stronger amongst the less healthy individuals. One can therefore expect that premium reductions will result in lower average claims at each age. Were we to use this variable instead of age, we would almost certainly get stronger confirmation of the economic inefficiency of community rating. Secondly we have only considered elasticity relating to the decision to enrol. Premium reductions will also result in healthier lives that are already members of medical schemes purchasing greater cover, and thereby contributing more to the underwriting bottom line.

Given the fact that the question of whether or not the community rate regime is Kaldor-Hicks efficient has not been answered conclusively, I would be hesitant to argue for a return to an age-rating regime. I however, regard the evidence as conclusive enough to serve as a note of caution against the adoption of community rating in countries in which it does not already exist. The results also serve as a cautionary note against entrenchment of community rating. At the moment we are faced with draft legislation that aims to extend community rating to children's premiums. This may make everyone worse off, or at the very least, benefit a few at the expense of many.

11. Philosophical Case Against Community Rating

The case for community rating is a normative rather than a positive one. Although this paper fails to determine conclusively whether or not such a pricing regime is Pareto optimal it does demonstrate that it is not economically efficient in the classical sense. This situation should then put the onus on the proponents of community rating to demonstrate that there are normative considerations that outweigh this shortcoming. These proponents argue that premium rating is socially inequitable because it results in some people being treated more favourably than others. It is difficult to dismiss these arguments lightly, moreso because those who will typically pay the highest premiums in a premium-rated environment happen to be the very individuals society looks upon as vulnerable.

What these advocates lose sight of is that the only reason that some individuals are charged higher premiums is that they are, in effect, buying larger quantities of these goods. I have no objection to the concept of subsidies for certain sections of society in respect of certain goods. Where I differ with the proponents of community rating in its current form is the basis of subsidies, i.e. who is subsidised by whom and in relation to which goods? I am in agreement that healthcare is an essential good and is as deserving of State intervention to ensure that no one goes without as is food and shelter. But I contend that age is an inappropriate criterion by which to select who gets the subsidies.

The second aspect of the basis of subsidies that I disagree with is the criterion used to determine who pays these subsidies. The current basis of community rating has had the unintended effect of some young low-income earners being required to subsidise the medical costs of some wealthy pensioners. One must not be misled by the fact that a cursory examination of the medical schemes data may not indicate that pensioners may have higher incomes than the employed. The fact of the matter is that pensioners are often not burdened by the costs of mortgages, children's education and general upkeep, transport costs to work etc. Secondly, whatever the relationship between average incomes and age is, there are still numerous individual cases of low earning young medical scheme members and wealthy pensioners on medical schemes. Thirdly the vast majority of young low income earners, and even those who are considered middle income, are simply missing from medical scheme membership rolls because, given their other commitments, medical scheme membership has high opportunity costs for them. Finally, pensioners on medical schemes are typically already in receipt of a medical insurance premium subsidy from their former employers. In contrast, employers have in recent years started to shift to a "cost-to-company" remuneration basis. This means that the typical pensioner may already be facing a lower price for his benefits than those of working age.

Should society feel that age based premium rating is not consistent with its values then these subsidies must be met by society as a whole. The entire burden cannot be imposed on those who choose to purchase medical insurance.

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