

## **Risk Selection by Private Health Insurers: Why Regulation Alone Cannot Solve the Problem**, by Timothy Stoltzfus Jost, [jostt@wlu.edu](mailto:jostt@wlu.edu)

### **Facts:**

- Five percent of the population accounts for fifty percent of health care costs and ten percent for seventy percent
- Health insurers avoid people with costly conditions to maximize their profits.
- People with complex conditions are hard-pressed to buy insurance in the individual and small group markets that protects them financially against the high cost of health care.

**Solution:** A health insurance market that both regulates private insurers and offers a public health insurance option to guarantee quality affordable health care to people with complex conditions

### **Regulations alone cannot create a functioning health insurance market**

- Even if insurers must cover everyone, without regard to pre-existing conditions, and charge everyone a community rate, insurers can still charge excessive premiums and attract low risk and discourage high risk enrollees.
- Without a legally defined benefit and cost-sharing package, variations in plan design will lead to risk selection
- Unless marketing is prohibited, insurers can market directly to the healthy individuals and incentivize brokers and agents to avoid selling policies to high-risk individuals.
- So long as insurers can limit their network providers, insurers can make their doctors and hospital networks unattractive to people with costly conditions.
- Unless insurers are not allowed to deny or delay care to people with costly conditions, they can make it difficult for doctors to provide needed care and referrals, encouraging patients to disenroll from their plans.
- Unless government has adequate resources to investigate and prosecute insurers where appropriate, insurers can easily violate complex underwriting regulations.
- **Conclusion:** Reasonable market regulation that leaves room for plan competition cannot eliminate risk selection.

### **Beyond regulation, how can the government address risk selection issues?**

- Ex ante risk adjustment and ex post risk pooling cannot solve the problem of risk selection completely. They require extensive data collection, and can be manipulated by insurer “upcoding.” Ex ante risk adjustment has rarely succeeded in encouraging private insurers to compete for enrollees with costly conditions. Ex post risk pooling has the advantage of relying on actual data, but it may reward high-cost plans that are inefficient rather than plans that are driving value.
- High-risk pools and public reinsurance can also allow private plans to avoid high-risk individuals and encourage them to behave inefficiently, reining in costs and discouraging inappropriate use of services.

**A public health insurance option coupled with regulation and risk adjustment can ensure everyone equitable access to good affordable, efficiently-financed, health care.**

## **Risk Selection by Private Health Insurers: Why Regulation Alone Cannot Solve the Problem**

Timothy Stoltzfus Jost

One approach to health care reform that is currently receiving a great deal of attention would be to impose an individual mandate to force Americans to buy private health insurance, and then to rely on competition among private health insurers to bring down health care costs and to make insurance more affordable. The most substantial problem that must be surmounted in any health care financing system built on competition among private insurers is how to deal with risk selection. It is a well known fact that in any given year, a very small proportion of the population accounts for a very large percentage of health care costs.<sup>1</sup> The most profitable strategy, therefore, for a health insurer in the individual or small group market is to refuse to insure very high cost applicants; to calibrate premiums to match the risk of other applicants (higher premiums for higher risks, lower premiums for lower risks); and to use pre-existing conditions clauses, policy exclusions, and even post-claims underwriting to back up underwriting requirements and limit insurer risk.<sup>2</sup> While risk selection is profitable for insurers, however, it makes health care less accessible to those who need it most and makes a solidarity-based sharing of risk broadly across the population impossible. Risk selection, moreover, can result in the chronically ill and others with high medical needs receiving poorer quality care and poorer service. Finally, risk selection represents a deadweight welfare loss for society since it results in insurers devoting significant resources towards a zero sum game that does nothing to benefit society, and certainly nothing to improve access to health care or lower its cost.<sup>3</sup>

One of the most common responses to insurer risk selection is regulation. Insurers can be required to guarantee issue and renewal of their policies to any person who wishes to purchase them. Guaranteed issue and renewal requirements are imposed in the small group market by the federal Health Insurance Portability and Accountability Act (which also requires guaranteed renewal in the individual market) and by all states.<sup>4</sup> Premium disparity between high and low risk individuals and groups can be limited by “rate bands,” which, for example, limit the highest rates an insurer may charge to twice the rates charged to healthier insureds.<sup>5</sup> Some jurisdictions go further and require community rating, i.e. charging all applicants the same rates, or modified community rating, allowing rate variation based only on age or geographic location, for example. New York permits variation in small group premiums based only on geography and whether the policy is for an individual or family. Jurisdictions can also limit or ban preexisting conditions clauses (as HIPAA does for group policies), and try to prohibit post-claims underwriting, under which insurers retroactively deny coverage once an insured files high cost claims based on renewed scrutiny of flaws in the application process. Regulation of insurer risk selection practices is ubiquitous in the small group market in the United States, and has been applied by a number of states to the individual market as well.<sup>6</sup>

## Regulation Prohibiting Risk Selection Does Not Eliminate Risk Selection

Simply prohibiting risk selection through regulation, however, does not by any means end it. Insurers have a variety of tools available to continue to risk select even if explicit risk underwriting is prohibited.<sup>7</sup> First, as long as any variation is permitted in insurance products, differences in insurance products can be used for risk selection. Benefit packages can be designed, for example, to attract good risks (including athletic club memberships or running shoes, for example) or to deter bad (by, for example, limiting benefits or excluding coverage for chronic diseases such as mental illness). Insurer advertising can also target low risk groups, attracting the young and healthy for example. Insurers can offer policies with high cost sharing and “consumer-driven” account based products, which are likely to attract good risks and to be unattractive to bad risks.<sup>8</sup> Rate regulation usually considers only rate variation with respect to a particular product, but premiums can vary dramatically between policies offering slightly different cost-sharing or benefit packages as members sort themselves out (or are sorted out by agents) depending on their perceived need for coverage.<sup>9</sup> Insurers can also use their provider networks for risk selection, offering, for example, outstanding sports medicine providers but limited diabetes care resources.<sup>10</sup> Even under strict community rating, insurers are still allowed to vary their premiums based on the nature of the product they sell, thus insurers can steer higher risk enrollees toward higher cost products that offer marginally more benefits or less cost-sharing.<sup>11</sup>

## Private Plans Market to the Healthy

Marketing strategies can also assist in risk selection. Insurers may offer favorable group rates to faux associations, formed solely to attract good risks. There is evidence in the United States of the formation of “air breather” associations (associations that are open to anyone who breaths air, and is a good risk) to siphon off good risks from regulated markets, and of subsequent wild swings in rates as these associations attract poorer risks as well.<sup>12</sup> In the Netherlands, where insurers are allowed to offer a discount of up to ten percent to group plans, group rates have apparently been used to attract low risk groups and not been offered to groups offering worse risks.<sup>13</sup> In Switzerland, where risk underwriting is prohibited, health insurers, who must by law be nonprofit, are often linked with for-profit companies that sell other insurance products that can be underwritten, such as supplemental health insurance.<sup>14</sup> These products can be linked with health insurance products and offered at favorable rates to good risks. In the United States, insurance agents have been used to attract good risks and stave off bad risks, so-called “field underwriting.”<sup>15</sup> Insurers have manipulated commissions to discourage certain kinds of high risk policies or to give incentives to agents who steer good risks to the insurer.<sup>16</sup> In Australia (another jurisdiction in which health insurance is community rated), insurers have reportedly opened offices on the second floor of buildings without elevators to discourage the physically challenged.

## Private Plans Encourage People with Costly Conditions to Disenroll

Disenrolling high cost insureds can be even more beneficial to the bottom line than enrolling low risk insureds (a practice known as “lemon dropping” in contrast to the other primary insurance risk selection practice, “cherry picking”).<sup>17</sup> Rigorous utilization review and poor service can encourage high cost enrollees to seek coverage elsewhere.<sup>18</sup> In jurisdictions where reissue of a policy must be guaranteed, insurers can discontinue a particular policy (a “closed block of business”), leaving high risks in the closed pool but selectively offering low risk insureds in the pool access to other plans.<sup>19</sup> As the experience of the vestigial plan deteriorates, the insurer raises rates until those remaining in the plan abandon it (or pay something close to their actuarial cost).

### Regulators often Lack the Resources to Oversee Compliance by Private Plans

Finally, just because a regulation exists on the books does not mean that it is effective. Regulators commonly simply require the chief actuary of an insurer to certify compliance with rating requirements and do not look behind the certification.<sup>20</sup> Alternatively, the regulator may require insurers to file rates or policies. If insurers are allowed to vary their rates based on the benefit package, cost-sharing, provider networks, age, or geography, a regulator may be dealing with dozens of rate packages from one insurer. Regulators often lack the resources to determine whether rate variation is in fact legitimate. Increasingly, moreover, regulators rely on complaints to identify noncompliance, but rarely would an applicant know that the rate it was offered was illegally high.<sup>21</sup> Even if a regulator suspects that an insurer is violating risk underwriting rules, the regulator may lack the enforcement resources or tools to go after the insurer. A regulator, for example, that has no enforcement response other than license revocation may well be powerless in the face of suspected minor manipulation of rates, as may a regulator who must convince an overworked attorney general’s office that an insurer’s violation of a regulation is serious enough to warrant the dedication of scarce legal resources.

### Incentives for Health Plans to Serve People with Costly Conditions

If regulation does not stop risk selection, how can it be addressed? One solution is ex ante risk adjustment of premiums to reward insurers who accept high risk enrollees.<sup>22</sup> Another is ex post risk pooling among insurers to require insurers that attracted lower risk insureds to compensate insurers who ended up with higher risk insureds. Yet another strategy is public reinsurance to compensate all insurers for particularly high cost cases. A fourth is high risk pools, which provide public insurance for persons who are so high risk that they cannot find insurance in the private market.

### Risk Adjustment is Difficult, and Easy to Game

Risk adjustment of premiums usually requires premiums to be collected by a central fund, which then pays them out to insurers after adjusting for the risk of individual insureds, and perhaps adding public subsidies. Premiums for Medicare Advantage plans and Part D prescription drug plans, for example, are risk adjusted. Premiums in the Netherlands and Switzerland are also risk adjusted. If risk adjustment is dramatic enough, it can even turn the

tables on which applicants are most attractive to an insurer. But risk adjustment is only effective to the extent it is accurate, or at least as accurate as the insurer's estimation of risk. For example, simply adjusting for age and gender, as Switzerland has traditionally done, is not enough to discourage risk selection.<sup>23</sup> If risk adjustment adjusts only for certain risk factor, it may encourage gaming by insurers who focus on the particular conditions for which rates are adjusted. Risk adjustment can be undermined by "upcoding" by insurers to make their insured population seem higher risk than it actually is, as has apparently occurred in the Medicare Advantage program.<sup>24</sup> Further, risk adjustment formulae may become outdated as newer technologies emerge for treatment of particular conditions that are more or less expensive than prior technologies. Moreover, it is unlikely that premiums can ever be adjusted sufficiently to make the highest risk patients attractive. Finally, risk adjustment depends on the extensive collection of data, which could be quite burdensome to the authority charged with risk adjusting and to insurers.<sup>25</sup>

### Risk Pooling is Also Problematic

Ex post risk pooling by insurers is also a common approach to even out risk among insurers. Seven American states have provision for mandatory reinsurance programs among health insurers in the small group market, while nineteen states have voluntary programs.<sup>26</sup> The Netherlands and Germany have ex post risk pooling arrangements for insurers.<sup>27</sup> Ex post risk pooling has the advantage over ex ante premium adjustment that it is possible to adjust payments based on the actual experience of health insurers. It is problematic, however, to the extent that it risks rewarding insurers that experience high costs because they are administratively inefficient or because they do a poor job of controlling utilization and prices.<sup>28</sup>

Thirty-five states have established high risk pools to insure individuals who are otherwise uninsurable.<sup>29</sup> Risk pools make insurer risk selection more acceptable because they provide access to insurance for some individuals whom insurers turn down. On the other hand, eligible applicants usually have to pay high rates for risk pool coverage, often up to 150 to 200 percent of a standard insurance premium, making coverage unaffordable to many who do not qualify for private insurance. In most states, risk pools have remained quite small, only six states have over 10,000 members.<sup>30</sup> High risk pools, moreover, may actually facilitate risk selection by insurers to the extent that they make it less problematic. They effectively provide public subsidies for private insurer cherry picking. They also do nothing for people who develop costly conditions while already insured in a regular insurance plan.

Finally, public reinsurance of high cost cases can reduce incentives to risk select.<sup>31</sup> The Medicare Part D program assumes 80% of the risk for drug expenses exceeding \$6154 in total drug costs in 2009. New York also offers reinsurance for high cost cases in the small group market. Reinsurance should make high cost enrollees more acceptable to insurers, and also reduce the costs of insurers who would otherwise have to protect themselves against high cost cases. But if the government is going to invest tax dollars in health insurance, one must ask whether backstopping private insurers is the most efficient way to do it, particularly since reinsurance not only decreases the incentives insurers face to take high risk cases, but also decreases their incentives to control health care utilization and cost and operate efficiently.

In sum, there is no perfect solution to the problem of risk selection. Regulatory interventions that require guaranteed issue and renewal, limit the spread of premiums, or limit preexisting conditions clauses are one part of the answer, but certainly not the whole answer. Risk adjustment of premiums and risk pooling by insurers and possibly public reinsurance can also help, but each approach is only partial and several create perverse incentives.

#### Public Health Insurance Option Helps Ensure Equitable and Affordable Access to Health Care

One final approach to the problem must be considered, therefore. A public health insurance plan would provide an alternative source of coverage for people who could not find acceptable coverage under a private plan. Indeed, it is likely that if a public plan were created, it would inevitably have a worse risk pool than private plans, just as traditional Medicare does now compared to Medicare Advantage plans, or like the Blue plans traditionally have had when compared to commercial insurers. This tendency should be resisted to the extent possible—private plans should still be required to guarantee issue and to limit risk underwriting—because a public plan should not exist simply to subsidize risk selection by private insurers. A public plan would not be a tenable alternative if it truly became simply a high risk pool. But it must be recognized that even if underwriting is regulated closely the public plan will still be less able to defend itself against high risks than will private plans. Moreover, it should not defend itself against high risks. One of the primary reasons for the existence of a public plan is to assure that all have access to real insurance, that protects them from financial risk no matter what their health care needs.

Two further steps, however, would help protect the public plan. First, there needs to be either ex ante risk adjustment of premiums or ex post risk pooling by insurers. If this is done right, it will inevitably result in the public plan receiving higher subsidies than private plans because the public plan will attract worse risks. If the public plan receives subsidies in this way, it will inevitably be claimed that the playing field is not level, that the public plan is receiving unfair subsidies. This argument must be rejected, as the subsidies are merely intended to level the playing field made unlevel by private plan risk selection.

Second, if there is an individual mandate, a possibility to consider would be to assign persons who are required to purchase insurance but fail to do so to the public plan. It is not clear that this strategy would in fact help, as the uninsured tend to be less healthy than the insured.<sup>32</sup> It is likely that higher risk persons would be more likely to actively seek out insurance once subsidies made it affordable, while those left to default assignment would probably be those less in need of insurance. Using the public plan as a repository for those who did not otherwise choose a plan might go some distance toward leveling the playing field between the public plan and private insurers.

In conclusion, it must not be assumed that simple regulation of private health insurance will make quality affordable health care available to all Americans.. A public plan is needed to assure equitable and affordable access to health care.

## Notes

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1. Marc L. Berk & Alan C. Monheit, The Concentration of Health Care Expenditures Revisited, *Health Aff.* 20(2), 2001: 9, 12.
  2. Risk selection is less of an issue in the large group market since groups assembled for employment purposes usually are large enough to present an acceptable risk pool to insurers.
  3. Wynand P.M.M. van de Ven et al., Risk Adjustment and Risk Selection in Europe: 6 Years Later, *Health Policy* 83, 2001: 162.
  4. Susan Laudicina, Joan Gardner & Angela Crawford, State Legislative Health Care and Insurance Issues, 2008 Survey of Plans (Washington, D.C.: Blue Cross and Blue Shield Association, 2008), 57.
  5. See, exploring the complex issues involved in rate regulation, Mark Hall, The Structure and Enforcement of Health Insurance Rating Reforms, *Inquiry* 37, 2000/2001: 376.
  6. See on small group market regulatory reforms and their effects, Kosali I. Simon, What Have we Learned from Research on Small-Group Insurance Reforms, in Alan C. Monheit & Joel C. Cantor, eds, *State Health Insurance Market Reform: Toward Inclusive and Sustainable Markets* (New York, N.Y.:Routledge, 2004), 21-45 (finding regulatory reforms had little effect on the extent of insurance or on the availability of insurance offers, and either increased price or had little effect of it); and on individual market regulatory reforms, Deborah Chollet, What Have we Learned from Research on Individual Market Reform?, in Monheit and Cantor, *supra*, 46 (evidence is inconsistent on effects of individual market reform). See also on individual market reforms, Beth Fuchs, Expanding the Individual Health Insurance Market: Lessons from the State Reforms of the 1990s (Robert Wood Johnson Synthesis Project, 2004) (finding increased average premiums and access for high risk applicants following individual market reforms).
  7. These tools are comprehensively described in Wynand P.M.M. van de Ven, et al., Risk Adjustment and Risk Selection on the Sickness Fund Insurance Market in Five European Countries, *Health Policy* 65, 2003: 75, 91-92.
  8. See Milliman, Inc., Consumer-Driven Health Care Impact Study (2008) (finding that consumer-driven plans attract a significantly more healthy population than traditional plans).
  9. One study found that insurers in the New Jersey individual market in 1999 charged \$3,312 more per year for single coverage with a \$500 deductible than for a policy with a \$1000 deductible, i.e. the difference in premiums was six times the difference in benefits. Mark Hall, Elliott Wicks & Janice Lawlor, HealthMarts, HIPCs, MEWAs and AHPs: A Guide for the Perplexed, *Health Aff.* 20(1), 2001: 142, 148.
  10. Wynand P.M.M. van de Ven, Access to Coverage for High-Risks in a Competitive Individual Health Insurance Market: via Premium Rate Restrictions or Risk-Adjusted Premium Subsidies?

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J. Health Econ. 19, 2001: 311, 321.

11. “Standard” or “basic” policies required by state law have, it is believed, become dumping grounds for high risk applicants in some states. Chollet, *supra* at 52.

12. Hall, Wicks & Lawlor, *supra* at 150. Indeed, the usual regulatory division between individual, small group and large group plans creates the possibility of a wide variety of strategies, such as group trusts, self-insured small groups, and list billing to avoid underwriting and rate regulations and support risk selection. See Mark Hall, The Geography of Health Insurance Regulation, *Health Aff.* 19(2),2000: 173.

13. Van de Ven, Risk Adjustment, 6 Years Later, at 169.

14. See van de Ven, Risk Adjustment, *supra* at 91-92. This strategy is also possible in the Netherlands.

15. Mark Hall, The Competitive Impact of Small Group Health Insurance Reform Laws, *U. of Mich. J. L. Rev.* 32, 1999:685, 724-25

16. Mark Hall, The Role of Independent Agents in the Success of Health Insurance Market Reform, *Milbank Quarterly* 78(1), 2000: 23.

17. See Karen Pollitz, Private Health Insurance Market Regulation, Testimony before Senate Finance Committee (June 16, 2008).

18. Van de Ven, Access, *supra* at 319.

19. Chollett, *supra* at 51-52.

20. Len M. Nichols, Improving State Insurance Market Reform: What’s Left to Try? in Monheit & Cantor, *supra* at 134, 137.

21. Nichols, *supra* at 137.

22. See, discussing risk adjustment strategies and technology, Joseph P. Newhouse, *Pricing the Priceless* (Cambridge, Ma.: MIT Press, 2002).

23. van de Ven, et al., Risk Adjustment, 6 Years Later, *supra* at 170.

24. January Angeles & Edwin Park, “Upcoding” Problem Exacerbates Overpayments to Medicare Advantage Plans (Washington, D.C.: Center on Budget and Policy Priorities, 2009).

25. M. Susan Marquis, How can Reform Work Better, in Monheit and Cantor, *supra*, at 123, 125.

26. Laudicina, Gardner & Crawford, *supra* at 57, 59

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27. van de Ven et al., et al., Risk Adjustment 6 Years Later, *supra*.

28. Edmund Haislmaier, *State Health Care Reform: A Brief Guide to Risk Adjustment in Consumer-Driven Health Insurance Markets* (Washington, D.C.: Heritage Foundation, 2008).

29. Laudner, Gardner & Crawford, at 68.

30. *Id.*

31. See Kathryn Swartz, *Reinsuring Health: Why More Middle-Class People Are Uninsured and What Government Can Do* (New York, N.Y.: Russell Sage Foundation Press, 2006).

32. Kaiser Family Foundation, *Key Facts About Americans Without Health Insurance* (Washington, D.C.: KFF, 2008), 25.