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Economic and Social Research Institute

# Issues in Coverage Expansion Design

## Coping with Risk Segmentation: Challenges and Policy Options

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A factor that complicates almost all proposals to extend health insurance coverage is how to cope with risk segmentation in the small-group and individual insurance markets. Experience in these markets shows that if market forces are left to operate unfettered, people seeking private health insurance will be segregated into small risk pools that reflect their expected risk of incurring medical expenses and charged premiums accordingly. Premiums will vary widely across the spectrum of expected risk, and risk will not be widely shared. These are problems that generally do not plague large employers, because they are large enough to form their own risk pools and self-insure; that is, costs are sufficiently spread among higher-risk and lower-risk employees within the group. So the discussion that follows applies to health insurance for small employers and individuals buying coverage on their own.

Risk segmentation and the consequent wide variation in premiums create at least two kinds of problems.

First, some high-risk people are not able to afford coverage. Second, the wide premium spread requires some people to pay much more than others for identical coverage, which many would consider inequitable. Both of these points will be discussed in more detail later, but to clarify the problem it is useful to begin with a discussion of the purpose of insurance.

### Health Insurance and Sharing Risk

The purpose of health insurance is to protect people from the financial burden of incurring a large, *unpredictable* medical expense. Because of the unpredictability and size of the possible loss, people cannot easily budget for such costs by regularly setting aside a specific amount. So they need insurance protection. They acquire this protection by sharing risk; that is, they trade off the certainty of incurring a small cost—the insurance premium—to eliminate the uncertainty of incurring a larger unpredictable cost—having to pay for a major

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medical event. This risk sharing is possible since medical events that are unpredictable for individuals are predictable for large groups because of the law of large numbers. Actuaries can predict with reasonable accuracy the amount of medical expenses that a large group of people will incur even though they cannot predict which individuals in the group will incur those expenses. This information is used to determine the average cost and the average premium, which everyone in the group then pays. The result is that those who incur large (insured) losses in a period are subsidized by those who incur low or no expenses.<sup>1</sup>

But risk of future losses is not equal for all people. Certain characteristics of individuals—age, health status, previous medical experience, and type of work, for example—can be used to predict the likelihood that an individual or a subgroup of the population will incur high medical expenses. Low-risk people can take advantage of this capacity to measure risk differences by separating themselves out and pooling risk only among themselves. Their average medical expenses and thus their premiums will be lower if they exclude higher-risk people. The potential rewards for finding ways to distinguish low risks from high risks are great. As a rule of thumb, in a typical population group, 10 percent of the population accounts for about 70 percent of the medical costs in a year.<sup>2</sup> That

<sup>1</sup> Of course, current health insurance covers more than the cost of large, unpredictable losses. It also covers relatively small, relatively predictable expenses—office visits, routine lab tests, routine prescription drugs, etc. Because people could budget for these costs, when they buy coverage for them, they are really *prepaying* these expenses rather than insuring against them.

<sup>2</sup> Marc L. Berk and Alan C. Monheit, "The Concentration of Health Care Expenditures, Revisited," *Health Affairs*, Vol. 20, No. 2, March/April 2001. However, this information does not tell about the variation in expected or predictable expenses, which is probably less.

means that successfully identifying and excluding only 5 of the 10 very high-risk people out of each 100 applying for insurance would produce savings of about 35 percent of medical expenses!

Of course, no risk assessment process can identify all—perhaps not even most—of the people who will incur very high costs, because many catastrophic medical events are random, that is, not related to characteristics of the individual. Moreover, some people who are low risk in one year will become high risk in another.

Although individuals would have a hard time identifying other lower-risk individuals to make up a risk pool, they will reward insurers for doing it for them. And insurers have a strong incentive to do so because if they are more skilled at it than their competitors, their medical claims and thus their premiums will be lower, and they will be able to attract additional low-risk customers and gain market share. This process of seeking to identify and attract low-risk people and to identify and exclude high-risk people is risk selection. In a market without rules to prevent risk selection, the result could be an extensive segmentation of insured people into differentially rated small groups, each with slightly different levels of expected risk. Insurers have an incentive to develop ever more discrete groups of varying risk because they can then offer a slightly lower premium to the new low-risk group and thereby attract customers away from other insurers.<sup>3</sup> They will continue the process so long as the benefits of risk segmentation exceed the cost of distinguishing risk differences among

<sup>3</sup> This kind of risk selection—separate groupings of people on the basis of expected risk—occurs in other kinds of insurance, for example, auto insurance or life insurance. We seem to view this as less of a problem (although some forms of risk rating are prohibited for even these types of insurance).

groups. The more skilled insurers get at selecting risks and dividing a population into separate risk pools, the more the sharing of risk is diluted, that is, the less the transfer from those who incur low medical expenses to those who incur high medical expenses.

Once a significant number of insurers begin to risk select, others must adopt similar policies. Otherwise, they will be left with only the higher-risk people, their rates will be forced ever upward, and they will lose enrollment. To avoid becoming a victim of this “death spiral” of adverse selection, no insurer operating in a competitive situation can singly decide not to practice risk selection.

## Problems Resulting from Risk Selection

From a public interest perspective there are several problems with letting the market produce this kind of risk segmentation. In essence, the problem is that risk is not broadly shared. The risk pools become small, and the variation in premiums becomes very large. One undesirable result is that insurance becomes unaffordable for some higher-risk people. These are people who could afford to pay premiums for the coverage that the person of average risk pays, but they cannot afford the premium that is necessary to cover people in their high-risk group. At the extremes, they become the so-called uninsurable. (They are uninsurable only in the sense that they cannot afford the premiums that would cover their risk; or to put it more objectively in strict economic terms, given their income, desire for other goods and services, and tolerance for risk, they make the decision to bear the risk rather than paying the cost of protecting themselves against the risk.) If as a society we think everyone should have health coverage—perhaps especially those who are most likely to need expensive

medical care—a system which prices high-risk people out of the market is a problem.

Many people would argue that extensive risk segmentation is also a problem because it is inequitable: people have the good fortune to be charged low premiums or the bad fortune to be charged high premiums based on individual (or group) characteristics over which, in most respects, they have little or no control. When market forces are allowed to freely operate, the result is a redistribution of income (after insurance premiums) away from those with higher risks to those with lower risks.<sup>4</sup> This contrasts with most goods and services that people buy other than insurance; the price does not usually vary much according to the person’s characteristics. For most goods and services, prices are “community rated”—everyone in the community pays approximately the same price, and the price is not dependent on the nature of the person doing the buying.<sup>5</sup>

Policies to cope with risk segmentation are motivated primarily by a desire to protect consumers. But risk segmentation, resulting not from intentional risk selection but from other factors, can be a problem for insurers as well. Even if there were legal prohibitions that prevented all forms of intentional risk selection, some insurers could easily end up with more higher-risk enrollees than others if people’s choice of insurers is not

<sup>4</sup> The same could be said for any kind of insurance where market forces are allowed to set rates based on risk differences. But in the case of auto and fire insurance (but not life insurance), people have a large measure of control over how much they pay because of the choices they make regarding their driving habits and the protections they provide to ensure that their house is not damaged by fire or other insurable occurrence.

<sup>5</sup> It could be argued that high-risk and low-risk people are buying different products, since the average high-risk individual will use more medical services than the average low-risk person. According to this line of reasoning, a risk-based price differential is justifiable.

completely random. Evidence shows, for example, that people with existing health conditions (which add to treatment costs) are more likely to maintain enrollment in health plans that offer few restrictions on choice of providers. To use another example, an HMO might have a reputation for providing high-quality care for people with certain high-cost chronic conditions. As a result, it might attract a disproportionate number of people with these conditions, who would be more expensive to care for than the people enrolled by other competitor insurers who serve a lower-risk population. The HMO would be forced to set its premiums at a higher rate, which would make it even harder to attract lower-risk populations. The HMO would be put at a competitive disadvantage for doing what is socially desirable.

Through no fault of their own, health plans that consistently attract less healthy enrollees will not be able to survive in a competitive market. To preserve fair competition may require some method for offsetting plan-to-plan differences in risk of enrolled populations. Further, if there is no policy in place to limit or offset risk segmentation, plans will have strong incentives to compete on the basis of risk selection rather than by improving efficiency or service. Because the rewards for identifying and excluding very high-risk people are so high, as noted above, it will almost always be easier to save money and gain a competitive advantage through risk selection (where allowed) than by being more efficient or improving quality.

Policies to cope with risk selection, then, need to consider both how to protect higher-risk insured people and how to insulate insurers from adverse risk selection.

One key challenge of dealing with risk segmentation is deciding how broadly to spread risk. Few would argue that it would be desirable to have no constraints on the extent of

risk selection. On the other hand, many object to the idea of an equal sharing of risk among the entire population.

## Alternative Ways to Deal with Risk Selection

In the most general terms, there are two ways to deal with risk selection—prevent it from occurring in the first place, or allow it but offset its effects.

### *Prevent Risk Selection*

Risk selection reduces risk sharing. So all strategies to cope with risk selection involve moving toward greater risk sharing, that is, toward increasing the extent to which people of lower risk subsidize people of higher risk. The prevention approach accomplishes this in a before-the-fact way: at the time insurance is being purchased, the cost for low-risk and high-risk people is equalized, if not completely, at least to a greater degree than would occur if the market were allowed to operate without any intervention. Higher-risk groups pay lower premiums than they otherwise would, and lower-risk people pay higher premiums. This result can be achieved in a number of ways.<sup>6</sup>

### *Approach 1: Require insurers, in setting premiums, to community rate everyone.*

This approach involves regulating the individual or small-group insurance market to prohibit (or at least limit) variation in rates based on health status, claims experience, or, at the extreme, any characteristic of the enrollees. In setting their rates, insurers are required to charge everyone in the community the same (or close to the

### **An Alternate View**

Some analysts would take issue with the way the problem of risk segmentation is outlined here. They do not see substantial risk rating as necessarily undesirable, especially compared to community rating. They would argue that rather than trying to prevent risk rating, it is desirable to let the market work, perhaps within some modest constraints. They doubt that there will be destructive risk segmentation and a “death spiral” of adverse selection if risk rating is not regulated. In equilibrium, insurers will all have different premium rates for groups based on their risk characteristics, and insurers will all compete for low-risk *and* high-risk enrollees. If the risk variation makes coverage unaffordable for some higher-risk, low-income people, the preferable way to deal with that is to subsidize these people directly so that they can afford the risk-rated coverage (one of the alternatives discussed later in this paper). The commonly proposed alternative, some form of community rating, is inefficient, according to this view. By increasing the price for low-risk people, it discourages them from buying as much coverage as they really would prefer—and would buy—if their price were not artificially raised. They have to pay more than the resource cost of providing them with coverage, which is, in the terms of economic theory, an inefficient result.

same) rate regardless of risk. (Of course, rates will still vary from insurer to insurer.) New York State, for example, has used essentially “pure” community rating in both the individual and small-group markets, where the only factor insurers can use to vary rates is geographic location (different rates for different “communities”). Most states that have adopted rating reforms have done so for just the small-group market, and they have adopted some form of “adjusted” community rating, meaning that they have permitted the use of some rating factors but frequently not health status or previous medical experience. Age is always an allowable factor in these states, and many also permit rating based on geographic location and gender. But adjusted community rating regulations normally limit the amount of variation permitted even for the allowable factors. Maryland, for example, allows use of age and geographic location, but allows the total variation to be no more than  $\pm 40$  percent (a ratio of 2.3:1 between the highest and lowest premium).

Although pure community rating produces broader risk sharing than adjusted community rating, the concern is that it could cause some lower-risk people to drop insurance coverage when the purchase of coverage is voluntary, not mandatory. The purpose of moving to community rating is to make coverage more affordable for higher-risk individuals or groups, but their inclusion in the group will necessarily cause total medical costs for the insured community to be somewhat higher than they would otherwise be. The consequent increase in premiums could cause some low-risk people to drop coverage, which would elicit further rate increases and might set off round after round of departures by low-risk people and resulting premium increases. Adjusted community rating, since it allows some rating on the basis of risk differences, moderates the premium increase for low-risk people and thus lessens the chance that they will choose to go without coverage. Most analysts agree that in a voluntary market, where people have the option of dropping coverage, community

<sup>6</sup> Policies to deal with risk selection are usually not targeted to health coverage provided by large employers. As noted earlier, such employers are generally agreed to be large enough to form their own risk pools; that is, costs are sufficiently spread among higher-risk and lower-risk employees in the group.



rating needs to allow some variation for at least age.

Community rating in almost any of its forms is problematic for the individual market. People in the individual market are generally paying the full premium from their own resources. Unlike those who have employer-sponsored coverage, they get no tax subsidy unless they are self-employed. Coverage is more expensive than group coverage because of higher administrative costs. And many of the people needing individual coverage have relatively low incomes. Some are people who have lost their jobs and the associated employer-based coverage, and others are self-employed people, many of whom have low incomes. For all of these reasons, people buying individual coverage are more likely to buy coverage only when they anticipate needing expensive medical care (to cover an elective surgery, for example). But, of course, purchasing coverage on this basis conflicts with the basic principle of insurance—that the insured person buys protection against *unpredictable* losses. Community rating (along with guaranteed issue and prohibitions on exclusions for prior conditions) encourages this tendency to buy coverage only when medical expenses are anticipated. If these regulations apply to the individual market, individuals are assured of always being able to buy coverage at the community rate no matter their level of risk; so the incentive to always have coverage is greatly reduced. As a result, these people do not pay their fair share and drive up the costs for everybody else in the individual market. That can cause a spiral of adverse selection, with lower-risk people simply declining to buy coverage. That has been the experience in several states that have tried community rating in the individual market.<sup>7</sup> Thus commu-

nity rating, at least in its stricter forms, does not appear to be a viable tool to promote risk spreading in the individual market.<sup>8</sup>

Of course, the concern about having lower-risk individuals or small groups drop coverage under community rating is relevant only in a voluntary market. If a health reform policy required everyone to have coverage through one means or another, these problems associated with pure community rating would disappear.

Community rating in either its pure or adjusted form is not effective unless it is accompanied by guaranteed issue and guaranteed renewal requirements, which prohibit insurers from turning down any eligible applicant. The purpose of community rating—to share risk across the whole community—would be thwarted if insurers were permitted to exclude high-risk applicants.

Although the federal government did not impose any requirements regarding community rating in the Health Insurance Portability and Accountability Act (HIPAA), which regulates the small-group insurance

market in other ways, the issue would surely arise if the federal government were to move aggressively to subsidize the purchase of private health coverage for many or all uninsured Americans. Unless subsidies varied with each person's expected risk—which would be difficult to do from an administrative standpoint—a system that provided subsidies for people to buy private coverage *without a requirement for some form of community rating* would either provide inadequate subsidies to high-risk people or excess subsidies to low-risk people. If the subsidies for high-risk people were large enough to allow them to afford the high premiums they would have to pay, the subsidies for low-risk people would be larger than necessary to make their low-premium coverage affordable. Without community rating, the costs of the subsidy program would have to be higher to achieve a given reduction in the number of uninsured.

While helping to protect high-risk people, community rating increases the need to protect insurers against adverse selection. In a community-rated environment, health plans that start to attract a disproportionate share of higher-risk enrollees can do little to defend themselves. Their medical claims expenses will rise as they enroll more higher-risk people, and they will have no choice but to raise premiums, which drives away more lower- or average-risk people, and the spiral continues. In a less restrictively regulated market, where insurers have greater latitude to adjust premiums, health plans can respond to having a pool of above-average risk by starting a new pool that excludes the "old" high-risk enrollees. The new pool could offer lower rates to new low-risk enrollees (identified through medical underwriting) and thereby attract lower-risk people that would otherwise go to other insurers. The health plan can stay competitive by being able to es-

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the individual market, see *State of the States, 2000*, the Alpha Center, January 2000.

<sup>8</sup> Some have suggested the problems of risk selection in the individual market could be approached by a policy that allowed insurers to risk rate but required that once an individual was insured, the insurer would have to guarantee the right to renew and to limit any premium increases to the average for everyone in the same insurance pool. Thus a person who bought insurance when healthy would be protected against becoming high risk as long as he or she remained insured in the pool. A significant problem with this approach is that people seldom stay in the same pool for long periods. They may go to work for an employer and be covered under the employer's plan. If they then later need individual coverage and have become high risk for some reason, their rates could be very high. People who have to enter the individual market when they are not young and healthy are likely to face high rates. For a full discussion of this idea, see Vip Patel and Mark V. Pauly, "Guaranteed Renewability And The Problem Of Risk Variation In Individual Health Insurance Markets: An alternative to community rating," *Health Affairs Web Exclusive*, August 28, 2002, [www.healthaffairs.org](http://www.healthaffairs.org).

<sup>7</sup> For a discussion of some of the difficulties states have experienced in trying to reform

establish different pools and vary rates based on risk. Community rating prohibits the use of that tactic. But this means that the efforts to protect consumers through the stricter forms of community rating make it even more crucial to protect insurers, probably by some kind of risk-adjustment mechanism (which is discussed later).

**Approach 2: Require everyone in some subset of the population who purchases coverage to buy from a common source and have each insurer base premiums on the experience of all its enrollees in the pool—for example, require all small employers to buy from a purchasing cooperative or insurance exchange.**

This approach mandates all of a category of potential purchasers who choose to buy coverage to buy from the same purchasing entity; they cannot go outside the pool to get coverage. For example, everyone buying individual coverage or all employers with fewer than a certain number of workers (for example, 10) or all who receive subsidies might be required to buy through some designated entity. This would create a large risk pool, and insurers would be required to use the experience of all of their enrollees in that pool to establish a uniform rate. This approach eliminates the option for low-risk people to form their own risk pools. It could be thought of as a specific mechanism for achieving community rating. But, as with any form of community rating, there is always the possibility that the lower-risk people, who no longer have the option of buying coverage at a lower rate outside the pool, will simply choose not to buy coverage at all.

Similar benefits might result from allowing the designated group to choose from one of several competing purchasing pools. Allowing this kind of competition opens up the possibility, however, that the pools may be tempted to risk select. The protection

against this is to *require every pool to accept all applicants*. That way, if one pool starts to get a disproportionate number of lower-risk people, which is then reflected in lower premiums, the pool will become attractive to higher-risk people in the competing pools. The resulting migration of enrollees should cause risk disparities among the pools to largely disappear.

**Approach 3: Instead of charging people premiums, use public financing, as with the Medicaid and Medicare systems.**

If approaches to extend insurance coverage to more people use public financing rather than collecting premiums and make the coverage available to all who meet the eligibility criteria, there is no insurance premium and thus no problem of spreading risk among the insured people. Medicaid and the so-called single-payer approach to coverage extension rely on this solution. People who are eligible do not pay premiums. A variation on this approach is to rely *primarily* on public financing but also have a fixed-dollar premium paid by enrollees, as is the case with Medicare Part B (physician coverage). Of course, neither of these public financing approaches eliminates the need for low-cost users of medical services to subsidize high-cost users. But now the transfer from those who have low medical expenses to those who have high medical expenses is achieved through the revenue-raising arrangement that finances the public program. The redistribution occurs whether the tax that funds the program is progressive or regressive. To illustrate, assume the public program covers all medical costs and that the revenue is raised by a (highly regressive) “head tax,” with everyone paying the same absolute amount, say \$500. A person who incurs high medical expenses, say \$6,000 dollars, realizes a net transfer of \$5,500 (after the tax) because the people who incur no medical expenses pay \$500 each,

all of which goes to pay for the remaining \$5,500 of medical expenses for the person who incurred high expenses. A head tax is essentially like a premium, but virtually any form of tax-financed public system produces this transfer from high-risk to low-risk people.

It is important to note that as long as the approach to coverage expansion has different health plans serving the subsidized populations, the public financing approach solves only one side of the risk-segmentation equation—what enrollees pay. It may still be necessary to somehow fairly compensate insurers/health plans for the variation in risk associated with the different populations they insure. Even a single-payer system that retains an insurance role for health plans would need to address this problem, as with Medicare+Choice. This means that some kind of *risk adjustment* process would be needed.

**Approach 4: Single payer without health plans that accept any risk.**

A single-payer system that did not put health plans at risk—as with fee-for-service Medicare—would solve both sides of the risk segmentation problem. Enrollees would not pay premiums, and thus there would be no difference in cost associated with risk differences. And insurers would not bear risk—they would just administer the system—and thus there would be no reason to compensate them for differences in the risk of the people they enroll. There would be no risk segmentation because there would be only one insurer—government.<sup>9</sup>

<sup>9</sup> Since no one except government is at risk, this sort of single-payer system does not require risk adjustment. But unless providers were to be compensated on a cost-plus basis, which seems very unlikely, *provider payments* would probably still need to be adjusted (as Medicare does) because the patients they serve are likely to present different levels of severity.

### ***Allow but Offset Risk Selection***

A second general way to cope with risk selection is to allow it to occur but somehow offset its effects “after the fact.” These approaches tend toward letting the market determine the price and then finding a way to compensate the high-risk people to make unregulated market-priced coverage affordable.

***Approach 1: Allow wide (though perhaps not unlimited) variation of premium based on price, but provide subsidies to help high-risk enrollees pay the high price they will face.***

Since the basic problem with risk selection is that it makes coverage unaffordable for higher-risk people, one approach to solving the problem is to compensate high-risk people sufficiently to make coverage affordable. It would be at least theoretically possible to link the amount of the subsidy—for example, a tax credit—to an enrollee’s level of risk so that the after-credit cost of coverage would be approximately the same for people of different risk levels. High-risk people would get large credits, while low-risk people got small credits. In practice, it would be expensive to do this; it would require a mechanism to medically underwrite (risk assess) everyone who is eligible for a subsidy. It might also be difficult to do with accuracy.

While this approach might work for people buying individual coverage, it is not readily adaptable to the small-group market. A group that contains one or two very high-risk individuals could face very high premiums, which are a burden for everybody in the group, not just the high-risk people. It is not clear how a tax credit or other subsidy based on individuals’ risks could be translated into a lower premium for the whole group. At the very least, the administrative difficulties would be significant.

Another example of this general approach is the high-risk pool. This approach involves establishing a separate insurance pool for the so-called uninsurable—those who are so high risk that they could not afford coverage if they had to pay rates reflecting their risk. Instead of charging these people rates that fully reflect their risk, the rates are to some degree subsidized. Although in practice, the subsidies are usually financed from revenues collected from other insurers to avoid having to use tax funds, the subsidies could come from government tax revenues. Typically, the premiums that people in the high-risk pool pay are still considerably higher than what other less risky people pay, which still makes coverage unaffordable for some. But, at least in theory, the subsidy could be set at whatever rate was necessary to ensure coverage was affordable. The larger the subsidy, however, the higher the proportion of people who would choose the high-risk pool rather than market-priced coverage.

This approach still involves transfers from low-expense medical consumers to high-expense consumers, since the bulk of the funding for high-risk pools has to come primarily from people who do not incur high medical expenses.

***Approach 2: Make risk selection unprofitable by having a very good risk-adjustment process.***

Risk adjustment is a method for making transfers among health plans to offset risk differences in their enrolled populations; those with low-risk enrollees “pay” those with high-risk enrollees. A “perfect” risk-adjustment process would eliminate all advantage to—and thus the incentive for—risk selection, because all the gain from attracting lower-risk people would be offset by inter-plan transfers. If the method for determining risk differences among plans’ enrolled populations were so accurate that inter-plan transfers fully offset

the differences in medical expenses due to differences in the risk of plans’ enrollees (but not expense differences due to random events), plans that enrolled a disproportionate number of low-risk people would lose all the potential cost advantage. And plans that had high-risk enrollees would receive transfers to fully make up for that disadvantage. With such a risk adjustment process in place, insurers would be expected to set their rates at a level sufficient to cover their costs under the assumption that they would get an average risk population; so high-risk enrollees would pay no more than low-risk enrollees. Insurers would, in effect, community rate because they would have no incentive to risk select.

Of course, the current state of the risk-adjustment art is not perfection, and it never will be. But for risk adjustment to serve the function of reducing incentives for risk selection, it does not have to be able to predict differences for individuals, only for a risk pool. The ability to predict differences for individuals is limited, but predicting differences in expenses for groups is more accurate. Several risk-adjustment methodologies yield predicted expenses that quite closely match actual expenses for the group as a whole.<sup>10</sup> However, even a very good risk-adjustment mechanism would not eliminate the incentives for insurers to avoid the individuals who are likely to incur extraordinarily high medical expenses—for example, those with HIV or other conditions that require constant re-hospitalizations or a life-long regimen of very expensive drugs. To give insurers some protection for taking on such high-cost individuals, a separate

<sup>10</sup> *Proposed Method of Incorporating Health Status Risk Adjusters into Medicare+Choice Payments, Report to Congress*, prepared by the Health Care Financing Administration, Office of Strategic Planning, Research and Evaluation Group, Division of Payment Research, March 1, 1999.



method of compensation may be necessary.<sup>11</sup>

It is important to note that transfers to offset risk differences are not the same as transfers to offset after-the-fact differences in medical expenses. Some plans may have high medical expenses relative to others not because they have high-risk enrollees but because they are less effective in controlling the cost of delivering medical services. It would not be in the public interest to offset these cost differences, because to do so would eliminate incentives to be efficient and to control costs. Nevertheless, one way to reduce the extent of risk selection is to provide a *partial* offset for after-the-fact differences in medical expenses through use of “stop-loss” coverage. Stop loss coverage leaves health plans at risk for expenses up to some (high) level and then provides compensation for some portion or all of the expenses above that level. The stop-loss coverage can apply after an individual has reached a certain high level of expenditures or when an insured group’s total expenses rise above some predetermined level. Such an approach lessens the potential penalty for enrolling a high-risk person or group and presumably would make premiums lower and more affordable for these people. Even though very high costs are covered, the health plan still has incentives to control medical expenditures up to that level and perhaps thereafter if the stop-loss coverage leaves the plan at risk for some portion of the costs above the stop-loss level. A similar approach is to make transfers to health plans that enroll

<sup>11</sup> Even if there were a “perfect” risk-adjustment methodology, implementation would involve some practical problems. In many small-group and individual markets, the number of insurers selling coverage is very large, but most of them sell very few policies. Inter-insurer transfers would be difficult because of the very large numbers of insurers. Moreover, a risk-adjustment methodology works well only if an insurer covers a large number of people in the market where inter-insurer transfers are to be made.

people with specified high-cost diagnoses, such as for enrollees with AIDS or for severely premature babies.

Of course, health plans can and do buy stop-loss coverage in the private market. But plans with high-risk enrollees will pay more than those with low-risk enrollees. In New York, state government has begun funding this kind of stop-loss coverage for certain policies sold to low-wage employers and low-income individuals. Since insurers pay nothing for this protection against high-cost cases, the plans with a disproportionate number of people that are likely to experience catastrophic expenses are not at as much of a disadvantage as they would be if they had to buy stop-loss coverage.<sup>12</sup>

### **A Distinction Between a Pooling Arrangement and a Collective Purchasing Arrangement**

So-called “purchasing pools,” such as health insurance purchasing cooperatives or insurance exchanges, are often proposed as a way of addressing risk-selection problems; they are seen as a mechanism for pooling risk. Unfortunately, they generally cannot perform that function. The misconception that purchasing pools are a solution to risk selection results from confusing two functions—pooling risk and collectively purchasing coverage. Purchasing pools can be a vehicle for joint purchasing. They generally cannot be a vehicle for pooling risk.

Pooling of risk refers to putting all members of some group of people (for example, all workers employed by firms with 50 or fewer workers) together for insurance rating purposes and basing the insurance premium for all those people on the medical expenses of that group as a whole. Each insured person’s pre-

<sup>12</sup> Early experience with the program, called Healthy New York, indicates that the approach has produced lower premiums.

mium reflects the average medical cost (plus administrative costs) of the group as a whole. Together, all these people in the pool represent the “community” that is the basis for establishing a (more-or-less) uniform community rate for all people in the pool. In general, such a risk-pooling arrangement can be sustained over long periods only if the insurance rating rules require that *all* members of some defined group of people who buy insurance, *from whatever source*, must be included in a single risk pool. If the rules allow some people to opt out of the risk pool and get coverage elsewhere at a premium based on their own risk, the pool will disintegrate. For example, if insurers can charge different rates to small employers outside a purchasing cooperative than to those inside it, the insurers will have incentives to drain off the lower-risk people from the purchasing cooperative by offering them a lower rate and thereby gain a larger market share. The cooperative would then be left with only higher-risk people, and the process would continue, until the rates for the purchasing cooperatives were beyond what any but the highest-risk people would pay—the pool would suffer the “death spiral” of adverse selection.

One reason for the confusion between purchasing arrangements and pooling arrangements is that large employers serve both functions: they purchase coverage for a group of people, and they pool the risk for these people. It seems that a purchasing cooperative or similar entity could also perform both functions for a group of people not otherwise related. The difference is that the employees of a single employer are more or less a captive group. Especially if the employer contributes to the premium, it is seldom financially advantageous for lower-risk employees to leave the group and buy coverage elsewhere, particularly since large-



group coverage is the least expensive form of coverage because of the lower administrative costs and because the employer typically pays a substantial portion of the premium, which is not taxable as income to the employee.

The point is that purchasing cooperatives or insurance exchanges can purchase coverage on behalf of a number of small firms or even individuals—and perhaps realize some administrative savings. But they generally cannot pool risk. The risk pooling depends on state regulations that apply to all people who are insured in a particular market, not just those in the collective purchasing arrangement.

## Summary

If insurers are permitted to base premiums for individuals and small groups on the basis of risk characteristics of potential enrollees, they have strong incentives to segment the population according to risks. This risk selection results in widely disparate rates, which makes coverage unaffordable for some high-risk people and causes inequities because high-risk people have to pay much more for coverage than low-risk people who are otherwise in similar circumstances. The resources consumed in

doing medical underwriting and other risk-selection efforts produce no improvement in medical care and thus have little if any social utility.

The bad effects of risk selection can be ameliorated by legally restricting insurers' ability to risk select by requiring some form of community rating or by putting the risk on government rather than insurers through public financing. The alternatives to these activities to prevent risk selection are policies that allow risk selection but either make it less profitable or compensate the high-risk people who would otherwise suffer from risk selection. Effective risk adjustment makes risk selection less profitable by reducing the reward for enrolling lower-risk people. High-risk pools and other forms of subsidies for high-risk people aim at lessening the financial penalty for falling in the high-risk category. A disadvantage of these after-the-fact approaches is that they leave intact the incentives for insurers to use expensive resources to avoid high-risk people and attract low-risk people. Creating purchasing pools for certain segments of the population cannot prevent risk selection unless the insurance rules require insurers to community rate everyone in that population, whether they buy coverage within or outside the pool.

Whichever approach is chosen to deal with risk selection, the result will be that people with lower medical expenses have to subsidize people with higher medical expenses. The question is not whether there will be risk sharing, but when, how, and to what extent.

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