



# The Council for Affordable Health Insurance's ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

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## Should We Abandon Risk Assessment in Health Insurance?

Many health care reform advocates want to eliminate “risk assessment,” the ability of health insurers to consider the health of an individual or group when determining whether to provide health insurance and at what price the insurance is issued. They argue that considering the health of the applicant is unfair because it punishes the sick by raising their rates or limiting their health plan choices. These advocates’ solution is to require health insurers to accept every applicant, plus they want to charge everyone the same premium, or close to it. And they claim these changes will only work if everyone is required to have coverage.

The problem is that these changes, especially if people are given a choice of several plans and can switch periodically, will drive premiums significantly higher for everyone.

This paper presents an actuarial analysis of some of the reform options and demonstrates what those options will do to the cost of health coverage.

**The Role of Risk Assessment.** Risk classification is the process of determining how much risk a person, or group, brings to the insurance pool. That assessment will affect whether and under what conditions the person is accepted and how much the person is charged. Most types of insurance (e.g., life, property, auto, etc.) include a risk assessment, known as “underwriting.” The applicant is either accepted or rejected, and may be charged a standard or higher premium, depending on the risk. For example, drivers of high powered sports cars with a history of speeding tickets will pay much higher premiums than individuals who drive more sensible vehicles and have clean records.

Interestingly, while some claim that assessing the risk of health insurance applicants is “controversial,” no one seems upset that underwriting principles are applied to every other type of insurance. But it is important to understand that whenever the principles of risk assessment are set aside, there is an incentive for both the insurer and the insured to game the system.

**When You Can't Charge a Fair Premium, Then What?** Reform advocates claim that once insurers must accept everyone (guaranteed issue) and charge them the same price (community rating), insurers will quit “cherry picking.” But price controls create their own perverse incentives.

The Federal Employees Health Benefit Plan (FEHBP) provides a large number of health insurance options, each plan must accept any qualified federal employee who applies, and everyone in the group is charged the same premium — which is heavily subsidized by the government. In addition, insureds are allowed to shift plans once a year during what's known as “Open Season.”

Federal employees often shift plans when they need extensive care, moving from a less-expensive plan with higher co-pays to more comprehensive coverage. That “adverse selection” makes the premiums in some plans significantly higher than they otherwise would be.

**The Impact on Premiums.** In a health insurance system where:

- Every applicant is accepted regardless of health status;
- Everyone is charged the same premium, or relatively close to it (modified community rating), and
- People can shift from one plan to another;

Premiums will go up. By how much depends on the health insurance options available and the degree to which risk assessment is discouraged — that is, how aggressively prices are controlled. Ironically, the stronger the price controls, the higher the premiums everyone will pay.

The accompanying table compares the “individual market,” where individuals purchase their own health insurance, over two to three years. There are variables that include various combinations of underwriting, pure or modified community rating, whether or not there is an individual mandate, and whether there are several options for consumers to choose from.

The table begins with a health insurance market with full underwriting and no community rating — in other words, full risk assessment — no individual mandate and a full range of choices. The premium derived from this fully competitive and underwritten market is 1.0, or the most accurate premium.

Subsequent variations estimate what happens to the basic premium as politically imposed policies vary. For example, in scenario C1 there is no underwriting and all policies are community rated. There is no individual mandate, but people have several coverage options to choose from. It's the closest plan to what President Barack Obama, as a presidential candidate, proposed during his campaign. At 2.2 times the cost of standard coverage, it also has the biggest negative impact on premiums.

Some argue that guaranteed issue (and some include community rating) will only work if everyone is required to have coverage. They're at least partly correct. While premiums under an individual mandate are still significantly higher than in a fully underwritten market — at 1.95 they are nearly twice the standard, underwritten rate — they are still lower than under the Obama-like scheme. And premiums would be lower still if insurers were allowed to price them based on age, since that is a primary factor determining an applicant's future costs.

## Reform's Impact on Premiums in the Individual Market

Scenario	Underwriting	Community Rating	Coverage Mandate	Benefit Choice Leakage	Exemption Mandate	Benefit Level	Premium
A.	Full	None	None	Full	N/A	Low	1.0
B1	None	None	Yes	Full	None	Low	1.10
B2	None	None	Yes	No	None	Low	1.05
C1	None	Pure	None	Full	N/A	Low	2.2
C2	Pre-Ex Only	Pure	None	Full	N/A	Low	1.9
D1	None	Mod	None	Full	N/A	Low	1.6
D2	Pre-Ex Only	Mod	None	Full	N/A	Low	1.45
E1	None	Mod	None	Full	N/A	Mod	1.65
E2	Pre Ex Only	Mod	None	Full	N/A	Mod	1.50
F1	None	Mod	Yes	Full	20%+	Mod	1.95
F2	Pre-Ex Only	Mod	Yes	Full	20%+	Mod	1.75

All assumptions reflect the actuaries' judgment based on the 2008 environment. Results reflect a mid-point estimate 2 to 3 years after reform. Costs may vary by state because of other reforms and regulations.

The Massachusetts health care reform plan, which many reform advocates look to as a model for the rest of the country, is represented in F1 and F2. Of course, Massachusetts passed guaranteed issue and modified community rating 15 years ago. So premiums in the state were already significantly higher than the standard (i.e., 1.0) when the state passed its most recent reform effort. The state is now experiencing significant upward pressure on premiums — as the model predicts — even as government officials move to try to contain those pressures and force prices down.

**Implications for Policymakers.** What this table shows is that several of the health care reform initiatives will impose significant upward pressure on premiums. It is true that guaranteed issue combined with a robust individual mandate will likely decrease the number of uninsured. But it is also true that most reform advocates have many additional changes in mind. For example, many will demand that price controls be imposed on premiums, further limiting the role of risk assessment. Those who want to keep private sector insurers involved — as opposed to moving most people into what's being called the "public option" — also want to give people the opportunity to shift from one plan to another. The more freedom people have to shift, the more upward pressure on premiums, especially when insurers aren't allowed to accurately reflect the increased risk in those premiums. All of these efforts to micromanage health insurance premiums impose greater inefficiency, distortions and lack of transparency in the health care system.

By contrast, the freer the health insurance market and the more it adheres to the traditional principles of underwriting and risk assessment, the more competition will provide Americans with a wide range of competitive and affordable health insurance policies. That competitive market needs to include an effective, viable safety net for those who cannot get or afford coverage.

**Conclusion.** The solutions to fixing the health care system can be found in adhering to basic principles underlying actuarial science, economics, medicine and construction of well-functioning safety nets. Approaches that require open defiance of such principles simply create a combination of cost, access and quality problems that make things worse for everyone.

For years, our health care system increasingly ignored risk-assessment principles, and we are paying the price for that defiance. Returning to those principles, not abandoning them completely as most reform proposals would do, is the only way to create a system where the vast majority of Americans have access to affordable coverage.

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