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ADVERSE SELECTION IN A MULTIPLE-CHOICE ENVIRONMENT

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- o Morbidity characteristics
- o Selection patterns
- o Benefit/product design
- o Underwriting

MR. WILLIAM A. J. BREMER: The concept behind this program is to discuss the risk selection issues that develop when an insured (in a group environment) can select from among several levels of coverage, such as a rich HMO, a high-option comprehensive major medical program, and a low-option comprehensive program. I work at the Blue Cross and Blue Shield plan in Maine, and the modeling that we developed to deal with this problem incorporates our own HMO (which for us is just a little more costly than our traditional first-dollar program because of the latter's relatively low days per 1,000 utilization), a high-option comprehensive or our first-dollar traditional program, and a low-option comprehensive product with perhaps a $500 deductible. We haven't seen any adverse selection experience results yet because groups have tended to remain in our traditional first-dollar program, but I'll share some simple modeling that we've developed to help us learn about the dynamics of this problem. I presume that most of you have seen or developed something like our model.

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OPEN FORUM

In this open forum, we are going to discuss the morbidity characteristics and selection patterns of the insureds, some benefit and product design considerations, and the underwriting of the product.

One of the panelists is Mr. Ernest J. Lampron. Mr. Lampron is Underwriter and Associate Actuary of Blue Cross, Blue Shield of Massachusetts. He has been with Blue Cross for a number of years, and has seen or experienced most of the problems that develop in a multiple-choice environment. Also with us Mr. William J. Miner, Consulting Actuary, from The Wyatt Company in Chicago. Mr. Miner writes the monthly column "Ask a Benefit Actuary" for *Business Insurance*, and has done extensive consulting on this topic. Finally, we have Mr. Richard Ostuw, Actuary and a member of the corporate staff of TPF&C in Cleveland, Ohio. Mr. Ostuw has had a great deal of experience in developing and pricing flexible benefit plans.

As my staff and I were contemplating the adverse selection and assessment spiral problems that could develop in our group business in Maine, we certainly were aware of what has happened in other parts of the country. Since Maine is at the end of the trolley, so to speak, we usually see these sorts of risk management problems after they have developed elsewhere. Perhaps because there are few really large employers located or headquartered in Maine, group decision makers have not been aggressively pushing for new products or concepts that would tend to cause selection in their health insurance programs. As we thought about this adverse selection problem, we presumed that it was driven by those concepts in economics called total utility and marginal utility. Although most of our experience is with groups and subscribers whose total utility for health insurance coverage was in the 90%-98% range of potential liability, we wanted to contemplate the number of people who wanted coverage in the 60%-70% range of total potential liability.

Our model is based on the highest level of coverage, which for us is our HMO. We had to make some assumptions based on our evaluation of our enrollment data and age/gender distributions, so we defined contract (1) to be the lowest benefit program (such as a $500 deductible comprehensive), (2) to be the "middle" option (such as a $100 deductible comprehensive, or our first dollar traditional coverage), and (3) to be the HMO. We presumed that people choosing the low

option would contribute about 10% of the gross premium to the group, that the price ratio (price ratio meaning what we would charge for each option if everybody were rated in the same pool) of this program is about 70% of the HMOs, and that the use rate of these people would be really low, perhaps one-half of the entire pool's average. For contract (2), we assumed that the people who stay in that pool contribute about 50% of the premium of the entire group, and that their price ratio is about 92% of the HMOs. That's based on our observed pricing differences. We further assumed a 40% penetration by the HMO, set the HMO enrollees' price ratio at unity (by definition), and solved for u(2), the expected use rate of the insureds remaining in the middle or traditional coverage. We also expected the HMO enrollees' use ratio to be about 7.5% lower than the whole pool's average, based upon some age/gender modeling we did. If these assumptions are reasonably accurate, then the use rate of the people remaining in the middle option is calculated to be about 116% of the original group's.

Having started off with the utility curves, I'd like to rely on economics once more, and call the situation *informal laissez-faire* in which the employer and/or original insurer does nothing to manage risk selection in a multiplechoice environment. Thus, if the employer and/or original insurer do nothing in the face of an HMO penetrating the group, we would expect the group's experience to worsen, since it is likely that the HMO will draw off some of the better risks. As a result, the residual group members enrolled in the low and middle options require an immediate rate increase if the insurer wants to protect itself, or alternatively the likelihood of significant rate action at renewals. Once the HMO enrollees are out of the group pool, the remaining low-option insureds will contribute 16.7% of the reduced group premium, while those in the original middle option (now high-option) will contribute 83.3%. The price ratio of the low-option insureds to the new high-option insureds is 0.76; and the use rates become 0.476 and 1.105 for the low and high-options respectively. Presuming that the HMO charges the employer its community rate, the employer's new total premium bill (irrespective of the level of contribution) is 4.2% greater than when everyone was covered under one level of coverage. Our effort has shifted from treating our HMO as a separate entity to attempting to keep a group's HMO enrollees as part of the group pool.

If we can incorporate the presumed better experience of the HMO enrollees back into the employer group, then the employer's total new premium will be only 0.9% greater than before, and we certainly wouldn't go back to a group to ask for a 0.9% increase in rates!

MR. HARVEY SOBEL: You mentioned that in your calculations you have an increase if you're anticipating the penetration of your own HMO, and that leads me to wonder how you get the experience back together. On the HMOs' books, you'll be having the profits emerge from the favorable selection, and you'll have the losses on your Blue Cross statements. I'm just wondering if you are making any sort of adjustment for that, or is the experience just falling out as it falls out?

MR. BREMER: Our HMO is not a line of business but a separate downstream company because it is looking for federal qualification; clearly, we are going to have exactly that problem. We haven't really addressed how we are going to deal with it. My problem was that I had to convince my management that this kind of selection problem really existed, and that we have several choices. One was to do the actual pricing as necessary and perhaps annoy the groups that stayed with the traditional program; or not make these adjustments and just let the losses emerge on the traditional product. It may end up that we don't seek federal qualification if those issues go away that seem to make federal qualification necessary right now. If those issues go away because of federal legislation or revised HMO regulations, we would probably bring the HMO back into the company as a line of business, and that would make the financial transfer easier.

MR. JEFFREY J. NOHL: A problem seems to develop in that you're rating prior to the open enrollment, so that depending upon where you set your rate level, you are going to drive people into or out of the HMO. How do you handle that problem? Are you anticipating the percentage of people going into the HMO before they do, or are you going in after the fact to adjust the rates?

MR. BREMER: The interest in the low option has not materialized. Because the rate and benefit difference for us between our rich traditional program and the HMO is almost negligible, we are planning to market on a same-rate basis, at least for the present time. As I said, we have some age/gender modeling that our HMO consultant helped us develop, and we will test our actual results. We

hope to use this model in going into groups and explaining that this selection problem is not good for you or for us, and we'd like to work with you, the employer, to manage this problem. If we had to price something prospectively, we'd make some estimates about how much penetration the HMO would make. We expect somewhere between 20% and 40%. We would look at the results of our modeling within this range, and make a decision prospectively.

MR. ERNEST J. LAMPRON: When we talk about selection, I think we have to realize that for any good-sized account, about 60% of the employees are not going to have any claims at all, or very few. About 20% of the employees will account for about 20% of the claims dollars, and another 20% are going to account for about 80% of the claims dollars. So, depending upon which employee segment a particular program captures, it really can make a big difference in terms of whether that program has a surplus or a deficit. If an insurance company is providing the coverage on a premium basis, it will have the surplus or deficit; if the account is self-insured, it will see the results. It's very important that we always account for selection so that whoever is going to have the deficit makes sure of having some offsetting income. One of the best environments to study is the flex plan. There are all kinds of options, and you can see almost every possible aspect of selection. So I'm going to talk about a flex plan, but from the standpoint of selection, not the flex plan itself.

There are really three sources of selection. One is the choice of a traditional program option. If you have, for example, an employee who doesn't have any claims and he switches to a low option, he still has no claims. Your claim dollars stay the same, but he is contributing less to the pool's income.

So there is a little deficit that you have to build into your rates so that you can recover your full cost. The second thing that you have to account for is the selection caused by alternative delivery systems. If an HMO pulls healthy people out of the risk pool, the average cost will be pushed up for those who remain. A third consideration (and many accounts forget about this) is the no-coverage option. Accounts typically assume that if someone elects to take no coverage at all, they will save the full premium for that person. We have accounts that have fairly high employer contribution, so the employee will take the program but not use it. When these people come out of the program, the average cost is going

to increase. The account may save money overall, but the average cost is going to increase for those who remain.

Flex plans can be set up in different ways and have all kinds of options. The particular one that I am going to discuss has three traditional options: a high-option, a low $300 deductible option, and a lower $500 deductible option. An HMO and an IPA are also offered, and the no-coverage option is available as well. The high-option was the account's original program before they offered flex. In the first step, we adjusted the premium for the low and lower programs based on the savings expected from the deductible. These are simply the relative values of these programs without any adjustment for selection, but it's where you have to start once the company identifies what it wants to offer its employees. The second step in the process is trying to figure out how people are going to choose from among the options. This is the critical concern when you are calculating your total premium requirements. Mr. Bremer talked about a marginal utility curve, but how it usually ends up when you are dealing with a customer is a *guesstimation* curve. It's especially interesting because there are different points of view. I tend to pick an array of enrollment percentages that are on the conservative side. The account almost always has a consultant because flex plans demand a lot of specialized knowledge. Consultants tend to pick distributions that have a larger number of employees selecting the lower cost options. This is because the more employees select a low-cost option, the more the employer will save in total premium.

We had an interesting case where there was a debate in terms of how the employee selection distribution was going to go. We set up a mathematical model on a portable PC and loaned it to the account so they could calculate their own estimate of the selection distribution. Eventually we loaned them a disk drive and gave them reams of paper so they could record and store all the results of their *what-ifs*. Ultimately, their distribution came out to be very close to my original proposal, but at least the account felt better about it.

The third thing that you have to do in this process is to determine the characteristics of those people that are likely to switch coverages. You can use age/sex distributions and you can evaluate prior experience or what may have happened in a similar situation. Often we and the account simply guess what might happen and plug these guesses into our mathematical model. We start by

estimating the number of people that might select the no-coverage option. Then we estimate who might select the IPA (their relative cost tends to be about 85% of the average), and the HMO (their relative cost is somewhat lower than the IPAs), and so on until we have estimated who might select the three options (high, low, and lower) of the traditional program as well. Our approach is to calculate the cost of the health portion of the flex plan by multiplying the cost of each program by the number of persons enrolling in that program, ignoring selection. Then we repeat the process but include a loss ratio relativity factor to account for the selection. This adjustment can be sizable. We've seen it range from near zero when the traditional program rates were competitive with the alternative delivery system programs, and when few people selected a low option. And it's been as high as 20% in other situations. If you have a large account and their health plan is underfunded by that amount, it could cost a benefit manager his job.

One final thing that you have to consider when you have arrayed all the actuarial and selection costs is the contribution. A flex plan implies that people are asked to make reasonable choices, so that we encourage accounts to keep each program's rate relative to its actuarial value. What I generally recommend is that the company use the actuarial relationships and apply the overall adjustment factor caused by selection so that the rates don't turn out absurdly high (for the high-option) or low (for the lowest option).

MR. WILLIAM J. MINER: What I would like to do is to share with you some of the experience results that I've analyzed for one of our large corporate clients that installed a flexible benefits plan early in 1984. The group consists of 4,000 to 5,000 salaried employees spread all across the United States in different geographic and cost areas. In 1984, the employer installed the following flexible benefits program: a high-option $100 deductible, 100% outpatient surgery, 85% inpatient surgery, 100% x-ray and diagnostic, and a major medical program with a $150 per quarter deductible; a middle-option with the same basic pattern -- a $350 deductible, 80% coinsurance and a $350 per quarter major medical plan; and a low-option $1,000 deductible, 80% coinsurance comprehensive program. The employer also had employees covered by an HMO during this period, but this is not really that significant (with less than 5% HMO enrollment) for the purpose of focusing in on the effects of selection in a flex plan. The employees were offered a choice of the high, medium, or low

medical programs with corresponding dental programs having $50, $100, and $150 deductibles and basically similar types of other limits and reimbursements.

When this flex plan was installed, I was not the consultant on the case. Another actuary in the Chicago office of The Wyatt recommended the dental programs to help counter the effects of selection. Although employees could change their program level at the annual reenrollment (by one coverage level each year), the enrollment by program level runs fairly similar to that discussed by Mr. Lampron in his presentation. There is a preponderance of employees going into the high-option (70%), with fewer going to the middle-option (24%) and fewer still going to the low-option (6%). The selection pattern remained essentially constant over time with this particular client. With respect to dependents, the number of employees that had dependents electing coverage by plan also remained relatively constant. In other words, there weren't big differences in selection patterns between employees with or without dependents in the plan.

This plan had an employee coverage and family coverage type of premium structure. To develop the charges and credits that an employee would receive from making an election, the actuary involved initially calculated what he expected the cost of each of the programs to be if all the employees were covered under the high-option, the middle-option, or the low-option. These gross monthly composite premium rate values were calculated to be $134, $117, and $76 for the high, middle, and low options, respectively. While recognizing that the premium rate would influence the degree of selection experienced by the plan, the actuary involved developed the gross rates by surcharging the high-option rates by 10% (to $147), and reducing the middle and low-option rates by 6% ($110 and $72, respectively) in an effort to meet the client's goals of cost savings on its medical plan. Then the charges or credits that an employee would receive were taken to be simply the difference between the gross premium rate and what the employer would be contributing, which on a composite basis was $122 per month. Thus, the employee electing the high-option contributed $25 per month (on a composite basis), while he received $12 per month if he chose the middle-option, or $50 per month in the low-option.

In setting these rates, the actuary recognized that there would be selection against the plan. At the request of the client, he indicated what he thought the

loss ratios were going to be for each level of coverage: 116% for the high-option, 69% for the middle-option, and 50% for the low-option. With the wisdom of hindsight, you can see that the actual loss ratios for those three levels of coverage in 1984, 1985, and 1986 were worse than the actuary expected. For example, in 1984 there was a higher loss ratio than expected on the high-option program at 131%, and lower than expected loss ratios for the middle and low-option programs at 56% and 22% respectively. The conclusion that I draw from this experience is that you definitely can get a significant degree of selection in a flexible benefits plan. By taking selection into account in establishing the charges and credits in a flex plan, however, you can tend to minimize it and make it something the employer can live with.

MR. DAVID H. DUBOIS: Are the rates affected by inflation or are they adjusted to be at the same relative value?

MR. MINER: These values have not been adjusted for inflation. During this period, inflation was in the range of 6% to 10%, so that if I had adjusted the 1985 and 1986 net monthly composite premium rates for inflation, the percentage relationships would have been more constant.

MR. DANIEL L. WOLAK: What do you suggest should be done at renewal time given the experience we've seen? Should all rates be moved up the same percentage, or should the rates continue to be tilted so that the high-option rates would be increased by a greater percentage than the rates of the other options?

MR. MINER: The client in this case was interested in attempting to achieve further cost savings in its medical plan in 1987. We first installed comprehensive programs for the high and middle-options. The low-option remained unchanged as a comprehensive program with a $1,000 deductible. The primary objective of the client was to move employees away from the high-option, so that in developing rates for 1987 we calculated the premiums that we would expect if everyone were covered by the same plan, and then increased the rates for the high option by 10%, while reducing the rates for the other options by 10%. In my experience, much of the work that we do is governed by what the objective of the client is with regard to his medical plan.

MR. RICHARD OSTUW: Choice (in medical plans) is here to stay. We will see more and more choice and those who are concerned with it must learn how to deal with it. Employee needs are diverse, and employers are concerned about the cost efficiency of their programs. Cost efficiency means providing a level of benefits that is appropriate to each employee's needs. Redundant levels of benefits add unnecessary levels of cost. Adverse selection is certainly an important issue, but it's not a new issue. All contributory plans for years have borne some of the cost of adverse selection. We've seen it in plans that have gone from noncontributory to contributory. HMO options have caused adverse selection problems. If you understand how adverse selection works, you can see how to deal with it, and see that it is a manageable issue.

There are really two distinct areas of adverse selection in medical plans. One exists in multiple-option indemnity plans where it's all one risk pool.

The second exists when HMOs siphon off employees from the employer's risk pool. Triple-option programs that try to tie the experience back together will help solve that problem. The difference between the two types is that the type of selection is different. In an HMO situation, the young, healthy employees are attracted to the routine and preventative care in the HMO. They may feel that the coverage for the major hospital and medical-surgical expense is a phantom benefit. In multiple-option indemnity plans, young healthy employees gravitate to the lower option plans. Another difference that has been mentioned is that people who have an ongoing physician relationship are reluctant to change that relationship. Changing from the indemnity plan to an HMO requires such a change, or at least reduces the employee's flexibility in maintaining his choice of physicians.

One consideration that is worth noting in the HMO selection issue is that health status differences will tend to wear off over time. That problem is greatest at the original point of enrollment, but after four or five years, the health status of those who left for the HMO will be closer to the average of the employer's whole pool. Demographic differences tend to wear off more slowly, however, than health status differences. An employee who is several years younger than the average will likely still be several years younger than the average four or five years after the original point of enrollment.

One reason that selection need not be viewed with as much concern as people express is inertia. In almost all plans, the majority of employees stay with the high-option program if that was the predecessor program. Once people get into a program, they are not going to move around very much. Health care is an emotional issue in this country. People fear that they will have catastrophic claims. Really when we use the term *catastrophic*, we should use the term *non-budgetable*, because the level of insurance that people buy is the level that protects them against non-budgetable expenses, not really catastrophic expense. Not many people are willing to self-insure for more than a $300 or $400 deductible per year. So deductibles beyond that level will be attractive primarily to employees who have coverage available through a working spouse, and this diminishes the degree of selection. A lot of plans have controls. There may be controls in terms of preexisting condition limitations or how many coverage levels an employee can move up or down, or other controls that deal with people's ability to make changes. So those too limit the degree of selection.

Another thing that we often forget is that most medical expenses are not predictable. An employee may know that he has had expenses (or not had expenses) during the past several years, but his ability to predict next year's expense is very limited. Some people at the extreme high-expense end know they are going to have major expenses the next year. But the vast majority of people don't know, and what they are really buying is insurance that they're viewing as protection against unanticipated expenses.

Another thing that tends to limit the degree of selection is that the prices are often subsidized. Under most flexible benefit plans, the cost to the employee or the price differences among coverage levels are not the full benefit differences. For example, if the cost difference between two plans were $300 a year, the price difference to the employee might only be $150 a year. This provides some incentive for people to buy more coverage than they need, which fits in with their desire to buy more coverage than they need because of the conservative nature of most of us.

One last point that I would like to make is that we have an obligation to our respective clients to do the best job we can in terms of predicting these costs and predicting the participation patterns, because to the extent that we're

conservative in our estimates we cause our clients to make bad decisions. If we build in conservatism and therefore distort the cost relationships among the plans, it may drive the employer to design the program in the wrong way or cause him to change the prices in the wrong way because he wants to meet his real objectives. Employers are trying to develop programs that meet their objectives in terms of cost and employee relations issues. If we give them bad information (bad in the sense that we've imposed our conservatism), then we're really doing a disservice to them. To the extent that those bad facts translate to conservative prices or credits to employees, then it causes employees to make bad decisions. I think the educational process that Mr. Lampron talked about is very helpful in explaining to the client and having him understand what the alternatives are, and how different circumstances can change the alternatives, but our estimates should be on a true best estimate basis, and we should avoid leading our client into bad decisions because of our own biases and conservatism.

MR. ANDREW S. GALENDA: I would appreciate anyone's comments on any experience with long-term disability (LTD) in flexible benefit plans.

MR. OSTUW: We've seen long-term disability options in a number of plans. If the employee can elect LTD or exclude LTD, then the program is like an LTD contributory program. Even though there may be selection, the program should function satisfactorily. In fact, there are some 100% contributory LTD programs that have worked quite well. Where there are multiple-option LTD programs, it becomes more complicated because of the integration issues with Social Security. At some pay levels, the high LTD option or the low LTD option may provide the same benefit.

MS. DEBORAH MCSHANE: We had a recent experience with a flex plan in which a core benefit of 40% was provided for LTD, with the employees given the option to buy up to 60%. In the preenrollment survey that was done to determine the employees' attitudes and selections, there was very low interest in buying additional LTD. In the actual enrollment, however, after we had explained to the employees the probability of becoming qualified for LTD benefits versus becoming qualified for Social Security benefits, there was a significant improvement in obtaining increased enrollment in the high option and thereby decreasing the selection. Do you have any comments on that?

MR. OSTUW: It is true that employees need to know the definition of disability that is in their LTD program. If they really understood Social Security, then they would realize that that is an inadequate benefit. I don't think that employees are as concerned about LTD as they are about health care benefits.

MS. MCSHANE: That's true. In this case we found that a strong communication effort aimed at the employees to educate them on the LTD benefits and the probability of becoming disabled really seemed to help improve selection. The insurance carrier was much more comfortable with the results that we actually got in the enrollment than with what was expected based on the initial survey.

MR. ABE PAUL: As a result of that final enrollment, were you able to recalculate the rates? If Social Security accounts for 30% of the 40% basic benefit, you are only providing a 10% benefit on top of Social Security. In the 60% option, you are providing 30% on top of Social Security, and the rates are going to increase dramatically.

MS. MCSHANE: The 40% was a core benefit. The additional cost was to increase the benefit to 60%.

MR. PAUL: I guess it depends on whether you express your rate as a percentage of payroll or per $100, but if you calculate a certain rate as a percentage of payroll, that rate would increase quite drastically based on your final enrollment.

MS. MCSHANE: I can't comment on whether or not we were able to recalculate the rates, because I wasn't involved with that particular client.

MR. THOMAS L. HANDLEY: I have two questions. The first one pertains to multiple-choice situations in the medical market in which there are HMOs, PPOs, and traditional medical. Have you had enough experience or have you done any surveys to find out what type of employee chooses which option and why they choose it?

MR. LAMPRON: We haven't done a lot of surveys; we have done loss ratio and experience studies. We found that employees with the most favorable risk characteristics tend to join staff model HMOs. We found that the risks who join

IPAs, where they can keep their physicians, are a little less favorable. These have primarily been loss ratio studies. I must caution that when you look at this on an account specific basis, other results may occur. In one account, the employer offered a low-option program and an HMO to its part-time employees. The loss ratio was 30% for the low-option plan, so, in this case, the HMO saw the adverse selection. We've had some cases in which the salesman's objective was to get enrollment back from an HMO. The problem is that sometimes the enrollment coming back to the traditional program is of poorer average risk than the existing traditional program enrollment, and we've been in the predicament of having to raise the rates after increasing the enrollment.

MR. HANDLEY: When you looked at the loss ratio, did you compare the demographics before and after the open enrollment, showing how the utilization patterns of the employees who remained resulted in selection against the group?

MR. LAMPRON: We looked at the experience of the people who left the group, and at their demographic characteristics. We saw that the people who joined the HMO were typically younger, and also that there were more individual than family policyholders.

MR. HANDLEY: Have you evaluated the relationships among the benefits and rates for the different options, and tried to control the employer contribution? For example, have you asked the employer to set his employee and family contributions in any given way in an effort to control the selection and improve future results?

MR. OSTUW: We've done a lot of work with different modeling and strategic pricing approaches pertaining to how the employer should subsidize different options. Should the employer subsidize based on the same fixed dollar amount for all plans? Should there be a combination of that and a percentage approach? These are really key issues in the design of a plan that meets the employer's objectives. The pure actuarial issues of anticipating and analyzing cost must be tied into the employer's cost management and employee relation objectives. There are two different problems here. One is to identify the benefits cost for each program, taking into account the cost of adverse selection; the second is to determine how those costs should be split between the employer and the employee.

MR. HANDLEY: Are employers willing, through their contribution, to try to control adverse selection?

MR. OSTUW: There is a misconception that it is best to drive employees to the low-option program. The employer's real desire is to control his cost. If that is controlled, it may not matter to the employer which program his employees take. By properly structuring the plan, the employer can be ambivalent as to which option his employees take -- if employees are happier to pay the extra money to obtain a higher option program, that is acceptable.

MR. LAMPRON: You have to recognize the importance of employer contribution. It can make a difference in the distribution of enrollment among each of the programs. In a situation in which the contribution is not favorable to the programs that I offer, I probably will put in some margin. If the employer is willing to change his contribution in a way that would make my programs more attractive, I'd probably remove some margin.