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Health insurance: The anti-risk classification and rate regulation movement

by Mark Litow

Health insurance in the United States is facing a dilemma. Premiums are skyrocketing out of control, and the number of insureds is decreasing. To try to improve the situation, many regulators are taking the following initiatives:

- Minimizing the use of risk classifications in pricing insurance policies to try to improve access to consumers (that is, moving toward community rating)
- Increasing rate regulation to restrict the availability of rate increases and reduce the need for rate increases by requiring higher initial rates

First, let's examine the risk classification issue as it relates to insurance principles. Eliminating risk classifications does not support insurance principles, because a non-homogeneous risk group may result. Let's look at some examples.

Pooling of conversion with non-conversion experience

Many states are beginning to mandate this requirement as part of specific rating rules. Conversion business, however, frequently produces losses and represents a much higher-than-average morbidity risk group. Non-conversion business can represent any level of morbidity from very low to very high. Therefore, pooling these blocks where non-conversion experience is not developing very high morbidity levels usually will produce very high lapses on the non-conversion business.

Mandated benefits

Studies of mandated benefit programs have shown that individuals who use more covered mandated services often use more of other services. These individuals also are more likely to buy mandated plans; better risks with lower costs will not. The result is that plans with mandated coverage usually produce higher costs than if mandated benefits were not available.

Guaranteed issue

Many states have risk pools that issue policies to anyone who requests them. Some states only make these policies available if a person has been rejected by one or two carriers. These risk pools always lose money despite rates higher on average than those found in the marketplace. Why? Because, for the most part, only very poor risks will enter these pools. Even in states where a person must be rejected for insurance before entering the risk pool, the morbidity variations between levels of impairment are large enough to produce significant antiselection.

These illustrations show that combining dissimilar risks, where an individual is making the direct purchase decision, usually causes the experience of the entire group to move toward the experience of sub-groups with poorer experience. Therefore, eliminating risk classifications would produce an undesired result — more uninsureds and higher costs per insured.

Impact of rate regulation

Rate regulation is the other method being used to address this country's health insurance problems. This regulation commonly takes the form of state-by-state rate approval authority (whether explicitly, implicitly, or otherwise) and restricting the relationship of premium scales. In any case, such rate regulation has significant effects on the consumer and companies.

At first it might look like rate regulation would benefit the consumer, because it should mean lower rates, better control of costs, and more insureds. Just the opposite effect, however, usually occurs. For example, a study conducted by Milliman & Robertson on the individual health care marketplace found that:

- States that had more rate regulation were less competitive.
- States with authority to regulate rates had relatively low growth in insureds and high growth in uninsureds.
- None of the six most competitive states in the United States had the authority to regulate rates during 1989, the period of this study. However, four of the five least competitive states had such authority.
- Two-thirds of the states with authority to regulate rates had fewer than 10 companies issuing 500 or more policies a year. Two-thirds of the states that lacked the authority to regulate rates had 10 or more companies issuing 500 or more policies a year.

Rate increase issues

Many regulators recently have limited or denied rate increases because they believe that position is in the best interest of consumers. The results from studies show this is not the case:

- Limitations on rate increases can be a direct threat to the solvency of a company.
- Reduction or avoidance of rate increases often results in the need for larger rate increases later. Studies have shown that smaller, more frequent rate increases produce better results for the consumer and the company than a pattern of infrequent large rate increases.
- Delays or reductions in rate increases increase administrative costs because of the extension of filing periods for these increases and the need for additional filings. This process also usually extends the time required to receive the increases.

This suggests that the real value of regulation — to assist in making reasonably priced coverage available to consumers and to provide adequate oversight to avoid company insolvencies — is rapidly eroding. This erosion is threatening the viability of the entire market and causing a more rapid push toward radical reform, in whatever form it takes.

Rather than continue in this direction, the insurance industry and regulators should focus on the basic principles that work, but which have apparently now been abandoned. By not following such principles, we appear headed toward a health care system that does not solve its long-term problems, but only makes them worse.

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