Risk Selection in Health Insurance Markets

7.1 Introduction

In the 1990s, several countries exposed their social health insurers to an increased degree of competition in the hope of improving efficiency in health insurance and in their health care sectors. However, as shown in Section 5.4, competitive health insurers tend to charge a high premium to high risks and a low premium to low risks. This is nothing but a generalized version of the ‘price equal to marginal cost’ rule; after all, high risks are characterized by comparatively high expected cost of treatment due to a high probability of being sick. Moreover, for reasons spelled out in Chapter 5, the government wants all citizens to have health insurance.

One way to ensure universal access would be to subsidize the premiums of the poor. But governments traditionally have preferred premium regulation, prohibiting insurers to charge risk-based premiums, a practice called community rating in the United States. In addition, regulators usually require that insurers accept any applicant under an open enrollment policy. For example, public health insurance in Germany and Switzerland is organized according to these principles. In the United States, Medicare gives its beneficiaries a choice between the original Medicare Plan and competing health plans which receive a capitation payment.

For insurers the incentive for risk selection arises naturally in this type of system. The requirement to accept any individual at a uniform premium leads to expected losses with high-risk types and expected profits with low-risk types. Even if the health insurer is not for profit, it needs a sufficient number of low risks to balance its books and assure its economic survival. As always, ‘more is better’, calling for additional low-risk insured. Under competitive pressure, all insurers will engage in cream-skimming, i.e., attempt to attract favorable risks while excluding unfavorable ones.

Risk selection can take two different forms. On the one hand, health insurers can perform direct risk selection by influencing who signs a contract. For example, insurers may ‘lose’ the contract form handed in by a person who is considered expensive.
Individuals who can be expected to require little health care may be encouraged to sign a contract by offering them supplementary services at a discount or, in the extreme case, outright payments. *Indirect risk selection*, on the other hand, consists in designing benefit packages or by contracting with service providers who are attractive for low risks but unattractive for high risks.\(^1\)

Both forms of risk selection can only arise if insurers or consumers possess information about individual health care expenditure. Direct risk selection requires that insurers can observe characteristics of individuals which are correlated with their expected cost, e.g., gender and age, but also behavior. For instance, if healthy individuals use the internet more frequently, then a risk selection strategy is to market insurance contracts online. For direct risk selection to work, individuals need not know their risk type. For indirect risk selection, by contrast, this is a requirement. In particular, individuals must know their probabilities of using certain services. This allows insurers to design benefit packages and enlist service providers appealing to different risk types.

Direct and indirect risk selection can arise simultaneously. Measures which rule out one of the two need not affect the incentives for the other. For example, even if the benefit package is tightly regulated, preventing indirect risk selection, insurers will still be interested in attracting favorable risks, causing them to resort to direct risk selection. Conversely, if insurers have no possibility of direct risk selection, the incentive to design the benefit package in a way to attract low risks and to avoid high risks still remains.\(^2\)

To avoid risk selection, three types of measures can be taken, the underlying assumption always being that health insurance is compulsory so that low risks cannot escape cross-subsidizing the high risks by not purchasing insurance at all:

1. **Regulation of the enrollment process**
   
   Open enrollment guarantees that high risks cannot simply be rejected by insurers. Furthermore, obvious methods of direct risk selection can be ruled out by law and controls. For example, financial and other rewards for low risks may be prohibited.

2. **Regulation of the benefit package**
   
   Regulation of the benefit package is a measure against indirect risk selection. On the one hand, minimum benefits can be stipulated, forcing insurers to offer benefits that are of importance for high risks, such as treatment of diabetes. On

\(^1\) A similar distinction is made by GLAZER AND MCGUIRE (2002, p. 154) who refer to the *individual access problem* and the *quality problem*. The first problem corresponds to direct, the second to indirect risk selection.

\(^2\) Indirect risk selection is closely related to the phenomenon of adverse selection in insurance markets which arises if individuals are better informed about their risk type than insurers (see Section 5.3.3). The difference is that adverse selection emerges without intervention by the government. Indirect risk selection, on the other hand, is a consequence of government premium regulation, as first pointed out by PAULY (1984).