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THE RISKS OF IGNORING INSURANCE RISK MANAGEMENT

by Stanley Jones, Donald M. Cohodes, and Barbara Scheil

Prologue: Given America’s penchant for a limited government and private-sector collaboration in solving the ills of society, policymakers are forever looking for solutions that require private/public collaboration. The Clinton administration prescribed such a formula in its health care reform proposal, Ironically, at the same time that the president and Hillary Rodham Clinton were bushing the private health insurance industry for its traditional ways, their reform proposal called on insurers to assume an enlarged new role and bear greater financial risk in a reconfigured system based on managed competition. The three authors of this paper discuss the nature of this risk and underscore the danger that inadequate support for good risk management poses for reform. They propose a series of approaches that might help to reduce risk to a manageable level. Stan Jones, an independent consultant, is well respected in health policy circles as an analyst who delivers incisive perspectives without heavy ideologic baggage attached. Senate Republicans recently called on him to assume that role at a private retreat devoted to reform. Except for a three-year stint as director of the Washington office of the National Blue Cross and Blue Shield Association, Jones has worked as a consultant for the past fifteen years. Prior to that (1970-1976), he was on the professional staff of the Senate Labor and Human Resources Committee. Don Cohodes, who passed away recently (see From the Editor, page 5), directed the federal systems group within the Blue Cross and Blue Shield Association. Barbara Scheil, an actuary in independent practice, formerly worked for Milliman and Robertson and, prior to that, was chief financial officer of Virginia Blue Cross and Blue Shield.
Abstract: Health insurers face financial risks when they assume liability for the difference between premium revenues and their estimates of future claims costs for a group. Market reform proposals vastly increase the amount of risk health plans of all types will face. A case study is used to show how insurers bidding in an alliance environment must either commit contingency reserves to cover these risks, increase premiums to reduce them, or forgo the business. Unless legislation includes measures that reduce these risks or enable health plans to carry them, premiums are likely to increase greatly.

For several decades it has been popular in Washington and state policymaking circles to say that health insurers are no longer “at risk,” with the growth of self-insurance and state regulation, savvy policymakers assert that health insurance carriers have turned into service agencies-selling claims processing, utilization review, and a variety of other health insurance-related services to employers. More and more employers, smaller and smaller in size, have chosen to “self-insure.”

Of course, health insurance carriers have not been freed of all risk bearing. They have remained at risk for employees in small and medium-size employer groups and for individual coverage. Moreover, through reinsurance, they often have assumed some of the risks of self-insured employers. Finally, carriers bear risk for most of the members they enroll in health maintenance organizations (HMOs). As traditional carriers and physicians, hospitals, and other providers have gotten religion and formed more HMOs or arrangements that have capitation-like payment practices, the total amount of risk bearing being borne by private carriers no doubt has begun to expand.

However, several health care reform proposals, including those of the Clinton administration, the Conservative Democratic Forum, and Senate Republicans, among others, propose to reverse the trend toward self-insurance and vastly expand the amount of risk that carriers of all kinds must bear in the future. These proposals rely heavily on traditional insurance carriers and new health care provider/carriers to form integrated health plans that will compete to contain costs and assure the quality of the health services they insure. Encouraging insurers, physicians, and hospitals to organize such integrated health plans and become carriers of risk is at the heart of these proposals.

The shift to risk-bearing health plans by insurers and health care providers is so great and so rapid under these market reform proposals, however, that it could prevent their success. Government knows little about how either traditional or new provider/carriers operate, the speed at which they are able to form health plans that effectively manage care, and how much and what kinds of risk bearing will motivate them to contain costs. For example, it seems clear that the annual premium increase limits for 1996-1999 proposed in the Clinton plan, and the target proposed in the Conservative Democratic Forum proposal, do not reflect an objective assessment
of how fast the traditional and new carriers can move to manage care better, and whether these carriers can carry the level of risk involved in the proposals. Instead, the targets seem to reflect the savings needed to offset increased costs over the four-year period. If these targets are not reasonably achievable by good carriers, the results will be higher premiums, failure of provider-based plans with inadequate contingency reserves, and the rise of destructive forms of competition such as risk selection among carriers.\(^1\)

The government has limited experience in managing at-risk insurance arrangements. Fewer than two million of Medicare’s thirty&times; million beneficiaries receive services from HMOs on an at-risk basis. For the balance of the Medicare population, the Medicare program is itself the carrier of risk. However, if Medicare underestimates its future claims costs because of unanticipated changes in price, volume, or even adverse risk selection, government can draw down on the Medicare Trust Funds faster than anticipated, then freeze or reduce Medicare payments in succeeding years, or increase taxes to restore the funds. These tools relieve Medicare of carrying the year-to-year risk that drives private insurance.

This paper attempts to clarify for policymakers the nature of risk in health insurance, how health care reform proposals increase such risk, and what public policy tools might enable traditional and new health provider-based carriers to fortify health plans that manage the increased risks, especially during the period of transition to a reformed health care market.

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**A Case Of High-Stakes Risk Management**

As a basis for understanding risk issues, consider the following real case (names are excluded to protect the competitive).

At a midsummer meeting, presidents of a syndicate of insurance companies are collaborating on a bid to a very large U.S. employer to provide health insurance coverage to its employees for the year starting the following January. Several billion dollars in premiums are at stake. The employer has asked the bidders to carry the risk on the account—which is to say, the employer wants the bidders to commit to a premium six months in advance of the coming year and guarantee payment of all claims and other costs throughout that year, even if they turn out to exceed the revenues raised by the preset premium.

It is late at night in a meeting room at the O’Hare Hilton; the executives, consultants, and staff have flown in from their corporate headquarters. For some insurers, this employer’s contract, which they now hold, represents a substantial percentage of their total business. For all, it is a very prestigious account and could lead to other business.

But a problem has emerged. The consulting actuaries (among the best in
the country) have projected a wide range of potential claims costs for these employees for the coming year. The actuaries have suggested bidding a premium-experience rated, of course-in the middle of this range. However, if the costs ended up at the high end of the range, the carrier would “risk” being liable for several hundred million dollars more than the revenue the premium would raise. Such a bid would require the carriers to set aside enough of their contingency reserves to cover this potential financial liability. Their alternative was to raise the premium they bid nearer to the high end of the range, to cover more of the possible costs. This would lessen the financial risk and the need for contingency reserves. But it might make them lose the bid.

The executives were caught between the classic “rock and a hard place” of the health insurance business. On the one hand, they wanted the premium they bid to the employer to be low enough to compete with the other large carriers bidding for the business. On the other hand, they needed to limit their financial risks to what they could cover with their available capital, some of which was already committed to cover the risks of other accounts.

The meeting kicks off with hours of interrogation of the actuaries. “These projections of potential claims costs include a far wider range than usual,” the executives point out. Why? The group reviews in detail the factors contributing to the uncertainty. (1) National trends for health services costs of various kinds are showing relatively abrupt year-to-year fluctuations in what doctors, hospitals, and other providers charge for their services and in the volumes of different kinds of services they render, perhaps as a result of changes in nationwide Medicare policy changes. It is not clear how these shifts will “settle out.” (2) The claims experience now being collected for these particular employees shows that for the first four months claims costs have varied markedly from what was projected twelve months ago when the current premium was set, and have varied in ways different from the current variation in national trends. It will take many more months of data to figure out what is causing this variance. (3) The employer proposed new cost-sharing arrangements and coverage on which the actuaries had few data regarding their impact on prices and volume of services. (4) There has been an accelerating adverse risk selection problem in this employer’s account, with more and more employees who have low claims costs leaving the syndicates’ increasingly high-price plan during open seasons. Given the levels of publicity about plan changes and the general unrest in the employer group, one must assume that an all-time high number of basically healthy employees may leave the plan this year, leaving the very sick behind.

Eventually the group is resigned to the fact that the actuarial estimates
are the best that can be done given the state of the art, the data limitations, and the uncertainties about the future. The group then proceeds to an interrogation of the marketing staff: “Why can’t you talk the employer out of some of the insurance changes and publicity that are creating some of the uncertainty for the actuaries?” They review unsuccessful efforts made by the marketing team over the past few months to talk the employer out of these changes. They then turn to the question, “What are our competitors going to bid?” Ultimately they conclude that they will not be able to get the employer to change its insurance specifications and that their competitors will offer aggressive bids.

Finally, the group turns to the chief financial officers to ask, “How much contingency reserves can you (each carrier) commit to covering the several hundred million dollars in high-side financial risks the actuaries project?” After cajoling each other to commit more of their capital and sacrifice other potential business, and after recounting the total several times, the chief executives of the assembled companies realize that they do not have the contingency reserves to bid. They cannot carry the risk. To bid low without adequate capital to cover the risks could lead to financial ruin on an account this large.

They vote not to bid on the account and to surrender the business. As the enormity of the business loss sinks in to all present, each person leaves quietly, defeated by the financial risk in the health insurance market.

The case described above is unusual in today’s insurance market, but not in tomorrow’s market. The case illustrates the nature and source of health insurance risk that health plans will face when they formulate their premium bids to health alliances and/or hundreds of thousands of individuals and employees in gigantic open seasons. In this market competing health plans will walk through this kind of decision logic with far higher uncertainty about future claims costs, and they will need far higher contingency reserves. Those who do not understand such risk management will fail. Some who do understand may elect to reduce their risks by competing based on risk selection rather than by cost management.

### The Nature Of Health Insurance Risks

Policymakers often seem to think that health insurance risk is psychological, as if carriers lacked nerve and would take bigger risks if government forced them. Policymakers also have been heard to argue that experience rating eliminates risk, or that if a carrier comes out in the red on a contract in one year, it can recover its losses by raising its premiums in future years or by tapping into earnings on other accounts where it comes out ahead, or that carriers can always purchase reinsurance.
No doubt insurance managers differ in how much personal psychological risk they are comfortable taking. However, insurance risk is financial; it is quantifiable in dollars and cents. It is simply the difference between the revenues estimated to be produced by an experience-rated premium set well before a plan year begins and the reasonable range of estimates of the claims costs that might be incurred throughout that year by that business.

Risk is a function of how precisely an actuary can estimate future cost. Risk actually increases as the imprecision or uncertainty of estimates of future claims costs increases. Many factors can affect this precision. The above case illustrates several: changing national health services prices and volume trends; unexplainable changes in claims costs; lack of complete or current data on the cost experience; new coverage or insurance arrangements required by the employer; and increasing adverse risk selection against the syndicate’s plan in the form of younger, healthier workers leaving the plan and sicker workers staying. These factors vary in importance for different groups, for different insurance markets and competitors, for different coverages, for different years, and for different geographic areas. The more turbulent the environment, as under health reform, the greater the uncertainty and imprecision of the estimates of future claims costs of a given “account” or group, and the greater the risk.

Risk is also a function of how high or low the carrier sets its experience-rated premium for a group. If it sets the premium high enough to cover the highest possible estimate of future claims costs, there are virtually no risks for insurance purposes, except the risk that the actuary’s calculations were not conservative enough, and the risk of losing business because of a high bid. If the carrier sets the premium lower to attract more buyers, the risks are higher. If the actual claims costs eventually experienced in the account exceed the premium revenues, there is said to be a “risk loss” on the account. The competent insurance or health plan manager tries to be in firm control of how much risk the company takes.

Contingency reserves are a measure of a carrier’s or health plan’s capacity to take risk, that is, to bid competitively in the face of uncertainty about future claims costs for a group. The more risk the carrier decides to assume in bidding on an account, the more contingency reserves must be set aside to cover it. A carrier with strong capital positions can bid in new markets, invest in new managed care systems, and bid on the low side to capture market share. A carrier or health plan with limited contingency reserves must be very careful in all of these areas.

Setting aside contingency reserves incurs high opportunity costs for the carrier. If contingency reserves are committed to cover the risks, the funds must be kept in lower-yield, liquid investments, to be available if needed. In one sense, the opportunity cost to the carrier of committing contingency
reserves is equal to the return the carrier forgoes by not putting the same capital in a comparably high-risk investment in the stock market. But the real opportunity cost to the carrier of committing capital to cover a bid for a group’s business is its loss of capacity to cover other bids for other groups. The carrier’s objective is to invest its limited capital wisely to win business in the most desirable markets—that is, markets in which it can most successfully and profitably compete for market share. Another opportunity cost is the forgone investment in new lines of business, such as developing an HMO or another more price-competitive product for the future.

Reinsurance frequently does not solve the problem of inadequate contingency reserves or high risks for the carrier. In the above illustration, the most sophisticated reinsurers in the world declined to share the insurance syndicate’s risk. The uncertainty was simply too great. In other cases, reinsurers may cover part of the risk, but their high charge must be built into the premium (there is nowhere else for it to go), perhaps making it uncompetitive.

Insurance executives are hired and fired, deemed successes or failures, based on their ability to manage risk: to measure and assess it accurately, to set premiums that are competitive, and to manage their contingency reserves over time to hold or expand their share of the market and produce a positive bottom line. The fact is, if the carrier comes out short on too many accounts in the same year and/or cannot raise premiums in future years because of competition, it will lose market share, and it can become insolvent. State insurance regulators prevent the company from selling new business or force it into receivership if its contingency reserves dip below state-required minimums to cover possible outstanding claims. Such a situation reflects cumulative bad risk management in dozens of cases.

In the illustration, the carriers elected not to bid on important business because they could not see a way to quote a competitive premium and also cover the high financial risks associated with the group. It is safe to say that these financial risk issues prompt actuaries and insurance executives to take a conservative attitude about risk and the implications of change.

Health Reform, Risk Levels, And Contingency Reserves

Carriers will find that their need for contingency reserves, and their need to take risk, will vastly increase under the various reform proposals. Carriers will face a triple whammy. They will need more contingency reserves because a greater proportion of business will be on an at-risk basis. In addition, they will need more contingency reserves to cover the higher risks of bidding for contracts in a health care environment that is disrupted so that past trends are poor indicators of the future. Finally, they will need
capital from contingency reserves to invest in forming integrated health
plans that manage care more aggressively.

**More persons insured on at-risk basis.** Many health care reform
proposals build on individuals purchasing insurance directly from health
plans that are at risk. Employers would be involved only as administrative
agents and contributors to the premium. Only very large employers would
self-insure. Putting the carrier at risk for more of its clients increases its risk.
If a carrier enrolls 100,000 persons on an at-risk basis, it will need about ten
times more contingency reserves to cover the potential high-side costs than
if it is at risk for only 10,000 persons.

This need for higher contingency reserves catches carriers at a time when
contingency reserves have been reduced because of the prevalence of self-
insurance. Low contingency reserves will force health plans in a reformed
market to limit their risk by bidding high and by limiting to which alliances,
purchasing cooperatives, or employers they bid at all. Alternatively, they may take advantage of the Clinton proposal’s provision that allows
health plans to limit the number of people they will enroll during an open
season based on their capacity to deliver services or their need to “maintain
financial stability” (Section 1402[a]).

Health plans would aim to set their premiums high enough to build up
their contingency reserves over time to levels that allow them to compete
in aggressive and innovative ways, as envisioned by reform proposals. The
amount of contingency reserves health plans would need to accumulate in
a reformed market is substantial. Most states now require carriers to main-
tain enough contingency reserves to cover one to three months of premi-
ums for at-risk business. This converts to one-twelfth to one-fourth of an
entire year’s premiums for at-risk business. In addition, carriers now need
additional months of such capital to allow them to bid aggressively to enter
new markets, develop HMOs, and weather cyclical changes in experience.
This very large buildup in reserves needed to compete is a cost of reform
that does not seem to have been adequately considered in the premium
targets and estimates of the costs of various health reform proposals.

Some provisions of reform proposals are thought to address the health
plans’ problems in carrying more risk. Insurance guaranty funds, for exam-
ple, are useful for assuring persons that their claims will be paid even though
their carrier becomes insolvent. However, they do nothing to ease the
higher risks to the carriers competing in a reformed system. Similarly, the
Clinton proposal’s pro rata reduction in insurance premiums and provider
fees for health plans that cause an alliance to exceed its premium target
does not reduce risk to the carrier. This provision would reduce not just the
carrier’s fees to providers, but also its premium revenues by a commensurate
amount. The carrier continues to be at risk for whatever imprecision was in
its original estimate of future claims costs and the premium it set to cover them. In fact, the pro rata reductions put the carrier at higher risk. The reduction in provider fees may not adequately offset the reduction required in the carrier’s premium because of unanticipated increases in provider volume of services. In addition, the fee reductions may put the health plan in a highly risky position for the next open season, when unhappy doctors may urge patients to abandon their plan for one that pays better.

**Accurate estimation of future claims costs.** The factors that made actuaries uncertain in the case study are even more powerful under health care reform proposals. Most lead to higher risks, and the need for either higher premiums or higher contingency reserves to cover them.

**Lack of data.** Most reform proposals assume that more people will purchase health insurance as a result of government subsidies or mandates. They also assume that different kinds and perhaps fewer health plans will compete for clients during open seasons. This will produce a different mix of people signing up in each plan than was true in the past. In addition, the group will include people who are not now insured by anyone, or are insured by public programs. The question for actuaries is what the future claims experience of this new group of people will be. It is not clear how accurately data on existing groups covered by a carrier will reflect the claims of this new population. This lack of relevant data will increase the uncertainty of actuaries’ estimates.

A variety of new databases are proposed by advocates of market reform. These might be developed with actuarial use in mind so as to ease somewhat the uncertainty factor resulting from previously uninsured or publicly insured people joining the group. The first three or so open seasons after reform, before carriers have developed basic data, will involve high risks.

**Changing prices.** Health care reform would seem likely to cause large aberrations in trends in health services prices and volumes as providers attempt to maintain their revenues and business interests within the complex web of new incentives put in place by reform. A large displacement in these trends for private carriers resulted from the introduction of Medicare’s prospective payment system (PPS) for hospitals and its relative value-based physician payment system. It took years for these reimbursement systems to sort out, and they caused unexpected risk losses in the private insurance industry in the interim.

The scale of change entailed by market reform proposals dwarfs these Medicare changes. It may take years before the system shakes down and enough data are available to develop trends adequate for precise estimation of future claims costs based on past trends. In the meantime, health plans will face larger financial risk. They will, consistent with the intent of reform, attempt to share some of this risk with providers in integrated
health plans or pass it on in the form of new provider network and incentive payment arrangements. Such risk sharing will not be accomplished overnight, however, and in some areas, such as rural and inner-city areas where providers are scarce, it may never be accomplished.

The Clinton proposal does contain a provision relevant to this risk factor. It would require all fee-for-service plans to pay standard fees to hospitals and physicians. These fees would be negotiated by state or area agencies. Since as much as 50 percent of the insurance market can be anticipated to be in such plans during the early years of a reformed system, a large part of the insurance market would operate under a government rate-setting system that determines prices and their annual increases. This takes the "price factor" out of trends but does not remove the uncertainty in volume and mix of services. Prices have never been set for so large a portion of the market. It is uncertain how providers will react, increasing or shifting volumes of services to compensate. In addition, these price controls will not apply in integrated health systems.

New coverage arrangements. Health care reform proposals include a variety of standard benefits (for example, mental health benefits) and coverage arrangements (for example, point-of-service arrangements) that are different from those with which many carriers and HMOs have experience. Policymakers see many new benefits as helping to contain the costs of health care, such as preventive services. Most actuaries are fond of saying that they never saw an additional benefit that reduced claims costs. In any event, they never saw a new benefit on which they lacked data as reducing risk. Carriers are likely to add to premium charges to cover the costs of these new services and the imprecision involved in estimating them.

Greater risk selection. Risk selection may be the most important risk factor in the reform of the health care market. It was the most important factor in the illustrative case study. Health care reform proposals pose very large adverse and favorable risk selection potential. Consider the following: (1) With fewer and different types of carriers and HMOs competing than in the past, they may well divide up the pool of sick and healthy persons differently than in the past. (2) The sheer volume of people (millions) changing plans at the same time during open seasons can make a small amount of adverse selection go a long way. (3) During the first open season, when everyone chooses a plan for the first time, the potential for being hurt or experiencing a windfall from risk selection is great indeed.

Reform proposals include a number of provisions intended to ameliorate the risk selection problem. Most standardize benefits and propose a process whereby plans’ premiums are adjusted up or down to reflect the extent of favorable or adverse risk selection they have. Some regulate marketing practices by carriers. The Clinton plan makes it illegal for a plan to differ-
entiate among people or providers based on the perceived health care use of the patient. The reform plan sponsored by Rep. Jim Cooper (D-TN) monitors those joining and leaving health plans to see if they are healthy or sick. All of these provisions seem relevant and helpful, but they are only a start.

We do not now know how to effectively ameliorate risk selection or adjust premiums for it. Popular knowledge on the subject can pretty much be summed up in the truisms that healthy people choose less comprehensive benefits and sick people choose more comprehensive benefits, and risk selection involves avoiding people who are sick. These generalizations, perhaps, lead policymakers to believe that standardizing benefits and banning medical underwriting will go far toward easing risk selection.

Working knowledge in the insurance industry, which has invested in research on this topic, suggests that the provisions embedded in market reform proposals will ease risk selection only somewhat. As a rule of thumb, carriers involved in multiple-choice arrangements such as those envisioned in health care reform can hope for at most 20 percent of the potential risk selection to be corrected by premium adjustments.

Working knowledge also suggests that a health plan that wants to achieve favorable risk selection, even within the constraints of the reformed health insurance market, could pursue a number of strategies, such as the following: (1) Invest in research on what makes healthy and sick people join or leave plans. Interview people who join and leave the plan, and find out what plan features attract and repel people who use little care and people who use a lot. (2) Wherever “discretionary services” are permitted by the reform legislation, offer the benefits known to attract healthier or lower-utilizing persons. (3) Invest most heavily in services attractive to the healthy. Staff heavily in family practice, internal medicine, and pediatric and obstetric services, to maintain short appointment times. Staff specialty services more thinly, for longer waiting times, especially those for the chronically ill. (4) Try to avoid including in a physician panel highly regarded specialists who have long-established practices in town and who may have attracted the sickest and toughest cases (they may bring their patients along with them into the plan). Instead, try to include very highly credentialed physicians who are newer to the area. (5) Contract with the prestigious teaching hospitals on a referral basis to advertise quality, but establish tough protocols for who gets referred there. (6) Market a plan with sophistication-selling a plan as the one for healthy folks and not advertising that a plan is the best in town at taking care of the chronically ill, even if it is. (7) Within the capacity of the regulators to catch on, market and make services most accessible to work sites and institutions where healthier people, on average, are found. Never put plan brochures in doctors’ offices or clinics. Find out what worries low users (healthy members) about HMOs.
Structure advertising in ways that feed their anxiety so they stay with the plan. There are likely to be scores, even hundreds, of health plans competing within an alliance; there is no way they can monitor each plan closely enough to eliminate these practices. (8) Operate an informational 800 number during open season through which trained counselors ask questions of prospective enrollees that subtly tilt high users away and low users toward your plan. These and newer techniques for risk selection could well enable less efficient plans to underbid more efficient plans that end up with adverse selection.

Public Policy Tools For Measuring And Managing Risk

How bad can it get? Given how health reform proposals increase the sources of risk and make it more difficult for actuaries to precisely predict claims and other costs—and given the increase in contingency reserve requirements or premiums to cover financial risks—what could happen? Could we have a case like that described above, in which health plans decline to bid because they do not have the capital to cover the projected potential loss? Could the alliances hold a bidding party and find that no or too few plans come? The answer is clearly “yes.” Fewer health plans than desirable may bid for the insurance business in an area. Or the “wrong” plans—that is, those with less potential for managing care—may bid because they have access to capital and others do not. For example, innovative physician- and hospital-based systems are not likely to have “deep pockets,” much less risk management experience. Or, plans that do bid may set limits on their enrollment that do not add up to the number of people in the area.

Alternately, could health plans offer alliances and the public substantially higher premiums than projected by health reform advocates, to cover risks and build contingency reserves? The answer here is also clearly “yes.” It is almost a certainty. The dangers of submitting a low premium for many plans will far outweigh the consequences of submitting a high bid. This is particularly true of those pursuing a targeted geographical marketing strategy. They would rather be disqualified as a bidder than take on business they might find financially unattractive. In some markets they may be the only game in town.

Finally, could high-quality health plans with high-utilizing members be driven from the market? Could fear of risk selection force health plans’ annual premiums above the budgeted targets in the Clinton plan? Could individuals be attracted to plans with good risk selection by low premiums, and away from more efficient plans, thereby increasing the costs of the whole system? The answer here also is “yes.” The challenge in all of these
areas is to develop policy tools so that this risk can be managed. Following are some suggestions.

**Government expertise in risk measurement and management.** Given the key role that at-risk health insurance plans are to play in health care reform, public policymakers need to move quickly to become knowledgeable about private insurance and risk management. Federal and state governments need expertise in the state-of-the-art tools used by private insurance actuaries and managers to measure and manage risks.

Among the boards and advisory committees envisioned by the legislative proposals, someone should carry out the functions of a risk management board. This board should include actuaries, but also experienced general risk managers—that is, insurance industry executives who should chair its work. The board should be staffed with seasoned actuaries, financial managers, and general managers from private insurance who are accustomed to using private-sector actuarial work.

This group would advise the government on the cost and premium implications of risk at the national, state, and alliance levels. During the early years of reform the group also would advise on the budgetary requirements of the policies suggested below to reduce or share financial risks for health plans. Such a group might well be equipped for its work by actuarial-oriented data files built from required contributions from competing health plans across the country. These data files do not now exist in the public domain. If developed, they may well enable the group to advise on solutions to some of our toughest insurance risk problems, such as measuring adverse and favorable risk selection. Most of the databases recommended in health reform proposals do not focus on the needs of actuaries and risk managers. Finally, and most importantly, this group could oversee publicly funded research in the area of risk selection.

**Building contingency reserves adequate to the risk.** Inadequate carrier contingency reserves could undermine health care reform based on competing health plans. Health reform legislation needs tools for enabling carriers to build up capital, or to quote premiums that are lower than they ordinarily could quote based on limited contingency reserves. A number of policies might be considered.

On a transitional basis, federal or state government might assume the large employer’s current role and bear part of the risk. Government could establish risk-sharing funds to back all or some health plans—in effect, assuming the role of a reinsurer. For example, government’s risk might begin after the health plan has absorbed a negotiated level of losses and extend to a negotiated maximum after which the plan is again at risk. These risk-sharing corridors could be defined in advance as part of the construction of health plans’ bids. Public funds might be more generous and easily
available during the first years of the new system and then phased down. Two types of funds, at least, might be required: (1) a “risk-sharing fund” (perhaps in the form of an unfunded government liability) to share financial risks associated with new coverage arrangements and a share of unpredictable changes in the price and volume of health services resulting from health care reform legislation (these funds might be available for negotiated solutions between the alliances or state governments and health plans based on guidelines established by the risk management board); and (2) a “risk equalization fund” that is derived from assessments on each participating plan’s premium and redistributed among plans according to their favorable or adverse risk selection. Risk selection results in an uneven distribution of sick and healthy persons among competing plans, Risk sharing in this case can take the form of a redistribution of plan revenues. How this redistribution might be made is discussed below.

**Adjusting premiums to compensate for risk selection.** Several steps might be taken in legislation to strengthen the hands of employers, alliances, or purchasing cooperatives that purchase from health plans, until government has developed an algorithm for measuring risk selection and redistributing premium revenues to compensate for it.

First, we might allow alliances or health plans to use state-of-the-art actuarial and risk management tools to make more extensive risk adjustments than are possible with existing algorithms. Actuaries can estimate the probable favorable or adverse selection among competing plans. A study of the Federal Employees Health Benefits Program (FEHBP) by the Congressional Research Service used such techniques to estimate the risk selection between the FEHBP’s high- and standard-option plans.’ (Plans differed in premiums by almost 100 percent, while benefits differed by only 5 percent—the cause is selection!) A number of national benefit consulting firms have done similar work.

Given such measurements, it would be possible for alliances to negotiate settlements among competing plans to adjust for risk selection. Like risk-sharing agreements with plans using the risk-sharing fund described above, these agreements need to be negotiated, at least transitionally until a better algorithm is designed, between alliances and competing plans. The Clinton proposal now allows only the nationally approved approach.

Second, the number and kinds of competing health plans in an alliance might be limited to make it feasible for managers to police and adjust for risk selection. This could be done in one or both of two ways. First, the state or federal government authority that licenses health plans might set and monitor standards for product design, marketing, and rating practices, including provider network composition and other factors, to discourage participation of plans whose market success depends on risk selection
techniques, and to encourage plans whose cost containment potential is high. Second, alliances might be permitted to limit the number of competing plans by the same criteria and/or their best management judgment. These steps have disadvantages both politically (reducing the number of carriers that can compete in the new market) and competitively (limiting the access of innovative new plans to the market). However, the difficulty of managing risk selection in the new environment may require compromises of this sort—at least until better risk adjusters are in place.

**Concluding Observations**

Not all approaches to health care reform entail the risks and costs of risk described above. A single-payer system or a Medicare-for-all approach, for example, would require no contingency reserves or risk taking by private carriers. The risk would be carried within government budgets as under Medicare. Nor would such an approach entail any of the risks associated with health plans bidding in a competitive and uncertain market.

Not only does the market-improvement approach to health care reform entail greater risks, but risk is essential to its basic incentives to health plans to contain costs and assure quality.

Risk management is sufficiently arcane and complicated that it readily puts interested parties to sleep. It would be a terrible error to overlook the problems of risk management in health care reform, however. We have tried to point out the significant and real danger that inadequate support for good risk management poses for health care reform. We have raised difficult technical issues to resolve. We have proposed a series of approaches that might help to reduce risk to a manageable level. Further efforts are needed, and more energy must be put into researching and understanding this issue. The risk of ignoring risk management issues or hoping that the market will somehow self-correct is that competition among health plans in the marketplace may not produce integrated plans that are capable of containing health care costs and assuring quality of care.

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**NOTES**

1. The term *contingency reserves* is used here in the same way as *surplus* is used by most insurers and reserves by most policymakers. It refers to a carrier’s capital that is over and above liabilities.