Draft annex 3 to Technical Paper VIE 8074

Restrictions on risk classification and market failure

This heading shows the impact of restrictions placed on insurers' ability to use risk classification to price insurance in terms of market failure. One of the biggest threats to private insurance is **adverse selection**. Adverse selection is a result of the contractual freedom ruling private contracts. This principle means that consumers have the freedom of choice if, when, against which risks and for which amount they look for private insurance coverage. Therefore the condition for the functioning of this system is to have risk-equivalent prices, i.e. the price of the private insurance reflects the risk insured. Social insurance has not to face the same threat as it constantly receives new healthy applicants because of the legal obligation for consumers to be insured.

The following examples illustrate the mechanism of adverse selection on the basis of real cases:

Illustration 1[1]: Travel Insurance more expensive because of higher risks

In the context of the Health Reform in 1989, the German legislator removed the travel coverage from the compulsory health insurance and urged the private health insurers to propose a product which accepted the people with an acute need of treatment. But very soon the sale of that product had to be ceased as it was not financeable. As this tariff was a little more expensive due to the higher expectancy of claims in comparison to other travel insurances which excluded acute illnesses from their coverage, the healthy insured chose to buy only the less expensive tariffs while the first mentioned tariff was mainly bought by dialysis patients who nearly had a claim with each travel.

Illustration 2[2]: Health Insurance in the State of New York, USA

Since 1 April 1993, all insurance companies selling individual health insurance to individuals or employee groups with less than 50 employees in the state of New York were required by law:

– to accept all applicants at flat community-rated premiums, with adjustments only for geographic location (i.e. no adjustment for age or gender), and

– to cover all pre-existing conditions (i.e. conditions for which individuals sought or should have sought treatment in the six months prior to seeking coverage) after a 12-month waiting period, and

– to recognise any months of prior coverage towards meeting the pre-existing condition limitation.

The few private insurers in the state who decided to remain active in the individual health market immediately increased their deductibles from USD 1.000 to at least USD 2.500 and introduced limits in their policies to cap certain benefits.

However, one local company, the Empire Blue Cross Blue Shield (EBCBS) of Greater New York, did not receive approval to modify its cost-sharing provisions (i.e. to increase its deductible) or limit its benefits in other ways, which opened the door to very strong antiselection. Its experience deteriorated rapidly because some of its good risks either abstained from medical insurance completely or were able to purchase coverage more reasonably elsewhere; most of its poor risks had no option but to stay where they were; and private companies' poor risks chose to move to EBCBS.

[1] Example from the Gesamtverband der Deutschen Versicherungswirtschaft e. V.
[2] Mr. André Chuffard and Prof. Philippe Maeder †, *Asymmetric information in personal insurance underwriting – effects, consequences and countermeasures*, 2007, p. 11-12.

In 1994, the incurred claim loss ratio exceeded 150%; the financial losses shot up to almost USD 100 million. EBCBS then requested a 43.5% premium hike for 1995, which would have reduced the expected loss ratio from 193% to 143%; the supervisory authority, however, only approved a 21.8% rate increase for individual major medical products, generating a then expected loss of about USD 107 million.

EBCBS's net enrolment dropped rapidly by 13–15% each year, while their members' average age rose from 44.2 years in 1992 to 49.8 years in 1994 (> 10 years older than the industry average): alone this ageing trend translated into more than 60% higher expected morbidity costs.

Particularly interesting is a comparison of the 1993 average annual claim cost per insured with the average annual claim cost of those insureds who cancelled their contract the same year: USD 3.398 and USD 1.877, respectively.

In 1993, among those covered by a major medical product, the frequency of high-cost claimants (> USD 25.000 in annual claims) was almost four times that experienced by the large groups: this multiple lay at around three times for heart disease, cancer and trauma/burns, and ten times for AIDS. The AIDS claims as a percentage of total medical claims were about 2% for both the small and the large groups, but 11% for individuals.

In summary, we may say that the intention of the law was indeed to increase the number of people benefiting from medical insurance. Unfortunately, the plan backfired, and at the end of 1995, the fewer New York State residents had medical coverage – whether an individual health policy or a small group health contract – than on 1 April 1993.

Illustration 3[3]: Life insurance product without medical risk assessment

In the UK, a specific life insurance product did not need a medical risk assessment for young couples who were planning to build a house. The idea behind was that a person with an acute illness would not undergo such a long-term life planning. After a few years, the sale of this product had to be stop as the result of big losses. Reason for these losses was an adverse selection process: as this product could be concluded without any medical risk assessment, an increased number of people with a high risk bought this product.

[3] Example from the Gesamtverband der Deutschen Versicherungswirtschaft e. V.