SOCIETY OF ACTUARIES

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A look at community rating

by Alice Rosenblatt

In recent years, medical insurance rate-making in the United States has incorporated such factors as age, sex, industry, geography, historical claim experience, policy duration, health status, and plan design. Carriers have used these to match the best prices with the best risks and to help avoid adverse selection.

Recent state reform of the individual and small group health insurance market has prohibited or limited the value of some of these rate-making factors.

Questions arise as reform efforts continue to focus on increasing access and affordability of medical care. Should older or high-risk individuals (or employers with such employees) pay more for their health coverage? Should younger or lower-risk individuals subsidize others? Community rating has been one approach used to address these issues.

finition and changes in community ing

Pure community rating can be defined as a system that recognizes only geography and plan design and overall experience of the "community." Community rating by class refines this approach by adding certain demographic characteristics, such as age and sex. Adjusted community rating refers to the addition of historical claim experience.

Many Blue Cross and Blue Shield plans were using pure community rating at a time when health care costs were much lower. As the market became more competitive and many insurance companies began to use risk classification, many Blues plans changed their rating practices to avoid adverse selection. Other Blues plans were unable to change their rating practices due to legislation. At the beginning of the HMO movement when it was important to be federally qualified, most HMOs also used community rating. Many HMOs itched from pure community to mmunity rating by class or adjusted community rating when allowed by federal qualification standards.

Most players in today's insurance market experience-rate employer groups with 50 or more employees. Many of these groups rely on some form of self-funding, which sometimes avoids certain carrier-related retention charges and permits an employer to avoid state mandated benefits and state premium taxes.

Advantages and disadvantages of community rating

Your view of pure community rating is affected by how you feel about its effects on the allocation of health care costs across society and the incentives inherent in various rating methods affecting the level of these costs. The impact of community rating obviously varies widely among different population segments or groups, depending on their level of expected cost.

A significant advantage of pure community rating to an individual or small group is lack of a penalty (higher than average premium) for poor health status, high previous claims cost, or older age. In addition, compared to a risk classification employer-centered health system, incentives preventing job mobility may be reduced.

A disadvantage of community rating is that it increases cost for those who are better risks. On average, they subsidize the poorer financial risks. If medical insurance is not mandatory in a pure community rating system, these better risks may choose not to purchase insurance at all.

Many larger employers who are experience-rated or self-insured may resist joining a community pool for the following reasons:

- The cost of health care could increase for many employers whose experience has been better than the pool's experience. A reduced incentive for prevention of overuse of health care services may result.
- Some employers have invested in or promoted lifestyle programs, including smoking cessation, weight reduction, or exercise facilities. These employers expected to see their investments offset by reduced costs for medical insurance.
- An emphasis on cost control and accountability for a more efficiently run system may be more difficult if employers' costs do not directly reflect the cost of their own health care program. They often hold their insurance carriers or administrators (for self-funded plans) accountable for utilization review and accuracy of claim payment.

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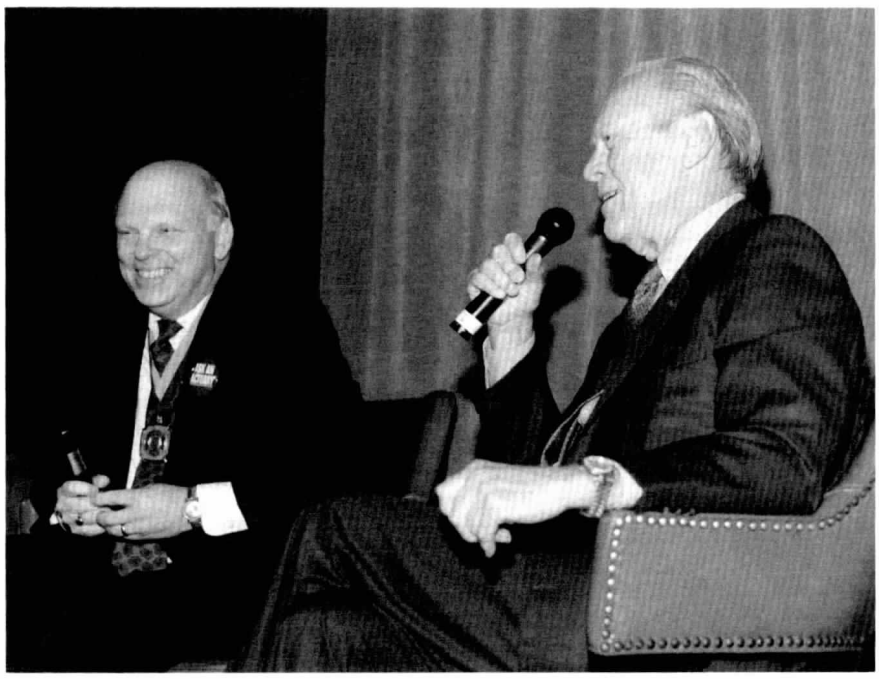

Keynote speaker for the San Diego health and pension spring meeting, President Gerald Ford (right), exchanges quips with Society members and SOA President Walter Rugland (left) during the Q&A session.

New SOA material addresses hot health topics

by Richard Bilisoly
SOA Education Actuary

If you would like to expand your actuarial expertise in the Health Systems practice area, then you may be interested in new syllabus material added to the Group Benefit Track courses in the spring and fall of 1993. Many topics included in these courses go beyond basic principles into "hot" practice areas. These areas include flexible benefits, managed care, continuing care retirement communities, long term care insurance, post-retirement life and health benefits (including SFAS 106), and national health policy. Following are new course readings.

Course G-320 — Design and Distribution of Group Benefits

- Chapters 1, 2, 3, 7, and 9 in the new book, *Group Insurance*, edited by William F. Bluhm (ACTEX 1992)
- Readings in recent volumes of the *Record of the Society of Actuaries (RSA)* — "Health Care Trends Update," *RSA* 16 No.1; "Brave New World of Health Care," *RSA* 17 No. 3A; "How Will Society Deliver Adequate Health Care to All?" *RSA* 17 No. 4A
- Study Note 320-45-93 — Creditor's Group Insurance Guideline Canada 1992

Course G-420C — Group Financial Management and Regulation - Canada

- Chapters 28, 30, 31, and 34 in *Group Insurance*

Course G-421U — Group Financial Management and Regulation - U.S.

- Chapters 10, 28, 30, 31, and 34 in *Group Insurance*

Course G-422 — Group Insurance Pricing

- Chapters 13, 14, 17, 18, 21, 22, 25, and 26 in *Group Insurance*
- *Actuarial Issues in the Fee for Service/Prepaid Medical Group* (1992) Sutton and Sorbo

Course G-520 — Cost Containment/Managed Care for Health Benefits

- Chapters 12 and 19 in *Group Insurance*
- Readings in recent *RSA*s — "Effect of Resource-Based RVS in Medicare on Private Health Insurance" and "What Employers Can Do To Reduce Medical Cost," *RSA* 17 No. 3A
- Chapters 9 and 10 in *Actuarial Issues in the Fee for Service/Prepaid Medical Group* (Second Edition 1993) Sutton and Sorbo

Course G-522 — Continuing Care Retirement Communities and Long Term Care Insurance

- Actuarial Standard of Practice No. 18 — Long Term Care Insurance
- Readings in recent *RSA*s: "Financing of Long Term Care Costs: Government Proposals," *RSA* 18 No. 1B; "Long Term Care Insurable Events: Emerging Prominence of ADL Benefits," *RSA* 18 No. 1A
- 1991 Long Term Care Continuance Tables - E. P. Barnhart, *Proceedings of Conference of Consulting Actuaries* 1991
- Study Note 522-33-93 Interim Report (Revised) to NAIC Life and Health Actuarial Task Force from SOA Long Term Care Valuation Task Force
- Study Note 522-32-93 Group Long Term Care Topics

Course G-523 — Post Retirement Life and Health Benefits

- Study Note 523-24-93 Retiree Life and Health Plan Funding Vehicles
- Study Note 523-26-93 Actuarial Methods for Retiree Life and Health Plans
- "Postretirement Medical" *RSA* 18 No. 1B
- Study Note 523-31-93 Retiree Medical Liabilities: Problems and Solutions

Course G-525 — Flexible Benefit Plans - U.S.

- *Fundamentals of Flexible Compensation* (Second Edition 1992) Gifford and Seltz

Please call the SOA Study Notes Department, 708/706-3525, to order study notes. Please call Joanne Temperly, 708/706-3500, to order other material.

In memoriam

Wesley W. Fulford ASA 1960, FIA 1953

Humbert J. Graziadei ASA 1937

Community rating cont'd

The instability of community rating in a mixed premium competitive market

In many states, a mix of rating practices co-exist, with some carriers using pure community rating, while others use all or most of the rating variables. This may create an adverse selection spiral for carriers using pure community rating. The better risks can find coverage at rates lower than the pure community rate with carriers that use rates reflecting age and health status. The remaining community risk pool then deteriorates in health status and age, which drives up the pure community rate, forcing still more of the better risks to leave the community pool.

Even in the states that have prohibited or limited some of these rating practices, a significant transition issue exists, because the risk pools of each existing carrier have a different average claim cost.

Some carriers have been using medical underwriting to select the best risks and using aggressive rating to compete for these best risks. They can end up with the lowest price if forced to do pure community-rating, even if these carriers are the least efficient in medical management.

Methods of overcoming the instability

Methods using risk adjustment have been developed to avoid the adverse selection situation described. Reinsurance mechanisms have been instituted in various states over the past several years to spread the cost of high risk individuals. Health care cost is heavily influenced by the few high amount claimants. A recent study by a Blues' plan of insured individuals found that 4% of claimants generated 48% of claim costs.

Recently introduced legislation in New York includes a process by which the relative degree of risk in various blocks of business results in a system of monetary transfers among carriers. In New York, the risk adjustment transfer uses differences in the age/sex distribution in the various carriers' risk pools to determine if the particular carrier will make or receive payment from the pool. The carrier with younger insureds generally would make payment to the carriers with older insureds. In addition, a catastrophic reinsurance system pays predetermined amounts for particular treatments, such as organ transplants.

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Dear Editor:

A look at future math education

If you have not spoken to a teacher recently, you may not be aware of how much elementary and high school math education has changed since your school days. The National Council of Teachers of Mathematics (NCTM) published a landmark document in 1989 called *Curriculum and Evaluation Standards for School Mathematics*. It outlines NCTM's vision of what the school math curriculum should include in the next decade. I highly recommend that you read this document, available from NCTM by calling 703/620-9840.

You also may not be aware that each state has a coalition of teachers, parents, and business leaders who are interested in improving math education. Actuaries would be an excellent resource to help bring more real-world math into the classroom. I encourage you to contact your state math coalition. Their addresses are available from Joan Donahue at the Mathematical Sciences Education Board, 202/334-1488. Get their newsletters and discover how you can contribute to their efforts.

Jerome E. Tuttle

Consequences of new ASA requirement

After reading *The Actuary* article (April 1993) on the planned strengthening of the ASA designation, I am compelled to comment on what I see as a likely consequence of these course changes. The article states that anyone who has earned the ASA designation before July 1995 will not be affected. However, after reviewing the changes to the curriculum, I do not believe this statement is entirely accurate.

Although they will not be required to take additional exams to retain their Associateship status, they will be affected. This change in educational requirements will create two classes of Associates, placing many pre-July 1995 Associates at a distinct disadvantage. Many "career" Associates with several years working in the industry may have enough practical experience to offset the negative impact of not having passed Courses 200, 210, 220, and 230. However, those of us who have only recently become Associates may find that our work experience is not enough to outweigh the obvious benefits of completing the Series 200 courses.

Of course, pre-July 1995 Associates can study for and attempt to pass Series 200 courses. The disadvantage is that their Series 200 credit will be valid for at most nine years if they decide not to attain full Fellowship status. Persons attaining Associateship under the strengthened program will receive permanent credit for Series 200 courses without having to proceed to Fellowship and without having to make such an all-or-nothing decision.

The Society can rectify this inequity either by allowing pre-July 1993 Associates to reapply for Associateship under the strengthened curriculum once they have successfully completed Series 200 requirements or by eliminating the expiration of any Series 200 credits earned by pre-July 1993 Associates. Such action will strengthen the ASA designation for all Associates, not just those obtaining their designation after July 1993. Without providing such an alternative, the Society's plan will weaken the ASA designation earned by pre-July 1995 Associates.

I fully support the Society's efforts to make the Associateship designation a more valuable commodity in the insurance industry if such action does not devalue the standing of another segment of its active membership.

James W. Brumbaugh

Reply from Marta Holmberg, SOA Education Executive

We are aware that fairly recent ASAs may share the concerns raised by James Brumbaugh. As he points out, the potential negative impact for an individual is a short-term one that can be addressed in two ways: by acquiring valuable practical experience and by completing the Series 200 (Core) basic practice examinations. The latter course of action could fill the gap while the individual acquires more practical experience.

In a sense, the need for the Series 200 examinations is a temporary one for a new ASA who is not going on to FSA. We recognize, of course, that the possibility of later losing the Series 200 credits because of the current rule is not a happy one. However, it is not intended that the rule would be applied automatically. The E & E Committee is reviewing the underlying policy and related rules with an eye to ensuring that policy concerning course validity is fair and reasonable. The review may well lead to some changes in that policy.

Community rating cont'd

One of the biggest obstacles to many of the risk adjustment methods that have been proposed, such as Ambulatory Care Groups (ACGs) or Diagnostic Cost Groups (DCGs), or the use of self-reported health status indicators, is the huge expense involved in collecting, processing, and verifying the needed data.

A perfect risk adjustment method would allow consumers to price shop, based on a premium or contribution that reflects a carrier's ability to manage medical and administrative costs efficiently, not the particular risk characteristics of that carrier's block of business. Such a risk adjustment method would need to be reliable, unbiased, easily calculated with data readily attainable, timely, and accurate.

The trade-off for risk adjustment methods is between accuracy and simplicity. The goal should be to find a model that is accurate enough to create a level playing field and simple enough to minimize administrative costs.

Alice Rosenblatt is senior vice president and chief actuary with Blue Cross/Blue Shield of Massachusetts.

Mail alert

Second ballots for the Society of Actuaries' 1993 elections will be mailed to all Fellows on July 20. Ballots must be returned to the Society office by August 20.