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Janet M. Carstens
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Anna M. Rappaport, FSA, President
Bradley M. Smith, FSA, Director of Publications

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EDITORIAL

Safe, and growing

by Janet M. Carstens

If you had asked me four years ago about the future of health actuaries, I would not have viewed the situation with much optimism. My perspective has changed dramatically. This is an exciting time of growth for our area of actuarial work.

Four years ago, with national health insurance reform legislation on the horizon and the threat (however small) of a U.S. public health insurance system, I wondered what types of employment opportunities would be available for a health actuary. I was too young to realize that my predecessors asked this same question back in 1973 when public health insurance was proposed.

Having practiced in Europe, I know firsthand that the opportunities for a health actuary in a public health system are very different from those in a private system. In many European countries, private insurance is offered to supplement public coverage, but it generally represents a small percentage of the total. While I found several health care consulting opportunities there, I saw very few health actuaries working on staff in these predominately public systems.

Luckily for us, we have legislation on our side. Boy, did I misjudge the role that it would play! It's because of both state and federal legislation that the opportunities for health actuaries continue to grow.

What makes this an exciting time?

In addition to health actuaries' traditional roles, which legislation has not diminished, new opportunities have arisen — created by two very significant pieces of legislation: the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Balanced Budget Act of 1997 (BBA). These are summarized in three articles in this edition.

Before HIPAA's enactment, several states had implemented their own health care reform legislation. HIPAA now challenges health actuaries to determine how the federal legislation coordinates with state legislation. In addition, actuaries will need to estimate the effects of various HIPAA mandates, including the effect of guaranteed issue.

The BBA requires health actuaries to take a fresh look at the products offered to Medicare eligibles. Old products need to be eliminated or revised to reflect changes such as the level of federal reimbursement and the type and extent of provider networks now allowed under the act. Perhaps the most interesting aspect of the BBA for health care actuaries, however, is the legislation that allows providers to contract directly with the federal government to provide Medicare services. This enhances the existing opportunities for health care actuaries to assist the provider community as they operate as insurers. What remains to be determined for provider-sponsored organizations are the solvency requirements they will have to meet. This is the topic of a fourth article in this issue.

It is refreshing to work in a field where things are constantly changing and learning opportunities never cease. I suspect that a public health care system may once again be proposed in the future. Until that time, I can enjoy being a health care actuary.

Editor's note: *We welcome Janet M. Carstens as a new associate editor of* The Actuary. *She takes the post held by Robert H. Dobson, health actuary with Milliman & Robertson, whose 1995-97 term expired in August. Dobson brought important insights on health issues to our readers, and we thank him for his contributions.*

Jan Carstens is a principal of Towers Perrin Integrated HealthSystems

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Trying to adapt (continued from page 1)

gender, and family composition of the employees). The adjusted manual rate would then be increased or decreased based on the underwriter's assessment of the general medical condition of the employees. To determine this, the underwriter would review an employer's claim history, the duration since the group was last fully underwritten, and employee health surveys that would indicate the employees' current health status. The NAIC model law limited the underwriter's ability to vary the rates for groups with identical case characteristics to no more than 25% from the index rate for that class of business. The index rate for one class of business could not exceed that for another class by more than 20%. The model law also limited the maximum annual adjustment to 15% for changes in a group's medical condition.

In July 1992, the NAIC issued the "Small Employer Health Insurance Availability Model Act," which expanded on the 1991 model rating law. The 1992 model act suggested limiting pre-existing condition exclusions, developing "basic" and "standard" health benefit plans to be offered to all small employers (i.e., two guaranteed issue products), and establishing a state reinsurance pool.

Throughout the early 1990s, many states followed the guidance of NAIC model laws but modified them to meet the states' own market and political environments. Table 1 summarizes the percentage of states that allow with unspecified limits, allow with specified limits, or disallow the use of each of the NAIC's case characteristics. Table 2 summarizes the percentage of states that allow deviations for claims experience, duration, or health status by the size of the deviation allowed within a class of business.

Table 1: Percentage of states with unspecified limits, specified limits, or prohibitions against the use of case characteristics to price small group health insurance products, March 1997

Characteristic	Limits not set	Limits Set	Prohibit
Family composition	88%	12%	0%
Age of employee	72%	26%	2%
Gender	62%	16%	22%
Size of employer	48%	28%	24 %
Geographic area	62%	34%	4%
Industry	22%	56%	22%

Source: Towers Perrin

According to the article "Federal Insurance Reform: A Drop in Your State's Bucket?" in *Business & Health* (October 1996), 37 states enacted guaranteed issue laws and 45 states passed laws that limited the pre-existing condition exclusions.

Small group pricing in a post-HIPAA world

Unlike the NAIC model laws, HIPAA does not address the issue of affordability. Instead, its intent is to guarantee access and continuation of coverage to those who already are insured and to minimize the barriers preventing those who do not have coverage from obtaining it. (See story, "Overview," page 4.)

While many states have modified their small group health laws to comply with HIPAA, most states have not altered their small group rating laws. Therefore, HIPAA's provisions will affect each state's small group market differently. Depending on how much flexibility exists within a state's rating limitations, the pricing actuary will want to reflect the cost of HIPAA as an adjustment to the manual rate or to the case characteristics used or as an additional adjustment for a group's medical condition.

Table 2: Percentage of states by maximum allowed rate difference due to health status/claims experience/duration, March 1997

Not Specified	8%
+/- 60%	2%
+/- 50%	2%
+/- 35%	10%
+/- 33%	2%
+/- 30%	4%
+/- 25%	36%
+/- 20%	12%
+/- 10%	4%
Not Allowed	20%

Source: Towers Perrin

Three HIPAA provisions that might affect the pricing of products are:

- The guaranteed issue and renewability of all small group products to all small employers
- The limitations on pre-existing condition exclusions
- The health status nondiscrimination rule

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Safe, and growing (continued from page 2)

Consulting and practice manager of the Minneapolis office. In 1994-95, she worked in the firm's Milan office, consulting with clients across Europe.

Carstens is a member of the Health Committee of the Actuarial Standards Board. She also chairs the SOA/AAA Health Benefits Systems Communication Committee.