

Institute of Actuaries of Australia

## **One Price Fits All**

A Review of Community Rated Private Health  
Insurance

Prepared by Andrew P Gale

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The Institute of Actuaries of Australia  
Level 7 Challis House 4 Martin Place  
Sydney NSW Australia 2000  
Telephone: +61 2 9233 3466 Facsimile: +61 2 9233 3446  
Email: [insact@actuaries.asn.au](mailto:insact@actuaries.asn.au) Website: [www.actuaries.asn.au](http://www.actuaries.asn.au)

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## 1. Overview

Many voluntary health insurance markets operate on the community rating principle, where restrictions are placed on the use of rating factors in setting premiums. These price restrictions are often supported by risk equalisation systems to redistribute the impact of risk variation between market participants.

This paper reviews the different community rating systems in operation in Australia and other markets and the regulations and mechanisms that support their operation.

Despite my efforts, this paper represents simply a work in progress on this topic. My research has been far from comprehensive and private health insurance environments around the world are subject to continual change. I can only hope that I have accurately portrayed the material that has crossed my path during my brief and haphazard research, and encourage others to add to what I have discovered.

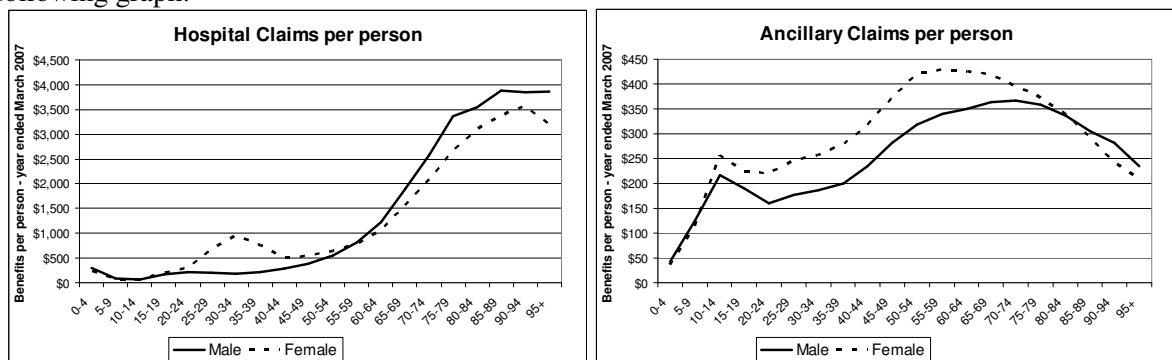
## 2. Why Community Rating?

Community rating is the central tenet of private health insurance in Australia. The fundamental principle of community rating is that persons should not be discriminated against in obtaining or retaining health insurance. Community rating is a form of solidarity, which Wilkie has defined as the sharing of costs without reference to the best estimate of the risk. It is a deliberate modification of usual premium structures to achieve the intended objective of ensuring affordable access to insurance coverage for high risk individuals.

Community rating appeals to social justice and egalitarian values in ensuring equity and access in the provision of health services to all members of the community.

Community rating requires that the young and healthy subsidise the old and sick. Attracting and retaining the young and healthy is critical to survival of a voluntary community rating system.

Private health insurance hospital product claims are highly age-correlated as illustrated by the following graph:



Source: PHIA data for year ended 31 March 2007

Community rating restrictions mean that funds cannot risk-rate, or price premiums at actuarially fair prices. Ancillary claims do not exhibit the same age correlation, however they are also subject to community rating restrictions in Australia.

### 3. Origins and Development of Community Rating

Community rating has been the basis of private health insurance in Australia for more than half a century. The origins of community rating in Australia date from the period surrounding the introduction of the *National Health Act* in 1953.

This Act implemented a scheme developed by Dr Earl Page, Minister for Health, for the provision of Commonwealth subsidised hospital and medical treatment administered by the non-profit voluntary health funds.

The *National Health Act 1953* laid the foundation for community rated health insurance in Australia. In his speech to Parliament, Dr. Earl Page, Minister for Health, said that:

*It is recognised that there will be people who, because of age or chronic infirmity, will be unable to join such organisations, but it is hoped that as the scheme develops and the organisations become stronger financially, they will be able to give an increasingly wide cover to these persons.*

*Experience in the operation of voluntary hospital insurance organisations has shown that as the number of insured people increases, it becomes possible to progressively reduce, and in some cases, remove, the qualifications of membership and entitlement to benefit which are imposed by such organisations. Because of this experience it is confidently expected that organisations conducting medical benefits funds will soon be able to reconsider the provisions in their rules relating to age limits and limitations on benefits, waiting periods and so-called chronic conditions.*

*By providing a full and complete medical and pharmaceutical service to pensioners and their dependents, the Government has met the needs of this main group which would normally be unable to insure. (Hansard, House of Representatives, 27 March 1953)*

The Page scheme was heavily influenced by the practice of some private health insurers who had begun to abolish the application of risk factors such as age in the setting of premiums and removal of restrictions on who could join a health fund.

For example, when the Medical Benefits Fund was established in 1946, it limited membership to persons aged 60 and under, with no cover for pre-existing conditions, a 12 month waiting period for maternity benefits and a 2 month general waiting period except for accidents. MBF reserved the right to order a medical examination of any prospective member prior to acceptance. Separate contribution rates applied to families, singles over age 21 and singles under age 21, with families paying twice the single rate and singles under age 21 paying two-thirds of the rate for singles over age 21. In 1952 as the Page scheme was being finalised, MBF removed its age restriction on membership access. Many aspects of the Page scheme enshrined in the *National Health Act 1953* were based on MBF's terms of membership.

The Page scheme was enormously successful, leading to an increase in the proportion of the population with private health insurance from 40% in 1953 to 70% in 1960.

Over time, the Page scheme encouraged uniformity of industry practice and the *National Health Act* prohibited discrimination on the basis of age, health status or other defined circumstances.

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Community rating is currently defined by the *Private Health Insurance Act 2007* which prohibits health insurers from setting premiums or paying benefits on the basis of health status, age (other than age at entry under Lifetime Health Cover), race, sex, sexuality, use of hospital, medical or ancillary services, or claims history. However the Act expressly permits prices to vary based on state of residence, and allows limits to apply to ancillary benefit payments.

Section 55 of the *Private Health Insurance Act 2007* prohibits improper discrimination, which is discrimination relating to:

- (a) the suffering by a person from a chronic disease, illness or other medical condition or from a disease, illness or medical condition of a particular kind; or
- (b) the gender, race, sexual orientation or religious belief of a person; or
- (c) the age of a person, except to the extent required by the Lifetime Health Cover provisions; or
- (d) where a person lives (except that contributions and benefits may vary by state of residence); or
- (e) any other characteristic of a person (including but not limited to matters such as occupation or leisure pursuits) that is likely to result in an increased need for hospital treatment or general treatment; or
- (f) the frequency with which a person needs hospital treatment or general treatment; or
- (g) the amount or extent of the benefits to which a person becomes entitled during a period (except that maximum limits may be placed on general treatment benefits)

Beyond the pricing restrictions imposed, community rating also extends to the following features of the Australian private health insurance environment:

- Waiting period limitations
- Portability requirements between insurers
- Product design restrictions
- Membership categories

### **Waiting Periods**

Waiting periods are limited to 12 months for pre-existing ailments (where the signs and symptoms existed at any time during the preceding 6 months), 12 months for obstetric conditions (increased from 9 months in 1998) and 2 months in other circumstances. Funds often waive waiting periods as part of marketing campaigns.

### **Portability**

Portability requirements were introduced in October 1988. These requirements ensure that persons transferring between private health insurers are given credit for any waiting periods served with their previous fund for equivalent levels of benefit. Waiting periods can be applied for any increased benefits. This facilitates the movement of members between funds and enhances competition.

### Product Design

Health insurers have gradually been able to develop a comprehensive range of products. From September 1985, front end deductibles, excesses and co-payments were permitted, and from June 1995 exclusionary products were permitted.

The types of treatments for which funds typically apply exclusions or reduced benefits includes:

- cornea and sclera transplants, eye cataract and artificial lens surgery
- hip and knee joint replacement surgery
- plastic, cosmetic and reconstructive surgery
- dialysis for chronic renal failure
- psychiatric services or conditions
- rehabilitation
- palliative care
- obstetric or pregnancy related services
- assisted reproductive services, infertility investigations, infertility treatments
- cardio-thoracic surgery, invasive cardiac investigations, invasive coronary artery procedures
- bone marrow transplants, stem cell collection, donated blood, collection and storage

Benefits payable for specified services may be sufficient only to cover charges in a public hospital, or there may be no benefits payable at all. These lower levels of benefits may apply for a specified period of time, or may be permanent.

The expansion of the product range occurred in response to market demands and affordability concerns. However product proliferation has led to some relaxation of community rating requirements by allowing stratification of risk to occur through member self-selection and product marketing. Ultimately, exclusion products fragment risk sharing as different risks separate and reduce the level of subsidy between the risk groups.

In July 2007, the Government amended regulations to ensure that all open products are available to all members.

### Membership Categories

Traditionally health insurers offered two categories of membership: single and family. The price for family contributors was fixed by the *National Health Act* at twice the single rate.

From 1 October 1996, these two categories were replaced by four categories of membership: single, couple, family and single parent family. The requirement for the family contribution rate to be twice the single contribution rate was removed, with no specific requirements for the relativity of contribution rates between the four categories. Funds were also given the flexibility not to offer all categories of membership for a given product.

Despite this relaxation of the rules, most funds have continued to charge families twice the single price, and there have been only a few instances where funds have offered lower prices for couples and single parents. Some funds have launched new products targeted at singles, couples or families and only offered these products to one category of membership.

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In April 2007 changes were made to the risk equalisation arrangements to reduce the share of the risk equalisation pool borne by single parent families. In response, a number of health insurers reduced contribution rates for single parent families.

### Lifetime Health Cover

The origins of Lifetime Health Cover date from 1973 when Deeble and Scotton examined the role of private health insurance as a supplement to the proposed universal health scheme. They considered that a modified form of community rating should apply *“under which the premium paid by an insured person – as in life insurance – would be based on age at entry and maintained at the same level (as a proportion of the premium charged to a good-risk entrant) for as long as the contributor remained insured. Contributors carried over from the voluntary insurance scheme would be enrolled in the new table at the “good-risk” rate, and special actuarial reserves to cover the transitional underpricing of high-risk contributors would be created by transfers from the existing reserves”*. (The Making of Medibank, p274). However, what seemed to be an elegant prescription for the regulatory framework of private insurance in the context of a universal Medibank program did not fit in with departmental thinking of the time.

On 17 September 1996, the federal treasurer announced that the Industry Commission would conduct an inquiry into private health insurance. An interim report was published in December 1996 and the final report was published in February 1997. This was a landmark inquiry, with almost 200 submissions and 100 supplementary submissions received.

The commission’s interim report considered the problems of community rating in a voluntary environment, and recommended a system of extended age-related waiting periods (similar to those existing in Ireland). Immediately prior to the inquiry, the concept of entry age rating had been discussed, and found its way into submissions to the inquiry and was discussed at the public hearings in January 1997. Those organisations supporting the concept of entry age rating were National Mutual Health Insurance, The Institute of Actuaries of Australia, MBF, The Australian Health Insurance Association, the Australian Private Hospitals Association and the Australian Medical Association. The concept was similar to that described by Scotton and Deeble above, with actuarial reserves established from premiums to be drawn upon in later years as costs increased while maintaining a level premium (in relative terms). The biggest hurdle to the introduction of entry age rating was how to finance the shortfall in reserves that would be required to ensure that the existing community rated group paid no more than the lowest entry age price during any transition period. The Industry Commission estimated this shortfall at \$28 billion in 1995 prices.

The author, appearing at the public hearings, described an alternative system of unfunded lifetime community rating, where a fixed scale of entry age prices would apply, without the establishment of policy reserves. As under the previous arrangements, current year’s claims costs would be financed from current year’s premiums on the new entry age scale. It simply represented a more equitable way of spreading costs amongst members.

When the final report was published, the first recommendation was “The Commission recommends the introduction of unfunded lifetime community rating for private health insurance, under which people entering insurance late, for example after the age of 30 years, would pay higher premiums than those who enter early”.

Following the publication of the report, the Institute of Actuaries of Australia Health Practice Committee formed a task force which published a discussion paper on Unfunded Lifetime Community Rating containing a number of proposals for implementation.

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In May 1999, the federal treasurer announced in the Budget that Lifetime Health Cover (the new name for unfunded lifetime community rating) would be introduced in July 2000, with a transition period allowing those currently uninsured to join at current rates. The scheme involved a fixed scale of late entry penalties of 2% for each year of age above 30, with a maximum loading of 70% applying at entry age 65.

The Lifetime Health Cover scheme was modified in the April 2007 reforms by requiring the removal of premium loadings once a contributor reached ten years of continuous membership.

Possible future modifications could include changes to the scale of fixed premium loadings and discounted rates for those joining prior to age 30.

### **4. Risk Equalisation**

Some form of risk equalisation arrangement is generally required to support community rating restrictions. Risk equalisation mechanisms can often have multiple objectives, but a principal purpose is to adjust for variation in risk between insurers and groups to provide appropriate compensation and remove incentives for the avoidance of high risk individuals. In practice there is difficulty in adequately adjusting for risk variation without reducing incentives for efficiency.

Although the community rating requirements date from 1953, the risk equalisation arrangements to protect health insurers from high cost claims did not commence until several years later. A history of the risk equalisation arrangements that have applied to private health insurance in Australia is set out below.

#### **1 January 1959**

Health funds were permitted to establish Special Accounts under which the Commonwealth Government reimbursed health funds for the cost of providing insurance cover for people who would otherwise be uninsurable. The arrangement was voluntary – funds were not required to establish a Special Account if they did not wish to do so.

Benefits (at a defined rate of benefit) in respect of contributors over 65 years of age, for those with pre-existing and chronic ailments (which were generally excluded from payment under fund rules) or benefits paid in excess of fund annual limits, could be debited to the Special Account. The Special Account also received contributions in respect of these contributors, and funds were also permitted to debit reasonable management expenses to the Special Account. Any deficit in the Special Account was then reimbursed by the Commonwealth Government. Once transferred to the Special Account, contributors had to remain there for a minimum of two years, after which they could be returned to the ordinary account at the funds' discretion.

Members were automatically transferred to the Special Account on attainment of age 65. This requirement was based on the opinion of the Commonwealth Government Actuary that the aged represented an unduly expensive group for health funds. However the health funds believed that this was not the case as the medical fund special account had a significant surplus of contributions over expenditure.

Following the unanimous agreement of health funds, in August 1959 the Government agreed to retrospectively remove the compulsory transfer of the over 65s to the Special Account with effect from 1 January 1959.



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### 1 October 1976

Hospital and medical special accounts ceased following the introduction of Medibank, the universal health scheme. They were replaced by the Hospital Benefits Reinsurance Trust Fund established to share the cost of providing basic hospital benefits for long-term hospital patients (referred to as “chronically ill”). Initially the benefits that could be debited to the reinsurance trust fund were for those memberships where hospital treatment had exceeded 60 days in any one year. A few months later this was reduced to 35 days. The reinsurance trust fund operated on a national basis. The reinsurance trust fund was financed by private health insurers based on membership, with a Commonwealth Government subsidy allocated amongst those funds that were required to pay into the fund, reducing their payment.

Commonwealth Government contributions to the fund have been:

1976/77 to 1979/80	\$50 million per annum
1980/81 to 1982/83	\$100 million per annum
1983/84 to 1984/85	\$20 million per annum
1985/86	\$5 million
1987/88	\$1 million
1988/89	nil
1989/90	\$1 million
1990/91	\$15 million
1991/92	\$5 million

### 1 January 1984

The Hospital Benefit Fund in Western Australia were dissatisfied with the operation of the reinsurance trust fund on a national basis, arguing that it did not reflect the different costs of health care in each state. The cost of operating nursing homes was one of the factors driving different costs between states. It was claimed that high cost states were being subsidised by low cost states (in particular Western Australia) through the reinsurance trust fund. Hospital utilisation was also another factor, with the average length of a hospital stay per reinsurance pool member varying significantly between states. There were also varying public hospital and medical charges by state.

The Commonwealth contribution to the reinsurance trust fund was increased in 1980/81 in response these concerns about the inequity of the arrangements.

On 1 January 1984 the reinsurance trust fund was changed to operate on a state by state basis instead of an Australia-wide basis.

### 1985

The Hospital Benefits Reinsurance Trust Fund changed name to the Health Benefits Reinsurance Trust Fund.

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### **1 June 1989**

The reinsurance trust fund was expanded to provide for a greater sharing of benefits for aged and chronically ill members. The changes involved the inclusion of benefits paid from supplementary tables for hospitalisation in excess of 35 days in any 12 month period, inclusion of all hospital benefits paid for persons aged 65 years and over, and introduction of a revised membership formula to redistribute benefits between funds. This formula was designed to encourage the take-up of supplementary cover. New memberships were excluded from the redistribution formula for their first 12 months of membership.

### **1 April 1991**

Restricted membership funds were required to report members by state of residence rather than only in the state of their head office. States where membership was small (less than 5% of their total membership) could be reported together with their largest state.

### **1 October 1991**

A revised weighted membership formula was introduced. This was directed at preventing inequities which had developed through the introduction of insubstantial supplementary tables by a number of funds to gain advantage through the weighted membership formula which reduced the share of the pool borne by contributors with supplementary cover.

### **1 January 1995**

The Government implemented changes following a report into the reinsurance arrangements prepared by MIRA Consultants. The changes involved the establishment of separate pools for basic and supplementary tables, a reduction in the level of benefits that could be pooled from 100% to 85% and simplification of the membership formula used to allocate finance the pool.

### **1 July 1995**

The reinsurance arrangements were changed to return to a single benefits pool with 80% of benefits pooled.

### **1 October 1995**

The reinsurance arrangements were changed to reduce the level of benefits that could be pooled to 79%. In addition, medical gap benefits up to 116% of Medicare schedule fee could be pooled. Health funds were required to participate in the reinsurance pool in each state where they had more than 500 resident Single Equivalent Units.

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### 1 April 2007

Changes were made to the risk equalisation arrangements to replace the 79% with a set of age related pooling factors to more closely match the increase in claims costs by age:

Age	Old % pooled	New % pooled
0-54	0%	0%
55-59	0%	15%
60-64	0%	43%
65-69	79%	60%
70-74	79%	70%
75-79	79%	76%
80-84	79%	78%
85-89	79%	82%
90-94	79%	82%
95+	79%	82%

The pooling of benefits for those contributors with hospitalisation in excess of 35 days in a 12 month period was replaced with a high cost claims pool, where benefits in excess of \$50,000 in a 12 month period were pooled (after the operation of the age-based pooling).

The cap of 116% of the Medicare schedule fee for pooling of medical benefits was eliminated, and the threshold of 500 Single Equivalent Units for reporting in each state was also eliminated.

The definition of Single Equivalent Units was changed to count single parent families as one SEU instead of two for the purposes of the funding of the risk equalisation pool.

Benefits eligible for pooling were extended to include defined hospital-substitute treatment and chronic disease management programmes.

Risk equalisation transfers between funds are significant, with a total of \$218 million transferred between funds in the year ended 30 June 2007.

Risk or cost sharing mechanisms or funding formulas similar to the private health insurance risk equalisation arrangements apply in other markets. For example, levies exist to fund the Universal Service Obligation in telecommunications (see section 7 below), the Australian Health Care Agreements provide funding to state governments for Medicare services based on a risk-weighted formula, and state governments allocate funds to hospitals using cost weighted formulae.

**5. Community Rating in other health insurance markets**

Community rating requirements also apply in some other private health insurance markets around the world. This section describes the restrictions that apply in each market. A number of countries have national health insurance arrangements that are financed by compulsory levies. These systems are generally not considered here as they do not have the same features and pressures as those systems that operate on a voluntary basis.

**Ireland**

The private health insurance environment in Ireland has many similarities to that in Australia. Premiums are community rated, prohibiting prices from varying based on age, sex or health status. Open enrolment and guaranteed renewal also apply. Over 50% of the Irish population has private health insurance, and premiums are tax deductible. One distinguishing feature is the existence of age-related waiting periods for new entrants:

<b>Entry Age</b>	<b>General treatment</b>	<b>Hospital treatment</b>	<b>Pre-existing ailments</b>
Under 50	None	6 months*	5 years
50 to 54	6 months	6 months*	5 years
55 to 64	1 year	1 year	7 years
65 and over	2 years	2 years	10 years

\* 12 months for maternity benefits

The limit of age 65 on joining a health fund was removed in 2001. The *Health Insurance (Amendment) Act 2001* has enabled the commencement of Lifetime Health Cover, similar to that applying in Australia. Late entry penalties will apply for those joining after age 35. There is no firm date for the introduction of Lifetime Community Rating. It is expected that maximum loadings will range between 10% at age 35 to 80% at age 65 and over.

Until recently, the market was dominated by a single government owned insurer, the Voluntary Health Insurance board (VHI), which was established in 1957. Under European Union reforms, the market was opened to new entrants in 1996. The most significant new entrant was BUPA which achieved a 22% market share by 2006. Vivas Health also entered the market in 2004.

When the market was opened to new entrants, the need for risk equalisation arrangements to support community rating in a multi-insurer environment was recognised. A risk equalisation scheme was developed in 1996, however new entrants were given a three year exemption from participating. The Minister for Health and Children commissioned a report on risk equalisation arrangements, which was published in 1998. The report makes multiple references to the recently released report on private health insurance from the Industry Commission in Australia. The report recommended the introduction of Unfunded Lifetime Community Rating (which had been recommended in Australia but not implemented at the time of the report). It also recommended the removal of community rating for ancillary services. It affirmed the retrospective risk equalisation arrangements in place, but suggested modifications to equalise not just for age and gender, but also for insurer specific diagnostic related group claims cost data.

Following a decision to commence risk equalisation arrangements from January 2006, BUPA challenged the introduction of the risk equalisation arrangements in the High Court. In November 2006 the High Court upheld the risk equalisation arrangements. It is understood that the decision of the High Court is being appealed to the European Court of Justice as being in breach of the 1994 third non-life insurance directive.

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In December 2006 BUPA announced its decision to withdraw from the Irish market after assessing that it would be required to pay €161 in risk equalisation payments over a three year period. In January 2007 BUPA announced that the Quinn group would acquire its Irish business and had guaranteed not to increase prices in 2007.

In April 2007, the Government announced that the proposed risk equalisation formula would be diluted by 20% from July 2007, and that the solvency exemption in place for VHI would expire by 2008.

### South Africa

From 1967 to 1989 medical schemes (private health insurers) operated on a community rated basis, with premiums varying by family size. In 1989 the Medical Schemes Act was amended to allow medical scheme premiums to be determined based on age, health status and claims experience. In 1995 a committee of inquiry into a national health insurance system recommended that medical schemes return to community rated premiums supported by a risk equalisation fund.

Community rating was re-introduced on 1 January 2000 for medical schemes. About 9% of the population is covered by medical schemes. Risk equalisation arrangements have only recently been developed for implementation from 2009, with significant input from the Actuarial Society of South Africa. The risk equalisation arrangements will operate on a prospective basis with risk factors for age, chronic conditions and maternity.

### Netherlands

Community rating was introduced from 1 January 2006 for private health insurance in the Netherlands. The Health Insurance Act required health insurers to accept all entrants for basic cover, but may refuse applicants of supplementary cover. The new scheme covers all of the population, with costs funded by premiums paid by individuals (about 50% of costs) and an income related contribution of 6.5% of income (financed by employers). A risk equalisation fund distributes the income related contributions to insurers as a risk-rated premium subsidy. It is intended to minimise the cost differences between insurers resulting from health profiles of insured persons, and is based on defined risk characteristics including age, gender, health status and cost groups (for diagnosis and pharmacy usage). In order to limit opportunities for selection, there is also separate risk sharing of outliers and proportional risk sharing.

### Switzerland

Community rated premiums apply for basic health insurance which has been compulsory since 1996. There is no underwriting and automatic acceptance applies. Additional supplementary insurance is also available on a voluntary basis, and community rating and automatic acceptance does not apply. A retrospective risk equalisation scheme operates for each of the 26 cantons, with age and gender as risk factors.

### United States

The health insurance market in the United States is fragmented, with varying state regulations. In some states, modified community rating applies, where risk factors are restricted and a limit is placed on the maximum variation in premium rates.

Community rating was a deeply rooted value in the Blue Cross and Blue Shield system, which commenced in the 1930's. However competition from commercial insurers and the lack of a risk equalisation mechanism forced most to abandon the subsidies implied by community rating over time.

Thirty-three US states have high risk pools in operation to provide subsidised access to health coverage for people with serious or chronic illnesses who would otherwise not be able to obtain insurance. These pools have various funding sources, including levies on health insurers and specific taxation revenue.

### Pure Community Rating

Pure community rating, with no rating factors allowed, applies in New York, New Jersey and Vermont. Pure community rating also applies to Blue Cross / Blue Shield and HMOs in Pennsylvania, Blue Cross / Blue Shield in Michigan and HMOs in Oklahoma. Some rating factors (but not health status) may be allowed in the group market.

#### *New York*

New York introduced guaranteed issue and pure community rating in April 1993, requiring insurers to accept all applicants regardless of health status and charge everyone the same price. In the first year of community rating, there were large premium increases for younger and low risk members, and coverage reduced from 2.8 million persons to 2.3 million persons as some members chose to cancel their cover. A risk equalisation pool was introduced in 1993, but was phased out in 2001 in favour of a state funded stop loss reimbursement mechanism.

#### *New Jersey*

New Jersey introduced pure community rating in August 1993, along with guaranteed issue and renewal, limits on pre-existing condition exclusion periods (up to 18 months) and portability. Modified community rating applies to small employer group plans, with premiums varying within limits based on age, gender, family size and location. These reforms were accompanied by a significant reduction in membership coverage and a reduction in the number of insurers. Discussions continue about further reforms, including moving towards modified community rating and the establishment of a high-risk pool or reinsurance mechanism to offset large claims.

#### *Vermont*

Vermont introduced pure community rating in 1991. The legislation included the provision for rates to vary by up to 20%. This variation was removed for the group market in 1999. A reinsurance mechanism was proposed but has not been implemented.

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### Modified Community Rating and Rating Restrictions

Modified community rating, or restrictions on rating apply in the following states: Maine, Massachusetts, Oregon, Louisiana, Kentucky, Iowa, Idaho, Minnesota, Nevada, New Hampshire, New Mexico, North Dakota, South Dakota, Utah and Washington.

These arrangements usually place limits on allowable rating factors and place limitations on the maximum variation in premiums from most expensive to least expensive or variation from a central rate. Often the main objective of regulation is to exclude health status as a rating factor.

#### *New Hampshire*

In 1995 New Hampshire introduced modified community rating with maximum variation due to age limited to 300%. In 2002 it removed the modified community rating regulations. Following large premium adjustments both upward and downward, legislation was enacted in 2005 re-introducing the former modified community rating arrangements.

#### *Iowa*

Iowa has rating restrictions limiting price variation to a factor of two (excluding differences due to benefit design) and has a mandatory risk-adjustment system that spreads claims costs between health insurers.

#### *Massachusetts*

Modified community rating was introduced in 1996, with rating factors limited to age and geography with limits on rating bands of 200% for age and 150% for location. Further reforms were introduced in July 2007. A tax levy applies to persons without private health insurance.

#### *Washington*

Modified community rating was introduced in 1993, with rating factors limited to family size and geography. In response, a large number of insurers ceased providing cover. In 1995 modifications were made to allow age and industry as additional rating factors. In 2000 rating restrictions were removed.

#### *Kentucky*

In 1993 Kentucky passed laws mandating modified community rating, guaranteed issue, guaranteed renewal, portability and limitations on exclusions for pre-existing conditions. Allowable rating factors were age, family size and location but not health status. Separate rates could be charged for singles, couples, single parent families and families. Premium rate variations were limited to 300% from highest to lowest. In response to the reforms, a number of health insurers withdrew from the Kentucky market, with only two individual market insurers remaining by 1996.

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In 1996, the community rating requirements were modified to allow gender and occupation as rating factors and the maximum rate variation was increased to 500%. In 1998, following the collapse of Kentucky Kare, a government owned health insurer, the modified community rating requirements were removed, with health insurers permitted to use health status and claims experience to set premiums, although some limits were placed on the amount that could be charged based on health status and increases that could be applied on renewal.

The regulatory arrangements include regulator approval of premium rate increases once each year, and premium rates are guaranteed for each policyholder for 12 months from the date of renewal.

### *Maine*

Maine introduced modified community rating in 1993 with gender, health status, claims experience and policy duration prohibited as rating factors. Maximum premium variation of 20% from the average rate was permitted.

Other states (including Maryland and South Carolina) have previously had community rating regimes which are no longer in force.

### Possible future US health insurance reform

As the debate about health financing and access to health insurance continues in the United States, it is possible that some form of community rating may play a role in extending private health insurance coverage. On 15 September 2007, The New York Times reported that Senator Hillary Clinton, a candidate for Democratic presidential nomination, is reviving a health plan that was previously debated in 1993. She accused health insurers of “*spending tens of billions of dollars a year figuring out how not to cover people and how to cherry-pick the healthiest persons, and leave everyone else out in the cold*”. She was quoted as saying “*we could require that every insurance company had to insure everybody, with no exclusion for pre-existing conditions*” and that the plan could “*end the practice of insurance company cherry-picking once and for all by allowing anyone who wants to join a plan to do so, and by prohibiting insurance companies from carving out benefits or charging higher rates to people with health problems*”. However, insurance representatives commented that the plan “*while trying to make insurance more affordable for older, sicker people, could unintentionally drive up costs for young, healthy people and ultimately for everyone.*”

Besides health insurance, the US Medicare prescription drug plans (Medicare Part D) also operate on a community rated basis.

### **Belgium**

While not mandatory, some mutual insurers provide health insurance on a community rated basis. An age limit of 65 applies to cover.

### **Luxembourg**

While not mandatory, some mutual insurers provide health insurance on a community rated basis. An age limit of 60 applies to cover. Private health insurance premiums are tax deductible.



## New Zealand

Southern Cross, the largest health insurer in New Zealand, maintained a system of community rated premiums for many years. However, in the face of competition for younger members, and in the absence of regulation and risk equalisation arrangements, it moved towards a system of attained age prices. Many markets have had a similar experience.

## Age at Entry rating

While not operating on a pure community rated basis, health insurers in Germany and Austria set rates based on age at entry (with the build up of policy reserves) in addition to other factors.

## 6. Community Rating beyond health insurance

Community rating in private health insurance is simply a specific example of a more generally applicable common pricing structure. A feature of these common pricing structures is that providers of goods or services do not seek to recover their costs precisely in accordance with the costs of providing those goods or services to specific individuals.

Examples of 'community rating' in the provision of goods and services where prices do not reflect the individual costs of services include:

- Club membership fees
- Car registration fees
- Broadband and telephone connections. For example, one telecommunications provider is providing home phone and broadband services for a flat monthly fee, which includes unlimited local and national telephone calls and broadband usage up to a limit
- Roadside assistance services
- Buffet restaurants!
- Airline lounges
- Sporting clubs
- Gym membership
- Public transport fares (within zones)
- Provision of services in rural and remote areas
- Price of standard postage stamps (provided by Australia Post under a universal service obligation)

Examples of voluntary subsidies include:

- Discounts for pensioners, children and students

The reasons for adopting these artificial or average pricing approaches are:

- Simplicity
- Individual costs may be difficult or costly to determine
- Not significant variation between individual costs
- Government regulation or policy
- Sense of social fairness or recognition of capacity to pay which is generally accepted by the community

One could ask how prevalent these common pricing structures, with their inherent cross subsidies, should be within the community. They often depend on the goodwill of the provider of the services and the absence of significant anti-selective behaviour. Most of these examples above do not involve the level of variation in costs that exists in private health insurance, reducing the risk of anti-selection against a flat pricing structure. The importance of the pricing structure also depends on whether there are alternatives available to good risks to find cheaper alternatives.

### 7. What has telecommunications got to do with health insurance?

Some parallels can be drawn between community rating, risk equalisation and the long-running dispute between Telstra and the Commonwealth Government over the terms of access for competitors to Telstra's Unconditioned Local Loop (ULL) network. The following extracts from newspaper articles sets out the issues involved in the dispute.

*High-speed broadband is not a public good or an essential public service like a road or health care, but it is increasingly viewed as a commodity that must be provided at a reasonable price. Herein lies the conflict between what the federal government would like to provide, reasonable broadband pricing, and what Telstra must achieve for its shareholders, an adequate return on capital. What does need to be resolved is the tension between what investors can reasonably expect from their investment in Telstra and what can reasonably be charged for a telecommunications service used by the wider public.*

Australian Financial Review, p14, 4 June 2007

*Last December the Government formalised what had been long-standing policy by making explicit the obligation on Telstra to maintain pricing parity – to average its retail prices – across its customer base. Unfortunately for Telstra, the prices it charges its competitors for access to the ULL – the copper lines that connect customers' homes to Telstra exchanges – are "de-averaged" to reflect variance in Telstra's costs between regions. These costs vary wildly, from about \$3.42 per customer per month in the CBDs of the capital cities (band one) to \$11.89 per customer per month in the wider metropolitan areas (band two) to \$26.11 in regional areas (band three) and \$145.20 per customer per month in rural and remote areas (band four). Telstra argues that the combination of averaged retail prices and de-averaged wholesale prices would be horrendously destructive and could cost it as much as \$800 million a year. More politically sensitive however, has been its argument that today it uses its profits from bands one, two and three to subsidise the high-cost band four (bush) customers and that, if the ACCC's approach were adopted, its ability to maintain that cross-subsidy would be undermined, with dire implications for customers in rural and remote areas. If competition in the city undermines Telstra's profitability, it won't be able to sustain a cross-subsidy. The tension between the Government's social policy and the ACCC's competition policy seemed irreconcilable. The ACCC wants de-averaged, cost-reflective wholesale prices because it wants to encourage competitor roll-outs of digital subscriber line multiplexes (DSLAMs), equipment they can install in Telstra exchanges that enables them to offer their own broadband services. Averaged prices would inhibit that roll-out by raising the price of wholesale access to the ULL in urban areas to finance below-cost services in the bush. The ACCC is believed to be concerned about the implications of averaging for the 8.8 million services in bands two and three. If the wholesale prices don't reflect Telstra's actual costs in those bands – and band three costs are double those in band two – it would distort the price signals for competitors.*

Stephen Bartholomeusz, The Age, p10 Business section, 24 March 2006

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*A key stumbling block on the fibre broadband network is likely to be whether averaging pricing will be acceptable. Telstra has historically been wedded to an averaged wholesale price for its proposed access regimes, which means competitors are charged the same fees for accessing its network in depopulated rural areas as they are in highly populated cities, despite sharp differences in infrastructure costs.*

*The ACCC wants a de-averaged pricing model – with different prices in cities, suburbs and the country. The ACCC firmly rejected the suggestion that averaged pricing could be acceptable to the commission. “We’ve taken a fundamental view that the methodology of averaging is ultimately anti-competitive.” The ACCC said that there were more efficient ways to achieve the government’s objective of retail price parity between city and country areas, such as a universal service obligation and cross subsidies.*

*Australian Financial Review, p5, 26-27 May 2007*

*Telstra insists country customers will suffer under the ULL regime because the ACCC is setting access prices lower in city areas, a structure that must eventually flow into retail prices. Telstra wants its \$30 price to be a national average regardless of geography.*

*Australian Financial Review, p6, 16 November 2006*

*Telstra wants its wholesale customers to pay a single national average price of \$30 per line per month for ULL access, while the ACCC argues the price should be reduced in the cities because the network’s underlying cost structure is lower in built-up areas. The ACCC’s view is that as a general principle, prices should reflect costs – otherwise efficient investment and competition are less likely to materialise. The ACCC warned that a single national average wholesale price structure, as sought by Telstra, would not reduce retail prices for rural customers but would force up prices for the mass market, particularly city customers. If costs in remote areas are much higher than in other bands, an averaged price will mask those costs and create inefficient investment signals. This might discourage investment in options that allow for more efficient supply of broadband in regional and rural areas.*

*Australian Financial Review, p3, 8 March 2006*

*It is understood that the regulator remains open to one of the options raised in those talks, a surcharge that would be placed on every line to cover the costs Telstra incurs to provide universal service in country areas. But the level of the surcharge was in dispute. The company wanted to apply a monthly surcharge of \$13.69 per service but the regulator proposed \$1.77. The ACCC said yesterday Telstra’s ULL price undertaking was unlikely to promote the long-term interests of end users, would harm the interests of those seeking access to its network and would exceed the cost of providing access.*

*Australian Financial Review, p14, 29 August 2006*

*Telstra says it is losing at least \$1.5 billion a year in the bush, which results from the fact, claims Telstra, that each phone line in Band 4 (that is, regional and remote Australia) costs \$150 a month in capital and maintenance, but the national line rental is capped at \$30 a month. Multiply the difference by a million bush phone lines, and it equals \$1.45 billion. Divide that by the 9 million other phone lines in Australia and that equals \$13.42 per month, which is the surcharge Telstra wants placed on city lines to pay for the bush losses. Pretty simple really. The sum was probably done on a restaurant napkin before being transferred to 1000 pages of submission to the people at the ACCC, who then laughed and produced their own napkin with \$2 on it. The bush/city subsidy argument is the essence of the dispute between Telstra and the ACCC/Government. Telstra wants to focus the collective political mind on the need to fix the Universal Service Obligation, which is meant to subsidise bush phone services but which only coughs up \$150 million a year, or roughly 10 per cent of the losses claimed by Telstra (and denied by the ACCC).*

*Alan Kohler, The Age, 23 August 2006*

*Telstra, which owns the copper phone line network other carriers must rent to deliver telephony and broadband services, has to adhere to prices set by the competition regulator. The copper line, also known as the unbundled local loop (ULL), is priced in four bands that represent regions spanning built-up metropolitan areas to suburban areas to rural and regional areas. The ACCC has previously set so-called metropolitan band 2 pricing on the network at about \$17.70 a month, a price Telstra said was too low. It is understood the commission is now seeking to lower the price even further, to near \$14.*

*Australian Financial Review, p13, 30 June 2007*

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*The Australian Competition Tribunal's refusal of Telstra's appeal against de-averaged pricing of unconditioned local loop (ULL) is not as clear-cut as the ACCC suggests. All seven findings against Telstra are about the level and not the structure of prices. Yet, the key issue is about cross-subsidies.*

*There is a conflict between economic and social policy. Competition drives prices towards costs – everywhere. But social policy through price controls on Telstra dictates that customers pay the same price everywhere. Telstra argued that the average retail pricing forced on it by its price control obligations should be mirrored in averaged ULL pricing. Telstra's argument is that it would be the one to provide the increased competition if the cream-skimming between de-averaged ULL prices and averaged retail prices could be eliminated in urban areas.*

*Everyone agrees that averaged prices are not economically efficient and result from retail price controls. Optus says the Universal Service Fund is the appropriate social policy instrument for compensating Telstra for any losses it incurs in providing retail services at below-cost prices in rural areas.*

*Now only a ministerial direction to the ACCC on averaging ULL can settle this conflict between equity and efficiently differently and open the way to increased investment in new broadband networks.*

John de Ridder, Australian Financial Review, p63, 31 May 2007

*Telstra's High Court challenge to the laws governing the Australian Competition and Consumer Commission's pricing of access to the telco's fixed-line network alleges that the access pricing regime does not deliver just compensation for the compulsory acquisition of Telstra's property – the forced sharing of its copper network with competitors. Last year the ACCC rejected a Telstra undertaking to provide ULL access for \$30 a month on a nationally averaged basis. Telstra argues that an averaged pricing regime prevents competitors from targeting/cherry picking its most profitable customers while ignoring the high-cost markets.*

Stephen Bartholomeusz, The Age, p8 Business section, 25 January 2007

*The key dispute ... seems to have been whether it was reasonable, and lawful, for Telstra to adopt flat, average pricing for access to its network (so that country users paid no more than city users – a not uncommon practice for many products); or whether different prices should be set for city and country areas.*

R. Gilbert, Letter to the Editor, Australian Financial Review, p59, 21 May 2007

*Labor is looking at whether access to broadband would be included within the universal service obligation. At present, the USO ensures that all people in Australia have reasonable access on an equitable basis to standard telephone services. It is funded by an industry levy which is given to Telstra in part compensation for providing the services.*

Australian Financial Review, p10, 7 February 2007

*The Universal Service Obligation (USO) was introduced at the onset of deregulation of the telecommunications sector. It imposed an obligation on Telstra to provide access to basic telecommunications services to all Australians on equivalent terms regardless of where they live – and of how much it costs to provide the service.*

*In recognition of the reality that Telstra is forced to provide and maintain services that would otherwise be uneconomic, the industry (including Telstra) is levied to finance the deficit.*

*Telstra has, however, consistently complained that the payments it receives are grossly inadequate to cover the deficit created by the USO. While there have been wildly differing estimates as to the actual size of the deficits there is a reasonable consensus that the USO payments don't cover them.*

*The Australian Communications Authority estimated the cost of the USO to Telstra at \$548 million. Next year Telstra will receive \$145 million to cover these costs.*

*The USO issue has bedevilled the fibre to the node network (FTTN) debate because Telstra has insisted that access pricing for a new network be set at levels that allow it to do what it has effectively been doing throughout its history and use urban profits to subsidise losses or sub-economic services in the rural and regional areas.*

*This is what underpins Telstra's complaints that it is effectively forced by the USO to charge averaged retail prices while the Australian Competition and Consumer Commission insists on de-averaged wholesale prices, allowing its competitors to cherry-pick its most profitable urban customer bases and undermining its capacity to maintain the mandated cross-subsidy without damaging its shareholder returns.*

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*If Telstra could be properly compensated for meeting its obligations and that compensation was funded by the taxpayer rather than the industry, it could change the framework for the FTTN debate.*

*If taxpayers fully subsidised Telstra's rural and regional operations there would be no need for a continuing cross-subsidy between Telstra's urban customer bases and the bush – and no need to build the cost of that cross-subsidy into its urban access prices.*

Stephen Bartholomeusz, p10, Business section, The Age, 28 June 2007

The present impasse has been caused by the Australian Competition and Consumer Commission's desire for a price structure for ULL access that will encourage competition, while such a pricing regime would result in Telstra losing customers with lower servicing costs that presently cross subsidise customers with higher servicing costs. In simplistic terms, Telstra is being required to community rate its services without the benefit of requiring competitors to contribute to the costs of providing services to customers with higher servicing costs.

The equivalent problem in private health insurance is addressed by the risk equalisation arrangements. The Universal Service Obligation levy has parallels with the risk equalisation pool, however disputes have arisen over whether the USO levy adequately supports the provision of services to customers with higher servicing costs. Telstra accuses its competitors of cherry-picking by targeting cheaper services in the lucrative city areas while ignoring the more expensive lines with high service costs and low customer numbers in the bush.

The similarities between private health insurance and telecommunications continue when considering issues of product cannibalisation. Product cannibalisation has been a recognised feature of private health insurance as existing customers can choose, or be induced, to take reduced cover in the form of excesses or exclusions in return for a lower premium, generally resulting in lower margins for the health insurer. Similarly, telecommunications organisations with significant revenue from fixed telephone line rentals face cannibalisation from competitors and themselves as they see customers dropping fixed line services in favour of mobile telephones and internet VOIP phone services. The difficulty is to decide how much customer loss to accept before actively retaining customers on lower margin products.

### **8. A community rated future?**

Is community rating in a voluntary private health insurance environment sustainable? A letter to the Financial Review clearly identified the problem of adverse selection in a voluntary community rated environment:

*One of the chronic problems facing the private health insurance industry is brought about by community rating and adverse selection. Community rating is the government requirement that, while the health funds can offer a range of policies, each of the policies must be offered to all members of the community. The resulting adverse selection problem is that the people most likely to buy the policy are those who expect to have high health costs. This pushes up premiums, driving healthy people away from the insurance market. To sustain the insurance industry the government uses carrots and sticks to keep healthy people in the system. The carrot is the 30 per cent tax rebate, and the stick is the lifetime health cover penalty for people who delay joining a fund.*

Graeme Wells, Letter to the Editor, p57, Australian Financial Review, 30 May 2006

What factors contribute to community rating being sustainable?

- Mandatory purchase (or very strong inducements through incentives or penalties)
- Legislation prohibiting use of rating factors
- Risk equalisation mechanisms
- Community acceptance

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The maintenance of community rating without significant participation across all age ranges is difficult. As the age mix deteriorates, so too does the viability of community rating. Recent Government policy initiatives (30% rebate, Lifetime Health Cover) have focussed on addressing this problem. The existence of Medicare contributes to the problem of sustainability of community rating as it provides a safety net to the young and healthy who may choose to remain uninsured and therefore not provide any cross-subsidy to the higher costs of care for sicker and older people.

In Australia, Lifetime Health Cover certainly brought community rating back to life from the adverse selection death spiral of the 1990's by providing the incentives and penalties for a change in behaviour that has improved and increased the size of the risk pool. The question remains whether community rating in Australia is sustainable or whether further reforms will be necessary to avoid its eventual death.

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