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The Dilemma of Experience Rating

In the jargon of the insurance industry, experience rating refers to the practice of relating the premium for an insurance coverage to the loss experience of the specific group covered by the contract. Most people are familiar with some of the manifestations of experience rating in the form of attempts of the sellers of automobile insurance to isolate what is expected to be a low-risk group by occupation or other criteria (e.g., government employees, teachers, and members of automobile associations). Another familiar example is the practice of varying premiums according to the age of the drivers in the household or the number of years a driver has been insured without filing a claim.

The insurance principle involves spreading the cost of an unpredictable individual loss over a group of persons exposed to the same risk. Dividing the insured population as a whole into smaller units for rate-making purposes raises the question of the size and the composition of the group of persons to be included. If the group is defined as including an above-average number of "bad risks" with reference to the contingency insured against, the premium rate for this group will have to be higher than the average for the insured population as a whole to cover the losses that can be expected to occur. Conversely, a group whose members can be expected to suffer lower-than-average losses can be charged a below-average premium without a resulting loss to the insurer. In practice, high-cost health insurance groups are usually offered a combination of higher premiums and more restricted coverage but the net effect is the same.

It might appear that an insurance company practicing experience rating would be indifferent to the characteristics of the groups it insures since the premium rates are varied to compensate for the differential risks of loss. So far as this study is concerned, there are a number of flaws in this assumption. In health insurance the variation in rates of loss for groups with different characteristics is difficult to predict in advance. In the absence of exact knowledge, competitive pressures for underwriting volume may lead the rate makers to underestimate the possibilities of loss. A rate that experience shows to have been set too low may result in a loss that cannot be recovered. A group of insured persons whose losses turn out to be lower than was assumed at the time the premium was determined may often be successful in getting a "retroactive" rate adjustment or a rebate of premiums as a condition for continuing the contract with the insurance carrier. It is very difficult, however, for a carrier to reverse the situation and recover a loss suffered in a past period by charging higher premiums in the future. The carrier attempting this tactic finds that other companies stand ready to underwrite the coverage as entirely new business at its true future cost.[17]

A possibly extreme example of the situation that can arise in dealing with high-risk groups is provided by the experience of the welfare funds of the Joint Board of Culinary Workers and the employer associations. Each of the four funds was underwritten by three different insurance companies, each of whom lost money on the business. This was true even though the later underwriters had the records of the loss experience of the previous underwriters on which to base the premium rate to be charged.[18] At the time of contract renewal the insurance companies faced the question of whether to write off past losses, adjust premiums to cover future costs, and try again. Evenutally, each of the four commercial companies involved withdrew and left the field to Kaiser and the California Physicians Service.

Difficulties would arise even if the cost of insuring any specific group could be made completely predictable in advance. The premium that would have to be charged certain groups would be so high as to be unworkable in many cases. If the group is one in which membership is universal, as is the case in the negotiated plans, the required premium may be higher than the group can or will pay. If the group is one in which health plan membership is voluntary for each member, the difficulties are compounded. The higher the premium charged a voluntary group,

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[17] Usually the costs of the initial year of a contract with a specific carrier are higher than for subsequent renewals, so that changing carriers does involve some additional cost. Instances exist in which companies have quoted an artificially low initial rate in order to exploit this fact and "buy" future renewal.

[18] Anthony Anselmo, secretary of the joint board, reports that this loss record occurred not only in the face of the availability of actual claim experience for earlier years but also despite tighter administrative control over claims in the later years. A possible explanation that has been suggested is that the public controversies over the costs of the insurance plans have acted as a sort of advertising campaign for medical care. "It's like the 'Drink More Milk' campaign."

the more likely are the chances that adverse selection will occur. The members who feel that there is little likelihood of incurring substantial medical expenses remain out of the plan while those who believe that they are likely to incur such expenses enroll in the plan. This amounts to saying that the higher the premium, the more probable it is that the better-than-average risks in a group will, in effect, self-insure, leaving the poorer risks to participate in the insurance plan. This, of course, tends to raise the required premium still further. This is the sense in which it is sometimes remarked that continued increases in medical costs may "price voluntary health insurance out of the market." To hold a mass market, voluntary health insurance has to be inexpensive enough to persuade persons with relatively low chances of incurring large medical expenses to purchase the *protection* the insurance affords. At high premium rates the potential purchasers tend to be limited to those who feel that they are buying *medical service* they probably will need rather than buying *protection* against the possibility of loss.

The conclusion to be drawn is that groups so constituted as to include a relatively high proportion of persons likely to have high medical costs are difficult if not impossible to deal with in a system relying on commercial insurance companies practicing experience rating. There will always be groups for which the required premium rate will be so high as to make them unwilling or unable to participate in the health system. This will be true even if insured groups are limited to employed workers and their dependents, but it is particularly so if the concept of a group is expanded to include the unemployed, the disabled, families without breadwinners, the aged, the isolated worker, and other problem spots in the economy.

One method of dealing with this problem is to define the group to be used as the base of the insurance system so broadly as to spread the costs of the "problem" members thinly over the rest of the insured population. One obvious way to do this would be through compulsory health insurance in which the entire population of a state or the nation is considered as a single group. To date, this alternative has not been adopted in the United States. We have instead attempted a massive experiment in recruiting very large groups through the "Blue" organizations to serve as

a base for a system of health insurance in which participation would be voluntary. Although private bodies such as employers or unions may bring about involuntary participation by some individuals as a condition of employment or membership, the apparatus of the state is not used to enroll any sizable proportion of the general population.

This experiment in voluntary insurance was pioneered by nonprofit community organizations, usually allied in some way to the hospitals or the medical profession. The Blue Cross plans and the various versions of the Blue Shield-type of plan began operations with a concept of the "community" as a base for the group that would be used for premium rate-making purposes. Although for administrative purposes they enrolled a multitude of separate membership groups of all sizes in the pattern of commercial group insurance, the contract groups originally paid the same premium for the same coverage. This rate was developed from the financial results of the operation of the entire plan in that community, considered as a unit. In a sense, Blue Cross and Blue Shield rates for each separate geographical area could be regarded as representing a form of experience rating since there were a large number of such plans and their rates for the same coverage differed among different areas, in part because of differences in the medical experience of each plan's membership. The crucial point, however, is that, as originally organized, each plan had an exclusive geographical territory in which it operated without competition from other plans. The premium rates developed by each separate plan were "community rates" in a meaningful sense. As initially conceived, the Blue Cross and Blue Shield-type plans really did represent an attempt to devise a workable nongovernmental alternative to compulsory health insurance for the general population. This alternative had many of the advantages of the compulsory system but relied on persuasion rather than compulsion in recruiting membership.

With the entrance of the commercial insurance companies into the field of health insurance, the situation was radically changed. Their plans were competitive with the existing Blue plans in every community. The inevitable introduction of a system of experience rating in which the individual membership group served as the rate-making base rather than the "community" as a whole

placed the community-wide plans under great pressure. As a general rule, in the new situation any individual membership group that had a lower loss ratio than the average for the insured population of the community as a whole could improve its position by insuring with a commercial carrier rather than one of the community-based plans. The low-loss groups in the latter organizations had been paying their own medical costs and contributing to the medical costs of the high-loss groups in the community at large. Through the operation of experience rating, they were offered the alternative of buying a contract in which their premium rates would reflect only their own medical costs.

Under the slogan of "Get the Most for Your Welfare Dollar," employers and union officials began investigating the merits of "competitive bidding" and the apparatus of experience rating. If the employer and union trustees of a welfare fund were laggard in discovering these advantages, they were aided and abetted by the employee benefit consultants,[19] the representatives of the insurance industry, and even legislative investigating bodies. This hardheaded, businesslike approach to health insurance saved some of the low-loss groups substantial sums of money. In the Bay Area, for example, two large negotiated plans are reported to have secured repayments from the medically sponsored service organizations amounting to several hundred thousand dollars as a condition for the renewal of their contracts.

Once experience rating is introduced into an area, the pressure on the plans attempting to retain the "community-rate" concept becomes irresistible. Unless they are to lose their low-loss groups to the commercial insurance carriers, they must meet the competition and experience rate these groups. And as a spokesman for California Physicians Service put it, ". . . Once you experience rate the good groups you have to experience rate the bad groups too." In the Bay Area both Blue Cross and CPS have had to adopt experience rating for at least a major part of their membership.[20]

[19] Many consultants and insurance brokers have been cool toward the nonprofit service plans because originally Blue Cross and Blue Shield organizations did not pay brokers' commissions. In the Bay Area, only the Kaiser Plan clings to this position at this time.

[20] In practice, carriers utilizing experience rating sometimes use it in a selective fashion. Most "bad groups" tend to be experience rated but only those "good groups" for which competition exists tend to be so rated. In connection with experience rating a Senate report noted that ". . . It has been pointed out that some insurance carriers do not treat all policyholders alike." Committee on Labor and Public Welfare, *Welfare and Pension Plans Investigation*, Senate Report No. 1734, 84th Congress, 2d session, p. 28. This report contains a wealth of factual and technical information on all aspects of the subject.

As of 1958 only the Kaiser Plan has retained the community-rate system and in that year it introduced an additional surcharge for members over 65 in order to meet some of the problems created by experience rating. Kaiser's reluctance to experience rate stems from a combination of loyalty to the community-rate principle and the fact that experience rating individual groups would force the keeping of detailed records on every service rendered. The administrative burden would dissipate one of the cost advantages of the plan.

Under any circumstances, experience rating would have made the nonprofit plan's adherence to a community-rate structure difficult, but two other factors made it decisive. The first was the rapid increase in over-all medical costs and the resulting increase in group insurance premiums. As premiums rose, the absolute differential between a community rate and a low-loss group rate came to represent important savings to a large plan. With the increase in premiums, even powerful unions in prosperous industries found their health plans under financial pressure, particularly if employer contributions were fixed by contract for a specific time. At any given negotiation there are limits to the possible gains that may be secured from the employer. Unions therefore found themselves buying the same "welfare package" in later negotiations at progressively increasing costs. Under these conditions it became important to seize any opportunity to effect a cost saving.

A second factor lending weight to the impact of experience rating was the growth of the negotiated health plans. Since almost all of these plans are at least partially employer financed, a more sophisticated insurance buyer used to dealing in commercial insurance incident to his business operations was brought into the picture. In addition, the unions themselves are better organized and staffed to realize the possibilities and to exploit them than were the more informal voluntary groups that preceded them.[21] If the unions adopted a policy of including coverage for their retired members in their health plans, if would help to solve part

[21] Some unions, e.g., the United Automobile Workers, have officially supported the "community" approach to health insurance.

of this major problem but only a minority of unions cover retired members since, under experience rating, this raises premiums.

In the Bay Area there is no question but that unions and employers who have been introduced to health insurance as a result of collective bargaining have played a major role in making experience rating almost universal. It is not uncommon for negotiated plans to contract explicitly for a premium rate that exactly covers medical costs incurred plus a percentage allowance for a "loading" factor (administrative costs, profit, etc.) equal to the average "load" for the insurer's health business as a whole. The possibility of this kind of negotiation with the other carriers is an important reason why "good-risk" plans have been reluctant to offer their members a choice of Kaiser coverage at the Kaiser community rate.

It is questionable whether Kaiser can continue indefinitely to resist experience rating. As Blue Cross, CPS, and the commercial insurance carriers raise the premiums of the high-loss groups, the Kaiser community rate becomes more and more attractive to these groups. Insistence on the choice system affords Kaiser no protection against adverse selection since the insurance company alternatives become progressively less attractive in the high-loss groups as their cost rises and their benefits shrink. It is not accidental that the Culinary Workers' health plans have finally come to rest in the hands of the Kaiser Plan and CPS, after passing through four commercial insurance companies. Although less is known of the utilization of health services by members of the International Longshoremen's and Warehousemen's Union, the fact that, according to the welfare fund administrator, the average longshoreman is 55 years old suggests that they also may be a high-utilization group.[22]

In the title of this section the problem of experience rating is referred to as a "dilemma." This is a literal description since although its effects on the experiment in broad-scale voluntary health insurance are, in the writer's opinion, deplorable, it is extremely difficult to see how the situation could have been avoided once a compulsory health system was ruled out. Consider the following points:

[22] The ILWU's smaller warehouse group has an average age of 47. The ILWU is proud of the fact that the longshore welfare plan has covered retired workers but since 98 per cent of the men are Kaiser members, this was more to the credit of Kaiser than of the ILWU. In 1958 when Kaiser levied the over-65 surcharge, 19 per cent of the ILWU members were over 65. The fund has continued its coverage of these members although the composite premium was raised about $65.

1. Once the commercial insurance companies entered the field of health insurance, it was inevitable that they would compete against each other and against the nonprofit carriers for the good-risk groups. Had they entered into an agreement not to do so, it would have been impossible to enforce, would have been objected to by many of the insured groups, and probably would have been illegal. (The Senate report cited earlier did not object to experience rating but only to the fact that it was not uniform and universal.) To illustrate the difficulty of enforcement, note that requiring uniform premium rates for all contracts in a given area (a community rate) would not solve the problem unless all insurers were required to accept any group that applied for coverage at that rate.

2. Once experience rating was introduced, it was impossible for the nonprofit carriers to refuse to adopt it, but in doing so they abandoned their distinctive contribution to health insurance—the community rate. If Kaiser is able to hold out, it will be because the plan is a system of health care for which indemnity insurance is not a complete substitute at this time.

3. Once experience rating was introduced, it was inevitable that most trustees of welfare funds would take advantage of its operation wherever possible. In a real sense, it could be argued that it was their duty to the beneficiaries of the funds to do so. If the fund managers are to be criticized, criticism must be on the ground that their interpretation of the scope of the "group" to which they were responsible was too narrow. A very good case can be made that a welfare fund ought to regard its retired members as an integral part of the group entitled to protection. It might be argued that the social responsibilities of the welfare funds extend still further from the hard core of employed members, but it is not surprising that the financial costs of showing such responsibility are avoided by the great majority of plans.[23]

[23] In May, 1954, it was reported that only 7 of the 325 negotiated plans in Northern California provided retired members with as much as one year's health coverage at reduced benefits. California Department of Industrial Relations, *Health and Welfare Plans*, 1955, p. 64.

4. Even if some way had been found to protect the exclusive rights of the community-based nonprofit carriers in a given territory, eventually a variation of experience rating would probably have been introduced through the device of self-insurance. As they acquired experience with health insurance, large funds with below-average loss ratios probably would have left the community plans to underwrite their own members at lower cost.

Whether inevitable or not, the effect of experience rating has been to deal the promising concept of a virtually universal, voluntary, community-based health insurance system a mortal blow. It has become almost certain that substantial numbers of persons who might have been covered successfully by such a system will eventually be part of some form of governmentally sponsored health insurance. The rapid spread of negotiated plans contributed to the speed and the certainty with which experience rating has accomplished this result. Two of the Bay Area's large negotiated plans spearheaded the movement that brought about the use of experience rating by Blue Cross and CPS. There is reason to believe that the net effect of the inclusion of the negotiated plans in the Kaiser system has been an increase in cost for the plan as a whole. The collectively bargained health plans might have been the means of bringing health insurance to some of the problem groups in the population but so far, through encouraging experience rating, their net effect has been to worsen the situation of the marginal groups. This worsening has occurred because of the inability of the community plans to offset the losses incurred by high-cost groups against the gains formerly accruing from the low-cost groups prior to experience rating.

The ILWU and the San Joaquin Foundation for Medical Care

One of the most interesting outgrowths of the combination of collective bargaining and health insurance is the program worked out between the welfare fund of the International Longshoremen's and Warehousemen's Union and the Pacific Maritime Association and the San Joaquin Foundation for Medical Care.[24] The latter

[24] Information in this section was secured from publications of the society and the foundation and interviews with Dr. Donald Harrington, president of the foundation, Boyd Thompson, secretary of the society, and Mrs. Goldie Krantz, administrator for the ILWU–PMA welfare fund.

organization is a subsidiary corporation set up by the Medical Society of San Joaquin County in 1954.

San Joaquin County is outside the geographical boundaries of the Bay Area proper but well within its sphere of influence in medical and labor matters. It lies immediately east of Contra Costa and Alameda counties and its county seat, Stockton, is a city of some 80,000 population. Stockton, despite its location 100 miles from the ocean, is the third largest seaport in California. As a result the ILWU has about 700 longshoremen members working at the port. The medical society has approximately 200 active members and maintains its headquarters, staffed since 1952 by a full-time secretary in the Alameda pattern, in Stockton.

As in most of California, the labor movement in San Joaquin County is dominated by former AFL unions. In 1956 the secretary of the medical society estimated that there were about 36,000 union members in the area. During the hectic period of welfare fund activity in 1953, rumors circulated in Stockton that the Kaiser Foundation Health Plan had approached the local labor council with a health center proposal and that the labor groups in the area were also investigating the possibility of a labor-sponsored independent health center. The local Central Labor Council had been involved in the 1954 health and welfare conference in San Francisco referred to in chapter vii. The expansion of Kaiser into Pittsburg (described in chapter viii) in 1953 is also relevant to the background of the development of the San Joaquin Foundation since Stockton is only about forty miles east of Pittsburg.

The San Joaquin society reacted to the hectic events of the 1953–1954 period in a way that went a good deal beyond developments in either the San Francisco or the Alameda-Contra Costa medical societies.[25] Like the California Physicians Service at the state level, the foundation is a separate corporate organization, in this case sponsored and governed by the county society. It contracts annually for the services of member-doctors and as of May,

[25] The relationship between incidents in Pittsburg and the Bay Area proper and the foundation is pointed up by an editorial in the November, 1953, issue of the *Bulletin* of the San Joaquin society, ". . . To delay [the presentation of the Foundation proposal for membership approval] would be to invite disaster from three quarters: invasion of this area by outside closed panel systems, defections to closed panel medicine from within our own Society, and a demonstration to the public that we doctors are incapable of solving the economic ills of medicine." (p. 6).

VOLUNTARY HEALTH INSURANCE AND RATE MAKING

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Preface

IN mid-1961 around 132 million Americans, between 70 and 75 per cent of the population, had some kind of health insurance protection. The economic and social benefits therefrom are substantial, but dissatisfaction about health insurance seems to be on the increase. This dissatisfaction has various causes—mounting costs, limited benefits, high hospital charges, and so on—but part of it is premised on enrollment versus the lack or absence of enrollment.

It will not be easy to enroll those currently unenrolled, especially 8 or 9 million such individuals who are over 65 years of age. Most of the uninsured are self-employed persons, casually employed workers, employees of small firms, or unemployed persons. They cannot readily be signed up in groups. Some have very low incomes. To enroll them on a person-by-person basis requires large selling and enrollment expenses. Those insured on an individual basis, particularly the over-65 group, typically are heavy users of benefits. Not only does their enrollment increase overhead expenses, but it also usually increases claim or benefit expenses. Unless the premium costs for older persons are subsidized from some outside source—extra contributions by other insureds, excess premiums from those enrolled on a group basis, or outright subsidies from tax funds—to enroll these individuals privately is apt to mean either (1) that they will have to be given lower benefits or (2) that they will have to pay higher premiums. To many groups and organizations (including the private insurance companies, the

(3) *How should medical services be organized?* Should the ultimate objective be to encourage solo practice and payment for services on the traditional "free-choice" and "fee-for-service" basis? Or should other, less orthodox methods of organization and payment—such as group practice, with physician payment on a capitation or salary basis —be encouraged and expanded? Many non-Blue Cross and non-Blue Shield medical service organizations have been identified with group practice, as have a number of labor unions, while the private insurance companies and the Blue Shield carriers (which are sponsored and largely controlled by physicians) have a strong stake in fee-for-service medicine. Although there are unmistakable signs that the medical profession is becoming more tolerant of new methods of organization and practice,[17] so-called "closed panel" group practice, with payment on other than a fee-for-service basis, remains the uncommon method of organizing and financing medical care. The conservative buyer often rejects comprehensive, group practice prepayment in favor of more traditional approaches.

(4) *Who should control hospital and medical services—and in whose interest?* Shall control lie with the vendors of services (physicians and hospitals)—with the prepayment organizations that now underwrite and finance more than 50 per cent of all nongovernmental hospital costs and more than 25 per cent of the cost of physicians' services [18]—or with the employers and unions whose joint efforts in the past 10 years have funneled hundreds of millions of new dollars into prepayment channels rather than into wages? Obviously, this question cannot be settled to everyone's entire satisfaction. But some iconoclasts argue that none of these interest groups ought to have full control, if only because their concept of the public interest is bound to be distorted by their desire to perpetuate and strengthen the institutions they represent.

(5) *What should be the relationship of voluntary health insurance and governmental activities in the medical care field?* As was pointed out earlier, voluntary health insurance plans provide some measure of protection against hospital, surgical, and medical expense costs to almost 130 million Americans. Since at the end of 1940 only about 12

[17] See particularly the "Report of the Commission on Medical Care Plans," *Journal of the American Medical Association* (hereinafter cited as *JAMA*), Jan. 17, 1959, and the AMA's House of Delegates approval of this Report on June 11, 1959.

[18] Agnes Brewster, "Voluntary Health Insurance and Medical Care Expenditures: A Ten-Year Review," *U.S. Social Security Bulletin*, Dec., 1958, p. 13, Table 6.

million people [19] were so covered, there has been an enrollment increase of approximately 900 per cent in the succeeding 17-year period —a spectacular gain. Yet to the private insurance companies and the nonprofit prepayment plans, this expansion has not been an unmixed blessing. As the nation has grown accustomed to prepayment, the demands for expansion, both horizontally to cover more people and vertically to embrace more (and more comprehensively prepaid) benefits, seem to have grown more insistent.

Since the insured population consists largely of employed persons and their dependents, by definition it is a healthy, even a select-risk, population group. The self-employed, the unemployed, the retired, and their dependents are less well protected. They constitute a poorer risk group, hard to enroll and expensive to cover. But this group—particularly where the aged and the retired are concerned—enjoys considerable public sympathy and great political influence, if not outright political power. Thus, voluntary health insurance faces a Sisyphuslike task: as an endeavor with a public interest, it cannot relax its efforts to liberalize benefits and to plug the "enrollment gap," lest government move in to do what voluntary health insurance has not done—and, perhaps, cannot well do. The voluntary agencies generally fear—and resist—governmental action. But they recognize the strength of the political pressures for liberalization of benefits and expansion of coverage.

THE EXPERIENCE RATING–COMMUNITY RATING ISSUE

(6) *What is the most desirable and the most equitable method of apportioning prepaid medical care costs among the consuming public?*

To a considerable extent the issue of experience rating versus community rating underlies and cuts across the problems mentioned earlier. Traditionally, the nonprofit hospital and medical service plans—almost all of which have some kind of a geographical or community base—have calculated their premium or subscription charges by averaging costs over the entire population enrolled in their community. Their charges to subscribers are not specifically loaded (increased) on the basis of age, sex, or other factors presumed to produce above-average benefits or abnormal losses. Even though their rates may vary according to family composition, their loss costs are spread rather evenly over the total insured-population universe. Their charges are thus called "community rates."

[19] Health Insurance Council, *The Extent of Voluntary Health Insurance Coverage in the United States as of December 31, 1957* (New York, 1958), p. 11.

For example, early in 1959 Group Hospital Service, Inc., the Blue Cross plan in the Syracuse, N.Y., area, charged the following subscription rates for 21-day hospital coverage to subscribers enrolled in groups:

	Monthly	*Annual*
Individual	$2.68	$32.16
Family	6.62	79.44

These were net rates, identical for all subscriber groups.

Assume that employer "A" had 1,000 employees (700 of them married and 300 single) in his group. The annual GHS premium on this group would have been $65,256 (700 × $79.44 plus 300 × $32.16), no matter what claims or benefits experience developed on the group,[20] for example, whether these, 1,000 employees and their dependents incurred $10,000 or $70,000 of hospital service costs in any year. Thus GHS (and the other nonprofit community-rated plans) spread, equalize, or, as some say, socialize the costs of hospital care over the entire group-enrolled subscriber population.[21]

The private insurance companies, on the other hand, generally calculate net group insurance premium charges according to the anticipated or the incurred claims experience of the particular classes or groups of individuals covered by the insurance policy. Given claim experience sufficiently below average, a group insurance premium might be reduced in advance (prospectively) or a dividend might be paid at the end of the policy year (retrospectively), whereas above-average claim experience probably would mean a rate increase. In other words, premiums are largely a function of the group's claim experience—and are said to be "experience-rated."

Using the hypothetical 1,000-employee firm in the GHS-community rate discussion, assume that the Beneficial Family Life Insurance Company, a completely hypothetical carrier, is on the risk and charging a gross manual (or rate book) premium of $75,000. During the policy years 1957 and 1958 the risk (group) incurred claims and was charged with overhead costs (home office expense, printing, taxes, reserves and surplus, claim adjustment charges, commissions, etc.) as follows:

[20] Although Group Hospital Service is an example, it should be noted that GHS experience-rates one large group. GHS rates have been increased since this illustration was prepared.

[21] If these community-rated subscription charges were insufficient to cover GHS benefit costs and overhead charges, GHS would be forced to seek a rate increase. But under community rating these increased rates would be uniformly applied to all groups regardless of previous benefit usage.

Year	*1957*	*1958*
Manual premium	$75,000	$75,000
Incurred claims	55,000	63,000
Overhead ("retention") costs	10,000	11,000
Total charges	$65,000	$74,000
Uncommitted premium	$10,000	$ 1,000

At the end of the 1957 policy year the Beneficial probably would pay a $10,000 dividend to the employer in whose name Beneficial issued the master group insurance policy. At the end of 1958, a much smaller dividend, $1,000, would have been payable. On the other hand, if the 1958 claims increased to, say, $70,000, the insurance company might request a rate increase for the following year.

Obviously, then, if a group is a "good" risk, it will often be to the financial advantage of the master policyholder (employer, union, association, or trust fund) to select an experience-rated insured health prepayment plan. On the other hand, a "bad" or high-risk group (one with a high percentage of females and many older workers, for example) may do better financially with a community-rated, nonprofit plan. Thus, as competition has grown more intense, many groups have shifted plans for financial reasons.

Table 2. Income for medical and hospital care among voluntary health insurance plans, by type of carrier or plan, 1950, 1954, and 1959
(000,000's omitted in income)

Type of plan	1950		1954		1959	
	$	%	$	%	$	%
Blue Cross plans	362	35.7	804	29.2	1,522	29.6
Blue Shield plans	93	9.2	330	12.0	635	12.4
Insurance companies	461	45.4	1,389	50.4	2,639	51.3
(Group)	(241	23.7)	(867	31.5)	(1,853	36.0)
(Individual)	(220	21.7)	(522	18.9)	(786	15.3)
All other plans	99	9.8	233	8.5	343	6.7
Total—all plans	1,015	100.0	2,756	100.0	5,139	100.0

Source: Adapted from *U.S. Social Security Bulletin*, Dec., 1960, p. 9; Dec., 1955, p. 13; and Dec., 1951, p. 22. Percentage totals may not agree because of rounding.

Table 2 shows, for example, how Blue Cross plans have seen their share of total U.S. dollar expenditures for health insurance drop from

36 per cent to 30 per cent, while the rapidly expanding group insurance coverages written on an experience-rated basis have come to take more than one-third of the total business. If health insurance dollar expenditures are broken down to reflect expenditures for hospital care —as distinct from medical, surgical, and other care—similar changes become evident, as Table 3 shows.

Table 3. Income for hospital care coverage by type of plan, 1950, 1954, and 1959
(000,000's omitted in income)

Type of plan	1950		1954		1959	
	$	%	$	%	$	%
Blue Cross plans	431	49.6	787	44.5	1,485	43.9
Blue Shield plans	5	0.6	16	0.9	34	1.0
Insurance companies	389	44.8	838	47.4	1,708	50.5
(Group)	(198	22.8)	(516	29.2)	(1,141	33.8)
(Individual)	(191	20.0)	(322	18.2)	(567	16.7)
All other plans	44	5.1	126	7.1	156	4.6
Total—all plans	869	100.0	1,767	100.0	3,383	100.0

Source: Adapted from *U.S. Social Security Bulletin,* Dec., 1960, p. 9; Dec., 1955, p. 13; and Dec., 1951, p. 22. Percentage totals may not agree because of rounding.

Tables 2 and 3 give a partial picture of competitive developments in voluntary health insurance. By and large the nonprofit hospital and medical service organizations have lost ground in the race to provide more people with more health benefits (although the Blue Cross and Blue Shield shares now seem to be stabilizing). The private insurance companies now have more than 50 per cent of the hospital insurance market, and their share of that expanding market still seems to be growing slowly where group insurance is concerned. Much of this percentage gain has been at the expense of the Blue Cross plans.

IMPLICATIONS OF EXPERIENCE RATING AND COMMUNITY RATING

It may well be that the controversy over experience rating and community rating was effectively settled in 1950–1953, when a number of Blue Cross and Blue Shield plans began to experience-rate national and large local contracts (see Chapter V). Since then, however, increasing pressures in behalf of the aged have reopened the question. It is known that the aged (those 60, 65, or 70 years of age and more), as

well as those in other unenrolled or underenrolled segments of the population, constitute a high-risk, high-insurance-cost group. The nonprofit hospital and medical service plans generally have been quite responsive to their needs and have raised few barriers to their enrollment. The community rate has been a convenient vehicle to spread the higher loss costs attributable to these groups over the total enrolled community.

But as interplan competition sharpened in the early 1950's, experience rating emerged as an effective weapon for the insurance companies. Some low-risk groups found it financially advantageous to drop Blue Cross–Blue Shield coverage (where the group's good claims experience subsidized high-risk subscribers in the community) and to buy experience-rated coverage. As more and more low-risk groups "select out," Blue Cross–Blue Shield enrollees increasingly can take on the characteristics of a high-risk, high-benefit-cost community, whose community-averaged premium rates are inadequate. As rate increases become necessary, still more "select" groups may find it advantageous to experience-rate. Hence, over time most of the community rate carriers have been faced with two theoretical alternatives.

First, they can stay on the community rate. To do this, particularly when they have enrolled only a low percentage of the total community, is to risk becoming a dumping ground for the community's high-cost risks. This means skyrocketing subscription charges, and the plans will probably either price themselves out of the health insurance market or be forced to offer reduced, even substandard, benefits.

Secondly, they can abandon the community rate, either wholly or partially, adopting experience rating in order to remain competitive. But although competition from private insurance companies may drive them in this direction, they fear that this approach will not satisfactorily meet the insurance needs of many of the unenrolled, particularly the senior citizens whose small fixed incomes will usually buy only the cheapest health prepayment protection, if that. Thus some thoughtful men, both with the nonprofit plans and with the private insurance carriers, are concerned about the ultimate implications of experience rating for the very existence of the voluntary health insurance in which they so stoutly believe. To expand experience rating may mean pricing out of the voluntary health insurance market the very groups whose need for protection is the greatest. Thereby governmental participation and, perhaps, control are invited (or guaranteed) in an area heretofore largely reserved for competitive private enterprise.

Organization of Subsequent Chapters

The preceding pages provide the backdrop, in oversimplified fashion, for more detailed discussion of experience rating and community rating in contemporary U.S. voluntary health insurance. This controversial issue is primarily a question of dollars and competitive cost. But experience rating and community rating cannot be separated from other crucial issues which involve the deepest and sharpest disagreement about the kinds of benefits, the types of organization, and the nature of control over the lusty health insurance movement. Finally—and, in the judgment of the writer, most important—experience rating and community rating ultimately may involve the whole future of U.S. health care, for in the background is the specter (or the long-awaited hope) of an increased governmental participation in health insurance matters. Before analyzing these and other problems in more detail, some rather complicated questions have to be answered.

Why and how did experience rating develop? What elements of insurance industry philosophy and practice intensified and accelerated the expansion of experience rating? How did experience rating expand from, say, the workmen's compensation insurance business into accident and health insurance? How do current experience rating plans, particularly those of the life and casualty insurance companies which dominate the group accident and health insurance business, work in theory? How are they actually applied to cases and groups? These questions are dealt with in Chapters II and III.

And what of community rating? Chapters IV, V, and VI develop the history of rate and rating practices in Blue Cross, Blue Shield, and some of the other nonprofit medical service organizations. These chapters describe how these plans have moved from total reliance on simple, even crude, community-average rates to a more complex, or more refined, rate structure and finally how some plans, under the pressures of competition, have been lured or forced, happily or reluctantly, into experience rating.

Neither experience rating nor community rating could have succeeded or expanded without substantial acceptance and support from buyers and communities. What social, economic, and political factors, in addition to dollar costs, have influenced consumers' and buyers' decisions with respect to these two apparently antithetical rate systems? What support do they enjoy from business, labor, and government, to

say nothing of doctors, hospitals, and other vendors? Chapter VII deals with these questions.

With—it is hoped—a good understanding of the true meaning of experience rating and community rating and with a grasp of the competitive forces within the voluntary health insurance industry and knowledge of the viewpoints of business and labor, Chapter VIII brings into consideration some fundamental questions of public and private policy, the future of the two rating systems, and their merits and demerits for the future of voluntary health insurance.

rating is, to say the least, judgmental. Another weakness stems from its inability to measure accurately human or other intangible factors.[47] Although schedule rating is still used in fire and casualty insurance, its "use in workmen's compensation insurance, where it was once very important, is now very limited." [48] And since, to the writer's knowledge, schedule rating has never been utilized in voluntary health insurance,[49] only limited further reference to it will be made. The balance of the discussion will emphasize prospective experience rating and retrospective experience rating.

A prospective rating plan fixes, on the basis of past experience, a modified (increased or decreased) rate for the ensuing policy year or some other prospective (future) period of coverage. Thus a prospective experience rating scheme's method of rate making is quite similar to the method employed in calculating industry, classification, or other manual rates but adds an additional step, modification of the manual [50] rate according to the presumed prospective loss experience of one risk. Since both prospective and retrospective experience rating schemes [51] involve at least partial "predication of the current rate for a given risk upon . . . the past experience of such risk," [52] how is retrospective experience rating defined? It differs from prospective rating because

[47] How, for example, can factors like "safety organization," "employee selection," and "co-operation" with insurance carrier, which are included in the National Bureau of Casualty Underwriters Automobile Liability Experience and Schedule Rating Plan, be precisely measured and evaluated?

[48] C. A. Williams, Jr., "An Analysis of Current Experience and Retrospective Rating Plans," *Journal of Finance*, IX, no. 4 (Dec., 1954), 378.

[49] However, manual health insurance rates may be "loaded" (increased) to reflect presumed variations in loss experience. For example, most manual group accident and health insurance rates assume that not more than 11 per cent of the covered employees will be females. But where more than 11 per cent and less than 21 per cent of the insurance is on female employees, the manual rate will be increased 15 per cent. Where more than 91 per cent of the coverage is on females, the manual rate can be loaded 95 per cent—practically doubled.

[50] The prospective rate normally will not be based on 100 per cent individual risk credibility. Rather it will represent a credibility-based compromise between the individual risk's own loss experience and class-average loss experience.

[51] Although the term "experience rating" is here used to cover all types of individual risk rating plans (whether schedule, prospective, or retrospective in nature), there is disagreement about this use of terminology. Retrospective experience rating, at least in compensation insurance, dates only from the mid-1930's. Hence rate bureaus and texts (Kulp, *Casualty Insurance*, p. 500; Williams, *op. cit.*, p. 379) often equate "experience rating" with "prospective experience rating," the older rating method. The director of the Blue Cross Commission of the American Hospital Association, eager to emphasize distinctions between Blue Cross and private insurance, has used the term "group rating" instead of "experience rating."

[52] W. W. Greene, "Should the Compensation Premium Reflect the Experience of the Individual Risk?" *PCAS*, II (1916), 347.

rate adjustments are made retroactively, that is, on the basis of the risk's actual incurred loss and expense experience calculated after the policy year or other experience period has been completed.

THE HISTORY OF EXPERIENCE RATING

Experience rating has its roots in casualty insurance, particularly employers' liability insurance and its allied (or successor) form, workmen's compensation insurance. Its history is one of almost uninterrupted expansion.

Between 1880 and 1910 England, the United States federal government, and most American states adopted Employer's Liability Acts. These acts grew out of intense dissatisfaction with common-law doctrines governing the responsibility of the employer (master) for the social and economic costs of on-the-job industrial accidents suffered by his employees (servants). Although employer's liability laws did not, in the opinion of most legislatures, provide an adequate remedy for the occupationally injured workman, they firmly established the principle of statutory employer liability for certain industrial accident costs. To cover this liability many employers bought insurance. The first policies protecting U.S. employers against the cost of damages because of job-connected injuries were written in the late 1880's.[53]

Employer's liability rates were classification rates, high for hazardous industries such as mining and low for, say, mercantile establishments. At first most of the business was written by stock insurance companies. As more jurisdictions adopted employer's liability laws, the volume of insurance increased. As more companies entered the business, competition became sharp and some carriers incurred underwriting losses. In 1896, to stabilize rates and cut losses, a number of liability companies formed a rating organization, the Liability Conference, to promulgate co-operative or "bureau" rates. This early rate-making agency worked satisfactorily for about a year, but "the competition of outside [that is, nonbureau] companies soon forced a crisis within the Liability Conference." [54] To protect member companies the Conference rules were amended to permit "special rates" on individual risks, as long as the writing carrier filed certain loss and payroll data with an arbitrator who was also the actuary of the Liability Conference.

Initially the arbitrator's approval was required for all "special rates,"

[53] Michelbacher, *op. cit.*, p. 10. The Travelers was the pioneer U.S. carrier.

[54] Brief submitted to Superintendent of Insurance Phillips by T. E. Gaty of the Fidelity and Casualty Company of New York, printed in *N.Y. Journal of Commerce and Commercial Bulletin*, Feb. 22, 1916, p. 8.

and all bureau companies were notified when they were granted. But, as time passed, the arbitrator's veto power was eliminated and rate notification was abandoned. Still later, to enable Conference companies to vie for new business, "special rates" were made available to new—as well as old—risks. By 1905 competition had pretty well wrecked Conference rates; the Liability Conference had become a statistical agency, with each company making "its own rates in its own way." [55] This was the situation in the 1910–1913 period when more than 20 states adopted a new kind of legislation—workmen's compensation—wherein employer liability for the costs of industrial accidents was statutorily fixed, regardless of negligence or fault.

It is one thing to mandate a course of action by legislation and quite another to implement that mandate effectively. It was not, perhaps, difficult to make employers statutorily liable for the costs of industrial accidents, but it was difficult to guarantee that every employer subject to a state compensation act would—and could—meet his required financial responsibilities for benefits. With admirable pragmatism, not unmixed with antipathy to state insurance and similar "socialistic" concepts, state after state turned to the casualty insurance industry to underwrite the necessary financial guarantees for employers.[56] Since workmen's compensation coverage was often limited, a substantial volume of employer's liability insurance was still needed for uncovered firms and employees. And since employer's liability insurance underwriters had underwriting experience based on work accidents, it was logical that state legislatures should turn to the private casualty insurance companies.

What happened to rates and rating practices in workmen's compensation insurance? Again Mr. Gaty's words are illuminating:

> In August, 1910 . . . there was an organization formed to prepare rates and deal with the situation in New York under the Wainwright Workmen's Compensation Act. . . . Competition, however, soon made itself felt, and when the Workmen's Compensation Service Bureau was organized in December, 1910, there was a demand on the part of a large number of companies for a special rating rule whereby the carrying company could protect its business against competition. These rules were restrictive at first . . . [but] became so loose . . . that . . . the New York Insurance Department, when it made its examination in 1913, criticized the Bureau . . . [because] ". . . special rates were granted, mainly, in order to meet the competition of non-bureau companies. . . ."
>
> . . . . . .
>
> I do not think it possible to offer any logical sound argument in support of special rates. The name "experience rating" was introduced for the reason that the practice of granting special rates submitted such a rebuff when the New York Insurance Department made its examination of the Workmen's Compensation Service Bureau in 1913, that *those advocating special rates changed the name to "experience rates."* [57]

Gaty's brief shows, then, that "experience rating" was a new term, first coined in 1913 to describe competitive rate practices in a new line, workmen's compensation insurance. Actually, however, "experience rates" were not new; they were "special rates" with an alias. And "special rates" or "preferential rates" in employer's liability insurance date back to 1896, if not earlier.

There was a good deal of disagreement about experience rating in the early days (1910–1920) of workmen's compensation.[58] But in Joseph H. Woodward's words experience rating was desired or necessary for three principal "practical" reasons:

> (1) An employer who, through good fortune or good management, has fewer and less costly accidents than other employers in the same business or industry, regards his rate, justly or unjustly, as excessive and insistently demands relief.
>
> (2) Under conditions of unregulated competition between insurance companies, experience rating has in the past offered a convenient and specious means of granting discriminatory favors to particular policyholders and of conciliating agents and brokers controlling compensation and other collateral lines of insurance.
>
> (3) . . . By properly rewarding an employer for good experience and penalizing him for bad experience, we have a cheap and easy means of encouraging organization for safety. . . .[59]

[55] Gaty, *op. cit.*

[56] A few states (Oregon, for example), by providing so-called "monopolistic state funds," shut out private insurance.

[57] Gaty, *op. cit.*; emphasis supplied.

[58] The earliest proceedings of the Casualty Actuarial Society (then known as the Casualty Actuarial and Statistical Society of America), especially vols. I, II, III, and IV, covering the years 1914–1917, deal predominantly with workmen's compensation and, significantly, with fundamental issues in experience rating. Papers by I. M. Rubinow (vol. I), Joseph H. Woodward, E. H. Downey, and Winfield W. Greene in vol. II, and A. H. Mowbray, A. W. Whitney, and G. F. Michelbacher in vol. IV are of particular interest, representing as they do the views of men whose stature as insurance thinkers is beyond dispute.

[59] J. H. Woodward, "The Experience Rating of Workmen's Compensation Risks," *PCAS*, II (1916), 356.

Given these hard competitive facts, experience rating flourished, schedule rating and prospective experience rating being the principal techniques utilized.

Schedule rating, once widely utilized, especially during the 1910's and the 1920's, now has been largely abandoned in workmen's compensation insurance. Emphasizing as it did the inspection and valuation of physical hazards, schedule rating lacked wide applicability. For example, it could not readily be used in the construction industry, where a single contractor might have a dozen different jobs in widely separated locations, each with disparate hazard-producing characteristics. Nor was it designed for office and clerical operations, which have few physical hazards. As the years passed, schedule rating was applied in the main to manufacturing operations. It was expensive to apply, too, for application involved heavy expenditures of time, not only in risk inspection but also in applying schedule debits and credits to risk manual rates. Equally important, schedule rating became unpopular with the insurance-buying public. Not only did it apply to a relatively small number of risks, but for those covered, the relationship between schedule rates and actual loss experience became increasingly less clear.[60]

In 1915–1916, before all these deficiencies had become fully apparent, the first workmen's compensation prospective rating plans had been introduced.[61] Although the original plans have been revised and replaced many times, analogous plans are to be found in nearly all states.[62] For example, New York State has a mandatory prospective experience rating plan, applicable to all risks whose average annual premium (at manual rates) has exceeded $750 for a period of two or more years or whose past-year premium has exceeded $1,500. "About 10% of all insureds in New York State are subject to [prospective] experience rating and represent approximately 80% of the total premium volume." [63] Carefully developed as the prospective rating plans may be, they have inherent limitations. The plans are complicated,

[60] N.Y. State Compensation Insurance Rating Board, Memorandum, Feb. 3, 1941.

[61] The best historical summary of early plans is found in Mark Kormes' paper, "The Experience Rating Plan as Applied to Workmen's Compensation Risks," *PCAS*, XXI (1934–1935), 81.

[62] For details, see the National Council on Compensation Insurance publications *Workmen's Compensation and Employers' Liability Manual* and *Experience Rating Manual*, both published by the Council.

[63] New York State, Executive Department, *Costs, Operations, and Procedures under the Workmen's Compensation Law*, Report to Hon. Averell Harriman by Joseph Callahan, Jan. 28, 1957, p. 141.

hard to explain, hard to understand. Mixing as they do both manual-average and individual risk experience, prospective rating schemes produce credits for the better risks. On the other hand, there is evidence that, under the stress of competition, they may produce over-all premium declines, even deficits (in insurance jargon, "off-balances").[64] Further, as individual risk experience is combined with class or average loss experience, the relationship between safety work, accident prevention, loss experience, and premiums often becomes blurred.

For these and other reasons, retrospective experience rating was seriously discussed in the industry as early as 1916.[65] The Great Depression of the 1930's focused employer attention on compensation insurance costs. Twenty years of experience with compensation led many large employers with relatively consistent year-to-year accident costs to believe that their rates were too high when measured against incurred losses, claims settlement, accident prevention, and other costs. Some employers shopped around for lower rates,[66] often going from stock carriers to mutuals (where good claim experience might produce dividends) or to self-insurance, which was—and is—authorized in nearly all American states. To meet the demands of large insurers, to conserve old business, and to recapture business lost to self-insurance and the mutuals, retrospective experience rating plans, first promulgated in Massachusetts in 1936, have been almost universally adopted. In form and in ultimate cost retrospective experience rating approaches self-insurance. Heavy credibility is given to the experience of the individual risk. At the same time, the ultimate premium, by formula, can neither exceed nor fall below specified maximum and minimum charges.[67] To the extent that retrospective rating has become a "loss-

[64] In theory, the rate credits earned by low-loss risks should equal, or be offset by, increases in the premiums paid by high-loss risks. Or, in different words, a theoretically perfect experience rating plan should simply redistribute premium income without altering the total amount of premium. To the extent that the off-balance factor is due to preferential treatment for some larger risks, it is inequitable to expect a mass of small risks—80 per cent or more of all insureds—to soak up costs theoretically chargeable to their larger competitors.

[65] See the papers by Woodward and Greene, *PCAS*, II, 356 and 347, respectively.

[66] A quotation by Leon Senior, made more than 45 years ago when workmen's compensation was in its infancy, is still appropriate: "The education of employers as to methods for reducing premiums is growing apace. . . . Tremendous pressure is exerted by companies and their agents to enhance the [rate] credits" (*PCAS*, I [1914–1915], 233).

[67] The New York Plan is available to risks with $5,000 in premiums or more. In 1956 only ¼ of one per cent of all New York risks (but involving 10 per cent of total premiums) were under retrospective rating. The National Council on

cost plus" plan for large risks, it appears to have met the self-insurance "threat."

Nearly 50 years of workmen's compensation experience is now available. During that time experience rating schemes have changed many times, but the experience rating technique has expanded to cover more risks and an increasing dollar volume of workmen's compensation insurance premiums.[68] Experience rating has spread into other casualty insurance lines (burglary, glass, automobile, and general liability and some bonding coverages) as well as fire and inland marine insurance.[69] Under these circumstances, it is easy to see why casualty insurance companies are impelled by an almost irresistible weight of tradition to experience-rate their health insurance offerings, particularly group accident and health.[70] If tradition and accumulated experience are not enough, there remain the forces of competition with life insurance companies.

How did the life insurance companies come to adopt experience rating? The by-now-familiar statutory requirements of rate "equity" and the omnipresent pressures of competition were quite important. The concepts of "mutual" insurance and the "participating" policy returning policyholder dividends also were influential.[71] Loss prevention incentives, so important in liability and casualty lines such as workmen's compensation, have had only limited influence on the development of experience rating in group accident and health insurance.[72] Finally, group insurance concepts, applied in the early years to insurance on lives and to wage loss insurance and then, in the last two decades, to hospital, surgical, and other nonoccupational medical expense protections, have been of great importance, first to the life companies with which group insurance originated and later to casualty companies entering the accident and health business. Although group insurance seems to have contributed little new theory, its size and the rocketing expansion it has undergone have lent new importance to the whole concept of experience rating.

Life companies write more than 75 per cent of the U.S. insurance company accident and health insurance business.[73] These statistics have significance for experience rating because U.S. life insurance companies traditionally write most of their business, whether ordinary insurance or group insurance, on a participating basis. To be more specific, the five largest U.S. insurance companies, ranked in 1959 order of admitted assets, were the Metropolitan, the Prudential, the Equitable, the New York Life, and the John Hancock. All are mutual companies, theoretically owned and controlled by their policyholders; they generally write participating contracts, charging their individual policyholders a gross premium somewhat higher than is necessary but returning the excess charge as a "dividend" at the end of the policy year.

Historically the stock life insurance carriers wrote nonparticipating

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Compensation Insurance plans generally apply to risks generating more than $1,000 in annual standard (manual) premiums, but one plan (Plan D) combines all third-party liability lines (automobile physical damage, manufacturer's and contractor's liability, etc.) with workmen's compensation. Plan D is available to risks with standard premiums above $5,000. Plans A, B, C, and J provide a veritable *smörgåsbord* of risk rating choices to buyers who do not want to combine their liability coverages.

[68] According to the U.S. Social Security Administration, in 1957 employers spent more than $1,760 million "to insure or self-insure their risks under compensation programs." About 70 per cent ($1,223 million) of this total went to private insurance companies, of which the greater portion involved premiums for experience-rated risks. About 8 per cent ($140 million) represented self-insurance costs, and the balance ($399 million, or about 22 per cent) went to the various state funds, almost all of which offer experience rating plans ("Workmen's Compensation Payments and Costs, 1957," *U.S. Social Security Bulletin*, Dec., 1958, p. 18). The competitive state funds (like the giant New York fund) usually belong to rating bureaus. The laws governing many of the monopolistic funds—for example, see *Revised Code of Washington*, vol. VIII, secs. 51.16.010, 51.16.020, and *Wyoming Compiled Statutes (Revised), Workmen's Compensation*, secs. 72.118–72.122—not only require experience rating but specify by law who is covered, how losses shall be charged, and how premiums shall be modified.

[69] C. A. Williams' paper (*op. cit.*) is a careful summary of industry practice in the major lines.

[70] For practical purposes, workmen's compensation insurance could be termed group occupational accident and health insurance. The life insurance companies are writing more and more "occupational" business—"24-hour" accidental death and dismemberment coverages, "nonoccupational" wage loss insurance to supplement workmen's compensation benefits, and "nonoccupational" hospital, surgical, and medical coverages for occupational accidents and sickness in states (such as Missouri) that have "elective" workmen's compensation laws.

[71] Mutual insurance and the participating policy are by no means exclusive life insurance property. A number of fire and casualty carriers follow similar practices.

[72] The accidents covered occur away from the office and factory, often miles from "employer control." "Prevention" of sickness would involve the home and the employee's wife and children. Whereas workmen's compensation insurance in most jurisdictions is employer-financed, group accident and health insurance quite frequently involves employee contributions. Technically it is hard to see how group accident and health insurance could become involved in employer-sponsored loss prevention activities or safety work of an engineering type.

[73] "Aggregates of Accident and Health Business as of December 31, 1957," *Spectator Accident Insurance Register*, 1958, p. 3. Of about $3.5 billion in net premium reported there, 336 life companies received about $2.8 billion, approximately 80 per cent, and 84 property (fire and casualty) companies wrote slightly less than $700 million (20 per cent).

life contracts; rates were fixed in advance and remained unchanged during the life of the policy. Since nonparticipating contracts do not provide for dividends, gross rates and net rates are identical. These historical distinctions have largely disappeared. While stock life insurance companies such as the Connecticut General write nonparticipating policies, they also write a good deal of participating business.[74] At the end of 1958 "approximately 68 per cent of the total life insurance in force with U.S. life insurance companies was on a participating basis, with about 32 per cent nonparticipating."[75] Of this total business, mutuals had "about 62 per cent of the life insurance in force, with stock companies accounting for the remaining 38 per cent."[76]

Mutual life insurance and the participating individual life policy, particularly the latter, are dominant in the United States. If more than 125 million Americans own some kind of life insurance, for most of these people "participating" insurance and the insurance "dividend" are part of their cultural-economic heritage, known and expected, even if not well understood.[77] Stripped of technicalities, a participating life insurance policy is like a policy written under a retrospective experience rating plan; the net or final premium is determined on the basis of incurred loss and expense experience after the policy year has been completed. Given millions of policyholders for whom "dividends" are not only a learned experience but also a source of financial satisfaction, the general idea of experience rating can be haloed by substantial popular approval.

Group insurance and group insurance practices strengthen the experience rating idea. Group insurance dates from 1912, when the Equitable Life Assurance Society wrote a group life policy on the employees of Montgomery Ward and Company.[78] Group wage-loss cov-

[74] Theoretically stock life companies do not pay "dividends." Instead they offer "rate credits" to their policyholders. There is nothing to prevent a mutual life company from issuing nonparticipating policies, and a few do so.

[75] Institute of Life Insurance, *1959 Life Insurance Fact Book*, p. 13.

[76] *Ibid.*, p. 13.

[77] Analogous practices by some fire and casualty carriers sharpen the "dividend" image. Some of the largest property insurance carriers are mutuals, the Liberty Mutual to name one. There are also hundreds of small local mutual or "cooperative" fire insurance companies. Some function on an assessment basis, while others are advance-premium, dividend paying companies.

[78] Actually an earlier policy (1911) was issued on the employees of the Pantasote Leather Company. A form of blanket casualty insurance, Workmen's Collective Insurance, supplementary to employer's liability insurance, was written as early as 1896. For a detailed discussion of these early developments see L. W. Ilse, *Group Insurance and Employee Retirement Plans* (New York: Prentice-Hall, 1953), pp. 36–55 and 164–171.

erage also was available, but most of the larger life carriers did not begin to write it until after World War I.[79]

It was not possible to determine exactly when and where experience rating first was adopted in group life insurance. Some of the early group life policies were not written on a one-year renewable term basis but applied group underwriting methods to ordinary life insurance coverages.[80] It was to be expected that mutual[81] companies would apply normal ordinary life insurance practices (that is, a redundant rate, subsequently modified by policy dividends) to their group policies, including those written on a one-year renewable term basis. Competition from the mutuals tended to force the adoption of similar practices by stock companies. Hence the stock carriers writing group life insurance provided "retroactive rate credits," these credits being used to reduce their initial rates. In any event, by 1919 the Metropolitan had stopped guaranteeing

> the rates in [its] group policies . . . beyond the period of one year. Policies are issued as participating contracts and where we make money we ought to be in a position to declare dividends whereas when we lose money on account of an inadequate rate we ought to be in a position to increase it.[82]

Mrs. Louise Ilse's remarks on experience rating have a reminiscent ring:

> In the early days it was the general practice of participating companies to consider all groups in one general classification and to pay the same percentage of dividend to each, irrespective of the actual claim experience of the group. As a practical matter it was difficult to explain to a large group which had a mortality rate, say, of 60 per cent, why it received a dividend based on a general loss ratio of 85 per cent. Nor was it found practicable to assess expenses at a uniform rate to groups of all sizes, since, in general, the administrative expense for individual groups decreases with the increase in the size of the group. Furthermore, in large groups particularly, the total return had to be kept as high as justifiable, to avoid the possibility of self-insurance.[83]

[79] *Ibid.*, p. 170.

[80] E. B. Morris, "Group Life Insurance and Its Possible Development," *PCAS*, III (1916–1917), 151; also W. A. Graham, "Group Insurance," *TASA*, XVII (1916), 267.

[81] The Metropolitan mutualized in 1914; the Equitable did not mutualize until 1925.

[82] J. D. Craig, in "Discussion of Group Insurance," *RAIA*, IX, (1920), 259.

[83] L. W. Ilse, *Group Insurance and Employee Retirement Plans*. © 1953. Prentice-Hall, Inc., Englewood Cliffs, N.J. P. 124.

Other evidence could be given in support of Mrs. Ilse's statement.[84]

There was sharp group life insurance competition in the period 1920–1925. Ultimately rate cutting became a problem.

No tendency to cut rates unduly became noticeable until the latter part of 1925 at which time competition for large risks reached the stage where a rate war was threatened and in fact resulted in cutting rates below what in the opinion of this Department the companies could safely charge and continue to do business.[85]

New York's superintendent of insurance, James Beha, called a conference of the principal group-writing companies to deal with this rate war. "At that time it was agreed by those present that minimum premiums for the first year of group insurance should be required by law." [86] Although reports of the Temporary National Economic Committee throw a rather different light on these developments,[87] the important thing is that the 1926 legislature gave rate-setting authority to the New York superintendent. The statute explicitly authorized "readjustment of the rate of premium based on the experience thereunder, at the end of the first year or of any subsequent year of insurance thereunder, and such readjustment may be made retroactive only for such policy year." [88]

[84] The reports on wartime experience with the Red Cross and YMCA group insurance policies, involving the Equitable, the Metropolitan, and the Travelers, show that the policies in question were experience-rated (*TASA*, XXI [1920], 288, 574). In his 1920 paper cited earlier, Mr. Craig said: "The employer will naturally compare the amount of [group insurance] premium paid to the company with the amount the company has paid back in claims. What are you going to say to him if he thinks he has paid too much?" (*op. cit.*, p. 259).

[85] New York State, *Insurance Report*, 1926 (business of 1925), pt. 1, p. 9.

[86] *Ibid.*, p. 10.

[87] A TNEC report (*Study of Legal Reserve Life Insurance Companies* [monograph no. 28; Washington: USGPO, 1940], sec. XI, pp. 141–149) stressed the activities of a loose organization of large group carriers (notably the Aetna, Connecticut General, Metropolitan, Prudential, and Travelers) where "informal" agreements about rates and other matters were worked out. "By 1926 the situation became acute. The Travelers Insurance Co. had cut rates, the Aetna had violated the rules and the other companies were threatening a walkout. . . . On March 5, 1926 a formal constitution was adopted by 10 companies . . . the charter members of the Group Association." According to the TNEC "sometime after the organization of the Group Association, a law was passed in the State of New York giving the superintendent of insurance authority to establish initial group life rates . . . this law was opportune . . . the association immediately recommended the "T" rate to the superintendent who adopted it without modification and invested it with all the sanction of the statute."

[88] *New York Insurance Law*, sec. 204.2.

The 1926 law is still on the statute books. Another section of the New York Insurance Law requires out-of-state (or "foreign") insurers doing business in New York State to follow New York requirements with respect to all their insurance business, not just that portion of their business transacted in New York State.[89] Thus all New York-admitted insurance companies writing group life insurance are required to charge the first-year minimum rates prescribed by the superintendent and are authorized thereafter to experience-rate their cases. This provision regulates more than 80 per cent of all the group life insurance written in the United States. In summary, since 1926 New York insurance law, which governs more than 80 per cent of the group life insurance in force in the United States,[90] has specifically authorized experience rating of group life contracts.

Seven New York-admitted companies [91] write more than 75 per cent of all U.S. group life insurance. Four of these organizations are mutual companies (Equitable, John Hancock, Metropolitan, and Prudential) while three are stock carriers (Aetna, Connecticut General, and the Life Department of Travelers). All write a large volume of group accident and health insurance.[92] Many group insurance policies are written on some "package" basis, that is, involve group life insurance

[89] *Ibid.*, sec. 42.5. The consitutionality of this requirement was upheld in *Firemen's Ins. Co.* vs. *Beha* (D.C. N.Y. 1928, 30 F. 2d 539). However, New York regulatory requirements are still criticized as "extraterritorial" and as "one-state regulation."

[90] According to the Institute of Life Insurance, on Dec. 31, 1959, about $160 billion of group life insurance was in force. The New York State Insurance Department (in *Advance Printing of Principal Statistical Tables* [1960; business of 1959], vol. I, Table 6, pp. 29–31) reported that New York-admitted carriers had $154 billion in force.

[91] Ranked in 1959 order of group life insurance in force, they were: the Metropolitan, the Prudential, the Equitable, the Travelers, the Aetna Life, the John Hancock, and the Connecticut General (New York State, Insurance Department, *Advance Printing of Statistical Tables* [1960; business of 1959], vol. I, Table 6, pp. 29–31).

[92] Following are their reported accident and health insurance earned premiums (given in thousands) for 1958, taken from *Argus Chart, 1959, Accident, Sickness, Hospitalization*. "Individual" figures include accident, accident and health, noncancelable accident and health, and hospital and medical business.

Aetna Life (indiv., $8,954; group, $294,060; total, $303,014); Connecticut General (indiv., $6,138; group, $90,420; total, $96,558); Equitable Life (indiv., $1,942; group, $188,693; total, $190,635); John Hancock (indiv., $1,544; group, $75,862; total, $77,406); Metropolitan Life (indiv., $58,939; group, $324,914; total, $383,853); Prudential Life (indiv., $67,983; group, $144,055; total, $212,038); Travelers, Life Dept. (indiv., $28,736; group, $242,202; total, $270,938); totals (indiv., $174,236; group, $1,360,206; grand total, $1,534,442).

and group accident and health insurance written by the same carrier. Logically, the accident and health (or "disability") coverages should be experience-rated along with the life coverages.

This is exactly what has happened.[93] The private insurance companies entered the hospitalization insurance field subsequent to the Blue Cross plans, their first group hospitalization policies being written in 1934.[94] Dependents' group hospitalization coverage was added in 1938,[95] and group surgical expense insurance went on the market in the same year.[96] The first general medical expense insurance, involving nonsurgical services, was offered in 1944,[97] and group major medical insurance was first written in 1949.[98] Group hospital, surgical, and medical expense insurance coverages arrived on the stage 20 years after group life insurance and 10 years after the fundamental principles and practices of group insurance had been developed. Under the circumstances, the newcomers followed already-established, quasi-traditional group insurance practices—including experience rating. As casualty insurance carriers began to write group accident and health policies, they followed the same well-worn path (out of their familiarity with experience rating in workmen's compensation and for competitive reasons).

Valentine Howell, vice-president of the Prudential, said a number of years ago:

> The net cost of group insurance is fundamentally based on the theory of experience rating; that is, the larger the aggregate exposure for the particular group, the more the net cost depends on the individual loss rates of the group and the less on general experience factors for all groups together of the type used in determining dividends on individual policies.[99]

[93] *New York Insurance Law*, secs. 221.9 and 216.2.

[94] Ilse, *op. cit.*, p. 232; Myer, *op. cit.*, p. 159.

[95] E. B. Whittaker, in "Discussion," *RAIA*, XXX (1941), 235; J. H. Smith, "Group Health Insurance," in Chamber of Commerce of the United States, *A Look at Modern Health Insurance* (Washington: The Chamber, 1954), p. 88. The Metropolitan had covered its own employees about 10 years earlier.

[96] G. W. Fitzhugh, in "Discussion," *RAIA*, XXVIII (1940), 154; "Report of Committee to Prepare Mortality and Morbidity Claims," *TASA*, XLIX (1948), 142.

[97] Smith, *op. cit.*, p. 88; M. D. Miller, "Group Medical Expense Insurance," *TASA*, XLIX (1948), 365.

[98] A. M. Wilson, "Origin and Development," in Chamber of Commerce of the United States, *Major Medical Expense Insurance* (Washington: The Chamber, 1956), p. 2.

[99] "Comparative Net Cost Factors on Ordinary, Group, and Industrial Insurance," in David McCahan, ed., *Life Insurance—Trends and Problems* (Philadelphia: University of Pennsylvania Press, 1943), p. 131.

Mr. Howell's words are as valid at present as they were in 194

Recapitulation

Experience rating has a long history. It was born in employer liability insurance and fostered and nurtured in the workmen's com pensation insurance business. Over the years it has come to be accepte in most other liability and casualty lines. Given established legal theoretical concepts of "rate equity," it was not difficult for the devic to spread into the life insurance business. In fact, its spread was prob ably accelerated by widespread use of participating policies and th growth of mutualization in the large life insurance companies an some property companies. The lusty new line, group insurance adopted experience rating almost as soon as it was written. Finally, ex perience rating was stimulated at every step, in every coverage, by the simple fact of competition—competition between carriers and competi tion from the self-insurance idea. As a widespread, even pervasive, in surance practice, just how does it work? What is prevalent insurance company practice, particularly in health insurance (or, more techni cally, accident and health insurance)? These questions—and some re lated issues—are next to be discussed.

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RIGHTS OF CREDITORS IN LIFE INSURANCE POLICIES
REGULATION OF BLUE CROSS AND BLUE SHIELD PLANS

REGULATION OF BLUE CROSS AND BLUE SHIELD PLANS

by

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to my father and mother
Ben J. and Pearle L. Eilers

chapter II

HISTORY AND DEVELOPMENT OF VOLUNTARY MEDICAL CARE COVERAGE

THE EMBRYONIC STAGE OF MEDICAL CARE PLANS

After 1900, bonds of kinship weakened and family ties loosened. As a result, the family unit became increasingly isolated, both socially and financially. Gregariousness and financial necessity stimulated the origination and expansion of groups which could, in certain respects, fill the relationships that had previously existed among families and in the community type of living. Fraternal societies flourished in the early part of this century among those having nationality, occupational, political, and religious bonds.

Insurance became enmeshed in the sociological change. The insurance mechanism offered a financial substitute for the former reliance on the family unit. In this scheme, individuals were brought together in an attempt to pool their common hazards.[1] As a part of the insurance system, a person became a member of a "family" gathered together for financial, and sometimes other, purposes.

[1] Insurance is "a formal social device for the substitution of certainty for uncertainty through the pooling of hazards." (C. A. Kulp, *Casualty Insurance* [3rd ed.; New York: The Ronald Press Co., 1956], p. 9.) As is to be expected, there is considerable argument among scholars as to the elements which are necessary in the insurance device. There is no need for this study to enter the conflict, as Dr. Kulp's definition suffices for purposes of illustration.

The grouping of individuals for the prepayment of medical care expenses is of more recent origin than the association of persons to pool their funds in order to provide loss-of-income or death benefits. Experiments in the advance payment of hospital care started in the late 1800's. After the turn of the century some group hospital insurance was available for employees. Several insurance companies sold hospital coverage as a part of their individual disability income contracts; these were not widely purchased, however. A typical provision was to pay additional income benefits if the insured was hospitalized.

There were isolated cases of occupational groups and a few nationality-type organizations "chipping in" in advance of the occurrence of a contingency requiring hospitalization, rather than contributing through sympathy after the event. Such organizations were characterized by local coverage and employee financing.

One of the earliest groups to be formed for the coverage of medical care expenses, as such, was the Northern Pacific Railway Beneficial Association, founded in 1882 by the railroad's employees.[2] Washington and Oregon were the sites of several early group-type medical care organizations, most of which made available only the services of a company-hired physician.

The usual pattern for the development of benefits by insurance companies was to have income replacement policies and subsequently—often not until the second or third decade of the twentieth century—to add some type of hospitalization coverage to the original benefit structure.

A forerunner of service-type benefits appeared in 1922 when Grinnell College in Iowa contracted with a local hospital to provide services for students.[3]

[2] Franz Goldman, *Voluntary Medical Care in the United States* (New York: Columbia University Press, 1948), p. 37.

[3] The plan, which originally offered three weeks of hospitalization for a yearly payment of $8, continued in existence until 1943 when the membership became Blue Cross subscribers.

BLUE CROSS BIRTH AND INCUBATION, 1929–1940

The first "family" of individuals to give pronounced impetus to the birth of medical care insurance was a group of teachers in Texas. The superintendent of schools in Dallas, Dr. Justin Ford Kimball, had originated a loss-of-income plan among this group. When Dr. Kimball went to Baylor University as executive vice-president in 1929, he found that unpaid bills of many school teachers were among the heavy accounts receivable at the University's medical facilities. After studying the hospitalization costs of teachers, Dr. Kimball drew up a hospitalization prepayment plan along the lines of the loss-of-income plan he had implemented earlier.

For a monthly payment of fifty cents by 75 per cent of the 1,500 teachers, the use of a semiprivate room and other services for twenty-one days were prepaid in the Baylor Hospital.[4] A one-third discount on the next 344 days was provided. Mental and nervous diseases, venereal diseases, tuberculosis, and certain contagious diseases were excluded from coverage.[5] The plan became effective on December 20, 1929. Business groups in the area subsequently joined the arrangement. For this reason such organizations were initially referred to as "group hospitalization associations."

Dr. Rufus Rorem, then of the Rosenwald Foundation, visited Dallas a few months later and gave nation-wide publicity among the hospitals to the way the plan was working out in Dallas. Dr. E. H. Carrey, at that time President of the American Medical Association . . . by his great professional medical prestige held back medical suspicions until the new experiment could have fair trial. . . .[6]

[4] Richard M. Jones, "The Blue Cross Movement," *A Look at Modern Health Insurance* (Washington, D.C.: Chamber of Commerce of the United States, 1948), chap. 10, pp. 1–3.

[5] Louis S. Reed, *Blue Cross and Medical Service Plans* (Washington, D.C.: Federal Security Agency, 1947), p. 10.

[6] Jones, *op. cit.*, p. 4.

In the early 1930's the Baylor Plan was copied in several states. California, New Jersey, and Minnesota were the earliest starters. This was a time when great numbers of individuals were in a financial position similar to that of the Dallas teachers; many had insufficient funds to pay for hospitalization in the event of accidents or illnesses.

The expansion of the group hospitalization idea required decisions as to which hospitals in a community could and would cooperate in the arrangement. The urging by professional groups, who were anxious for individuals to be able to choose both their physicians and the hospitals in which they would be admitted, broadened the original type of organization to include a prepayment of services in *any* licensed hospital which would cooperate in the movement in a particular locality.

By 1933 the American Hospital Association had accepted the importance and desirability of prepayment associations and had established several requirements to be met before an organization would be "acceptable for group hospitalization."[7] These became the stipulations with which an association had to comply in order to use the Blue Cross emblem.

Shortly after these early starts at hospitalization insurance, economic rumblings commenced which became what is now known as the Great Depression. As unemployment increased and incomes sank, businesses observed the precipitous plunge of expenditures for their products and services. Not the least affected was the hospital "business." With high overheads, large funding commitments, and an increasing volume of charity cases, hospitals realized that some method was necessary to increase their paying bed-occupancy rate. Hospital prepayment offered the desired financial assistance.

In the 1930's, politicians, as well as hospital and insurance

[7] "Essentials of an Acceptable Plan for Group Hospitalization" required that an organization: (1) stress public welfare; (2) limit its protection to hospital charges; (3) enlist professional and public interests; (4) provide free choice of physician and hospital; (5) maintain itself as a nonprofit organization; (6) maintain itself on a sound economic basis; and (7) promote itself in a cooperative spirit and dignified manner. (*Ibid.*, p. 5.)

groups, were beginning to consider the expenses created by accidents and illnesses as possibly having a social implication, and bills for the solution of sections of this problem began to appear in Congress. Dr. Louis Reed, a highly respected hospital economist, said in 1937 that despite the growth in group hospitalization, "It will not solve the medical care problem. It is incomplete, and there is little prospect, so long as plans are on a voluntary basis, that any large proportion of wage earners will enroll."[8] The next two decades showed this commonly held opinion to be erroneous. States and municipalities gave their support at this time to the prepayment organizations in a desire to have the many medical indigents removed from their rolls.

The social environment which shrouded the movement can be better understood when it is realized that a sizeable percentage of the organizations were started by at least quasi-social institutions. Of thirty-nine hospital service associations studied by Dr. Reed, twenty-two obtained their initial funds from hospitals. Five received capital from both hospitals and civic leaders, while six obtained their start through support of local foundations. None of these organizations started with more than $30,000 of capital. Two commenced with less than $1,000; thirteen began with from $1,000 to $5,000; seven with $5,000 to $10,000; four with $10,000 to $20,000; while eight had from $20,000 to $30,000.[9]

The medical care protection movement was not without its problems. For some promoters, both in the hospital service associations and in insurance companies, the scheme was looked upon as a funnel flow of easy money. Some backers invaded the till and departed; rates often rose drastically. The need for increased supervision of associations by some governmental body was apparent.

A perplexing problem in the development of medical care

[8] Louis S. Reed, *Health Insurance the Next Step in Social Security* (New York: Harper and Bros., 1937), p. 189.

[9] Reed, *Blue Cross and Medical Service Plans*, pp. 13–14.

protection was presented by the fact that the associated contingencies failed to meet some of the requirements for an insurable hazard. To be eligible for insurance it has been customarily held that a hazard should embody the following features: (1) there should be a large and homogeneous group of risks; (2) the potential loss should be definite and measureable; (3) the loss should be fortuitous, unexpected, and uncontrolled; (4) the loss should be serious in nature; and (5) risks should be widely disbursed and not subject to catastrophic loss. The insurance industry was wary of hospitalization insurance during its early stages because there was a question whether the medical expense hazard could meet the second, third, and fifth principles.

So complete had been the disdain of commercial carriers for medical care coverage that only sketchy historical information can be located about their experiments with it prior to the 1930's. It is known that a few individual policies were available after the turn of the century, although they were sold with little enthusiasm and enjoyed only limited acceptance.

Prior to the success of the group hospitalization associations, most insurance companies had felt they could not satisfactorily insure against medical care contingencies. After insurance companies saw the popularity and favorable results of their own group contracts, individual policies began to be projected with more vigor.

From their early beginnings, and to the present day, Blue Cross plans and insurance companies have taken divergent approaches to the problem of protecting against medical care expenses. As one example, Blue Cross has employed "service-type" benefits while insurance companies have sold "cash-indemnity" policies. The former entitles a subscriber to a certain number of days in a member hospital with a specific type of accommodation, generally semiprivate, including meals and general nursing service. Certain hospital services are also provided, including drugs and medicines while in the hospital, surgical dressings, and use of operating

rooms. X rays and laboratory tests are usually available to hospitalized subscribers without charge up to specified dollar limits. The Blue Cross plan to which the patient belongs pays the *hospital* for the above services when rendered, according to a reimbursement contract between the hospital and the association. The major control on benefits in Blue Cross plans is the limit on the number of days of hospitalization that will be provided.

Insurance company contracts agree to pay the *insured* (or more correctly, to *indemnify the insured*) up to specific dollar amounts for services he receives from hospitals. The policy specifies the daily room and board limitations, amounts which will be reimbursed for special services and doctors' visits in the hospital, etc. If the charge for services exceeds the contract limitations, the uncovered amount must be paid by, or for, the insured. The maximum hospital confinement period during which benefits will be provided is generally longer under insurance policies than under Blue Cross certificates. The control on benefits is exercised through dollar limitations and often through such contractual features as deductibles.

Both group and individual coverages are available under the service and indemnity types, although some associations have limitations as to when individual protection may be purchased. Dependents' coverage may be included under either benefit arrangement.

Blue Cross coverage is normally obtained through direct contact between the employer or insured and salaried representatives of the associations. Individual insurance policies are purveyed through salesmen who are compensated by commissions, while group-insurance salesmen are paid either by salary or commission.

Subscribers must use Blue Cross member hospitals to obtain service benefits; otherwise they receive cash-indemnity benefits of a reduced type. (Over 90 per cent of the hospitals in America currently participate in Blue Cross programs.) Insured policyholders may use any accredited hospital.

Blue Cross plans are largely autonomous on a local or state basis and often have a community sponsorship aura. Insurance company policies generally have a national uniformity of benefits within each company.

BLUE SHIELD GENESIS AND GENERATION, 1939–1945

Analogous to the Blue Cross movement to cope with the hospital expense hazard is the Blue Shield evolution for protection against medical-surgical expenses. The latter associations followed in the wake of the former, with the result that the development and current administration of Blue Shield has been closely intertwined with Blue Cross in many areas.

Prior to 1938, several experiments with medical service plans had taken place in the Northwest. The accepted starting point, though, for the acceleration of these organizations was the California Physicians' Service, organized by the California Medical Association in 1939 to counteract proposed state health insurance legislation. The result was a state-wide prepayment plan for physicians' services which was controlled by the medical profession. Under the first arrangement, employed persons earning less than $3,000 annually could obtain one of two contracts: full physicians' service for $1.70 monthly, or a contract with a two-visit deductible for a monthly payment of $1.20.[10] An unexpected volume of service demanded by subscribers made the operation financially unsatisfactory for participating doctors; a considerable modification of premiums and benefits resulted.[11]

During the early stages of the medical service association movement, doctors, as well as medical societies, for the most part maintained a suspicious attitude toward the prepayment idea. Only when doctors controlled an association and

[10] Reed, *Blue Cross and Medical Service Plans*, p. 137.

[11] Frank E. Smith, "Blue Shield Develops," *A Look at Modern Health Insurance*, chap. 11, pp. 1–5.

all of the doctors in the locality could participate was support given by the profession. The fear of encroachment on professional prerogatives was widely evidenced, as in the following minority view of the Committee on Costs of Medical Care:

> It is our conviction that the Committee on the Costs of Medical Care would have served its stated purposes and the cause of medical progress and the people's health much better if it had taken a strong stand against all of those methods of caring for the sick which have in them the dangers and evils of "contract practice." By doing so they would have come to the assistance of the medical profession in a battle against forces which threaten to destroy its ideals, disrupt its organization and completely commercialize its practice, and which are at the same time opposed to the public welfare.[12]

The physicians' dissatisfaction was attributed to two causes: first, the contractual prepayment of physicians' services removed many people from the "market" when such individuals would otherwise have gone to doctors who were charging fees-for-service; second, there was the fear that a reduction in the traditional quality of medical care would result if doctors were to work on a mass contractual and commercial basis.[13]

Favorable aspects of the California Physicians' Service were duplicated in other states and counties after 1941. Initial expansion was slow. Problems associated with income limitations for service benefits, excessive utilization by insureds, and abuses by physicians were some of the early obstacles.

In 1942 the American Medical Association gave its approval to the movement. At the same time the Association set forth requirements that plans should meet:

> . . . all features of medical service should be under the control of the medical profession . . . no third party must be permitted to come between patient and physician in any medical relations . . . the patient must have absolute freedom to choose any participating physician . . . the confidential nature of the patient-physician relationship must be preserved . . . medical service should be paid for by the patient in accordance with his income status and in a manner that is mutually satisfactory.[14]

[12] *Medical Care for the American People, the Final Report of the Committee on the Costs of Medical Care* (Chicago: University of Chicago Press, 1932), p. 167.

[13] *Ibid.*, pp. 200–201.

The growing acceptance of Blue Cross was part of the force which added to the launching of Blue Shield plans. The two services—hospital and physicians'—went hand-in-hand; in addition, the two working together were better able to meet the competition from insurance companies whose policies included both hospital and surgical care. This tie-in of benefits, as well as the interdependence in development, accounts for the large number of Blue Cross and Blue Shield plans which are being operated by the same staffs at the present time.

Three Blue Shield organizations started in 1944, ten in 1945, and twelve in 1946.[15] Like Blue Cross, Blue Shield developed as locally autonomous organizations. The early growth pattern of Blue Shield, when contrasted with the far-reaching significance of these associations less than twenty-five years later, presents part of the necessary background for a discussion of regulation in this area. The divergencies in governmental supervision of associations is more easily understood when it is realized that these organizations were initially viewed as small, local groups. It is doubtful whether association executives, let alone regulatory officials, conceived that Blue Cross and Blue Shield would one day be covering such an important portion of the country's entire population.

THE MATURATION, 1940–1955

As Table 2–1 reveals, the phenomenal growth of Blue Cross occurred after 1940. Not until 1937, seven years after their birth, did Blue Cross plans have more than a million participants. In 1940 a total of 12.3 million persons—9 per

[14] Smith, *op. cit.*, chap. 11, p. 5.

[15] Reed, *Blue Cross and Medical Service Plans*, p. 145.

cent of the population—had some kind of hospital coverage, approximately one-half of which was provided by associations. Those protected against surgical expenses in the same year totaled 5.3 million—4 per cent of the population—

TABLE 2-1

NUMBER OF PEOPLE WITH HOSPITAL EXPENSE PROTECTION, 1936-1960 (000 omitted)

End of Year	*Grand Total**	*Blue Cross, Blue Shield and Medical Society Plans*
1936		608†
1938		2,874
1940	12,312	6,012
1942	19,695	10,215
1944	29,232	15,772
1946	42,112	24,707
1948	60,995	31,246
1950	76,639	38,822
1952	90,965	43,475
1954	101,493	47,484
1955	107,662	50,726
1956	115,949	53,162
1957	121,432	54,923
1958	123,038	55,205
1959	127,896	56,825
1960	131,962	58,050

* Net total of people protected, eliminating duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same kind of coverage.

† Columbia University School of Public Health, "Hospitals and Blue Cross," Lectures at Columbia University School of Public Health of the Faculty of Medicine, Institute of Administrative Medicine (rev. October, 1957), p. 3.

Source: Health Insurance Council

while 3 million—2 per cent of the population—had medical expense coverage.[16]

The acceptance of group insurance by management and the pressures of the labor movement were of considerable

[16] Odin W. Anderson and Jacob J. Feldman, *Family Medical Costs and Voluntary Health Insurance: A Nationwide Survey* (New York: McGraw-Hill Book Co., Inc., 1956), p. 11.

importance in the upsurgence of medical care insurance during the war period. Management, moved by a combination of social and mercenary motives, came to view medical care coverage for workers in much the same light with which they looked upon the workmen's compensation idea. Labor, often unable to obtain money increases because of wage freezes, strove for expansion of fringe benefits. Contractors on governmental cost-plus assignments did not oppose the extension of medical care coverages as they might have under less advantageous financial contracts. Between 1940 and 1946 the number of individuals with hospital-surgical coverage quadrupled. The absolute number covered by Blue Cross–Blue Shield in 1946—24.7 million persons—was close to double those protected by insurance companies.

Over the 1947–49 period the National Labor Relations Board declared that employers were required to bargain with employees regarding group medical care programs; failure to do so would result in an unfair labor practice. This solidified the position of hospital, surgical, and medical types of protection among group fringe benefits and greatly enhanced their expansion. "Between 1946 and 1950, hospital insurance coverage increased by about 80 per cent, surgical insurance by about 190 per cent, and medical insurance by 230 per cent."[17]

The fantastic acceptance of medical care insurances from 1940 to 1955 brought with it developments which influenced the regulation of the medical care field:

> . . . it is likely that developments in health insurance, as in almost any other line of human endeavor, are not necessarily the outcome of well-reasoned choices from many possible alternatives. Rather, the form that health insurance has taken and will take is a tenuous balance between the many elements that make up the complexities of personal health services: people, hospitals, physicians, insurance, and finance, interlaced with philoso-

[17] Milton Silverman, "Post Reports on Health Insurance," *Saturday Evening Post*, 230:25-27 (June 7, 1958), p. 128.

phies of government and private enterprise and with the level of public information and knowledge.[18]

From 1946 to 1956 Blue Cross and Blue Shield plans added an additional 3 million members yearly. The ten-year period saw the total number of persons covered by hospital-expense protection climb from 42 million to 116 million individuals; 53 million of these were in Blue Cross–Blue Shield.

THE PRESENT, 1956–1962

Few economic issues are of more interest to the American people today than the costs of medical care and how best to meet them. Indeed, in recent years, some of our most vigorous (and bitter) national debates have raged around these matters. To many it may seem strange that such concern should develop at a time when clearly more Americans are receiving better medical care and living longer and healthier lives than ever before. The situation, however, becomes much less paradoxical when the amazing strides taken by medical science in the past fifty years are viewed in the light of the social and economic conditions they create and in the total social context of our times.[19]

Personal expenditures on health in the United States totaled $19.6 billion in 1960, which amounted to approximately 6 per cent of total personal consumption expenditures.[20] In addition, about $6 billion was spent by the various governmental levels. The position held by Blue Cross and Blue Shield plans can best be seen and analyzed through a consideration of the individuals covered and the benefit structures for those having medical care protection of this type. An analysis of benefit structures includes a discussion of the types of benefits—hospital, surgical, and medical—and the adequacy of these payments.

[18] Anderson and Feldman, *op. cit.*, p. 89.

[19] Franklin D. Murphy, Chancellor of the University of Kansas, in the "Foreword" to Anderson and Feldman, *op. cit.*, p. v.

[20] Health Insurance Institute, *Health Insurance Data, 1961* (New York, 1961), p. 49.

Enrollment

The growth rate in medical care coverage during the late 1950's was less pronounced than it was in the earlier developmental stages. This is natural as the base on which the rate is calculated grows to include an increasing portion of the population. Though more gradual, the persistent increase in the percentage of the population whose medical bills will be at least partially covered continues to make the over-all movement spectacular. Seventy-three per cent of the civilian population was covered by some type of voluntary medical care insurance in 1960, an increase of approximately 4 million persons over 1959.[21] The 1960 figure was comprised of 131,962,000 individuals. Over 92 per cent of these had the combined protection of both hospital and surgical coverages.[22]

The following factors are among those which have influenced the growth of Blue Cross and Blue Shield and, thereby, largely determined the areas in which current expansion would be most rapid: (1) adequacy and organization of voluntary hospitals, (2) nature of urban and industrial environment, and (3) level of local per capita income.[23] Where voluntary hospitals have been important in a

[21] The figure of 85 per cent has been mentioned as a possible population coverage goal for medical care insurance. The remainder would include those in various government institutions, military personnel, and those obtaining government assistance. If the 85 per cent is realistic, then about 86 per cent (73 divided by 85) of the *coverage goal* has been reached.

[22] Health Insurance Institute, *op. cit.*, pp. 5, 6, 21. The coverage breakdown at the end of 1960 was:

Type of Protection	*Number of Persons Protected (000 omitted)*		
	Primary Coverage	*Dependents' Coverage*	*Total*
Hospital expense	55,283	76,679	131,962
Surgical expense	49,306	71,739	121,045
Regular medical expense	36,248	51,293	87,541
Major medical expense	10,498	16,950	27,448

[23] Reed, *Blue Cross and Medical Service Plans*, pp. 28–30.

amount for their hospitalization or medical-surgical treatment, other than for excluded services and procedures, unless they are confined beyond the number of days for which benefits are provided. Thus, associations which have used deductible or coinsurance features have been chastised as violators of the service approach. This is an overly harsh attitude, particularly since, in reality, service benefits are not necessarily synonymous with first-dollar benefits. Benefits can be provided in terms of hospital or medical service, even if members pay the first few dollars of a daily hospital rate, for example, during initial days of confinement.

The service approach is unique historically and currently with hospital and medical service associations and the independent group health clinics. Then, too, Blue Cross and Blue Shield plans are under continuous pressure from their national organizations to expand the use of service-type contracts. It seems appropriate, therefore, in light of the foregoing discussion to consider the service characteristics as a proper generalization for Blue Cross plans, and in specific instances for Blue Shield associations.

CONTRACTUAL RELATIONSHIP WITH HOSPITALS AND DOCTORS

One of the most obvious, as well as least debatable, characteristics of Blue Cross and Blue Shield is the contractual relationship these organizations have with hospitals and doctors. Over 6,000 institutions, which account for approximately 90 per cent of the hospitals in America, have contracts with Blue Cross plans. About the same percentage of doctors cooperate in Blue Shield arrangements. Insurance companies generally have no prearranged commitments from hospitals (or doctors) to provide services for policyholders, nor are there any widespread financial arrangements between hospitals (or doctors) and insurance companies as to amounts of reimbursement if services are rendered to policyholders.[9] Some of the most important pioneers in the Blue Cross and Blue Shield movements feel this contractual relationship is the most important distinguishing feature of the associations.

The association between Blue Cross–Blue Shield and the hospitals and doctors is closely aligned with service benefit contracts. Service benefits could not be made available without prior commitments from those who provide medical care.

COMMUNITY RATING PROCEDURES[10]

Dr. Kulp's definition for insurance, which was employed earlier (p. 8), revealed that a pooling or averaging of exposure was a prerequisite. The debate in most lines of insurance, not the least of which is the hospital and medical area, is how broad an exposure classification must be in order to meet the pooling or averaging requirement. It is self-evident to those familiar with the mathematics of insurance that as exposure limits are narrowed in the desire for greater homogeneity and sophistication, the number of exposure units contained within the category is reduced. The ultimate in this type of refinement is an individual exposure unit. When the rate paid for the coverage of a particular exposure unit is affected to some extent by the loss experience, and possibly the expense experience, of such a unit, the procedure is called "experience rating."

Originally, Blue Cross and Blue Shield plans used broad class-rating procedures exclusively. That is, the experience of covered groups was combined to determine a "community" rate. This rate was paid by each member of a class of subscribers, and no modifications were made on a particular group's rate if its experience differed from the average of

[9] Physicians have cooperated in a few "state surgical plans" under which prearranged fees are paid for certain services rendered to individuals who have approved insurance coverage and whose incomes are below a specified limit.

[10] Chapter XI is devoted to the subject of rates and rate regulation.

the entire class. Actually, a class rate was determined for single group members, group subscribers with one dependent, and family group members. Similar classifications were used for nongroup subscribers and often for group conversion members.

The philosophy behind a community rate was in keeping with the social aura which surrounded the "Blues." If this was a social technique to meet a social problem, then it was felt that all groups cooperating in the system should share the cost of operating the scheme without individual consideration. An "average" rate for an entire class of subscribers carried out this principle. If deviations from the average rate were allowed for groups with good loss experience, the result would be that those groups with poor experience would be paying higher rates for their protection, and a basic tenet behind the social insurance-type system would be broken.

As insurance company encroachments into the hospital and medical coverage field increased, many Blue Cross and Blue Shield plans were forced to compromise with their philosophic principles and adopt some of the methods of their competitors. This was particularly true for the rating of "blue-chip" corporations who, understandably, would otherwise procure their coverage from insurance companies which would provide similar benefits at lower cost to the insured.

In relation to nongroup coverage the community-rate idea has been more zealously defended. Some would say that a *true* community rate for those not having group coverage would charge the same amount for each "spending unit." In this manner single wage-earners would contribute the same amount as those spending units with several dependents. Most Blue Cross and Blue Shield plans, however, have three broad classifications: single-person units, two-person units, and family units. Thus, all single subscribers pay the same rate, although it is less than that charged a two-person unit.

The community-rate principle is particularly evident in the family coverages. In most associations a family with ten children pays the same rate as one with two children.

PREPAYMENT PRINCIPLE

Among the other characteristics attributed to Blue Cross and Blue Shield as bases for differentiation from insurance companies is the idea that associations are "prepayment programs."

> Blue Cross is a prepayment program for the purchase of hospital service. It is not insurance, but it operates on the basis of insurance principles. This distinction is frequently challenged as being meaningless. There is a technical difference between prepayment and insurance . . . which gives validity to the distinction, leaving aside the social concept of Blue Cross, which separates it from the insurance industry as such. Insurance is a device whereby a numerous group of individuals through a system of equitable contributions may reduce or eliminate any measurable risk of economic loss common to all. Each element of this definition has some significance. The first element is that the group must be large; it is not a phenomenon in which a single person or two or three persons may participate. Second, contributions are necessary and these contributions must be equitable. Third, the risk must be measurable, it must have to do with an economic loss.
>
> The distinction between Blue Cross and insurance comes on this third aspect of the definition. Insurance, notably casualty insurance of which commercial hospital insurance is a part, measures a risk in terms of dollars of protection. Blue Cross measures the risk in terms of needed care. Although there are obvious deviations, Blue Cross is basically a vehicle for providing hospital service when needed without concern to dollar value of the care required by any individual participant in the risk. This is the concept of "service benefits."[11]

[11] Columbia University School of Public Health, Institute of Administrative Medicine, *Lectures: Hospitals and Blue Cross* (rev. October, 1957), pp. 21–22.

It is difficult to perceive how a scheme could utilize "insurance principles" yet not be "insurance." It is true that the means of measuring the potential loss experience is more difficult under Blue Cross (and Blue Shield) where service benefits are offered; nevertheless, Blue Cross and Blue Shield actuaries obviously use mathematical techniques to convert "needed care" into dollars of expected claims. In addition, they use pooling or averaging methods, which was all Dr. Kulp required to constitute "insurance."

The word "prepayment" in itself is confusing, because insurance policyholders could be considered to "prepay" for the protection they receive. As used by Blue Cross personnel, however, the term is meant to imply "prepayment of all the services required." It has been previously noted that full service benefits are not offered by all associations, so this also reduces the value of the distinction.

Finally, those associations which utilize retrospective rating do not technically have a prepayment of benefits for contracts so rated inasmuch as payments are determined after the protection period is completed.

HOSPITAL ADMISSION PROCEDURES

Blue Cross plans emphasize the advantage their subscribers have when hospitalization becomes necessary. Upon entry to a hospital a member merely shows his Blue Cross card and no deposit of money is needed. In the past those protected under insurance company policies often had to make such a deposit. The hospitals justified this treatment by saying that there were so many insurance companies and so many types of benefits offered by each company that a hospital could not possibly know whether a patient had sufficient coverage to pay a major portion of the hospital bill, even if he was insured.

Some of this difference regarding hospital admissions has been manufactured by certain Blue Cross plans and hospitals, as may be seen in the following quotation:

Concerted action by hospital groups have [*sic*] stymied efforts of insurance companies to force hospitals to grant them the same rights that Blue Cross had in the matter of admissions, billings, etc. It is this type of public relations efforts that Blue Cross needs from hospitals.[12]

It *is* simpler for a hospital to determine the nature and extent of benefits to which a patient is entitled under Blue-Cross than under the policies of insurance companies. When a subscriber is admitted to a member hospital in his home area, the hospital contacts the association's headquarters under a routine arrangement to determine the patient's eligibility for benefits. Even when an out-of-area member is hospitalized, the use of the Blue Cross Private Wire Communications System will provide the necessary eligibility information.

Insurance companies have countered this disadvantage through a procedure developed by the Health Insurance Council. This body established a standard qualification procedure for hospitals to use regarding hospital insurance policyholders. Under this arrangement, most insureds do not have to make a cash deposit upon entry into the hospital. Thus, the difference in hospital admission procedures between Blue Cross–Blue Shield and insurance companies is being reduced. Where this difference does exist, it is much less important to insurance commissioners than it is to hospital patients.

Another possible variance in Blue Cross and insurance company procedures concerns the billing of a patient upon his discharge from a hospital. A Blue Cross member pays only the difference between his total bill and the amount of his Blue Cross benefits, if he has been in a cooperating hospital. The Blue Cross plan pays the hospital according to predetermined rates for the facilities and services included in the subscriber's coverage. A policyholder can now usually authorize his insurance company to pay the amount

[12] *Ibid.*, p. 45.

chapter XI

RATES

Scholars often characterize the "rate" as "the heart of the insurance transaction." It is understandable, then, that regulatory problems concerned with Blue Cross and Blue Shield rates are as old as public supervision of the associations. In fact, much of the logic behind governmental authority over hospital and medical service associations is the alleged undesirability, or inability, of these organizations to "regulate" their own rates. Blue Cross plans, for example, had a monopoly in the hospital prepayment realm in the early 1930's. To give an association free rein over the rates it would charge subscribers was considered by some states as possibly subjecting enrollees to the same type of overcharges characterizing monopolies. In many areas Blue Cross and Blue Shield plans themselves requested governmental supervision. This would help assure subscribers they were being treated fairly.

RATE MAKING AND RATING METHODS

Community Rating

One early goal of Blue Cross and Blue Shield was to make hospital service available to all segments of a community. To do so involved covering poor risks as well as average and better risks. This was considered in the community interest, and all covered elements of the community were averaged. All subscribers supposedly paid the same rate, and, about two decades after the inception of associations, this technique became known as "community rating."

Actually, at no time have all subscribers paid identical rates. Most associations have differentiated between single subscribers, those with one dependent, and families. As Blue Cross and Blue Shield plans expanded their enrollment methods to embrace nongroup members, a different rate was used for these direct-pay subscribers. Conversion privileges, a traditional feature of group certificates, developed another type of member, the group conversion subscriber. The higher claim costs incurred by those who convert have often been felt to necessitate a special rate for this membership category.

From the very beginning, then, departures have been made from the principle that each subscriber should pay the same rate regardless of his claim potential. A pure community rate would probably have been one whereby each spending unit made the same contribution to an association without such payment being influenced by any other factor.[1] Thus, "community rating" becomes a matter of definition.

The concept of community rating was first considered an *actuarial-statistical technique.* In this rate-making sense it implied a pooling of risks among the members of a community, with the "community" including either all of the citizens in an association's area or all of the subscribers. Averaging resulted in the low-loss subscribers subsidizing the high-loss members.

"Community rating" came to mean more than a method for determining rates, however. Hospitals were in the social and community interest and the medically indigent presented a social problem. Since Blue Cross and Blue Shield were able to assume part of this social burden, the community-rating concept they employed began to take on *sociopolitical overtones.* In the latter context community rating has received adverse as well as favorable comment. When combined with the nonprofit characteristic of associa-

[1] Some observers feel that a rate based on ability to pay would be more equitable than even a pure community rate, i.e., a rate based on the benefit structure. The judgment and administrative problems connected with rates determined by ability to pay have prevented their serious consideration by associations.

tions, community rating has implied to many that socialistic principles are being utilized and that the entire process is against the American ideal of private enterprise.

Internally, community rating is a critical issue because those who abandon its use are considered by some other associations as having compromised a basic characteristic of the Blues' movement. At the same time the mavericks are felt to have moved closer to insurance-company-type operations. Community rating has become an external problem because most associations are competitively handicapped with it.

Experience Rating

"Experience rating," also called "merit rating" or "self-adjusting rates," is a method evolved to deal with the inadequacies of the community-rating technique. The "new" device goes beyond the deviations for family composition and type of membership used to modify a pure community rate. It allows, in addition, the actual loss experience of a group, and sometimes the expense experience as well, to influence the rate paid.

State laws often prescribe who may be considered a "group" for health insurance purposes. Generally allowable are employees of a common employer, members of a labor union, those who belong to an association not created for the purpose of obtaining insurance, and trusteeships of multiple employers-employees. In this latter arrangement small groups of certain sizes, such as between ten and twenty-five members, are combined and a collective group rate is determined. The same might be done for groups with twenty-five to fifty members, for example, and all over fifty would be individually experience rated.

An experience rate is determined through the application of three, or possibly four, elements: the class rate (often known as the community rate), group experience, and group credibility. The fourth element is an allowance for contingencies. By taking into account the anticipated loss or claim

costs, expected administrative costs, and contingency reserve requirements for each class—e.g., single group subscribers, family group subscribers, etc.—the community rate is ascertained basically by dividing the total of these amounts by the total subscribers in the class. A prospective determination is involved in that last year's class experience plus trend factors are used to compute the rate for the coming year. The three primary trend factors for Blue Cross are changes in hospital admissions, length of stay, and hospital costs. The adjustments for Blue Shield are utilization of doctors' services and changes in medical-surgical costs.

A group experience trend is then estimated by comparing the group's actual loss ratio with its expected loss ratio for the past period. Actually, the statistics from several past periods may be utilized. Loss ratios are essentially the proportion incurred claim costs, actual or expected, bear to earned subscription income, actual or expected.

The degree of reliability of the expected experience loss ratio is determined by the group's credibility factor. A controlling determinant of this factor is the size of the group. The larger the group, the more trustworthy its experience. A credibility factor may vary from 100 per cent for groups of possibly a thousand or more members, down to 5 or 10 per cent for small groups, such as twenty-five members. The greater significance attributed to the experience of a large group means that its actual loss ratio is more likely to be free of accidental fluctuations and to represent its probable prospective loss ratio. Limitations imposed by the credibility factor stabilize the rates for smaller groups. Without these the widely fluctuating experience from year to year in small groups would call for unduly frequent rate changes.

Once the credibility factor is determined the final rate construction is carried out. If group size suggests a 30 per cent significance figure, then 30 per cent of the rate is based upon the specific group's expected loss ratio and 70 per cent is determined by the expected loss ratio of the class. The expense portion of the rate is generally added separately for

small groups, inasmuch as such groups can do little to affect expenses upward or downward. In some instances larger groups are allowed experience modifications of the expense element based generally on the proportional size of the case.

Some associations modify the experience-rating process by basing part or all of the credibility upon the total group payroll or upon the total premiums for medical care coverage.

The rate-making process described here is applied to all categories of a group's members: the single class, those with one dependent, and the family class.

The experience modifications may be made on a prospective basis, as described, or retrospectively. With the latter process, a group's actual rate is determined after the period of protection is completed. Thus, for groups with 100 per cent credibility, retrospective rating amounts to a cost-plus arrangement, with the "plus" the expense portion and any amount included for contingencies. (New York law limits the retrospective period to one year.)

Some associations apply the retrospective rate modification if it will result in a *lower* group payment; otherwise, the prospective experience rate is used. This is, of course, a competitive inducement. At first glance it would appear to encourage over-all rate inadequacy for an association since groups with poor experience would make no additional retroactive payment while those with favorable experience would be granted a retroactive credit. Aggregate rate inadequacy is averted when this provision is employed by including a contingency factor for such credits in all group rates.

It is possible for an association to lose money through experience rating. One large eastern Blue Cross plan recently lost $1.8 million on experience-rated business. Improper trend analysis in the *prospective* rate contributed to the loss, although the actual cause has not yet been determined with certainty. The association suspects utilization of outpatient diagnostic benefits is partially responsible.

Stimuli for Experience Rating. The growth of experience

rating was fostered by insurance companies after World War II when increased intensity of business competition forced an emphasis on cost reductions. At the same time, the upsurge in utilization and cost of associations' benefits caused many groups to change their former support of the community-rating principle and its associated high-cost elements. Groups with favorable experience saw the opportunity to obtain hospital and medical insurance coverage at a reduced outlay if such cost were based upon their own losses rather than those of an entire class. Insurance companies developed experience rating partly as a means of providing rate equity and also because many employers and unions were threatening to self-insure if experience rating techniques were not adopted. Blue Cross and Blue Shield thus had some of their largest groups switch to coverages offered by insurance companies. A perplexing enigma developed. The departure of low-loss groups would leave Blue Cross–Blue Shield with predominantly high-loss elements. Rates would have to be increased. Higher rates in themselves would discourage the continuation of favorable groups remaining with the Blues, as well as deter those considering membership. Further losses of subscribers to insurance companies would ensue. This pattern actually occurred, and the proportional loss of subscribers discussed in Chapter II is partially explained by the failure of associations to utilize competitive rating methods.

A further dilemma appeared. The supposed goal of Blue Cross and Blue Shield was to enroll elements of the community for whom coverage was otherwise not obtainable. Generally those citizens lacked coverage because they could not afford to pay for protection. Blue Cross and Blue Shield were able to include a portion of these elements because their rates were subsidized by low-cost risks. If favorable risks moved out of the Blue Cross–Blue Shield system, the accompanying rate increases would preclude high-cost elements from retaining, let alone expanding, their membership.

It has become evident, therefore, that community rating, even with its modifications, can include the major part of *all* segments of the community only if it has a virtual monopoly in the area.[2] The aged, in particular, have so few funds with which to purchase medical care protection that it requires the inclusion of a great proportion of low-cost subscribers to offset the adverse selection the elderly present and at the same time to bring the rate within their financial means. Governmental contributions at some level would undoubtedly be necessary before all of the aged could be covered.

Competition has not been the sole mover behind experience rates. It is no secret within associations that many organizations have used experience rating as a means of *circumventing rate hearings.* About 60 per cent of the executives contacted in associations which used experience-rating methods said that the prime motivator for the adoption of the technique was to by-pass public hearings. Organizations with enrollment among the state population as high as 80 per cent have implemented experience rating. With this just short of a monopoly in hospital and medical prepayment, certainly something more than present competition must have encouraged a change in rating methods.

Whenever a community rate is altered, most commissioners feel state statutes give them the authority to hold public hearings if they deem it necessary in evaluating the propriety of rate changes. In the case of experience rates, however, the regulatory authorities are usually concerned only with the initial experience formula. Once this is approved, it may be applied year after year without investigation by the supervisory official. Only when an experience formula is modified does a commissioner enter the scene again in most jurisdictions.

[2] The federal government, for example, uses community-type rating—considering all the insureds as the "community"—in its disability income program under the social security system, and the same would presumably be true for any system of socialized medicine.

There is not an automatic by-passing of all hearings, however, just because a plan employs experience-rating techniques. The application of individual experience as a modification of rates is limited to subscriber *groups;* direct-pay subscribers and those who are group conversions are still rated on a community basis even when experience rates are used for group risks. (Classifying memberships as to direct-pay, group conversion, etc., is more appropriately considered class rating rather than experience rating.)

It should also be mentioned that even the approval of an original experience formula is not as thoroughly scrutinized by most commissioners. They feel group buyers are more capable of looking out for their own interests than are direct-pay members. The responsibility of attending to the public interest is focused primarily on the direct-pay and group-conversion rates.

In addition to the fact that competition and the possibility of circumventing rate hearings have stimulated the expansion of experience rating, Blue Cross and Blue Shield plans have looked upon the technique with favor for other reasons. First, experience rating will ward off many pressures by employers and unions[3] to pay noncovered services and overpay claims. Second, rates influenced by individual group experience will focus attention on the high-cost elements. Third, experience rates can be a factor in controlling unwarranted increases in hospital and medical costs. As more and more groups, particularly those of large size, see that approximately 90 per cent of their medical care insurance costs are determined by expenditures to hospitals and doctors, they are going to become much more concerned with the "whys-and-wherefores" of such payments. Direct accounting to groups as to the nature of these costs is already a reality. They themselves can quite conceivably exert pressures on associations, vendors of association services, and regulatory officials to rectify abuses in the use of benefits and to correct

[3] In most cases unions are more concerned with rates if employees contribute in the premium payment.

what they judge improper increases in the medical care costs. It will be surprising if uniform accounting, central purchasing by hospitals in a community, and other features which may foster economy are not brought about more readily through the influence of group buyers.

Utilization of Experience Rating. Blue Cross. Approximately two-thirds of the Blue Cross plans in the United States allow experience rating for at least some groups. A

TABLE 11-1

THE USE OF COMMUNITY RATING AND EXPERIENCE RATING BY BLUE CROSS PLANS, 1959

Rating Method	*Plans*		*Total Subscribers*	
	Number	*Percentage*	*Number*	*Percentage*
Community rating only*	35	44.9	18,819,247	36.2
Community rating with experience rating available	26	33.3	19,504,371	37.5
Experience rating required for groups above minimum size	17	21.8	13,643,705	26.3
Total	78	100.0	51,967,323	100.0

* Thirteen of these plans, with an enrollment of 6,579,553, will use experience rating for national accounts.

Source: Blue Cross Commission, *Research and Technical Assistance Service Bulletin*, Number RT-59-1, p. 1.

study by the Blue Cross Commission in 1959 revealed that 64 per cent of the subscribers were in associations which employed experience rating to some extent. Part of the commission's study is summarized in Table 11–1. It should be noted that enrollment statistics refer to total subscribers and not just to group members although the latter would be those to whom an experience rate would apply. The actual proportion of group subscribers whose rates were influenced by individual group experience is not known.

The Blue Cross plans in California and Illinois are among those which require experience rating. Associations in New York and Pennsylvania are about split as to the use of only a community rate or experience rating on an optional basis.

Associations which compel the use of experience rating do so only for groups above specified member size. The require-

ment to use this rate-making method does not apply to direct-pay subscribers, group conversion members, or non-eligible groups.

A total of fifty-six of the seventy-eight Blue Cross plans used experience rating for national accounts. Thirteen of these organizations would not allow self-adjusting rates for local accounts. National accounts extend beyond the borders of any individual state and thereby involve more than one hospital service association if their members are to be covered by Blue Cross. Where an association refuses to base the rate for members of national groups within its area on the over-all national experience, the community rate is the payment which must be made if such members are to be covered. The variance of rates by associations, when they refuse to experience rate, has been of more competitive disadvantage than even the refusal of some organizations to cooperate in offering a uniform benefit structure throughout the country.

An indication of the size limits placed upon experience-rated groups may be seen in Table 11–2. The wide range of these restrictions imposed by Blue Cross plans indicates that most state laws and regulatory officials have either not resolved the size limitations desirable for group rating, or else they have not done so with any degree of uniformity.

TABLE 11-2

SIZE LIMITS FOR EXPERIENCE-RATED GROUPS IN BLUE CROSS PLANS, 1959

Minimum Number of Contracts	*Experience Rating Required*		*Experience Rating Optional*	
	Number of Plans	*Percentage of Plans*	*Number of Plans*	*Percentage of Plans*
25 or less	9	53	3	11
50	1	6	6	23
75	1	6	1	4
100	6	35	11	42
250			1	4
500			2	8
Other			2	8
Total	17	100	26	100

Source: Blue Cross Commission, *Research and Technical Assistance Service Bulletin*, Number RT-59-1, p. 2.

Blue Shield. Statistics are not available on the total number of medical service associations allowing experience rating. Information has been obtained from the largest Blue Shield plans, and it is summarized in Table 11–3. The giants among Blue Shield plans are, it may be seen, on both sides of the rate fence.

TABLE 11–3

THE USE OF COMMUNITY RATING AND EXPERIENCE RATING BY BLUE SHIELD PLANS HAVING OVER ONE MILLION SUBSCRIBERS, 1962

Area	*Local Groups*		*Percentage of Area Population Enrolled, December 31, 1961**	*National Groups*	
	Community Rate Only	*Experience Rate Available*		*Community Rate Only*	*Experience Rate Available*
New York City		X	41.10		X
Pennsylvania		X	37.37		X
Michigan	X		41.67	X	
Columbus, Ohio	X		32.26	X	
Massachusetts		X	46.62		X
Chicago		X	22.20		X
New Jersey	X		35.41	X†	
Indiana		X‡	30.37		X
Texas		X	13.90		X
Connecticut	X		47.29	X	
Cleveland, Ohio			52.64		
California		X	6.41		X
Total	4	7		4	7

* Source: Blue Shield Medical Care Plans, *Enrollment Reports, Blue Shield Plans, December 31, 1961*, pp. 2–3.

† Special legislation was enacted to allow the plan to participate in the Federal Employees Health Benefits Program which uses an experience-rating system.

‡ On January 1, 1961, the plan adopted an experience-rating program for all groups above fifty. The plan considers the new program basically still a community-rating technique, however, because the rate variations are so small.

Source: National Association of Blue Shield Plans and correspondence with some of the plans

The proportions of enrollment do not give any clear indication as to variances in the use of experience rating with changes in subscriber percentages. Nor is there any apparent geographic pattern in the use of rate methods.

Problems Associated with Experience Rating. Contingency Factors. One debatable issue in the construction of experience rates is whether there should be any contribution

to a contingency reserve. A reserve of this type is used to offset the higher claim costs an association incurs on behalf of high-loss subscriber segments, particularly the aged. When an employee with Blue Cross–Blue Shield group protection retires from a company, three choices are available regarding his coverage. First, the firm may keep him on the subscribers list and pay the enrollment fees for him. Experience-rated group employers who retain retired employees' coverage for them obviously have their premiums increased. Premiums rise more than the per capita subscription cost because the aged have both a higher incidence of hospitalization and a longer average stay once they are confined to a hospital. Similarly, their utilization of doctors' services is higher. Several associations grant special experience-rate credits to encourage employers to retain the coverage of retired employees. For example, double credit may be given for additional payments made on behalf of the pensioners. Credits, however, do not generally keep the premium per subscriber from being above what it would have been if pensioners had been excluded. Thus, employers who are motivated more by economic considerations than social and labor pressures are likely not to retain retired employees on subscriber rolls.

Retired employees not kept in the subscriber group may convert to an individual member basis. In this event they are called "group conversion" subscribers. Benefits under a converted contract are similar to those of group members. The rates for group conversions, however, are generally higher than they would have been under a group certificate, even if the employer had not contributed any portion of the premiums. Table 11–4 reveals that while the rate relationship between group conversions and original direct-pay subscribers is close, the difference between group conversion and group rates is considerable. Single group converters included in the table had a median rate 24 per cent higher than the single group members. In the family category there was approximately a 16 per cent increase from the median group rate to the group conversion median.

l Howe and Bill Strauss

A Hidden Tax on Young People

At the core of health insurance reform lies an enormous hidden tax on youth. It's called strict community rating. Politicians don't discuss it, the media don't cover it, but this multisyllabic catch-phrase threatens to move at least $40 billion a year out of the wallets of young adults (under age 35) and into the wallets of the middle-aged (age 45-64).

If strict community rating is enacted, you can ignore the talk about all the special "winners and losers" of health-care reform. The issue will be generational. The big winners will be Clinton-aged Boomers now entering midlife; the big losers will be the young men and women now entering the labor force.

Community rating is a much-heralded reform that would prohibit insurers from charging different premiums for different individuals. In its "modified" form, it would simply e that no one can be charged higher premiums solely due to poor health or pre-existing conditions. This reform appeals to our sense of fairness and entails no systematic income transfer. But in its "stricter" form, it would require insurers to ignore all distinctions among individuals—including age—and charge a single community-wide fee.

Is this fair? Only if you think the federal government ought to enact a large new social rance program that would tax the young to subsidize the middle-aged. Today, the typical 25-year-old consumes about $1,000 per year in health-care services while the typical 60-year-old consumes about $3,500. The premiums an individual pays out of pocket or the health costs companies take out of a worker's compensation generally reflect this differential. After strict community rating is enacted, however, people of all ages will pay the same premium—probably, around $2,000 per year for a single person. Presto! The 25-year-old pays 100 percent more and becomes a $1,000 yearly loser. The 60-year-old pays 40 percent and becomes a $1,500 yearly winner. For family heads, the gap will be even wider.

If applied to everyone, strict community rating would mandate a total income transfer of at least $40 billion yearly—flowing away from the 55 million adults under age 35 and enriching the 49 million pre-Medicare adults over age 45. This "reform" would be equivalent to a 7 percent tax on a typical young couple's combined wages. That would make it about as large as their personal FICA tax (through which the young are already subsidizing the health costs of seniors).

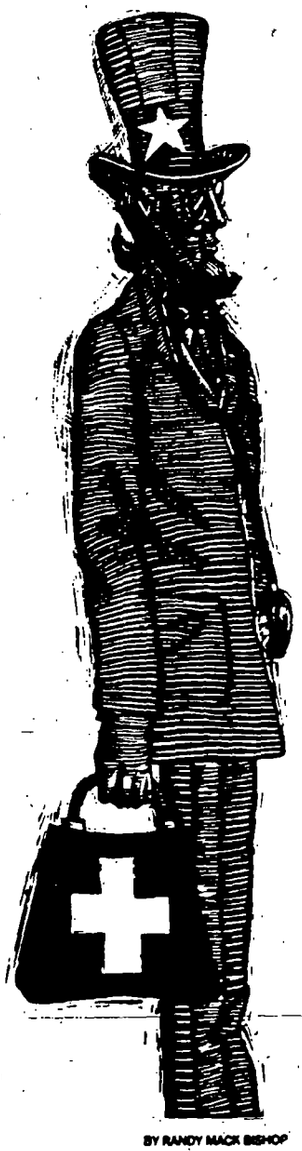
Such numbers are by no means hypothetical. Last year New York State instituted strict co nity rating for all small-group and individual insurers. On April 1, 1993, the price of a standard fee-for-service plan rose from $1,200 to $3,240 (a 170 percent increase) for a single 30-year-old male—while falling from $5,880 to $3,240 (a 45 percent decrease) for a single 60-year-old male.

Though not all the plans before Congress agree on this measure, the general outlook for young people is bleak. The Clinton, Kennedy, Gibbons and McDermott plans all prohibit any age-based variation in the premium or taxes payable for all insurance policies covered by their plans. Average price tag: $1,000 per young adult. The Chafee and Michel plans allow a little variation, but would still cost young workers about $700 each. The Moynihan plan would allow an age variation up to a multiplier of two, thereby extracting roughly half as much ($500) per young worker. The Rowland plan and the Dole plan (which allows premiums to vary up to a multiplier of four, close to the actual cost variation) are the only major proposals that would hold the young harmless.

Few national leaders have bothered to bring this massive youth tax to the public's attention. President Clinton has said that premium variations are unjust. If so, why for health insurance alone? Teenage boys pay four times more than their parents for auto insurance because they're four times as reckless on the road—and nobody says that's unjust. Some politicians argue that community rating, like Social Security, won't take anything from the young that they won't get back as they grow older. But this argument assumes that such young-to-old income transfers are forever sustainable (something most twentysomethings already don't believe about Social Security). It ignores the trillion-dollar lifetime windfall that community rating will bestow on Boomers (who incurred no corresponding cost when they were young). And it implies that most 60-year-olds are economically needier than most 25-year-olds (which is patently false).

Hillary Clinton has advanced the brassiest argument for picking the pockets of the young. One of the big problems with the current system, she says, is the health costs that millions of uninsured young people shift onto insured older workers. In reality, this effect is trivial, certainly when compared with the cost shifting by seniors with Medicare discounts. It cannot justify talking about community rating as an appropriate penalty for the irresponsibility of youth.

Given the political invisibility of today's young adults, strict community rating could well pass Congress. If so, brace for three consequences.



BY RANDY MACK BISHOP

First, today's young generation will become even poorer than they are now in relation to the old. Already, according to the Census Bureau, the real median income of households headed by people under age 30 is 15 percent lower than it was when Boomers were their age two decades ago. With strict community rating, their purc ing power could fall by another 7 percent.

Second, the new health law could defeat its own primary goal: universal coverage. Since adults under age 35 are currently the least insured age group in America, this goal will only be achieved if young people start purchasing more insurance. Huge premium hikes will have exactly the opposite effect. (Over the past 15 months, the New York experiment in community rating has ca d a 30 percent rise in policy cancellations by young males.) The only practical remedy to this problem w ld be to combine strict community rating with universal mandated coverage—which would seal young people into the system, force them to buy vastly overpriced insurance, and make them even more cynical about government than they already are.

The final and most spectacular consequence of strict community rating may be political. Right now, few young adults are paying attention to health care reform. But once community rating becomes law and young wallets are emptied, that will surely ge. Come 1998, people born in the '60s and '70's will comprise America's largest generation of voters. Once mobilized, they will start deciding elections. That's when those who taxed the young to enrich the middle-aged could get run out of office by those who find themselves stuck with the bills.

Everyone knows our health-care system needs change. Costs must be controlled. Poor families must gain access to doctors. Insurers must be barred from discriminating against the sick. All this can be done without forcing all younger workers to pay far more for health care (and all older workers far less) than what they actually consume.

Neil Howe and Bill Strauss are co-authors of "Generations" and "13TH-GEN."

Community Rating

:OG:

[- AHA/94167281
J - Stankaitis JA
[- Community rating--an approach that works.
] - Physician Exec. 1994 Jan;20(1):43-4.

[- AHA/94146290
J - Holmes A
I - Controlling the rate in community rating--experts aren't sure how.
] - J Am Health Policy. 1994 Jan-Feb;4(1):41-5.

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I - AHA/94167281
U - Stankaitis JA
I - Community rating--an approach that works.
O - Physician Exec. 1994 Jan;20(1):43-4.

I - AHA/94146290
U - Holmes A
I - Controlling the rate in community rating--experts aren't sure how.
O - J Am Health Policy. 1994 Jan-Feb;4(1):41-5.

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I - MED/93013455
U - Savage RA
I - A case for community rating [letter; comment]
M - Comment on: Health Aff (Millwood) 1992 Spring;11(1):174-80
O - Health Aff (Millwood). 1992 Fall;11(3):270-1.

:S 5 /C?
SER:

'ROG:

6
:I - MED/80181382
:U - Ruchlin HS ; Rosen HM
'I - Short-run hospital responses to reimbursement rate changes.
:O - Inquiry. 1980 Spring;17(1):42-53.

U - Cave DG ; Schweitzer SO ; Lachenbruch PA
I - Adjusting employer group capitation premiums by Community Rating by class factors.
O - Med Care. 1989 Sep;27(9):887-99.

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I - NP/015672
U - Lugg MM
N - Western Australian Dept. of Public Health, Perth.
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D - HRP-0006868
C - NTIS
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I - AHA/86270603
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I - Community rating: an historical perspective.
O - Bus Health. 1986 Jul-Aug;3(8):41-4.

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SER:

Ins Comm Rat

Recent HIAA Advertisement -- [or]
Why Insurance Companies Don't Like Community Rating

HIAA AD: The recent HIAA advertisement criticizes *"flat community rating"* as *"a very expensive experiment"* -- referencing articles on the effects of such community rating in the state of New York.

COMMUNITY RATING SHIFTS POWER FROM INSURERS TO CONSUMERS:

- Flat community rating *will* be expensive **to insurance companies**. They will have to discontinue their most profitable practice. Today, insurance companies pick and choose who to cover -- trying to insure only the healthiest people and excluding sick and old patients who need the most protection. They charge sick people significantly more based on their health care "experience", and charge older people and women more based on what their health experience *might be*.

  For example:

  - *"Insurers today charge much higher premiums to people who are old or sick. A 64-year-old may pay four to six times as much as a 20-year-old."* [New York Times, 5/22/94]

  - Men aged 25 to 35 typically pay less for insurance than women of the same age -- because the possibility exists that women might get pregnant. In fact, some women are given insurance policies that cover everything except pregnancy -- the one thing they most need health insurance for. [Women's Health Insurance Costs and Experiences, 1994; *"Why Women Pay More,"* The Center for Responsive Law, 1993] [**Note:** The HIAA has previously testified against legislation to prohibit insurance premium discrimination on the basis of pregnancy. (S. 995, 95th Cong, 1977)]

  - For comparable plans and benefits, health plan costs are 10 to 40 percent higher for small employers than for large firms. [GAO, 9/22/92]

- One of the main goals of the President's proposal is to prohibit insurers from discriminating against certain people: no more charging sick people more than healthy people, young people more than older people, small businesses more than large businesses. This will return insurance to what it used to be -- everyone pays in at the same *"community rate"* and their insurance is there when they need it, no matter what.

BUT COMMUNITY RATING WON'T WORK IF NO UNIVERSAL COVERAGE:

- But, all experts agree that, to be successful and fair, community rating will only work when all Americans have insurance that can't be taken away. In fact, the Wall Street Journal says that *"experts insist and real-life evidence shows"* that community rating is *"nearly impossible without universal coverage"*. [WSJ, 5/27/94]

- The New York example -- and all of the articles cited by the HIAA -- makes this point perfectly. When New York recently enacted insurance reform without universal coverage, rates for insured people went up by 35% and the number of people with insurance declined by 1.2%. [WSJ, 6/15/94]

- *Why did this happen?* Because all the sick people who had previously been denied coverage entered the system, driving up the rates for everyone. This caused young, healthy people and their employers to drop their coverage *"on the assumption that they can buy it later if needed"*. The result? *"With increasingly fewer healthy people counterbalancing the sick, the result . . . is the start of an upward spiral in rates for those still in the pool. If the trend continues, insurers contend, the very people that the program was intended to help could again be priced out of the market."* [Wall Street Journal, 5/27/94]

- In fact, the CBO has said that incremental reforms -- such as community rating -- without coverage for everyone -- can cause *"an upward spiral of premiums"*, with fewer people covered after "reform". [CBO, 5/94, p. xiv]

- Uwe Reinhardt, a Princeton University health economist, said *"Community rating without universal coverage will trigger the worst kind of behavior among insurers and patients."* [Wall Street Journal, 6/15/94]

- We must protect consumers from the premium increases that occurred in New York. That's why we are committed -- first and foremost -- to giving every American health care that can never be taken away. And we want it to be at a price they can afford.

HIAA CALLS COMMUNITY RATING "UNTESTED" -- WILL IT WORK?

- There are millions of workers in large companies today -- as well as in the federal government -- that are charged a "community rate". You never hear young workers at large corporations like IBM, Xerox, and General Motors complaining that their rates are too high. All employees contribute at the same rate and everyone's insurance is affordable.

- All federal employees -- and federal retirees -- also pay the same rate and are very satisfied with their affordable, comprehenive health plan. Under a popular choice offered in Washington DC under the Federal Employees Program, many young people pay less than $40 a month for a comprehensive package of benefits.

- Rochester, NY has often been cited as a model for reform. By utilizing "community rating", the city has lower costs per worker and higher levels of coverage. And Rochester's residents are far more satisfied with their health care than residents of the U.S. in general.

ROCHESTER, NY:
A MODEL FOR COMMUNITY RATING

ROCHESTER'S SUCCESS DUE TO COMMUNITY RATING:

- Rochester, NY has been called *"a jewel in a sea of health care despair"* by health experts and is looked to as a model for reform. Their costs are 25 percent below national levels and far more residents have health insurance. One of the cornerstones of the Rochester approach is community rating -- where families and individuals *"pay the same monthly premiums for each person as Kodak and Xerox, for equal benefits. And unlike most health care plans for small groups, no one pays more or is refused coverage because of age, sex or a previous medical condition."* [*"Rochester Serves as Model in Controlling Health Costs"*, New York Times, 8/25/92]

COSTS PER PERSON ARE LOWER IN ROCHESTER:

- In 1991, health insurance costs per employee in Rochester were 33 percent lower than comparable costs in the nation and 45 percent lower than in New York State." [*"Rochester's Community Approach Yields Better Access, Lower Costs,"* GAO, 1/93]

- "Some participants believe that in addition to contributing to increased access, community rating also helps to reduce the cost of health care. For example, community rating encourages Rochester's businesses and insurers to control aggregate health care costs because increases in community-wide costs would be directly reflected in the insurance rates paid by all businesses." [*"Rochester's Community Approach Yields Better Access, Lower Costs,"* GAO, 1/93]

- When community leaders in Rochester were asked to say what factors were responsible for cost control, community rating was their second choice [after community-wide health planning]. [*"Rochester's Community Approach Yields Better Access, Lower Costs,"* GAO, 1/93]

. . . AND ROCHESTER'S RESIDENTS ARE MORE SATISFIED:

- The residents of Rochester *"express greater satisfaction with their health care system than does the general U.S. population and indicate that they have less difficulty in obtaining care than residents of other areas."* [*"Rochester's Community Approach Yields Better Access, Lower Costs,"* GAO, 1/93]