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COMMUNITY RATING: CURE WORSE THAN THE DISEASE

Community rating is a requirement that insurers charge the same health insurance premium to everyone regardless of age, sex, location, occupation, or physical condition. It is a popular feature of the most intrusive health care reform packages.

Community rating is one of those superficially attractive ideas that becomes very unattractive on deeper reflection. The recent experiment with community rating in New York should give pause to those who are advocating such a system for the nation as a whole.

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Community rating is designed to hold down premiums for those who have, or who are at high risk of developing, expensive medical conditions. It does this by charging higher premiums than otherwise warranted to those members of the pool who are not at high risk. It prevents the relatively healthy from gathering themselves together (self-selection) or from being gathered together by insurance companies (cherry-picking), into low cost, low premium groups.

The incidence of illness and medical outlays rise sharply with age. Community rating has the effect of overcharging the young, who have relatively low income, to subsidize people in their late forties, fifties, and early sixties, who are at their peak earning years. If given a choice, people would probably prefer to have premiums that rise with their incomes as they get older, rather than community rating.

Community rating cannot work in a voluntary setting. The relatively healthy, including a large proportion of young people, would realize that the community rated premium far exceeds their expected medical costs, and that the insurance is a bad bargain for them. They would choose to go uninsured and walk away. They would spend their income on other products and services for which they get more value for their money.

With few of the relatively healthy, low risk individuals remaining in the insurance pools, premiums would have to rise sharply to cover the higher average per capita outlays of the remaining relatively high risk, relatively unhealthy individuals covered by the policy. In fact, premiums would have to rise to the levels that would have been in force if people had been accurately rated according to risk to begin with. That is, premiums would quickly get back to levels that would have prevailed without community rating.

The big difference is that many more people, those in the low risk groups, would now be uninsured. The very few in the low-risk group who happen to get very sick could very quickly get into financial trouble. That trouble would not occur if they and their low risk cohort had access to a fairly priced policy that they would all willingly have bought.

Some proposed systems calling for community rating also require guaranteed issue without exclusion for pre-existing conditions. That is, anyone could demand to buy a policy at any time, covering existing conditions with no waiting period.

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If this provision was in effect, people overcharged under community rating would simply stay out of the pool until they get sick, and then buy in. The pool would soon be populated only by those who have heavy ongoing expenses, all paying a high premium.

These results are not merely theoretical. They have been observed in practice. Five states have highly restrictive rules forcing insurance companies to issue policies to all who want them at severely regulated premium spreads, and all are having problems.

New York is the largest state to impose community rating. Premiums for young, healthy males jumped nearly 80% in the first year; premiums for men in their mid-fifties fell 25%. According to media reports, in the first year, one of the largest insurers in the state, Mutual of Omaha, lost 43% of its customers. The average age of its policy holders rose from 41.5 to 45. The average claim in New York more than doubled to $7,900.[1] The company was forced to request a 35% rate hike, effective last January, far above the normal year-to-year increase, as low cost individuals jumped out of the pool. The rate hike brought the premium for young men to about 225% of the pre-reform amount, and raised premiums for men age 55 back above the pre-reform level. The premium hikes will undoubtedly cause more young people to cancel their policies, resulting in further rate increases. This experience was typical of insurers who remained in the New York market.

Most of the major Democratic proposals (the Stark, Dingell, and Gibbons plans in the House of Representatives and the Clinton plan) include strict community rating, permitting premiums to vary only between single policyholders and those seeking family coverage (or families plus children). The Moynihan draft in the Senate Finance Committee allows limited premium differentials for age, family size, and geography. Of course, none of the plans is voluntary. Young, low risk individuals will not be allowed to walk away, but will have to pay premiums out of all proportion to their expected medical costs to subsidize older policy holders.

Young people may be told that community rating is not a bad deal for them over their lifetimes. True, compared to their current premiums, they will pay more — much more — under community rating while they are young, but when they are old they will pay less, being then subsidized by their over-charged children. Alas, this is a half truth. The same demographic shifts that are playing hob with Social Security will also play hob with community rating. There are a lot of baby-boomers on hand to help the current twenty-somethings to subsidize the relatively small current generation of fifty-somethings. But when the baby boomers hit their fifties, there will be relatively fewer young people to give them a windfall. The boomers will not get the same degree of transfers when they reach upper-middle age as the current fifty-somethings. People now in their twenties and thirties will face a further rise in premiums when the baby boom retires, and will in turn get less help from their children even though those children will be harder pressed in their turn while they are young.

The various alternative health reform plans being offered by Republicans generally have "modified community rating." Insurance companies would be allowed to vary premiums by age, sex, and geography, and perhaps by occupation. Most of the bills nonetheless place some over-all restriction on the variance in premiums. For example, the risks related to age would dictate a premium roughly 3.5 to 4.5 times as high for a 50 or 60 year old as for a 25 year old. Some of the "modified" rating bills (Michel, Gramm, Nickles, McCrery) limit the spread to two to one, raising the premium for the young and reducing it for the middle aged.

Even with modified community rating, companies unlucky enough to be approached for policies by an unusually large number of older customers would quickly be at a competitive disadvantage, and lose customers and money. That would be enough to scare some carriers out of the

business. Consequently, even modified community rating would not work well in the absence of reinsurance mechanisms, special high-risk pools to share the load, or corrective transfer payments from companies with lower-than-average-risk policy holders to those with higher risk customers. The House Republican (Michel) bill, which has no safety net for insurers so afflicted, would create an unstable market.

Modified community rating is an improvement over strict community rating, because much of the variation in incidence of illness is closely related to age. Nonetheless, failure to allow further adjustments for known medical risks is still a serious distortion. Imposing uniform rates within age groups to spread the cost of those known to be ill would add about 5% to the age-adjusted premiums of healthy 25 year-olds, and about 30% to the premiums of healthy 55 year olds.

The added loads imposed on the relatively healthy by elimination of rating for known conditions may be sufficient to cause many persons to prefer to go uninsured. That may be one reason why some of the Republican plans impose an individual mandate, requiring individuals to buy policies whether they wish to or not. It should not be necessary to point out that such coercive mandates and price restrictions can in no way be described as "free market."

Relatively few people face so high a high premium differential that they could not afford coverage. Relatively few people below Medicare age experience medical bills so high that they are impoverished. Such persons should be assisted by charities or through means-tested welfare programs. There is no reason to impose community rating and distort the price of health insurance for all buyers to help a small minority who cannot afford free market premiums.

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Endnote

1. "New York Finds Fewer People Have Health Insurance a Year After Reform", *The New York Times*, May 27, 1994, p.A2. "One Premium Fits All", *Time*, June 6, 1994, p. 29.