Product Preview

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I. Introduction

A. Provider network is backbone of any managed health care plan

B. Provider network consists of
   1. Contracted physicians, hospitals and health systems
   2. Non-physician professionals
   3. Ancillary and therapeutic services and facilities
   4. Any other providers of health care

C. Structural network issues are largely not dependent on type of plan

II. Why contract?

A. Contract between payer and provider differentiates health plans from indemnity health insurance.

B. Reasons a health plan wants to contract
   1. Better pricing
   2. Provider agrees to provide services to plan members
   3. Comply with states and Medicare service area access standards
   4. Meet required clauses by states and Medicare (if Medicare Advantage (MA) plan)
      a. Direct submission of claims—to payer not member
      b. No balance billing—member only pays deductible, coinsurance or co-pay
      c. Hold harmless—cannot bill member for plan o/s bills, or bankruptcy (HMOs and MAs)
      d. Participate in utilization management (UM) program
      e. Be part of quality management (QM)
      f. Allow audit of clinical and billing info
      g. No discrimination

C. Reasons why a provider wants a contract
   1. Favorable pricing when is at an advantage in negotiation
   2. Ward off competition by being part of the network for a large employer
   3. Direct payment
   4. Timely payment
   5. Members directed to providers, specialists and hospitals
   6. Business retention, members away from non-contracted providers
   7. Rights around disputes on claims and payments

III. Service area

A. Legally defined
   1. By state laws and regulations for HMOs, POS, managed Medicaid plans
   2. Federal laws and regulations for MA plans
B. A defined geographic area of the provider network where sufficient access is provided to members
   1. Identified by contiguous counties, no redlining allowed
   2. Directly affect an HMO, not an MA but PPO may not be affected in some states

C. Minimum access requirements
   1. Defined by state laws
   2. Also defined by Medicare for MA, PPOs and HMOs
   3. Large employers’ requirements
   4. Usually distance and number of providers, e.g., at least two PCP within 3 miles of each zip code in an
      HMOs service area
   5. Average travel time for distance
   6. Varies by PCP, specialty care physicians (SCP) and behavioral health care providers
   7. Different for rural areas
   8. Medicare defines minimum number of hospitals and physicians for each specialty by county for MA
   9. HMO contract includes minimum number of new members accepted before PCP can close practice
   10. Later development, in California, average length of time to book an appointment with a provider

IV. National provider identifier

A. National provider identifier (NPI)
   1. Ten digit number with tenth digit being a checksum
      a. Simply an ID
      b. One ID for all transactions in any location, for any plan type and for anything else
      c. Health systems possibly NPI per unit
      d. Physicians could be affiliated with a clinic NPI, a group NPI or as an independent contractor
   2. Phased in 2007-2008
   3. Replaced all other forms of provider identifiers such as
      a. UPINs (Universal provider identification nos)
      b. Blue cross blue shield nos
      c. Health plan provider nos
      d. TRICARE nos
      e. Medicaid nos
   4. No effect on
      a. Taxpayer identifying nos
      b. DEA nos for providers who prescribe or administer drugs
      c. Employer identification number for provider as an employer

V. Contract management

A. General
   1. Thousands of provider contracts
      a. Different models with different contracts per product
      b. Master contract with appendices per contract
B. Contract management systems (CMS)

1. Forms
   a. CMS capability integrated into IT system
   b. Free-standing CMS integrated into main system
   c. Not robust enough if only a basic structured query language (SQL)

2. Perform validity checks and reconciliation of errors, duplicates or multiple versions

3. Must be secure because of private or proprietary info

4. Network recruiting
   a. Identify network gaps and needed provider recruiting, off line using CMS data
   b. Track recruiting activities producing reminders and reports

5. Contract maintenance
   a. Generate new contracts, blank or filled in
   b. Storage of copies of all contract versions
   c. Document contract changes, why variance from standard form, language changes, exceptions to standard contract clauses and additional clauses to standard contract
   d. Track and manage permissions and sign-offs on standard contracts and contracts with non-standard terms
   e. Paperless contracting

6. Storage and conversion of signed documents

7. Schedule maintenance
   a. Early reminders or notifications
   b. Upcoming recredentialing or negotiations

8. Electronic data feed
   a. Demographic data to internal functions
   b. Relevant data to market-facing systems such as members portals

9. Contract modeling
   a. Changes to contract terms
   b. Payment terms changes
   c. At negotiations

10. Provider files
    a. Demographics
    b. Credentialing info
    c. Duplicate records, multiple versions, out-of-date versions

11. Easy internal access
    a. Care and medical management, prescription drug benefit management, quality management
    b. Marketing and sales, HMO enrollment
    c. Claims, fraud and abuse detection
    d. Member services, member self-service

C. Outsourcing contracting and network maintenance

1. To reduce admin cost
   a. New MLR (medical loss ratio) restrictions in the ACA
   b. Partial outsourcing possibly, network maintenance

2. Specialized products like MAs and managed Medicaid
   a. Partial outsourcing of recruiting
   b. Partial outsourcing of recruiting and maintenance as star rating of MAs plan affect payment
D. Rental networks
   1. No payer has a network in the whole country
      a. BCBS uses the Blue Card system which allows members to use providers in another BCBS plan’s service area as members
      b. Rent one or more networks – non-BCBS plans and TPAs
   2. Rental network
      a. Commercial PPO
      b. With a network of contracted physicians, hospitals and possibly ancillary service providers
      c. For a fee makes network available to payers or self-funded employers
      d. Some national, some local
      e. Locals contract with nationals
      f. Stealth or silent PPO no longer common because of several lawsuits
      g. Payers now include rental PPO’s logo in member ID
   3. How it works
      a. Members using network covered by its payment terms
      b. PPO charges access fee and separate fees for conducting UM in their network
      c. PPO provider sends claims to PPO which re-prices and forwards them to payer
      d. PPO gets a % of difference between full charges and discount

VI. Physicians and other professionals
   A. 87.6% of physicians participated in a managed contract
      1. Lowest among medical sub specialists, internists and family physicians, range from 86-89.9%
      2. 95.2% for pediatricians
      3. 90% of surgeons and ob/gyn
   B. Turnover rate has a median value of 7.1% for PCPs
      1. 0.9% fewer satisfied members for every 10% increase in PCP turnover rate
      2. Higher turnover rate associated with
         a. Lower rates of preventative care, immunizations, early well-child visits, cholesterol screening, cervical cancer screening
   C. Access Needs
      1. Related to service areas, which are minimum requirements
      2. Consider marketing and levels of service
      3. Two main issues
         a. Are PCPs accepting new members
         b. Waiting times to set up appointments with PCPs or SCPs
      4. HMOs affected more because confined to contracted providers
Introduction to Managed Behavioral Health Care Organizations

Albright et al, Chapter 12

I. Introduction

A. Behavioral health

1. Estimated prevalence of depressive and anxiety disorders in adults ranges from 2.3 million with bipolar disorder to 10.8 million with dysthymic disorder
2. Greater acknowledgement of mental health as an issue and how it magnifies the impact of chronic illness
3. Behavioral health tries to evaluate neurophysiology in the reflected behavior
4. Psychosomatic medicine, emphasis on connection between the body and the mind
5. Difficulty with clear diagnosis at the onset because of the multiple factors that could caused the behavioral health episode, such as a major depression
   a. Accuracy of diagnosis and appropriateness of treatment impacts morbidity, productivity and cost
   b. Chronic state of behavioral health disorders might not evolve until much later
6. Have to utilize prevention and disease management
   a. Intensive care management programs for the more serious or longer term needs
   b. Outcome measurement looking at lower morbidity and higher productivity

B. Legislation

1. Parity
   a. Intended to have coverage for behavioral health conditions similar to that for physical health diseases
   b. Instead concluded that management of behavioral conditions is just the same as management of physical health
2. ACA
   a. Expansion of coverage to 14 million beneficiaries who have serious mental health issues
   b. Low-income, single males who are substance users
   c. Opportunities to pilot programs with integrated approach to clinical management—integrated health homes
   d. 30% of the aged, blind and disabled and 50% of dually eligible individuals have a diagnosis of seriously mentally ill—currently covered and funded on a fee for service basis

II. General characteristics

A. Public sector

1. Medicaid is faced with complex issues wrt mental health for its beneficiaries
   a. Medicaid population has a higher incidence of schizophrenia and bipolar disorder than the general population
   b. Beneficiaries do not have financial access to the private health care system
   c. Less likely to comply with treatment and follow-up
   d. Minimal presence of support systems
2. Managed behavioral health care organizations
B. Networks
1. Establishment and use of credentialed clinical network
2. Managed behavioral health care organizations have matured into expanded networks
   a. Larger selection of providers
   b. More consumer choices
   c. Greater clinical specialization
   d. But reduced opportunity to collect and interpret data

C. Payment mechanisms
1. Initially same as in the medical services
   a. Then sharing of risk with large provider groups and service delivery systems thru capitation
2. Current financing strategies
   a. Outpatient on a FFS with variations on specific and negotiated fee schedules, fee schedules
      varying by provider, CPT and state
   b. Facility-based uses per diem schedules specific to type of service and program, variation by
      facility retail rate, location and competition
   c. Component execution strength
3. Revolutionary change in health information technology
   a. More effective programs
   b. Higher accuracy with more customer flexibility
   c. Actionable data allowing for timely decisions

D. New types of service delivery systems
1. PCMHs and ACOs
2. Medical home
   a. Not a facility but a type of clinical practice
   b. Focus on patients with serious mental illness and or chronic comorbid conditions
   c. A doctor coordinates primary care
   d. Higher integration of care because technology allows better sharing of information
3. Goals
   a. Quality of care, status of comorbid conditions and patient satisfaction
   b. Avoid hospitalizations, acute occurrences, inpatient and long term admissions

E. Professional providers
1. Licensed professionals
   a. Psychiatrists, psychologists
   b. Social worker, counselors, therapists and clinical nurse specialist
2. Subspecialties
   a. Child/adolescent, gay/lesbian/transgender issues
   b. Substance abuse, eating and anxiety disorders
   c. HIV/AIDS
   d. Faith based counseling, workplace/career issues
3. Access and density standards
   a. Access means availability of a provider within a certain distance from population, varying whether urban, suburban or rural
   b. Density means type and number of professionals by number of members, psychiatrists and nonpsychiatrists

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<th>Access</th>
<th>Urban</th>
<th>Suburban</th>
<th>Rural</th>
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<td>1 psychiatrist</td>
<td>90% - 10 miles</td>
<td>90% - 25 miles</td>
<td>90% - 40 miles</td>
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<tr>
<td>1 facility</td>
<td>90% - 25 miles</td>
<td>90% - 40 miles</td>
<td>90% - 60 miles</td>
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   | Density | 2 Psychiatrist | 8 Other | 10 Total | 10,000 lives |

4. Credentialing
   a. Standard credentialing—NCQA, JC, URAC
   b. Standardized credentialing applications
   c. Verification includes licensure, board certification, education, training, Medicare/Medicaid sanctions, work history and professional liability claims
   d. Primary source verification of credentials
   e. Review of supplemental information indicated by provider—clinical specialties, languages, special populations and ethnicity
   f. Clinical credentialing committee, final decision
   g. Ongoing tracking of any disciplinary actions on licenses and sanctions
   h. Fully credentialed every 3 years

F. Services
   1. Inpatient
      a. Highest level skilled psychiatric and substance abuse
      b. Often in a hospital
      c. 24-hour medical and nursing care
   2. Residential treatment
      a. Continuum of therapeutic services
      b. Licensed as residential intermediate or intermediate care facility
      c. 24-hour care
   3. Partial hospitalization
      a. 4 hours per day, 3 days a week, structured therapeutic services
      b. Multi-disciplinary team
   4. Intensive outpatient program
      a. Outpatient
      b. 2 hours per day, 3 days per week, structured therapeutic services
      c. Coordinated multi-disciplinary services
   5. Outpatient treatment
      a. Therapy
      b. Licensed professional
      c. Specified time period
6. Employment assistance programs
   a. Professionals
   b. Short-term, problem-focused
   c. For employees and family
   d. Free, 3-7 session models
   e. Outpatient

G. Public sector networks
1. Greater range of services and delivery systems
   a. Involves nontraditional provider and organizations
2. Supervised living
   a. Community-based
   b. Outpatient therapy and assistance in day-to-day living activities
   c. Residential detox
   d. Residential rehab like quarter or half way houses
   e. Foster care and group homes
3. Programs for assertive community treatment
   a. Members with pattern of recidivism, symptom chronicity and severity
   b. Standardized teams and delivery systems
4. Peer support
   a. By patients who have recovered and with behavioral health provider guidance
   b. To help other patients build confidence and better life skills
5. Continuous treatment teams
   a. Intensive continuous care
   b. Prevent moving a child from home to restrictive care
   c. Case management, treatment and rehab services
6. Community case management
   a. Within community
   b. Care and social services
   c. Collaborate with systems and providers

H. Accreditation of MBHOs
1. Joint commission, NCQA, URAC
   a. Continual revision of standards
   b. Voluntary accreditation
   c. External validation of quality
   d. State requiring accreditation for utilization review license or care delivery
2. Resource-intensive process
   a. Impromptu visits
   b. Random utilization file audits
3. Allow MBHOs to distinguish themselves
   a. MCOs requirement for carve-outs with impact on level of monetary guarantee
4. Identify opportunities to improve service and clinical areas with specified interventions
Reserves and Liabilities

Bluhm, Chapter 6

I. General

A. Types and uses of reserves and liabilities
   1. Concept
      a. When a cash flow has occurred and the event to which it applies has not or vice versa
      b. Reserves or liabilities are used to adjust for these timing differences
      c. So financial reports can reflect accurate measures
      d. Not cash but accrued (accounting) or earned/incurred (insurance)
   2. Basic principle
      a. Allow matching of revenues to costs over time
      b. Not holding reserves could be misleading
      c. Holding inaccurate reserves could create a false sense of financial security
   3. Situations
      a. Premium reserves – for coverage in a future period
      b. Policy reserves – future increases in expenses being funded now
      c. Claim reserves – incurred claims but not yet paid
      d. Gross premium reserve – deficiency reserves
   4. Reserve vs. liability
      a. Liability – refers to all financial obligations of a company in its balance sheet
      b. NAIC statutory accounting standards/practices – defines a distinction between liability and reserves
      c. Liabilities – incurred and accrued
      d. Reserves – not incurred or not accrued
      e. Importance in appropriate allocation in exhibits in financial statements
   5. Types of reserves by functions
      a. Premium reserves – convert cash accounting into accrual accounting
      b. Claim reserves – convert cash accounting into accrual accounting
      c. Policy reserves – reflect long term difference between revenue and benefit (expense) stream
      d. Gross premium reserves – reflect shortfall of future revenue streams plus reserves and liabilities against future costs
   6. Types of serves by context – reflect needs of authority defining standards
      a. Statutory statement – use statement blanks, instructions and accounting requirements of NAIC
      b. GAAP statement – Generally Accepted Accounting Principles by FASB
      c. Tax statement – in US, IRS, for immediate recognition of profits beyond a set level
      d. Embedded value based statements – set by IASB, codified by IFRS, for international companies or those owned by alien holding companies
II. Premium reserves

A. Definition
1. Premiums received by valuation date for coverage after that date
2. Premiums not received by valuation date for coverage before that date –held as an asset

B. Other considerations
1. Unearned premiums
   a. Usually pro-rata portion of premium received
   b. Gross UPR
   c. Approximated by half of all modal premium s in force at valuation date –usually inaccurate as most issues are first of the month or first and fifteenth, but conservative error
2. Typically required for active life along with policy reserves
   a. When policy reserves is mean not mid-terminal, assumes all premiums are annual
   b. Need an offsetting deferred premium asset, net premium unpaid for the year, not due but included in mean policy reserves
   c. Policy reserves using mean or mid-terminal, replaces gross reserve with net reserve, includes net premium used in calculation of benefit reserve factors
   d. By life insurers so often in DI and LTD coverage
   e. Gross UPR is floor
3. NAIC requirements for UPR
   a. Excluding premium paid in advance
   b. Exempted is single premium credit insurance, instead comparable liability for refunds
   c. Specifies as portion of modal premium for period beyond valuation date
   d. When there is a contract reserve minimum is net premium, else gross premium
   e. When net premiums plus contract reserves, in aggregate at least gross UPR
4. Premium paid in advance
5. Premium due and unpaid
   a. Limited to lesser of 90 days past due or one modal premium
   b. Consider what might be reasonably collected

III. Policy Reserves

A. General
1. Definition
   a. Current funding of costs over future lifetime of policy (contract)
   b. Time horizon of future lifetime of contract versus mostly the year following valuation date for premium reserves
   c. Active life reserves includes policy reserves and unearned premium reserves
2. Theory
   a. Visualize future stream of claim payments
   b. Visualize future stream of net premium payments (allowances for expenses and profits have been removed)
   c. Exact matching mean no need for policy reserves
   d. Variance between premium stream and claim stream means temporal reallocation of funds
   e. If net premium did not increase over policy lifetime, there is need for a higher level than initial claim cost but lower than the final claim cost
   f. Excess of net premium over claim cost is set aside into a reserve account, the policy reserve
3. Basic formula (prospective formula)

\[ \nu_x = PV \{ \text{Future Claims} \} - PV \{ \text{Future Net Premiums} \} \]

\[ = \sum_{i=t}^{\omega} \{ ip_x \times \nu^{(i-t)} \times i^z C_x \} - \sum_{i=t}^{\omega} \{ ip_x \times \nu^{(i-t)} \times i^z P_x \} \]

Where
- \( ip_x \) = probability of survival to \( i \) of policy issued to a life aged \( x \)
- \( \nu^{(i)} \) = \( (1 / (1+ \text{annual interest rate})) \) raised to the power \( t \), a present value factor
- \( i^z C_x \) = claim cost for a person age \( x \) at duration \( i \) for a policy issued in year \( z \)
- \( i^z P_x \) = net premium for a person age \( x \) at duration \( i \) for a policy issued in year \( z \)

4. Observations
   a. Note variable \( z \), year of issue
   b. Important for policies subject to calendar-based claim trends
   c. Like major med policies
   d. There is a retrospective formula very useful for auditors
   e. Claims assumed occurring at end of year
   f. Premiums assumed received at beginning of year

5. Complications and variations
   a. Expenses – early expenses are usually higher, issue expenses

6. Statutory accounting has no explicit recognition of expenses, but modified reserve method provides implicit recognition
   a. 2YFPT for all coverage other than LTC, 1YFPT for LTC
   b. 2YFPT – allow to hold zero reserves for first 2 policy years, 1YFPY – similarly
   c. 2YFPT, 1YFPT – treat policy as if issues 2 or 1 year later, so policyholder 2 or 1 year older than actual
   d. For medical coverage, not usually done with commutation functions
   e. But DI and LTC use formulas

7. GAAP accounting
   a. Expenses are explicitly reflected
   b. If future rate increases, net premiums assumed to change proportionately
   c. Does not imply recognition of future claim trends beyond current rating period
   d. Benefit reserve – make a company set aside funds which would otherwise be treated as profit for use for future costs

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 Advanced Group and Health Insurance Study Manual
Experience Rating and Funding Methods

Bluhm, Chapter 37

I. Introduction

A. Definitions
1. Experience rating
   a. Process
   b. Where policyholder
   c. Gets the financial benefit or be held financially accountable
   d. For its past claim experience
   e. In insurance rating
2. Prospective rate calculations
   a. Evaluations of past experience
   b. To predict probable experience for a future rating period
   c. Allowing determination of gross premium rates
3. Sans experience rating, manual rates or community rates
   a. Prospective rates based on
   b. Demographic or other underwriting characteristics of the group
   c. Not on its specific claim experience
4. Community rates, limited by law or regulation on what demographic factors can be recognized
5. Pooled rates, manual rates using the combined experience of a pool of similar policies
6. Retrospective rate calculation
   a. Evaluation and measurement of financial experience
   b. For a past period of time
   c. Largely based on the cost of providing insurance for that period
7. Retrospective rating
   a. Thru contractual arrangements
   b. Makes a policyholder
   c. Financially responsible for a cost of providing insurance after the fact

B. Reasons for experience rating
1. Policyholders preference to pay premium
   a. Based on the unique experience of their group
   b. Instead of based on their experience pooled with other groups
2. When is a group’s past claim experience statistically credible
   a. Insurer uses a balance between theoretical and practical considerations
   b. Will allow an insurer to use claim expectation based on a group’s own claim experience
C. Theoretical considerations
   1. Assumes stochastic independence of claims of each individual from one year to the next
      a. Existence and size of a claim in a given period is independent of claims that occurred in the prior period
      b. More or less true for non-occupational accidental death
      c. Definitely not true for medical expense coverages
      d. Correlation of experience over sequential time
   2. Auto-correlation
      a. Temporal independence means zero auto-correlation
      b. Rigorous development of credibility factors assumes non-zero auto-correlation
      c. Risk adjusters—models that use algorithms based on individual’s past claim experience and further the actual conditions and procedures for that individual

D. Practical considerations
   1. Insurers cannot afford to pool groups with credible experience
      a. Else groups with higher-than-average claim expectations will be subsidized
      b. Groups with lower-than-average claim expectations will leave the pool
      c. Resulting in anti-selection

E. Applicability—coverages and group sizes
   1. Experience rate
      a. If expected future claim experience is believed to be reliably altered
      b. By knowledge of past claim experience
   2. Size of the group is larger than a chosen level and the group have characteristics that would generate reliable claim expectations different from the average represented in the manual rates
      a. Demographic characteristics, lifestyle, employee turnover rates, average income, industry
   3. Theoretical considerations in determining credibility level
      a. Coverages and benefit designs with low frequency of claims
      b. Coverages with widely varying claim sizes
      c. Confidence interval (CI)–level of credibility that one can be sure X% of the time the claim level will fall within Y% of the observed value, X% at 90 or 95, single CI meaning one curve of credibility values as group size varies but usually different CIs by size of group
      d. Portion of experience due to statistical fluctuation—varying inversely with square root of number of claims or exposed lives or to double credibility there is need for 4x exposure
      e. Typical measure—number of lives covered, stochastically independent claims can increase credibility with longer experience periods not necessarily increasing lives so number of life-years not number of lives
   4. Practical considerations
      a. Competitive pressures
      b. Administrative and managerial units capabilities
      c. Trade-off between cost and gains in new business
      d. Effect on existing business
      e. Management philosophy
      f. Internal self-consistency between business classes