RECORD OF SOCIETY OF ACTUARIES
1975 VOL. 1 NO. 1

HEALTH INSURANCE—LEGISLATION AND INFLATION

1. Update of the potential impact of National Health Law legislation.

2. Inflation's influence on
   a) The relationship of actual claim levels to that expected.
   b) The design of new benefits and administrative controls and procedures.

MR. DARWIN S. LIGGETT:* Rarely, during the history of our country, has there been a more thought-provoking dialogue and opportunity for public participation on any single subject than that which has been associated with "Health-care," commencing with the advent of the Federal Medicare and Medicaid Programs in 1966.

It is well that we stop and take inventory of where we are today:

1. First and foremost, it has been generally concluded that health care is an individual right of every American and along with such right goes the responsibility for each individual who uses or provides health care services to do so in a judicious manner.
2. Next, we have learned that health care is a very precious and personal matter to each American and, as such, requires strict confidentiality among the relationships of all who provide and support required health care services.
3. Next, we have learned that the operational and management processes associated with our health care system require modification and added resources to achieve efficiencies and cost-effective results.
4. Next, we have learned the true perspective as to the economic impact of health care on our total national economy--and it is significant. 1974 statistics recently released by the Social Security Administration showed a total of $104.3 billion. This consisted of public spending in the amount of $41.4 billion and private spending in the amount of $62.9 billion. Department of Commerce statistics for 1973 tell us that medical care expenses represented 7.6% of Total Personal Consumption Expenditures.
5. Next, we have learned that our health care delivery system in the U.S. has many inefficiencies arising from the lack of proper planning and control.
   These inefficiencies arise from costly duplication of facilities and services as well as the structuring of processes by which patients enter and proceed through the system for required services.
6. Next, we have commenced to learn more about the environmental causes and effects on the health of Americans.
7. More recently, we are finding that the legalistic interpretation of quality of health care--in the form of medical malpractice litigation--requires major remedies to achieve reasonable protection of the providers of services and yet maintain appropriate and reasonable protection of the public served.

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8. Most recently, we are finding a void in our provisions for health care financing related to the unemployed, which requires correction.

Now while there are many other significant issues that could be mentioned, which have evolved from the dialogue and examination we have been going through during the recent 9-year period, those I have just identified seem to have most influenced the general public's attitude as of today. A recent survey by the Health Insurance Institute of these public attitudes, conducted in the spring of 1974, revealed strong public support for a continued private sector role in health cost financing. This report stresses the point that, philosophically, a private-public sector partnership in the national effort is in the mainstream of public opinion.

I do not mean to imply by my last statement that we do not have continuing differences of opinion in both political and public circles as to how National Health Insurance should be structured and operated. I do mean to suggest, however, that a posture of "compromise" seems to be developing among the parties at issue which will lead to enactment of a National Health Insurance program in the near future. Whether the near future means 1975, 1976, or later, is dependent on the priority of other major issues facing this nation (e.g., energy, inflation, tax reform, etc.).

I would like now to take a few moments to review with you the Health Insurance industry's legislation concerning health care. I am not going into all of its detail, but will make an overview appraisal of it.

I feel all of us within this industry can take great pride in the quality and stature of this legislation as originally introduced in 1970 in the 91st Congress by Representative Omar Burleson of Texas and subsequently reintroduced in the 92nd and 93rd Congresses by Representative Burleson and Senator McIntyre of New Hampshire. It is expected to be reintroduced in the current Congressional Session prior to April 15 of this year.

Over this period, many of the principles of our "Healthcare" legislation have either become widely accepted or enacted into law:

Examples:

1. It is now generally accepted that health insurance for everyone is not enough--changes must also be made in the health delivery system. As a consequence, Congress has enacted a national health planning bill which embodies the principles of the Burleson-McIntyre Bill.
2. Congress has recognized the need for manpower legislation to deal with the supply and maldistribution of medical personnel.
3. Congress has recognized the need for ambulatory care centers.
4. Congress has enacted Professional Standards Review Organization (PSRO) legislation to monitor the quality of services under governmental programs.
5. Social Security amendments of 1972 mandated the review of capital construction in health institutions using federal money to underwrite construction.
6. The current state of the economy and announced financial problems of the Social Security Trust Fund have pointed up the need for making full use of the private health insurance mechanism.
7. Our "Healthcare" concept of phasing in benefits and the need for cost controls have become widely accepted.

What has been accomplished during the past 6-year period is a reflection of a total industry commitment and effort joined by all three casualty insurance associations, the National Association of Life Underwriters and the Interna-

tional Association of Health Underwriters.

"Healthcare" is today supported by statewide committees in each of our 50 states. The chairmen and members of these committees are in frequent contact with their respective Congressmen to assure understanding of our views on the many issues affecting "Healthcare."

Needless to say, but I do wish to, I applaud the outstanding effort and contributions that have been and continue to be made on the national scene by Health Insurance Association of America (HIA) staff and members of the many technical and advisory committees of HIA who have devoted countless hours to a wide range of duties associated with Congressional testimonies, "Healthcare" amendments, and analysis of various state compulsory health insurance proposals.

Let me now briefly review emergence of concepts and philosophy to date in the National Health Care debate by a summary of the major legislation introduced to date.

At one end of the philosophical spectrum, we have the "Health Security Plan" (also called the Kennedy-Griffiths proposal). Essentially, this proposal would scrap the private health insurance plans, the copayment system, the Medicare and Medicaid programs, and encourage group practice and preventive medicine. It provides for total financing by new and existing federal taxes and federal administration. Immediate comprehensive coverage is to be available to all. This proposal has not seemed to retain its original "sex appeal" once the consequences of its cost and disruption of the present health care system became known and understood.

At the other end of the spectrum, we might place the "Comprehensive Health Insurance Act of 1974" (which is the current Administration's plan). Essentially, this proposal mandates health insurance coverage through the employer-employee mechanism and establishes civil court procedures for noncompliance. Risk pools would be established for individuals or groups not covered by other means. Medicare would be continued for the aged. This program would be underwritten by private carriers and self-insured employers working under Federal and prescribed State regulations with respect to employed persons and most of those persons now covered under the Federal-State Medicaid programs. The Federal-State Medicaid programs would be retained for the remaining poor people as to certain services not covered by the Comprehensive Health Insurance Act.

Near the center of the spectrum, we might place the "National Health Care Act of 1973." This legislation, which is also referred to as "Healthcare" or as the "Burleson-McIntyre Bill," represents the proposal of the Health Insurance Association of America.

Of the remaining major proposals under consideration, within this philosophical spectrum, "Medicredit" (the AMA proposal) would seem to fit between the Burleson-McIntyre proposal and the Administration's proposal. The "Catastrophic Health Insurance and Medical Assistance Reform Act" proposed by Senators Long and Ribicoff and the "Health Care Services Act" proposed by the American Hospital Association would seem to fit on the other end of the spectrum between the Kennedy-Griffiths proposal and the Health Insurance industry proposal.

The Long-Ribicoff proposal would provide coverage for all who are currently and fully insured under Social Security, their spouses and dependents, and to all Social Security beneficiaries. This includes approximately 95% of all persons in the United States. The vast majority of the remaining are federal, state, and local government employees who either have coverage or who could buy into the catastrophic program. The types of services covered would be similar to those currently covered under Parts A and B of Medicare except there would be no limitations on hospital stays or home health visits. The catastrophe

coverage would take over after the first $2,000 per family for physician charges and after the first 60 days of hospital care in a year. The program would be administered along with Medicare by the Social Security Administration. Financing would be by an added tax on employees and employers.

The "Medicredit" proposal (developed by the American Medical Association) proposes a support of voluntarily-purchased private health insurance premiums for the poor and near-poor with payment vouchers and a subsidy of these costs for others with a sliding scale of tax credits based upon income. It would establish minimum federal standards for health insurance plans and retain the present Medicare program for people over 65.

The "Health Care Services" proposal of the American Hospital Association would provide comprehensive health care for all U.S. residents through a reorganized and coordinated health system.

It would establish a new Federal Department of Health which, together with State Commissions, would implement federal legislation and regulations and develop state plans. It would create community-based Health Care Corporations which provide health care services. Employers would be required to purchase comprehensive benefits for their employees from the Health Care Corporation and pay 75% of the cost. Health Care Corporation members would receive 10% subsidy from the federal government. The aged would continue to be financed through a combination of Social Security and general federal revenues.

Now, let's take a look at the costs of the eight major proposals before Congress. The figures I'm about to relate are those released in July of 1974 by the U.S. Department of Health, Education & Welfare and are estimates for Fiscal Year 1975. They are to be viewed in two ways:

1. Total Personal Health Expenditures for the U.S. and
2. The rates of funding of the expenditures for the various proposals as between private and public financing.

	(in Billions)		
	TOTAL PERSONAL	SOURCE	
PROPOSAL	EXPENDITURE	PRIVATE	PUBLIC
Present System (no law enacted)	$103.0	$ 63.8	$ 39.2
Payroll Tax Financing:			
Health Security Act (HR 22; S.3)	$116.0	$ 13.3	$102.7
Comprehensive National Health Insurance Act (HR 13870; S.3286)	$112.3	$ 32.7	$ 79.6
Catastrophic Health Insurance & Medical Assistance Reform Act (HR 14079; S.2513)	$107.4	$ 59.9	$ 47.5
Mandated Employer-Employee Plans:			
National Health Care Services Reorganization & Financing Act (HR 1)	$114.0	$ 64.2	$ 49.8
Health Care Insurance Act (HR 2222; S.444)	$112.8	$ 70.2	$ 42.6

National Health Care Act (HR 5200; S.1100)	$111.0	$ 62.6	$ 48.4
Comprehensive Health Insurance Act (HR 12684; S.2970)	$109.5	$ 60.8	$ 48.7
National Health Standards Act (S.3353) (Medicredit)	$107.0	$ 63.6	$ 43.4

Under the present system, where total health care expenditures were $84 billion in 1973, costs were expected to increase by some 23% by 1975 to a total expenditure of $103 billion. However, we are already looking at something in excess of that figure since costs for 1974 were $104.3 billion.

Among these proposals there would be an increase in total expenditures ranging from $4 to $13 billion or more.

The massive shifting of the burden of funding these total personal expenditures as between private and public sources is of great significance, however:

Change in Private Funding Range = (-) $50.5 to (+) $ 6.4 billion
Change in Public Funding Range = (+) $ 3.4 to (+) $63.5 billion

Developments of late 1974 in Washington revealed a desire to proceed with some form of National Health Insurance before the end of that year. Compromise among legislative proponents of the various proposals appeared to be quite prevalent. Polls taken by Congressmen revealed a substantial majority of their constituency requesting action in 1974.

However, the costs I have just referred to concerning the major proposals before Congress, combined with the very major shifting of these costs toward public funding, did not appear to be compatible with the prevailing objectives of Congress and the Administration.

In summary, substantial progress has been made in defining the issues and in consideration of alternatives available for structuring and financing a national health insurance program. The Health Insurance industry has been responsive and persuasive throughout these considerations. I have confidence that Congress will "get on with the show" at an early date, construct legislation embodying the concepts of our Burleson-McIntyre Bill which builds upon the great strengths of our present system and corrects the known weaknesses that have been identified. Whether such legislation will be in the form of a comprehensive or catastrophic program, initially, remains a question.

There is no national health insurance program that will create Utopia. But, if there is to be a national program, it should build on what is already widely recognized as the best health care system in the world--a pluralistic system, financed with tax dollars, as well as private insurance and patient payments, and resting on the principle of voluntarism and the American tradition that the individual is important.

MR. RICHARD F. WYSE:

1. Actual vs. Expected Claims

When trying to answer the question of how inflation has influenced the relationship between actual and expected claims, we really must differentiate between two amounts for expected claims. One would be a realistic amount based upon the actuary's best estimate; the other would be the amount actually used in the rating development. Due to the limitations imposed by the Economic Stabilization Program on the rating component for inflationary trends, actual claims levels have been running substantially in excess of the latter. For several large accounts underwritten by Blue

Cross of Southern California which were rated during the final days of Phase IV controls, recent claims experience has been from 5% to 8% higher than the level anticipated in the rating. Removal of Federal controls has allowed the use of more realistic trending assumptions, which should eventually reduce the magnitude of this difference. However, due to the substantial time delays in implementing needed increases, the financial turnaround will be slow in coming.

Of course, there are other elements besides inflation which affect claims levels but, as a measure of the impact of increasing claims cost on Blue Cross plans in general, the following financial data may be instructive:

Nine Months Ending	Earned Income	Underwriting Gain (Loss)	Percent of Earned Income
September 30, 1973	$6.2 Billion	$161.2 Million Gain	2.6%
September 30, 1974	6.5 Billion	(6.7) Million Loss	(0.1%)

The effect of inflation on Blue Cross plans has probably been greater than on commercial carriers, due mainly to the fact that hospital charges have been increasing at a more rapid rate than most other types of medical care. The most recent CPI data indicate a 13.2% increase from removal of controls through January of 1975. Hospital benefits provided by Blue Cross are of a service nature, that is, written without fixed dollar limits for most services.

2. Inflation's Influence on Benefit Design and Administrative Controls

I would like to briefly review some of the causes which I feel can be expected to have an inflationary effect on the costs of medical care.

a. Duplication of facilities and equipment, including unneeded hospital beds and overconstruction of specialized care facilities. From 1968 to 1973, the number of beds in non-Federal short-term hospitals increased 12% while occupancy rates decreased from 78.2% to 75.4%.
b. Advances in medical diagnosis and treatment, using expensive hardware and requiring specialized training.
c. Inflationary increases in the costs of supplies, food, utilities, and other nonpayroll expenses.
d. Higher salaries, especially for hospital employees. The recent increase in unionization activity, due to inclusion of nonprofit hospital employees under the National Labor Relations Act, could have a significant effect on personnel costs which account for about 2/3 of the total hospital expense.
e. Increasing number of hospital employees per bed.
f. Increases in malpractice insurance rates which may result in an increase in "defensive medicine" with overutilization of services.
g. Increased demand for services.
h. The lack of incentive for providers to control costs due in part to the current funding mechanisms.

As apparent from this admittedly incomplete list, even the greatest efforts in the areas of benefit design and administrative controls would result in only a partial and perhaps temporary solution to increasing medical care costs.

At this point I would like to review for you some of the activities within the Blue Cross organization, and, more specifically, at Blue Cross of Southern California, in an attempt to deal with this problem of esca-

lating costs. Blue Cross plans are including a number of experimental programs in these areas.

Expansion of Outpatient Benefits

In an attempt to help reduce the utilization of inpatient facilities, the most costly form of treatment, Blue Cross plans provide an ever-increasing number of outpatient benefits. The following list of benefits and comparison of the numbers of plans offering these benefits will indicate the extent of this activity.

Coverage	No. of Blue Cross Plans Offering Coverage	
	1970	1973
Outpatient		
Accident	70	72
Minor Surgery	68	71
Diagnostic Lab	54	67
Diagnostic X-Ray	58	67
Out of Hospital		
X-Ray	46	51
Lab	46	51
Outpatient Hemodialysis	54	65
Pre-Admission Testing	55	56
Physical Therapy	39	61
Home Care	41	54
Nursing Home Care	52	57
Out-of-Hospital Drugs	63	67
Multi-phasic Screening	0	6

(Source: BCA Statistical Enrollment Report of December 1973)

Group Practice Plans

A number of differing group practice plans are operational or under development within the Blue Cross organization. I would like to speak briefly about the recent activity of Blue Cross of Southern California in this area.

a. Medical Plans

Blue Cross of Southern California, through a program called "CommuniCare," contracts with established medical clinics to provide full medical coverage (with or without a small copayment by the subscriber) on a prepayment basis. These clinics are reimbursed on a capitation basis, with the clinics assuming the entire risk for physicians' services. It is thus to the advantage of the medical group to reduce unnecessary services and to avoid costly medical services that could be replaced by more timely care, less expensive care, or preventative medicine. The hospitalization risk is shared between the clinic and Blue Cross so that the clinic will benefit financially from low hospitalization rates, but will assume a partial risk when hospital claims exceed the expected level.

Of the few groups analyzed to date under this program, the rate of inpatient utilization has been substantially below that for our regular business. Not all of this reduction can be attributed to the risk-sharing arrangement (for example, the average age of individuals enrolled in these programs as part of a dual-choice option tends to be lower than for those under the Fee-for-Service plans).

b. Dental Plans

Blue Cross of Southern California offers a plan of prepaid dental expense in conjunction with a number of individual dental groups and

offices. The dentists assume the underwriting risk and are reimbursed on a capitation basis, with varying amounts of copayment payable by the subscribers. The copayments are fixed by procedure and perform a dual function of (1) helping to lower the cost of the program and (2) lessening the risk of the providers by providing a source of additional funds when more expensive procedures are required.

c. Others

Medical plans are written in conjunction with foundations for medical care. Besides the fact that reimbursement is based on a fixed conversion factor with the California Relative Value Study (CRVS) (thereby controlling charges), the foundations provide peer review activity. One other program under development is the establishment of Independent Physicians Associations (IPA's). The control of costs by risk-sharing under this type of arrangement is less certain since the individual physicians are reimbursed on a Fee-for-Service basis, the real risk being assumed by the IPA itself.

Activities by other Blue Cross plans include:

1. New methods of hospital reimbursement to provide incentives to reduce costs.
2. Development of concurrent review programs in which a patient's expected inpatient stay is established upon entry, and is monitored during his stay to determine whether or not extensions are necessary.

In Summary

Most of the efforts made within the Blue Cross system to help counteract the effects of inflation have been in the areas of outpatient benefits, experimentation with new methods of provider reimbursement, and the development of alternative delivery systems. One additional item worthy of mention at this point is that there has not been an effort to control claims costs by moving away from the traditional service type of benefits and towards benefit limitations or reductions.

MR. HERBERT ORENSHEIN: Beneficial Standard is a medium-size life insurance company with approximately 80% of its premium income in the accident and health area. The imminent national health insurance program has caused us to reconsider our future marketing plans.

Beneficial Standard has decided to encourage future sales in the life insurance, pension, and mass-marketed hospital indemnity coverages. We have deemphasized health insurance plans available for sale except through select general agents and have substantially eliminated the sale of major medical policies by modifying the commissions payable on that product to a level commission scale (first year and renewal).

We believe the mass-marketed hospital indemnity product continues to be a desirable one from a marketing and profit point of view since (1) the product is simple, (2) it lends itself to a mail sale, and (3) it can be underwritten and administered with mechanized procedures at low costs with relatively little fluctuation in cost as wages increase. The benefits themselves are not subject to the effects of inflation and we believe there is little probability that the incidence or duration of hospital stay for underwritten lives will increase in the future.

We believe hospital indemnity products can supplement the national health insurance program that may be enacted within the next several years. Since the product will not be subject to lapsation when national health is introduced, the company will be able to recover initial costs over a reasonable

period of time.

Beneficial has changed its renewal provisions for new products from "guaranteed renewable" to "collectively renewable by state," i.e., retaining the right to cancel all policies of a given form in a given state. We believe this protection is necessary. In the past, we have experienced antiselection by policyholders to such an extent that any reasonable rate increase was inadequate to cover the cost of benefits. In those rare instances, we find that the ability to terminate the contract is the only viable solution for the company.

Beneficial produces a claim follow-up report by policy form for determining the amount of liability required at year-end per claim. The ratio of the 1974 payment per claim on claims in inventory December 31, 1973 to the 1973 payment per claim on claims in inventory December 31, 1972 was 107% on our major medical policies with internal limits. For these forms, only a 7% increase can be attributed to inflation.

Greater than the effects of the inflation we are experiencing are the effects of depression and unemployment upon our loss-of-time coverage. In 1974, the number of claims with a period of disability of at least one year per 1,000 policies in force at the prior year-end had increased to 6.0 per 1,000 from 3.6 per 1,000 the prior year, an increase of 67%. This created an unusually large increase in reported claims and, consequently, reported claim liability. The problem is further magnified by the increase in unreported liability which is developed from reported liability. As a result, Beneficial, in 1974, showed substantial loss in accident and health loss-of-time business.

When national health care becomes a reality and if it eliminates the need for certain individual accident and health coverages which may have been sold on a guaranteed renewable basis, it is possible that legislators or insurance department personnel will "suggest" that guaranteed renewable reserves be distributed to remaining policyholders. I question the wisdom of that concept. My reasons are:

1. A substantial portion of the reserves being held by the insurance companies were accumulated on major medical and loss-of-time forms. The companies probably have incurred losses on these products. Therefore, these dollars should be returned to the insurance company's surplus to offset prior losses incurred.
2. The rates charged for the policies did not anticipate that guaranteed renewable reserves would be refunded to policyholders. They were to be used to pay benefits as and if benefits accrued. If these reserves were to be used for cash values, the rates should have been increased to pay the extra benefit.
3. The guaranteed renewable reserves were derived not only from premiums collected on current in-force policies but on lapsed policies. If distribution is to be made on an equitable basis, lapsed policyholders have an interest in these reserves. For a form issued over several years, it would be impossible in most cases to determine all persons entitled to these monies or the amount due to them.
4. The stockholders of the insurance companies are entitled to profits since they must sustain the losses as a result of poor experience on accident and health policies.

At the present time, we cannot make long-range decisions on the company's future actions with respect to national health care because of the multitude of proposals in existence. Our position should be to act or react as the situation develops.

MR. ERNIE FRANKOVICH: As an actuary for a small life insurance company providing health insurance, can you explain why you are in this market? Based on the rapidly developing trends, we see little possibility of profit with large

expectation of loss in the near future. Let us first look briefly at the factors which indicate that the small life insurance company should not be selling health insurance today.

1. National Health Care
   You are probably looking at an operational National Health Care program in some form within three to five years. This means that extensive development costs for new forms or review of systems will probably not be recoverable from future profits.
2. Severe Inflation in the Medical Reimbursement Area
   Inflation is causing severe problems for companies that have a significant volume of business in the medical reimbursement area. This inflation is due to many causes, many of which cannot be controlled by small life insurance companies. A company that "follows the leader" will be taken for a scary ride because its actions will come two or three years too late.
3. State Insurance Programs to Provide either Comprehensive or Catastrophe Medical Care for the Inhabitants of the State
   A number of states have either passed or will probably pass in the near future state health insurance programs that will preempt all of the private sector. In fact, the National Association of Insurance Commissioners has developed a model catastrophe health insurance bill to be used as a guide for the states. The effect of the catastrophe law will be increased administration costs on the part of the insurers.
4. State Minimum Standards Law
   The NAIC has recently approved an Accident and Health Minimum Standards Law. Florida, Massachusetts, West Virginia, and California, have passed some form of Minimum Standards Law. As usual, each state has a different law. The net result will be increased filing costs to obtain insurance department approval and increased costs to actually issue the policies.
5. Competition in the Disability Income and Medical Care Fields
   Currently we find extreme competition in the disability income markets as a result of a highly favorable economic period during the 1960's and early 1970's. Some companies are so competitive I do not believe their product would be profitable even if the favorable morbidity experience of the 1960's continued. Inflation has set us up for a severe fall. Inflation produced high interest yields on investments to be used as offsets to higher expenses and morbidity costs. But it also brought dramatic increases in benefits from Social Security and State Cash Sickness Laws, resulting in significant overinsurance in a number of markets. Even now, we are entering an adverse economic period, with losses appearing in the Group Long-Term Disability (LTD) market and in some individual disability income markets (primarily, the blue collar market).

   In the Medical Care area, we are seeing the combination of, shall I say, inadvertent competition and inflation. When introducing health policies, insurers make a competitive premium comparison three to six months before the product is introduced. Thus the premium for the policy is only marginally profitable, if profitable at all, at the time it is introduced. With morbidity costs increasing 15%, the rates are soon inadequate for new issues.

Many companies will be unable to immediately withdraw from the health insurance marketplace due to company or agent pressures or economic realities. The remainder of this talk is designed to help you minimize the potential losses that may occur in the coming years. The most important step is to change your thought patterns and to eliminate your complacency that the right to increase

premiums gave you. Many of us entered this decade with concepts that were developed in the 1950's and the early part of the 1960's.

But we are in a rapidly changing economic period that promises to take us for quite a ride. In the 1970's, we have had moderate inflation (5%-10%), a price freeze, a moderate form of price stabilization, severe inflation (15%-20%), stagflation, and now deep recession. Through all this, the morbidity costs are increasing at various rates. Let us examine the impact that inflation has had on three major occurrences in the life of a health insurance policy.

A. Calculation of Gross Premiums

Establishing gross premiums for a health policy involves three steps:

(1) calculate theoretical premiums based on a number of assumptions,
(2) adjust the theoretical premiums to be somewhat competitive to similar policies that other insurers are currently issuing (usually downward), and
(3) obtain approval from the various states and begin issuing the policy.

Although this was a reasonable approach in the 1950's and early 1960's, now problems arise in step (1) where future inflation was not introduced, or was significantly reduced because the resultant premiums would be grossly uncompetitive, and in step (2) where the comparison was to policies that should have been pulled from the portfolio within the year because premiums are inadequate.

Assuming that the ratio of the present value of future benefits to future premiums is 50% and that the company has only a 5% profit margin because of competition in the first year the policy form is on the market, we find that policies issued during the second year and the third year can expect to lose 2.5% and 11.1% respectively. Note that this is your issue expenses going down the drain.

The solution is to set the premiums high enough to be uncompetitive in the first year that it is on the market. In the second year, it will be moderately competitive and in the third year it is competitive. In the fourth year, it could be pulled off the market.

B. Replacement of Currently Issued Policy Forms by New Ones

The traditional approach is to review the cash loss ratio or the incurred loss ratio for the policy form. Unfortunately, the loss ratio is a combined loss ratio for all years of issue. When the loss ratio reaches some point, let us say 60%, the insurer begins to develop a replacement form to be introduced 6 to 12 months later when the loss ratio will then be about 65% due to the influx of new business. A year later, the loss ratio is approaching 80% (15% inflation plus the increase due to the underwriting selection wearing off).

The actuary can no longer use the loss ratios as a basis for replacing policy forms with new forms unless he has developed a set of expected loss ratios for comparative basis and maintains the loss ratios separately for each year of issue.

Two other alternatives would be:

(1) to automatically replace a medical reimbursement policy if it has been sold for more than a specified number of years, such as 3 years; or
(2) to set the expected loss ratio at a lower level, such as 40% or 45%.

Replacing policy forms at regular intervals before the experience

turns sour will:

(1) allow the insurer to recover some of the acquisition expenses before a rate increase is required,

(2) allow the effects of the underwriting selection process to wear off before rate increases are sought,

(3) prevent the agent from rewriting the policy to a form that is currently being issued because the current premiums are lower than the increased premiums on the old form.

C. Premium Rate Increases on Existing Forms

Traditionally, management uses loss ratios to trigger corrective action such as a premium increase. In the past, a 75% or 80% loss ratio was used as the basis for obtaining a rate increase if the company was watching the form closely. Otherwise, the loss ratio was probably in the neighborhood of 100%.

Again, we find that delay can be disastrous. Assuming that the loss ratios for the previous calendar year are not available until March, there will probably be a 9 to 12 month delay before the rate increase becomes effective. If the loss ratio initiating the request for a premimum increase was 80% and there is a 15% inflation rate, the form now has a 92% loss ratio before the rate increase becomes effective. The company now needs at least a 50% rate increase to bring the loss ratio down to 71% in the year following the rate increase.

Compare this result to that of a similar company that begins preparing for the rate increase 6 months or a year earlier when the loss ratio was 70%. By determining that a 30% rate increase would be requested before the end of the year but waiting for actual experience to confirm the result, they could make the rate increase effective April 1. This latter approach is preferable because the expected loss ratios would be 76% and 81% in the calendar year that the rate increase is effective and the following year, respectively, and because the 30% rate increase will result in fewer of the better risks replacing their policies.

In summary, I believe that small life insurance companies should not be in the health insurance market at this time. If they are currently in the market and must remain there, then they should begin to remove policies with inadequate premiums from their existing portfolio and to seek rate relief on policies where losses are developing before the traditional measures of either cash loss ratios or incurred loss ratios indicate that action should be taken. Before severe losses develop, the company should invest either the time of their resident actuary or obtain the services of an actuarial consultant to determine the potential problems in the health insurance portfolio before they become astronomical.