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CLASSIFICATION AREAS

Moderator: HARRY L. SUTTON, JR. Panelists: ROBERT D. BERGEN, DARRELL W. EHLERT**, HARRY A. WOODMAN, JR.*

1. Discussion of areas of regulatory and social policy encroachment on risk classification systems.
   a. Individual Life and Health Insurance
   b. Casualty Insurance - Personal Lines
   c. Group Health and Life Insurance
   Panel members will relate their field of experience to the classification areas currently under attack or likely to be under attack from the standpoint of social policy, statistical verification of risk differences, civil rights regulation in addition to insurance regulation.
2. For each of the areas discussed above, analysis of some of the potential effects relative to the following:
   a. Possible changes in underwriting/marketing strategy because of changed regulatory requirements: sensitive areas such as geographic location, moral hazards, life styles, marital and employment status; underwriting factors that may not be subject to statistical evaluation.
   b. Use of the social imperative via regulation or legislation to mandate availability of coverage to high risk classifications; possible alternatives to subsidy by low-risk insurance purchasers.
   c. Implied use of the risk classification system to provide incentives to control socially undesirable behavior.
   d. Potential use of private mass coverage to minimize the impact of risk classification systems for coverages mandated by law or social policy.
   e. The ultimate in risk classification systems: self-insurance.

MR. HARRY L. SUTTON, JR.: In the earlier sessions, we have heard about discussions about rate classification systems. We would like to structure this session more like a Workshop, so please settle near the microphones. We shall try to take no more than half of this session for prepared discussions and we would like to develop some interplay and reaction from the audience on the various elements of risk classification that we are going to talk about briefly.

In particular, if there are any people here working for insurance departments or others who have social involvement in the risk classification system, we would like to hear discussions from that side of the house, because most of the speakers here have been related to the insurance industry. We would also like to provoke some discussion as to solutions. Perhaps futurism can point out methods through which our insurance rate classification systems can change, to avoid or minimize some of the problems that we are talking about.

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**Mr. Ehlert, not a member of the Society, is a Fellow of the Casualty Actuarial Society.

Today we have four of us up here on the podium and I would like to hold the questions until we are through the prepared presentations. We are going to have four short presentations --- one on individual life and health; two on casualty; and a final brief commentary on group health. Then, as moderator, I propose to throw out a few items as food for thought which we might think about in trying to improve our relationships with social and regulatory authorities, as far as the risk classification systems go.

MR. HARRY A. WOODMAN, JR.: Until recently, companies writing individual life and health insurance have had complete freedom to select those persons whom they wished to insure. It has been good business for us to be free of unfair discrimination in our selection process in order to offer standard insurance to most applicants. When we have chosen to reject an applicant, no explanation or reason has been necessary or often requested, until recently.

In the early days of insurance, companies were quite selective in their markets, selling only to males of the merchant and professional classes. Later, sales spread to lower income groups, and then to females and children as companies became aware of good business opportunities among these persons. Due to competition, markets have continued to open to persons previously considered uninsurable so that all but 1% to 2% of life insurance applicants can now purchase insurance at a reasonable price. Not every company sells in every market but there are sufficient companies in each market to provide a large choice which, of course, promotes excellent competition.

Originally, there was minimal if any risk classification because companies had not become aware of the danger of anti-selection. Underwriting subsequently developed as a necessary protective device to keep the life insurance business on a profitable and competitive basis. Each company's underwriting was geared to its own market and pricing objectives and to this day varies greatly among companies. Unlike many other industries, we have many smaller companies who have competed successfully with the giants by designing their operations largely to cover special markets.

Competitive pressures and the selection process have been successful in keeping unfairness out of insurance discrimination. If a person has been rejected or rated by one company, he or she has been able to get a reasonable offer from another --- barring known terminal illness, of course. Because of the infinite variety of markets that can be developed through different approaches to risk classification, there has always been considerable competition in the life and health insurance industry.

One of the most sensitive areas over the years has been the underwriting of morals. Some critics have accused the insurance industry of using the risk classification system to control socially undesirable behavior. Although it is impossible to completely eliminate the influence of an underwriter's own moral criteria, the basic objective of underwriting philosophy is to take adverse action only to the extent that the life-style increases the risk. Underwriters have felt that persons whose life-styles have been viewed as undesirable have consequently been subject to social pressures which have contributed to higher accident, homocide and suicide rates as well as a greater incidence of emotional and physiological disorders. Now that life styles deviating from the norm have become more acceptable, social pressures have diminished, and competition has caused many companies today to provide coverage at standard rates to homosexuals, unwed mothers and persons involved

in extra-marital relationships. We will never know whether we were correct in not previously insuring persons with these life styles because we have no policies in force to measure mortality. However, we may subsequently be able to determine in some measure whether these life-styles affect mortality, if we can accumulate sufficient data.

Another example of how competitive pressures work is in the risk classification of smoking. Since the early sixties, when the first studies were published indicating substantial excess mortality among smokers, individual companies have acted in different ways according to their assessment of how these studies pertain to their own objectives.

Some companies have felt that the nonsmoker market is one that they should strive for through special pricing. Others have felt that special rates for nonsmokers would, in effect, create a large substandard class for smokers. This would be inconsistent with their general policy of offering standard insurance to about 90% of their applicants.

Another group of companies has recognized more favorable nonsmoker mortality by giving credits which could result in standard insurance or a lower substandard class for a risk that would otherwise be more highly rated; or they have given mortality debits for smoking as is done for overweight, elevated blood pressure and other medical risk factors.

Still other companies have felt that they cannot obtain sufficiently reliable underwriting information regarding smoking habits of applicants to consider it as a rating factor. This freedom of action in dealing with smoking is as it should be.

The point is that there have been a variety of actions taken in the freedom of the marketplace that have given the nonsmoker applicant a choice. This was the answer given by John Snore of the Prudential on behalf of HIAA and ACLI in response to Secretary Califano's recent suggestion that major insurance providers consider offering special premium discounts and other advantages to nonsmokers. While few in the insurance industry would argue against the position that smoking is harmful to health, it would be difficult and undesirable for the industry to take a united position in offering premium discounts and other advantages when a large percentage of its potential buyers are smokers. It could also be argued that we could improve our industry standard mortality by charging automobile drivers an extra premium but, obviously, most companies would not feel that this would be a desirable action.

Probably the first instance where government intervention intruded on insurers' freedom of choice was risk classification by race. Companies had charged higher premiums for blacks and orientals because of poorer mortality experience than whites. When civil rights legislation and insurance department regulations prohibited questions regarding race on the application, race as an underwriting criterion was effectively eliminated.

However, many companies had already eliminated selection by race in their underwriting and pricing. Hence, even without legislation, it was possible for minorities to obtain insurance from a large number of companies at the same rates as for whites. Mortality differentials per thousand between white and nonwhite insurance applicants had decreased to the point where many companies felt that different rate structures were no longer needed,

particularly when it was not clear whether the mortality differentials were due to race or to other factors. In any event, the industry cooperated willingly and fully with this needed social legislation.

More recently, there has been other legislation and regulation to force companies to take uniform action, the most significant requiring that companies have the same underwriting rules for females as for males. In most cases, there were companies already applying the same rules but the prevailing consumer opinion has been to force all companies into the same mold.

This legislation, though not terribly harmful, is intrusive on the rights of private insurers as well as being unnecessary in view of the excellent record of the insurance industry in providing coverage to meet needs. However, other legislation based on equal treatment of the sexes has created insoluble problems, particularly in the health insurance field. Legislation in New York, Minnesota and Kansas pertaining to maternity benefits has forced insurers, if they wish to continue writing business, to insure an event which, because it is largely predictable, cannot be covered by any reasonable premium. This is an instance where the law, in order to promote equality, has overriden the common sense of equity. It is unreasonable that governmental interference should give a company a Hobson's choice between insuring a predictable event and therefore having other insureds subsidize the cost, or withdrawing its business completely. The matter is discussed thoroughly in an excellent paper in the DRAKE LAW REVIEW by Messrs. Gillooly, Holmes and Hurley of HIAA.

Although some of the current social policy actions are not unreasonable, they nevertheless appear to be unnecessary. There has been recent action in some states to force all companies to write physically handicapped risks at standard rates provided there is no progressive disease. This type of legislation could proliferate as states tend to leapfrog each other in extending coverage to impaired groups for political reasons.

The pressure to insure handicapped risks may have come about largely because a number of handicapped persons who have been declined or rated have interpreted their own experience involving one, or perhaps a few, companies, as the uniform results for the industry. However, in any situation where there is a reasonable argument for standard insurance, there are usually a number of companies eager for the business and willing to provide coverage at standard rates. Mandatory action through legislation will simply result in some companies removing agents from markets which they don't want by revising their recruiting and training methods.

The recently appointed Industry Advisory Committee to the NAIC Task Force on Blindness took a survey of its members and found that most of the 12 companies represented offered standard life insurance to blind persons, slightly over half offered standard ADB and medical care coverage, and slightly under half standard waiver of premium and disability income coverage. Since the blind person can obtain standard insurance from a substantial number of companies, legislation that would force standard issue by all does not appear to be needed.

In order to most effectively deal with the problem of increasing legislation to bar discrimination against certain handicapped risks that has already been enacted in various forms in 12 states (Arizona, California, Florida, Iowa, Maine, Massachusetts, Michigan, Minnesota, North Carolina, Rhode Island,

South Carolina, Washington), the HIAA and ACLI have appointed a Joint Task Force on Classifying Physical Impairments. This committee is searching for a suitable type of compromise legislation which will affirm that the insurance industry will not discriminate unfairly, but which will retain the right to be selective based on reasonable assumptions. Such legislation should relieve companies of the unreasonable burden posed by certain states (notably Minnesota) to support their underwriting through statistical evidence as well as independent medical judgment.

The unreasonableness of legislation requiring statistical proof is, of course, that it is impossible to obtain exposures and claims for persons considered uninsurable and for conditions excluded by rider. Moreover, it is difficult, even in the case of most handicaps that are insurable, to accumulate enough data to produce significant results. There appears to be a general misunderstanding on the part of legislators that we have, or can readily obtain, data on every conceivable risk. Therefore, they may not realize that they are putting us to an impossible task.

One may ask why we cannot absorb all handicapped risks with excess mortality in our standard experience since their numbers are not great. This might be possible if such risks would apply for amounts in the same proportion as the nonhandicapped and that each company would get a proportionate share. However, we have no way of setting controls to see that this would occur.

A reasonable alternative to forcing all companies to assume certain risks at standard rates would be to require that they reinsure the risk, or at least inform the applicant that there are other insurers who will provide coverage.

There should probably be a social device to provide for the very small percentage of people who are unable to obtain insurance from any company at reasonable rates. Just as people who cannot obtain work can apply to the government for unemployment benefits, it may be socially desirable to have a program where people who cannot obtain insurance would be able to apply to the government for insurance benefits at a reasonable rate. Government subsidy would be necessary because it would be unfair to ask only those who are insured through private carriers to bear the burden of covering impaired risks. This burden should be shared by all society, both insured and noninsured. Under such a program, it would be necessary (1) to develop a system which would encourage persons to obtain insurance through private carriers unless unable to do so, and (2) to prevent extreme anti-selection by uninsurables by having specified enrollment periods.

We, in the life and health insurance industry, have on the whole done and, I am sure, will continue to do a good job in anti-discriminatory risk classification. However, some of us have on occasion lacked sensitivity in dealing with emerging social issues that have changed the perspective for classification of certain risks. The adverse reaction and resultant legislation that has come about because of this insensitivity has placed an unnecessary burden on all of us that may have been possible to avoid. In the future, we should all be more conscious of the potential long-range effects of our actions so that we can retain the freedom to make our own risk classification decisions.

MR. DARRELL W. EHLERT: I am here today to talk about discrimination by age, sex and marital status in automobile insurance ratemaking. To some people, discrimination in any form is evil. To some (especially actuaries) to make

indiscriminate rates is also an evil. If the actuary has knowledge that rates should differ significantly between two large classes, and does not recognize the differences in his ratemaking, he is not performing his actuarial function --- nor is he allowing insurance to perform one of its primary social benefits.

Others, although they cry "discrimination" in loud and persistent voices, are not primarily interested in discrimination. What they are doing is trying to influence public opinion in their favor in order to lower the rates for the class being discriminated against. For example, the feminists who dispute the rating and/or benefit structure of loss of time coverages, pensions and annuities have seldom, if ever, brought discrimination charges against life companies or auto insurance companies because they charge less for females. Likewise, senior citizens may be very active in the fight against discrimination in health insurance rating, but are silent in auto insurance where their rates are generally lower than most other age groups.

These inconsistencies have led me to believe that the issue is not discrimination. The real issue is the price levels at which insurance is sold, or affordability.

But this is not the whole issue, because affordability is relative. Those with affluence should be able to afford to pay more. The problem is that in automobile insurance, the prices are higher for young people who, in many cases, cannot afford the product. Auto insurance is also one of those products which, for all intents and purposes, is required if you are to own a car. For all of us in our society today, the car is a necessity of life. Without a car, one is limited in mobility, a place of residence, in jobs and even in social intercourse.

Thus, the cost of insurance, which limits car ownership, also limits the social and economic development of a person. The real problem is not discrimination, but affordability. We in the casualty insurance business have recognized discrimination as the problem, but have been ineffective in dealing with the problem, because it is really one of affordability.

We should realize that if the product we sell becomes unaffordable, and yet is required by government, then our insureds will turn to government to make it affordable or to actually provide the coverage and we will be out of business.

Part of the affordability problem has to do with the position of the automobile in our society. Our living patterns and life styles are dependent on the automobile. Automobiles are expensive to buy and maintain; yet, we must have one if we wish to continue the life style we are accustomed to.

Automobiles cause expensive accidents. Auto repair facilities do not have the same efficient procedures as an assembly line. Including parts and labor, a $5,000 auto costs over $20,000 to put together in a body shop.

The automobile is a deadly machine, causing about 50,000 deaths and 2,000,000 disabling injuries each year. The automobile is the leading cause of death in the 15-24 age bracket. The death rate by automobile is greater for this age bracket than the next five leading causes of death combined.

The cost of the automobile in terms of property damage and life and limb is astronomical, especially among the young. The cost of insurance is merely a reflection of this cost. Yet the protests do not center on this cost, but the distribution of the cost.

Another part of the affordability problem is in the method of reparations. In the U.S., the tort liability system, designed to protect the innocent victim of auto accidents, has become part of the problem. Over the years, the tort liability system has been altered to try to fit it into the mold of a reparations system for all accident victims. The adversary nature of the system has made it a major source of income for attorneys. As a reparations system, it is duplicative of other systems, inefficient, and not fair.

The cost of this system again hits hardest at the young, who have more than their share of accidents, more than their share of serious accidents, and more than their share of at-fault accidents.

For these reasons, auto insurance is getting expensive for all. For the young, especially the young male, and most especially the single young male, auto insurance is getting to be unaffordable.

One of the social benefits of insurance has always been to point out those endeavors in society where the risks may be reaching a critical point. For example, I imagine that insurance on super oil tankers is going to get even more expensive and hard to buy. The high cost or unavailability of insurance for supertankers might call for rethinking the whole system of moving crude oil around the world.

In auto insurance, the high cost and unavailability should lead to the same rethinking of the role of the automobile (i.e., what can we as a society do to reduce the danger to life and property of the automobile?), but, it does not. We are dealing not with supertankers, or with war, we are dealing with a necessity of life to many and especially the young, although that point could be debated.

Rather than dealing with the real problems of cost and social necessity, many attack the auto insurance business for its classification systems and for its ratemaking processes.

Neither attack is justified. All available statistics, insurance and otherwise, show that young drivers have more accidents than older drivers. Auto insurance rates follow the actual experience, not some theory. We do not make up the numbers, they are real.

We use age, sex, and marital status to classify risks. These criteria are easy to determine and do separate drivers into classes with distinctively different accident likelihoods.

We are told that these differences are not due to age, sex and marital status, but to other characteristics that are correlated with these factors, such as immaturity, lack of social responsibility, environmental factors, etc. Then, in the next breath they tell us that these factors are too subjective to be quantitatively determined and trying to determine them would probably violate the insureds right to privacy.

They also tell us that our statistics are biased, that what is true for some areas is not true for their state or their territory within a state, or that our whole classification system is "inefficient" (whatever that means) and therefore can be replaced by a simpler and even less efficient system, without much loss of statistical purity. All of these attacks have gained attention because they give a reason for disbelieving our statistics and for the lowering of auto insurance rates.

The reasons for disbelief, however, have more to do with social pricing than insurance ratemaking. We have examined our statistics in great detail. We have examined the reports quoted by the attackers of our rate classification system based on age, sex, and marital status. We are convinced that our system is valid and correct. However, facts are not important in this battle, it is social justice that is important. A social justice that calls for equality in all things. The American dream of equal opportunity for all has become an equality of results for all.

For example, schools must adjust entrance examination scores so that each student gets the same grade. Taxing powers must be used to redistribute wealth so that each person has the same amount regardless of his ability to contribute. Insurance rates must be the same for all classes regardless of the risk involved or prior experience.

The problem we face is not a statistical one. It is a political and social problem. We, as actuaries, have tended to fight this battle using our knowledge of risks and statistics. This line of attack cannot convince those opposed to classification. There is no way that we can prove that a given individual --- male, teenaged, single --- has a greater likelihood of accident in the next year than another individual --- female, middle aged, married. Likewise, life actuaries cannot prove that an individual who is female and teenaged is going to live longer than another person who is male and middle aged.

However, life actuaries are certain that, on the average, the population of teenaged females has a longer life expectancy than the population of middle aged males. Casualty actuaries are just as convinced that their rating plans based on averages are valid. However, we in the casualty business are being told that using averages causes certain individuals to be overcharged. If this be true in auto insurance, it should also be true in life insurance. If age is not a valid criterion for casualty insurance, it should also be invalid in rating life insurance and annuities.

The consequences of eliminating age, sex, and marital status as rating criteria in auto insurance would be as devastating to the marketing of auto insurance as it would to life insurance and annuities if age could not be used. Additional laws would have to be passed to force companies to maintain availability of the product. The ultimate result would be chaos and the only way to maintain such a system would be a government takeover of the insurance business, converting the insurance business into a welfare program similar to social security.

In conclusion, the battle over rating plans based on age, sex, and marital status is not statistical, but political and social. If we try to fight this battle on purely technical, actuarial grounds we will lose, because our opponents are not interested in facts. Persons intent on producing equality of rates will not be impressed with arguments about the equity of class rating.

The only viable solution I see is to attack the real causes of the unaffordability of auto insurance rates. Areas of possible activity are the following:

1. Raising the legal driving age to 18 or 21.
2. Raising the legal drinking age to at least 21.
3. Working to make cars more damage resistant, safer for occupants and less costly to repair.
4. Meaningful reforms in the tort liability system.
5. Meaningful reform in the people repair business --- the high cost of medical care, duplication of benefits, etc.
6. Increase our efforts to stem the tide of inflation in all areas of our economy.
7. Work for safer highways and more effective traffic law enforcement.

We cannot keep our heads buried in our actuarial tables and statistics and be lulled into a false sense of security because our rating plans are built on sound actuarial principles and since they are "true" and "right" we will be vindicated in the end. Unless we become more aware of the trends in society and use our brains to solve societal problems, we will be buried with our mathematical proofs.

MR. ROBERT D. BERGEN: An area not yet mentioned today has been the private passenger merit rating plan which further categorizes risks based upon the driver's past motor vehicle accident and conviction record. This classification criterion, which at first glance might seem to be statistically unsupportable, has proven to be another valuable tool for distinguishing potentially bad risks from good.

Merit rating was introduced as a competitive tool, with the consumer benefiting both from more accurate rates, as well as from greater insurance availability. In addition, there is much public sentiment for a system which surcharges drivers for their own actions rather than for their uncontrollable characteristics such as age and sex. Also, this program, based upon individual driving record, has the additional advantage of encouraging highway safety by providing the lower premium incentives for the good driver. However, the plan itself has not been adequately explained to the public. An individual having his insurance premium raised because of past accident involvement may believe this increase to be unfair because of the misunderstanding that he is being surcharged so that the insurance company can "recoup" the dollars spent on his claim. The consumer has not been made sufficiently aware that the real reason he will pay more for his insurance is that history has shown that on average, an individual recently at fault in an accident is more likely to be involved in an accident again in the near future. Another common criticism of the merit rating system is that in most plans where, in addition to accident involvement, motor vehicle violations trigger surcharges, true equity in the program exists only if the judicial and law enforcement systems operate uniformly and consistently throughout the state.

Turning our attention briefly to commercial lines, we recall what Bill Gillam told us yesterday, that,for commercial lines, the insured is generally a corporation, partnership, or unincorporated association and obviously age, sex, and marital status are not used as classification criteria. A major risk characteristic that is commonly utilized in commercial lines for classification purposes is the nature of the business operation. Additional

characteristics used for fire insurance classifications include the type of building construction and the quality of fire protection facilities. None of these has been subject to severe regulatory or consumer criticisms. For commercial automobile insurance, the vehicle's size, usage, radius of operation, age and price, are all different classification criteria. Here, too, little controversy regarding the classifications has occurred.

If, however, we expand our definition of the word "classification," we can include the characteristic of geographical location of risk, otherwise known as territory rating, as an item that has stirred controversy.

Private passenger auto insurance makes a good example. Territorial rate differentials are based upon the location of principal garaging of the insured vehicle. Large states such as California and New York may have over 40 different territories within the state, with the higher-rated territories having differentials six or more times as large as the lower-rated areas.

The reasons for varying rates by territory are clear. Environmental factors impact loss potential and these factors can and do differ geographically. Traffic density, road conditions, costs of auto repairs and medical services are some of these factors which directly influence insurance costs. Other factors, perhaps not as clear-cut as those of the prior group, also impact loss levels. These include degree of law enforcement, court conditions, and theft rates.

There is little controversy related to the statistical justification for these differentials; however, complaints are heard. Since many of the conditions which result in higher rates tend to occur in the urban areas, many of the concerns originate in the large cities. The concern is registered that insureds living in the urban areas "subsidize" the suburban and rural insureds who are charged the lower rates. What makes this further unpalatable is that the urban drivers tend to be less well-off financially when compared to the more affluent nonurban residents. Therefore, those charged the highest rates are those that are least able to afford the price. In addition, the cry is heard that good drivers, who happen to live in high-rated urban areas, are being penalized by high rates for environmental conditions that are beyond their control. Critics also mention that because of suburban/urban traffic patterns, suburban residents are a major cause of urban congestion, and therefore, it is unfair for the urban resident to bear the entire cost burden.

On the other hand, advocates of the existing territorial system point to the statistical support for the rate differences and the fact that premium surcharges are assigned to the territory where the at-fault car is garaged; hence, the charges resulting from suburban motorists being at-fault in city accidents do not penalize the urban insureds. Critics point to the arbitrary nature of territory boundaries which perhaps reflect ethnic variations more than degree of loss potential. Also, the critics attack the unfairness of a virtually unaffordable rate for the poor urbanites.

Regarding this controversy, a thorough re-examination of the statistical evidence and the actuarial techniques used must be conducted. If from a statistical-actuarial viewpoint these territorial differentials are found to be improper, corrections must, of course, be made. Nevertheless, even after

the factors are finally judged actuarially acceptable, the question of affordability will probably remain, with the "remedy" of a uniform statewide rate being advocated. If, however, uniform statewide rates were to be implemented, the present lower-rated insureds would have their premiums increased to the statewide average, as a subsidy for risks in the higher-rated areas. Insurers that have large writings in suburban and rural areas would, out of necessity, avoid marketing in urban areas because their statewide rate would be inadequate for the high-risk urban insureds. Companies presently writing predominantly in high-rated areas would not be able to compete in the other areas of the state because their statewide rate would be too high for competitive purposes. Therefore, the tendency would be for insurers to concentrate in different geographical areas of the state, resulting in the marketplace maintaining separate rate levels by geographical area, but with a decrease in the number of companies writing in each territory. This would probably result in higher expense ratios for all companies operating in the state.

Since uniform rates cannot exist in a free marketplace, the use of a residual market should be explored. Although a residual market in the form of an assigned risk plan or a reinsurance facility can alleviate the availability crisis, the historical results of these programs have highlighted the inadequacy of their rate levels. If these residual markets charged adequate rates, both the availability problem as well as the industry's concerns for an adequate rate level would be alleviated, but the unaffordability situation would remain. In fact, however, the continuing underwriting losses in the residual market combined with an increasing volume of this business, places the insurer in a difficult position. Companies can either simply absorb these losses or, more realistically, be selective concerning where to actively market. Since the statewide residual market share for an insurer is basically in proportion to the company's statewide voluntary writings, the company has the following two choices: it can informally recognize in its voluntary rate the cost of doing business including the residual market, or it can consciously construct its companywide potential in jurisdictions where the residual market is relatively large and inadequately priced.

It is unreasonable to expect any other scenario. Availability of insurance for the high risks at an inadequate rate level based upon average risk loss potential is not a characteristic of a free marketplace. Regulators and legislators must choose between forcing uniform average rate levels upon insurers and consumers, hence causing an availability crisis, or choosing availability of insurance as the most desirable objective, even at the risk of raising rate levels to an adequate level. From recent events in both personal auto and commercial lines, we have seen regulators at both ends of the spectrum --- some advocating territorial rate uniformity so that a few insureds will have their insurance costs reduced substantially at the expense of the majority who will pay slightly more for their coverage --- while other regulators press for the establishment or expansion of territorial rate differentials in order to encourage the availability of coverage.

In closing, I believe that this tug of war between the forces behind rate equity and those advocating complete social acceptability of classifications is one of the greatest challenges our business and profession has ever faced. Based upon a number of the comments we have heard over the last two days, I am hopeful that we can meet this challenge and develop a solution which will satisfy all parties involved --- before solutions are imposed upon us, to everyone's detriment. Perhaps some preliminary ideas can be suggested now from this large nonsmoker and small smoker gathering.

MR. SUTTON: Initially, a comment could be made that there has not been a tremendous problem with rate classification systems in the life insurance area. No one has yet come up with a conclusion that a person has an unlimited right to purchase life insurance regardless of health, income, etc. In fact, a dominant life insurer is the Federal Government through the Social Security System with widows' benefits payable where young dependents remain after the death of the employee. The balance of these remarks will relate to insurance covering medical expenses.

The pressures on health insurance (of which the political organization for NHI is only an example) relate to some of the social and other pressures referred to by the previous speakers. The fact is that our political system has now declared that the availability of complete health care is an inalienable right for all citizens. I do not know that we have yet reached the conclusion that the availability of an automobile and unlimited driving regardless of behavior is an inalienable right.

My interpretation of the social conscience then is that the government has spent billions of dollars producing physicians, building hospitals, providing direct services to certain areas of the population, and financing through a social insurance type of mechanism, or in some cases direct taxes, payments for health care services for underprivileged sections of society. After spending huge sums to increase access, much thought is directed to the emerging high cost.

Since governmental programs effectively reach maybe only 15% or so of the population, the private insurance system is being forced to adjust to make prepayment available to the majority of the population. To understand the group health insurance market, we must also recognize the existence of two major competitive forces --- first the Blue Cross movement which is essentially chartered by special statute and which generally comes under very close scrutiny of state insurance departments because of its privileged status with hospitals. In some areas, their reimbursement to hospitals is 30% lower than a commercial carrier. The other major force is, of course, the commercial insurance industry.

As indicated in other areas, the problem is primarily cost or affordability of the premiums, without any real evaluation of the availability or access to services, and, secondarily, the access to a prepayment mechanism at all, i.e., availability of insurance for a small minority of working poor.

By way of a small illustration, I would like to make what I hope is an inflammatory comment in that, if we had in the past approached health insurance the way we have approached automobile insurance, we would have had a national health insurance program ten years ago. For peculiar or perhaps accidental reasons, the health insurance market is a mass insurance market with a majority of the costs financed by employers and passed on to society through the cost of the products which they purchase. A relatively minor part of the cost is paid by the individual, in most cases through payroll deductions.

I have prepared a brief table showing some illustrative premium rates for rather extensive coverage offered by a large insurance carrier. When I hear discussion of the high cost of automobile insurance in certain areas of the country and for certain risk classifications, and at the same time

consider the typical insurance premiums available on an individual basis for health insurance, the hue and cry would be much worse if in effect the problems in managing health care in our society had not been masked over the past thirty years by the dominance of group insurance coverage. It seems that the individual premiums and differentials are at least as large as for auto coverage.

ILLUSTRATIVE GROSS RATES

INDIVIDUAL MEDICAL EXPENSE COVERAGE

Coverage: 80% of first $5,000 of medical, hospital expenses, 100% excess.

No Maternity Coverage

Premiums: Twelve times monthly rate --- annual outlay.

Anaheim, California		Full Coverage		Burnt Cabins, Pennsylvania		
Male	Female	Family	Age	Male	Female	Family
$ 645	$ 929	$2,490	20	$209	$300	$ 892
829	1,267	3,012	35	268	410	1,061
1,722	1,724	4,362	55	466	558	1,498
			500 Deductible			
$ 317	$ 453	$1,248	20	$112	$160	$ 440
405	614	1,886	35	143	217	528
918	867	2,262	55	324	306	798

Maternity --- $48 per $100 benefit, maximum - $800
Add Policy Constant $4

But even though the crisis in health care has only arisen during the past five or ten years because of Federal budget problems, and employers awakening to the fact that health insurance costs have gone from 1% or 2% of payroll to 4% to 5% of payroll, there have still been a number of peculiar areas in the health field where regulatory authorities and others have impinged on complete freedom to develop competitive classification systems.

Also, a number of the problems developing in the group health area are only indirectly related to the classification systems, and affect the scope of benefits which must be provided by statute, possibly expense or claim ratios which would be permitted by law; e.g., unlimited maternity without a waiting period; mental health; chemical dependency. These seem to exacerbate the problems which have generally been mild in the rate classification area.

It should be noted that historically the major employer groups have been experience rated so that the rate classification system applies only to an initial year of coverage and, even there, most carriers base their initial rate on the experience of a previous carrier, where one existed. A few Blue Plans and many HMOs are community rated.

Since I work more in the direct delivery of health services than in health insurance per se at the moment, I feel free to express the opinion that most insurance companies do not understand well enough the mechanics of the delivery of health care and, because of competition, inability to estimate patterns of services or changing demographic trends, have had difficulty in maintaining a profit consistently. There is an appalling lack of industry statistics; if you look at the Society of Actuaries publications, there are only four or five carriers committing data to studies of group hospitalization coverage and this may be discontinued because of limited sources. From experience with a large group underwriting company, I can assure you that their data does not generally have available any true indication of utilization patterns, cost patterns, etc., other than on an extremely gross basis, which is adequate to run their business but not adequate for them to determine the utilization patterns and demographic trends underlying their own business. Perhaps some of the carriers would care to argue with that statement later.

Currently, rating classification factors for group insurance have been related to industry characteristics, area, age and sex, marital status or dependency status. For small groups under 100 lives, it is common to use industry rating factors, which may vary by type of coverage. The industry classification adjustments range from approximately minus 10% to plus 40%. Income levels have frequently been used in major medical rate factors because of the assumption that more educated or higher income people will use more services and that physicians will charge them more money for the same services. Frankly, while many of the adjustments make sense apriori, it is not at all clear from data which I have seen, both from the insurance industry and outside, that these rating factors have ever been evaluated independently. An average theoretical rate calculation is so complicated that the data will not generally support it, because of the inability to eliminate the effect of cross variables in analysis.

The report of the Academy Task Force on risk classification oversimplifies the situation relative to group health insurance. There is an indication that in group insurance the ability to quantify risks is not worth the trouble. In my experience with HMOs, there are a lot of factors which affect the risk which insurance companies have not bothered to find or claim they are unable to obtain. However, HMOs obtain this data and could develop a much superior classification system. One of the major variables which the insurance carriers do not use (except to the extent that experience rating modifies initial expected results) is a true determination of average family size including age and sex of dependents. HMOs have developed demographic factors for certain industries which reflect the characteristics of those groups and which seem to maintain a consistent pattern. The family size, life styles, and patterns of seeking medical care differ for these industry groups.

Another important factor for many medical services is education level which is not necessarily commensurate with income. Actually, ethnic or religious factors of the community may also have a major impact, particularly for costs such as maternity.

Area factors are only partly based on the cost of hospital services or the medical fees of a given area. They are actually more affected by the indigenous pattern of practice in medical care than in the unit cost of the services. For example, the hospital utilization experienced generally

in North Dakota for a population under age 65 is about twice that normally experienced in the State of Washington. This is not necessarily because of the nature of the populations but because of the physician background, training and the control systems in use in a competitive environment in the State of Washington.

Time does not permit getting into much detail on the impingement on rate classification but the following are a few examples: (1) The Pennsylvania Insurance Department requires that individual policy rates and group policy rates be the same for Medicare supplements and requires a 2% community subsidy, i.e., a direct charge against group business as a retention item to reduce the premiums on Medicare supplement business. (2) In a number of states, Blue Cross is required to offer individual contracts at a community rate, i.e., a rate independent of age and sex. In the State of New Jersey, a retention item of 2% must be currently charged against all large group insurance programs to subsidize the community rates for small groups. (3) In the State of New Jersey, the Insurance Commissioner, because of a perceived high surplus level in Blue Cross, in the past required open enrollment without evidence of insurability for 20,000 persons at standard community rates. Since this happened in the early 1970's, the lapse rates have been relatively high at the younger ages, producing an older and older population at standard community rates. Based on last published reports, this is costing $2 or $3 million each year in Blue Cross - Blue Shield subsidy. (4) Many state laws and the Federal law on HMOs require periodic open enrollment with the HMO accepting all enrollees in the order applying without any restriction on benefits or underwriting. This was a big stumbling block in the original HMO law and has essentially been removed in practice, if not in principle. State laws frequently make this requirement only relative to group enrollments, if this is the only type of coverage offered by the HMO. However, the law would require that, if the HMO took individual enrollments, within two years generally it would be required to have open community enrollment for certain percentage of its population. (5) In recent years it has become almost universal that all group health insurance plans must continue dependents who are disabled past the normal limiting date; thus, slightly increasing the average cost of group insurance but affording relatively full coverage to retarded or other individuals incapable of self support. (6) Some states require group conversions, occasionally at controlled rates.

Our table above illustrated a sample rate classification system, but we should also recognize the current but apparent possibility that an HMO can operate successfully on a community rated system. Although many of the HMO plans are young, we should at least consider implications of this for other areas of insurance.

This completes some brief comments on the health insurance area, which may have left you casualty actuaries confused. I would like to close now as moderator with seven specific ideas to consider for discussion or individual company consideration in trying to ameliorate the problems in the risk classification area:

1. Should we consider that the individual marketing mechanism for areas of high social interest may no longer be possible and that we should move to mass coverage mechanisms (hopefully still outside governmental systems) through pooling of a wide variety of rate classifications

through an employer-sponsored program? While we have not gotten very far, we are moving into group legal insurance and possibly into group casualty insurance. Group dental insurance is one of the most rapidly growing coverages today. Using the employer as a base, we can provide coverage for maybe 60% to 80% of the total population under age 65. This would disburse the costs into products rather than into taxes and may have implications as far as inflation is concerned. We can say that substantial employer contributions will be essential.

2. Many of the social or regulatory efforts to adjust classification systems to meet the availability problem results in an increasing subsidy by a majority of the population who are average risks to cover a relatively small portion of the population which is a very high risk or has a low availability of funds with which to purchase insurance. Is it possible to satisfactorily explain this point to lawmakers to experiment with programs where tax money can be used to subsidize these areas deemed socially in need?

3. The HMO, and particularly as exemplified by the involvement of the Prudential Insurance Company of America, Connecticut General and a few others, offers an opportunity to the insurance industry to get involved financially, marketing and otherwise, in the direct provision of services through regional programs. We might argue that health insurance is not really an insurable risk but a budgeting mechanism since the possibility of events occurring which require expenses is very high. We have also seen experiments in heavily developed rehabilitation and job placement programs for disability and workmen's compensation. How feasible is it for auto insurance carriers to set up nationwide chains of repair services to at least work on controlling the cost and quality of automobile repairs? With this experience, they could possibly work with the automobile manufacturers in improving the design of cars to make them more repairable.

4. Closely allied is a question as to the morality or effectiveness of the whole democratic process. As we look at Washington today, the farmers are marching or riding on tractors demanding higher prices or subsidies for not selling or growing commodities; we see minority groups marching to get major subsidies for low-cost housing in inner city areas; we see the steel industry fighting for tariffs on foreign steel, or import quotas, which would in effect raise inflation in this country when their problem may be managerial expertise to improve efficiency; we see senior citizens lobbying for lower taxes in their community, circuit breakers and special allowances for their group. We seem to be in a form of government where decisions are made through the squeaky-wheel process where the complaints of the small minority group seem to have more influence in the course of legislation and government policy than the interests of the majority. While the insurance industry must recognize the need in certain areas to meet society's demand for quality, availability and reasonable affordability of coverage, can we not through the ballot create some sense of working for the total population through the interest of the majority.

5. To some extent, the risk classification system produces incentives of its own to change socially undesirable behavior. I see this as good --- not doubtful as others have implied. For example, if an individual

policy is issued with a high rating because of overweight, there should be some inkling in the insured's mind that something is wrong and that if he were to control his weight or blood pressure problem, he is likely to have a reduced cost for life insurance, health insurance, or whatever. Because of the high cost of medical care, some individuals are questioning the fact that they should be pooled with others, whether it is because of smoking, driving, alcoholism, etc. Some consumers are asking why they have to pay such high premiums to cover the cost of people who do not take care of themselves. Group insurance does not allow much room for variation in risk classification relative to these things, but employers are looking at incentives to try to lower their employee benefit costs.

6. One of the major factors other than certain social discrimination problems referred to occasionally are the effects of inflation on the affordability of insurance coverage that is relatively comprehensive for any type of service. If health insurance costs had not increased 100% in the last four years, we would not be having quite the uproar we are having today. I am sure some of the same cause is involved in the problems of the automobile insurance business. A stronger government and business involvement in controlling our economic environment and reducing rates of inflation would certainly in the long run reduce the problems we are discussing.

7. Finally, we have one major additional problem which affects areas where insurance is not essentially mandatory. In group insurance lines as well as in some commercial casualty lines, larger employers have become self insured. For these employers, they have made a direct choice for the ultimate in risk classification systems. If they can work to control their own costs, whether it be plant or employee's health care experience, they can receive the benefit directly. Social insurance schemes in these areas may ultimately work to the destruction of the employers' incentive to control costs. We should think twice before complete destruction of the risk classification system in areas where control to prevent abuses is highly possible.

We hope that these comments have evoked some interest or possibly even provoked some antagonism or questions. We invite you all to give us your own ideas and would particularly like to hear comments from the regulatory side of our industry.

MR. JAY C. RIPPS: I have a comment. Although I am not in the individual personal lines casualty business, I suspect I could construct a rating scheme that demonstrated people with certain hair and eye color would have some correlation to their accident experience. I rather suspect more strongly that I could demonstrate the same sort of correlation with regard to race. It has been accepted that this is just not an acceptable classification scheme. It seems that the matter of classification and rate making, based on classification, is enormously more complicated than determining the actuarial facts. And in fact the sooner actuaries stop talking about the actuarial facts as if they were some platonic reality, the better off we are going to be in terms of getting on with the question of solving this difficult *trade off between what is statistically valid and what is socially acceptable.* It seems there should be countless valid classification systems.

MR. ROBERT H. WALDMAN: It is important to draw a distinction between trying to decide what kind of classifications are proper and what underlies the difference in experience, for example, between male and female drivers. Is it perhaps a difference in mileage driven? It is important to make this kind of distinction on public policy questions as well as on questions of public sentiment where people feel that they are being punished doubly when they have surcharges for accidents. In any case, I agree we should never be pushed by mass sentiment which may or may not have any foundation of fact.

MR. SUTTON: In the group health conversion area, there is often a subsidy by employers. In group health insurance, generally the rates are nearly self sufficient but insurers frequently make a charge against the employer on the basis that the terminating employee became sick during his employment. The employer has indirectly a continuing responsibility to subsidize this excess health insurance cost. Also, in the group life insurance, standard procedure is to charge $65 per thousand or some graded amount for each thousand of life insurance converted, which is then issued at standard rates, even though the person is often highly substandard.

MR. LOUIS WEINSTEIN: I am a consulting actuary in life insurance and what troubles me a great deal, gentlemen, is that I always feel very sympathetic to the industry on the life insurance side, but having no experience in casualty whatsoever, I feel totally unsympathetic to industry on the casualty side. I do own an automobile. I happen to live in one of the 40 areas of the State of New York which has the highest territorial charge. Our hospitals have very high costs, our auto repair costs are outrageous, there is little to no law enforcement available, there are very very high death rates. It troubles me greatly to realize that if a young driver from the suburbs should drive me off the road, as we both lie on the streets of Brooklyn waiting for an ambulance to come, my insurance rates are going to go up. Very likely, his will not, particularly because he happens to live in and garages his car in some sleepy community in New Jersey.

I would also like to point out that I do not agree with you gentlemen about the issue being affordability. The civil rights movement has heightened a sense of what is fair to this group or that group. This sensitivity or awareness has caused individuals to challenge the fairness of rate classifications that the insurance companies have. It is not the cost.

MR. BERGEN: First off, from the point of view of the merit rating system, if the other individual was at fault, your rate would not go up because of that accident. From the point of view of territorial differentials, if you live in an area where bombs are exploding, and cars are coming at you from every direction, obviously, you are more vulnerable to be involved in an accident and any prudent insurance company would try to reflect that higher hazard in their rates. Unfortunately, the individual who lives in the suburbs might be coming into this high density area only one day a week, and the remainder of the week might be out with the cows and the grass and not be subject to the exposure of automobile accidents.

MR. GARY VENTER: I would like to comment on the notion of the equity of a classification scheme. The most prevalent idea of equity seems to be that a class plan is equitable if the pure premiums underlying the class differentials are equal to the expected losses for each class. Given enough data, any class rating breakdown should be able to meet this criterion. Because not every class proposal meets the judgmental test of fair play, I would argue that the "charge the mean" criterion is not sufficient as a definition of the equity of a class plan. In any case, this standard does not provide a means of measuring the relative equity of alternative methods of classifying risks.

One ideal sometimes proposed is that each insured be charged his expected losses (not actual losses or there would be no spreading of risk). Measures of equity can be constructed to reflect the divergence from this ideal. One such measure is the ratio of (1) the average (over all classes) of the variance of the individaul means within a class to (2) the variance (over all classes) of the class means. It would seem for most risk-generating processes that this criterion would lead to the conclusion that the more refined the class plan is, the better. It is not clear, however, that this criterion corresponds exactly to our intuitive notion of equity in all cases. Moreover, even if a grouping of individuals into classes seems to minimize this measure, some test must still be applied to determine if the class means or other statistics should be the basis of the premium charges.

Another way of measuring equity would be in terms of the degree of subsidization between insureds. Within any class, the low risk individuals subsidize the high risk ones, and there may be subsidization between classes as well. A method of quantifying subsidization would be to calculate the average value of the square of the differences between each individual's charged pure premium and his expected losses. Taking the square rather than the absolute value of this difference reflects the notion that it is more fair to have many contribute a little than to single out a few to contribute a great deal. Taking the square rather than some higher power is an arbitrary choice here but subjecting individual examples to intuitive examination could refine this selection.

I believe a much better measure of subsidization would result if the mean square subsidy of only those paying no less than their expected losses were taken into account. This avoids the double counting of the same dollars by those paying and those receiving, and reflects a prevalent social value that only those paying extra are being unjustly treated. In addition, in actual examples, this measure seems a better specification of the intuitive notion of equity. It should not be difficult to construct cases where a less refined class plan would be more equitable than a more refined plan under this criterion, with both charging class means. Also, some degree of subsidization between classes may, under this measure, be preferable to maintaining all subsidization within classes.

I would like to conclude that a class plan has not been "actuarially justified" unless a specific standard of equity has been presented and a reasonably valid demonstration that the plan in question meets that standard has been offered. Furthermore, we as a profession cannot expect

to influence public policy in the classification area unless we are willing to debate the appropriateness of the standard of equity we wish to use in addition to showing the result of its application.

MR. EHLERT: The big problem is to make assumptions as to what the accident likelihood within a class is. You can say that the variation in a class is either large or small, because there is no way you can check it out. So some assumption must be made, but there is an intuitive feeling that there are probably some people in a high accident likelihood class that have a low likelihood of loss. The big problem is trying to figure out who they are.

An automobile accident, especially one with a bodily injury, is a relatively rare event. If you are an average driver, you will have an accident in which you injure someone once every 39 years. So you can go quite a long time without an accident and might think your accident likelihood is close to zero. I have been driving for 30 years and I have never had an accident where I have injured someone. But I do not know yet whether I am an average driver or not because I have not passed the 39 years. Even when I get there, I will not be sure because I might have two the next year, which would put me worse than average.

So the problem is trying to develop parameters and the assumptions you make give you an answer. But you do not know for sure whether or not the assumptions are valid.

MR. VENTER: It is the problem of not knowing the parameters for each individual that makes perhaps a less refined class plan a better class plan in some cases. This might be behind a lot of the public feeling that charging young drivers so much is not fair because the arguments you hear are that a lot of young drivers are good drivers and you are charging all the young drivers because of a few bad young drivers.

MR. EHLERT: It might be actually statistically valid or maybe an accurate feeling on the part of the public that there are good young drivers and that it might not be equitable for the good young drivers to bear the whole subsidy of the bad young driver.

Part of the problem, too, is our annual rating system. If a company were sure that they were going to keep the same young driver when he started driving at 16, through the rest of his life, then, they might be able to work out some system where, if the driver gets to age 25 without having an accident, you return some money. This is similar to health plans where, if you do not have a claim for a certain length of time, you get the premiums back. But the marketplace itself, the competitive nature of automobile insurance and the fact that people often change insurers make it seem impossible.

On the young drivers, I would like to make one other statement. It seems that either one of two situations exists --- the younger drivers have something in their nature such that there are not that many good ones, or else underwriters cannot tell the difference. If you look at the residual market of the assigned risk plans, you will find that the experience of young drivers who are put into the assigned risk plans (probably because the underwriter does not want to accept the risk) is not that much worse than the

risks accepted in the voluntary market. And so it seems that the variance of each individual from the mean in the young driver category is much less than it is in the adult class. The experience for adults in the assigned risk plans is 50% or 75% worse than the adults in the voluntary market.

MR. SUTTON: How about using psychological risk analysis?

MR. EHLERT: There was a small company in Iowa which did this at one time I believe. I do not know if they are still doing it, but they were telling parents to pay $50 to have their son psychoanalyzed. If he turned out to be a stable risk, then they charged him lower rates.

MR. RONALD E. BACHMAN: I find it interesting when we talk about equity in the pricing structure. Of course, for pure equity we would wait several years and charge back to each individual the actual costs that were incurred. But the underlying concept of insurance is spreading of risk. Obviously, you have to have some kind of risk classification system. It is a matter of judgment which classification you want to take into account. I am sure all casualty people, as in health insurance, do not use the same classification schemes. Some companies find different classification schemes that give them a better rate structure if they can properly identify varying risks. So, in the marketplace there is a better product, and they have better customers. I do not feel that we can make up some arbitrary classification system because the marketplace will force us to a structure where the classes are equitably founded. Within a given range of classification, we have to have equity.

I would really like to comment that in group health we do not have quite the same degree of intervention that they have in the casualty lines. We certainly have statutory requirements like mandated coverage in certain states, but the actual intervention in certain states in the casualty lines, as in Massachusetts, where authorities are actually defining rate structures --- now that kind of scares me. Are there any suggestions as to how we can prevent this kind of development in the group health area?

MR. SUTTON: I do not know that I have any suggestions. The residual market, if you want to call it that in the group health line, is going to be a problem. There are three states with catastrophic health insurance laws which superficially sound like a Fair plan for individual health insurance risks. In Minnesota, and I am not an expert, they average the individual health insurance rates of the five largest writing companies and, if a company rejects the risk for health insurance, the risk is placed in a pool at a standardized rate. The State has provided some funds to cover the subsidy since the insurance companies claimed they would lose money. The plan has only been in force for a bit over a year. What happened is that the State did not believe the claim reserves set up by the insurance administrators, although a true claim level really has not emerged yet. While the State finally agreed to the reserves, they would not let the insurers recognize their reserves as part of the incurred claims in setting the premiums for next year and limited the increase to 25% (versus 100% estimated). I see in the Fair plans that the regulatory authorities are not likely to allow very much inflation in rates and similarly restrict increases.

The residual market is pretty small in the health insurance area and I frankly favored a well-designed state plan to pick up a residual market where the insurance companies would not have to subsidize it. The state should put up enough money to cover the excess cost over premiums, in effect, the insurance companies would administer it as intermediary. The Health Insurance Association of America has at times proposed programs like this.

I frankly think the individual market for basic health insurance will terminate. Eventually whatever form of National Health Insurance we get, or even an expanded Medicare-Medicaid program or catastrophic coverage, will seriously diminish the individual health insurance market. The group market will still exist somewhat the way it is today for a time but the costs are going up so rapidly that other forms of control --- whether governmental as in regulation of hospitals or HMOs or whatever --- are going to be tried to limit the employer's cost. You also have the employer interested in what happens to the individual's health care expenses, since the employer pays for most of it. Mass coverage will still minimize the availability and affordability problems seen in auto insurance.