RECORD OF SOCIETY OF ACTUARIES
1981 VOL. 7 NO. 2

RISK CLASSIFICATION FOR INDIVIDUAL HEALTH INSURANCE

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How has the present system evolved? What social goals underlie current legislative/regulatory trends in this area? What issues are likely to emerge? What role should actuaries take?

1. Rationale for risk classification in individual health
   Grouping like risks; use of benefit limits; broad vs. narrow classes; traditional view of "equity"

2. Update on current regulatory restrictions on insurer's ability to classify health insurance risks
   Extent of restrictions; social goals; consumerist's ideas of "equity;" concept of "actuarial justification"

3. Impact of regulations on traditional practices in pricing and plan design
   For medical expense insurance; for loss of time coverage

4. The health insurance risk-sharing pool; is this the answer?
   If so: who shall be covered? What benefits? Any limits? Who pays what costs? Role of actuaries in such programs?

5. What can actuaries do in their public role to respond to issues involving risk classification in health insurance?
   Recap of recent activity; setting goals for the future

MR. CHARLES HABECK: Risk classification is a very important issue for the insurance industry. As you can see from the program for this meeting, three sessions have been set aside to consider risk classification as it may affect various insurance products in underwriting. At this session, we wish to concentrate on health contingencies as opposed to life contingencies. Of course, the classification issues tend to overlap somewhat and there is even blurring with certain other issues such as privacy, loss ratio requirements, minimum benefit standards and so on. Much has already been said on this topic at various meetings of the Society of Actuaries and in formal statements by the American Academy of Actuaries. Some of these references are included in the list of readings that you should have picked up as you came in.

*Ms. Bach, not a member of the Society, is an attorney with the Office of the Commissioner of Insurance, State of Wisconsin.

Our first speaker is Alan Ferguson, Vice President and Actuary of the Prudential Insurance Company of America. Alan will present a review of the traditional practices in underwriting individual health insurance. He will then discuss the impacts of current regulation on the marketing of medical expense insurance, a field in which his company is one of the well-known leaders.

MR. ALAN N. FERGUSON: I am going to speak about health care insurance, the factors that are involved in risk classification and how we develop the information to classify people by those factors. Mainly, I will be talking about Prudential's individual health care product which we call CHIP. CHIP is a comprehensive major medical plan. It pays usual and customary doctors' charges and hospital semi-private room rates at an 80% coinsurance rate. Deductibles range from $100 to $1,000. We started issuing CHIP in 1973, and we have about 300,000 policies in force. They are all either individual contracts or family contracts. The premium rate is guaranteed for one year and the policy is renewable except under certain conditions.

What are the risk classification factors involved? The first factor involved in setting the rate for an individual is age. As an example of the variation by age, our rates for males at the oldest ages are four times what they are at the youngest ages.

We also vary our rates by sex. The rate for females is 50% higher than the male rate at the youngest ages, and is 10% lower than the male rate at the oldest ages. In New York, where we are obliged to provide maternity benefits, the rates for females, instead of being 50% higher than the male rates at the youngest ages, are 100% higher than the male rates. We also have a unique distinction in New York in that we vary the rates according to marital status. Because of the maternity benefits, we charge more for married women than for single women (reflecting our conventional view of the relative risks involved). In none of our other individual products is marital status a risk classification factor.

Health history is another factor involved for both our disability insurance policies and our CHIP policies. For CHIP we have five classes of risk. There is a standard class into which most people fall (about 85%) and then we have classifications ranging up to 100% extra premiums, depending on the health history. We reject 5% of the lives for health reasons, and about 5% of the policies have waivers attached. The sources of information which we use to establish these ratings are attending physician statements for about 35% of the cases, inspection reports for about 20% of the cases, and MIB reports for 100% of the cases. We do not use any physical examinations for CHIP.

Another possible risk classification factor is occupation. For CHIP we do not vary our rates depending on the occupation of the insured. There are, basically, two reasons for this. One reason is that it is not occupational coverage although I am sure that there are differences in the quality of risk depending on the occupation of the insured. But the main reason is a practical one. We have a wide variation of rates for other reasons (by geographical area, for example) and to complicate our rates by adding another factor for occupation just seemed to be too much. We do require attachment to a job and CHIP is not available if the job offers group

insurance. We do not want people coming into and out of our CHIP plan depending on when their group insurance has lapsed or when they are once again covered by group insurance. This can be quite a problem. So that we could offer coverage to those who do not qualify for CHIP (such as the unemployed, persons in the service waiting period for group insurance and so on), we have a single premium temporary insurance policy, which is available for 3 to 6 month periods and provides generally the same kind of benefits as CHIP. Although there is no underwriting, it has a pre-existing clause, which we do not include in CHIP.

For disability income, of course, we do have occupational classifications and we have four classes of rates depending on occupational classification. I should add that because of laws in Illinois and Ohio, we have provided disability income coverage to homemakers in those states which we do not provide elsewhere.

Another possible risk classification factor is income. Some people feel that income should be a factor for major medical coverage but again, in order to avoid complications, we decided not to use it as a factor with our CHIP policy.

Geographic area is a very substantial factor in our CHIP rating structure. The range in ratings by geographic area is about as broad as the range of ratings by age. Rates are established to zip code and range from a factor of 45% of standard in Vermont to 200% of standard in Los Angeles, reflecting the fact that the overall costs of providing medical care in Los Angeles are about four times what they are in Vermont. On the other hand, we do not vary disability insurance rates by area. We have noted differences in results by area, but so far the differences have not been sufficiently great for us to reflect them in our rates.

Smoking is not at present a risk classification factor for either our CHIP or disability insurance policies. Neither is drinking, per se, although evidence of excess drinking could result in an extra premium or even rejection. Avocations such as scuba diving, hang gliding, etc., would require an extra premium. We will not issue a CHIP policy if substantial other coverage is in effect, and the availability of disability insurance depends on what other coverage is already in force.

Up to present, I believe that, as far as risk classification is concerned, there has really not been much impact because of changes in laws or regulations. New York's mandatory maternity coverage required some changes in our policy. We have, as I indicated, provided disability coverage for homemakers in Ohio and Illinois, but we have had very few applications and they have not caused any problems. Because of various laws, we have been obliged to add coverage in CHIP; for example, coverage for alcoholism and drug rehabilitation centers. The laws pertaining to discrimination against the handicapped and the blind have proved not to be a problem. We did have one situation in Illinois where we, together with several other companies, were charged that we were discriminating against persons with a history of epilepsy. Resolving the problem was very interesting, and I think it illustrated that we do not do a very good job in developing statistical data on the effects of health histories on the cost of health care. Part of the problem is that in many situations involving serious impairments, we have declined to issue health insurance and so we have difficulty in finding data which would help to estimate the cost if insurance had been provided.

As a result of states' privacy laws, The Fair Credit Reporting Act, and the Privacy Commission Report, we have made some changes in our processing of applications for insurance, but none have been particularly onerous. There is more disclosure, and we give reasons for our underwriting actions directly to applicants, which was not done in the past. I think this is something that was long overdue and which we should have been doing without any regulations.

What about the future? I have emphasized the range in our prices for age and geographical area because I think that those are the factors that we cannot afford to be without. I think it would be virtually impossible to run an individual health insurance business if you were not allowed to classify your risks by age, geographical area, health condition or history, and occupation (for disability income). While I am convinced that there are basic differences in male versus female mortality, I think we could survive with unisex rates, although it would be more difficult if maternity coverage was mandated. I think it is possible to survive unisex rates because I think it may be easier to avoid anti-selection with sex than it is with the other factors. With our CHIP policy, we have approximately as many women insured as we have men. Over 90% of our disability insurance policyholders are males --- a situation which will probably change as more women move up through the work force. There could be problems with unisex rates for disability insurance but even though I would prefer not to have them, I think we could live with them.

MR. HABECK: Our second speaker is Mary Michal Bach. She is an attorney attached to the Office of the Commissioner of Insurance of the State of Wisconsin. Today she will tell us about the development of the Wisconsin Health Insurance Risk-Sharing Plan and describe how actuaries can become more involved in the legislative process.

MS. MARY M. BACH: In the past two years, during which I have been involved in the creation of Wisconsin's Health Insurance Risk-Sharing Plan (HIRSP), I have discovered two major bits of knowledge which will come as no surprise to you as actuaries. First, the health risk-sharing pool concept is the flip side of the discrimination issue as it relates to classification of individuals with physical or mental handicaps. That is, like prohibitions against risk classifications based on certain handicaps, the risk pool idea is based on certain key social goals which may clash head-on with long accepted insurance principles. Second, the role of actuaries in shaping legislation, regulation and policy is critical to the effective implementation of any risk-sharing pool, and that role is too often underutilized, particularly during the legislative process. Actuaries can be the bridges between high risk would-be insurance consumers and the industry, in our attempts to reconcile the goal of providing a funding mechanism to help people who would otherwise be wiped out by medical bills, with the goal of maintaining the basic principles underlying the concept of insurance.

These points impact on two key questions. First, can the health risk pool concept meet the needs of the people it was designed to serve? Second, what are the social costs involved in this approach?

The public served by the pool is that group of people considered to be medically high risk and, therefore, unable to obtain adequate health insurance coverage. These are the people who fall between the cracks. They do not have access to group health insurance. They do not qualify for federal programs such as Medicaid. They may be well able to afford insurance, if only it were made available to them. They may have catastrophic medical bills or they may never seek health care, but because of a condition such as cerebral palsy or diabetes or epilepsy or a history of psychiatric treatment or drug dependency are unable to purchase coverage.

The threshold issue is whether the particular individual is in fact high risk. The legislation in Wisconsin which created the Health Insurance Risk-Sharing Plan contained a provision prohibiting discrimination on the basis of physical or mental impairment in the absence of sound actuarial data or reasonably expected experience. As you know, this business of unfair discrimination is a hot potato: How can the industry rate individuals who have traditionally been uninsurable? What do we really know about ex-drug addicts or those who have received some psychiatric treatment in the past in terms of health care costs? One complaint received by our office involved a blanket denial of major medical coverage for a woman who received treatment for postpartum depression five years prior to application. On what basis can it be determined that this woman is not a standard risk? To go into the issue of unfair discrimination in more depth is beyond the scope of this panel discussion. However, it is important to emphasize that the pool, in Wisconsin at least, is for those who are in fact high risk. We will have to do some searching to obtain credible statistical data, and it will likely be necessary to go outside of the industry, to government programs for instance, in order to determine actual costs for covering certain classes of individuals.

MR. FERGUSON: It is not always going to be possible to develop statistical data. Sometimes it will take years to see the results of a new method or treatment. Therefore, there is some subjective judgment involved which has to be allowed.

MS. BACH: It is an aspect that everyone is struggling with now. Having identified the group of people to be served as high risk individuals, what more can be said about them? In Wisconsin, we saw various advocacy groups emerging as particularly forceful lobbyists: mental health organizations, epilepsy groups, parents of children with cystic fibrosis. We also saw a strong push from rural, agricultural interest groups, since high risk people in farming communities can be expected to have less access to group insurance.

As an important aside, another piece of legislation was passed by the Wisconsin legislature at the same time as HIRSP. Chapter 285, Laws of 1979, mandates that terminated group insureds be offered the opportunity to continue to receive up to 12 months of group coverage at the group rate, and the right to convert to individual coverage at the end of 12 months. This measure is expected to greatly limit the number of people who will fall between the cracks and therefore require a subsidy through the risk-sharing plan.

It is clear that both government and industry are committed to the health insurance risk-sharing concept. President Reagan considers it the preferable alternative to National Health Insurance. The U.S. Senate Committee on Finance recommended it as an integral part of its employment based catastrophic health insurance program. The Health Insurance Association of America is studying the potential for federal and state solutions and analyzing how state plans should be structured.

The policymakers and the affected interest groups agree that there should be a funding mechanism for those who are medically uninsurable. The question is: How can this funding mechanism be designed in a manner consistent with meeting the needs of medically uninsurable people while being mindful of the social costs involved, which must be borne by another segment of the population, either taxpayers or the insured public?

In designing a state plan, the basic questions are: Who will be covered? Who will pay? What will be covered? How will the plan be administered? These questions are largely determined by legislators, often without much assessment of needs, probably without much actuarial participation, perhaps without consciousness of the trade-offs being made, and subject to political whims. Implicit in this critique of the legislative process is a suggestion for actuaries to get involved early and to make yourselves available to lobbying groups, because your expertise is vital to the process. Actuaries can provide a service both to consumers and to the industry. As I said earlier, you can build bridges by explaining the impact of certain mandated coverages, length of pre-existing conditions limitations, caps on premiums, etc. on the cost of the program. You can explain what the public will be getting and what they will be giving up.

I would like to explain what I mean by picking several key provisions in the Wisconsin law and comparing them with corresponding laws in Minnesota and Connecticut, the only other states with ongoing major medical health insurance risk-sharing plans.

ELIGIBILITY

I think eligibility is the first critical area to examine. The Wisconsin plan allows for coverage of Wisconsin residents who are less than 65 years old, not eligible for Medicaid and who have received one of the following:

A notice of rejection or cancellation from two or more insurers.

A notice of reduction or limitation which substantially reduces benefits compared to benefits available to standard risks.

A notice of an increase in premium by 50% or more unless the increase applies to substantially all of the insurer's health insurance policies then in effect.

A notice of premium for a policy not yet in effect from two or more insurers which exceeds by 50% or more the premium charged a standard risk.

Coverage does not extend to families of individuals who meet the eligibility requirements.

The differences in the plans for Wisconsin, Minnesota and Connecticut reflect significant policy decisions. First, in Minnesota and Wisconsin, only those residents who have proof of medical uninsurability are eligible. In Minnesota, this does include families of uninsurables. In Wisconsin it does not. In Connecticut, the comprehensive health care plan is available to all residents of the state who are not eligible for Medicare, regardless of insurability. This distinction represents a major policy decision. Should this particular kind of funding mechanism be available to all? Connecticut may be in a better position to keep plan costs down since standard risks are allowed to participate, and at some ages actually find plan rates lower than individual coverage. The question of whom to subsidize is a major policy decision with significant cost implications. Actuarial expertise should be utilized to define the likely impact of either choice.

Likewise, the impact of offering or not offering family coverage could significantly alter the cost of the plan. Some industry lobbyists in Wisconsin sought to strictly limit coverage to only high risk individuals. They argued, successfully, that other members of the family could get coverage elsewhere. In Minnesota, a selected group of standard risks has been brought into the plan, based on a policy decision that if one member of a family is high risk, the entire family should have access to the state plan coverage. There is some indication that allowing these standard risk people to enter the plan also lowers plan losses. Again, this illustrates an important policy decision, one where actuarial cost projections could be helpful in the decision-making process.

Wisconsin and Minnesota offer a Medicare supplement. Wisconsin's is only for those under 65 who qualify for Medicare on the basis of disability. Minnesota's is only available to those age 65 and over. Once again, legislative lobbying influenced these policy determinations. In Wisconsin, the rationale was that those who are eligible for Medicare on the basis of age already have access to Medicare supplements regardless of health condition, since several individually marketed Medicare supplements have open enrollment for those who qualify for Medicare on the basis of age. Yet, these policies are not available to those under age 65 who qualify for Medicare on the basis of disability. This is another potential area for actuarial participation during policymaking.

Critical to the eligibility determination process is the "two rejections" requirement in Wisconsin and Minnesota. Seen as a protection to keep standard risks out of the plan, both states may have overlooked the costs involved in requiring that individuals who are clearly uninsurable go through the underwriting process twice. It is a matter of continuing controversy in Minnesota, and will likely be controversial in Wisconsin as well. Again, it is an area where policymakers need to understand, from a cost perspective, the kinds of trade-offs being made.

There is a major difference in Connecticut, not only in terms of eligibility criteria, but also in terms of marketing. In Connecticut, the plan may be offered directly by the insurance company when an adverse underwriting determination is made, or the applicant may be referred to the Health Reinsurance Association, at the option of the company.

It should be noted that while the Health Reinsurance Association pools its risks among members, Blue Cross and Blue Shield of Connecticut have been permitted to offer the state plan separately. Therefore, there are a large number of standard risks entering the state plan through Blue Cross and Blue Shield, and this may lower plan costs.

FINANCING

A second major consideration is analyzing the risk pooling concept and comparing the three states' approaches is the question of who pays for it. Under the Wisconsin law, the plan is designed to be self-sufficient after its first three years of operation. For the first three years, premiums are limited to 130% of the standard individual rate for comparable coverage. Rates are set by rule by the Commissioner of Insurance. Health insurers, including health maintenance organizations and self-insurers, are assessed the difference between plan costs and premiums collected, based on the ratio of the premium volume, subscriber charges or self-insurer costs of each to the aggregate. The self-insurer question is now in litigation in Wisconsin. It is unclear whether the states will be able to include self-insurers in this type of assessment. This is similar to the Connecticut approach, except that in Connecticut, rates for the commercial pool may not be less than 125%, or more than 150%, of the average group rate charged for a group of ten lives. Connecticut, like Wisconsin, assesses insurers for plan losses. Unlike Wisconsin, it provides a mechanism for some flexibility in rate setting. The statutory language in Wisconsin has been a thorn in the side of the plan's actuarial committee, since the 130% maximum creates a very steep slope in terms of age. Premiums rates for 1981 range from $330 per year for a major medical plan participant under age 30 to $1,560 per year for persons ages 60 - 64. These rates were established to reflect 130% of standard rates for persons in those age groups, however, it is doubtful that these rates reflect actual costs for people who are medically uninsurable. It seems likely that uninsurable children should be rated much higher than 130% of standard and uninsurable 60 - 64 year olds much lower. This is just another example of the need for actuarial participation in shaping legislation. The HIRSP actuarial committee is currently studying the rating system, and it may take legislative action to establish a more equitable set of rates.

Minnesota sets rates at 125% of the average rates charged for standard individual coverage by the five leading insurers. Under this formula, premiums for the plan are actually lower than equivalent plans offered by some companies. Minnesota began with an assessment mechanism similar to that of Wisconsin and Connecticut, but has since gone to an offset of premium taxes as the means of financing losses of the plan which, by the way, are averaging about $100,000 per month after four years of operation. Given the unwillingness of state legislators to increase the tax burden during the current fiscal climate, it appears unlikely that Wisconsin or any other state will adopt this financing mechanism in the foreseeable future.

What is the outlook for future financing? Wisconsin law calls for the plan to be self-sufficient within three years. Clearly, this is unrealistic if the plan is offered only to medically uninsurable people. In Minnesota, where rates are set at 125% of standard individual rates, approximately 2,000 persons are insured under the plan, after four years of operation.

Affordability is considered to be the primary reason why the number of plan participants has not been higher. If they are to succeed, there is no question that plans covering only uninsurables will require a subsidy. The only issue, and one in which actuaries must play a central role, is how much of a subsidy. At what point on the scale will the premium rate put the plan in competition with insurance companies offering standard coverage? At what point on the other end of the scale will adverse selection increase to the extent that the plan collapses? One possibility is a sliding scale mechanism, based on ability to pay. Also, as we scrutinize federal programs such as Medicaid, it is important to see the interface of how state plans pick up where federal government programs leave off. How and to what extent the plans should be subsidized are matters of broad social importance.

COVERAGE, DEDUCTIBLES, PRE-EXISTING CONDITIONS, MAXIMUMS

Other important considerations, largely determined by state legislators, include coverage, deductibles, pre-existing condition limitations and maximum benefits.

All three states have very broad coverage. In Wisconsin this includes a variety of benefits mandated under other statutes, such as home health care, skilled nursing home care, and coverage for nervous and mental disorders, alcoholism and drug abuse. A choice of deductibles is offered in Connecticut ($200, $500 and $750) and Minnesota ($500 and $1,000), but not in Wisconsin, which has only a $1,000 deductible for major medical coverage. How this high deductible will affect entry into the plan remains to be determined.

A critical consideration in developing a risk-sharing plan is the pre-existing condition limitation. Wisconsin has only a 30-day limitation for illnesses or injuries diagnosed or treated within the six month period prior to application. This has been soundly criticized by those who believe it will encourage disastrous adverse selection. Proponents of the short pre-existing condition provision argued successfully to the legislature that victims of disease who incur catastrophic medical expenses and who find themselves ineligible for other coverages will be wiped out financially, and will be forced into requiring government assistance if they have longer waiting periods. Once again, the jury is out on what long-term effect this liberal provision will have for the plan. Perhaps it will be counterbalanced by the provision in Wisconsin prohibiting reentry into the plan for 12 months after voluntarily terminating. Minnesota has a six month pre-existing condition limitation, while Connecticut's limitation is 12 months. Connecticut, of course, offers coverage to standard risks to whom the waiting period is much less significant. It will be interesting and useful to compare plan participation and costs, based on differing pre-existing condition limitations, as risk-sharing plans are developed in other states.

In conclusion, more and more states are currently in the process of enacting health risk-sharing pool legislation. As this trend is expected to continue, the role of actuaries becomes increasingly important.

Based on the Wisconsin experience, I would like to suggest a few areas where I believe actuarial expertise is particularly important.

1. The legislative process. Actuaries are in an ideal position to point out trade-offs as legislation is being developed. What level of benefits should be provided? What deductibles? How should rates be set?

2. The rate development process. Should standard slopes apply to a substandard population? Perhaps in dealing with high risk individuals, traditional cost assumptions will no longer be valid.

3. Record-keeping. It will be important for the success of these plans to identify plan participants and their level of usage of plan benefits.

4. Calculation of assessments. How will plan costs be projected? There are important political reasons for keeping assessments as low as possible, while ensuring that plan reserves are sufficient to cover claims and administrative costs.

I am grateful for this opportunity to let you know how important, even critical, I believe actuarial participation is during every step in the process. We have been very fortunate in Wisconsin to have the strong commitment of actuaries who are able both to communicate the needs of the industry and to recognize the importance of providing a viable system for meeting the needs of the medically uninsurable.

MR. ANDREW M. PERKINS: In the case of a plan where standard risks are eligible to participate, such as in Connecticut, do you feel that there should be any notification to potential participants that it is a substandard plan?

MS. BACH: I think that it is an excellent idea. I do not know if it is being done in Connecticut, but I think that kind of notice would be an effective means of providing consumers with the information that if they are standard risks, their rates may be subsidizing people who are high risks.

MR. FERGUSON: I think as a practical matter, that is already taken care of. These plans are issued either by the Health Reinsurance Association or I think there are two companies who have their own plans. These people are approached by agents who are going to sell them their companies' plans, and it is only if they turn out to be unacceptable that it would make sense for them to buy the Connecticut plan.

MR. PERKINS: I think it may be different with respect to Blue Cross.

MS. BACH: Because this is the only individual major medical plan Blue Cross and Blue Shield of Connecticut offer, they are indeed offering it to a large number of standard risks. They are now covering approximately 7,700 people in Connecticut, and it is found that particularly men at the younger age group find this to be a better buy than other individually marketed comparable plans. So there is an issue here, and in fact it has become a rather sticky one in Connecticut because the rates under the Blue Cross and Blue Shield plan are actually lower than the plan offered

through the Health Reinsurance Association, which is the association of all the other insurers who participate and pay assessments based on their market share. There is some question about how these two plans are going to continue to function given the rate differential and given the fact that the Health Reinsurance Association is losing money at the rate of $250,000 to $300,000 per year. The notice question is therefore quite important. If standard risks are buying into this insurance plan, they should know that they are buying into a plan that is also being made available to people that are not standard risks.

MR. HABECK: Our third speaker is Andy Perkins, Actuary for the Travelers Insurance Company. He will discuss some of the impacts of current regulation on the marketing of disability income insurance and future trends that will affect us.

MR. PERKINS: There has already been a tremendous number of regulations in the general area of risk classification, but I am in general agreement with some of Alan's comments that so far there has not been an overwhelming impact on individual health insurance. There have been some restrictions on availability of coverage and we have to justify pricing differentials, but this has not had too severe an effect on our industry. There is a potential in the future for a very drastic impact on individual health insurance for both disability and medical expense coverages. It is something we have to watch very carefully and we should participate in the decision process as much as possible.

One of the things that could happen to us would be to have unisex ratings required for all individual health insurance plans. That would certainly be a very radical change. It is well documented that there have been significant differences in claim costs between females and males, and I am not aware of any individual disability plans where coverage is voluntary that currently use unisex rates. There is general concern within the industry that such a requirement would, because of a mismatch between price and value, result in less widespread purchase of insurance among healthy males and raise the overall cost. Such a result would not benefit either the industry or the public. A second possibility is mandated maternity coverage. The cost of such coverage would be very significant and there are very serious questions about whether it is in the public's best interest to include it in voluntary insurance plans.

Many other restrictions have also been proposed, from requirements that standard rates be used for individuals with medical or physicial disabilities, to requirements that preferred rates be used for specialized groups. During the last few months, bills have been proposed in the Oregon and Massachusetts legislatures which would require lower rates for non-smokers. Generally, enacted state regulations with respect to rate differentials are reasonable, in that they permit premium differentials when justified by historical experience. In the future, however, we can certainly expect different groups within the population to press for the elimination of pricing differentials. They might use as arguments questions about the credibility of the data, contentions that experience is changing, or general arguments about the legal rights of individuals not to be classified with groups.

Finally, other characteristics such as age, occupation, and geographic region, could potentially be restricted or barred from use in our classification schemes.

Questions related to classification by sex have been at the forefront of current discussions, and I think they provide a good indication of the arguments that can be used against different criteria in our classification systems. An important example is provided by the deliberations of the NAIC Task Force on Sex Discrimination. During 1978, that special Task Force recommended to the Life, Accident and Health Technical Subcommittee that unisex rates be mandated for all health insurance. They also proposed that maternity coverage be mandated in accident and health insurance contracts. They then suggested that existing state regulations should be reviewed with respect to their requirements on those two points. The industry, through the HIAA and ACLI and also through the American Academy of Actuaries, provided voluminous statistics documenting experience differences between females and males. The sources used included the Reports of the Society of Actuaries for both group and individual disability, and for individual hospital and medical expense insurance, Social Security disability data, statistics from the New York State Insurance Department's study of male and female disability claim costs, work loss days and other statistics from the Public Health Service's Vital and Health Statistics, and other miscellaneous information.

Generally a very reliable and familiar pattern appeared. The female claim costs, after adjustment for occupational differences and some other differences in the data, were somewhat higher at the lower ages, substantially higher between the ages of 30 and 50, and the ratio would decline to unity or below unity at the older ages. The NAIC has not yet acted on the Task Force's proposals. It is still possible that legislation could be imposed upon us either on a federal or state level.

Even if we are not required to use unisex rates, I feel very strongly that the industry should be careful to watch the trends in the relationships between female and male claim costs. I have some statistics from the Society of Actuaries biennial individual disability reports for both the 30 day elimination period and 0 - 7 day elimination period. These are ratios of female claim costs to male claim costs for all ages combined. For each elimination period a uniform age distribution was used for both sexes and for all biennial periods to eliminate changes in the age distribution. You can see that there was a steady decline in the ratio of female to male claim costs through the study for 1974-1975. The decline offers a suggestion that the relationship in our experience is changing. For the last biennial study, the numbers jumped back up to a point almost as high as a decade earlier. That may be at least partially due to a significant change in the list of contributing companies.

Certainly there are questions as to the credibility of the data. In addition to the change in contributing companies, other variables may have changed during this fifteen year period. I think it suggests that we should not be too complacent about the accuracy of data that we have used in the past. I should also point out that, although the ratio of female to male claim costs seems to be declining, when the data is broken down into separate age groups there are still very substantial differences at the younger and middle ages. Another point should be noted. The 0 - 7 day elimination

INDIVIDUAL DISABILITY INCOME

RATIO OF FEMALE TO MALE CLAIM COSTS

CLASS I

YEARS	ELIMINATION PERIOD	
	30-30 DAYS	0-7 DAYS
1962-1963	---%	136%
1964-1965	---	124
1966-1967	165	126
1968-1969	162	119
1970-1971	149	117
1972-1973	135	102
1974-1975	127	106
1976-1977	163	122

period statistics seem to indicate a closer relationship, but that is partially explained by the fact that an older age distribution was used, and we recognize that the female to male claim cost ratios are not as great at those older ages.

It is not surprising that the statistics could change. While there are permanent, universal physical differences between the sexes which can cause differences in health insurance claim costs, there are many other things which affect claim costs. Some of these things are work attitudes and work pressures, attitudes about careers, degree of dependence on earned income, differences between the sexes in participation in hazardous occupations or hazardous duties within an occupation, and life style differences - diet, smoking, exercise patterns. Many of the things that the industry has long believed affect disability claim costs, and which may have contributed to the relative levels of female and male claim costs, are changing in our society. Some of those changes would probably be expected to cause increases in the differences, whereas others would be expected to decrease those differences. We should be watchful for the impact on our statistics.

If unisex rates are required, I do not believe any contractual changes would be effective in eliminating the actual experience differences. I also do not believe that the industry is likely to try to redirect its marketing efforts to the male segments of the population, even if it were legal to do so. I suppose it is possible that unisex rates for individual disability insurance might not be devastating. A minority of the business is currently written on females, so if we had to use unisex rates the effective rate increase for males would be low enough to avoid discouraging most healthy males from purchasing coverage. There would probably be some change in the overall cost. Companies with a different distribution by sex could be more seriously affected, as could the medical expense line, since it probably has a much more even distribution by sex.

What concerns me most about the potential for a mandate of unisex rates is that I think it could be the beginning of much more serious changes limiting other classification factors. If we are prohibited from differentiated premiums for males versus females, it will be in spite of the documented differences and experience. I suspect the reasons for such a prohibition would be the legal arguments for individual rights which seem to be central to the civil rights and equal opportunity movements in our country. Those legal arguments would be equally applicable to our other classification factors, certainly to age and geographic regions, and perhaps even to occupation, which we consider crucial for disability insurance. I doubt very much whether our industry could remain stable without these other major classification factors.

For those of you who are interested in risk classification, I strongly recommend that you read a recent article from the University of Chicago Law Review entitled "Sex Discrimination in Employer-Sponsored Insurance Plans: A Legal and Demographic Analysis." While not dealing specifically with individual health insurance, this analysis documents and clearly expresses many of the major arguments against the use of sex as a tool in risk classification. There are people taking that position who have analyzed the issues extensively, who have organized their presentation, and who can heavily influence both the public and the courts. If we are

concerned that our industry cannot survive under a scenario that will eliminate the classification factors which we are now using, and I am concerned with it, then we must do our homework as well as those in favor of changing our classification system. We must show why it would create serious problems for the insurance system to eliminate those classification factors, and we must explain clearly to the public the effect of such a change.

MR. JAY C. RIPPS: Recently, Senator Hatfield, in introducing the Women's Economic Act of 1981, gave out a press release which said that disability coverage in some states is not available to women at any price under any conditions. Is that true?

MR. FERGUSON: No, it is not. It is not available to certain classes of risks, but this is not on the basis of sex. Any homemaker, male or female, who is not earning an income is not, in our opinion, a desirable risk for disability income insurance.

MR. PERKINS: I think it is a very tough issue because the contribution a homemaker provides to the family is valuable and there is an economic loss when the homemaker becomes disabled. However, it may not be an insurable risk.

MR. FERGUSON: Despite our reluctance and skepticism about homemakers coverage, I think minimum amounts can be made available. It has not hurt us in Illinois and Ohio, and I think it could be made available elsewhere too.

MS. BARBARA J. LAUTZENHEISER: This is one of the issues where there has been confusion between sex and occupation. When you are discussing the homemaker, the classification is occupation, although it is often equated to the sex instead.

I wanted to share some perceptions that I think have been underlying to the risk classification issue and how they may be changing. There has been confusion as to what the differences are of accomplishing things through a social program versus a free market program which has led to the pools. How much social policy can be effected through the voluntary market system? How much subsidization should there be, if any, and at what level? It really stems from two definitions of equity. Depending on whether you are a "preferred" risk or a "substandard" risk, equity is defined as equality (paying the same price) in one case, and in the other case equity is defined as in the preferred rates for non-smokers. In the past, we have had more pressures toward the equality definition, especially from the disadvantaged groups. I see now a trend in the other direction. With the inflationary economy, people are becoming more protectionist and there is more anti or reverse discrimination on the forefront. Do any of you see such a trend?

MR. FERGUSON: We have state pools because as a society we generally believe that everyone should be entitled to health care insurance. Unfortunately, with the high prices of today, this insurance is often unaffordable for the poor risks, and sometimes even for standard risks. These pools must somehow be subsidized, since there is a limit to how much a person can pay.

Barbara, were you suggesting that there may be a limit on how much the private sector can subsidize, and that the additional subsidies necessary should be provided from tax revenues?

MS. LAUTZENHEISER: I sense that people feel that since they can hardly pay for the insurance they need, they are questioning how much they are willing to subsidize other people.

MR. FERGUSON: I think the funds are more likely to come from the insurance industry, self-insurers, Blue Cross, Blue Shield, etc., because it is less easy to identify these funds. If the subsidies were to come from tax revenues, income taxes and sales taxes would have to be increased and this would be readily identifiable. There are not enough tax revenues to cover state expenses even without paying for any health income subsidies.

MS. BACH: In the Wisconsin experience, many people argued that the system should be financed through the taxpayers. The Wisconsin legislature, however, was not going to enact a plan that would have a fiscal note attached. I think we are going to see more of this attitude.

MR. HAROLD N. DERSHOWITZ: What impairments which the insurance industry has traditionally considered uninsurable have been accepted officially by the Wisconsin department, if any?

MS. BACH: None have been officially accepted. Everyone, regardless of impairment, has to go through the eligibility process which I mentioned earlier. There are no disabilities which automatically qualify a person for the plan.

MR. DERSHOWITZ: Doesn't the insurance company have to justify to the department why the person was rejected?

MS. BACH: There is no requirement that the company justify a rejection, but whenever a person is rejected due to an adverse underwriting decision, the company must send a notice to the applicant with information about access to the Wisconsin plan. If a person thinks they have been unfairly discriminated against, they may submit a complaint to the Office of the Commissioner. The Complaint Bureau would then ask the company for actuarial justification of the rejection.

MR. DERSHOWITZ: Have there been questions of discrimination against the handicapped?

MS. BACH: Our office is just now beginning to receive inquiries and complaints from would-be consumers who are unable to get coverage. As was pointed out today, it is tremendously complex to deal with these cases because there is often no experience to determine whether the decision is a result of fair or unfair discrimination.

MR. ROBERT SHAPLAND: I have several questions or observations:
First, I wonder if substandard risk pools can work with self-sufficient premiums as the law calls for in Wisconsin. I would guess that this would be changed as it was in Minnesota. Rate increases to cover substandard morbidity could drive out the better risks and create never ending anti-selection cycles.

Second, unisex disability rates have been in use for many years in the individually solicited franchise market for members of occupation associations.

Third, disability insurance has been available to homemakers, I believe nationally, for as long as 30 years or more, since it has been marketed that long by Mutual of Omaha.

Fourth, I wonder if a citizen's responsibility to himself and to society has been discussed when substandard risk pools are being debated. When considering such pools, shouldn't there be a penalty for citizens who choose not to enter insurance pools when they are healthy but instead wait until they are impaired? The minimum penalty should be a premium at least 50% higher than normal and a waiting period considerably longer than the 30 days in Wisconsin.

Lastly, I believe that the use of surrogate rating factors will be related to the degree of price competition in the marketplace. Where price is important, competitors will look for ways to gain a competitive advantage. Our simple way to do this under unisex rating is to rate by occupation. This is because there are many occupations which are made up of mostly one sex.

A Selected List of References*

1. The Society of Actuaries Record contains many discussions of risk classification at prior concurrent sessions. These include:

   a. Volume 1, Number 1. Los Angeles, 1975. Pages 11-20.
   b. Volume 1, Number 2. New York, 1975. Pages 217-230.
   c. Volume 2, Number 2. Houston, 1976. Pages 363-382.
   d. Volume 2, Number 3. Chicago, 1976. Pages 567-582.
   e. Volume 3, Number 4. Boston, 1977. Pages 703-717.
   f. Volume 4, Number 1. New York, 1978. Pages 23-75.
   g. Volume 4, Number 2. Dearborn, 1978. Pages 443-470.
   h. Volume 4, Number 3. Portland, 1978. Pages 639-654.
   i. Volume 5, Number 2. New Orleans, 1979. Pages 123-134.
   j. Volume 5, Number 3. Banff, 1979. Pages 639-663.
   k. Volume 6, Number 1. Hartford, 1980. Pages 165-183.
   l. Volume 6, Number 2. Minneapolis, 1980. Pages 397-416.
   m. Volume 6, Number 3. San Diego, 1980. Pages 857-873.

2. The American Academy of Actuaries has also prepared statements about risk classification, including:

   a. Report of Academy Task Force on Risk Classification, August, 1977.
   b. Risk Classification Statement of Principles - Exposure Draft. October 19, 1979.
   c. Risk Classification Statement of Principles. June, 1980. Final.
   d. A number of statements on this subject are contained in the Journal, American Academy of Actuaries, 1980, q.v.

* Presented as a resource aid to those who attended this session.

3. Some other important references are:

   a. "Challenges to Sex-Based Mortality Tables in Insurance," by Jeannette Blevins. Women's Rights Law Reporter 6 (Fall/Winter, 1979-1980), pages 59-83.
   b. "Sex Discrimination in Employer-Sponsored Insurance Plans: A legal and Demographic Analysis," by Lea Brilmayer, Richard W. Hekeler, Douglas Laycock, and Teresa A. Sullivan. University of Chicago Law Review 47 (Spring, 1980), pages 505-560.
   c. Case, Daniel F., "1979 Bills on Risk Classification." Newsletter, The American Academy of Actuaries 8 (May, 1979), pages 8-9.
   d. "EEOC Affirms Use of Unisex Mortality Tables." The National Underwriter (L/H), November 29, 1980, page 9.
   e. "Shock Waves from the Manhart Case," by Albert B. Lewis, New York State Superintendent of Insurance. The National Underwriter (L/H) in three parts: March 7, 1981, page 11+; March 14, 1981, page 13+; March 21, 1981, page 11+.