RECORD OF SOCIETY OF ACTUARIES
1982 VOL. 8 NO. 4

THE FUTURE OF INDIVIDUAL COMPREHENSIVE MEDICAL EXPENSE INSURANCE

Moderator: ALAN N. FERGUSON. Panelists: PAUL BARNHART, WILLIAM F. BLUHM, JOHN B. CUMMING

- Recent history and financial experience
- Plan design and methods of obtaining satisfactory experience
- State regulation
- Future trends and alternatives

MR. ALAN N. FERGUSON: I'd like to set the stage for our discussion this morning by recounting a rather sorry tale of Prudential's experience with our "Coordinated Health Insurance Program" (CHIP). Let me start by reviewing its brief history. We introduced CHIP in 1973 with two plans: a major medical plan and a major medical 80 plan. The major medical had some first dollar options. Under the major medical 80 plan, all charges were subject to a deductible and then 80% coinsurance. Both plans covered semi-private room rates and reasonable and customary surgical charges. Originally the only deductible was $100. In 1975 we eliminated the pre-existing condition exclusion, thinking that since we were underwriting we were taking care of most of the pre-existing conditions and that if we found that there were conditions which we did know about, we could lift or reform the policy. Originally we didn't have any waivers--we simply rated policies that were substandard--but in 1976 we started using waivers. We found that the turnover on the business was much more than we had anticipated and so in 1976, to reduce the lapse rate, we limited sales to those we felt were attached to a job and didn't have group insurance available--namely, we stopped selling to the unemployed and the newly employed. That did reduce the lapse rate somewhat. We came to realize that larger deductibles than $100 were necessary so we introduced $300 and $500 deductibles in 1977.

Our commission scale at the outset had been 25% first year and 6% renewals. About a third of our business was sold by brokers, with the balance split evenly between our two agency forces. In 1977 we flattened the brokerage scale, changing it to 15% first year and 10% thereafter. In 1978 we eliminated a limit that we had on outpatient charges for mental illness. We were obliged to do so in California as a result of a suit related to our contractual wording. For consistency, we decided to remove the limit everywhere and that was probably an unfortunate decision.

In 1979 we introduced a $1,000 deductible option. We also introduced TEMP, a policy very much like CHIP but only available for a term of 3 months or 6 months. TEMP was a further attempt to avoid selling CHIP (which was designed for the long term) to people who really didn't need a long term plan. Then in 1981, when things were rapidly getting worse, we reduced the brokers commission scale on CHIP to a level 10%. Finally, at the end of the year and in the face of persistent and heavy losses, we declared a moratorium on CHIP sales and we have not resumed its sale since then.

CHART 1

CHIP ISSUES AND INFORCE

NUMBER OF CASES (THOUSANDS)

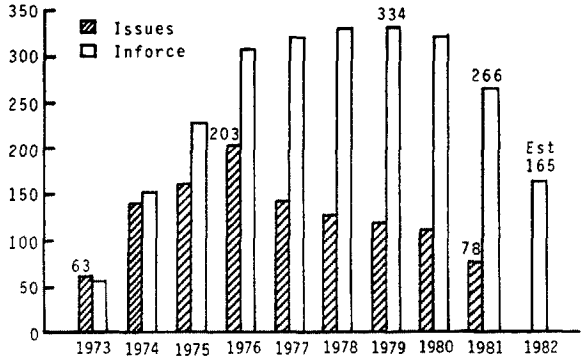
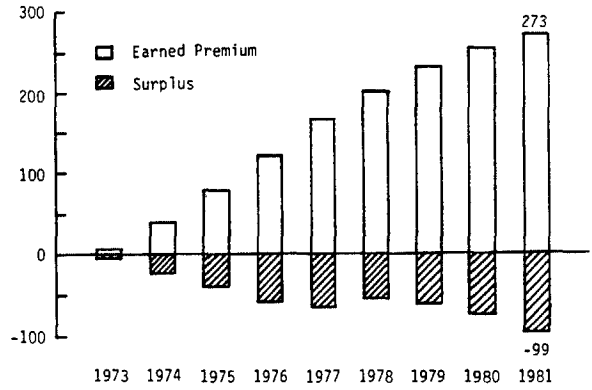


Chart I shows the progression of our issues and our inforce. We hit our high point in sales in 1976, selling over 200,000 policies. Sales declined from that point as other companies were getting into the business and our rate increases were beginning to be quite substantial. We reached a high point in our inforce in 1979 when we had over 330,000 policies in force. We estimate that by the end of 1982 the inforce will have declined by more than half from that high point.

CHART 2

CHIP FINANCIAL RESULTS

(MILLIONS OF DOLLARS)



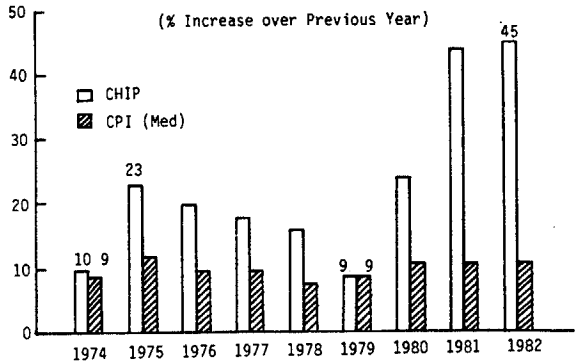
Our financial results are shown in Chart 2. At the end of 1981 earned premium had risen to 270 million, the amount of premium increase caused by higher premium rates having more than offset the reduction in the number of cases in force. Our surplus never got above zero. In 1978 we had positive earnings reducing our accumulated deficit by a very small amount, but that was the only year that happened and at the end of 1981 our accumulated deficit was almost $100 million.

What about our rate increases? We make them once a year beginning March 1 --policies reaching their anniversaries on and after that date are subject to the new scale. Chart 3 shows the rate increases and compares them with the consumer price index for medical care which has run about 10% for each of the years shown. Our rate increases were down to 9% in 1979. Since then, they have run as high as 45% (in 1982).

CHART 3

CHIP RATE INCREASES

COMPARED WITH GROWTH IN THE CPI FOR MEDICAL CARE



Why are rate increases so high? I have said that the annual CPI growth has been about 10%. The CPI measures the price of a package of medical services, but it does not measure other factors such as the rate of utilization, new procedures, federal cost shifting, and the leveraging effect of higher deductibles. Perhaps with all of these together you can get a trend of healthcare cost increases of close to 25%. Why are CHIP's rate increases so much higher?

CHART 4

CHIP TREND AND RATE INCREASE HISTORY

Effective Date (March 1)	ANNUAL TREND			ACTUAL RATE INCREASE
	Latest Available	Actually Used	Ultimately Emerged	
1976		17.8%		19.6%
1977		17.8		17.5
1978	16%	17.8	18%	16.1
1979	17	13.9	21	9.3
1980	22	13.9	27	24.4
1981	28	24.0	42	43.6
1982	32	32.0		44.6

Chart 4 shows the same CHIP rate increases as were shown in Chart 3. In developing these increases, we used trend factors for increases in claim rates shown in the column headed "Actually Used". Now when we're selecting the trend to use, we are selecting it much in advance of the date that the rates are actually put into effect. The latest trends that were available for our review at the time that we selected those trends are shown in the column headed "Latest Available". For the rate increase effective in March 1978, we were looking at the third quarter of 1977; comparing our healthcare costs then with our experience a year before, we found that the increase in healthcare costs was about 16%. We actually used 17.8%, the same trend we had been using for the prior two years. The resulting rate increases (averaging 16.1%) went into effect on policy anniversaries ranging from March 1, 1978 through to February 28, 1979, and the rates remained in effect for a year after that so that the period over which these rates were in effect was two years from the date that we first put them into use. On the average over that period we found that the actual trend that we experienced was not 16% but actually 18% (i.e., close to the 17.8% we assumed). More recently, for the March 1, 1981 rates we used a trend of 24% which was actually less than the trend that we seemed to be experiencing (about 28%). It produced a very high rate increase (43.6%) and caused substantial problems in getting approval from state insurance departments, but the actual trend which we have experienced to date is 42%. Last year about this time, when we were filing for our rate increases to be effective in March 1982, we used a 32% trend because that was about what we were experiencing but our latest actual trend figures are way above that, even above the 42% level.

Why are the trends so high? Why are they so much higher than the 25% that might be considered a basic level, a combination of the cost price index figures and all the other factors I mentioned? Well, one of the factors is CAST, the Cumulative Anti-Selection Theory which is the subject of a paper by Bill Bluhm. It seems clear to us that a very significant part of our problem has been caused by the cumulative effect of policyholders selecting against the company, aggravated by the size of the rate increases which we've been obliged to make. For example, a family in their 40's with children can easily be spending $300 a month for a health insurance plan. Now if there's a chance that they're not going to need that plan and they'd rather spend the money on something else, there's a good probability that they'll drop it. If there's a chance, however, that they're going to use that plan--if somebody in the family has a health problem--then the likelihood is that they'll keep it.

What can be done about this? One answer is to do what we did--get out of the business. We stopped selling the CHIP product at the end of 1981 and we still do not at this time have an individual health product, other than the short-term TEMP product. Another solution might be write short term contracts (longer than TEMP, but still limited in duration) so that you don't get the accumulative effects of anti-selection. Another possibility might be to anticipate CAST (and this is something that Bill has written about in his paper) charging enough at the outset and holding back enough in reserves to provide for that rainy day when this accumulative anti-selection begins to have a significant effect. Bill's paper deals mostly with hospital indemnity policies where one would not expect the same kind of inflationary factors to apply as to a major medical product. I would think personally that it's impossible to anticipate all of the accumulative anti-selection factors that exist with a comprehensive major medical product and to charge enough at the outset. For one thing, I don't think the states would approve the rates for it, and I don't think anyone would buy it.

Another approach we might have tried is to modify the coverage to provide an adjustment for the existence of other coverage. Our policy paid in addition to whatever other coverage someone had. Of course, we wouldn't issue the policy if we knew they had other coverage, but if somebody subsequently became eligible for group coverage (and that was a substantial reason for our lapses) they were then in a position to select against us. If they had a health problem they'd keep our plan, pick up the group coverage, and get paid twice. To stop that, you need a floating deductible with the deductible being the greater of a specified flat amount ($100, say) and the amount payable by the other coverage.

Another solution might be to write only basic plans with scheduled benefits--rather than covering reasonable and customary charges and semi-private room rates where you can't control the costs. A partial solution might be to be more restrictive in underwriting. We found that about 40% of our business was written in the lower two occupational classes where the loss ratios were 10% to 20% higher than for the better occupational classes. Another possibility might be to find more effective ways to control the quality of business that your field force writes. Another partial solution might lie in a better control of expenses. As I said, we brought down our commission rates to brokers, but we did not reduce commission rates for our own agency force, part of which is unionized. We had, in fact, bargained with them for a reduction which would have gone into effect next year if we had continued selling CHIP--it would have brought the first year commission rate down to 20%. Even

that may be too high, although I think that some of the other companies now in this business are paying even higher commissions than that.

MR. JOHN B. CUMMING: A medical expense product is both a matter of necessity and controversy. It's a necessity because the public needs it and demands it, and this makes it a political product. Profit is elusive, so the product is controversial. The cost of medical care in the country today is about 10% of GNP, so some kind of mechanism is needed to spread that cost out. Most people wouldn't pay 10% of their pay, much less 10% of whatever is represented by the personal income component of GNP, for health insurance--so this presents a challenge to all of us.

The product is controversial. Prudential is out of the business and now New York Life is in. One thing that I think we can learn from Prudential's experience is that you can't just adapt a group product unchanged to individual markets. Even if you can control the initial selection, you can't control the selection that takes place when the individual makes the decision each year to renew or not to renew.

The public would like to have full coverage at low cost and obviously that's impossible. So the task of plan design is to decide where to pay less than 100% along the spectrum from first dollar coverage to catastrophic care and along the spectrum of available medical services from acute intervention in the event of disease or accident to long term care such as a therapist might provide. As actuaries, most of us would probably favor applying any available premium dollars to catastrophic care. But the public wants first dollar coverage even if it's uneconomical and we see that in the popularity of hospital indemnity plans. This, of course, runs counter to our social obligation to encourage cost containment.

With this background, let me tell you about our Equitable individual healthcare product which we introduced last year. First, we had a history of offering a profitable major medical plan. For a period of 8 years our statutory earnings were positive for an existing major medical plan. The plan was a liberal one with no inside limits. The key to its profitability, however, was twofold. First, we had what Alan referred to as a floating deductible--we call it a variable deductible. The stated deductible is a high amount and the coverage pays after either that stated deductible or any other insurance coverage, whichever is the greater amount. People tend to obtain additional base plan coverage when inflation is high and that helps to ameliorate the effect of inflation on our plan. This makes it less necessary for us to seek those very large rate increases which can drive healthy lives out of the book of business.

Another key feature was a per-cause deductible. That too helps to avoid the use of major medical to pay for routine medical care--in effect, it is a kind of budget mechanism and confines it to more catastrophic type illnesses.

In 1973, we began a program of filing for regular rate increases and tried to keep them moderate so that the policyholders would accept and pay them. Our first rate increase in 1971 had been 55%, and we saw how that drove people out of the book of business. So we tried to go for more frequent and more modest rate increases. Over time, that program proved effective.

We tried to avoid the lag factor, to which Alan has alluded, by anticipating the creep we would experience so that the rates could be set for the period in which they would apply. I can't emphasize enough how very difficult that is to accomplish. We all know the problems of persuading regulators to look at the future applicability of rates on the basis of projected experience but, if you don't, that lag can add up to a lot of red ink over time.

What we did last year was to add to the major medical the availability of scheduled base plan coverage. Some features were added to the major medical to be more modern, with a competitive stop loss and with no benefit maximum. The outcome was that we achieved enormous sales--three to four times our expectation. This created great administrative and claim management problems. Shortly after our introduction of the plan, Prudential withdrew CHIP from the market. Our sales force had not been averse to selling the CHIP plans, and this swung a lot of business over to us.

Disturbing results were quickly manifest. In response to pressure from the sales force we had introduced a $500 deductible, which was lower than the lowest deductible we had previously had available. We soon found that 65% of our sales were on the $500 deductible. Our sense was (and we have since confirmed it) that those sales were coming in without base plan coverage which meant that we were carrying the full load. Since those plans were not properly priced to stand alone without base plan coverage, and represented 65% of our business, it was clear from the beginning that we had problems. As I say, this is a very difficult business to manage; you've got to be on top of it all the time, and sometimes you can make mistakes.

Another problem was the use of monthly premiums. Alan has mentioned that for a family under their CHIP plan the premium can be $300 a month, so that it would be very difficult to require an annual premium. Subject to certain minimum size requirements,we allowed monthly premiums provided the first premium was paid on a quarterly basis. We also have annualization of commissions. That caused us some strain when the very large sales came in, so we had some financial problems right from the start that had not really been anticipated.

The base plan protection that we made available included a hospital benefit to be paid not unlike a hospital indemnity plan. It's not administered as a reimbursement plan. We make available $50, $100, $200 or $300 a day. Our aim was to simplify the claims payment process. With the hospital benefit we offer a surgical benefit with a schedule of $1,000, $2,000 or $3,000.

We also have a Doctors Visit Program with a per-visit payment and a three-visit deductible. Our aim was to try to attract younger people, who might have children and would look closely at coverage for pediatric visits, into our book of business. We had previously found that younger families were more profitable business. That was probably not a good idea. It might have been better to have simply made available in that third base plan slot a first dollar outpatient type of coverage or supplemental accident benefit.

In effect, the Equitable healthcare plan combines the cost control of scheduled base plan benefits with effective catastrophic protection. I believe that this concept is still sound, but we need to fine tune it, to encourage higher deductibles and try to create incentives to guarantee that people do have the base plan coverage. This might be a way in which our

industry could continue to make available this necessary coverage to the public. The cost, with this type of approach, can be tailored to the client's resources. You try to get the agents to sell the idea of putting the money first on the catastrophic major medical protection and then build in the base plan coverage later. Perhaps the agent's compensation should be higher for higher deductibles.

The field is wide open for plan design and effective agent training and promotion. All of these things have to be integrated to achieve financial success. Individual medical insurance is price sensitive but it is not price driven. Competitive comparisons are complex for agents and customers, and this creates a great opportunity for actuaries to use effective plan design as a way of dealing with some of these problems. There are companies which are able to profit in this market, so profits can be found. This is not a commodity market in which customers shop identical policies solely on price.

MR. FERGUSON: I'd like to make a couple of additional points about our CHIP experience. The first one emphasizes the problem of CAST. We looked at our 1981 loss ratios for CHIP policies divided into two groups--the loss ratio for cases which were still in force at the end of the year, and the loss ratio for cases which were no longer in force at the end of the year. For the second group the loss ratio was 56% which represents the loss ratio for the time that they were in force during 1981. The loss ratio for the first group (the ones that stayed with us) was 85%, or 50% higher than for the ones that left. This is dramatic evidence of the problem that you have with selection against the company by people staying with you who are the less healthy lives.

Referring once again to Chart 4, one thing that I should have explained is why we used such a low trend as 13.9% in each of the two years 1979 and 1980. Those were the years during which the Council On Wage and Price Stability (COWPS) guidelines were in effect, and so we were restricted in the amount of trend that we could use. We would, of course, have used much higher trend factors had those guidelines not applied.

Jack Cumming referred to where their business was coming from. In 1981, 92% of our sales were on our major medical 80 plan (the one without any first dollar options). Our plans had gotten so expensive that very few people bought first dollar coverage. Over half of the people, however, were still buying the $100 deductible. Incidentally, when I referred to that $300 premium, it was just an average premium for a family in their 40's. For older lives and for high cost areas the prices could easily be twice or higher than that--in Los Angeles, for example.

One last chart--in Chart 5 you see that our first year lapse rates declined somewhat after we had restricted CHIP sales at the end of 1976 to those we felt were more likely to keep the policy, not selling it to the unemployed or to those who were only on the job for a short period. They still remain very high, however--over 40%--and even in the second year they're still high.

CHART 5

CHIP LAPSE RATES

Year Of Issue	First Year	Second Year
1974	45%	37%
1975	46	37
1976	46	38
1977	41	36
1978	42	34
1979	42	

MR. PAUL BARNHART: For individual comprehensive plans without inside controls or limits, the experience of the last two years has been generally disastrous among both commercial and non-profit carriers. Losses leading to rate increases of 50 to 75% were commonplace during 1981. Some of the reasons why costs continue so dramatically to surpass all the price indices are well known and a couple of these will be repetitive of what Alan had to say at the beginning.

First, a virtual blank check situation exists for providers with little counteracting cost containment. Few competitive alternatives are really available to most consumers, and negative incentive actually exists for the providers in the direction of maximization of utilization and continual escalation of charges. Second, little or no incentive really exists for policyholders to contain costs or to restrict utilization once modest plan deductibles have been exceeded. From what you heard earlier in Alan's comments,you might say that there is a lot of incentive for insureds to contain costs, but the trouble is they don't relate their own utilization and their own submission of claims to next year's rate increase. They just don't see the direct connection to renewal rate increases. It's my view that little or no recognizable incentive really exists for policyholders to contain costs themselves. Third, vastly increased costs of modern medical technology, along with whole new cost areas such as life support, can reach astronomical levels very rapidly. Fourth, defensive practices by providers fearful of law suits proliferate diagnostic and other supportive services. Fifth, artificial cost controls under publicly funded programs accelerate the cost shift toward private plans--and artificial controls have an impact in other ways as Alan pointed out where for two years they were obliged to use a lower trend rate than they knew to be necessary because of artificially imposed controls.

Those are some of the reasons for cost escalation, but knowing them is not enough. Solutions have been slow to emerge or to have substantial impact. First, cost containment programs, however well meaning and well conceived, tend to be cumbersome, expensive and gradual in their effect. Second, alternative financing and delivery systems have a similar effect--they tend to have a gradual and sometimes questionable effect, and they are often cumbersome and expensive to work into the total marketing and administrative process of health insurance. Further, many of these programs have proved to be slow to achieve public and provider acceptance.

What potential solutions have perhaps not been given enough testing or experimentation over time? It's my opinion that the only ultimate effective incentive to contain costs rests with the consumer--the one who, after all, is going to pay for it. Not with the providers, nor with the government. Any real solution must involve incentive to the consumer. I feel first that benefit design itself could do more to provide consumer incentive to contain costs, as well as to adjust to cost inflation without simply perpetuating the blank check for the providers. Let me suggest a revival of a type of plan design rather commonplace 20 years ago, but which lost out competitively to the more open usual, reasonable and customary plans, which proved to have better market appeal. This was the unit value approach, which had a brief flurry of good market acceptance back in the early 60's. The reason that a revival of this kind of approach would make a lot of sense today is that today's costs are so far out of control that this type of plan may once again become acceptable to the buyers. We hear about the preference on the part of buyers to have first dollar coverage, low deductibles, comprehensive coverage, and (of course) at little cost. But I'm inclined to feel that today the way costs are so out of control that the public is perhaps a little more ready to accept plans with realistic controls and limitations on them. Many people are at the point where they just simply can't afford to pay the price for the liberal broad coverage they would like to have.

To illustrate what I'm talking about in a unit value type of contract, look at Example A. It illustrates a comprehensive type of plan that utilizes inside limits to a very extensive degree. Even the deductible can be in units. You can have plans with some portions of the coverage in dollars and others expressed in units. In this example, I'm describing a plan where everything possible is described not in dollars but in units. For illustration, I have shown a deductible of 150 units and a hospital room and board benefit of 25 units a day. For the miscellaneous expense, which needs some scheduling, I have suggested for in-hospital coverage 50 units plus 10 units per day (thus increasing as confinement continues) and for out-of-hospital coverage just 50 units. Intensive care would be double the normal hospital room and board, adding another 25 units a day. I provide for 10 units a day in a skilled nursing home up to a 90 day limit with respect to a benefit period. Doctor calls (in or out of the hospital) would be covered up to 4 units per day. Surgery would be covered under the old relative value type schedule where the maximum procedure value is 400 units. Anesthesia would pay up to 15% of the allowance for operating surgeon. Private Duty Nursing would be covered for 10 units a day, but only for 30 days.

EXAMPLE A

ILLUSTRATIVE UNIT VALUE PLAN

(All Benefit Amounts Expressed In Units)

	Number of Units
Deductible	150
Hospital Room	25 per day
Miscellaneous Expense:	
In-Hospital	50, plus 10 per day
Out-of-Hospital	50
Intensive Care	Add 25 per day
Skilled Nursing Home	10 per day for 90 days
Doctor Calls (in or out of hospital)	4 per day
Surgery	400 maximum
Anesthesia	15% of surgical
Private Duty Nursing	10 per day for 30 days
Out-of-Pocket Limit	1,000 per year
Maximum Benefit	10,000 per year
1982 Unit Value Range (illustrative)	$3 Minimum, $10 Maximum

For the out-of-pocket limit, an important feature of plan design, I have suggested 1,000 units per year. The out-of-pocket limit is there to give the insured some assurance that his out-of-pocket costs under an inside limit plan will not rise indefinitely; that is, that the plan will at some point pick up the excess of his necessary aggregate expenses over the covered limits. Depending on the unit value, this can be a pretty high out-of-pocket limit but it nevertheless can serve to give some ceiling of protection to the buyer. He does not have to worry about facing a possible claim where his out-of-pocket expenses mount higher and higher without some kind of limit. And then a maximum benefit-- e. for illustration, I have used 10,000 units per year.

If this plan were on the market today, it would be my feeling that a reasonable range for the unit value would be from about a $3 minimum (which would be $75 a day for hospital room and board) up to maybe a $10 maximum (which is $250 a day for hospital room and board). But with this kind of plan you have the obvious need to keep coverage up to date and this is where the problems begin to arise. One way of doing this is to provide some measure of guaranteed insurability so that upon renewal the policyholder has the option of increasing his unit value, subject to certain limits and certain rules. Note that in this plan if he exercises his option to increase coverage he also accepts a higher deductible, since the deductible is also in units. For this reason, this option does not automatically appeal to those in poor health who have had claims and might be disinclined to increase their deductible.

This feature of an indexing deductible, if I may call it that--a deductible that increases in some way with increases in medical costs--is an important design feature that has not been used much in health insurance plans, although some group plans do provide for adjustment of deductibles. One of the problems with fixed dollar deductibles, particularly the larger ones, is that even if there's no anti-selection, even if there's no adverse utilization--simply medical costs increasing at the same rate as the medical care component of the consumer price index--your claim costs will advance at a faster rate because of the deductible spillover. Smaller claims which would not have gotten past the deductible now result in claim payments as costs rise, so you automatically have costs increasing at a higher rate under the program with a front end deductible than the underlying medical care cost index is advancing. In order to increase the possibility of having premiums match the actual rate of increase in medical care costs, you've got to have some means of adjusting the deductible, and this concept does it--as the policyholder exercises his option to raise his unit value he is also saying, "I will accept an increase in my deductible."

The maximum here for illustration is 10,000 units a year, so that if you had a $5 unit value the maximum would become $50,000 a year. That may not, as a practical matter, result in much cost control, but I think it's desirable from a market acceptance standpoint. If the insured exercises his right to increase his unit value thereby taking a higher deductible, he at least also gets a higher maximum benefit along with it.

There are several devices inherent in this plan that amount to trying to strengthen consumer incentive for cost control. First of all, many people are not going to have the money to buy the highest possible available unit value so they may well accept something that is less than what their charges and costs are actually going to be. One of the marketing difficulties of this kind of program is to try to see that agents and buyers have some knowledge of cost levels in their area. They ought to know what the local hospitals are charging for semi-private rooms and have some idea of the adequacy of coverage they are obtaining. It is important to bring home to the consumer himself some recognition of cost and what it means to him in terms of what he's got to pay for.

Obviously this kind of program is going to be no more invulnerable to rate increases than any other kind of a medical care insurance plan that is attempting to do any sort of realistic job. There are going to be rate increases and that's going to involve anti-selection. First, the policyholder can elect to increase his contract unit value and thus elect to pay a proportionate rate increase. In other words, he can elect to increase his own rate by electing a higher unit value in order to keep his own coverage up to date. Second, when a rate increase with respect to each $1 of unit value must be filed with an insurance department, there would be some dampening of the increase because of the other features such as advancing deductible and other flexible types of inside limit control. There are obviously still going to be the problems of rate increases and the inevitable consequences of policyholder anti-selection, but the hope would be that they would be a little more controllable and somewhat more dampened under a program of this kind. And last, of course, are the inside limits themselves. Those policyholders who do not elect to increase their own unit value will have a plan with inside limits that will continue to apply. That, of course, will have a further dampening

effect on cost increases and the necessity to increase rates per dollar of unit value.

Another approach would be to have both the rates and the unit values automatically indexed by contract based on some objective scale--something like, perhaps, the medical component of the consumer price index. One advantage would be that it would preclude individual election--everybody is going to get the automatic adjustment in both rates and unit value without a choice. The likelihood of anti-select lapsation will increase, however, if people have no choice to hold their unit value where it is or to respond in some way to keep their premium under control. Whenever you automatically index both rates and unit values, you're going to get a related increase in anti-select lapsation.

One more device that I want to describe is one that I haven't seen used yet, but it is being considered in one program with which I am involved. I have received at least some preliminary favorable reaction to it from one insurance department which is concerned about the enormous costs and anti-selection problems that have been arising because of increased lapsation caused by very large rate increases. This approach would involve a limited individual experience rating corridor. To illustrate, the first 200 units of covered expense above the deductible--that is, once the person starts into a claim--would have a renewal rating factor applied according to the utilization of the individual policyholder. The idea would be to put a direct financial incentive on the policyholder to show him in very specific terms that when his claim costs and utilization become high it will have a direct effect upon his premium cost for the next year.

To illustrate, let's say that your standard rate scale assumes that if there's no utilization at all of this benefit corridor, a 20% discount will be allowed on the renewal premium with respect to the corridor portion of the claim cost. On the other hand, if the policyholder uses that entire 200 unit claim corridor, his renewal premium would automatically increase 10%. For individual policyholders, something like a maximum accumulative discount of 40% and maximum accumulative surcharge of 30% would be imposed. Each successive year, an adjustment would be made (positive or negative) from the prior year's rating level, subject to accumulative maximum deviations from "standard" of 40% down to 30% up.

I'm sure that the first reaction to this is that it is very complicated. But the problem we are trying to bring under control through this approach is a massive one. Costs are out of control, and I think one has to consider any kind of reasonable possibility even if it might be complicated. One of the most complicated programs on the "market" today is the medicare supplement plan, tied as it is to yearly changes in both Part A and Part B of the Medicare Program, yet a lot of that coverage is being sold. So I think we have to be harshly realistic about this whole problem. The alternative may be some artificial and irreversible government solution that almost surely would seal the sad final fate of the health care financing system--and that would be a fate, not a solution.

MR. WILLIAM F. BLUHM: I have to start off, as most insurance department people do, by saying that whatever I do say is my own opinion and not that of the New York department.

On the question of experience, I had somebody in my office review the experience of a number of companies that I knew had major medical and comprehensive policies, both currently being issued and closed blocks. We took the experience for 1980 and 1981 and the loss ratios we came up with were 58.8% in 1980 and 59.5% in 1981. That's on 34.5 million dollars of earned premium. It didn't include Prudential's results, which would have rendered the data meaningless because of its size, but it seems to indicate that some companies are keeping abreast of inflation despite the horrible experience of some of the ones you've been hearing about. It also includes a few products in 1981 that were not being sold in 1980--while this may not seem fair, I thought that the good experience they were enjoying in 1981 might be in part due to the fact that they were able to take select risks out of the bad experience of the other companies.

I looked at those same companies to see the annual trend assumptions that they were using and it varied from 10% up to 32%. The comprehensive policies were in the range of 18% to 32%, with the average probably being the mid 20's. It seems to me that the trends that are being used in the aggregate seem to be fairly successful--companies seem to lose control when inflation gets out of control and regain it when inflation drops a little bit.

I've been seeing a lot more of indexing in benefits, including things similar to what Paul was describing. So far, they haven't been out long enough to tell whether they are going to be successful. And so far nobody has been successful with the comprehensive product over an entire block, an entire life time of policies.

I agree with Jack that rate increases for policies should be prompt and moderate--not only will that reduce lapsation and keep anti-selection under control, it's a lot less catastrophic to the block of policyholders to keep things on a normal keel when they expect a rate increase every year--there's a lot less harm done to the block of business.

I agree with Paul that it's important to promote public awareness of cost benefit considerations, but I think it's also important to make doctors aware of cost benefit considerations. It seems to me that those are the people that are really causing the problems.

I think that first of all you have to differentiate between legislative regulation and departmental regulation, which many people don't do. Legislative regulation is obviously very political--there are special interest groups that are being heard all the time and the mandates that have been coming down in many states come from legislators starting to listen more to the industry. There are fewer mandates and there is more concern for cost containment measures. As evidence of that you may have heard of the new Blue Cross/Blue Shield differential being put into effect in New York which reduces the differential between commercial and Blue Cross insurers. I think that the improved attentiveness of the legislature towards us depends on our response to cost containment problems.

Turning to the Department, you may have heard of Regulation 62 which reflects the Department's current thinking on the subject of health insurance regulation. Despite the fact that it is much more complex than before, and looks like a lot more regulation, it is not necessarily bad. I think it is going to make medical insurance a lot more viable in New York. First of all,

we are now using actual to expected ratios to look at experience. Many of you have already been doing that, but many companies have not, and many companies have not even been aware of their own experience. The new regulation will help them become aware of it. The loss ratio minimums have been changed and are much more reflective of what the industry task force considers appropriate; they're much closer to the NAIC guidelines now than they were. The scope of the regulation is also vastly larger than before. It's going to require that each insurer monitor its own health experience, and if the experience fails to meet the standards of credibility for the block of business they will have to report to the Insurance Department what they are going to do about it. The sophistication of the system, I think, will help eliminate a lot of the problems we are now having with both rate increases and decreases. There is no handbook any place which tells people how to calculate rate increases or decreases, and we see the same mistakes and the same disagreements over and over again. I think the new regulation will minimize the misunderstandings that occur and will probably reduce the rate approval delays that I'm sure you're all aware of. Once we have a more uniform methodology set forth, there will be a lot less for us to argue about.

As for the future, the current high rates of increase in medical costs obviously can't continue. They are compounding faster than the overall inflation rate, and are becoming an increasingly bigger piece of GNP; there's a limit to how far healthcare expenditures can go. That limit may take the form of legislation from either the states or the federal government. I think it's important for the actuarial profession to provide input on a professional level, separate from the health insurance industry which provides input representing a special interest group of insurance companies. I think that this has not been emphasized in the past and it is not realized that the difference between the industry and the profession is not maintained in the minds of people both in the state legislatures and in the state insurance departments. Another major problem which should be addressed is proper rating and reserving practices, a subject which hasn't been adequately taken care of yet.

MR. FERGUSON: Paul, you mentioned a deductible in units. Were you thinking of an annual deductible or a per-cause deductible?

MR. BARNHART: Either way, but I think I'd lean toward an annual or calendar year type of deductible.

MR. FERGUSON: Just one point on something to which both Jack and Bill referred--the necessity for prompt and reasonable rate increases. I think we tried to make our rate increases as prompt and as reasonable as we could, but in the face of our emerging experience we had no choice but to go with very high rate increases. As for timeliness, Jack, you're not suggesting that you're going to make them more frequently than once a year?

MR. CUMMING: No, I don't think you can increase them more frequently than once a year. I think you get into problems when the amount of the rate increase is significantly greater than the rate of inflation. The customers then perceive the increase to be unfair or unwarranted, and they start considering alternatives. You saw that pattern with your CHIP business.

MR. FERGUSON: Well, I'm not going to be argumentative about it, but of course the rate of inflation in hospital expense alone is perhaps 17%, which is much

lower than what group cases are experiencing (with all of their other factors of increased utilization, leveraging deductibles, etc.) Would anyone in the audience like to ask any questions or make a statement about what they're doing or what they see as a solution?

MR. CHARLES W. KRAUSHAAR, JR: At New York Life, we decided that the comprehensive field was for us and we came out with a new product on October 1. It includes most of the safeguards which Alan and Jack mentioned. It has a broad price range, which we think is terribly important. We think that this product is viable, certainly in the near term, but only for the people who can afford it. We are very concerned about it being sold outside of its proper market. We will be monitoring our individual agents in this area to make sure that they are marketing it in proper markets. We are talking about a level 10% commission, rather than a higher first year with lower renewal commission. I have a question for you, Alan--what do you think was the long range impact of the lid on rate increases that the wage price controls imposed?

MR. FERGUSON: I think it limited some health care insurance increases for awhile, but it just put a lid on the steamer and it exploded later. Charlie, are you going to have some income limits on those to whom you will sell this policy?

MR. KRAUSHAAR: We have income guidelines, and are gathering information so that if we wanted to we could impose income limits.

MR. FERGUSON: One thing, Jack, that you may want to comment on is that initially you limited your underwriting and you ultimately removed the limitation.

MR. CUMMING: Alan is alluding to the fact that we started out with a noble experiment in which we sought to rely on the pre-existing conditions exclusion under age 40 to avoid the cost of underwriting. What we were looking for was a trade-off of the morbidity cost against the cost of underwriting. We had some preliminary industry data that suggested that we could do that. We wrote about 10,000 policies during the initial period, and we'll be examining the experience curve that emerges from that block as it matures. We backed off partly in response to field pressure (which made it easier to do). They were concerned that it might sour the book of business and destroy the product.

I remember one agency manager who called me up and said that one of his agents was soliciting business in the local hospitals going through the wards and asking if the people were under 40. The manager said "I don't feel in good conscience that I can prevent my agent from doing this," so with that kind of solicitation it seemed that perhaps we couldn't expect to get the same experience that other companies were able to obtain.

MR. FERGUSON: So agency controls are important.

MR. CUMMING: Yes, Sir!

MR. RICHARD B. SIEBEN: I disagree with Mr. Cumming's comment regarding the frequency of price change. I think that more frequent than annual price changes in the size and environment that we're dealing with is only good common sense. There's no public utility that will wait until their required rate increases build up to 17% or 18%--they start to nibble away with 7%'s.

We have similar examples in the casualty field. It creates a lot of problems, but as frequently as you need 10% (even if that's every 3 months or every 6 months) I think you have to go for it in this environment.

I think that, more than the COWPS controls and what they did to our pricing for a period of time, the whole environment of controls created some real aberrations in the rate of inflation of health care. I'm referring to the threat of hospital cost containment regulation in 1979, as well as the so-called voluntary effort. From everything that I have read and people that I've talked to in the provider end of the business, it appears that the providers sat on their hands. We experienced the phenomenon from 1978 to 1979 of having the medical component of the CPI about equal to the average CPI. That was the first time that I can remember that ever happening. So there was catch-up on the part of providers, and with the kinds of threats that have been going on recently (a couple of years in a row of high inflation and the threat of more Washington intervention) I think there's been a lot of positioning and strengthening of prices by the hospitals in anticipation so that they won't be caught like they were before. So we've had maybe five years of inflation in three. The good side of that is that it can't go on forever, and perhaps we're going to have a pleasant cyclical surprise in terms of a lower rate of provider inflation. But don't count on it until you get it.

MR. FERGUSON: Concerning more frequent rate increases, I think there is a substantial problem of getting them approved by state insurance departments.

MR. DONALD M. PETERSON: It seems to me we've glossed over one detail in this that has to do with the lapse rate. From the figures in Chart 5, Alan, it appears you have less than 30% of your CHIP business still on the books at the end of 24 months, so why did the 70% leave? They left because they didn't have many claims and yet they're looking for low price. Using Dick Sieben's approach we'd hit everyone with a rate increase. I think we have to separate the claimants from the non-claimants. I lean towards what Paul has put forth--the idea of finding a low price vehicle for those people who are not going to over-utilize. On the other hand, when you provide average semi-private accommodations for that other 30%, they aren't going to have any regard or concern for over-utilization or for the price that's being charged for services. My company has used a unit type of product for the last 12 years and while we have not come out great winners, we at least haven't run into the type of problem which Prudential encountered with CHIP. One question--are other companies facing the same problem with lapse rates? What has been the impact of the TEMP product on your lapse rates, Alan?

MR. FERGUSON: I don't think TEMP has had any effect on our CHIP lapse rates. It is sold to a class of policyholders that weren't eligible for CHIP. Jack, do you have any comment on lapse rates? Are yours better than the ones I showed?

MR. CUMMING: Our lapse rates are better. With the new product we do have some concern, but we're getting a completely different block of business, so it's hard to tell. But the ameliorating effect of the variable deductible and the scheduled base plan on rate increases helps to control the lapses. The time when you increase the rates is when you get the greatest resistance and the lapses are more likely to occur, so anything that helps control rates helps lapses.

MR. PETERSON: It seems to me a re-entry term approach with select and ultimate type rating might be the solution. Alan, what are your lapse rates beyond the second year? Do they stay at 30% or do they finally drop down at later durations?

MR. FERGUSON: By the fourth year they're still in the high 20's.

MR. BILL S. CHEN: If we use a variable deductible in the structure of a major medical policy, what should be the appropriate index for this variable deductible--a medical cost index or a wage index? In the past few years, the medical cost index generally has outpaced the wage index; if we use the medical cost index, therefore, it might create financial difficulties to the policyholders in the long run.

I have studied the unit value approach, such as the one described by Paul, extensively in the past. The problem that I perceive for this approach is to maintain the appropriate relationship among the various components of the medical/hospital costs. For example, since 1975 the hospital cost index has increased more sharply than the medical cost index. This creates an imbalance of the relationships of the various components.

MR. BARNHART: That is a definite problem and that problem is going to exist with both of the two approaches I described. In other words, if the plan is automatically indexed in relation to something like the medical care component of CPI, it does not handle well the situation where hospital rates are going up at a different rate of increase than medical care rates. That's one of the defects of this approach, but I think there are defects in just about anything anyone is going to dream up. The same defect actually operates in the other approach I described as well where the policyholder has some kind of guaranteed insurability and he can elect to increase his unit value. The fact that the plan itself defines the benefits in terms of units automatically creates a parallel increase among all benefits when the plan is increased. If the policyholder increases the unit value he gets a certain amount of additional hospital room and board coverage but he also gets a proportionate increase in his surgical and doctor calls schedule, so you're increasing those benefits at the same rate even though the rate of rise in cost may be unequal.

MR. CHEN: Alan, what were the primary causes of the failure of the CHIP program? Were the causes primarily external or were they internal, such as too liberal underwriting or benefits?

MR. FERGUSON: I think we had fairly rigorous underwriting standards--about 25% of the business was rated, for example. I think the problems with CHIP could have been helped by a floating deductible and some other changes that you can make which can moderate the effect of the inflation, but I'm really quite apprehensive about an open ended major medical type product without limits. I wonder about some other companies getting into this market because I think that it takes time for experience to sour as it did with our product.

MR. ROBERT SHAPLAND: I was surprised at something you said, Alan. Did I understand that your blue collar experience showed higher claim costs than your white collar experience?

MR. FERGUSON: Yes.

MR. SHAPLAND: I've always had the impression that it would be the other way around. People with higher education, for example, would utilize medical care more than blue collar workers.

MR. FERGUSON: Well, it may require further analysis, but overall our experience on blue collar workers was worse than on the better occupation classes.

MR. SHAPLAND: One problem that I see in applying a deductible in a policy where you have internal limits is that the deductible has to apply against the limited benefits. In other words, if a person is charged $200 a day and only has a $50 a day benefit, then you're taking the deductible away from that $50. I wonder if the insured really understands that not only is his benefit limited but the deductible applies to those limited benefits.

We're in the process of re-designing our major medical policy to try to deal with some of these things. In regard to other insurance, we're planning to put in a provision giving us the right to increase the deductible amount if the person acquired, after the policy was issued, other insurance which would have violated the underwriting rules in place at the time of issue. As to the frequency of rate increases, we've always had a provision that the increase in rates would take place on the anniversary, but we're changing that to give ourselves the right to raise rates at any time. The step rate for age would still take place on the anniversary, but we would have the right to increase rates at other times and I believe that's a very important feature.

We're also planning to reserve the right at any time to increase deductibles, stop loss limits, and maximums. When we apply for a rate increase, if we think that the rate increase will cause heavy lapsation and anti-selection, we'll be able to automatically increase deductibles or stop loss limits or maximum amounts to offset that rate increase.

Finally, I might mention that we had a major medical policy with a $2,000 deductible and then we sold an internally limited plan to cover the first $2,000 (with room and board limits and so on) and we have seen no deterioration in health or loss ratios on that block of business. In other words, if you look at that business by year of issue and compare each year of issue with earlier issues and later issues, there's actually sort of a declining loss ratio as business ages. So I don't think that we're faced with an unsolvable problem; I think there are instances where we can look forward to financially viable insurance in this area.

MR. JAMES OLSON: Jack, you didn't indicate whether your new product was level premium or one year term.

MR. CUMMING: It's not a step rated product. It's a level premium product, theoretically, but we do increase the rates--that works as kind of a bonus to encourage persistency. The premiums will increase on the major medical portion, but we preserve the original issue age.

MR. OLSEN: In regard to your variable deductible, what does that save you--about 20% of the premium that you'd need if you didn't have it?

MR. CUMMING: The savings are enormous. It varies by the amount of the deductible--it can go as high as 45% to 50%.

MR. OLSEN: Alan, you mentioned that your 1981 experience showed that for the business that stayed in force the loss ratio was 85% and the loss ratio for those that left was 56%. What was your average loss ratio in the period?

MR. FERGUSON: 78%.

MR. OLSEN: Bill, I'd like to ask you a question about level premium vs. one year term. The New York Department at one time had a position, as I understand it, that they would not allow a level premium on the kind of policy which anticipated rate increases and therefore really could never be level term premium. Does the Department still have a position on that?

MR. BLUHM: I'm not aware of the position you're referring to. We obviously don't have it now because we have approved level premiums in Jack's case and we are approving step rated policies also. I think that the level premium is probably a better idea because it helps you to set aside some extra money early and be better off later on.

MR. FERGUSON: Our time is up and we must end this discussion. I would like to thank the panelists and those members of the audience who participated in the discussion.