

# RECORD OF SOCIETY OF ACTUARIES 1984 VOL. 10 NO. 2

## INDIVIDUAL HEALTH INSURANCE AND RATE REGULATION

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Recorder: TIMOTHY D. LEE*

1. Regulatory objectives
2. Experience monitoring
3. Supplemental statutory reports
4. Rate filing
  - a. Initial requirements
  - b. Refiling (rerating problems)
5. Company responses

MR. STORM JOHNSEN: There are five subheadings for the topic of this panel discussion concerning individual health insurance and rate regulation. I will limit my remarks to the regulatory objectives and closely related topics. My remarks are further limited to the objectives as they apply to the state of Washington. The remarks are mine and do not necessarily represent the position of my employer, the Insurance Commissioner for the state of Washington, or the opinions of his staff.

The purpose of my contribution to this panel discussion is to provide a description of our regulatory objectives and of a problem with which we are concerned.

What are the regulatory objectives of our State? There is one objective that overshadows all other considerations: the protection of the consumer. This is our primary commitment. We have a strong consumer protection department and a well-run SHIBA program. The acronym SHIBA stands for Senior Health Insurance Benefits Advisor. The first priority of all the activities of our Office is the protection of the consumer.

RCW 48.02.060 enables the Insurance Commissioner to make reasonable rules and regulations for effectuating the provisions of the insurance code. The rules and regulations promulgated by our Office are reviewed with this statute in mind; the insurance code is for the protection of the public and any rule or regulation must have this as its first objective.

Having defined our objectives in this simple, yet comprehensive way, I should like to share some statistics with you. These statistics will illustrate a concern of ours. My intent

is to present the statistics and let you draw your own conclusions. I will consider a few interpretations but will not promote any favored line of reasoning.

Our Office has a computer terminal tied to the NAIC data base located at its central office in Kansas City. Two or three years ago we requested loss ratio calculations based on Washington data only. These calculations were based on information from the state pages of the life insurance and of the casualty insurance annual statements for the years 1978, 1979, and 1980. The information we received was startling.

An updated summary of this loss ratio experience was included in a news release from our Office, dated August 30, 1983, in conjunction with the effective date of our present loss ratio regulation. A copy of the news release is available from our Office. It contains the statistics that follow.

Aggregate Loss Ratio Experience, 1978-80  
State of Washington Only

(1) <u>Return to Policyholders for Each Premium Dollar</u>	(2) <u>Number of Com- panies</u>	(3) <u>Earned Premiums</u>	(4) <u>Incurred Claims</u>	(5) <u>Claims as a % of Premiums</u>
		- - - - - (000 omitted) - - - - -		
\$0.90 or more	45	\$ 4,604	\$ 6,629	(144 %)
\$0.80 but less than \$0.90	16	2,738	2,334	( 85 %)
\$0.70 but less than \$0.80	17	5,174	3,853	( 74 %)
\$0.60 but less than \$0.70	26	18,459	11,932	( 64 %)
\$0.50 but less than \$0.60	<u>44</u>	<u>69,436</u>	<u>37,294</u>	<u>( 54 %)</u>
Sub-Totals	148	100,411	62,042	(61.8%)
\$0.40 but less than \$0.50	49	44,703	19,540	( 44 %)
\$0.30 but less than \$0.40	29	32,305	11,436	( 35 %)
\$0.20 but less than \$0.30	22	10,755	2,787	( 26 %)
\$0.10 but less than \$0.20	22	5,598	849	( 15 %)
Less than \$0.10	<u>64</u>	<u>1,275</u>	<u>79</u>	<u>( 6 %)</u>
Sub-Totals	<u>186</u>	<u>94,636</u>	<u>34,691</u>	<u>(36.7%)</u>
GRAND TOTALS	<u>334</u>	<u>\$195,047</u>	<u>\$ 96,733</u>	<u>(49.6%)</u>

This table summarizes the disability insurance experience in the state of Washington for the years 1978, 1979 and 1980. Disability insurance, in our regulatory jargon, includes A&H and monthly income disability benefits. The table sorts all of the 334 companies having disability insurance in force in our state into categories defined by how much of the premium dollar was returned to the consumer in the form of benefits. There are, for example, 45 companies in the top category. Each of these 45 companies returned more than \$0.90 on the dollar to the consumer. The earned premiums of the 45 companies totalled \$4.604 million and the incurred claims \$6.629 million. These 45 companies returned an average of 144% of the premiums to the policyholders in the form of benefits, calculating the loss ratio as incurred claims to earned premiums.

There are many reasons why a company may have a loss ratio of 144% over a three year period. For one, it may be a mature block of business where it is expected that the last few persisting policyholders will generate claims well in excess of the premium income, drawing on reserves set aside in earlier durations. Many of these companies are no longer active in the health business.

Another reason is the smallness of the statistical data and the random fluctuations associated therewith. The earned premiums for these 45 companies is \$4.6 million or approximately \$100,000 each. Since these are three year figures, the average annual premium is about \$35,000. This is a pretty small block of business, subject to statistical aberrations.

There are, however, some small companies, Washington domestics and semi-domestics, for which a 144% loss ratio on a \$35,000 block of business can adversely affect the surplus account and the continued operation of the company. A semi-domestic is defined as a foreign company which has a substantial proportion of its business within our state. Our Office is greatly concerned for the solvency and continued operation of these companies. I can recall our Office having such concerns and questioning more than a half dozen companies in the last two or three years.

148 companies, or 44% of the 334, had a loss ratio of 50% or more, with an average of 61.8%.

186 companies of the 334, or 56%, had incurred claims of less than 50% of the earned premiums.

The 49 companies in the 40% to 50% classification returned an average of 44%. It would be quite likely that a company just entering the health business would have a loss ratio in this range. Or one with a large volume of new sales. There may be other reasons as well.

At the bottom of the table, 64 companies, or 19%, are apparently returning less than 10% of the premium dollar to the consumer in the form of benefits. There are many good reasons why a company will not return a reasonable proportion of the premium to the consumer in any given year or even over a three-year period. The members of this panel and the audience have a much better understanding of this than I do. I will, therefore, entertain only a few of these reasons.

The 64 companies in the bottom category have an average loss ratio of 6%, as shown in the right-hand column. The category shows earned premiums of \$1.275 million, which is about \$20,000 for each company for the three year period, or about \$7,000 per year. These blocks of business are small enough to have substantial fluctuations in claims and, in fact, to present no claims at all within a calendar year or two.

On the other hand, the statistics cover a three year period. The incurred claims must have been zero for a number of years for several of these 64 companies. What is the likelihood that 64 companies out of 334 should have such favorable claims fluctuations continue over a three year period? Could that happen within the reasonableness of a bell shaped curve or is there an underlying reason not immediately apparent?

What type of benefits could have an experience of no claims over several years? I can think of several, such as accidental death and dismemberment, accident only and others. How many of the 64 companies sell only, or predominantly, this type of policy? Some companies undoubtedly do, but most would have a more balanced portfolio.

The Washington Insurance Code requires the Commissioner to disapprove a policy form if the premium rates are unreasonable relative to the benefits. In the years included in this study, and over the prior decade, our Office used the then NAIC loss ratio model as a guide in reviewing premium structures and rate increases without having formally promulgated it as a regulation. This model had general standards of 50% or 55% with exceptions going as low as 35% for small premiums and special types of policies.

The most generous premium standard that we could possibly have approved would have included an estimate of at least a 35% loss ratio. I have a hard time believing that we have 64 companies selling only policies qualifying for a 35% loss ratio and that all 64 have favorable claim fluctuations at the same time. I am not drawing any conclusions. I am just saying I have difficulty accepting it. Perhaps someone on the panel or in the audience can dispel my disbelief. Or it may be easier to run another study this year to see what the 1981 and 1982 business looks like.

Could it be possible that some of these 64 companies do not live up to the standards promised in their rate filings? Are there companies which price their product line for the benefit of their stockholders or their selling agents without concern for the policyholders? Could such companies attach actuarial justifications to the rate filings which are based on overly optimistic or pessimistic assumptions? An actuarial assumption is a judgement item and pretty hard to question unless it is rather extreme.

The 64 companies in the bottom category list earned premium of about \$1.25 million as compared with about \$69.5 million in the 50% to 60% category. It appears that the companies in the latter category insure 55 or 60 times as many policyholders, or even a larger multiple considering the small premiums in the bottom category. Would it, therefore, not be a fair statement to say that the consumers in the state of Washington receive a reasonable return of benefits for their premium dollar? Why the concern with these 64 companies?

By and large this is true, but there is a flaw in the logic. The reasoning is the same as some companies use when they justify a 300% rate increase by stating that there are only two policyholders left in our state. How would you like to be one of those two? Rate increases may be granted because the claims or expenses are higher than what was originally projected but not for reason of a dwindling number of policyholders.

I can put together a long list of reasons which may explain the low loss ratio performance. I can also put together an equally long list of valid questions which imply an unfair practice on the part of the companies. These lists will not prove anything one way or the other. At this point I have no answers, but I relate the concerns of our Office to you. The statistics seem to be fairly bleak and I can understand the reactions of our non-technical staff and the supervisory personnel responsible to enforce the insurance code.

Pausing for a moment to consider a side issue which has been brought up at the TSAG meeting on several occasions in the last three or four years, what is the credibility of an actuarial certification, demonstration or justification?

When I was reviewing policy forms I became concerned by the number of life insurance nonforfeiture calculations which were in error even though certified by a Fellow of the Society. I ran a sample of 100 consecutive filings of life policies with nonforfeiture values. 22 of them were in error.

The reason for most of the errors were peculiarities of the Washington law or inadequate computer programming, but then most of the actuaries certified compliance with the Washington law. It was a very small sample from which any valid conclusions may not be drawn. Most companies make only an

infrequent error, if at all. Our experience with health insurance filings is similar. Many demonstrations and justifications employ actuarial assumptions and techniques which are not reasonable and which are not upheld when questioned.

Most of the companies licensed in the state of Washington are well-run and well-intentioned companies which provide a valuable service to our consumers. There is, however, a minority of companies whose management practices and conduct in the field may be questioned. There are probably good reasons why most of the 186 companies which appear not to meet regulatory requirements of reasonableness have average loss ratios below 50%. On the other hand, there are probably several companies which would have difficulty showing why their policy forms should not be disapproved and premiums refunded to the policyholders.

MR. MARK E. LITOW: The topic I would like to address is how rate regulation can be dealt with as effectively as possible by an insurance company while still meeting Company objectives. In the process, my remarks will focus in varying degrees on regulatory and insurance company objectives and the procedures used in rating, monitoring of experience and rerating by the insurance industry.

In taking a broad look at rate regulations and responses that some companies make to state objections or inquiries, some of the more interesting ones I have heard or seen are:

- .... We will not sell in that state (for new filings) or, we are not selling much business in that state so why bother (for rerating).
- .... Spending three or more months sending letters back and forth; this generally also includes numerous phone calls.
- .... Deciding to give the problem low priority because the product is being sold as a "lead in" to sales in other areas, and the company does not expect to make money on the product anyway.
- .... Doing nothing and hoping the problem will go away (in a refiling situation).
- .... By cursing under their breath and carrying out some combination of the above.

Certainly, all companies that sell individual A&H insurance to any significant degree have had some difficulties with regulators. However, in my opinion many of these difficulties could be minimized or perhaps avoided through more diligent efforts by the insurance company. In order to more closely assess this statement, let us look at the objectives of rate regulation and state regulation in general versus that of the insurance company.

### Objective of the Regulator

The number one objective of regulators is consumer protection, with probably few exceptions. (Storm Johnsen has stated that this is true in Washington). Regulators have many methods of affording the consumer protection, which include:

1. General statements in the code or guidelines that premiums must be reasonable in relation to benefits provided (as an example, Michigan, I believe, has a designated maximum annual premium limitation for Medicare Supplement policies for a standard plan.)
2. Minimum loss ratio standards (emanates from #1).
3. Discrimination in benefits (i.e., sex, age, mandated benefits).
4. Cost containment (i.e., switching an individual to a plan with higher deductible at approximately the same premium as opposed to a rate increase - Wyoming requires this option).
5. Statutes specifying a policy must be guaranteed renewable (i.e., North Carolina, Maryland).
6. Simplified language.

A secondary concern of regulators is solvency. They generally do not worry about this until some "red flags" appear in an overall examination of the company or in reviewing statutory reports. Naturally, you would hope that a company is aware of a surplus problem well before an insurance department becomes interested, but this is not always true. In any case, even where current or future solvency is in question, the insurance department's interest in the company's health is predicated on protection of the consumer and not of the company. This means a company must take care of itself.

### Objective of the Insurance Company

The objective of the insurance company is to produce a profit for either shareholders or policyholders. This is generally accomplished in individual A&H through the proper development and management of policies which include initial rating and the subsequent cyclical process of experience monitoring and rerating.

### The Interaction of Policy Development and Management with Rate Regulation

If the objectives of regulators and insurance companies can both be met through proper development and management of policies, then it would certainly seem in the best interest of a company to achieve a rating, monitoring, and rerating process consistent with such objectives.

As a means of examining the development and management processes used by insurance companies in general, let us look at some of the problems which often lead to regulatory difficulties later on.

Under initial rating (or policy development), two types of problems often occur which lead to regulatory difficulties. These are:

1. Benefit and expense percentages or ratios are not paid enough attention in conjunction with minimum loss ratio standards. Two of the most common examples are:
  - a) The minimum loss ratio is met but the expenses are too high in conjunction with this loss ratio to produce the profit desired. Typically, this occurs because the expenses are not evaluated rather than because the company decides to sell at a substandard profit or loss.
  - b) Claims plus expenses are compatible with the profit objective initially, but the loss ratio realistically expected is less than the minimum required and expenses are too high to meet the minimum (cannot occur if a state rejects the policy because the loss ratio is too low). The reasons why realistically expected claims might be less than the minimum loss ratio could be:
    - i) a margin is included in the morbidity to meet the loss ratio minimum,
    - ii) the plan was approved prior to effective date of minimum loss ratio regulations,
    - iii) others probably also exist.

Whatever the reason, if losses exceed the expected claims assumed the company cannot increase its rates until the expected loss ratio over the life of the policy exceeds the minimum. Thus, the product will produce an unacceptable profit or a loss.

2. The incurral dating rules used are not consistent with rating principles and/or do not produce an appropriate matching of claims and premiums. Three common examples we have seen in which the incurral dating rules were not established with these criteria in mind are as follows:
  - .... Reserves for reported and pending claims for a disability plan were set up by calculating a reserve at the report date and recalculating the reserve at six month intervals. For intermediate valuation dates, the reserve was set equal to the CDT reserve at the last calculation date minus the claims paid since that calculation date.



.... Incurral dates have been established for a specific cause and no "separation period" has ever been applied for that cause. A "separation period" is defined here as a period of time for which no claim occurs or services are performed, thus resulting in a new incurral date for a subsequent claim or service. In this situation, the claim could run for a long time and in some cases, until death. Obviously, therefore, a separation period is an important consideration in rating a policy in order that claims and premiums are matched properly.

.... Calendar year - all cause incurral dating, where the first date of treatment within a calendar year is designated as the incurral date. This method is used by many insurance companies in dating Part B claims on Medicare Supplement policies, and results in downward loss ratios throughout the year. (I will discuss this shortly in more detail).

Naturally, any rating problems or irregularities can affect claims monitoring and subsequent rerating. Incurral dating inconsistencies, in particular, result in monitoring problems because claims data are not consistent with rating principles and do not provide a proper matching of premiums and claims.

In regard to monitoring of results, two types of problems prevail:

1. Incurral dating problems - Some of these are discussed earlier and their impact on experience results has been noted. However, the calendar year method of incurral dating poses an additional problem with respect to analyzing results. This problem can be found in the dramatic seasonality of incurred claims, whereby January incurrals are very high and incurrals then decrease with each succeeding month until the following January where a large increase occurs. In some instances, rapid growth and/or severe fluctuations can camouflage this slope of incurral claims for a while, but a study of lag factors should indicate when a calendar year incurral dating method is used.

Two examples of calendar year incurral dating methods are shown in the example exhibits.

The first exhibit is for a Medicare Supplement plan with both Part A and B benefits with a valuation date of 3/31/84. Note the slope of the loss ratios from quarter to quarter in 1981, 1982, and 1983. These are as follows:

.... The 1981 loss ratio ranges from 79.5% in the first quarter to 44.7% in the fourth quarter.

Exhibit 1

Summary of Plan Experience  
Medicare Supplement Plan  
Aggregate (All Subsegments Combined)  
Part A and B Benefits Combined

<u>Incur- ral Period</u>	<u>Paid Most Recent Quarter</u>	<u>Cumulative Paid to Date</u>	<u>Estimated Ultimate</u>	<u>3/31/84 Reserve</u>	<u>Premium</u>	<u>Loss Ratio</u>
1978	343	1,279,283	1,279,283	0	2,145,884	59.6%
1979	3	1,730,487	1,730,487	0	3,028,986	57.1%
1980	305	2,251,754	2,252,254	500	3,960,633	56.9%
1981-1Q	149	911,866	912,779	913	1,148,048	79.5%
2Q	2,165	695,495	696,547	1,052	1,255,696	55.5
3Q	2,960	712,841	714,127	1,286	1,395,582	51.2
4Q	93	684,494	686,470	1,976	1,535,694	44.7
	<u>5,367</u>	<u>3,004,696</u>	<u>3,009,923</u>	<u>5,227</u>	<u>5,335,020</u>	<u>56.4%</u>
1982-1Q	3,856	1,904,971	1,910,467	5,496	1,733,223	110.2%
2Q	3,594	1,301,322	1,305,924	4,602	1,932,140	67.6
2Q	8,218	1,103,759	1,109,337	5,578	2,174,767	51.0
4Q	27,743	950,486	958,234	7,748	2,388,455	40.1
	<u>43,411</u>	<u>5,260,538</u>	<u>5,283,962</u>	<u>23,424</u>	<u>8,228,585</u>	<u>64.2%</u>
1983-1Q	387,088	3,338,569	3,531,306	192,737	2,760,213	127.9%
2Q	273,115	1,823,167	1,960,395	137,228	3,223,180	60.8
3Q	496,505	1,545,910	1,776,908	230,998	3,729,111	47.6
4Q	839,125	1,085,468	1,552,752	467,284	4,402,024	35.3
	<u>1,995,833</u>	<u>7,793,114</u>	<u>8,821,361</u>	<u>1,028,247</u>	<u>14,114,528</u>	<u>62.5%</u>
1984-1Q	549,109	549,109	6,372,892	5,823,783	5,310,743	120.0%

Total Reserve at 3/31/84

**\$6,881,181**

.... The 1982 loss ratio ranges from 110.2% in the first quarter to 40.1% in the fourth quarter.

.... The 1983 loss ratio ranges from 127.9% in the first quarter to 35.3% in the fourth quarter.

Also note how the relationship of the first to fourth quarter loss ratios change with the volume of business. As business begins to mature, the slope tends to increase because more policies present a full year of exposure versus a partial year. In other words, if a policy is in force at January 1, Part B claims for that policy will tend to have an incurral date early in the year with larger amounts paid on the claim rather than a later incurral date with lesser amounts. The reasons for this relationship are:

- i) Multiple claims receive an incurral date of the first treatment date in that year, resulting in decreasing frequencies throughout the year.
- ii) Incurrals earlier in the year have more time to accumulate dollars of claim for additional services or treatments.

In moving to 1984, what loss ratio would you choose for the first quarter of 1984? Based on trend, would you choose 150% for a total reserve of approximately \$8,475,000? Or how about 120%, since the volume of new business is increasing very rapidly, for a reserve of \$6,880,000? What about the impact of automatic rate increases to recognize the impact of the Medicare deductible? At any rate, the estimate of the first quarter loss ratio is difficult if not impossible and this estimate is only a little easier at the end of the second quarter due to the slow run off for the first quarter. Generally, only at the end of the third quarter, can you start to have some confidence in your first quarter loss ratio estimate and estimated reserves.

The calendar year method also raises other questions:

.... How do you adjust earnings during the year for a quarterly statement? If not adjusted, large losses will generally appear in the first quarter and large profits in the fourth quarter. It seems any method here must be artificial unless a per cause rule is used simultaneously to help estimate the effect.

.... This method also seems to impose an automatic delay in generating credible results for more recent periods at certain times during the year (i.e., at end of first and second quarters). This can result in delays in implementing rate increases and thus lost dollars as well as make control of the overall loss ratio more difficult.

The second exhibit in the handout is for a Part B only plan through 12/31/83 with no new sales since the third quarter of 1981. Note the change in the loss ratios again from the first to the fourth quarter. You can see the slope is much greater than for a plan with Part A and B benefits; just imagine how difficult it would be to estimate a reserve for this plan at the end of the first quarter.

Also you will note in this second exhibit how unprofitable the plan is. This has continued to be the case in 1983 despite rate increases totalling well over 100% in the last two years. These results are typical of the effect which rate increases often have on the loss ratio; in other words leveling rather than decreasing it. Note, however, that when the loss ratio exceeds 90%, we have generally found that rate increases will tend to lower the loss ratio some.

Based on these examples, I hope you can see how important proper incurral dating is. Without it, the methods you use to calculate claim reserves will probably not produce a representative result. Therefore, once a company has established incurral dating rules, then and only then should methods of claim reserving be considered.

## 2. A General Problem in Setting Claim Reserves.

After establishing the incurral dating rules, three methods generally exist of setting claim reserves. There are the lag method, case method (as for long term disability claims), and a formula approach (such as paid claims for the last three months plus 50% of that total for incurred but not reported claims).

I always recommend the lag method where enough data is available and benefits are short term (a ten year run out or less until the last claim is paid). This method allows a fairly sophisticated analysis, but additional information such as pending claim counts, reporting lags, processing time, and other information from the claims department should be gathered to the extent possible. In other words, any information which might be helpful should be considered in the analysis.

As for the case method, this method generally requires some estimate of the additional amount to be paid on claims or the implementation of a lag factor. Since this requires more knowledge of the lag pattern, why not perform a lag study if possible. We have seen a number of companies use the case method for short term benefits, only to ignore or add a clearly insufficient amount for the additional run out. This will occur because the average claim amount is determined from year end open and closed claims combined - or closed claims only which represent an immature block of business.

Exhibit 2

Summary of Experience  
Medicare Supplement Plan  
Part B Benefits Only

<u>Incurral Period</u>	<u>Paid to Date</u>	<u>Estimated Incurral Claims</u>	<u>12/31/83 Reserve</u>	<u>Earned Premiums</u>	<u>Loss Ratio</u>
1979 (Sept-Dec.)	\$ 136,612	\$ 136,612	\$ 0	\$ 420,747	32.5%
1980	2,556,069	2,556,126	57	3,246,506	78.7
1981 - 1Q	3,038,989	3,041,430	2,441	1,128,976	269.4%
- 2Q	1,128,560	1,129,935	1,375	1,223,777	92.3
- 3Q	632,425	633,787	962	1,151,811	55.0
- 4Q	<u>250,046</u>	<u>255,560</u>	<u>514</u>	<u>957,337</u>	<u>26.7</u>
Total	5,055,020	5,060,312	5,292	4,461,901	113.4%
1982 - 1Q	2,742,920	2,752,885	9,915	850,000	323.9%
- 2Q	560,176	564,698	4,522	746,806	75.6
- 3Q	182,849	185,351	2,502	613,531	30.2
- 4Q	<u>92,882</u>	<u>94,704</u>	<u>1,822</u>	<u>540,523</u>	<u>17.5</u>
Total	3,578,877	3,597,638	18,761	2,750,860	130.8%
1983 - 1Q	1,581,485	1,989,294	407,805	493,996	402.7
- 2Q	205,470	277,841	72,371	474,767	58.5
- 3Q	67,504	114,414	46,910	438,073	26.1
- 4Q	<u>3,412</u>	<u>42,389</u>	<u>38,877</u>	<u>423,889</u>	<u>10.0</u>
Total	1,857,975	2,423,938	565,963	1,830,725	132.4%
Total Reserve at 12/31/83			\$ 590,073		

Concerning the formula method, this is still simpler than the case method and often not as accurate; thus this method is probably appropriate only for small blocks of business. Note that we would certainly recommend a case method over a formula approach for long term benefits where volume is significant.

In general, companies have also had trouble establishing appropriate claim reserves because of failure to recognize important influences in the claim reserving process, besides incurral dating. These include:

- .... variations in claims processing (i.e., staffing changes, known backlogs, new computer systems, etc.)
- .... changes in exposure
- .... premium increases
- .... relative maturity of the block of business
- .... impact of large claims

Once the experience analysis is completed and recognizes all pertinent influences, proper and timely actions, if necessary, should be taken using the results as a guide (this includes rerating, cancellations, etc.). If a company pays close attention to experience monitoring and does a quality job, the effect can be to avoid large rate increases (in excess of, say, 30%) and/or cancellation of products where the product was properly designed at the beginning. If design was poor thus precluding profits, close monitoring will allow the company to minimize losses by affording this information more quickly. This naturally makes dealing with rate regulation easier than it would be if action was delayed and results continued to deteriorate. Obviously, however, proper experience monitoring does not mean that experience estimates will always be accurate, and that all problems can be avoided.

In summary, then, if care is taken in rating the product, rating principles are applied on a consistent basis and close and appropriate monitoring is done, the impact of rate regulation should be minimized and generally easy to deal with. Stated another way, most of the problems occur when companies have not done a good job in product design, initial rating or in the monitoring/rerating cycle.

MR. DAVID B. TRINDLE: My remarks are organized in two related subject areas: a response to the specific data shown, relating to loss ratio experience in Washington, and a development of some general guidelines for measuring credibility.

Response to Washington Loss Ratio Report

On my first look at the figures presented in this report I was surprised at the large number of companies experiencing extremely low loss ratios. Upon closer review it was apparent that there was not enough exposure to draw a valid conclusion for many of the companies in the study.

For example, the 64 companies experiencing the lowest loss ratios averaged less than \$7,000 in premium for each year of exposure. This could be fewer than 10 Medicare Supplement policies or perhaps 25 average sized Hospital Indemnity policies. These are certainly not large enough samples to be statistically credible.

The loss ratio index, although convenient, is an unreliable and sometimes misleading measure of value to the policyholder and should be used cautiously. The loss ratio is an aggregate measure; it does not apply to individuals. We may say that a group of policies is expected to experience a certain loss ratio. Then, given a large enough group and enough time, it would be reasonable to assume that the loss ratio would actually be achieved if the assumptions originally used were valid. However, we cannot predict that each and every subset of the group will achieve the expected loss ratio. In fact, we should expect fluctuations to become significant as the size of the subset decreases. Therefore, the more you subdivide a set of loss ratio statistics, the more likely you are to see extreme results in certain subsets due purely to random chance.

This is the case with the Washington report which, for many companies, is more a demonstration of statistical principles than a demonstration that their products do not return a reasonable benefit in relation to premium.

I suggest that the data indicates a large number of regional companies that do not sell policies in Washington but do have a handful of policyholders in the state who moved in from somewhere else. The data also reflects those companies operating only in the group market; many of these companies have only a few conversion policies in force. Neither of these situations provide a statistically credible sample from which you could draw meaningful conclusions concerning any individual companies.

I do not mean to say that the data is not useful but only that it should be interpreted cautiously. It is certainly not a demonstration of widespread abuse. It could serve as a useful tool in guiding a regulator where to look for problems though.

But this is only an indication of where to start looking. I would suggest that the next step would be to look at the nationwide experience of the companies reporting the lowest

loss ratios. This information is readily available in the Policy Experience Exhibit and would quickly eliminate those companies with credible experience nationwide but non-credible experience in Washington. The next step would be to ask the remaining companies for more detail including:

1. Type of business--accidental death, disability income, etc.
2. Maturity of business
3. Expected future loss ratio development

I do not think you can avoid this type of in-depth analysis if you really want to identify bona fide problem areas. You cannot just look at a set of broad statewide statistics on a large collection of companies and expect to draw any meaningful conclusions about any individual company. You must take credibility into account.

#### Credibility Guidelines

The table on the following page summarizes the results of several Montecarlo simulations we set up on our personal computer in order to get a feel for the amount of exposure needed to draw conclusions from loss ratio statistics with some degree of confidence. In each case we simulated the experience of ten separate companies over a one year period.

Assumptions were as follows:

	<u>Rate of Claim</u>		<u>Distribution</u>	
	<u>Source</u>	<u>Rate</u>	<u>Claim Size</u>	
			<u>Percent</u>	<u>Amount</u>
Accidental Death	59 ADB Age 42	.00040	100.0%	\$10,000
Disability Income	64 CDT 90 Day EP Age 42	.01257	100.0	10,000
Medicare Supplement	Company Experience	.30000	70.0	200
			15.0	350
			10.0	650
			3.0	1,500
			1.0	3,500
			1.0	6,000

Although the simulations produced a wide variety of results two general conclusions can be drawn:

1. Credibility is highly dependent on frequency and therefore on the type of product being evaluated. For example, a block of 5,000 Medicare Supplement policies with its 30% claim rate is more credible than a block of 10,000 accidental death policies.



Montecarlo Simulation of Claim Loss Experience  
Showing Degree of Fluctuation in Loss Ratios

Results of Simulation of Ten Companies For One Year

<u>Product</u>	<u>Policies Exposed</u>	<u>Earned Premium (Thousands)</u>	<u>Expected Claims (Thousands)</u>	<u>Expected Loss Ratio</u>	<u>Loss Ratios Experienced</u>		<u>Number of Companies Experiencing Loss Ratios</u>			<u>Total</u>
					<u>Lowest</u>	<u>Highest</u>	<u>10% or More Below Expected</u>	<u>Within 10% of Expected</u>	<u>10% or More Above Expected</u>	
Accidental Death	1,000	\$9	\$4	45.0%	0.0%	112.5%	6	0	4	10
	2,500	22	10	45.0	0.0	90.0	5	2	3	10
	10,000	89	40	45.0	22.5	90.0	4	3	3	10
	100,000	889	400	45.0	40.5	60.8	0	9	1	10
Disability Income	500	140	63	45.0	28.6	71.6	3	4	3	10
	1,000	279	126	45.0	35.8	71.6	0	7	3	10
	5,000	1,397	629	45.0	36.0	55.8	0	9	1	10
	10,000	2,793	1,257	45.0	39.4	49.4	0	10	0	10
Medicare Supplement	500	100	60	60.0	45.6	75.0	1	7	2	10
	1,000	199	119	60.0	44.9	73.7	1	8	1	10
	5,000	994	596	60.0	53.7	62.4	0	10	0	10

DBT/5-2-84

2. There are always some unusual results. Even with the higher credibility expected from the block of 5,000 Medicare Supplement policies (\$1,000,000 in earned premium) one company experienced a loss ratio more than 6 percentage points below expected--purely due to random chance.

This table only provides some general guidelines for credibility. There are certainly other approaches and sets of assumptions that would be just as valid. The important point is that we need to be cautious in presenting loss ratio figures to our managements and clients whether they be insurance companies, regulators or policyholders. Where statistical credibility is an important factor in a loss ratio study, it should be taken into account and addressed as part of the loss ratio presentation itself.

MR. THEXTON: There seems to be some lack of communication between the regulator and the company actuary. The regulator finds himself defending some statistics which his commissioner has found showing the companies with some very poor payouts for this period and the actuaries find themselves defending some very high or very low loss ratios in their own company from their top management or trying to attack the problem of a very high loss ratio with a regulator whose current biggest concern is the low loss ratios of other forms. If someone has some ideas as to how you deal with rate filings in your company, please share some of those formats or concepts with our audience.

MR. TRINDLE: We talked about two problems. One of the problems was how does one deal with a politician who is reading a loss ratio report like Storm was presenting and is not really all that interested in the actuarial science of it all. He is trying to make himself look good and promote his political ambition, and he sees 64 companies that have a 6% loss ratio, and thinks "there has got to be abuse going on out there". I think it is our job to try to deal with those kinds of misinterpretations of the information. But it is a hard job and we are never going to do it completely. There is always going to be someone out there who wants to lie with statistics. We have discussed some of the ways of getting around it in terms of setting up contingency reserves by state where, knowing that your loss ratio, which may only have been 6% in one year, was only a statistical fluctuation, maybe you should allocate a reserve to that - call it a contingency reserve, which brings that loss ratio up to some kind of expected level. In that way, you allocate a contingency reserve across all of the states which, in effect, takes that small cell of data that you have to report and inputs to it a loss ratio that is more like the nationwide loss ratio that you are experiencing. Then you can avoid the whole problem.

MR. JOHNSEN: I agree with the technical analyses presented by Dave and Mark. I have given a lot of similar explanations to non-technical and supervisory people within the department and

also to the public. Without a computer, I cannot do Monte-carlo, and so my explanations have not been as sophisticated. Most people however, are not educated in statistics, or in actuarial science, and they do not believe the explanations. It makes no difference how much explanation you give and how much valid proof and justification you give, the fact is that the statistics as they are shown are not socially acceptable.

MR. LITOW: I find that contingency reserve concept interesting but it seems to create a lot of artificiality. My concern is that, that might help you, Storm, in showing your results as 50% or 55% but it would also allow the companies that really are ripping off the public to build up their reserves artificially and you would not catch them, or have less chance of catching them. So in terms of taking away some of the political criticism, it would help but in terms of actually catching the companies that are ripping off the public, I do not think it would do any good at all.

MR. TRINDLE: The contingency reserve allocation to states only really pertains to very small exposures and, for very small exposures, there is no way you can tell whether that company is ripping off anybody. That is one part of the problem. There are companies out there with loss ratios that do not meet the minimum but focussing on what is a statistical aberration is not the way to get at the problem.

Another area that we got into is what kinds of things can be done to improve the results of rate increase filings. Some of the things we have learned over the past couple of years, with 12,000 rate increase filings last year and slightly more the year before that, is that the best way to get a rate increase approved is to present absolutely all the possible data that you can present about that product. Do not try to base your presentation to the state based on what they have wanted in the past or what you think they want. Our experience has been just the opposite. I suggest you put together a rate increase filing that has everything in it: a description of the product, a description of what you are trying to accomplish, why you are trying to get a rate increase, what, if anything, went wrong, how you expect to fix it, what kind of product it is, what does it cover, who is it sold to, how many policyholders are affected in the state and nationwide, what are the status of the filings in other states, what is the actual history of the claim losses by policy year, what is your future projection of what the losses are on a current rate basis and on a basis of the rates actually charged, and what have been the results of your product on an actual to expected basis (if you expected a 35% loss ratio the first year and 50% the second, what did you actually get?)

We have attached copies of the policy forms themselves to the filings and copies of the rate sheet before and after the rate increase. What we try to do is leave nothing to the imagination. We did this about a year and a half ago and it worked

wonderfully. The number of questions that we got back from the insurance departments just dropped off to the point where the few questions that we were getting were things like "what's the loss ratio on a current rate basis" - well, it was on page 7. Most of the questions that we were asked were on this or that page.

We also do it using the NAIC guideline approach. We tell them that and we have a page in our rate increase filing that goes through the simple, step by step loss ratio tests in the NAIC guidelines. You still need to have special filings in some states where they require certain information in a format that has to be just the way they want it, and you cannot avoid that, but it has worked very well to file on a standardized and complete basis.

MR. DONALD G. HAMM: Regarding interaction between the calendar year incurral dating process and pricing, what approaches are currently being utilized? What do you recommend as opposed to what is being utilized and how do you handle the problem where you have a claim with various dates of service?

MR. LITOW: On Part A a 60 day separation period is used by almost all companies which coincides directly with Medicare. For Part B a calendar year all cause approach is used, where the first treatment date during the year is incurral date regardless of cause and that carries over until the next January when it rolls over. We have a few clients that use a per cause rule and that is what I would recommend. Part A would be the same as under the calendar year approach. Under Part B a six-month separation period should allow a situation where treatments really have stopped for a while and the cause would really be a separate cause. In other words, if someone has treatment in the first four months of the year through April, and then has a treatment months later in August, then another in December, then that would still be the same cause and the same incurral date. But once there is a six month separation period, where the person that has treatment in April and does not have another through the end of September, that would be a six-month separation and so anything in October or later would then get a new incurral date. You could therefore have a separate incurral date for Part A and for Part B claims under the same rule. It is a little more complicated but it makes the actuary's life easier in establishing claim reserves, explaining the results of quarterly financial statements and looking at rate increases. It will save actuarial fees or staff time within the company.

MR. LITOW: How do you react if a company files for a 120% increase versus 30%? Does the size of the rate increase have anything to do with it or do you look strictly at the projection made and decide on that basis?

MR. JOHNSEN: The size of the increase would have something to do with it, but what I like to look at is the projection that

was made at the time of pricing. At the time of pricing the actuary says that two, three, or four years down the road the claims experience is going to be such and such. I like to have that compared to the actual experience in an actual to expected kind of approach. If that would qualify them for the rate increase, or 30%, 60%, or 90%, then that is it. If the rate increase gets rather large I have asked the company from time to time if they would consider two or three rate increases, because I think when you put through a large rate increase there are going to be some people who drop their policy and there is going to be some selection in that time. Perhaps with a series of smaller rate increases it would work better.

MR. THEXTON: I remember when Prudential had its CHIP form. It announced to its policyholder when it made the sale, "here's the rate now, and this is what the rate will be next year if nothing happens. But something is going to happen. You can depend on it. We're going to have a rate increase. We expect there will be a rate increase every year because medical care costs are going up every year". They have made a big point of their honesty and straight-forwardness and so forth, and I guess they did it that way. My question is, when most companies originally file what do they say to the regulator, and what does the regulator ask them to say, about what their rate increase practice is going to be? Also, if a company overlooks a rate increase, or fails to make a request for a rate increase for whatever reason, is the company expected thereafter to forego that piece and only try to get the future pieces? Trying to go back and get two years in one, as I understand it, is most likely to be fatal.

MR. JOHNSEN: Most of the companies will not make any reference to rate increases. As a matter of fact I have sometimes asked companies at what time they would anticipate to have a rate increase and I have sometimes been given answers from known actuaries that they expect these premiums to hold for the life of the policy. The particular policy forms in question were major medical type policies that were subject to inflation. This is an attempt at justification which is not reasonable.

MR. THEXTON: Is that a good thing when companies do not say anything and everyone else knows there is going to be a rate increase?

MR. TRINDLE: On an original filing of Medicare Supplement we file it per unit of benefit and tell the regulator that the premium rate will not go up but the premiums will go up each year with the medicare deductible. On a non-medicare policy it is really not that clear. When someone says that the premium rates are going to be valid for the life of this policy, I think that he is probably saying that in good faith. He is saying that the premiums are going to be valid for the benefits provided at this point in time for the life of the

policy. In other words, it is not going to be adequate for increases in benefits in later years, but for the benefits that are in place right now the premiums are intended to be adequate for the life of the product.

MR. CHARLES HABECK: Any company that says the major medical premium is going to be adequate for the life of the policy will face certain failure in a very short time. No projections that we do of gross premiums include an inflationary trend factor for more than a couple of years. The accepted projection period is about ten years in which to recover the initial acquisition expense.

I have thought of three companies using attained age rating methods which have filed methods for determining the rate increases. Some of these companies have filed rates that apply for six subsequent calendar years. Any deviation from the expected trend (which could be anywhere from 15% a year at low deductibles to 30% at high deductibles) would call for an additional increase in that scale. The actuary from one of those companies has told me that the method that he filed was accepted in most states. Other clients did the same thing. They filed a method that was appropriate in all states, except Connecticut. They did not renew the twelve policies they sold in Connecticut. I find it difficult to believe that anyone can seriously say the major medical rate is going to last any longer than about two years.

The real question I have about attained age rating is whether it is viable at all. Clayton Cardinal has written on this subject. He theorized on what the true rate increase would be if you matched up the premium and the expectations from year one on and gave an "equitable" rate to the policyholder. These articles appeared in the National Underwriter. It was alarming to see that if you told the policyholder the real truth, he would get something like a 54% rate increase after the first year and very substantial steps after that. What happens to the success of the product is that the lapse rates preclude the possibility of recouping your acquisition expenses.

One of the disastrous areas where the attained age rating is coming in is in the rating of Medicare Supplement policies. Many states actually require that these Medicare Supplements be guaranteed renewable and that almost mandates an issue age rating system. I use the phrase issue age in distinction to level premiums. I think the same effect can be achieved by issue age rating with a policy reserve as can be achieved with attained age rating and a premium stabilization reserve, if you want to call it that.

MR. TRINDLE: I think that many of us have the opinion that attained age rating will not work, that you really have to price it on a level premium basis and have a rate increase pattern that tracks benefit increases, whether that is

inflation or medicare deductible increases. If you try to rate by attained age you are going to need rate increases larger than the benefit increases and that is where you are going to get anti-selection. So what I am promoting is level rating because you need that to minimize the anti-selection.

At the same time we are having regulators tell us that we cannot calculate the rate over the lifetime of the product. What that means is if you have to shorten the period of time over which you calculate that rate, you are moving away from level premium pricing toward YRT pricing.

What some regulators are saying is that if the rates are not going to be adequate for the lifetime let's just calculate the premiums over three years or so. What happens is that you lose the normal aging part of your premium rate. When I tell a regulator that my rates are adequate over the life of the product what I am trying to do is build into my rate all the normal aging that I expect. The marketplace will not let me build inflation into it, so what I try to do is price it with all the normal aging in place and increase the rate each year with inflation. But Washington for one has a regulation which shortens that calculation period and moves us more in the YRT direction. I think that is where the issue of how long a premium is to remain valid becomes important because that regulation is working against the kind of pricing that minimizes the anti-selection spiral.

MR. JOHNSEN: I do not think that the Washington regulation states that you cannot price the product on a level lifetime basis. What we are trying to do is have the company not tell us that they never anticipate a rate increase. What we would like to see is a company filing a set of premium rates, saying that they anticipate that these premiums will be adequate for the next two or three years and at that time they would like to come for a rate increase. That does not mean that the pricing actuary cannot calculate level premiums for the lifetime of the policy. But do not file those level premiums stating that you do not anticipate a rate increase. It is surprising the number of companies that do this.

MR. TRINDLE: That is a totally different question and I think that is a totally different way than some regulations operate. I do not think we would have any trouble at all, and it would probably be a good idea, giving the regulators some advance warning of what we think the future inflation trends are going to be. But has your regulation shortened the calculation period and does that move us towards YRT pricing?

MR. JOHNSEN: I think what we have done is identify a calculating period over which the pricing actuary feels that the rates will be adequate. But that has nothing to do with the calculation of the pricing actuary or premiums over the lifetime of the policy. Those calculations, as we talked about previously, are going to include rate increases for inflation and other reasons.

MR. TRINDLE: Suppose I priced a product that was going to experience 10% inflation a year, in our opinion, but priced it at today's benefit levels over the lifetime of the product and I present to your department a projection of what the future claims and premiums are going to be. I expect inflation, but I'm doing this pricing calculation based on today's benefits and telling you I expect inflation and rate increases in the future. Will you let me calculate that premium rate or show that projection for longer than the calculating period?

MR. JOHNSEN: I have priced products for a long time and I think that any pricing actuary would calculate premiums on the lifetime of the policy. However, we would not want to be in the position of approving a premium that is calculated over a long period of time, such as a twenty-year period or longer, for benefits which are obviously subject to inflation. What we prefer to do is to approve the policy form and the reasonableness of the premium to the benefits. We would approve that reasonableness for a shorter period of time, such as two or three years, within which we may have some kind of an idea of the type of inflation that we might be exposed to.

MR. LITOW: What Storm is saying is that regulators want to know how many years of inflation is built in to the rate. So if you built in two years of inflation you are saying that the rates are only good for two years and you anticipate a rate increase after that period of time. Is that a correct interpretation?

MR. JOHNSEN: Yes, and I think our regulation may attempt to do something else. It makes a specific provision for carrying funds forward. For example, you calculate a premium on the lifetime of a policy, but at the end of the calculating period, which may be two, three, or four years long, there should be a fund build-up since in the early years loss ratios might be considerably lower than the 55% or 60% objective. That fund should be carried forward into the next calculating period. You may call that a fund, a premium stabilization fund, or a contingency reserve, as long as it is carried forward and is accounted for or used in your next premium calculation.

MR. ROD ROSS\*: If we are trying to develop a minimum loss ratio of 60%, for example, are we developing the loss ratio on the life of the policy under the assumption that the benefits remain constant? Are we building something in for inflation? Are we tossing our contingency reserves into the picture? I am a little confused as to how the whole thing works out. My understanding, not being able to forecast the future, is that there is a certainty that health care costs are going to increase and yet we find today that in some instances they are actually decreasing. We do not know if they are going to go up or down and therefore we can only base our projections on what we know today. If it takes ten years in order for a product to turn a profit how can we achieve a 60% loss ratio in two or three years?

\* Mr. Ross, not a member of the Society, is with Equitable Life and Casualty Company.



MR. LITOW: In answering the first part of the question, when you price for a 60% loss ratio you would only have a couple years of inflation built in even though the aging would run over the life of the policy. When you put in a rate increase again you would probably be adding for a few more years of inflation but you would never be adding inflation over the life of the policy as that would put you totally out of the marketplace.

MR. TRINDLE: I'm confused too, but I think that what Storm is saying is that if you shorten the calculation period to three years and set up a reserve of some kind, then that represents the policy reserve that is based on the lifetime expectations and we are doing exactly the same thing in a different way. Is that right?

MR. JOHNSEN: Yes. To simplify it, let's suppose that the calculating period was three years, and that the lifetime of the policy was twenty years, but due to all these reasons we discussed we are choosing to use the three year period. We are shooting for a 60% loss ratio. Let us assume that the loss ratio in the first three years is projected to be exactly 40%.

The difference between the 60% objective and the 40% expected loss ratio in the first three years is 20%. Therefore the fund that you should carry forward at the end of the three-year period would be 20% of the earned premiums, assuming that the actual experience is exactly like you expected. If the 20% of the earned premium fund is carried forward into the next calculating period, say of three years, then presumably there should be a large enough fund to carry the policy through the life of the contract.

MR. THEXTON: To me, you are saying that while the 40% is incurred claims you have another 20% of reserves meaning that total loss ratio for that three year period was 60%. But, of course that policy reserve has to be a credit to the future experience that you are now anticipating. Because your original calculation assumed no more inflation and you actually anticipate more inflation you now have to have a further rate increase. That rate increase must contemplate the value of this 20% reserve.

MR. HABECK: In that connection, I think that the same objective is achieved by use of a GAAP type reserve, such as described in Joe Pharr's paper, where he equalized the loss ratios over all of these years at about 53% or so. In that way you are not earmarking the thing as a separate contingency reserve. It is above the line and is a required reserve.

I have a question on what the panel thinks is the nature of this fund. First of all, who should hold the fund? Should the company hold it or should it be a deposit held by the insurance department, as was suggested by the actuary from Florida? Is it enough that the fund be unallocated and be

part of the company's surplus? This would be the normal way a company would operate with this kind of risk. They would be trying to determine their surplus needs based on all the risks - life, health, disability, and so on. What do you see as the proper way to provide for these future contingencies?

MR. TRINDLE: I would call it a policy reserve. It is just like a GAAP reserve, or the same concept, where you are trying to match expenses and revenues and you are trying to level that benefit cost and if all the GAAP assumptions are exactly valid you will have a level loss ratio.

MR. JOHNSEN: I would like to say that the Washington Department would not like to hold those funds. I think that the company should hold the funds. I believe we would like to see them at the time of the rate revisions. If there is a question regarding the size of the surplus account we would like to see a demonstration that the surplus account is in fact adequate and large enough for all the funds that the company has said they are holding.

MR. LITOW: I'm sure that the companies would not like that either. You are really talking about a fundamental change in statutory accounting principles and, lest we forget, there is also an item called deferred acquisition cost, and if we are going to force the companies to hold this large extra reserve it almost seems fair to let them take some credit for this item which heads back in the direction of GAAP.

MR. WILLIS W. BURGESS: Storm Johnsen said that some companies do not live up to the standards promised in the rate filings. We are all health actuaries trying to do the best job we can, both from the regulatory and corporate standpoint. But we are not soothsayers and nobody's promising what those rates are going to provide in the way of loss ratios on the individual policy forms. A responsible regulatory actuary's main concern has to be with the consumer. As responsible corporate actuaries, our responsibilities have to be to the overall solvency of the corporation through the overall adequacy of rates for various blocks of business. Let's give the responsible corporate actuary the flexibility to do everything in his power to see that the rates are adequate and that reasonable and proper premiums are charged in relation to the benefits. If we take that approach, and continue discussions like this, we will be working toward a reasonable solution to this problem.

MR. JEROME M. STEIN: I appreciate Pete's comments on how we started with CHIP - with almost a promise that there would be rate increases. Unfortunately, we learned something very dramatic from this. We came up with a policy that protected the policyholder who became sick from the ravages of inflation. But we found those who did not become sick were not willing to share the cost of inflation when the necessary rate increases started to be very large. As a result, the antiselection shot

way up. Healthy policyholders who were able to seek other coverage left us, sick policyholders stayed on because they had no choice, and we had the disaster which has been previously recounted.

We have had problems with the State regulators, with regard to our new attempts to market a socially responsible and hopefully not financially losing product, not with our premium structure but with the benefits that we wanted to provide. Our attempt was to offer a policy that would provide adequate protection for people who had claims, provide good protection against catastrophic claims and yet would have provisions that would, if not immunize the premiums against inflation, would greatly decrease the probability of another inflation spiral. We produced a policy which has scheduled daily room and board benefits, and scheduled surgical benefits with no carry-over of any excess into the major medical part of the coverage. We had a front end deductible for hospitalization which we wanted to have equal to the selected daily room and board charge. In a number of states there were statutory or regulatory inhibitions to this which required us to have a lower daily room and board deductible than we were seeking.

We wanted a variable deductible before our major medical coverage took effect and we wanted it to be a large number like \$1,000 plus any other major medical coverage that the policyholder would have. Many states allowed us to have that but there were a number of others who allowed us to only have a deductible which was the greater of either \$1,000 or the other coverage and there were some states that required us only to have a fixed and non-variable deductible. Another area that we felt was in the consumer's interest and which we tried to have included was third party liability offsets so that if the claims were going to be paid by a third party, perhaps under a no fault auto insurance or some other liability insurance, that we would not be duplicating that payment. Here again we got the cooperation of most states but there were a number of states that would not permit us to have this in the policy. We are approved in almost all states now and we compromised on these areas rather than say that we will not operate in the states that would not allow us to have the policy that we wanted. We really hope that this is a policy which will not require annual rate increases and where we may be able to go for a longer period of time between rate increases. Of course, that will depend greatly on whether inflation returns to the high levels that we were experiencing a couple of years ago or whether inflation will continue to drop and give us breathing space of several years and allow our healthy policyholders to stay for many years with the premium structure that we have.

MR. THEXTON: It sounds as if you had to have a lot of state variations regarding the variable deductible, hospital deductible, third party liability and so forth. Did you end up with fifty-one forms?

MR. STEIN: I think our standard policy is in effect in about one-half dozen states, but there are dozens of variations, some minor and major.

MR. THEXTON: Then each one, in effect, has a rate structure of its own. What happens when a person moves from state to state? Have the regulators been giving you a hard time about it or have they even noticed?

MR. STEIN: Some of these are questions that we have not yet had to face. We started selling in August, 1983 in about ten jurisdictions. So we are still in the first policy year, even on our oldest policies.

MR. TRINDLE: Jerry, do you expect to have to raise the premium rates as that block of business ages?

MR. STEIN: Yes, we think that if there is continuing medical inflation at some level, and that seems inevitable, that the time will come when we will have to raise the rates. We do not know whether that will be within a year or several years, but it is our anticipation.

MR. TRINDLE: There is a scheduled portion of the policy that is not inflation sensitive, right?

MR. STEIN: It's not inflation sensitive to dollar inflation but it is subject to variations in utilization which conceivably could go down as well as up.

MR. TRINDLE: If there were no changes in utilization and no inflation would you expect to have to raise rates in the future?

MR. STEIN: Yes, because there is a major medical portion which is picking up other expenses besides room and board and surgical. The deductible before you enter this major medical portion will become less and less significant as inflation continues. A \$1,000 deductible today may shelter us from a lot of major medical claims, but it may shelter us from very few a few years down the road. So there is an inflation sensitive part of the policy that in time probably will lead to the need for rate increases.

MR. TRINDLE: In most states did you file the policy in today's benefit levels and then presume that if inflation occurred that you will have to raise the rates proportionately.

MR. STEIN: Yes.

MR. TRINDLE: Did you tell the regulator that you expect rate increases?

MR. STEIN: Yes.

MR. TRINDLE: But you didn't build any inflation into your existing rates?

MR. STEIN: That's right.

MR. TRINDLE: Suppose there were zero inflation and zero change in utilization. Would you expect to have to change your premium rates just for the aging of the business?

MR. STEIN: It would depend on the pattern of sales, persistency and in-force. If, for example, the block of business we have today turns out to be our total book of business, because for some reason our agents were unable to sell any policies after today, I would expect that over time the persisting policyholder's health would start to deteriorate. Perhaps some of our healthiest policyholders would drop out to buy other coverage, and there would probably be a secular deterioration in the health and the experience of the group.

MR. TRINDLE: So you have not priced it on a level premium basis. You have priced it on an attained age basis?

MR. STEIN: Yes.

MR. LITOW: Because of all your variations by state, are you going to be able to combine experience by state when asking for rate increases or are you going to have to keep each state separate, except where they use the same policy?

MR. STEIN: Some of the differences are much more significant than others. For example, there may be a certain mandated benefit in a particular state whose real total effect on the premium is small enough that it has not been recognized for a separate rate. I did not mention mandated benefits, but that is another area where we had problems. We do have a number of separate rate bases, and if the experience was sufficiently divergent, I could imagine us having different rate increases for different states.

MR. HABECK: I think we are looking at rate increases in the wrong way. I think that major medical rate increases should be looked at as charging a higher premium as the benefits increase. What the process involves is a future increase option, or guaranteed insurability without evidence. This is what we are providing to the policyholders and, naturally, they have to pay for the additional coverage. The fact that a company is asking for a rate increase does not necessarily mean that they are acting contrary to the interest of the policyholders.

MR. LITOW: That would be like Medicare Supplement in California. California does not recognize automatic rate increases. You have to file for experience. So even though you know the Part A deductible is going up each year and you will need more premium to cover it you have to file it as though it's a regular rate increase.

