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

THE PROFESSIONAL CHALLENGE OF INDIVIDUAL MEDICAL INSURANCE

Moderator: CHARLES HABECK. Panelists: RICHARD W. ERDENBERGER, CURT L. FUHRMANN, PAUL JANUS. Recorder: DAVID W. KRUEGER

Insurers have been getting out of the individual medical expense market. This session will address the implications of such a decision:

- Nature of the problem
- Viability of individual medical products
- Challenge to the actuary
- Consequences of withdrawal
- Alternatives of withdrawal

MR. CHARLES HABECK: Good morning! This is panel discussion 35, "The Professional Challenge of Individual Medical Insurance."

Individual health insurance is an important part of the health care financing system now operating in the United States. However, except for the Medicare Supplement, it tends to receive much less attention than group insurance financing methods.

Today our panelists will review some of the main problems that must be solved in order to successfully market and manage the individual health line. These include:

- environmental problems
- plan design problems
- pricing and re-rating problems

Challenges to the actuary --in whatever role he plays-- will also be considered, as well as techniques to control the risk and cope with regulation.

Our first panelist is Curt Fuhrmann. Curt is Senior Vice President at Time Insurance Company. He is currently responsible for all actuarial functions in his company and for the individual product line: underwriting, claims, and policyholder services. Curt will discuss today's topic from the perspective of a company whose primary business is medical insurance.

MR. CURT L. FUHRMANN: To begin I would like to provide a brief background of Time Insurance Company, as a frame of reference for my subsequent remarks. Time is a subsidiary of N.V. Amev, a large Dutch financial services organization. During 1983, Time's earned premium totaled $262,000,000. Individual Health products accounted for $123,000,000 and Group Health products another $97,000,000. The Individual Medical premium was $112,000,000. Medical insurance is clearly our primary business. We offer a broad range of individual products, including disability income, medicare supplement, hospital indemnity, and comprehensive major medical. However, by far the majority of our premium comes from the comprehensive major medical products. We have been in the individual medical business for over 30 years and the line has been profitable in each of those years. The medical line has

consistently been one of our major profit centers. My perspective, thus, may differ somewhat from that of a person representing a more traditional life insurance company with life products as the primary focus, and my comments are addressed primarily to comprehensive product types.

Certainly when ranked on an overall basis, the individual medical business does not appear particularly attractive. The reasons are as follows:

1. Experience can be very volatile. Frequency, due to factors as greater health care awareness, the practice of defensive medicine, poorly designed coverage; and severity, fueled by inflation, technological advances and cost shifting, have both been rising at unpredictable rates. Impacting total claim costs are an excess capacity in the health care field and a lack of marketplace forces to control costs. It has been very easy to underestimate claim levels.

2. The business is highly regulated with laborious approval processes required before new rates can be implemented. Reaction time is long in contrast to the group lines. Staying current with mandated coverages and ensuring compliance with loss ratio standards present constant challenges.

3. Maintaining a spread of risks on in force business is difficult and the potential for antiselection and rate spirals is significant. Maintaining profitability of both old and new business is necessary.

4. The market potential has historically been eroded by group and government insurance programs. The current instability in the health care environment provides new threats. Alternative health delivery mechanisms are being explored with renewed vigor. HMO's are achieving increased attention and the impact of PPOs is a current unknown. Always existent is the possibility of nationalized health care.

5. The escalation of medical costs in relation to the overall rate of inflation has further eroded the market as affordability has become a concern, particularly for broad comprehensive coverage. The number of individuals without coverage has been growing simply because they no longer can afford coverage.

6. The risk of writing business has been affected by consumerist pressures and the propensity to settle claim disputes with litigation. With high claim frequency there is constant exposure to litigation due to claim settlement practices. On a proportionate basis, the individual medical line results in significantly greater legal activity than the other lines, and we regard prompt, accurate claim service as one of our competitive strengths. We strive to pay claims as rapidly as possible.

7. Requirements for management and actuarial resources are high. The line requires constant monitoring and maintenance. Experience studies must be performed on a frequent basis and the rate filing process is continuous.

8. As if these factors were not enough, an additional obstacle is provided by the tendency of the industry as a whole to operate at negative profit margins. Numerous small regional competitors are present who will frequently use price leadership to build volume. It is not unusual to see rates in the marketplace that are one-half of our premiums. While such pricing strategies do indeed build volume rapidly, there is some consolation in the fact that for a given competitor the dislocation is temporary in that the resulting losses manifest themselves in a short period of time.

Based on these items, it is quite apparent that companies are not clamoring to get into the individual medical business. It is a difficult business, fraught with many external and uncontrollable uncertainties.

Certainly there must be a few positives. While the plus side of the ledger is somewhat smaller, there are indeed some advantages in writing medical products:

1. The most obvious advantage is that, because of the many difficulties and uncertainties in managing the line, there is less competition than in the traditional life insurance business.

2. There are also no significant barriers to entry into the business. In contrast to a line such as noncancelable disability income, a new competitor can build volume rapidly. The only significant limitation is developing the necessary managerial and technical expertise.

3. Medical production can provide a significant source of agent earnings. Increasing rate levels provide an upward trend in compensation to offset declining life insurance rates. Medical insurance also provides a prospecting tool to generate life sales.

4. If a company can operate efficiently, theoretically attainable profit levels exceed those of life insurance and surplus strain is minimal.

So while the impediments are numerous, there is significant profit potential in a successful operation. To gauge why companies frequently have difficulty and leave the business, I have assembled some of what I regard as the critical success factors.

1. First is obviously a company commitment to the product line. Any business that is run as a sideline or an accommodation is going to have problems. For many life companies, individual medical is just that, a small accommodation line of business that is never given the necessary resources or attention. Unless a major commitment is made to developing the line on a profitable basis, success will be difficult.

2. The next place to focus attention is the marketing and sales areas. The attitude of the marketing department and their role in licensing and monitoring agents or distribution channels is critical. The orientation must be on quality of business and agent loss ratios as much as it is on volume. It may be necessary to restrict product availability or even to discontinue

relationships where clear abuses are present. These actions become very difficult where production of large amounts of life insurance is present. The complications become even more difficult in a career agent operation. When the medical line is small, it is very easy to make exceptions and to ignore problems in favor of the larger lines of business.

3. While sound product design is necessary, it in itself is not usually the cause of failure. An unstructured product that invites abuse, with first dollar coverage, few limitations on items such as mental conditions and nursing home care, certainly can result in huge losses, and notable examples are certainly present. But most product designs are viable, even with companies that have abandoned the line. Emphasis on cost containment and cost sharing with the insured can help control experience and are obviously desirable. Product design can make it easier to control, but there is a range of workable provisions.

4. The claims and underwriting functions do play a vital role in controlling the types of risks accepted and costs after issue. A thorough underwriting review affects the type of risk allowed to enter the pool and appropriate use of exclusion riders adds further control. Inadequate underwriting will seldom be apparent during the pre-existing, contestable period. A major challenge is maintaining profitability of seasoned business and efforts must be made to obtain a healthy group of insureds. Claims examination on contestable claims in combination with strict U&C guidelines and attention to other insurance is also important.

5. The importance of the actuarial role in pricing and rerating cannot be overemphasized. The road to insolvency is lined with companies that wrote large volumes of what appeared to be very profitable business in short time periods only to learn that the market was indeed informing them that they were underpriced. The risk of inadequate rates is significant. It is very easy to underestimate claim reserves and correspondingly underestimate true incurred claim levels. There are many judgmental decisions that must be made and pressures on profit can make those decisions too liberal. The underwriting process and pre-existing claims limitations also produce steep selection curves by duration. It is necessary to monitor experience by duration to ensure overall viability.

   Once a block of business lags the necessary rate levels, it is difficult to catch up because of the antiselection that large rate increases initiate. Thus constant monitoring and frequent rate increases should be utilized. The greatest danger, however, is one of procrastination. Overanalysis and paralysis of action are typical actuarial maladies that result in the right rate increase at the wrong time with rates always lagging claims experience.

   There are many reasons for seeking inadequate rate increases. Shock losses that are rationalized as isolated phenomenon and not incorporated in the pricing structure is a common error. Fear of the mystical assessment spiral is another. "If we seek the full rate increase all of the good business will leave, therefore let's

file a smaller increase and tolerate small but certain losses indefinitely" is often heard. My experience has been that a block of business will profitably tolerate higher rate actions than believed and that the greater danger is seeking too little. Virtually every department in the company will find reasons for minimizing rate increases and it is the actuary's job to ensure that the best rate level is sought and justified.

Another reason for moving rapidly is the length of time necessary to file rate increases. There is limited reaction time if a problem is discovered. It is also easy to underestimate the average effective date of a premium scale if implementation is delayed.

6. While all of the foregoing implies a high level of activity and extensive resources, it does not imply a high level of expenses. A company that can profitably tolerate a high loss ratio provides better value to the consumer and has an easier time justifying premium increases. It is certainly easier to file new rates on a block of business with an 80% loss ratio than one with a 60% ratio. Particularly when the industry operates unprofitably, to maintain profit margins at market rate levels requires a more efficient operation. Being the low cost producer is a significant competitive factor.

7. The major remaining issue is one of organizational clarity. A fragmented, functional organization provides many distractions to other frequently larger lines of business. The best focus can be obtained in a product line organization where all members devote themselves exclusively to the medical line. This structure provides the best opportunity to concentrate on the line and all of its components. It is also important that the business unit head be held strictly accountable for the line's results and that appropriate personnel actions be taken if results are not achieved. There must be a strong spokesperson for the line and profit must be the primary goal with volume an important, but secondary consideration.

From an actuarial perspective, the role that I am advocating goes well beyond the traditional pricing and experience analysis duties that are often practiced. I believe that it is important for the actuary to be involved in the total business process. He/she should be involved in developing agent monitoring tools, be aware of and develop input into underwriting and claims standards, and be an advocate for maintaining a sound product line. The results of experience studies should be communicated throughout the organization and understandable to everyone. The support of top management is important and they're not going to support things they do not understand. An advantage is that experience emerges rapidly and rate adequacy can be demonstrated much easier than with a life product.

In relation to life insurance, medical coverages require what might be called a property/casualty management mentality, a bias for action and a culture that is often not present in a life company. These are conditions that are very hard to create for a minor business unit and it is not easy to hire the necessary expertise. For many companies, withdrawal from the

medical line is indeed the proper course of action. Unless the proper commitment is present success will be difficult.

Yet many companies that are retail distributors and that have a large investment in their distribution channel can gain by having individual medical products available. The line can provide an additional source of agent compensation and can bear some of the costs of maintaining an agency operation. The answer in such cases is generally not to offer the product on a direct basis but to enter into a market arrangement with a company that can successfully manufacture and wholesale the product. Even in such combination cases, however, all of the conditions of success must be replicated. Controls on the field force and quality of business of the distributing company will be necessary and intrusion into rating actions will ultimately destroy the agreement. Nevertheless this may be the most expeditious way of obtaining the line's advantages from a sales perspective while minimizing exposure to the problems and complexities of managing a medical line of business. Broad product availability can be obtained despite a limited number of product suppliers.

From a consumer standpoint broad coverage availability is obviously very desirable. Limitations produce consumer dissatisfaction and encourage further government encroachment in the health care industry. Insolvencies caused by improper management and constant withdrawal of companies produce further strains on consumer and insurance department relationships.

In summary, it is important that a company accurately assess its objectives and its strengths and weaknesses in relation to the product lines demands and required skills. If the proper conditions are present or can be created, entry into the market can be profitable. Alternatively a distributors role may achieve some advantages while continuing broad coverage availability.

MR. HABECK: One comment that Curt made is the fact that his competitors are sometimes charging one-half of the premium that Time Insurance is charging. That made me wonder who calculated the premiums, and which insurance departments approved these inadequate premiums.

Our second speaker is Paul Janus. Paul is Senior Vice President and Chief Actuary at Bankers Life and Casualty Company. The involvement of his company in the medical insurance market is well known and of long duration. We are pleased that he could share his thoughts and experience with us this morning.

MR. PAUL JANUS: Bankers has also been in the individual health business for 30 years and we also have had a profitable experience every year. We have over $450 million dollars of individual medical expense and disability income insurance within Bankers and its affiliates. The types of insurance I am going to talk about today are really the high-ticket items, the comprehensive under 65 products and the more comprehensive medicare supplement products. I believe these products represent some of the major challenges that face us. My comments are going to be dealing with some specific challenges that have been on my mind, and some proposed or potential solutions that I see in the future. Perhaps some of these solutions are a little far out, but they are the directions that we are thinking of for the product in the next two or three years.

One thing I do have to say, and I agree very firmly with Curt, is that the most important single thing is resources applied to the business. We need to keep on top of the individual medical line, and the lack of a solution to a problem is no excuse for the lack of action. Rate increases or product changes are necessary, as quickly as possible, to deal with what's going on in the business today.

I. Nature of the Problem

When one talks about medical insurance, one talks about the "problem". I prefer the word opportunity. While I will mention a number of Challenges, I believe they will be met and the medical insurance field will be stronger than ever.

There are two distinct lines of medical insurance.

1. The comprehensive market providing nearly full hospital-medical-surgical coverage to individuals and families under 65, and

2. The senior citizen/medicare supplement market (There is a third market consisting of "specialty products", like cancer insurance, but I will not get into that today.)

Bankers Life and Casualty and its affiliates hold significant positions in each of these two markets. The challenges in each market are more similar than it may seem at first glance and many of my comments will apply to both.

I see several distinct challenges ahead of us.

1. Appropriate Benefit Structure. It was easy (and many of us did it) to write contracts which pay for nearly all medical care received and charged for by providers. Policies essentially paid all but $1,000 or $2,000 of medical care, no matter what.

   This created a situation where the type of care or even the amount charged by the provider were of minimal concern to the insured. Rapid inflation in costs plus "cost shifting" caused by underpayments to the government and Blues and our own contracts created a situation which got out of control.

   The answer to some in the industry is to limit our policies, and frankly Bankers has done some of that. This shifts the cost to the customer. The real answer must be to design contracts with benefit structures and company/policyholder relationships that assure that "appropriate" care is given at the lowest possible cost. When expensive care is needed, it must be provided for, but only when it is needed.

   This is a difficult challenge in any environment, but more so today because the medical care systems are changing. Many of the changes are potentially good ones -- helping the cause of the cost containment, but making the writing of good contracts difficult.

2. Policy Design is taking a number of turns and will take more.

a. Waiver of coinsurance for what is believed to be more cost effective care. Examples include home health care and second surgical opinions.

b. Semi-private room and board limits and surgical schedules have returned, but some companies have indexed the limits to keep up with inflation.

c. Increases in deductibles and out-of-pocket provisions are in new products today.

I see refinements in policy design as follows:

a. Renewal provisions which allow more frequent and selective rate increases.

b. Rehabilitation benefits which allow the insurance company to get involved in long term care, to assure that proper care is provided to speed recovery.

c. More refined definitions of providers and of the type of care. Home health care may be defined by type of care. Kidney dialysis is clearly cost effective. However, other benefits often result in paid-for nursing care, and therefore limits on each ought to reflect the need and encourage appropriate use.

d. We may see hospital stay schedules for diagnostic related groups. The policy would provide that longer stays are covered only with permission from the company. This may provide an involvement in the care of the patient early on. Claim adjusters may need to be trained as para-medics.

e. If anti-trust legislation can be modified, we will see policies directing the customers to certain providers, or to alternate care or alternate financing vehicles. For example, payments for all drugs may be at an agreed upon price with certain pharmacies or groups of pharmacies.

2. Control of Selection Process. There are two periods of selection that occur: at issue and after issue. Much of the concern today seems to be with selection after issue and more specifically at time of price change. It is clearly demonstrated that when a rate is changed, that the healthier policyholders tend to leave, creating a price anti-selection spiral, ultimately leaving the company with a group of highly substandard risks. Of course, selection always occurred at lapse, but the problem was controllable when level premiums were used, inflation was moderate and competition not as strong. This phenomena creates a number of unhappy situations --

a. Rate increases prove ineffectual in keeping a book of business profitable;

b. Prices for new policyholders must be different than for in force policyholders. This characteristic usually results in new product filings every 2-3 years; and

c. Highly substandard risks feel trapped into paying very high premiums which they may not be able to afford.

The challenge of selection at issue has received less attention but may be at least as important to profitable business.

Little published data is available describing the effect on morbidity of various factors: specific pre-existing conditions, occupation, avocations, income or family status. Methods of providing insurance at realistic cost to most people while preserving profitability and market share, are more important than ever as customers watch the dollars they spend on health care more closely.

Competition from other insurers, from other funding mechanisms and from other uses of the dollar are having a greater impact on this issue today. We need good data!

Special considerations exist. Mandated coverage for complications of pregnancy and newborn children make it difficult to insure pregnant women or even the husband since many of the largest claims occur as a result of child birth.

A sophisticated pricing mechanism is needed. The development of such mechanisms includes the following:

a. Term insurance pricing philosophy. Some have proposed a return to level premium pricing. While this might be theoretically possible if prices remained stable, I think that the high cost of insurance and competition from other sources will demand a pay as you go approach. Many sales are for relatively short term needs anyway.

b. Area rating, with some precision in determining area-related cost factors. At this time I do not recommend price changes with every move of the policyholder. While theoretically correct, it creates more selection problems because the policyholder is disturbed. A policyholder who is happy with his insurance is likely to stay with the company as long as he views his price increases as reasonable even if he has moved to a lower cost area.

c. After issue underwriting -- I think that we will see contracts which allow us to change rates by individual, depending on his health history at that time.

   The policy may guarantee renewability unless all policies in an area are non-renewed, but will guarantee only a premium for the individual up to some multiple of the standard premiums.

d. Price increases on existing in force will be more selective, with increases differing by state or even by an area where permitted, to try to keep the business in the better areas.

e. Pricing formulas to determine the "optimal" increase pattern will be developed. This is a real challenge to the actuary.

The optimal increase is the one which provides the greatest improvement in total profit - not profit margin, taking into account anti-selection and lapsation.

f. More frequent (e.g. quarterly) price increases may be seen and may be written into the contracts as automatic. This will require some testing to see if it would be acceptable to the customer.

3. Competition from other funding methods may present the greatest challenge. The competition that I see is from small group coverage, HMOs, PPOs, and non-insurance trusts.

All have very low or no commission. HMOs are expanding rapidly. Both HMOs and PPOs have control of provider services and costs. Insurance companies have difficulty in writing contracts which favor cheaper providers because of anti-trust interpretation.

a. MET and small group comprise a large market, but largely untapped by group companies. This is the source of a lot of individual business, sometimes on an association/payroll deduction basis.

Some group insurance attempts at this market have not been very successful. I think individual companies have a better chance, but must recognize that group commissions and smaller margins are probably necessary.

Group companies have to deal with anti-selection factors that are unfamiliar to them, and with more individual service and expense.

b. HMOs have been a threat for 10 or more years, but in the last 5 years, they have grown substantially. There are some large HMOs around with clout and marketing ability and they are profitable. There are no easy solutions here. Generally HMOs require a concentration of customers to work and are primarily marketing to employee groups. As HMOs grow in strength, they will be more successful in attracting individuals, but I believe there will be a considerable individual market remaining in both urban and rural areas.

c. Preferred Provider Organizations are a different type of HMO, under different legislation. PPOs are a significant threat, particularly to the senior citizen market. For the most part, PPOs agree to provide services at a cost below most other providers. Specifically, government legislation has established a per capita fee to be paid to PPOs, who agree to provide total care to senior citizens. Only the Medicare deductibles for hospital and medical benefits can be passed on to the senior citizen. The per capita fee is 95% of Medicare's cost in the area served. Several organizations in Florida and California have sprung up, offering complete medical care including some care not provided by Medicare and apparently are doing very well. This is a big threat to the Medicare Supplement market in highly populated areas. Low cost

supplements for people who want to use their "own" doctor may be the only saleable alternative. The PPOs may be a business that makes sense for an insurer in order to preserve his profitability and to provide for the development of future relationships with a low cost provider. The advantage is control of provider, and so individual health must move to this concept.

d. Finally, there is always the potential competition from Uncle Sam. I do not think this will come about in the foreseeable future. More likely the government may encourage more competition and may change the nature of the market, but I believe we will always see a health insurance need from the private sector.

By the way, there has been recent discussion on the fairness and effectiveness of the DRG system. I believe it is having a very positive effect. It got the attention of hospitals and has forced attempts at better management and more appropriate care decisions. It is a big boost to ALTERNATE CARE BUSINESS. It is not totally fair and some cost shifting may still result, but far less than the simple transfer of costs to the insurance companies. This is partly true because insurance companies have let hospitals know they will not stand for cost shifting.

4. Company resources are a serious issue. Most companies in my opinion assign inadequate resources. Mandated benefits, rate and policy approvals, medical care charges, the need to follow experience by area - all these demand exceptional resources, and, I believe the need for exceptional resources will accelerate. Keeping good data on diagnosis, the application of appropriate care or cost containment measures and the need to price more precisely will require significant computer power and analysis.

My hope is that regulators will see the need to let the marketplace set the pricing mechanisms and reduce rate regulation, at least for comprehensive under 65 and senior citizen products.

5. Finally, I would like to talk a bit about a specific challenge to the actuary, as actuary and as corporate officer. The challenge is dealing with cyclical and seasonal claims loss ratios. Claims loss ratios appear to move up or down in patterns which follow certain macro-economic patterns, and loss ratios are usually higher in the first quarter of the calendar year.

The primary challenge is to understand, predict, and explain these trends to management and to the stockholders. Some have suggested that the seasonal variation be smoothed through benefit reserves, in keeping with the principal that profits should emerge in proportion to premium. There is merit to this, but the mechanics and advisability need to be worked out by both actuaries and accountants.

Cyclical trends present more of a challenge because

a) we are not sure what causes them,
b) they are no more predictable than the economy itself, and
c) they could have a significant impact on pricing strategies.

Some have written that inflation and related government actions have been the primary factor causing cyclical trends. I am not so sure. In my own company's experience, the changes in loss ratios have been too sudden and too steep to support the theory that our inability to anticipate the price changes properly is the sole or even primary cause. My own theory is that recessions and related changes in unemployment are at least as important, and may be the primary cause. If this could be demonstrated more clearly, then pricing and state approvals might be based upon economic forecasts of the factors -- perhaps indexed to these factors.

The difficulty in making such a demonstration is that too many coincident events occur. For example, delayed rate increases when claims loss ratios are actually falling often exaggerate the cyclical patterns.

In closing, this is a tough business, but a good one if you can put the necessary resources to work on solving these problems and keeping up with the rapid changes.

MR. DAVID W. KRUEGER: Paul's comments on the MET/small group market are very true. In our work with these projects, we are applying some individual health techniques, such as recognizing selection by duration in the initial pricing, closing off existing blocks of business, and rating new issues lower than existing business.

MR. HABECK: Our third speaker this morning is Richard Erdenberger, a consulting actuary whose practice involves a lot of health insurance. His long exposure to the challenges in this area, especially as an outside consultant to a variety of client companies, should provide us with a first hand look at some of the ways to cope with these challenges. As Dick mentioned in our meeting yesterday, the answers may differ considerably depending on the circumstances.

MR. RICHARD ERDENBERGER: It is true that I have been exposed to many client situations, and as a consultant you actually do work both sides of the street. Thus, the problem is really defining the situation from your particular client's viewpoint. Often the client starts at a particular point, but I think their problems really began further back than that. They are coming up with solutions but they have not discovered the basic underlying problem. I think Paul touched on this aspect a little bit.

I represent a number of different entities all involved in providing some kind of care for individuals, being individual insurers, employers, associations, ERISA trusts. The basic underlying problem is "what is the cost?" If I am working with a hospital, we talk about cost containment. The hospital sets up its budget and goes from there. If somebody cuts out some of the compensation, the hospital will put it back in someplace else.

I may represent an employer who is negotiating with an insurer on a group contract. I am out there trying to get him the best buy he can get. And you are the competition to me at that point in time. We are trying to

design the product so the employer has the absolute minimum amount of contribution to provide the maximum benefits that his employees want, and you are trying to put in cost containment. But if costs are shifted, that hospital and those doctors want 'X' dollars of income. They have malpractice insurance and they have all these fancy pieces of equipment and they are trying to grow.

There has been some motion and some effort in certain areas to contain those types of costs. But what you do internally within the system is a cost shifting, not cost containment. For example, LTV has gone to a self insured status, and the employee benefits man was telling what a great job they had done in cost containment at a big plant at one location. They had banded together with a couple of other companies, and by golly they had gotten that hospital to reduce the cost to them. This is an example of cost shifting rather than cost containment. If the occupancy is down, the hospitals are going to raise their rates anyway.

My wife says that I ask too many questions. One day she found a Peanuts cartoon strip where Marcy was talking to Peppermint Patty. Peppermint Patty says, "I have the solution, there are always more questions than there are answers so I am going to be the one to ask the questions." Well, that is what we are doing. We are asking a lot of questions regarding cost containment, but we really do not have very many answers. It is sort of like squeezing a balloon. As you squeeze the balloon in one place, the air is going to pop up someplace else and all of a sudden someone else who had a product he thought was okay, finds that he is in trouble.

Your competition is each other. The challenge is keeping track of the competition. Within your own company your goal really is to make a buck for your company as best you can. But you better be watching what the other guy is doing because what you are really doing is probably reacting,not acting. We have been in a reactive mode for quite some time now. It is a real challenge to the actuary to keep track of what is going on in all facets of the business. I represent one ERISA trust that has a specific and aggregate stop loss, but basically it is individual coverage plan, marketing individual policies to a religious organization whose members are scattered all over the country. Coverage can be tailored to cut out a tremendous amount of benefits, but somebody is paying for it.

One valid area of cost containment is subrogation, to limit the total payout to the insured to 100% of what his total cost is. And to the extent that the limit is effective, the individual does not make money on his particular disability or condition, then you are having a containment. One of the problems that we create for each other, particularly on the individual side, a company can do a fantastic job of underwriting and designing a contract, and the next company comes along and issues a policy with no controls or limits. Thus you can have two or more contracts providing over 100% of the loss, with no subrogation or no coordination of benefits. There is a situation where a cost containment can take place, but you are trying to compete with each other. Both of those products may have started out initially with profitable margins, well designed and well marketed, and you end up bumping heads with each other.

As actuaries, you have to know what the other actuary is doing. Looking at your own data internally, you are following where it is going. But if you are not looking outside your window every once in a while to see if it is

raining, you are going to get wet because the other guy may be doing something to you that you did not expect.

Another challenge is keeping track of what is going on in all facets of this business, not only the individual market. As Paul mentioned, look at what the group guy is doing, the METs, and the association groups. Years ago I think Continental had a product that was called Westro; every individual who was a resident of the U.S. west of the Mississippi paid a buck and that was his association group coverage. He filled out an application, it was accept or reject. There is some beauty in this. A hot item I see right now is the association group coverage. It is a group contract, and you can raise the rates without going through the insurance departments. You can cancel. You accept or reject at issue almost like it was an individual contract. If the association group market grows, it will be tough for the true individual writer to compete, because the association has some leverage that individual medical does not have.

Some ERISA trusts are acting like an insurance company in their reserving and their pricing. Where you have mandated benefits you are going to have to provide the coverage. Where you have to provide coverage for certain providers, the trusts do not have to. They can put in some inside limits that insurance companies are not required to have. So there is some stiff competition out there other than just plain other individual policies. All I really want to do is get you thinking about some of these things.

MR. MARK E. LITOW: Paul, you were talking about Medicare risk contracting in Florida. I wanted to go over my understanding of the situation down there. I believe they are covering the Medicare part of the benefits only under the 95%, but they are also allowed to issue a type of Medicare supplement policy to provide full coverage.

Also, because of lower utilization and the lower expected length of stay through the HMO or PPO, Florida experience is coming well under that 95% limit. Therefore they are providing other benefits to the insureds, such as free vision care and other types of free care, which are being highly utilized. In addition, do these benefits include Medicare Supplement type of coverage?

MR. JANUS: It is my understanding that there is at least one plan called the IMC Gold Plan that advertises complete coverage for $75. The only cost you will have to pay after the $75 premium is the initial Part A Medicare deductible, and other benefits such as eye glasses and hearing aids are included. That does not leave much room for any other supplemental coverage.

MR. LITOW: I think that is their form of a Medicare supplement policy, but I think they also have a Medicare risk contract with the government, which winds up supplementing their other costs because they are coming well under that 95% limitation. It is like a cost subsidy.

Dick, you were talking about cost shifting and that is a very real problem. With respect to a lot of the discounts that PPOs are giving through the providers - hospitals and physicians, we see a lot of those costs being passed back to the individual health industry. What suggestions do you have along that line to prevent that type of abuse.

MR. ERDENBERGER: I am not sure that you can really ever change cost shifting. What you really have to do is go back and change the underlying cost. I think we are just stuck with it and I think you have to be aware that it is happening. If you represent a company or are working for a company whose goal is to make a profit on their product, you just have to try to stay ahead of it. One of the other things that comes to mind is that a lot of employers and insurance companies are promoting outpatient type of activity - wellness programs and preventive care approaches. Every one of those is fine in its own right, but if it does in fact reduce the income to the hospitals and the income to the doctors, you can bet your bottom dollar that the providers are going to find a way to get it back. As I mentioned before, LTV negotiated a 5% discount from the hospital and thought it was fantastic. The hospitals costs have not changed one iota and every time one of those HMOs or PPOs or whoever does that, someone else is going to get stuck with what is left.

MR. JANUS: One thing in the favor of everybody is that the hospitals have been generally poorly managed. They have not been managed to reduce costs. They have been managed to provide care to attract doctors. And this whole new environment has changed some of that. I know that Baxter Travenol is actively providing assistance and expense analysis for hospitals, finding out which of their services are not making money for them. There is an organization, in Boston I believe, that is bringing together some statistics for group insurers, pointing out which hospitals are charging three and four times more than the hospital next door, thus identifying those kinds of situations and helping both the insurers and the hospitals themselves make decisions about those types of inequities. I think there is a lot more of that going on and a lot of literature in the hospital magazines that will be helpful.

MR. FUHRMANN: I think that the ultimate answer is that the size of the health care system is going to have to shrink to be consistent with the necessary capacity. Until that is done, we are going to continue to have problems, but we have to highlight the areas of cost shifting and adjust to them temporarily. And ultimately this shrinkage is going to have to occur, because you simply cannot have medical costs outpacing inflation indefinitely.

MR. HABECK: You have made a good point about supply of providers, but I have not heard of any method to reduce their number. In Wisconsin, for instance, when PPOs were being discussed and the nature of the limitations on entry into these became apparent the doctors reacted strongly. Also, it did not make sense to the consumers that their choice should be limited.

MR. ERDENBERGER: My point was really that the problem starts earlier, and faced with those problems, everybody does have to price a product the way Paul and Curt mentioned.

MR. DAVID B. TRINDLE: Has anyone on the panel tried offering alternatives to rate increases, in terms of giving the policyholder a choice between the rate increase or some kind of reduced benefits?

MR. ERDENBERGER: Almost invariably.

MR. FUHRMANN: We will typically offer a higher deductible or some option to hold the rate increase down.

MR. ERDENBERGER: Yes, for Group, METs and individual policies, where there is a potential rate increase available on an individual policy. But again, if the cost of the hospitalization is going to be $3,000 it does not matter if you raise the deductible from $100 to $500, the cost has still got to be met.

MR. TRINDLE: It does matter to the people who would otherwise lapse their policy, because it seems like you get to a point where the so-called healthier people, the people who have not had claims every year are not willing to subsidize the rest any more. They were at first but they are not anymore. Is there any resistance from the states on individual filings for rate increases or reduced benefits?

MR. ERDENBERGER: Not if you have justified the initial need for the rate increase, and if they accept that the reduction in benefits is an actuarial equivalent.

MR. TRINDLE: And has the offering to policyholders typically been one where one choice is no rate increase but a benefit decrease, versus a rate increase.

MR. ERDENBERGER: In none of the ones that I have been involved in has there not been at least a token rate increase.

Charlie Habeck made a comment at an earlier session that I thought was apropos. We are not getting rate increases, we are providing additional benefits. Because as the costs go up, particularly under the major medicals, the level of benefits is going up and we are just keeping the price commensurate with that benefit. Rate increase implies that we are not making enough money out of it, and it is the other way around.

MR. TRINDLE: Has anybody tracked the experience of the two groups? The ones who selected the reduced benefits versus the ones who did not?

MR. JANUS: Yes, we had some years back made an offer of deductibles in lieu of rate increases. The offer was not accepted by a lot of people and there was a high level of anti-selection. We followed the loss ratios by each category of acceptance. We were very disappointed in the sense that we did not see this as a very useable vehicle to make our rate increases more acceptable. Our current contracts are very flexible in choices of deductibles and downgrading at the time of increase does occur. We have a captive agency force so this is usually done through the field force. And once again we have very little of that activity. People want coverage. And I think part of the reason is that there is somebody always cheaper around for most of these people, unless they are substandard. Substandard insureds are not going to accept the higher deductible, but rather take the coverage anyway. So either you are going to be able to sell the rate increase on the basis that this is a good company and that this is good coverage or you are not going to sell it. Providing alternative deductibles of $1,000 or $500 is not going to do the job.

MR. TRINDLE: Has Bankers stopped providing higher deductibles?

MR. JANUS: We still allow downgrades because our field force says they need that to save the business, but they do not save a lot of business that way.

MR TRINDLE: When you are evaluating the experience, you should expect anti-selection. That is, you would expect the people with more benefits to be the sicker people. So you cannot use the argument: "there has been anti-selection so it did not work." Don't you have to really compare it to the alternative, and the alternative would have been those healthy people who selected against you by taking the reduced benefit and reduced premium. Wasn't that better than the lapse of their policy altogether?

MR. JANUS: In terms of adding to our profitability significantly, not very many people accept the higher deductible in lieu of a rate increase, and we probably have a better chance of selling the rate increase to the better risk than in selling the deductible, unless the person just simply cannot afford the insurance. So we save very little that way.

MR. TRINDLE: Any idea of what percentage of the people accept a reduction? 5%? I would guess that would vary by the kind of product.

MR. JANUS: I really do not recall but five percent might be right. Again, we are talking about comprehensive type products. We have not made offers of alternates on more limited products because the rate increases are generally acceptable.

MR. FUHRMANN: Our experience shows a fair amount of activity in terms of people being willing to go to higher deductibles. Our philosophy is that if we can hold the insureds within the company in aggregate, we have a better class of risk in that pool than had they left.

MR. TRINDLE: Paul, you mentioned that you had experienced less of the rate increase anti-selection spiral on limited benefit products as opposed to comprehensive products. Any idea why or an explanation for it?

MR. JANUS: There are two reasons. One is that the loss ratios have tended not to get out of control nearly as quickly and so most of those customers were with us for a while. Most of those policies, by the way, were sold on a guaranteed renewable level premium type basis. And the second reason is that I think the rate increases have generally been smaller, in terms of dollars, not necessarily in terms of percentages. A 100% rate increase of a $50 premium is not nearly as bad as a 20% of $1,000 premium.

MR. TRINDLE: You also talked about a post selection mechanism whereby you really have two levels of rates. One for the select group and one for the non-select group. The only rate that you guarantee is the higher rate?

MR. JANUS: That is something that we are considering, trying to draft some proposed language in our contracts. This is going back essentially to the optional renewable contract, but giving one guarantee that we will not cancel the contract except possibly by state. Frankly, we picked up this idea through a person who has an ERISA trust arrangement, and he is applying rate increases on the basis of a multiple employer trust. He is able to put in rate increases by the individual employers in the group. I have to be careful about the contractual relationships. He will increase the price on the group of employees who have the higher loss ratio even though his contractual relationship is the same with all of them and, he does not apply any credibility standards.

I think in a small group market it is fairly common to have different levels of pools depending on the experience. Therefore, you have varying degrees of substandard pools. Can you carry that philosophy to the individual side? And should you? There is also an equity consideration as well.

MR. TRINDLE: Have you had any reaction from insurance departments?

MR. JANUS: We have not done it yet but I think this method probably provides a greater degree of fairness and control in terms of this anti-selection than other processes that have been proposed. The effect of having rate increases on blocks of business moving forward is to do the same thing, except that you wind up losing the good risk altogether and ultimately you drive yourself into a highly substandard group of people. Somebody has suggested that this mechanism might work in connection with state pools for the highly substandard and that is not such a bad idea. It is a little bit like the auto business.

MR. ROD ROSS: Assuming your agents are compensated mostly for new business, how do you compensate your agents for the service work associated with downgrades?

MR. JANUS: The first assumption is not entirely correct. Our second year commission to our agent is 20% on our under age 65 comprehensive business. The third year commission is 15% and the fourth and fifth is 10%. Then it is 5% after that. In addition, our managers have a carrot/stick type of compensation system where they can either make significant dollars by retaining business or lose significant dollars when they lose business. So they have a lot at stake.

MR. ROBERT SHAPLAND: I thought you might be interested in some things that our company is doing. You were talking about the anti-selection factor when you offer an option to take a larger deductible in offset to a rate increase. We have been making such offers. We decided to avoid the anti-selection by writing a policy that forced everybody to take the larger rate increase. Our new major medical policies have those provisions in them. There are quite a few states that do not accept that philosophy, and we have not implemented this contract yet. We decided to wait and see how large the next rate increase would be, and then we will discuss whether we are going to implement that provision in those states. We also have a contract that is written in an association group market, a small group market where we have a built-in change in the deductible every year. The deductible starts at $250 and next year it is going to go to $300 and $350 and so on. This is an attempt to hold down the anti-selection and the rate increase levels.

Paul, you raised a question about post-issue rating. I guess I have been somewhat convinced over the years that this is not an improper practice. On the surface that might sound anti-social, but I wonder if it is a necessary thing to do to maintain the viability of this kind of insurance. And in that regard we have just started an experiment in that direction which accomplishes the same thing through a different methodology. We are issuing our major medical policies this year with a rider that says that if you do not have a claim you get a 10% refund. The people that have health deterioration and have claims are going to pay the full premium and the people who do not have claims will end up paying a smaller premium.

Again, some states are not approving this concept, but a lot of states are. We have actually had conversations with some states that said they would like to approve but cannot because they interpret this provision against the company. We have implemented it in quite a few states and it will be interesting to see what happens.

Mr. ERDENBERGER: Bob, isn't that a little like the old UNAC policy, return of premium? The guy is going to get a $100 refund so he does not file a $20 claim.

MR. SHAPLAND: Yes, it has that connotation. The states have not objected on that basis. Some states say that the rebating statutes or something like that preclude a refund. They say you are discriminating.

MR. ERDENBERGER: If you did it in total within the block perhaps you would be acting like a life insurance mutual dividend.

MR. SHAPLAND: In life dividends you only give the dividend back to the people who did not have claims. So we are just following the same principle.

MR. HABECK: Does anybody have any information on the optimal rate increase based on your experience? One that balances off the persistency so you do not lose a chance to recoup your acquisition expense and also keeps those people in to maintain a reasonable loss ratio. Has anyone done any work in that area and where do your rate increases generally fall?

MR. SHAPLAND: We have a lot of rate increases and we have made some studies. We file at least a rate increase a week in our individual policies and a lot of those rate increases might encompass 50 forms. We have had a lot of experience over the years with rate increases. I cannot give you a direct answer but we have studied the anti-selection factor under those results. And have come to no conclusion. We did some work on persistency and other work that said you would never want to file for less than a 10% rate increase because it would not be a practical thing to do. And some cases, of course, the larger the rate increase the greater the anti-selection. But interspersed amongst all of those studies were a lot of policy forms where we saw no anti-selection. Our current experience on our major medical policies, in force since 1980, and a somewhat similar form that went back more years, shows no difference in the loss ratios between the policies just being issued and ones that went through a lot of rate increases. So we see no anti-selection taking place. That raises a question to the panel of what anti-selection or deterioration they see in their blocks of business that we do not see. I am curious as to what the two companies on the panel see in the difference between a loss ratio on a block of policies that was issued five years ago versus the loss ratio on the new issues.

MR. FUHRMANN: I think our experiences are uneven as well. We have blocks of business that behave exactly the way you would expect them to. You put the rate increase through, the loss ratio drops down to where it is supposed to be and it runs that way throughout the pricing cycle. We have old blocks of business as well as new ones that behave that way. We do have some blocks, on the other hand, that are well into what you could call a selection spiral and regardless of what we do with them, the loss ratio just keeps going upward. So we really do not know what differentiates those two but sometimes it works and sometimes it does not. It does not seem to be

directly related to the size of the increase either. We have blocks that have taken very substantial rate increases and performed in accordance with our expectations.

MR. JANUS: I would echo most of Curt's statements. It is clear that the size of the rate increase, more in dollars than in percentage, creates more lapsation. We are able to fairly well correlate the size of the rate increase with lapsation, at least on the same product. I think anti-selection occurs as you may be indicating, if you get into an unexpected rate increase situation early in the policyholder's life. I think you will get more anti-selection than if you had policies that were four or five years old with no past rate increases, and you began to increase the policyholder at least with some proper explanations. For that reason sometimes the increases that work the best are the ones on the policies that have maybe 60 or 65% loss ratios rather than the ones that have 90 and 95% loss ratios because you have hit those plans with 90 and 95% loss ratios so often that they just go into a spiral.

MR. SHAPLAND: Is it possible that the method in which you communicate the level of the increase has a lot to do with what happens to the recipient when he gets the notice? There is probably an art in doing that well.

MR. ERDENBERGER: Bob, I can remember one study that Mutual completed which echoed what you are saying about mixed results. There were people with known cancer conditions, known kidney conditions and things like that, and you would think that they could not afford to forego that policy. And they lapsed the policies for nominal rate increases. You would expect anti-selection and it did not occur. Just go back and study some of your lapsed policies and see what their health conditions were. I think that is one of the ways to test to see what kind of anti-selection is taking place. You might be amazed at what you find.

MR. LITOW: Just a couple of comments along those lines. First we have noted that where you put in rate increases in successive years, the lapsing tends to go up. Another item: even under medicare supplement policies where you have automatic rate increases, we have noted additional lapsing even though the premium increase corresponds to an increase in the benefit. That shows that people sometimes tend to react negatively to any rate increase and do not really understand it, as Dick has pointed out.

MR. HABECK: One of our clients carried out a fairly detailed study within his company. He narrowed it down, slicing the experience in many different ways and found that the optimum rate increase for them was around 40%. Another company that we have worked with has good results, with almost no adverse lapsing if they can keep the rate increase from 25 to 30%.