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INDIVIDUAL HEALTH INSURANCE AND RATE REGULATION

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MR. LEONARD KOLOMS: I was going to start the discussion with the statement that there are as many monitoring systems as insurance companies. However, this would have been a false statement because of the number of companies whose only form of monitoring is the review of reports we're required to complete for regulatory bodies.

For some companies this is a proper matching of monitoring systems to products, volume of business and marketing systems. For some of these companies with minimal systems, the investment of additional time and money in expanding this function would not be warranted.

However, there are other companies, who, for one reason or other, have not made a large enough investment in this area and, as a result, have lost substantial amounts of money and even become insolvent. I am quite certain that a number of recent company insolvencies could have been prevented had management made the required investment in a monitoring system which better matched their needs.

While we can be critical of companies whose losses are apparent, we all, to some extent, do not do all the monitoring required for our business. The extent to which our monitoring systems are deficient can, in many cases, be traced to badly designed data bases or retrieval systems.

For companies who are active in the individual health business, a properly designed data base and a flexible report generator are a necessity. Companies with well-designed data bases and flexible systems will make the changes, if any, because they are minor, while those without flexible systems normally do not fully implement the monitoring changes at the time of the other changes because they require too great an investment. In addition, a number of these same companies never make the changes or do only after losses develop. Those that do not initially make the change do so for good reasons. The first being the time and delay before measurable results are obtainable and the second being the delay it would impose on implementing the product or marketing changes which necessitated the monitoring system changes. There are also companies who do not implement the changes because they are uncertain whether the volume of business would ever warrant it. Of course, these companies should not make the product or marketing changes to begin with if they don't think the volume of business will increase.

As noted, the ideal situation is to have a monitoring system with flexible capabilities. However, these systems are very expensive and only companies with a large volume of health insurance can cost-justify them. Benefit Trust Life, the company I represent, has such a system.

While most companies need a good monitoring system to manage their health lines, our company needs it to survive, when one considers that 85% of our $155 million premium income in 1983 was from health insurance.

The current Benefit Trust Life monitoring system I will discuss was implemented in the early 70's and has required few changes, even though what we are monitoring has changed. Currently we sell a complete line of disability income and hospital/medical products. Our disability products are sold primarily to targeted markets, such as railroad, federal and state employees. Our medical portfolio includes guaranteed renewable hospital indemnity, basic hospital, major medical and medicare supplement products. The hospital products are both target marketed and brokered. The data bases we use are: Marketing, premium and exposure, claims payments, and open disability claims files.

From the marketing system, we monitor sales volume and persistency by policy from, agent, agency managers and market. The persistency report allows us to analyze reject, withdrawal, cancel date of issue and lapse rates for the first two years. From the open disability claim file, we monitor our disability termination rates and the adequacy of our annual statement claim reserves.

From our premium and claims data bases, we obtain reports on claims, premium and exposure by month for each month of the current calendar year and previous five years. These items can be obtained by nearly any set of criteria one can think of. That is, the data base not only contains benefit information, but also information on the persons covered, the agent, and the market it was sold in and we have flexibility to produce reports by these categories.

We realized a long time ago the need for having loss ratios based on incurred claims and earned premium. Therefore, our systems have been designed to produce both paid and incurred claims and collected and earned premium. However, most of our reports use incurred claims and earned premium. To obtain our earned premium reports, we have had to allocate, at the policy level, each premium collected to the month earned.

To obtain incurred claims, the system applies lag factors, which vary by month incurred, against the claims which have been incurred in a month. The lag factors are redetermined by the system each time reports are produced. The lag factors are either determined from the set of data for which the report is for, or from a set of data where we expect similar runoff factors. In cases where accuracy is important, more than one projection of incurred claims is produced for the same set. This method produces incurred claims with enough accuracy that reasonable loss ratios are produced for all months but the most current three months. That is, a report produced in April, 1984 will contain incurred claims to earned premium loss ratios on a month by month basis for the period January, 1979 through March, 1984 with reasonable accuracy for all months except those in 1984.

From our system we automatically produce standard reports monthly, quarterly and yearly. Reports are also produced on a request basis.

Any non-periodic reports are completely under the control of the user and do not involve system and programming personnel. In one pass of the data base, 150 different reports can be produced. Timing of the reports can be critical and most non-periodic reports can be obtained within three working days. We are trying to reduce that to overnight. On a monthly basis, we produce loss ratio reports for each of our major policy forms. On a quarterly basis, loss ratios on our currently issued policy forms are broken down by issue year. On a yearly basis, we produce loss ratio reports for each of our general agents. The general agents' loss ratio reports show five year calendar loss ratios by type of business. Loss ratios are also shown by issue year within each block.

MR. DINKAR B. KOPPIKAR: I have been working in the regulatory area for the past several years. Among my responsibilities is to review the rates proposed to be charged by insurers to insureds for individual health insurance and to inform insurers whether the rates or rate increases are acceptable from a regulatory point-of-view. Accident and health takes approximately half of my time.

Section 411 of Chapter 627 of the Florida Statutes gives the Insurance Department the authority to disapprove any form filed under Section 627.410 or withdraw any previous approval thereof, only if the form, among the grounds for disapproval

(e) If for health insurance, provides benefits which are unreasonable in relation to the premium charged or contains provisions which are unfair or inequitable or contrary to the public policy of this state or which encourage misrepresentation.

(2) In determining whether the benefits are reasonable in relation to the premium charged, the department, in accordance with reasonable actuarial techniques, shall consider: (a) Past loss experience and prospective loss experience within and without this state; (b) Allocation of expenses; (c) Risk and contingency margins, along with justification of such margins; (d) Acquisition costs.

Section 9641 of Chapter 626, titled "Policyholder Bill of Rights", states that the principles expressed in this section shall serve as standards to be followed by the department in exercising its powers and duties, in exercising administrative discretion, in dispensing administrative interpretations of the law and in promulgating rules. The principles applicable to rates and rating practices are: (a) Policyholders shall have the right to competitive pricing practices and marketing methods that enable them to determine the best value among comparable policies; (b) Policyholders shall have the right to obtain comprehensive coverage; (c) Policyholders shall have the right to insurance advertising and other selling approaches that provide accurate and balanced information on the benefits and limitations of a policy; (d) Policyholders shall have the right to an insurance company that is financially stable; (g) Policyholders shall have the right to an insurance company that provides an economic delivery of coverage and that tries to prevent losses and (h) Policyholders shall have the right to a balanced and positive regulation by the department.

It can readily be seen from the above that implementing laws pertaining to rates and rating practices and in enforcing them, there is considerable scope for judgement.

To date the department has established guidelines under the authority given to it as requiring the insurers to certify that the anticipated lifetime loss ratio on new policies will be at least 55%. Whenever insurers request approval of rate increases for existing plans, the department has followed the standard of 55% for open blocks of business and 65% for closed blocks of business.

The department is aware that in the present complex state of the health insurance business, the above guidelines are not sufficient and is in course of revising guidelines to establish rules and performance criteria appropriate to the business environment and which are adequate to protect the interest of insurance consumers. The department welcomes industry participation and assistance in accomplishing these goals.

Perhaps the only words appropriate to describe the individual health insurance are "bewildering variety". It is almost next to impossible for an ordinary policyholder to determine whether the policy he has or intends to purchase is "best buy or not".

For a few months now I have been assigned the additional responsibility of addressing complaints of individual policyholders about the rates or rate increase and advising them properly. While this is not strictly an actuarial function, it does bring me face to face with reality and is a refreshing reminder of whom I am working for. Most of them are persons in their 40's and above. When they face increases in premium rates far exceeding increases in charges by hospitals and the medical profession, they are naturally angry with everybody, medical profession and hospitals, insurance companies, bureaucrats, etc. If, as they usually claim in their complaints, they have not made any claims in recent years, their anger is all the more boiling. It is not easy to explain to them the mechanics of premiums and premium increases. Any such explanation however simplified is still likely to be complex and as such suspect in their eyes. What kind of advice can we give to such person? If he is insurable, it would be perfectly legitimate for such person to shop around, preferably for a policy with hgiher deductibles and coinsurance. But would it be advisable for a regulatory actuary to proffer such advice all around and thus subject exisiting blocks of business to assessment spiral?

I have tried to analyze the reasons for high rate increases that are within the control of the health insurance industry in the second paragraph of my letter to the "Actuary" January 1984 issue.

And here is our dilemma. If an insured is healthy and smart, he can minimize his insurance costs by continuous shopping around. If he does so, his insurance, most of the time, will be at first or second policy duration. From the information filed by the insurer with the department, the anticipated loss ratio at these durations is 30-35%. This means that 65-70% of such insured's premium is spent in insurer's marketing expenses. If an insured sticks with his policy, because of high rate of lapsation, he could face high increases in his rates even

without inflation in insurable medical care costs.

But neither a persisting insured nor a smart insured is protected from the danger of effective transfer of risk back to his shoulders when he becomes sick or uninsurable.

Another factor as a regulatory actuary I am concerned about is the justification of a fixed loss ratio, even 65%. That the insurable losses should increase at a much higher rate than inflation in insurable medical care costs because of the mechanics of pricing (effect of fixed deductible, assessment sprial, etc.) is bad enough. But is there any justification for increasing insurer retention at the same rate? Recently I received from an insurance company in liquidation process for approval of a rate increase of $9\frac{1}{2}$ times in order to maintain a loss ratio of 40%! Was there any justification for increasing the insurer's retention $9\frac{1}{2}$ times as well?

What we need is a pricing system in which the risk is really transferred from insured to insurer and insured's risk as to future price increases is not greater than inflation in insurable medical care costs. What we need is a system which ensures economic delivery of benefits. What we need is a pricing system that can be understood by the insureds as well as provide them with an incentive to minimize losses. We on the regulatory side need industry's help in establishing regulatory systems, which encourage efficiency in the insurance industry and protect the interest of the insurance purchasing public.