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# HEALTH RENEWAL RATING

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- o Pros and cons of the NAIC recommended rate filing guidelines.
- o Pros and cons of renewal rating practices of MET and individual major medical business.

MR. DAVID V. SMITH: The first topic is the pros and cons of the NAIC recommended rate filing guidelines. This will include the guidelines for both individual health insurance rate increases and small group health rate increases. The second topic is the pros and cons of renewal rating practices of Multiple Employer Trusts (METs) and individual major medical business.

Our first panelist is Bill Odell. He is President of W. H. Odell & Associates of Winston-Salem, North Carolina. Our second panelist is John Hartnedy. John is Vice President and Chief Actuary of Golden Rule Insurance Company in Indianapolis. Our third panelist is Ernie Frankovich, President of Ernie Frankovich & Associates of Burnsville, Minnesota and our fourth and final panelist is Susan Marsh, Associate Actuary with Phoenix Mutual Life Insurance Company.

MR. W.H. ODELL: In the interest of plotting some new ground, I would like to start with a topic which may be new to most of you, and conclude with reference to the guidelines that are going through the NAIC process. These comments concern re-rating of individual health insurance, with particular emphasis on comprehensive type benefits. It is no news to those familiar with the subject that the market for comprehensive individual health has shrunk considerably and that the rerating process is in a state of turmoil.

The consumer, as usual, is the greatest loser. These remarks will touch on the causes of this situation and suggest a positive approach. The combination of the expensive advances in medical technology and monetary inflation have all but spelled the death knell of entry age rated individual health insurance with reimbursement type benefits. The time has passed when a policy could be issued with some assurance that premium rates were not very likely to increase, and that increases, if any, would be relatively modest. In that bygone era, the company selling on an entry age basis had the advantage over a company selling on an attained age basis that its product would allow the insured to budget the amount of premium almost indefinitely into the future. Hence, a purchaser might well choose the entry age product as opposed to an attained age rated product with its constantly increasing premium.

The purchasers of entry age products did not switch to new policies as the years went by -- after all, to do so would cause an increase in premium rate. But now, with monetary inflation and spiraling costs of medical care, even an entry age rated product is bound to have frequent large rate increases. The consumer is now faced with a choice between two products which appear to be identical in terms of benefits and appear to be identical in their character of rapidly increasing premiums. There is a difference between an entry age policy and an attained age policy in that the entry age policy has premiums that go up only because of increases in cost and not because of increases in age. However, to the purchaser, this is a distinction without a difference. The entry age rating company is at an insurmountable marketing disadvantage and attained age rating prevails.

In the attained age rating market, the person who has held a policy for a number of years is paying at least as high a premium as the new purchaser of insurance (unlike the situation when products were entry age based) and can shop around at any point in time. If he or she is in good health, the purchase of a new policy is probably indicated. This produces the phenomena of a block of previously issued policies with claims cost higher simply because of their duration. Incidentally, there is a cogent argument that new buyers of insurance should not be assessed the higher premiums required of this group.

Hence, premiums on comprehensive individual health policies must be increased due to four reasons:

1. Advancing age;
2. Monetary inflation;
3. Increasing real cost of health care;
4. A phenomena which we choose to label cumulative antiselection.

To the extent the results of these causative factors are not anticipated in the premium rate scale, then the scale must be increased.

The competition of the free marketplace is, in the long run I believe, the best way to deliver an increasing stream of economic goods and services to individuals. However, this rerating process is no longer a free market exercise in which actuarial science plays a definitive role. Insurers are no longer free to increase rates based on their own judgment. The process is regulated. Politics has entered the decision.

The current regulatory mechanism is in disarray. There are observable inconsistencies in regulatory action as to how frequently rate increases are permissible and/or required; how risks may be classified as to age, year of issue, benefits, sex, area, etc.; what constitutes using the "loss ratio" as the measure to test "are benefits are reasonable in relation to premium?"; etc.

The report of the NAIC liaison subcommittee of the Health Committee of the American Academy of Actuaries concerning possible rate filing guidelines pointed out that: "rate regulation where it exists at all is often applied inconsistently and arbitrarily, leading to delays in obtaining necessary and justified rate increases on the part of many insurers and rate increases that, once finally obtained, are (or have become) inadequate."

Also, the retroactive aspect of some regulation poses a particular difficulty. An insurer may introduce a new policy form only to find out years later that the ground rules for determining its premiums have changed. To say that this dampens the enthusiasm of possible new entrants to the marketplace is an understatement.

It is not surprising, therefore, that the market has thinned considerably with the most recent and noteworthy example being the events at a nearby insurance company. As stated in the above cited report, "We believe this frustrating and chaotic situation has been the direct reason for the withdrawal of many reputable insurers from the A&H marketplace, to the growing detriment of the insurance buying public. Other insurers have sought out ways to frustrate or circumvent the regulatory system." (Probably the small group market owes much of its growth to the breakdown in the individual market, and the problems we see in the small group market are the result of what happened to the individual market).

We are, I believe, victims of the system and circumstances even though each of the players may be operating with the most honorable of intentions. Decisions need to be made on a complex, emotional topic through perceptions of the desires of the electorate. Further, the decisions are being made, generally speaking, by people whose money is not at risk. This is a very difficult situation.

We need another approach. I suggest there are two workable scenarios:

1. A free marketplace; or
2. Rate regulation based on an objective standard.

History which has shown a regulatory system not based on clear-cut criteria does not provide a fertile ground for the development and delivery of insurance products. By an objective standard, I mean one which has the characteristic that people knowledgeable in the field could apply the standard with very nearly the same results in each case over a reasonable range of possible circumstances and which by legislative fiat has the property that renewal rates calculated according to it would be deemed reasonable in relation to benefits and effective 30 days after filing.

Let us see if we can articulate such a standard.

The most vexatious questions in health insurance rating have been:

1. Trend,
2. The measure of current experience,
3. The level of losses for which it is appropriate to rate, and
4. Credibility.

Let's discuss these one at a time.

1. Trend -- Perhaps no subject has been more vexatious than this matter of trend (Table 1).

TABLE 1

Loss Ratios -- Experience

| Year | Duration | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| 1985 | 33.0% | | | | |
| 1986 | 42 | 55.0% | | | |
| 1987 | 48 | 68 | 75.0% | | |
| 1988 | 56 | 79 | 72 | 85.0% | |
| 1989 | 62 | 77 | 79 | 80 | 82.0% |

Notice the duration specific data. Notice the loss ratios displayed in columns for each duration. We have to separate the data by duration. Loss ratios worsen by duration so we must remove the effect of duration to get at secular trend.

In Table 2, to make the data in each cell comparable, we recalculate the earned premium as if the rate level presently in effect had been in effect all along. This is a simple exercise from Part 6 of the exam syllabus. If current rates differ by year of issue, that is also taken into account.

TABLE 2

Loss Ratios -- Current Rate Level

| Year | Duration | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| 1985 | 18.0% | | | | |
| 1986 | 22 | 29.0% | | | |
| 1987 | 26 | 36 | 40.0% | | |
| 1988 | 30 | 44 | 44 | 53.0% | |
| 1989 | 35 | 51 | 56 | 64 | 70.0% |

Table 3 shows the rate of change in the loss ratios by calendar year. The column over to the right shows for each calendar year the weighted average of those rates of change. The weights are earned premiums.

Based on these data, what is a representative rate of change for the current period? It is a good idea to get to the same answer more than one way. If one has to define a procedure, using an average of the results of two methods has a great deal to recommend it.

TABLE 3

Loss Ratios -- Change In

| Year | Duration | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | Average |
| 1986/85 | 22.2% | | | | 22.2% |
| 1987/86 | 18.2 | 24.1% | | | 19.9 |
| 1988/87 | 15.4 | 22.2 | 10.0% | | 17.0 |
| 1989/88 | 16.7 | 15.9 | 27.3 | 20.8% | 19.3 |

Table 4 shows the results of a weighted average (heavier weights for more current years) and of the least squares method and the average of the two. Our trend factor per annum is 18.0%.

TABLE 4

Trend

| | |
|---|---|
| 1. Average | 19.3% |
| 2. Least Squares | 16.7 |
| 3. Final | 18.0 |

We believe this is an objective, workable approach to get at trend.

2. The Measure of Current Experience -- We should note that this example has been simplified to make the major items more clearly discernable. We have a well-defined experience period of January 1, 1985, through December 31, 1989.

For the moment we assume we have a very large volume of data which is fully credible, the current period is 1989, and our rating period is calendar year 1990.

We take the experience of 1989 as the experience level from which we shall calculate our needed rate level change. How do we define the level of experience? The solution is to define it as the ratio of actual to expected claims (Table 5).

Actual claims are the claims incurred in 1989 taking into account claim reserves and liabilities. The expected claims are based on the premiums earned at current rate level during 1989. These premiums are set down by duration. The premiums for each duration are multiplied by the loss ratio expected for that duration as indicated in the original filing. Each product is the expected claims for the stated duration during 1989. The sum of the products is the expected claims for all durations combined during 1989. Dividing this into the actual claims produces a ratio of actual to expected claims. Our rating base is the level of actual to expected claims in the current period of 1989, namely 1.05.

This may seem obvious, but it is not. Two other approaches have been used. Let's call these alternate #1 and alternate #2 for convenience.

TABLE 5

Actual to Expected Claims 1989 Experience (Amounts in Ms)

| Duration | Earned Premium | Expected Loss Ratio | Expected Claims |
|---|---|---|---|
| 1 | $ 521 | 48.0% | $ 250 |
| 2 | 1,120 | 53.0 | 594 |
| 3 | 1,026 | 58.0 | 595 |
| 4 | 598 | 62.0 | 371 |
| 5 | 153 | 65.0 | 99 |
| 6 | | | |
| Total | $3,418 | | $1,909 |

| | |
|---|---|
| Expected Claims (above) | $1,909 |
| Actual Claims | $2,004 |
| Ratio Actual to Expected Claims | 1.05 |

Some rate level filings use alternative #1, which uses the experience of the entire observation period. In this approach, trend is calculated from the middle of the observation period to the middle of the rating period. This approach can be troublesome where a large volume of experience is grouped to one end or another of the observation period, and the trend from year-to-year during the observation period has varied considerably.

In alternative #2, the claims of each calendar year within the observation period are considered separately and are moved forward to the most recent year by applying an appropriate trend factor or factors. The sum of the claims for the current year so derived is compared to the earned premium for the entire experience period at the current premium level to derive a loss ratio for the current period. The difficulty with this approach is that it does not reflect to any inherent improvement or worsening in the business during the observation period. Table 6 shows this graphically.

TABLE 6

Actual to Expected Claims -- Claims 1989

| Year of Claim | Actual to Expected |
|---|---|
| 1985 | .76 |
| 1986 | .82 |
| 1987 | .90 |
| 1988 | .98 |
| 1989 | 1.05 |
| Total | .95 |

In the preceding table, the "actual" claims utilized in the numerator for each calendar year are the claims incurred brought forward to the 1989 experience level by applying appropriate trend factors. The premium in each denominator is the premium of the stated calendar year at current rate level. For example, the 1985 value of .76 represents claims of 1985 multiplied successively by trend factors for 1986, 1987, 1988, and 1989, all divided by the premiums earned in 1985 restated at the current rate level. The .76 says something to us like "if the claim level now in effect had been in effect all along and the premium level now in effect had been in effect all along, then our ratio of actual to expected claims representing the experience of 1985 is .76."

But even though the 1989 value is 1.05, if we look at the whole experience period together, the result is 0.95. The 0.95 is obscuring an inherent deterioration of the business (one can also theoretically argue that the slope of the expected loss ratios by duration is not representative).

The 1.05 is more representative as a base from which to set the new rate level than the 0.95.

Our selected approach, using the experience of the current period (as opposed to the experience of the entire experience period under either alternative #1 or alternative #2) is directly to the point and avoids the complications of the other approaches.

3. The Level of Losses for Which It Is Appropriate to Rate -- We select the point of view that the level of losses for which it is appropriate to rate is that indicated by the durational specific loss ratios indicated in the original filing. (There is another approach which we will examine).

We are now ready to consider the results of our rate making calculation (Table 7).

TABLE 7

Rate Level Change (RLC)

$$\begin{aligned} RLC &= A/E \times (1+t)^t - 1 \\ &= 1.05\ (1.18)^1 - 1 \\ &= .239 \\ &= 23.9\% \end{aligned}$$

What could be easier than saying that the rate level change is our actual to expected ratio of 1.05 brought forward from the midpoint of 1989, (the current period), to the midpoint of 1990, (the rating period), and of course, subtracting of 1 at the end of the equation.

Yes, indeed, it is simple. But, I stand in awe of mankind's ability to make the most simple things complicated.

The above selected point of view is that in the original rate filing the company indicated an expectation of having certain loss ratios at each duration and based the premium scale thereon. The minimum lifetime loss ratio, say 55%, was also shown to be satisfied.

Under this point of view, if the original anticipated loss ratios for Duration 1 and 2 were say 10% and 20%, and actual experience was 20% and 40%, then rates should be doubled.

Conversely, if one were rating for the later durations at which the original filing had indicated an expectation of 70% loss ratios, then rates should be set for a 70% loss ratio instead of a 55% loss ratio.

Now let's pick up that loose end. There is an alternate point of view that we should be rating for the lifetime loss ratio. Suppose the original filing indicated an intention to have rates which produced the 55% lifetime loss ratio. Therefore, rates would always be recalculated to achieve that objective. In the early years, even though there is poor experience, unless the 55% lifetime loss ratio would be exceeded during the rating period (which often is as short as one year in the future), then rates would not be increased. On the other hand, at later durations, rates would be set in order to yield a 55% loss ratio even though a higher loss ratio might originally have been indicated at those later durations.

The selected point of view has been taken above as preferable for use in our objective standard because its recognition of the effect of duration is closer to actual experience.

To sum up, our rate level change is that required to bring our actual to expected ratio to unity during the rating period.

4. Credibility -- Now some of you are probably wondering if this example isn't a little bit artificial because we apparently have such a large volume of data. Do we always have credible data? Absolutely not. Is there a solution? Yes, there is.

Credibility is treated on Part 4 of the examination syllabus and Part 6 as well. The paper by Longley-Cook "An Introduction to Credibility Theory," *Proceedings of the Casualty Actuarial Society*, Volume XLIX, provides some good insights and leads us to the selection of number of claims as the measure of credibility. (Incidentally, Herzog's recent paper is also an excellent reference.)

Two points in the calculations have credibility considerations: trend and measure of current experience. Concerning credibility with respect to trend, let us suppose that the volume of data for two consecutive years was not sufficient to provide full credibility.

Table 8 shows the experience of the state(s) and form(s) to which our calculation applies weighted together with national data for the same form(s) and, because even the national data isn't fully credible, with the trend indicator. A trend indicator is a published statistical series of data which is agreed upon at the time the policy is originally filed.

Here we see credibility considerations applied to the trend for 1987-1988. The trend from our work on these particular state(s) and form(s) is 17.0% (see Table 3).

TABLE 8

Credibility Trend 87/88

| | Trend | Weight |
|---|---|---|
| 1. State(s)/Form(s) | 17.0% | .473 |
| 2. Nationwide/Form(s) | 18.7 | .353 |
| 3. Trend Indicator | 25.4 | .174 |
| Total | 19.1% | 1.000 |

We do not have enough claims to make the data fully credible, but based on the number of claims in the experience, we compute the weight to be .473. Next, we have from related work product the trend for these forms nationwide at 18.7%. Last, we turn to the trend indicator to make up the balance of the weighing. The trend indicator yields 25.4%.

What is the formula for the weights? It is $\frac{\sqrt{No.\ Claims}}{20,000}$

The trend indicator specified in the original filing, we suppose, was 3.85 times the medical cost index increase which, for the years 1987-1988, was 6.6%. Hence, 3.85 times 6.6% equals 25.4%.

In Table 9 are the details of the calculation:

TABLE 9

Credibility Trend 88/89 Formulas

| | |
|---|---|
| General | $\frac{\sqrt{No.\ Claims}}{20,000}$ |
| State(s)/Form(s) | $= \frac{\sqrt{4,470}}{20,000}$<br>$= .473$ |
| Nationwide Form(s) | $= \frac{\sqrt{8,940}}{20,000}$<br>$= .669$ |
| Combined A/E | = (.473)(.170) + (1-.473)(.669)(.187)<br>+ (1-.473)(1-.669)(.254)<br>= (.473)(.170) + (.353)(.187)<br>+ (.174)(.254)<br>= 19.1% |

Hence, our credibility weighted trend for 1988/1987 was 19.1%. Repeating this for each pair of years and combining the results as before (calculations not shown; see discussion of Table 3 and 4) gives a credibility weighted trend of 20.0%.

Next, suppose the loss experience for 1989 is not fully credible (Table 10). This is weighted together with the expected losses shown in the original filing.

TABLE 10

Credibility Experience Level 1989

| Item | Amount | Weight |
|---|---|---|
| 1. Incurred Claims State(s)/Form(s) | $2,004 | .775 |
| 2. Expected Incurred Claims | 1,909 | .225 |
| 3. Incurred Claims (Credibility Weighted) | 1,983 | 1.000 |

Actual/Expected = $1,983/$1,909 = 1.04

Our actual claims for these particular state(s) and form(s) are $2,004,000 but the number of claims is not sufficient to provide full credibility. We weight this result with the claims expected according to the initial filing of $1,909,000 to get credibility weighted incurred claims of $1,983,000. Hence, an actual to expected ratio of 1.04.

The credibility formula is the same as that used for trend, but with full credibility based on half as many claims.

How many claims constitute full credibility? That depends on whether we are measuring the experience of one year or the rate of change between two years. It would appear that 10,000 claims will provide full credibility for the experience of one year and 20,000 claims full credibility for the change in experience levels between two years. Probably, further study will indicate that lower numbers of claims are sufficient for full credibility.

In any event, the question of credibility can be addressed in an objective way. It is not a real impediment to objective, effective rate level determination.

Let's revisit the rate level change calculation reflecting trend and current experience level taking into account credibility considerations (Table 11).

TABLE 11

Rate Level Change Revisited

$$\begin{aligned} RLC &= A/E \times (1 + t) - 1 \\ &= 1.04 \times (1.20)^1 - 1 \\ &= .248 \\ &= 24.8\% \end{aligned}$$

The result is a change of 24.8% (versus 23.9% obtained earlier). In summary,

1. The present system is not working.
2. We need either the free-marketplace, or an objective rate-making standard. A subjective rate-making standard, which is now de facto the environment, is not workable.
3. An objective rate-making standard is possible.
4. The suggested rate-making standard provides rates that will produce the expected loss ratio during the rating period. It is based upon the current level of experience and an objective measure of trend and an objective treatment of the matter of credibility. It is simple.

I believe that implementation of such a standard will do much to restore the individual comprehensive health market (and may be very useful in the small group environment as well).

The purpose of these remarks is to present, if not the final form of such a standard, at least a very good beginning. Refinements to this method based on objective criteria are welcomed and encouraged.

In these remarks, mention of the proposed rate filing guidelines that were making their way through the NAIC model creation process has been conspicuous by its absence. When this panel was planned, considerable hope was held out for the future of that proposal. At the present time, there is no consensus whatsoever concerning them and their future is at best doubtful. This state of affairs is due to a number of causes. Perhaps the primary cause is that many perceived these guidelines to require that, in all filings by all companies, if the actual loss ratio is greater than that filed, the company must absorb the loss, while if it is better than the loss ratio filed, the company must pay the difference to the policyholders. The preceding statement like most oversimplifications is not completely fair. Those interested are urged to consult the actual documents. Hopefully this guideline effort will be constructively revitalized. An objective standard could be promulgated as part of, as supplementary to or independently of this effort.

The questionable fate and uncertain final content of the guideline makes it even more important to implement an objective standard. Hopefully (and this may be hoping for too much), the political process will involve providing impetus to adopting such a standard so that the consumer may have again a viable market for this type of product but will not involve debate over what is the mythical "perfect" formula for each case. I believe that a sound objective standard is sorely needed.

MR. JOHN HARTNEDY: Health renewal rating has been plagued with a number of problems:

1. Lack of uniformity and consistency in present regulation;
2. Inconsistent interpretation of and compliance with existing guidelines;
3. Increasing burdens on regulators;
4. Companies failing to meet minimum projected loss ratios.

This had led to an almost combative situation between regulators and insurance companies as insurance companies seek rate increases. The battle has clearly gotten out of hand to the point where the consumer is suffering substantial losses.

As background for the previous statement, I would like to go over some things that have happened, particularly in the major medical business in the last few years. In 1988, Golden Rule's loss from operations was $18 million. Golden Rule is the largest writer in individual major medical business in the country, and major medical is, by far, our major source of production. It was also the major source of our losses in 1988.

Waiting for rate increases cost us $23,497,000. The following is an example of how I arrived at that number. On March 4, 1988, we filed for a 34% increase on our $100 deductible plan that had $39.6 million of premium. We finally implemented that increase on September 1, 1988, and there were still four states that had not approved the increase. The delay from April 1 to September 1 cost us $5.6 million. I have eight other examples calculated in the same manner for 1988 that bring the total to over $523 million.

Incidentally, it was in September that we put together the numbers for an October filing for the next increase on the same product. When you see this kind of results, it is not difficult to figure out why companies have left the individual major medical market. Just in the last 12 months we have seen companies like Travelers, Reserve Life, and Union Life leave this marketplace. Aetna Life and Casualty published the fact that they were considering leaving the marketplace. Among the major companies that have left the marketplace, many have begun selling our product. That list includes Equitable of New York, Life of Virginia, Lincoln National, Modern Woodman, New York Life, and Northwestern National. These major players have better things to do with their resources, most particularly their money resources, than to fight the game of delayed rate increases while sustaining substantial losses.

Earlier I said that the loser in this combat is the customer. There are 37,000,000 uninsureds, which has developed into a substantial social problem. This is of concern to every individual since the federal government is talking about solving the problem, which means that you and I will pay for any solution (including their method of administration) to this problem. A federal solution hardly seems appropriate in a country whose strength and growth has been based on the free market. Insurance should hardly be expected to solve the problem of all these people. Certainly, it should be able to solve some of their problems. Fifty-four percent of these people make at least 150% of the federal poverty level. It appears that they could afford something.

I just said that insurance should not be expected to solve the problem for all these 37 million people. I would like to explain why I said that. Going to Webster's Dictionary, I found the following two definitions of insurance: (1) "to indemnify against loss by a specified contingency;" and (2) "to reduce economic risk that is common to all of the group in employing equitable contributions out of which losses are paid." The references in the second definition, to a risk that is common to all of the group and that the contribution should be equitable, is clear support for our practice of risk classification. Note that the definition uses the word equitable and not equal which was a key point at

the American Academy's presentation on risk classification to the National Association of Insurance Commissioners. Namely, it is not fair to have equal premiums for everyone. Rather, it is fair to have equitable premiums for those in a group that have common economic risks.

Webster's goes on to define a contingency as "a condition occurring by chance and without intent." Webster's Dictionary further states that a loss is "the amount of an insured's financial detriment due to the occurrence of the stipulated contingent event."

Based on these definitions then, the issuance of an insurance policy has nothing to do with someone who is known to have AIDS. This is clearly not a contingency occurring by chance and without intent. It is clearly not a common economic risk to an entire group if we would include as a new insured someone who is pregnant. They will have the cost of delivery and the high risk associated with new babies.

Note that insurance is supposed to indemnify against a loss which is defined as financial detriment. Well child care cannot be defined as loss due to a financial detriment and due to a stipulated contingent event. This may be a worthwhile social issue, but it is not an insurance issue. Also, Coordination of Benefits is a legitimate limitation in the policy since insurance is defined as indemnifying only against financial detriment. This definition does not provide room for financial profit.

One could use this definition to at least somewhat chastise the insurance companies for the low deductibles that we sell. In the individual major medical market, one could probably safely say that if an insured can afford our premiums, then they probably can afford a $1,000 deductible. Therefore, true financial detriment should be recognized in the deductibles that we sell. The point of this background is the fact that we seem to have greatly confused the social issues of access to health care with the role of insurance. Certainly, important social issues include the poor who are not insurance risks because they do not have any assets at risk. The uninsurable are also important social risks. Medicaid and state risk pools should be enhanced to meet these social needs so that all people can have proper access to health care.

Insurance, on the other hand, should provide protection from economic risk from the occurrence of contingencies common to a group for the balance of the population.

Confusing access and insurance has made it difficult for insurance companies to stay in the market. The difficulty in obtaining timely rate increases has also made it very difficult for companies to provide accident and health coverages to the many people who need and can afford that coverage. With this in mind, a new rate filing guideline has been proposed. The key new issues are: (1) optional prefiling; (2) regulatory liability; and (3) monitoring.

What we tried to accomplish with optional prefiling was that when a company files its original anticipated loss ratio on a duration-by-duration basis, that it would, in effect, guarantee that it would meet those minimum standards. If for any reason the company fell short of that standard, it would set up a "regulatory liability" which could be used only for the benefit of policyholders.

Additional annual monitoring would be done in order to assure regulators that the regulatory liability was being properly set up. The advantage to the company, once they guarantee to meet the minimum standards, or the loss ratios as filed, if higher, is that the company will be able to take rate increases as needed simply by mailing the new rates to the regulator.

It was the intent of the drafters of this idea that the prefiling be strictly optional from the company's point of view and that the regulatory liability and additional monitoring be completely tied to the prefiling option. In the guidelines that were published, this idea was unfortunately not carried out by the NAIC Actuarial Task Force. They required the regulatory liability on everything and seemed to require additional monitoring. We need to convey to the regulators how important it is that we get an objective standard so that companies will feel freer to reenter the market to help solve the problem of the uninsured.

The losses that we incurred in 1988 are clearly not acceptable on an ongoing basis for us or any other company. It needs to be understood that more restrictions will simply drive more companies from the market and worsen the social uninsured problem. Meeting objective loss ratio criteria which is guaranteed is excellent protection for the consumer, and means the regulator is doing his job.

To put an additional requirement of affordability on premiums that the insurance company charges is again confusing the distinction that needs to exist between insurance and access to health care. Access to health care is clearly a social issue and a legislator's responsibility. If premiums cannot be afforded, that is a rather clear indication that someone has insufficient assets to really be an insurance risk, and therefore, they must be provided access to health care through a social mechanism.

We at Golden Rule have attempted to implement this guarantee idea in selected states. We took over a block of business from the insolvent Amalgamated Labor Life Insurance Company, and one of our conditions was that we would guarantee the loss ratios as originally filed for the product, but then we would also be able to take rate increases as needed considering them already approved based on the originally approved loss ratios. We further added that if in any year we do not meet the required loss ratio, we will make an immediate premium refund.

Since this business was mostly beyond the first year, our actual cumulative lifetime loss ratio will exceed 55 since we are basing our guarantee on the durational loss ratios as filed.

Fourteen of 16 states agreed to our proposition, and we took over the business. Two states, Iowa and Kansas, turned our offer down saying that they felt they would abrogate their authority.

I understand the policyholders in Iowa have all been canceled and that the Commissioner in Kansas was trying to find someone else to take over this block of business in Kansas. Guidelines are published, and all we attempted to do was make them objective. The refusal to accept those guidelines as published by the NAIC and refusing to accept a

guarantee of loss ratios already approved in each of those states with the policy as originally filed seems to be a requirement to have rate regulation for the sake of regulation rather than for the protection of the consumer.

South Carolina and Kentucky have the guaranteed loss ratio concept actually in the statutes. In North Dakota, the Insurance Commissioner has signed a guaranteed loss ratio agreement for all our accident and health products. In eight additional states, we have filed the guaranteed loss ratio concept in support of specific rate increases on particular products for usually a very limited period of time. The idea seems to be catching on. When I have been able to talk to legislators, I have generally gotten a favorable response because they can see that it locks the company in to a particular loss ratio. Some regulators seem to object simply because it seems to reduce their apparent authority.

We need objective and consistent standards so that we can encourage companies to meet the needs of those who are uninsured who, in fact, are true insurance risks. For this reason, I encourage you to support the concept of objective and consistent standards. Please address the new guidelines and let us know what needs to be done to protect the consumer and the companies in an effort to bring comprehensive health insurance to those people who are true insurance risks and thereby enhance their access to health care and protect their assets. As actuaries and professionals, I truly believe that we have a moral obligation to try and solve this problem.

MR. ERNIE FRANKOVICH: Dr. Alessandra's earlier presentation "Customer-Driven Service: It Does Make a Difference" helps to place profitability, government regulation, and the NAIC recommended rate filing guidelines into perspective. He identified that the function of a company is to get and keep customers and that a goal of the company may be to make profits. He stated that profits will follow if a company addresses its primary function of getting and keeping customers.

Dr. Alessandra divided the time when the customer is involved with a company or its product into three segments. These are the "moment of magic" when the company exceeds the expectations of the customer, the "moment of trust" when the company meets the expectation of the customer, and the "moment of misery" when the company fails to the meet the expectation of the customer. It is this last area, the "moment of misery," that causes increased regulation.

I believe that profitability of a company will improve if the company establishes the following goals:

1. Increase the number of policyholders;
2. Increase the penetration in the marketplace;
3. Improve operating efficiency; and,
4. Improve company credibility.

Unfortunately, companies have focused most of their attention on profits in the immediate future at the expense of one or more of these goals. In addition, companies have focused on getting new policyholders and have ignored existing policyholders. The result

has been that companies are not meeting the expectations of the customer or even of their agents. The increased regulation is the result of a huge cry of agony from the customers that also reflects the continuing loss of credibility of insurance companies.

Most insurance regulation is very important and needed. It provides the balance between a knowledgeable party, which is the insurance company and a relatively unknowledgeable party, which is the customer. A contract should represent an agreement between two equally knowledgeable parties who are seeking to obtain a fair agreement. I maintain that the only reason for a contract between two parties who trust each other to be fair, is to provide background documentation on the intent of the agreement. A contract changes when either party does not trust the other to be fair. This condition does not exist within insurance policies. The insurance contracts are drafted and written by insurance companies with little or no opportunity for the customer to change the contract. The insurance company administers the contract and determines how much the customer will pay after the contract is signed. Except for not paying the premium, which could be disastrous in some instances, the customer has no ability to effect the administration of the contract or the premium that will be charged for the contract. The result can easily lead to abuse and unfair contracts as some insurance companies induce customers to sign agreements and then renege on implied promises that were not expressly stated in the contract.

Insurance regulation is the means used to equalize the positions of the customer and the insurance company. Regulations pertaining to the benefit provisions, the initial premiums being charged for the benefits, and to advertising, are intended to create a more equal position between the customer and the insurance company when the contract is initially signed. Rate filing guidelines with respect to renewal premiums are intended to equalize the position of the insurance company and the customer after the contract has been signed.

Insurance companies have two options for equalizing the position of the customer and the insurance company. The first is to be more forthright and fair in following the intent of the agreement based on the knowledge that the customer probably had when the agreement was signed. The other way is to have more horrendous insurance regulation which increases the cost to the consumer. A major aspect in insurance regulation pertains to credibility. Insurers must improve their credibility before they will have an appreciable effect on regulation. Improved credibility will reduce the antagonism that a number of individuals in our society have toward insurance companies. This antagonism results from the many times that the customer had "moments of misery" in its dealings with insurance companies. The level of credibility that the insurance industry has can be determined by looking at the insurance laws that are being introduced in the states and the federal government and at the attitude taken by the bureaucrats, and at articles currently being published. I am a member of the National Association of Independent Businessmen. I would like to share with you the cover of one issue of a magazine that is sent to members of the NAIC. This cover says, "Health Insurance Horrors." To me, this sounds like businessmen in small companies hold the insurance industry in low esteem.

What are some of the attributes of good regulation? First, regulation should try to equalize the relationships between the customer and the insurance company as much as

possible. Second, the cost of the regulation should be commensurate with the benefits that are being provided. The cost of regulation which, includes the cost to the insurance companies to abide by the regulation, and the cost to the state to administer the regulation, should not be excessive. An example of excessive costs would be a company that is primarily selling insurance in key states, but has three or four policies in force in other states. Why should the insurer be required to incur $1,000 or more in expenses on actuarial, legal and filings costs simply to obtain a total premium increase of $200 if all the policyholders renew?

A third attribute of regulation is to create and promote an orderly market and positive competition. Positive competition means competition which is constructive and which will seek to reduce the costs to the consumer over the long run. Destructive competition is competition which results in efficient companies eventually being drive out of the marketplace. The long-term costs to the consumer will escalate rapidly with destructive competition.

The fourth attribute of good regulation is that it be simple and that it show flexibility to finding solutions. Golden Rule, by guaranteeing the loss ratio, has shown creativity in trying to devise an approach out of the current morass that exists.

The proposed NAIC Rate Filing Guidelines do not have the attributes for good regulation. The guidelines will be expensive to administer, are not simple, and will not promote an orderly competitive market.

The primary cornerstone for the rate filing guidelines is a relatively simple sentence, "The premium being charged to the consumer should be reasonable, with respect to the benefits provided." Unfortunately, the word "reasonable" has many interpretations. As a means of trying to define "reasonable," the NAIC and many states have established minimum loss ratios. Unfortunately, some insurance regulators and companies believe that the loss ratio initially filed defines the minimum loss ratio thereafter for the product even if the filed loss ratio is greater than the minimum loss ratio. Some states may try to hold the insurer to that higher loss ratio even though the law or the regulation does not require this. Another aspect is the requirement that the expected loss ratio is precisely stated. Some insurance regulators have returned my actuarial memorandums because they stated that the expected loss ratio was going to be greater than a certain percentage which was greater than the minimum loss ratio. The expected loss ratio is not easily determined from readily available information. Easy, less expensive tests can indicate that the expected loss ratio will be greater than a certain level. Insurers should not be required to spend significant time and energy to do sophisticated studies on all cells of a complex major medical policy just to calculate the actual expected loss ratio. This is too costly for the insurance company and this cost will result in the higher premiums.

Can rate filing guidelines help protect solvency? Solvency is determined by how well the company operates, by the level of expenses, and by the level of benefits costs. It is not concerned with the relationship of premiums to benefits. Solvency is best handled through other regulatory means and not through the rate filing guidelines. Rate filing guidelines should only address the reasonableness of the premiums. Unfortunately, the proposed NAIC Rate Filing Guidelines include solvency related subjects.

Insurance companies are in the business of insuring people. How many believe that insurance policies insure the incidence of accident, sickness, or in some cases, pregnancy? How many believe that it is something else? Major medical policies, MET policies and group policies do not insure the incidence of injury or sickness. They insure the expenses incurred while the policy is in force, due to accidents or sicknesses that have occurred while the policy is in force. As a result, the insurers use pricing approaches which encourage policyholders to seek other insurance companies every year or two and to eventually enter substandard pools.

Substandard pools were created for individuals who are not currently covered by insurance and who have conditions which make it difficult to obtain insurance at an affordable cost. A growing problem exits with these substandard pools when they are sued for individuals who are currently insured and develop medical conditions. As these pools get larger, more and more pressure will be placed on the states to eliminate the middle man, the insurance company, by creating state health care plans. A better approach would be to encourage insurance companies and employers to cover the incidence of accident or sickness.

When you develop premium increases on closed blocks of business, how many actually do competitive comparisons against policies that are currently being issued? I do. How can premiums, which are greater than those being used for new business, be justified if one of the functions of a company is to keep customers? Higher premiums for existing policyholders on MET or individual health insurance policies encourage the existing policyholders to replace the policy with that of another insurance company if they are insurable or to replace the policy with one from the substandard pool if they are not insurable. Is an insurer fulfilling its function to keep customers if it has a 25% or 30% lapse rate in the renewal policy years? It is possible to achieve lapse rates of only 10-12%.

There is a better means of regulation that is less expensive. It will result in improved customer relations and improved persistency. It means changes in how companies operate. Erroneous regulation will be reduced if we do simple things, like telling policyholders that they have the right to automatically convert to a new, currently issued policy form whenever premium rates increase. Can it be done? Yes it can! This is not something that should be mandated. It would evolve if prefiling, similar to the approach of Golden Rule is trying, is allowed by the states. The company would assure the regulator that the premiums are less than or equal to those currently being charged for new policies and that the loss ratio accumulated since inception, adjusted for interest is greater than the minimum loss ratio, that the expected future loss ratio will be greater than the minimum loss ratio in the future, and that the customer will explicitly be given the opportunity to convert to a currently issued policy.

In summary, regulators have concerns that must be addressed by the industry. One concern is that the premiums be reasonable for the benefits provided. Another is that companies will not use "bait and switch" tactics. "Bait and switch" is when a company advertises a lower premium for new business and then increases the premium rates very rapidly after the policy is issued. If these concerns are met, I believe that companies will have fewer problems with regulators.

MS. SUSAN DALY MARSH: Is tier rating abusive? All of us have read newspaper articles like this one: "Employer receives 440% increase in health insurance premiums because one employee required treatment for cancer." This is the result of abusive small group tier or experience rating. However, tier rating, when used appropriately, is a tool to keep a block of small group medical business financially sound, without the need for 440% rate increases.

I'll cover why tier rating is necessary, what's involved in the process of tier rating, and give a brief review of the recommendations to the NAIC on group rating. I'll start with a few definitions:

**Small Group.** Different carriers define "small group" over a range of size. In this discussion, I mean an employee group of 25 or less.

Community rating is the practice of using the same rate level for all cases, both new and existing, regardless of experience or medical problems.

Tier or pool rating is the practice of using an individual case's experience to place it in a substandard pool at renewal, where cases in substandard pools are charged higher premium levels than the level which applies to the standard pool or new business rates.

Why tier rate? The immediate result of tier rating is lower rates for the majority of employers. By placing cases with poor experience in a substandard pool with a higher premium level, the rate for cases in the standard pool is lower. My estimate is that reasonable use of tier rating can lower rates in the lowest pool about 20%.

Lower rates make your product more competitive and help you to maintain your market share.

Lower rates improve persistency of inforce cases. Small group medical has very high lapse rates as employers continually change insurers to lower their monthly medical premium. Use of tier rating permits insurers to renew groups at a lower rate that they could if all groups were at the same rate level. This increases persistency. Both higher persistency and larger market share help to reduce expenses, which also helps lower rates.

Lower rates also means that insurance is more affordable for the small employer. This is an issue which is currently of great public concern, with 37 million people uninsured in the U.S. today. About 40% of the uninsured work for small employers with less than 25 employees.

The ultimate result of tier rating can be financial solvency. Many small group insurers have been forced to withdraw from the small group health insurance market. Use of pool rating can help an insurer stay profitable and avoid an antiselection spiral. Use of community rating can drive an insurer into an antiselection spiral. In an antiselection spiral the insurer is forced to raise rates due to high claim levels. Using community rating, the insurer spreads the increase equally over all groups. Many good cases leave for lower rates elsewhere. That means that the high claims of the poorer cases are

spread over fewer employers, forcing more rate increases, and generating more lapses among the good cases. In the ultimate scenario, the antiselection spiral drives rates up so high that all the insurer can hold onto are the cases with ongoing medical problems. Use of careful tier rating can keep an insurer out of the antiselection spiral.

**Methodology.** One item I'd like to make very clear is that tier rating does not mean each pool is self-supporting. Instead, tier rating applies the concept of credibility to the small group market. Substandard pools pay a higher premium, since their claim history shows a higher level of claims. However, the substandard claims are subsidized by cases in the standard pool. The premium for substandard cases should not cover all the claims generated by substandard cases. A large part of the substandard claims should be covered by the premium from cases in the standard pool.

The rules for tier rating should be objective. Pooling rules should be established which insure that all cases with similar experience receive similar renewal rates. Care should be taken that subjective judgements are not used in place of objective guidelines.

The rules for tier rating should be practical. They should take into consideration what data are available by group and or employee. The rules should be applicable on a consistent basis to all groups, and should produce reasonable results.

**Equity.** Pooling rules should be based on future expectations. They should place cases in substandard pools which are expected to continue to have high claims. It is self-defeating to place a case in a substandard pool if the case had a single high claim which is not likely to repeat. Putting a case like this in a substandard pool is likely to result in a potentially profitable case seeking coverage elsewhere. The cases which you want in the substandard pools are those who have employees with ongoing medical problems, or those who have a consistent pattern of high medical utilization. Some carriers place cases in substandard pools based on specific diagnosis; others use loss ratios or modified experience rating. The method used should preclude placement of a case in substandard pool with a single instance of high claims which is not likely to continue. For example, if you use loss ratios for substandard pooling, you should require a high loss ratio in more than one year. This will increase the probability that the loss ratio will remain high in the coming year.

Any pooling scheme should include rules to move a case out of the substandard pool back into the standard pool if experience improves. This is important for persistency of cases with improved experience, and also to maintain equity among policyholders.

**Testing.** The pooling rules should be tested on inforce business and expected inforce business. You should project both claims and premium, for each pool and in total, to be sure that the proposed rules produce adequate premium to cover expected claims for all pools combined. As I stated before, do not expect the substandard pools to pay for all of their projected claims. This means that the expected loss ratios on the standard pool should be well below the loss ratio you want for the total block. It is important to include the effect of case terminations in your projections. With so many carriers requiring medical underwriting on small group cases, you can expect a high persistency among cases recently moved into substandard pools. However, when the experience of

cases in substandard pools improves, you can expect a high termination rate, unless your pooling scheme adjusts their rates accordingly.

Tier rating by itself will not keep a block self-supporting. You need to continually monitor experience. Standard or new business rates include rating adjustments for various parameters which affect expected claims, such as geographic location, age distribution, plan deductible and so on. The rating differential for each of these parameters should reflect the differences in expected claims for each parameter. Over time the relationships among rating parameters changes. To insure adequate rates you should regularly review these rating parameters and change them when necessary. Changes to rating parameters should be passed onto inforce cases at renewal as an addition to trend. Pool rating cannot take the place of changes to rating parameters when experience shows that such is needed.

**Recommendations to the NAIC on Small Group Guidelines**

There are two committees which have been working on recommendations to the NAIC for health insurance regulation. The rate filing guideline recommendations were drafted with the intent to apply them to individual policies. At the same time another committee has been working on recommendations for group health insurance. Given the many differences between individual and group health insurance, it is necessary to develop guidelines for each separately.

The approach developed by the industry advisory committee for recommendation to the working committee of the NAIC has four key requirements: disclosure, proscription of certain rating practices, actuarial certification, and legal intervention by regulators when necessary. The guidelines are intended to apply to groups of 1-25 employees.

The disclosure requirement calls for presenting a summary of the insurer's rating and renewal practices at the point of the sale. It requires more complete information be available at the home office. This is reasonable to let an employer know what to expect, and should help decrease future complaints if the employer has a better understanding of the kinds of renewal increases he may receive. The drawback to this requirement is that if the disclosure is not carefully thought out, you may end up restricting your options at some future date when you find that the current renewal processes are not working well. Proscription of certain rating abuses is designed to eliminate excessive renewal increases in response to individual case experience. The latest recommendation calls for a three-prong approach.

The first limit is on the increase a group may receive per year in excess of trend. The maximum limitation is still under discussion by the Industry Advisory Committee but is in the range of 15-35% in excess of trend.

The second limit is on the range of rates within a block of small group lives. Currently the committee is recommending a range of ±30% from the average rate.

The final limit is on the range of rates among all small group policies insured by the carrier. This limit is that the ratio of the average rates for the most expensive product to the average of the least expensive product may not exceed 1.2. This additional step is

needed since many carriers have several small group blocks with very different characteristics. For example, some blocks may be subject to full medical underwriting, while others are not. Some carriers sell health insurance through several different marketing networks. And finally, some carriers have special programs for association groups. These kinds of regulatory restrictions on small group rating contain the necessary limitations to prevent abusive tier rating, while at the same time giving the insurer enough flexibility to write and adequately renewal-rate small group health insurance.

The third step is actuarial certification of rate adequacy and compliance with rating restrictions. This should help prevent the insurance carrier who enters the market with inadequate rates. Such a carrier ends up handing out excessive renewal increases and/or withdrawing from the small group market, both of which are detrimental to the reputation of all insurers.

Tier rating, when used with the proper controls, is a reasonable alternative to huge rate increases for small employers with high claims, or to the insurer who is forced to withdraw from the small group market due to inadequate renewal premiums.

MS. MARY LOU MARICK: We are very supportive of some kind of objective renewal rate filing guidelines, but being a pragmatist, I guess I question the practicality of getting the regulators, particularly the regulators in the bigger states, to agree to any kind of consistent objective guidelines. It seems that we have consistently run into problems in the large states where the regulators have been unwilling to look beyond the existing guidelines.

MR. ODELL: I think at some point we're going to come down to a very key issue. Is the purpose of regulation simply to be sure benefits are reasonable in relation to premiums? Or is the purpose of regulation to review, reconstruct, and validate all the work that comes into the department. We do not have any power to answer that question one way or another. That is up to the departments. My own opinion is that the success of the effort for an objective rate making standard will depend on the regulators, perception of the insurance companies motives in striving for that result, and how well we communicate it. I think these will be the two criteria on which the issue turns.

MR. HARTNEDY: Your concern is a very practical and very reasonable concern. I think it is going to be an extremely difficult and uphill climb. We are actually going state by state and trying to get it, and hopefully we are going to build some momentum. I do not believe that it is hopeless. I believe it is extremely difficult at best, but the situation is so drastic with individual major medical, which is basically the alternative to group health, being a dying market. Drastic steps are necessary. I think it's worth the effort to try. I really think we have a professional obligation to at least try. And like I say, we have been able to convince not only a number of regulators, but a number of legislators. We have two avenues to go when one group is not cooperative. I think it is worth the effort and that is the best I can tell you.

MR. SMITH: As you know, I am a regulator and there is more than just the actuarial problem to consider when you are working for the state. You have the political problem

with smaller companies deferring applying for rate increases until they just have to have them. Then the rate increases are unacceptable from a political standpoint. A regulator cannot allow a 200 or 300% rate increase. This problem would be solved by ongoing monitoring of the products, and applying for the rate increases as they are needed.

MR. ANTHONY J. HOUGHTON: I would like to comment on some of Susan Marsh's remarks. I generally agree with her statements. I think it's important though, to expand on initial impressions rather than immediately assume that tier rating results in an immediate vindictive change based on something that has already happened. In my opinion, the best type of approach to put people in a reasonable category is based on prospective results. One approach might simply have a slightly lower premium rate for people whose loss ratio was very low; an average rate for people whose experience was average; and a somewhat higher rate for people whose prior experience was adverse. Some of those differences, while they're not directly prospective, have a very strong correlation in the subgroups, such that there is a very good likelihood that that's the proper rate in aggregate for those subpools. So to that extent, I think they can be considered to be prospective also. For example, if a group having a claim rate under 40% is given a 10% reduction from the next rate level, then it will surely correlate so that it's fair. And those people are still providing a subsidy for those people who may be charged 115% of average, when their prior loss ratio was very high. Tier rating by duration obviously has nothing to do with prospective rating for the individual unit. This would, after a year, have all the people in their second year charged 115% of the new business rate. It's not prospective with regard to the individual unit, but it may be completely prospective in the aggregate for the class of those people. It seems to me there are also some companies who are trying to set up ones which are completely prospective. We dealt with one Blue Cross plan that was trying to do it and looking at all the factors that would go into what their likely cost would be, including participation, employee contributions, ongoing diagnoses and all the rest, you could very well have people in the lowest pool who had disastrous prior experience, because of an acute one-time situation which would not occur again. In the same way, you could have people in a higher pool with low participation, excellent prior experience, but now indications that certain of their people have diagnoses that were likely to make them substandard. And again, it had some of the characteristics as Susan mentioned, which is a cross sub-space, so it's still the people in the highest classes who are getting the best relative bargain. And the people in the lowest were providing the greatest subsidy. And the program was intended to make the entire thing viable. So keep enough of those low risk people involved, that they would be there to provide those cross subsidies with the higher risk people.

MR. SMITH: With regard to tier rating, the states or at least the state of Florida, are concerned with accessibility. They want to have everyone covered. Susan is saying that you shouldn't tier rate them to the point that they can't afford it any more, and I agree with her. That's when we start having problems from a regulatory standpoint. The solution has been proposed to have state pools that take these substandard risks and we do have that in Florida, but they get so expensive that they don't want to fund them. So our preference would be for the insurers to cover the whole market as Susan had suggested.

MR. HARVEY SOBEL: I heard Bill make mention of a possible solution being a free market and I wonder, as one who believes in free markets and minimal regulation, whether you'd care to comment on that possible solution. I would like John's comment as well.

MR. ODELL: Yes, I'd be glad to. Let me pick up something else, as this does tie into tier rating for small groups. The comment of putting groups in categories depends on credibility. Experience is really quite old by the time it is available for analysis. One of the nice things about the things being considered for small group re-rating is a fairly objective standard. You may find a flight of any remaining writers of individual coverage to small group, in order to get an objective standard instead of the present situation. It is my opinion, that in the long run, a free market will do the best job for the consumer. It will bring products to the marketplace. If you have a large number of competitors, you generally get delivery of a good competitively priced product. This depends on a large number of players, full information between buyers and sellers, access to get that information, and the ability of people to buy. Generally, efforts by the government to solve a problem makes the problem worse. I think that what's happening in individual major medical is a very clear cut example of this. We have heard of, but have not been able to identify, studies that were done in the homeowners and automobile insurance markets by states that were considering file and use open competition, as opposed to prior approval. Presumably those studies showed that file and use was preferable. I have not mentioned those because I have not actually read them myself. The only other comment I would offer is that, generally speaking in the world economy, I think you'll find that the countries with the freest markets do the best. Since it is a very difficult subject on which to comment on objectively, those were opinions.

MR. HARTNEDY: As far as the free market, I agree with that. I think it's the best way. I've talked to a regulator who is an actuary of a state, so I won't identify him. He basically said that rate regulations in the health business are not working. Now that I have said that, I don't think the free market is a practical alternative, simply because of the nature of this country. In other words, there are going to be health rate regulations. I think we should accept that as a fact of life. So we are in the position now that we are actually supporting regulation, but we're supporting it from the point of view of seeking objective and consistent regulation. I think that is just the practical way to go. I have a comment on something that Bill brought up. There was a former commissioner in Illinois who commented that he had done a study which showed that file and use actually kept the rates down in Illinois. There was not enough information in the article to determine statistically how good his study was. But it was well published and he felt that rate regulation would cost consumers more. He was discouraging it in Illinois, and Illinois does not have rate regulation.

MR. DALE C. GRIFFIN: Most of my work is for the Michigan Insurance Bureau, so I think of myself as a regulator. I am disappointed in us as actuaries when we tend to take the point of view that the free market is the only way to go. I think it is really clear in this tier rating issue that the free market is not the way to go. I have not had a lot of exposure to the small group issue, but what I have seen was shocking to me. A plan will set up a tier rating structure, where 200% of average is the highest tier and that is for a two life group. One person is sick with cancer and is going to have expenses over the

next three years which are very predictable. However, that's not the point. It is not a very reasonable way to set up an insurance system. I think that from a policy point of view, it would be better to have regulation in that situation. The restrictions on the maximum difference between the top tier and the bottom tier effectively do the same thing, but it just seems clear to me that allowing companies to look out for their own best interest and charge 200% of average to a two life group is not a good example of a free market solving a problem.

MR. HARTNEDY: My reaction would be that I would fault the insurance industry in the way in which we are educating our consumers. A consumer ought to have an idea of the type of risk that they're taking. I don't think companies ought to do what you're describing and I agree that if our customers are properly educated, companies who routinely did that wouldn't get a lot of business. Regulation still does not educate the consumer, although thorough disclosure would help educate them. Ernie commented that we've got to improve our credibility and we haven't done a good job of that. We're trying to train our brokerage managers and our brokers. We're trying to make them understand a simple definition of insurance, like I went through here. We can explain what insurance is supposed to be doing and why we don't want to take known AIDS cases. We can explain that AIDS is a social issue, which needs to be solved, but by the appropriate party. I was almost shocked, when talking to some of our agents, that this was a complete revelation to them! We have really failed to educate people and now we're paying the price. The price we may have to pay is stricter rate regulation.

MS. MARSH: I agree with your comments about the inappropriate rate action for the two employee group. I think that the proposed regulations that I described should limit that. I think it's important that regulations like these be passed and one of the key components is disclosure, so that an employer can compare what different insurance companies are likely to do.

MR. DONALD L. PETERSON: I have a question for Susan. Do you have any speculation on when the NAIC guidelines for small group might be effective?

MS. MARSH: I have no idea. I know they're working hard on it and I know that several states have already passed regulations that are more restrictive than the regulations that the NAIC committee is recommending. That is what I wanted to say before. We need some flexibility in our rates in order to stay financially viable. We do not want a state to come in and say that you have to community rate all of your policies. I think that forces you into insolvency.

MR. HARTNEDY: I was at the last NAIC meeting where this was discussed, and I understand that the committee chaired by Howard Bolnick and the HIAA have now come to agreement. They are supposed to come together with an exposure draft, to be presented at the June NAIC meeting and the NAIC will expose it at that time. How it proceeds from there is going to depend on the response in from the industry.

MR. ODELL: My understanding of the schedule is the same. I believe it's under the guide of Trevor Smith from Florida.