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HEALTH REGULATORY ISSUES

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Panelists: MARK V. HARTMAN
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Recorder: RICHARD J. RUPPEL

- o Rate filing regulations -- current developments
- o Small group model update
  - -- State variations
  - -- Underwriting practices
- o Current issues

MR. JOHN A. HARTNEDY: Our subject is health regulatory issues. Our first speaker is Mr. Lee D. Tooman. He's the group product manager at Golden Rule Insurance Company, and in that capacity, he's responsible for the growth and profitability of Golden Rule's block of group insurance business. He's had a number of years of experience in the small group market; he has attended many of the NAIC meetings and spoken to people involved with recently proposed changes to group laws.

MR. LEE D. TOOMAN, JR.: I'm not an actuary. I am a marketing person by training. I have spent a great deal of time in the small group market developing products, trying to figure out ways to market them successfully and trying to maintain profitability all at the same time. That is not an easy thing to do.

At three different sessions, I heard requests by the speakers for actuaries to get involved as much as possible in what is going on in the regulatory and political fronts, and I would like to echo that. I have had no training in law, but with so many things happening in so many different states, I find myself being dragged in more and more to the governmental relations area. I think it is terribly important for all of us to do this because people who are less informed about group health insurance in general are making rules and laws that are going to change the way the world works with respect to group health insurance.

I'm here to talk about small group insurance. There is a great deal of interest in the subject of small group insurance because, from what I can gather, there are two fundamental things going on. One is the number of uninsureds in our country. Whether you believe that the number is 31, 37, or 44 million, or whatever number you want to agree upon, it is clear that the largest segment are people who work for small businesses or are dependents of people who work for small businesses. And despite many efforts at trying to deal with this problem over the last few years, not much has really worked very well. We've had conversion policies for some time. In recent years we've seen COBRA, we've seen state-mandated continuation, and we've seen high-risk associations; yet the number

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of uninsureds seems to continue to grow. The second aspect that has created a great deal of interest in the whole small group area is what has happened with renewal rating after many groups experienced several rate shocks. We've gone through periods of relative rate stability followed by periods of extremely high rate increases. It's a difficult market to work with because the small group employer puts many demands on us. The small group wants to be experience rated when the small group has no claims and it wants to be pooled when it is experiencing claims.

Regarding state variations, I would like to talk a little bit about what has taken place in three states: Connecticut, Maine, and Georgia. Group rate review in one form or another has been adopted by these three states. It is the law in those three states. Although it is being phased in over a certain period of time, it is the law and has been signed by governors. The concept of a reinsurance pool has been adopted in the state of Connecticut, and the subject of continuity of coverage for people who enter the health insurance system has been adopted by Connecticut and by Maine.

In Connecticut rates are limited for any one carrier to a range of two to one. No group rate can be twice as high as another group's rates in the state of Connecticut. There are demographic openings: a group can be rated differently outside of the two to one if it is based on sex, age, family status, geography and the like, but similarly situated groups must be within a range of two to one. Rates can be increased at a rate of the change in the lowest business rate plus 20% per year. That is the maximum rate increase. With respect to continuity, all groups have to be guaranteed renewable. A carrier that writes group business in the state of Connecticut may not single out a group and cancel it. The group must be guaranteed renewable except for fraud and nonpayment of premiums and the like. Preexisting conditions are limited to a definition of no more than 12 months back for treatment, advice or symptoms, and they cannot be limited for more than six months after the effective date. Just as important those who switch jobs or carriers, and who have previously satisfied part or all the preexisting condition limitation and were continuously insured are given credit for the preexisting limitation already satisfied.

In order to deal with some of the aspects of continuity of coverage and so forth, Connecticut has adopted the concept of a reinsurance pool that has been promoted by HIAA. The NAIC is currently working on appropriate models. With respect to the reinsurance pool, Connecticut has developed, as part of its code, two plans that every carrier that writes small group insurance in the state must have. The first one is called a special health care plan. The special health care plan is designed for groups that have not had prior insurance (for the previous two years). The second is the small group health plan which is basically available for any group. Once you start getting beyond that, what the Connecticut law says depends on whom you ask. Essentially, Connecticut has become a discontinuance and replacement state with respect to groups. Subsequent additions to the group, whether it's a special, a small group plan or another plan that a company may administer, have to be issued insurance. People can be reinsured to the reinsurance pool whether it's on a standard plan that you or I may market there, whether it's part of a small group plan or the special health care plan. There's a premium charge to reinsure people, and it is not like a high risk association where there's actually administration done by the reinsurance people. A reinsurance pool merely takes people

out of the risk directly to the insurance company, and the risk is then spread among all carriers in the small group insurance market.

The Connecticut bill is very long and complex. There are many issues that must be resolved over the next few months. The law was adopted early in 1990; in early September 1990 the Reinsurance Board was established, and in November 1990 there will be subsequent hearings and the rules will start to be written. It is of concern to some how the assessment mechanism is going to work. The assessment mechanism for the reinsurance pool is different than the HIAA's. The assessment mechanism is limited to 5% of the small group premiums. Should the losses of the reinsurance pool exceed an amount equal to 5% of the small group premiums in the state, assessments are subsequently made against other forms of health insurance premiums, such as medicare supplement, long- and short-term disability, dental, vision, and the like. What is left is essentially individual major medical and medium-size groups. There is no provision within the law to assess the large groups. The HIAA proposal in principle has that feature, the Connecticut law does not. So the Connecticut law is very long, sweeping and changes the rules significantly of how business is going to be done.

Maine has not taken that large of a step, but it has taken a significant step in the area of continuity of coverage. Maine has adopted rules with respect to group rate review. No group's rates can be more than 120% of a weighted average of all the small group premiums written by the carrier in the state. When Maine passed House Bill 1641 in early 1990, it made provisions for continuity of coverage for individuals working for small groups, groups changing from one carrier to another and individuals entering a small group or changing jobs. What Maine intended to do was say that, if someone enters the health insurance system, satisfies the preexisting condition and would want to change jobs then he or she should not have to face a new limitation, should not have to face underwriting again and should not be put in a position of being forced out of the health insurance system. That certainly is a worthwhile idea. Part of the problem is the way the law is worded. There's a task force that's trying to deal with this, and it is a very difficult area to wrestle with because the law says that an individual who has been continuously insured, has satisfied the preexisting limitation (whether with an individual plan or with a group) and wants to join a group plan can do so. That person must be issued insurance, and there must not be any new limitations for preexisting conditions so long as the person is not a late enrollee. (In all these laws there are provisions that exclude late enrollees.) The problem with the Maine Act, as I see it, is that it allows the system to be used. An individual could essentially buy a short-term major medical plan that doesn't require underwriting, and even though there is no provision for paying on preexisting conditions, that person has now become insured with an individual type of insurance policy. He could then join an employer's group, and provided he or she is not a late enrollee, that person would have to be guaranteed issue with no limitations on preexisting conditions despite the fact that the person had no coverage for those preexisting conditions. Maine is currently wrestling with this issue and plans to develop rules and regulations that deal with it.

The Maine task force also seems to be headed in the direction of recommending to the legislature that community rating be adopted for all carriers in the small group market. The Blue Cross organization currently does community rating. It and consumer groups

have become very vocal in saying it's a fair way to do business, and that is the way everybody should do business. That causes me some concern because I fear that by solving one problem, another one is created. Community rating has a strong appeal of fairness, and the consumer groups want to promote this as a way of being fair. The problem with community rating is that it may very well bring rates up for the younger healthier people and cause them to drop out of the system even more than they already do. In the literature that I've read, no one seems to have asked the question, much less answer it, "Why are the uninsured?" There are many anecdotes and scenarios of the poor people who lose their insurance through no fault of their own, but it's also clear many of the uninsured are young, healthier people, who have opted out of the system. Thus, community rating would have the opposite effect by driving out more of those younger, healthier people. In the long run it would also cause rates to be higher for the elderly people.

In terms of the states that have passed laws, Georgia passed a law that requires pooling for all groups with fewer than 50 people. (Connecticut and Maine have proposed in their code that it apply to groups of 25 lives and under.) All groups must be pooled. There is no durational rating, no tier rating whatsoever. Rates can still vary by age, sex, and avocation, the usual demographic classifications. New employees and additions to the groups can be ridered, or limited for preexisting conditions, or excluded, or rated up, but the Department has written rules that state you had better document your underwriting standards. Should you be questioned, you have to be able to prove from the documentation exactly how the person was underwritten because it is the view of the Department of Insurance in Georgia that anyone who is actively at work is deemed to be insurable. The same goes for dependents of employees. Therefore the documentation becomes a critical issue. In Georgia's law, as well as in the NAIC Model, one of the concerns I have is the effect of pooling and these group rate review requirements on the new carrier? It seems group carriers that have a large block of in-force business may find themselves penalized. They may find their new business rates are in fact a slave to their highest renewal rates. In the case of Georgia the rates are the same for both new and mature business. Georgia attempted to solve this problem by saying that any new carrier that comes into the state must guarantee rates initially for 12 months. For group carriers that are already doing business in the state of Georgia, six-month rate guarantees are adequate.

Going back to December 1989, the initial draft of the NAIC group rate review said that tier rating was permissible, but the rates in any one block of business could not be more than a ratio of 2.5:1. Rates can be increased for in-force groups no more than the change in the lowest business rates plus 35%. By the June 1990 meeting in Baltimore, it had changed so much that rates could increase no more than the change in the new business rates plus 15%. Rates within a block could be plus or minus 30% of an index rate, and the index rate between blocks could not be any more than 1.2:1, the highest index rate could not be more than 20% higher than the lowest index rate. Subsequent to the June 1990 meeting, the rates within a block of business were further ratcheted down from plus or minus 30% to plus or minus 25%. That's where the Model Act stands right now. The Model Act calls for all groups to be guaranteed renewable, for disclosure of rating practices and for self-policing through actuarial certification. Some states have not

waited for the NAIC Model Act to go into force. Connecticut, Maine, and Georgia have already taken steps to adopt it.

I would like to close by stating that it is terribly important that you who have more expertise in the numbers and profitability of small group insurance become more deeply involved in what is happening in these states and where they are going with it. Since we operate in 49 states, I find myself having to look at many different laws, and because they're going in so many different directions it's just not easy. I think we've made a little bit of difference in a few areas, and I certainly urge you to do the same.

MR. HARTNEDY: Let me introduce to you our next speaker who is Mr. Mark Hartman. He is a consultant with W.H. Odell and Associates. He's also been with Occidental Life and Integon. He has experience in accident and health as well as life and pensions.

MR. MARK V. HARTMAN: I'm going to discuss current developments in individual health rate filing regulations.

As John indicated, I am a member of the AAA's Subcommittee on Liaison with the NAIC Accident and Health committee. This Subcommittee was asked by the NAIC Life and Health Actuarial Task Force (LHATF) to revise the current Rate Filing Guideline. First I will give a brief history of the current draft of the revised guideline, including some examples showing the additional liability that could be required under a revised guideline. Finally, I will discuss some of the major issues that are still unresolved.

In June 1988, our Subcommittee was asked by the LHATF to look at revising the guideline and to consider including the benefit ratio reserve concept, which had been deleted from the A&H Reserve Standard. A draft of a new guideline was presented to the LHATF in June of 1989. Some revisions were made, and the guideline was accepted and exposed by the Health Section of the SOA in summer 1990. Over 30 comment letters were received by members of the LHATF. As a result the Subcommittee has made various modifications, both minor and major, over the past year. At this time, the Subcommittee's current draft has been given to the LHATF, and a subgroup of the LHATF will make further revisions. It would like to have a new draft that could be accepted for exposure following its December 1990 meeting. I'd like to discuss the major concepts of the revised Rate Filing Guideline.

The first area is the scope of the guidelines. We have defined three different classes: individual, group, and quasi-group. The intent is this guideline should cover individual insurance and should not cover true group insurance, and that it should cover quasi-group. Many people feel there is a large gap in current regulation that allows a company to establish a trust, sometimes referred to as an air-breathers trust, and avoid rate regulation.

Basically, quasi-group is insurance that has the attributes of individual insurance, such as individual solicitation, individual underwriting, and individual premium responsibility but is sold under a group contract. However, we have found it difficult to precisely define quasi-group and to avoid duplicating coverage of contracts with group regulation. Thus,

the Subcommittee changed the current draft to address only individual coverage until more work can be done regarding the quasi-group questions.

The main concept introduced in this guideline is the prefiling option. Prefiling of rates would be an option available as an alternative to submitting rates and waiting for approval from the insurance department. Under the prefiling option, rates would be considered filed and effective as submitted. For rates filed using this option, however, the insurer would be subject to additional monitoring requirements and, if experience warrants, to establishing a regulatory liability for that policy form. Under the monitoring requirements, a company must file additional information each calendar year. This information includes the earned premiums and incurred claims, by year of issue, and a calculation of the cumulative actual to expected (A/E) loss ratios. For each form where the A/E ratio is less than 1.0, the insurer would have to establish a regulatory liability that would bring the A/E ratio up to 1.0.

The regulatory liability is established to support a commitment that insurers make in exchange for the prefiling option. When a company originally files rates, the actuary demonstrates how the minimum lifetime loss ratio will be met. If experience is worse than anticipated, the insurer could raise rates through the prefiling option. If experience is better than expected, the insurer would have to establish a regulatory liability to bring cumulative experience back to target.

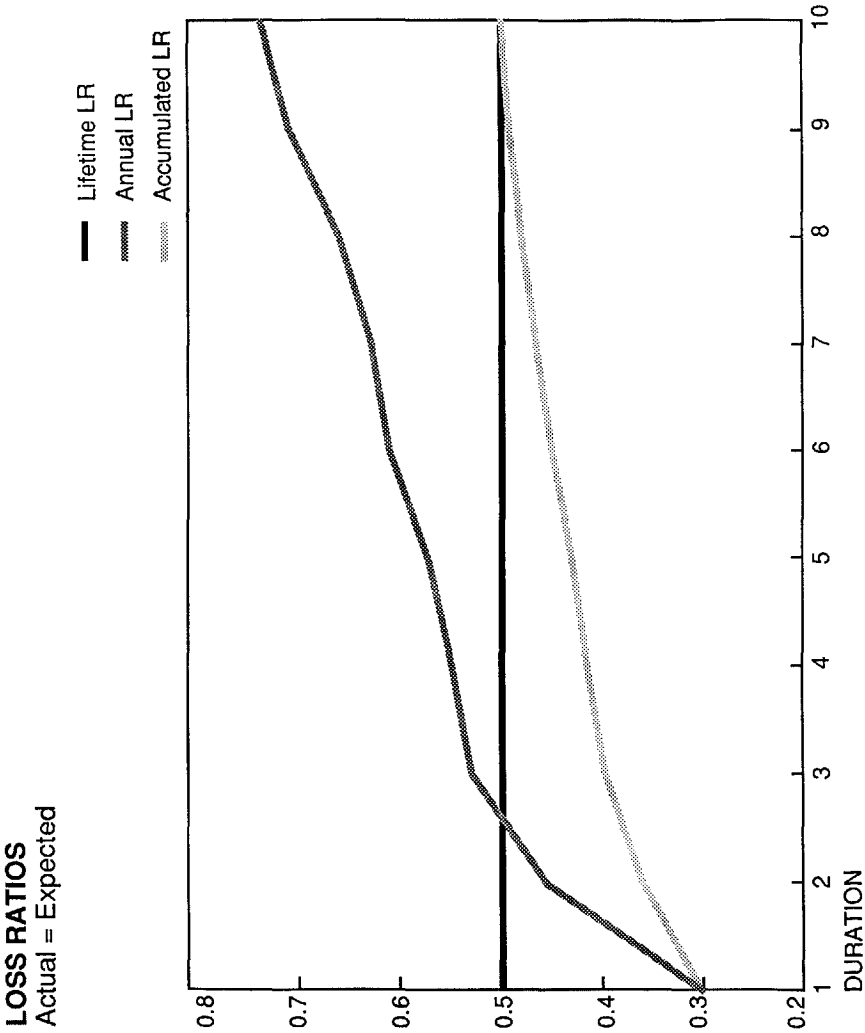
I have prepared several graphs to illustrate the regulatory liability concept. These graphs show several different scenarios.

Chart 1 shows loss ratios for a representative plan. This is a level premium plan with loss ratios increasing by duration and is designed to hit a 50% lifetime loss ratio at the end of ten years. The top line with the plus signs shows the durational loss ratios. It starts off low in the early years, then reaches the 50% target at the end of ten years.

Chart 2 shows the liability under each of the three calculation methods when the actual experience is equal to the expected experience. The lower line with the boxes, which is coincident with the x-axis, shows the regulatory liability as it is currently defined. It is zero at all durations because the actual experience does not differ from that expected. The top curve shows the benefit ratio reserve. This can be compared to a natural benefit reserve. This method causes the ratio of incurred claims plus increase in reserve to equal the 50% target in each year. The lower curve shows the modified benefit ratio reserve. This uses the two-year preliminary term method so that reserve is zero for the first two years. This then grades into the benefit ratio reserve at the end of ten years. In this example, since we're looking at a ten year period to reach our lifetime loss ratio and the actual experience is equal to expected, we exactly reach that loss ratio at the end of ten years, and all three methods produce a liability of zero at the end of the ten year period.

Chart 3 shows the same type of situation. Again the actual experience is equal to that expected in pricing; however, this time the lifetime loss ratio is not expected to be met until the end of 20 years. The regulatory liability is zero at all durations because the experience does not differ from that expected. However, the benefit ratio reserve

CHART 1


LOSS RATIOS
Actual = Expected
Lifetime LR
Annual LR
Accumulated LR
0.8
0.7
0.6
0.5
0.4
0.3
0.2
1
2
3
4
5
6
7
8
9
10
DURATION

LIABILITY
Actual = Expected

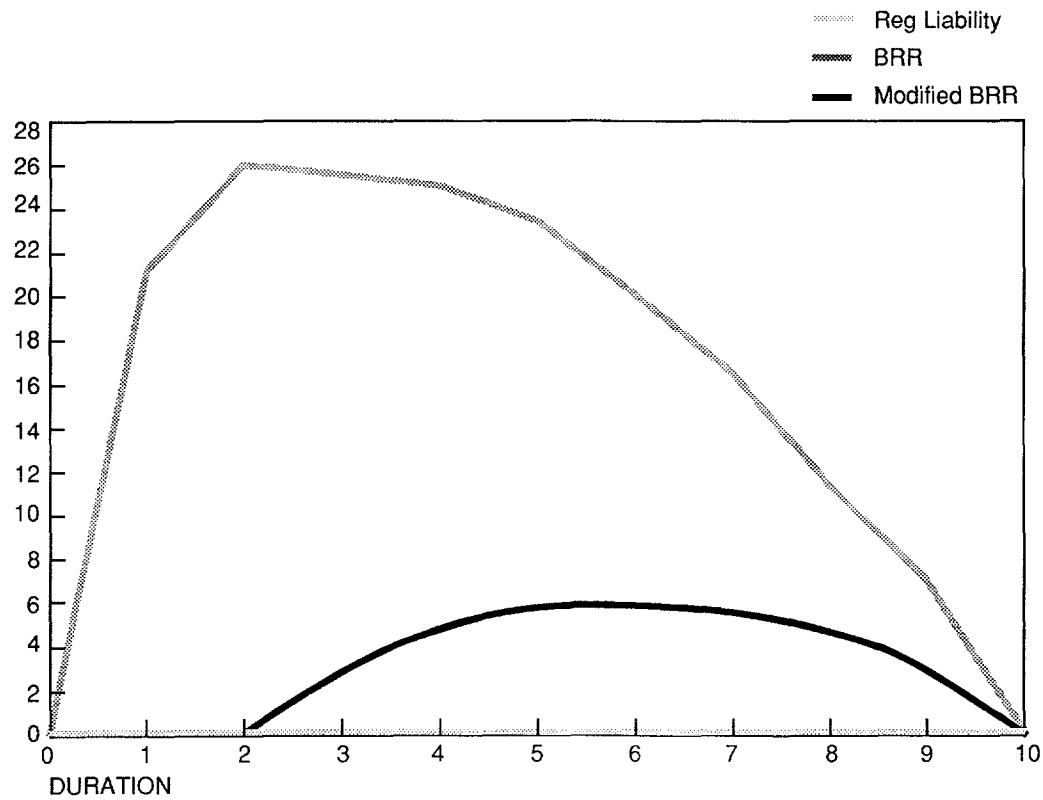
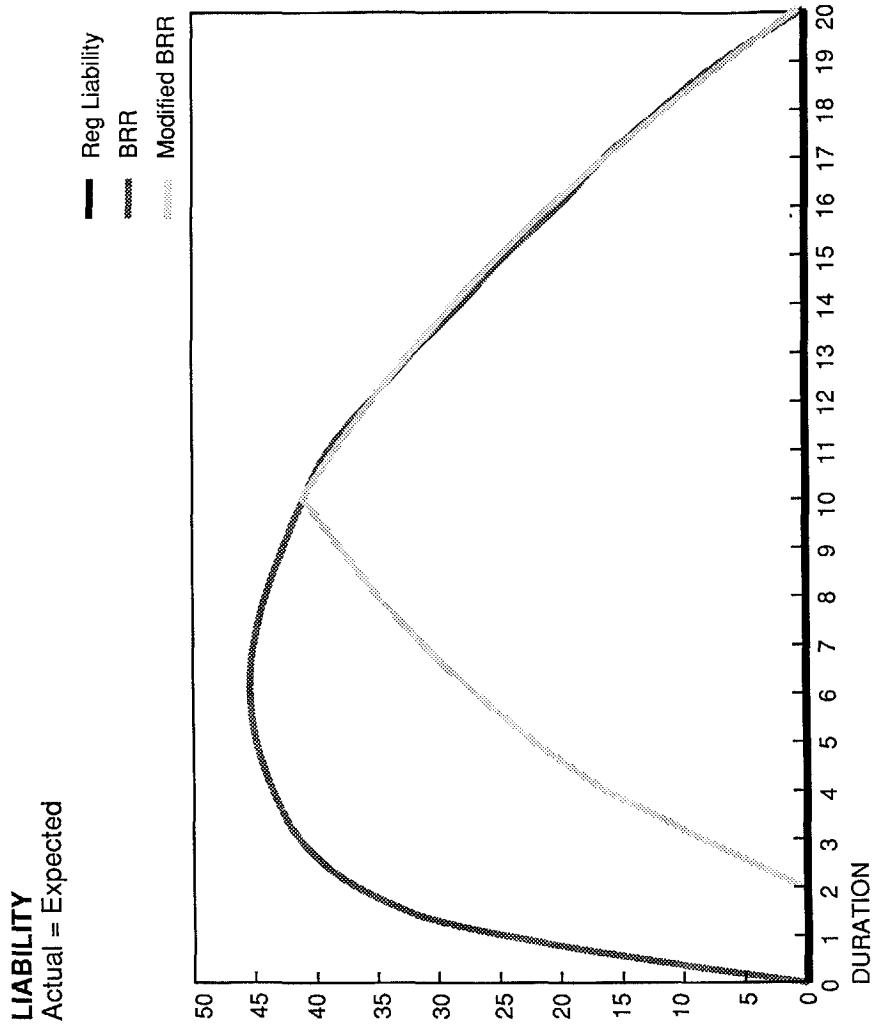


CHART 2

CHART 3


LIABILITY
Actual = Expected
Reg Liability
BRR
Modified BRR
50
45
40
35
30
25
20
15
10
5
0
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
DURATION

method produces fairly significant reserves in the early years and then grades back to zero at the end of 20 years. Also, you can see more clearly how the modified benefit ratio reserve method starts at zero after two years and then grades into the benefit ratio reserve. I think the main point Chart 3 makes is the difference in purpose of these different methods. The benefit ratio reserve methodology performs a reserve function by leveling loss ratios. The regulatory liability, however, only performs the function of bringing actual experience back in line with expected. What our Subcommittee has suggested is that reserve principles would be dealt with in a reserve standard and that tracking actual experience against expected should be dealt with in the Rate Filing Guideline.

Lets move to the next scenario (Chart 4). Again, we're using a 10-year period to reach the lifetime loss ratio. In this case the actual claims are less than those expected in pricing. The top curve shows the durational loss ratios, and the bottom curve shows the cumulative lifetime loss ratio. Actual experience accumulates to only a 40% loss ratio as opposed to the 50% target.

As we look at Chart 5, you see that the regulatory liability is positive after the first year and continues to grow the entire 10 years since actual experience is less than expected each year. The benefit ratio reserve methodology again produces a larger liability as it's building reserves in the early years. And again, all three methods produced the same liability at the end of the 10 years.

Chart 6 shows what happens when lapses do not equal those expected although the durational loss ratios are exactly equal to those originally anticipated. The top curve represents the durational loss ratios, and these are the same as those shown in Chart 1. However, under this scenario actual lapses are greater than expected, so as shown by the bottom curve, the cumulative lifetime loss ratio does not reach the target at the end of ten years as originally anticipated.

Chart 7, shows the liabilities generated under this scenario. The regulatory liability becomes positive after the first year as lapses are greater than those expected and then continues to increase as actual experience differs from expected. The benefit ratio reserve methodology produces much larger liabilities in the early years which then decrease over time, again following the natural reserve pattern.

As a final comment on the differences in these methodologies, I will point out that the regulatory liability as proposed here would be in addition to any policy reserves generated, and the benefit ratio reserve would be inclusive of active life policy reserves. Thus, if this were a level premium, an entry-age-rate guaranteed-renewable product with reserves generated on similar assumptions, the differences in these methods could be fairly small. However, if this were a conditionally renewable attained-age-rated product for which no active life reserves are carried, the differences can be quite large.

The prefiling option, regulatory liability, and monitoring requirements are the major concepts introduced in the guideline are still unresolved, and I'd now like to discuss five major issues.

CHART 4

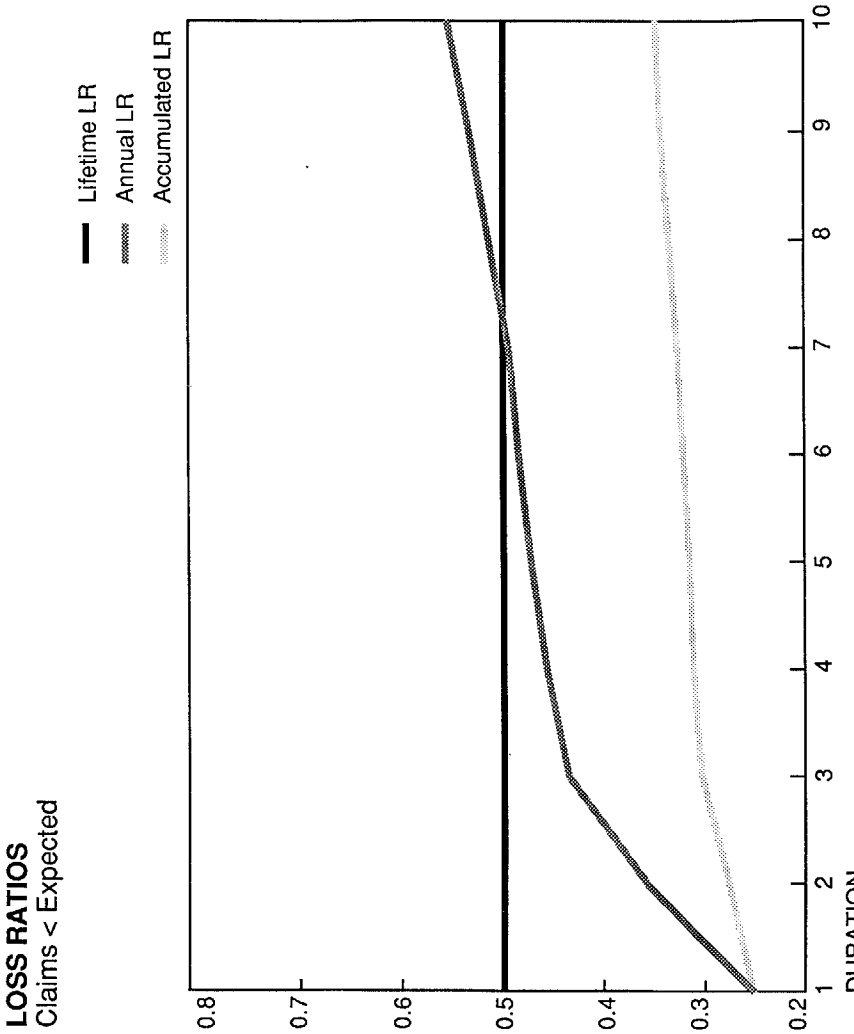

LOSS RATIOS
Claims < Expected
Lifetime LR
Annual LR
Accumulated LR
0.8
0.7
0.6
0.5
0.4
0.3
0.2
1
2
3
4
5
6
7
8
9
10
DURATION

CHART 5

LIABILITY
Claims < Expected

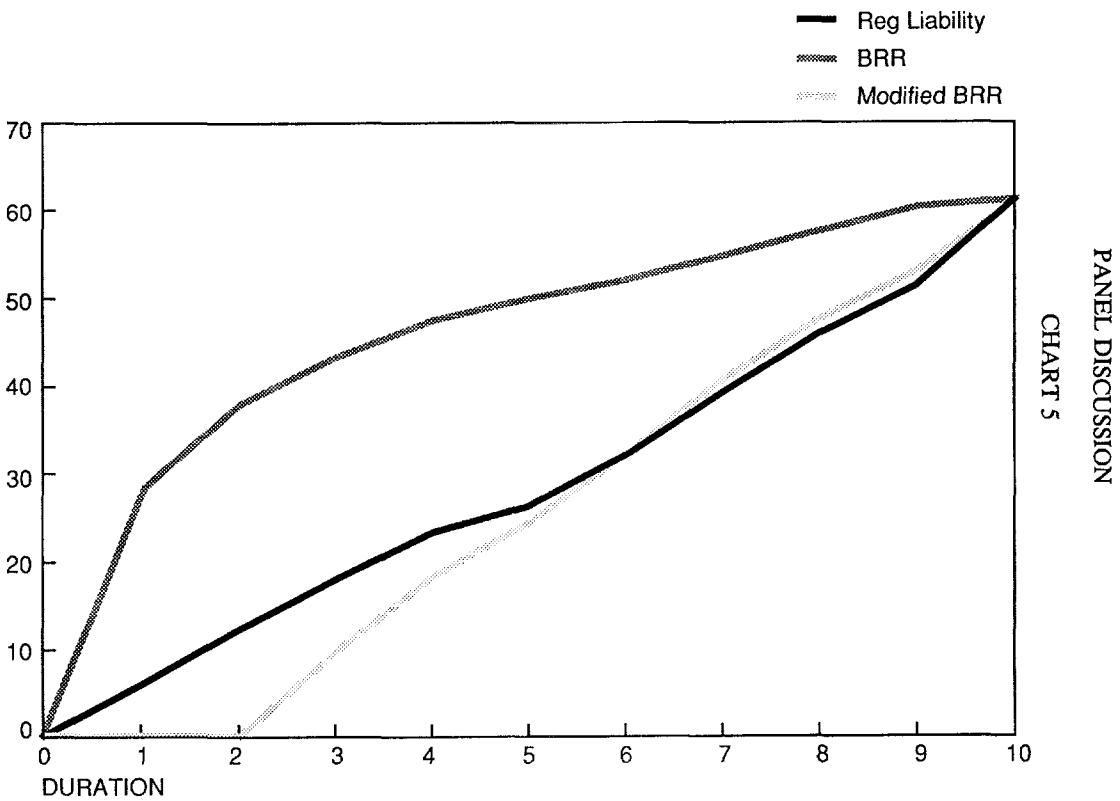
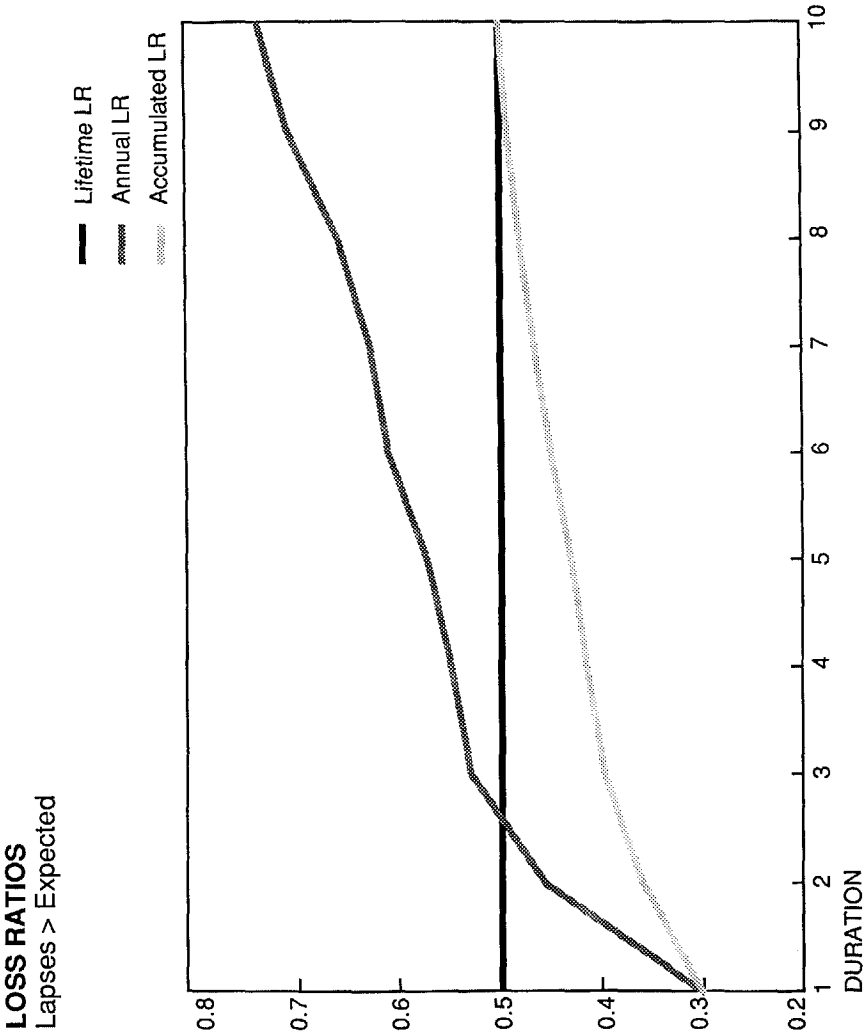


CHART 6


LOSS RATIOS
Lapses > Expected
Lifetime LR
Annual LR
Accumulated LR
0.8
0.7
0.6
0.5
0.4
0.3
0.2
1
2
3
4
5
6
7
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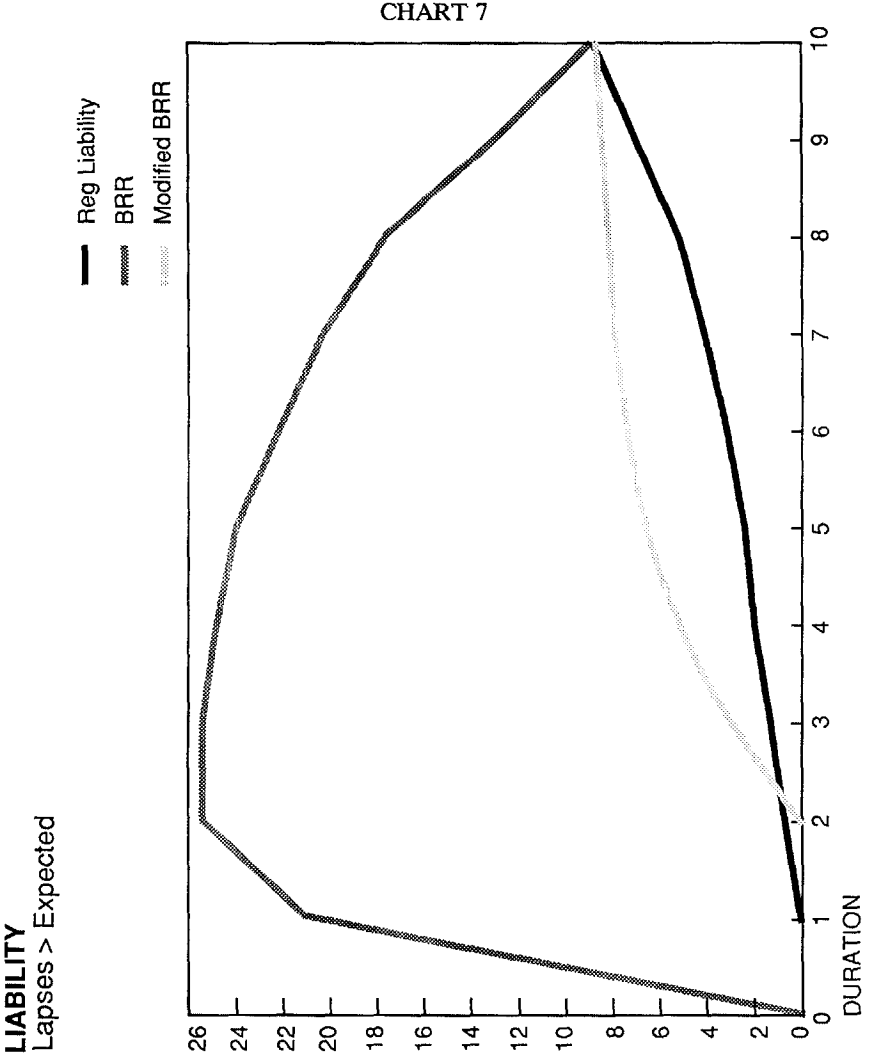
9
10
DURATION

CHART 7


LIABILITY
Lapses > Expected
Reg Liability
BRR
Modified BRR
26
24
22
20
18
16
14
12
10
8
6
4
2
0
0
1
2
3
4
5
6
7
8
9
10
DURATION

The first issue is guaranteed renewability. The LHATF has indicated that the prefiling option should be available only if a form is guaranteed renewable. The Subcommittee has argued that the prefiling option will make pricing on inflation sensitive products more viable and guaranteed renewability will do the opposite. In September 1990 in Los Angeles, the LHATF said guaranteed renewability must be required.

The second issue concerns a higher loss ratio requirement. The LHATF has indicated that the prefiling option should reduce the risk and expense to companies, so a higher loss ratio is justifiable. It appears that some companies feel that is acceptable, while others feel reductions in the current minimums are needed.

Third, in order to make rates affordable and predictable, the LHATF saked the Subcommittee to include a maximum rate increase for prefiling. The Subcommittee suggested a limit of 60% in any one year and 100% over two years. Some members of the LHATF have said that they feel half of these amounts would be more acceptable.

Fourth, there has been discussion regarding whether the regulatory liability, based on actual to expected ratios, or a liability based on the benefit ratio reserve concept should be used. This gets into the purpose for establishing this liability and some concerns over including reserving principles in a rate filing guideline. Additionally, there is a question of whether the liability should be treated as a benefit to the policyholders, or as an overcharge (and thus a refund) of premium.

Last, there has been discussion regarding state-by-state versus nationwide reporting requirements. Some interesting situations can arise if a company monitors and reports information on a nationwide basis but writes business in states that both and do not allow prefiling with the monitoring and regulatory liability requirements. It can become very cumbersome to maintain the necessary data for each state and each policy form.

All of these issues and further revisions to the Rate Filing Guideline are being reviewed by the LHATF. Many people in the industry feel if too many restrictions are put on the prefiling options, companies will not use it. Many regulators feel that if enough restrictions are not included, companies will abuse the option. The LHATF hopes to have another draft ready for exposure by the end of 1990. I hope all of you who are interested will review the guideline and give the LHATF the benefit of your comments.

MR. HARTNEDY: I'm Vice President and Chief Actuary of Golden Rule Insurance Company. You've probably seen our ads. We are known as the quiet company. I'm a Member of the AAA and an FSA. I serve on the AAA's Subcommittee on Liaison with the NAIC Accident and Health committee. I'm also serving on the Indiana governor's Health Care Task Force. I'm going to address some current regulatory issues I believe you should be aware of.

The first one is guaranteed loss ratio. This is similar to the concept of the regulatory liability. This is the law in South Carolina and Kentucky. It is permitted in the state of North Dakota. We have used it in about 16 different states, primarily in a situation where we took over a block of business from an insolvent company.

This is a brief description of how the guaranteed loss ratio works: (1) Inception-prior approval, (2) End first year refund extra set rates year two, (3) End second year refund extra set rates year three, (4) Audit of results each year, and (5) Each year company takes loss or pays refund. Table 1 represents one calendar year, the sample shows 1992, where the loss ratios were filed and approved by the state by duration. So what we have is expected claims of $1,220.

TABLE 1

One Year of Issue Taken Alone

Policy Year	Expected Loss Ratio	Earned Premium	Expected Claims
1	45%	$200	$90
2	50	130	65
3	60	100	60

Policy Year	Actual Claims	Refund <Loss>
1	$105	$<15>
2	60	5
3	61	<1>

In Table 2 at the bottom, if actual claims were $1,200, then there would be a refund due of $20. This refund would be spread out over all the people who have policies in force as of December 31, 1992, in proportion to the premium that they paid. If your actual claims were $1,300, the company would suffer a loss of $80. One of the points to note here is the refund is in proportion to the premiums that were paid during 1992 and not in proportion to gain or loss on a given policy or policies within a particular duration. This result is audited each year. We have already sent out audits to the states where we have this particular arrangement. The audit is done by our independent auditing firm.

TABLE 2

One Calendar Year -- 1992

Policy Year	Expected Loss Ratio	Earned Premium	Expected Claims
2	50%	$500	$ 250
3	60	600	360
4	65	400	260
5	70	300	210
6	70	200	140
Total			$1,220

If Actual 1992 Claims Are	Then 1992 Refund <Loss> Is
$1,200	$ 20
1,300	<80>

This approach was approved in the original filing with the state (Table 3). It can see the loss ratios and the anticipated lifetime loss ratio and approve those before this ever takes effect. We have already implemented one increase on one of the policy forms under this method. Basically we sent supporting actuarial data and the complete actuarial memorandum to the states, and we did implement the rate increase. We feel this meets the basic purpose of regulation in being sure that benefits are reasonable in relation to premiums since the guidelines specify the loss ratios, and we basically guarantee that those loss ratios will be met not only on a year-by-year basis but also on a lifetime basis. The standards are objective which is the main reason for supporting them. By doing this we hope to encourage more people to market the individual health products, particularly those that are sensitive to inflation because it sets an objective standard for the determination of what the rate should be.

TABLE 3

Rate Increase High Early Lapse Lifetime Loss Ratio Limitation

Rating Period -- 1995		
RLC (Per 1994 Experience)		
Actual Claims		$108
Expected Claims		$ 60
Trend		30%
RLC = (108 x 1.30)/60-1		134%
Lifetime Loss Ratio (55% is Criteria)		
Year	Earned Premium	Claims
1991	$1,000	$ 450
1992	100	60
1993	100	65
1994	100	108
1995	100	65*
1996 + Later	300	75*
Total	$1,700	$ 823
Lifetime Loss Ratio		48.41%
Is RLC of 134% ok?		No
Acceptable RLC to get 55% lifetime LR		
What is RLC?		14.6%
1991-94	1,300	683
1995 + Later	196	140
	1,496	823

* Projected with rate increase.

Another thing we believe this approach will do is help protect the solvency of insurance companies. I use the example of what happened to us in 1988 when we lost $18 million. If we could have taken rate increases 30 days after the time we filed them, it would have made a difference to us of close to $23 million just because of timing. I would like to preface with a definition of insurance. This is straight from Webster: "Insurance is to indemnify against loss by a specified contingency." Another definition of insurance in Webster is "to reduce economic risk common to all of the group and employ equitable contributions out of which losses are paid." I will relate some things that are going on in the various states to these definitions. But first let's be a little bit more precise. Contingency is defined as something that occurs by chance and without intent. Loss is the amount of an insured's financial detriment due to the occurrence of a stipulated contingent event.

First example, well child care is clearly not a contingency. It is certainly not financial detriment when you look at the cost of well child care versus the cost of insurance premiums. That is something in the area of prevention. I think prevention is absolutely the key to the future costs of health care. The point is, it is not insurance. The reason that this should be important to us is we're being asked to cover things that are not insurance. They're driving up the cost, and now we have a product that is unacceptable to our customer because of unaffordability. We should be involved in prevention, but we should separate it from true insurance so that we have something that is affordable. How many of us really addressed that? Have we looked to the fact that maybe the way to solve it is, in order to get our children registered in school, they have to have certain medical exams? We do that now with shots. There are certain things our children are required to have before they go to school. That may make more sense. It doesn't solve all of the problems, but it is certainly something that we should be addressing as actuaries because it is not insurance.

In more and more states we can't do coordination of benefits. What insurance is supposed to do is protect against financial detriment to the individual, by Webster's definition. It is not for the purpose of people making money. Therefore coordination of benefits is something worthwhile if what we are doing is selling insurance.

Closed blocks of business are a serious problem. As the blocks close, should they be supported by new business? I would propose to you that they should not for a good reason: When you look at the definition of insurance, we're talking about risk common to all of the group and employing equitable contributions. It's not equitable to have new, fully underwritten people paying the premiums that support people who have been around for six, seven, or ten years. That's inequitable, and does not meet the definition of insurance. But, on the other hand, are the reasons particular regulators who are trying to stop us from doing this totally unfounded? Unfortunately they aren't, because we have done things, like cherry-pick out of a block of business the healthy lives, leaving the unhealthy ones there. In my opinion, when we do that we are violating the principle of insurance because we have created a group, we wait six months, a year or two years, take the healthy lives out of it and destroy the risk group across which equitable premiums are supposed to be paid. Now in that kind of situation, maybe if you take the old group and combine it with the new, it would make some sense. I'm not saying companies should not be allowed to combine, but I don't think they should be required

to. Competition should help determine what I believe is part of the problem in the small group market where people began to rate on two, three, four, or five lives. There is not an actuary here who would stand up and tell you that this is credible, that it meets the definition of risk common to a group. We can't measure that. We're the ones who created the problem in the small group market because we forgot what insurance was. A possible idea would have been (and I didn't hear anybody suggest it) to sell individual policies. That's not totally self-serving. Even though we are a big individual writer, we write in the small group market, also. Why individual policies? First, we could not create rates or rerate based on two, three and four lives at a time. Rates would have to be across a much broader spectrum than that. Second, the policies are not cancelable by groups of two, three and four. We would have solved two of the big problems that existed in the small group market, but we forgot what insurance is supposed to be doing.

I don't think community rating should be prevented, but I don't think it should be required either for this reason: Community rating is grouping people together who are not of a similar risk. The best way for actuaries to determine the similarity of risks is to have a group that's large enough that we can measure some sort of credible difference. When we can do that, then to charge an equitable premium means we charge those two groups different rates. There are problems with community rates. If you're involved in health insurance at all, you know there's a lot of variance by geography, age and sex. Should people be required to separate those? I don't believe so. Let competition do that. But they should not be required to combine them either because there are measurable differences, and to charge someone an equitable premium, we should recognize measurable differences.

I am not aware at this time that anybody sells individual major medical on a purely select and ultimate basis. If I haven't said anything really argumentative so far, this one ought to do it. I would like to see somebody be comfortable enough to hit the street anticipating a first year loss ratio of 55%. The reason being, we've heard about the 33 million uninsured. But some of the census data showed us that over a 24-month period, there were over 60 million people who did not have health insurance at some point in time. Many of the studies say the major reason people don't have it is affordability. That's my point. If you really could sell select business, maybe we could drop the rates even further and encourage more people to buy. In other words, the problem is affordability. I can't imagine anybody in their right mind who would do that because with no trend, and strict underwriting, your second-year increase is going to be in the vicinity of 50% and now tack a trend on that. You're into the realm of what may appear to be ridiculous. The fact is that, in many cases, regulation prevents us from doing that. Are the regulations unreasonable? Unfortunately I have to say "no" because we are not telling the policyholder what to expect. I'm talking about disclosure. We don't do it. I don't know of anybody that does it except Aid Association for Lutherans. It discloses two different rate sets. I think that is great. If we had more of that, we might be able to put out a set of rates that is very competitive in the first year to help cover these people who for some reason are between jobs, but they don't know for how long. It's difficult for them to buy our short-term policy because they don't know how long they need it. We've got to get these people covered with something that is affordable. If we disclose to those customers what is liable to happen to them, then I would suggest to you that we're alright.

I believe that we have managed to get the words "access to health care" and "insurance" regularly confused. Somebody who has AIDS is not an insurable risk. According to the definition that we talked about earlier, we are indemnifying against loss by a contingency. If somebody walks in with AIDS, he or she should not get insurance. There is no contingency involved. Should people with AIDS have access to health care? My personal belief is absolutely, yes, they should. That is a social problem. If enough of us are concerned, we will get risk pools in the states. We will support that. We will support additional taxes so somehow these people can get access to health care. They do not belong in insurance because it is not an insurance risk. The uninsurable, by their name, are not insurance risks. Should they have access to health care? Yes! Should they have access to insurance? No, because there is no contingency involved. It's driving the cost up substantially, making our product very unaffordable.

The poor are not an insurance risk because they cannot suffer financial detriment due to a contingency. They do not have assets to lose. They are not an insurance risk. Should we do something to see that they get access to health care? Yes, we should! I'm willing to pay taxes to see that they get access to health care, but it does not involve insurance because they don't have assets to protect. It is a social problem.

I mentioned to you earlier that we have taken over a block of business, Amalgamated Labor Life. We had 16 states agree to let us do the guaranteed loss ratio. Two said no, Kansas and Iowa. The reason they gave was it would "abrogate" their authority. If we are meeting the loss ratios, if we are meeting the guidelines and we have an independent audit, what authority is being abrogated? They are certainly giving up some power, but I didn't see that either of those states did anything for the consumers.

As most of you know Reserve Life has stopped doing business. It has basically shut down. It sold a lot of its business and some of its health business, but it began canceling a bunch of its individual major medical. We came to Florida and said, we'll take this over under a guaranteed loss ratio basis. Florida put some conditions on this. One was that we would run this at a 77% loss ratio. Our chairman was there and he said "yes." I asked him afterwards, "Are you sure you did the right thing," which is about as bold as I've ever been. But I only said that once, and I didn't press the issue. As you know, that's a hefty loss ratio but he said it, and he said he was going to keep it. We would run that entire block at a 77% loss ratio on a year-by-year basis!

The second condition was that we would submit to a maximum rate increase under the guaranteed loss ratio. Anything above that had to be approved. We wouldn't agree to that. I felt that to insist that possibly this block be subsidized by other blocks would be unfair to our other policyholders. So we should not agree to something like that. This was a pretty substantial block. It could be funded and supported on its own, which is how we handle our various blocks. We don't take small groups and rate them on their own experience, and we've had small groups running in excess of a 100% loss ratio and done very little, sometimes nothing about it. They're too small to be credible. We look at them and check consistency of rates with the rest of our business. This is what we intended to do with this block although it's not in writing.

Florida also wanted a 90-day notice of termination. That is also something we turned down. We weren't taking this block over to terminate it. If we ever got to the point of having to terminate the block, it would be a last ditch type of decision from our point of view. Individual major medical is our lifeblood. To terminate blocks of business on the individual side is a very painful thing for us. We've done it very few times, with only a few hundred policies or less, and it's where we absolutely could not get needed rate increases. We said we won't give the 90-day notice. After taking over a block of business, you know what it would do to us to then terminate the block. But if we have to do this, there is a risk pool in the state.

After these discussions with Florida, we went back to the company. The company said that's good, we don't want to do it, we're too far down the path of termination. I was disappointed in their response from the point of view of the business that we're in. We want to protect these people. We really didn't want them to be terminated. We were there voluntarily, willing to take over a block of business that did not have good prospects, and were trying to protect a line of business that's our lifeblood. So that is not all goodwill, but would hopefully help keep the industry in this market. The company said no. At that point I don't think that was a good decision. It should have been willing to take some pain to see that these policyholders would be protected.

Again in Florida, we received a letter that said we're supposed to use five-year trends in developing medigap rates. We argued about this. We went to the press, (I'm sure that surprises all of you) to raise our objections to the light of day and see what happens. We have good persistency in that block. I don't think that it is right to insist that we do that type of thing. It would push rates up too much, and then if you wait five years and take a rate increase for five more years, you can get an idea of the size that rate increase would be. It is not the right thing to do.

On the other hand, there have been problems within the Medicare supplement market. I will give you one example. I've heard complaints about the administrative costs of insurance companies. I pulled out some of our own experience. I looked at 1989 experience on 22,000 policies. We had 12,600 claims. No matter how many times a policyholder submitted expenses during the year, I counted it as only one claim. So this is basically a count of policyholders who submitted any claims. I was really disturbed to find out that 5,000 of these 12,000 claims had an average size claim of $30. Over half, or 6,400, had an average size claim of $55. No single claim in that group was as high as $200. We have to administer all these claims, and that costs money. Now go back to the definition of insurance. It spoke of loss due to financial detriment. This is hardly a financial detriment to somebody who is paying an average premium of $800. I can't help but wonder whether we couldn't run at a noticeably higher loss ratio if we didn't have to administer those. That, I don't believe, is insurance. The reasons I hear that we're in Medicare supplement is because people want it and it is profitable. And then we wonder why we have trouble trying to define what business we're in, what insurance really is. The biggest claim for 1986 was $16,000, and we had a number of claims that exceeded $7,000. My point is, that is financial detriment. I'm convinced there is a good insurance reason for Medicare supplement business. I'm also convinced that the majority of what we spend money on is not truly insurance because the claims are entirely too small.

I believe we should support risk pools to make sure that the people who don't have insurance coverage can get into risk pools and have access to health care.

Are you aware of the document produced by the Heritage Foundation entitled "National Health Systems for America" or the document produced by the National Center for Policy Analysis called "An Agenda for Solving America's Health Care Crisis"? We, particularly, need to be aware of these things. They are addressing some of the problems with the health care system. If anybody should be aware, you and I should, and we need to speak out. We are losing a marketplace. I listened to the people who spoke about the health care systems in other countries. I didn't hear anybody really praise them. The thing that they say is everybody has access and then there are problems. It seems to me if we end up with something that we already know has problems, it doesn't say much for the intelligent effort that a group like us could put behind them. There are other ways to solve the problem and to make sure people get access with cost control. I think those of us in this room, in particular, need to be informed, need to read. I believe in personal choice! I believe in private enterprise! We've seen in the eastern block that the people there have dropped their socialistic approach and are moving towards private enterprise.

I have six children, which probably explains why I may seem a little flaky to some of you sometimes. Three of my children have Attention Deficit Disorder (ADD) with hyperactivity. When we moved to Arizona we joined an HMO. I think it was a good option, but we could not get the care we needed for this particular medical problem. We had to search for doctors who were really well-acquainted with this particular problem. To be confined sometimes, as some HMOs are, is taking away my choice. Because it's so personal is why I care so much. I believe in HMOs. They serve a very useful purpose. We ought to have the option of having them, but don't make that situation my only choice. I do need special care. I do have to pay extra for it; I'm willing and able to do that, but please do not do something to take away my choice. I also have a foster child who I found out after I got her is covered by Medicaid. I say "afterwards" because it's been very interesting to watch the state process. This is a child who was neglected and abused. The court made a decision without checking us out for licensing. I tried to get her under our policy and then found out that she was under Medicaid. We got a card in the mail and called the phone number on the card because I had some questions. I went through nine different phone numbers, one of which was disconnected, and finally got somebody who was the new caseworker. I had never met the old caseworker. The new caseworker could not answer a number of my questions. We just decided to get the child medical care. We're going to send in the bill and see what happens. I don't know who's going to pay for it, but we're getting her medical care. I see things like this and can't imagine that people really want the federal government responsible for the health care of their family. I like the choice, but I want the other people out there to have some choice also. But I cannot believe among us we can't figure out how to get them there.

In summary, I would like you to support the concept of guaranteed loss ratio. Think about it. When this draft comes out in December 1990, read it. If you've got problems with it, please comment. It's important to the marketability of this product. Think about

the things that are being done and the reasons we should or should not do them. I encourage you to separate between access and insurance.

MR. ALAN W. FINKELSTEIN: Does the 1989 Vermont law regarding benefits for part-time employees (i.e., must be as generous as those offered full-time employees) affect insurer B if:

1. Insurer A provides coverage to full-time employees only?
2. Insurer B provides coverage to part-time employees only?

If the answer is yes, this could drive companies out of the part-time employees market if they have a packaged product at a standard premium rate, with limited benefit amounts payable.

I'm concerned about the possibility that other states will enact similar laws, thus greatly expanding the potential benefits well beyond what we anticipated.

MR. TOOMAN: I'm not familiar at all with Vermont, I'm just not well-versed enough to answer that.

MR. HARTNEDY: I'm sorry I can't handle that either. Is anybody familiar enough with Vermont to address that? I'm sorry we can't help you.

MR. MARK E. SHAW: I have a couple questions about the guaranteed loss ratio concept. In the first example by Mr. Hartnedy, there was no concept presented as to the time value of these cash flows. When you do a loss ratio at the time of filing and you're anticipating a 55% loss ratio, let's say, you would expect, as you have shown, an increase in loss ratios by duration. Of course, all that is present valued by persistency and interest, and in the calculation that you showed, which granted was an example, there didn't seem to be any attention given to the fact that persistency may have been different from duration to duration than was anticipated which may ultimately affect the lifetime loss ratios. All that seems to be monitored was the claims for the given year as a percentage of premium that was expected, and it seems to me, even if those things were in line, you could still be off in your lifetime loss ratios. I just wondered if there was more detail in the concept; if it just wasn't presented or if that was unaddressed at this point.

MR. HARTNEDY: I just failed to go into enough detail, but you're right. When you do the original filing, both persistency and interest will be in there, which means that they affect your durational loss ratio in order to meet the lifetime loss ratio. That's the first point. Interest was not involved in the example you saw because interest is going to have a minor effect at this point, namely in one calendar year, when I'm doing the actual calculation. Those expected loss ratios would have been affected by interest because they were developed in the original filing in getting to the 55% loss ratio. So they are higher because of interest, and that's all that's in there because the refund is made basically within 12 months. Interest will have a minor effect at this point, but it is in the original filing. The second thing is persistency. Yes, you could meet that and not be meeting the lifetime loss ratio. I have another graph, a lot longer, that does make the

point that the ultimate goal is the lifetime loss ratio. In effect that's really what we're guaranteeing. The example is an easy way to show it. But you're right, I imagine a regulator could care less about what we're doing duration to duration because what we're suppose to guarantee is a 55 lifetime. We do a test each year to see that cumulatively we are in fact meeting the lifetime loss ratio. That was brought out more clearly in Mr. Hartman's remarks where he was explaining the regulatory liability. You just don't refund the money; you can build it up to offset future premiums or increase benefits or something like that. The cumulative lifetime loss ratio is really the basic test so that if you hit 45 at the end of the first year and all the business terminates, for example you cherry-pick or nonrenew, then you will have immediately created a 10% liability, and you'll have to make a refund.

MR. GREGORY B. DAVIS: In your definition of insurance, you were talking about the types of risks that we should require or the kinds of things we should not cover as insurance. I would like to join you on your soapbox because I think there are a couple of other important industry coverages that we address that some states have already started to take action on, e.g., mammograms. We can argue whether the cost of administering or the cost of including this is going to be worth the lower claims. Also we have in vitro fertilization, which is something that, in my opinion, we shouldn't be covering, but in certain states we have to offer that coverage. What do you think the trend will be in the future; are we going to see more of these things? Or do you think that maybe things are going to start changing, and we're going to see only actual insurable contingencies being covered?

MR. HARTNEDY: You bring up two very good examples. Since mammography is good preventive medicine, we ought to find ways to support that. It is not insurance, I agree with you.

It is my opinion that things will start to change. One of the biggest detriments to what insurance is doing is the federal tax system. If you think about it, what we should be trying to do is get our employer to pay everything. And a lot of us think in terms of employers paying as no cost to us. My employer makes a return on his equity, and the costs to hire an employee includes health insurance. He's aware of what he's paying. But a lot of times I am unaware that I'm paying. My point in the tax situation is that, if that tax situation was changed and the employer allocates the money for health to me, then I've got to make a choice on where that's going to go and everybody gets the same tax treatment. Self-employed, not employed, employed by a small or large employer, all get the same tax treatment. I'm not going to open Pandora's box by saying what that ought to be, but I'm just saying it should be the same. Maybe there can even be a federal penalty if I don't properly take care of my health care needs. When that happens, I begin to think in terms of spending my money. That is what I think will begin to change things. And I don't see much else on the horizon. I'm concerned with someone else managing my health care. I'm concerned with someone else determining what a doctor thinks is best for me. I've heard some stories of how that's failed particularly in Medicaid. If I sit down with a doctor and he says he wants to run five tests and I say wait a minute, this is my money, why do you want five tests and he tells me I may opt for two, I've done something about the tort situation as well as the cost because I've signed off on it. I only want two tests; I don't want five, because I have to pay for them.

I may get that money from a medical IRA where I continually deposited money, so I have the money to go in for $500 of tests but when I spend it, I've spent my money. Now I'm going to judge the quality of that doctor as to what he's done and I'm going to watch it. I say that forcibly because it happened to me twice.

One member of my family is subject to migraines. We went to the emergency room just after we moved to Indianapolis as I've done frequently in the past. We got a $110 bill of which my insurance company paid $40. And I said, "What are you doing?" Well, if yours truly would have completely read the policy, I would have realized emergency room care is basically for accidents. I found a medical clinic, and it now costs $50 and my insurance company still pays $40. I understand that that emergency room is losing money at $110. I took that financial motivation, I cleaned up my act and I cut down the cost of health care in that example. My point is I think health care is going to have to move to the individual. If we do that, then we will get insurance really covering insurance. Until then, the mandates are going to increase even though everybody is crying foul and concerned about cost. When the individuals are in there, they're going to eliminate some of this stuff, and we hope we will educate them well enough to practice preventative medicine. They will get the mammogram and the well child care, etc., on their own.