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INDIVIDUAL HEALTH RATE FILINGS

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Recorder: RICHARD J. RUPPEL

- NAIC model
- Actuarial memorandum
- Special state requirements
- Loss-ratio requirements
- Rate increases
- Long-term care
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MR. JOHN A. HARTNEDY: We will discuss seven questions, and address each of those questions, pro and con. We'll take a few minutes to give you arguments for each side of each question. Then after each question, we'll accept comments from the floor for a few minutes. All seven questions are currently being discussed by the Life and Health Actuarial Task Force of the NAIC. A couple of years ago this task force requested that the American Academy that it produce new rate-filing guidelines in the health area. The American Academy has made proposals. You may have seen the draft, which is nearly two years old now, and we have yet to come to an agreement on what needs to be involved in new health rate guidelines. We are seeking your opinions. The thing I want to caution you about is, I would like you to look at this as an informed consumer. You have just quit your actuarial job, and you're going to drive Jeeps in Arizona for tours. You now have to buy insurance, and you certainly want it to be user-friendly to you, but you also want a company that's going to last. We're getting that kind of scrutiny from consumers, so when you vote on these issues, you need to think as an informed consumer.

Bob Duncan is associate actuary of the California Department of Insurance, a member of the American Academy of Actuaries, and a qualified health actuary since 1984. Bob began his career in 1972 with Blue Cross/Blue Shield of New Jersey. Since then he's worked with Blue Cross/Blue Shield of New Hampshire/Vermont, also with Blue Cross/Blue Shield of California until he joined the California Department of Insurance in March 1990. He's in charge of individual filings, health-carrier field examinations, and review of legislative bills, and he's active on four NAIC committees.

MR. ROBERT M. DUNCAN, JR.: I certainly appreciate being on this panel with John Hartnedy. He has a completely different point of view than I do about health rate filings, but I think the diversity of opinion in working on this issue through the NAIC group with the Academy advisors is what makes it interesting. My dad, an actuary for 30 years, always taught me to be a little bit outrageous in bringing up new ideas and said, "Don't be afraid to speak your mind." That's the way we learn.

I'll talk a little bit about John Hartnedy since he was very courteous to me. He's the vice president and chief actuary of Golden Rule. He says Golden Rule is the largest writer of individual major medical in the country. In the last three years he's been testifying at state legislative hearings on insurance law. He's met frequently with state regulators. We know that he's been to California several times, regarding

proposed laws and regulations. He's testified at administrative hearings on health matters and spoken frequently at actuarial functions. His actuarial career spans 30 years, with eight different companies, involving health, life, annuity and financial reporting. Since I joined the Department, I've been working for John Montgomery whom many of you know. When John Hartnedy invited me to be on the panel I felt I should ask John Montgomery what I might be able to do here. He said say anything you want, but say you are not speaking for the California Department. So, my opinion is based on my experiences and observations, being influenced by my many years in the Blues. It's been a very interesting year for me to work with many of you on the commercial side and see that you do business differently. You have different concepts as to how you work with your rates, and I appreciate that very much.

There are approximately six large states that have been spearheading an effort to change the rate-filing guidelines for individual health insurance. Questions have been raised as to why the NAIC actuaries are involved in this process as opposed to the carriers, and why this isn't going through a legislative process either in Washington or the states. The first response is that we're looking for better actuarial data to be put into the filings. I've noticed in reviewing rate filings in California and having gone into many organizations that it's very difficult to figure out exactly what the filing is trying to achieve. Some of these filings are rather lengthy but don't really contain good actuarial data for evaluating the merits of the rate increase. The Actuarial Standard of Practice entitled *Regulatory Filing for Rates and Financial Projections and Health Plans* gets back to basics as to what a filing should contain.

The second reason for the NAIC wanting to get into this was to follow the path of the valuation actuary and get an actuarial certification on these filings. There could be a tendency for claims costs to be understated in the early years of the filing's effective period or to be overstated in later years. It was felt that there is a need for a certification to tie in with the rest of the company's business.

The third reason is that reform is needed in the individual business. If we actuaries don't affect reforms, state and federal governments will impose standards that we will not like and may be detrimental to the individual insured.

The fourth NAIC related area is an awful lot of consumer distress and abuse in the individual market. It's not uncommon to see annual premium rates approaching $5,000 a year for a comprehensive major medical policy, and if that money is coming out of your pocket as an individual, that's a lot to pay for insurance. And whether conscious or not or prepared by a computer or not, I receive a lot of complaints about people getting premium bills over $10,000 a year for a major medical policy. Insurance is just not affordable or accessible on this basis, and we have to do something about it.

So, that was the purpose of addressing this topic. The way we want to address this topic is as a package rather than as individual items. The primary components are guaranteed renewability, minimum loss ratios, rating caps, filing requirements, product reforms, and finally reserving methods and solvency guarantees if we move to a different basis.

MR. HARTNEDY: The first question that we're going to address today is, should individual accident and health be guaranteed renewable? My position is, no, it should not be. Guaranteed renewability will discourage companies from participating in the market. It could actually end up causing insolvencies when regulators in certain states won't approve the rate increases requested. I'll give you one rather strange example. The Blue Cross/Blue Shield of Illinois, at one time through the political process, could not get appropriate rate increases, and its solvency was endangered until the company actually mutualized. I feel that guaranteed renewability is not necessary because there are really relatively few cancellations of individual products. This occurs when there's an insolvency, when there's a company withdrawing from the market, or when there is a lack of regulatory approval of a needed rate increase. Conditionally renewable is somewhat similar to the small-group reforms that have been discussed extensively and considered as a renewal base -- different but probably closer than any of the other three definitions of renewability. It might be in our best interest to drop using something like optionally renewable where a single insured can be addressed. Guaranteed renewability prevents us from changing policy wording and benefits that have become out of date, possibly because of government action. We may need to make a deductible change, which a number of companies did a couple of years ago, in order to prevent a policyholder from being subjected to a rather substantial rate increase. Guaranteed renewability would raise the premiums that we need to have for the purpose of the active life reserves you need and for the additional risk that the company is going to take because it cannot change the policy, its benefits or its wording, nor can the company cancel the policy. The last thing we need to do today because of the affordability problem in individual health is raise the premiums.

MR. DUNCAN: Consumerism is sweeping the way through health insurance, and there's a need for some uniformity as well as some consistency in what the consumer perceives when he buys health insurance. Therefore, it is of very fundamental importance to the NAIC people looking at this process and to many consumers that guaranteed renewability must occur. We recognize the concerns of the industry that guaranteed renewability may affect pricing, but we offer some alternatives to make it possible for the industry to continue to do business. Nevertheless, when the consumer buys a policy as an individual, he's doing it because of a strong need, and he also has an expectation that he's going to have continuity in his policy, and that he's not going to have to go through preexisting conditions and underwriting throughout his life while he holds an individual policy. This is particularly so for someone who works for a small business that can't afford to buy insurance for its employees and who has to go out on the open market to buy insurance for his family. He must have some assurance that he has portability or guarantee that he is not going to lose his policy at the whim of the insurance company. The idea that the NAIC is trying to put forth is that the ball has to switch to the insured in terms of his needs rather than the company's needs, and they've got to work together on this.

The second reason I believe that the time has come for guaranteed renewability is that it is already appearing in other lines. It's now mandated into Medicare supplement policies, and it will soon be mandated into the small-group reform process.

The third area I would take issue on is that we want to forestall the market decline that's going on in the individual market. Carriers are dropping out. With remaining

carriers, the in-force business is going down. There is a market for this insurance, and we believe it should continue to be there, and we want to improve the availability not restrict it. We feel that by putting a positive image on it through guaranteed renewability that we'll be able to do that. We need to bring back people who need individual insurance who may have canceled it, and we also want to make room for new carriers and new people to enter the market.

There are, as John mentioned, approximately three definitions involving renewability. The NAIC people are willing to modify the guaranteed renewability definition by something they would call perhaps "qualified guaranteed renewability" that would give the carrier some opt-out situations when it became obvious that there was a price barrier or a need for a change in a deductible or some product change that had to occur there, but we feel that approval should rest with the regulator and with the insured, not with the insurance company to decide when it wants to cancel blocks of business or shift risks around.

MR. RODERICK E. TURNER: We write guaranteed-renewable major medical. My company is probably one of the largest writers of that in the country. Bob, one of your comments tended to make me think that you think that a guaranteed renewable policy is for people who want to buy insurance and keep it for a long period of time, and that's a very important issue right now. I might say that our lapse rates on our policies are really not significantly different than any other policies that we sell that are conditionally renewable. We still find people keep our policies for 2.5-3 years, even though they are guaranteed renewable for life, and we cannot cancel. So, I think that the fact that there are a lot of people out there who really want a guaranteed renewable policy is probably an erroneous assumption. We market in most of the states in the country, and we have not found that particular issue gives us any great marketing advantage, improvement in lapse rates or anything like that. I just don't think that that's really an issue. I think that the people who want that type of benefit are extremely in the minority.

Another problem we've had with guaranteed renewability is that it seems to be a one-way street. We cannot change anything, but we have had states tell us that we must change our policy forms when they want us to. They have said, if we want you to do this, you do it. We never have an option to do the things that they're suggesting. They've forced mandated benefits into our policies, even though the policies say nothing can be added without the consent of the insured. So, if guaranteed renewability were put in place for everybody with the same type of rules that exist today, it would be an onerous burden on the insurance companies. There would have to be some very strict rules as to what could be and what could not be done by the states, and I think everybody knows as well as I do that that's very difficult, to get all states acting the same way on policies.

MS. BARBARA J. LAUTZENHEISER: I have a question for you, Rod. I am self-employed. I may be one of the few in the room who buys these individual policies, so I have a slight vested interest in what's going on here. Would those seeking guaranteed renewable contracts, in fact, end up with higher claim costs? I'm thinking this mainly because those who could would move some place else when the rate increases come out, and so you'd end up with an assessment spiral. Those who were concerned about renewability for some reason known to themselves, that was

not adequately controlled by the preexisting clause, could have caused higher claims. Are you seeing any different claims experience on the guaranteed renewable?

MR. TURNER: I would say definitely that we have some of the situations you've mentioned. We have some older blocks of business that definitely have only unhealthy people left in those blocks, but I don't think that's really any different than on a conditionally renewable policy because, if people do not cancel those policies, which I have not heard a lot that they have, what's the difference? I mean that part; I think this is inherent in it. I do agree with you that, if there's a person out there who knows that, say, his parents had cancer or had heart problems or an illness runs in the family, since that's not on anybody's application currently, that person may find it definitely in his interest to seek out a guaranteed renewable product. So, we are probably being selected against in that situation.

MR. BRADFORD S. GILE: I think the issue of guaranteed renewability probably is a nonissue. In my thirteen years with the Wisconsin Insurance Department never once did I see a health insurer drop a block of business, even when it had the right to do so. I think basically if you had a policy that's nonrenewable for stated reasons only, that as a practical matter it is guaranteed renewable. You're not going to see a company drop a block of business, in fact, unless possibly the business is about to go down the tubes, and in that case you better let it go. My company has a very sizeable block of health insurance in twelve states. We don't issue guaranteed renewable policies unless we absolutely have to. They're nonrenewable for stated reasons only, and I might add that the driving reason behind that is what Mr. Hartnedy pointed to right in the beginning, the very possibility that some state insurance commissioner can literally hold a company hostage, and we just don't feel that it's fair at all for one state to get a free ride from all the other states. If we ever did get to a point where one state was dragging its feet, say, for five years, and we were subsidizing that state with the other states, we might think of pulling that block, but I think it would take an extreme thing for guaranteed renewability to even play a part in that. The comment was just made about persistency. In our case, as I said, most of our policies are not guaranteed renewable. We never have nonrenewed a policy anywhere. Our persistency is pretty level by duration. The first-year persistency rate is about the same as the tenth-year persistency rate. It just doesn't seem to matter. So, I don't really think it's a large issue, but I do think it is a large issue if you're going to mandate guaranteed renewability of contracts. I think you'll see some companies being far less willing to keep on going in the individual major medical market.

MR. SPENCER KOPPEL: A lot of the comments from people who are writing guaranteed renewable or who have considered writing guaranteed renewable recognize the significant risk that's involved in doing so, and the only current motivation that I'm aware of for companies right now to write guaranteed renewable is that there is a lower loss-ratio requirement by about five points, and that apparently isn't sufficient to motivate companies to write guaranteed renewable. That tells you something about the increased risk associated with writing guaranteed renewable in this kind of a line. It's got to be worth more than five points apparently. I think that's a significant thing. I would suggest that perhaps a better approach would be to encourage companies to write guaranteed renewable in some form or another through motivations, through incentives of that type, allowing different kinds of

provisions or allowing some lower loss ratio or perhaps requiring a higher loss ratio at nonguaranteed renewable forms as a means to accomplish what you're trying to do.

MR. DUNCAN: The second question we want to address is, should there be rate increase caps? I'm going to take a position, or at least it's an NAIC direction, that there should be rate caps. Some of the same reasons are involved as we talked about with the guaranteed renewability in the age of consumerism. The consumer needs to find that what he can buy is affordable overall and that he can budget for it annually. There needs to be consumer protection in that area. He needs to have some idea of how much his rate is going to go up each year. He cannot afford to get a 100% rate increase, as very often occurs, because a carrier neglects to file a policy form for two or three years and gets stuck with a few large claims and then cries that he has to have the rate increase otherwise he's going out of business. Rate caps will force better data to be put into filings to justify how trends and experiences are merging and the relationship of that particular policy form to the other policy forms in the carrier's book. Part of the reform that we're discussing would require annual filings of all policy forms so that we don't have the problem of policy forms getting out of date or out of track and needing huge rate increases. One of the other ways that we feel that the rate caps are appropriate is that we hope through this process that the administrative and commission costs of individual policies could be better managed or reduced so that there is not the same inflation or trend factor applied to that portion of the premium rate as is applied to the medical inflation portion of the rate. We recognize that, during the 1987, 1988, 1989 period, there was excessive inflation going on, which has since been trended through by many filings into 25 or 30% annual rate increases. We don't think that that pattern is going to persist into the future. However, if it does, we'd be willing to look at individual cases, but for now we are looking at rate caps in a reasonable area, probably somewhere in the 25-30% range annually so that we can get a better hold on the premium cost and keep the consumer better under control so that he doesn't lapse. We feel that this is an overall part of the effort to reduce the cost of health insurance to these folks, and we stand behind that as a necessity because of the abuses that are out there.

MR. HARTNEDY: My position is no to rate caps. The reason being: what are your options if there's a rate cap? You can cancel the business. If you have guaranteed renewable business, then you can go insolvent. You could raise the initial premiums higher so that you don't violate the rate caps, but the biggest complaint that I hear out there is affordability. Therefore it doesn't make sense to me to raise premiums in order to address some of these other problems. We are selling a product that basically has an undefined benefit. The policyholder determines by usage how much this benefit is going to be. How can we say any particular rate cap is appropriate? You know from trying to predict trend that a major medical trend is a very volatile item. Therefore I think we cannot have any particular, set-maximum rate increase.

Disclosure is a much better solution than rate caps. I would not object if we had to show a history of what our rates were and the percentage of rate increases so, when a policyholder buys my product, he will be aware of the kinds of rate increases that I have, in fact, implemented as opposed to having a rate cap. I do agree with Bob about timely rate increases. Maybe five years ago this wasn't that important. You could give a policyholder a break and say, hey, you got a better deal if you don't

have to pay any dollars today. But maybe that was when, after I stored up for two or three years, I still may have no more than a 20% rate increase. But today when trends are 20% or more, I think he's right. We should not store up rate increases for two and three years and hit our policyholder with a 60% rate increase, which is extremely difficult to budget for or to afford. But we don't have to solve that with rate caps. If there is some kind of annual reporting, for example as in connection with optional prefiling that gives the ratio of actual-to-expected loss ratios, then you have a clue as to how much your rate increase can and should be. I'm concerned about higher initial premiums, since that's unfair to the people who have their policies for a short period of time. Rate caps would force that issue.

A rate cap is going to also eliminate the high deductibles. You are familiar with deductible leveraging. Assume there's a rate cap of 20% on a $0 deductible, with an $800 average claim. That's not that much out of line with some of the things I've seen on some of our products. If claim costs go up 12%, then I need a 12% rate increase if I have a $0 deductible, but if I have a $500 deductible, my cost has gone from $300-396, and I need a 32% rate increase. We should be selling higher deductibles in my opinion. This will mitigate against that.

There is concern that these large increases improve profits because they are also applied to the expense portion of the premium. What has it done for the profitability of the A&H industry? You look at the A&H cycle, and we haven't seen a big increase in profitability because these percentage increases have also been applied to the expense margin. This is a more expensive business to administer. I notice when we process rate increases (most of our business is monthly), that I don't see a big increase in premium over the next couple months. I'll see a slight increase, then it begins tailing off immediately. My point is a lot of our rate increase is offset by lapse. If we're going to recover initial expenses, unfortunately, we need that percentage rate increase to apply to everything. I don't see the connection between expenses and rate caps. My suggestion to you is the vote needs to be, no, we should not have rate caps.

MR. GILE: First of all, the comment was made about trend rates being high today, maybe not so high five years ago. I would submit that even 15 years ago this problem existed, and I think anybody who was working in health insurance 15 years ago faced high trend rates, and the high trend rates have been in existence for a long, long time. I think the idea of rate caps is misdirected. I think the crux of the matter lies in a company filing a rate change and doing so according to sound actuarial principles. As you've suggested, in these filings proper information should be given so that the regulator can make a proper review, and I would really underline that word *proper*.

This becomes, then, a question of who, among the regulators, is going to perform this review? I have made some very detailed rate filings with states. I show them everything I possibly can, and sometimes those rate filings are 20 pages long, and I give them all the information I can. Unfortunately, in some state insurance departments there is no one who is capable of reading that stuff. I've had market-conduct examiners not just reviewing rate filings but making the decisions as to what will be done with those rate filings. That's a very real problem. The best way to make sure that you avoid abuse in the rating process is twofold. One is the old tried and true

answer of the marketplace. But the other one, which is needed because the marketplace won't do it alone, otherwise the regulators wouldn't exist, is the notion of getting a filing from a company that is filed by a qualified actuary following accepted actuarial principles and practices. The actuary signs on the dotted line that he's following those principles and practices, and if he's not, then indicate where the deviations are and why they're there. That's all you need.

I don't think you need to start putting on caps. When you start putting caps on, then you run into problems like the high deductible problem. In trying to solve all the problems, you'll end up with a very complicated structure, and I suggest that you use the actuary to handle that complicated structure.

MS. LYNETTE L. TRYGSTAD: I agree. It's too much change. You can have rate increase caps, but I also agree that you want to try to protect the consumer and you want to try to get a long-term contract. So, I like the idea of annual reportings and trying to keep rate increases minimized that way. In regard to the deductible problem, I think you should look at products that would increase the consumer's deductible and out-of-pocket maximum each year that would also tend to hold down the rate increases over time with high trends.

MR. ROBERT J. CALLAHAN: I'd like to see your question broken down into two parts. John, you're the author of these prefiling requirements, and at one time it was discussed that there be a rating cap only applied to the optional prefiling and that, if a company wanted a higher rate increase, then it should go the prior approval route. Later down the road we got talking in terms of rate caps even for prior approval, and I think the way things now stand is that there is talk of a different set of rate caps for the optional prefiling as for the prior approval route. So, I really would like to see your question broken down into those two parts.

MR. DUNCAN: Bob, as a clarification, do you mean the fact that there might be different rate caps for that or just the fact that one of these options should have a rate cap and one should not?

MR. CALLAHAN: That one should have a rate cap, and the other should not.

MR. DUNCAN: One should have a rate cap, and another should not. In other words, should optional prefiling be subject to a rate cap? Should regular filings not be subject to a rate cap? We will discuss optional prefiling in one of the other questions. If you're not quite sure what that is, you'll have a chance to go back to this question if you need to.

MR. ROBERT J. TIESSEN: Has the NAIC considered just giving a guideline rate cap like a suggestion? Anybody asking for rate increases within this guideline would get a speedy rate increase, and anything above that must be approved on a special request basis? Is there anything like that?

MR. DUNCAN: I think I alluded to that by saying that, if the proper need is shown for some increase beyond the guideline cap, the individual state would look at it on that basis.

MR. TIESSEN: Would there be a maximum cap?

MR. DUNCAN: Right, there would be a guideline as to what the maximum cap could be, but we feel it should be understood.

MR. TIESSEN: I'd just like to add that we want to be able to look at it in context of a carrier's book of business, not just an individual form, so that, if a large rate increase might be obviously needed in one particular form, and increases weren't, as an extreme, needed on any other forms in the carrier's book, then it may not be appropriate to be giving a large increase.

MR. KOPPEL: You're not suggesting that a rate cap be a prima facie evidence that it's acceptable all by itself, are you?

MR. TIESSEN: No.

MR. HARTNEDY: Our third question is, should duration rating be permitted? My answer is yes. Durational rating is a valid risk classification. The American Academy of Actuaries has an excellent paper on what risk classification should be. An administrative judge in the state of Michigan has recently supported the fact that durational rating is a legitimate risk classification. At that hearing this was supported by such actuaries as Mark Litow, Barbara Lautzenheiser, and Mark Hartman. It is inequitable to require other policy forms to support older policies. I do feel that a block of policies should be self-sufficient. It would make sense if we could somehow fund cumulative antiselection, except I'm not sure what the definition should be. The problem of not allowing durational rating is that at some point you have a purchaser who is going to feel that his sense of fairness is being violated. He is not paying a fair price for the benefits that he is, in fact, receiving. The test to me would be credibility. That could be done by premium volume, or policy count. We could even combine all higher durations, say durations six and later. I don't mean that they should have the same rates, but after you reach that point, with a lot of experience, the things that differentiate a block will have worn off, and they are grouped for the percent of rate increase that they should, in fact, receive. Again, disclosure is a much better solution than prohibiting durational rating, namely how you intend to treat a policyholder over the short haul and the long haul. I will say that if a company cherry-picks its own business, (an older block of business that was a legitimate risk classification or risk cell that the company has purposely destroyed), then the company should not be able to let that block stand by itself. If you cherry-pick your business, that block should be combined with the new block. One of the ways to attack the real problem is that we be required to file durational loss ratios. The higher durations should have higher loss ratios. My point is that this is a legitimate risk classification. Although there may be some abuse, the solution is not to abandon durational rating. I feel durational rating should be allowed.

MR. DUNCAN: I'd be opposed to durational rating based on my own experience in the Blues where it is not used, and a lot of other carriers that I see that don't use durational rating, or to be a little bit frank -- bait and switch. It's somewhat arbitrary in how you set the rates in the initial year for the individual assuming the effect on the rates of underwriting and preexisting conditions. The process eventually catches up with you in later years where the rates have to go up not only for experience but

also for trend, and you soon have some pretty high double-digit increases going on in maybe the fourth or fifth year of the policy. I just don't think it's fair to the policyholder. I think he feels that he's been swept in with a low rate and it might be affordable at that time, but three or four years down the road it's not going to be affordable, and he doesn't realize that. I'm much more in favor of community rate in the individual market. I think it's much more appropriate here. I don't think that you can attach enough credibility to any one carrier's book to deal with this kind of durational problem. I don't think putting up estimates of what the persistency or experience in the early durations is fair to the policyholder, and I think it ultimately leads to some severe rating spirals. It is also a given that tier rating is certainly going to be out of the question and so may aspects of durational rating. To the extent that we will talk later about small-group reforms spilling over into the individual market as necessary, I don't think that it's good public policy to do this. I recognize the actuarial principles involved, and I'm not trying to go against them because I've read them and studied them, and I appreciate them, but risk classification is an important thing.

What's available to work with is limited and a different set of principles needs to be looked at. The other thing that is important is that by establishing a fair rate at the beginning and looking at the subject of reserving methods and solvency, you'll build better policy reserves if you have higher premiums upfront and can spread that out into the future rather than taking it all out of expenses and other things in the earlier years of the policy. I think you provide a fairer rate and a better place to bank current premium income in the form of policy reserves. So, in conclusion, I don't think that durational rating, although it has been used widely in the past, should continue as a common practice.

MR. GILE: This time I find myself much more on Mr. Duncan's side. I don't feel strongly against the theoretical notion of having durational premium rates. However, one comment was made regarding disclosure. It's one thing to say, with something like this, obviously we have to have disclosure. I think you'd have to be awfully careful about it. The person who buys from a company that uses durational rating at a premium rate that's 60% of its competitive neighbor and then finds that his rates double in the second year is going to be mighty unhappy, even if the agent says, "Oh, by the way, here's a piece of paper that the state of California or the state of Wisconsin or whatever requires you to see."

I think there are very real problems with dealing with the public in this product. I also think that there's an additional problem with the product that hasn't been mentioned yet, and that is one of adverse selection. I believe this happened in life insurance when people tried a select, term-life-insurance product in which you had special rates. If you underwent medical underwriting and then went to renew the policy five years later, if upon renewal you went through the regular underwriting process, you continued to get the select rate, but otherwise you went on at the "regular" rate. The basic problem is you've got to keep the select rates down because of competition, but the renewal rates are just going to have to stay, and you're going to get killed. Well, I think the same thing is going to happen in the long run with the durational-rating product; when people's rates go up, they find that they can just turn around and buy another low first-year premium, either with the same company, if it's not careful, or with some other company. You're just going to get bagged with a

product. I also heard the comment that higher durations should have higher loss ratios. I think perhaps this was predicated upon the notion of a level-premium product and a product written by a life company that traditionally has a high first-year expense ratio. There are some of us property/casualty insurers whose expense ratio is pretty constant by duration so that we feel that, in our case, the duration should have little effect on loss ratio. There is some underwriting selection that gets it a little bit lower earlier, but it's not that big a thing.

MR. WILLIAM THOMAS AYCOCK: I'd also like to support Mr. Duncan in this. I can certainly appreciate the actuarial principles involved in doing durational rating as well. I've worked with Mark Hartman, for example, and consider him a fine technical actuary. I know he understands it far better than I do. But I have to classify this practice in the category of a game we play that could cost the private health insurance industry its business altogether. I recall an article in the *USA Today* a few months ago in which a sidebar listed questionable and unethical practices of the insurance industry, and one of the practices listed was underwriting. I feel we have to defend the basic tenets of our industry and concentrate on those as opposed to trying to maintain practices like this that in theory might work, but I just don't feel it's practical to limit the abuses that occur.

MR. CALLAHAN: Did your company get turned down by a state insurance department as having too low a rate, and was that too low a rate because of your using durational rating?

MR. HARTNEDY: Yes, we have been turned down in one case by an insurance department saying that our rate was, in fact, too low. To the second part of your question, I believe the proper answer is, no, Bob, it wasn't because we use durational rating.

MR. CALLAHAN: I was asking was it too low because you did use durational rating? I mean was it considered too low by the insurance department because you did use durational rating?

MR. HARTNEDY: I can't say that I fully know why the department turned it down. I would be surmising. It was a Medicare supplement premium that for a half a dozen years the average rate increase had been, I think, just below 10%, and I don't believe any single year exceeded 15%. The department's action did not make sense to me, Bob. The loss ratios that we tend to file with our products begin at 40% and increase to 70%. We were turned down for the rate increase as being too low. I would say the reasons were certainly durational, and trend. I'm not sure what else the department had in mind that would be part of that.

MR. CALLAHAN: From your comments at another session, I take it that the courts felt as though the commissioner exceeded his authority and your company was upheld. Is that correct?

MR. HARTNEDY: That's correct. The case of the premium being too low was a different state than the court situation. The court situation had to do with whether the commissioner, in fact, had rate authority in that state, which was Michigan, and whether he could deny the risk classification of durational rating. The administrative

judge concluded that the commissioner did not have rate authority and that duration was, in fact, a legitimate risk classification.

MR. CALLAHAN: Well, whether it may be connected with durational rating or somewhat related thereto, you are aware that many insurance companies have underwritten small groups and have been able to offer a lower rate than what has been the Blue Cross/Blue Shield community rate, pulling them out of the pool and thereby driving up the rate. In one state here recently the Blue Cross/Blue Shield wanted to divide its community rate-up into a couple of categories depending upon underwriting characteristics. It was turned down, but along with a recommendation made that perhaps legislative action be taken to require that the insurance companies community rate the same as the Blue Cross/Blue Shield. Do you have any comment on that?

MR. HARTNEDY: Yes. Community rating, I believe, violates basic fairness, and that's my main point. Consider a very simple example to make my point. If I have a 27-year-old, healthy female and an 85-year-old sickly male, and they want to buy life insurance, community rating says if they both want $100,000, I have to charge both of them $50,000 because this is a sickly 85-year-old person who probably won't last a year. That's community rating. Do you really think the female is going to pay $50,000 for $100,000 of coverage? The answer is obvious. Okay? Now, the only way that community rating is going to work on a volunteer basis is, if the customer is dumb enough to pay the premium. That's my honest belief. The problem that we have with health insurance is affordability, and who are the uninsured? Two-thirds of the uninsured are age 30 or below. If you community rate, we're going to address the people who are complaining about affordability by raising their rates. It is not a practical solution in a voluntary market. You can't do that. You will do a lot of harm to the current situation. You can community rate when you require it. You must pay the premium. It's like taxes. It doesn't make any difference how old I am or anything else. I pay the taxes. It doesn't even make any difference whether you consider it fair or not. Community rating will be unfair. Few people will pay a fair premium. There'll be a bunch overcharged. There will be a bunch undercharged. Eventually there'll be more undercharged because the ones being overcharged won't pay, and the reason I know they won't pay is, look at how many are uninsured already. They've told us what they think of what we're charging. I classify myself in a higher age bracket, and I think it'd be a great deal for me. It'd lower my premiums. But let's face it. Most of the people who are in the higher age brackets are covered. They're making the salaries and can afford it. The problem is the young and healthy. Community rating is a step backwards.

MS. LAUTZENHEISER: I've spoken long and hard on what I call cost-based pricing, and I would agree with John that in any voluntary market you need to do cost-based pricing. My biggest concern with all that we are doing is that we are continually addressing how insurance is charged as opposed to the costs. I would suspect, if we do end up with elimination of durational rating and require community rating, we are, in fact, going to end up with policies that are unaffordable; and I'm back to saying again I'm one of those people who buys individual insurance. At one point in my life I literally looked at the risk pool to see whether or not it wasn't just as cheap to wait and buy later, and it almost was. I'm out there in that open market, and we do make decisions based upon what the cost is. So, if you go to eliminate durational rating,

the affordability goes away. You've got fewer people buying. The uninsured population goes up when you go to community rating. My bottom line is, until we as an actuarial profession jointly with the regulatory bodies or with the industry find some way to contain costs, we are not going to find solutions. We are just going in circles because whatever we do isn't going to work, and it's going to continue to go around and around. The only way any of this works on a level basis is through a nonvoluntary market.

MR. DUNCAN: The fourth question is, should optional prefiling be permitted? I think this issue revolves around what a state wants in the way of its prerogatives. Certainly a state like mine is not going to allow optional prefiling. Perhaps in states where it's been mentioned they don't have the sophistication to deal with rate filings or they want to permit optional prefiling. That's fine for those states to do that. I want to address prefiling simply from the standpoint of where it is not permitted and why and leave it to those other states to decide whether they want to allow prefiling. They may want to allow some form to be prefiled at the option of the insurer or to designate to the insurer what they will allow to be prefiled as opposed to requiring prior approval. Again I have to come back from a regulatory standpoint to the consumer. The consumer is uncertain in a prefiling situation as to what rate increase he's going to get. He doesn't know where the loss ratio's going to come out. He doesn't know whether he's going to get two or three increases in a year. He may get a 10%, and he may get a 30% rate increase in the first quarter of the year and think that that's it, and then the carrier might come back with another 20% in September. He doesn't know that, and that makes it unfair to him and may cause him to lapse the policy on the second increase. Certainly I feel that where prefiling is in place states should require guaranteed renewability even if guaranteed renewability were not required under a prior approval area. The second area of concern on prefiling is, it really leaves nothing for regulatory review and control of what the carrier is doing, and I think that given as much integrity as is involved in the prefiling process, and proof and refunds and all that, the regulators need to observe what's going on from the standpoint that form increases should not be looked at solely on the basis of a single form. The whole process needs to be looked at in terms of the book of business of the carrier. If the carrier is not raising rates or is not decreasing rates that have not met loss ratio and is simply picking on the forms that it's prefiled to put rate increase on, then that's just not fair. I know that John feels very strongly in the other direction, that prefiling should occur, but I, being from a large state, don't feel that it's practical.

MR. HARTNEDY: I'm for optional prefiling. It assures a fair return to the customer. It requires approval of lifetime and durational loss ratios. It addresses part of the problem of taking care of those who are around for a long period of time, because the regulator must approve the presumably higher loss ratios for longer durations. It provides for corrective action. A report is given each year if you use optional prefiling, and it shows whether you're meeting your loss ratio, whether you've had to set up a regulatory liability or not. Instead of a regulatory liability you can make a refund, but you have to meet durational loss ratios and lifetime, which is some risk to the company. The benefit to the company is the filing and using of rates. Yes, the policyholders won't know how many increases they'll get or the size of them, but they don't know that right now. The advantage here is an objective standard. It is set by the loss ratios. It gives the company a set of rules that it's going to play by. I

don't know why you would need regulatory review if there's a good set of objective standards, and that is the basis for this. It's going to discourage things like low-balling. For one thing the durational loss ratios must be approved. If I get approved, a low loss ratio, 40% in the first year, I'm clearly not low-balling. If I exceed it, and I do 100% and low-ball, how do I make that up when I have to meet all my durational loss ratios? It discourages that. It improves constructive oversight because annual reports must be sent in. Half of it, in effect, is now being used in Medicare supplement. We have to guarantee the loss ratio, but we don't get the file and use of rates. It's very consumer-oriented, very regulator-oriented, very company-oriented. If companies can set their price, I feel they will play.

MR. CALLAHAN: Bob Duncan and I are both on the NAIC subgroup working on the premium filing requirement. However, when we got going on this, it was clearly understood that certain large states such as California, New York, etc., would not use optional prefiling but that the NAIC working group in dealing with prefiling would be recommending it as a device for smaller states that did not have adequate staff to review it, such that it is very consistent for members of that NAIC working group to say that their state will not allow optional prefiling and yet to recommend it as part of the model premium-filing guidelines.

MR. KOPPEL: I don't know why anybody would want to prefile, given the practicality of what insurance departments are likely to do in the forms of rate caps and in the forms of changing their minds at the time when things go in the other direction. So, while I think theoretically optional prefiling is a very good idea and something that in a Utopian world would be great, I don't think it's practical in our country as it stands right now.

MR. HARTNEDY: My only response to that, Spence, would be it is the law in six states, and by putting the objective standard into the law we've overcome the subjective reviews. In other words, it is objective. If you opt for it, you're locked in on the company side, but you're also locked in from the point of view that you get to file and use the rates. But you raise a good point. If it's in a guideline, and regulators change their minds, where do we stand?

MR. KOPPEL: I'm also concerned that at a point in time the states may find that the circumstances, whatever those would be, are intolerable to them and they would invoke executive privilege of some sort and say, that was fine when you filed it, but we can't abide by it today, and we're going to have to do something different.

MR. HARTNEDY: If it's the law of the state, you do have court action on that. It is not in the policy, and you raise a good reason for it not being in the policy if the ball game changes. But it would be difficult, I think, to change when it is statute. I see your point.

MR. TURNER: I agree in theory with prefiling, that it is a very good situation for an individual company to be in. However, I disagree with the idea that it's a good thing for states with weak insurance departments, if I may use that term *weak*. The crux of this matter as I see it is that everything has to be approved up-front. In other words, anything that is filed has to be approved once. Therefore, it is critical that initial approval be extremely, thoroughly researched and approved by the state

insurance department. In my opinion, the rules need to be set up for that, which requires a strong insurance department that's very comfortable with what it can approve up-front because the form only gets approved once. So, I disagree with the idea that prefiling makes sense in states with insurance departments that are not so sophisticated. It is appropriate in insurance departments where the prefiling can be researched, looked at, and disclosed. I do agree with the disclosure factor.

MR. JAMES R. SWENSON: Basically I've had a number of discussions with John regarding this subject. What I have mentioned to John is that in the state of Oregon our legislators and our governor wanted us to do more rate review rather than less, and I thought the politics in our state would not permit an optional prefiling. However, as an actuary I'm not philosophically in disagreement with the proposal. In fact, I see some merit in it but would only favor it if there are some, what I would characterize as moderate, rate caps with the proviso that the regulators would be required to review a rate filing that could exceed those rate caps. So, if we are going to put it into an automatic pilot, if you will, wearing my former regulator hat, there would be both the option for the company to file for a higher rate but an obligation at the same time on the regulators to give that higher rate request a fair review.

MR. GILE: If there were a prefiling option that companies could follow in order to get quick, speedy action, I would hope that would not slow down the action given to companies that did not take this option, but that did, indeed, make good filings in the first place. I think that would be a terrible injustice.

MR. HARTNEDY: Our next question is, should loss ratios be increased? My position is no. This is a transition market, namely, the major medical market. It's not like Medicare supplement. It's not like long-term care. And increasing the loss ratio would cause companies to omit people who now purchase this product, namely, people who might be between jobs and are actually causing higher lapse rates among our products as they take our product on a temporary basis. It would cause us to economically underwrite, in other words, eliminate the low-income people, particularly again people who are between jobs, because we can't really survive with the high lapse rate of this product and also a higher lifetime loss ratio.

Now, it would make sense to me to say that you might make some requirement for durational loss ratio so the people who stay are assured of a higher loss ratio at a later duration. One of the things we could do is cut commissions if loss ratios are pushed up. Generally, our first-year commission now is only 25%. One of the studies that we saw pointed out not only that the uninsured population at the moment was around 15% or approximately 35 million, but also it looked at people who were without insurance over approximately a 24-month period. That number exceeded 60 million people. We are not appropriately penetrating the market of the uninsured, not only because of the 35 million but also because of those who temporarily needed coverage. We need to have a product that meets short-term needs for people who don't know how long they are going to need it. I think higher lifetime loss ratios will do more harm than good. If we're going to address loss ratios, possibly we should address them on a durational basis.

MR. DUNCAN: I looked at the 1989-90 loss ratios of the major carriers writing individual business and found that their loss ratios across all types of renewability are

pretty much at the level that we would ask that they be increased to. The minimum standard is 55%. Most carriers' books of business are running at 65%. That's where we think the loss ratio ought to be. We think that from the standpoint of consumer equity, if consumers were aware that they were only getting 55 cents on a dollar out of their policies, they would be very upset, particularly when they have a general impression that the loss ratios are much higher for group business, that they are going up to 65% for Medicare supplement, and that they are already at 60% on long-term care. So, as a matter of equity and as a matter of customer fairness, we feel the loss ratios, particularly for those that are under 50% now, need to be raised. That may force the elimination of some products. It may cause some financial difficulties in the short run to carriers. It may cause some carriers to think that they should not be in this business. I would somewhat go along with all of those possibilities as likely outcomes here. Not everyone can survive in this market, but I don't think it's fair to a consumer in terms of equity to have the low loss ratios that are going on now in many companies. I've seen companies with a book of individual business with a loss ratio well below 40%, and I don't think that that's fair. Obviously, as John mentioned, increasing the loss ratios is going to cause rethinking of the administrative costs and commission levels that are charged, and I have no problem with them thinking that they ought to do something about that. I'm willing to grant that higher administrative costs could be granted for companies being able to get advantages of PPO networks or do utilization review in the individual market, although I know it's more difficult to do reviews there than it is in the group market, but we would certainly support efforts going on there.

Question six deals with applying the pending small-group regulation laws over to the individual policy area. The NAIC people have already recognized that some of these rules are going to have to carry over so that a certain amount of cherry-picking doesn't get involved to avoid the small-group limits. I think that the consumers who leave small groups or who are on the borderline, particularly those single entrepreneurs or someone in a two-life group should expect the same kind of rules being applied to them as being proposed nationally for groups.

MR. HARTNEDY: I feel the same rules should not apply. My reason is that individual is already substantially regulated. Small-group access rules are going to raise rates. The most optimistic I've heard is 4-7%, but I hear numbers from Gary Claxton, for the NAIC, mentioned in Maryland of 10-15%; Community Mutual of Ohio, 20-25%. And I have other numbers that are higher. Individual is portable. It is subject to limited cancelability now, and if we're going to raise rates and we pay attention to the biggest complaint, which is affordability, we are going to shoot ourselves in the foot. Golden Rule also sells in the small-group market as well as the individual market. If we have the access law, and separate individual from it, I grant you people are going to buy individual. But we'd have a chance of cutting down the uninsureds by broadening the market. If we make individual subject to the small-group market, and we've raised the rates, we're going to cut people out of the market. We haven't helped ourselves. As a company we are willing to cope with the fact that individual will be excluded from these rules, and, yes, it'll create some problems on the small-group side, but I think we'll more effectively reach people.

Our final question is, should the loss ratio be the only determinant in the approval of a rate change, that is, are benefits reasonable in relationship to premiums? I say, yes,

the loss ratio should be the only determinant, and the reason is that competition should be the main driver of what rates should be, and there should not necessarily be a requirement at all, but most state statutes make reference to benefits being reasonable in relationship to premium, not premium in relationship to benefit. There is a well-established standard for benefits being reasonable in relationship to premium, and that is the loss ratio. Companies are leaving the market because of demands being put on them oftentimes by state insurance departments. We need objective rate filing requirements that a company knows it can meet. That can be done if we limit it to loss ratios. We will not solve solvency problems by reviewing the rates of one form in one state. That is a much broader, significant problem that has to do with financial examination, risk-based capital, and state solvency requirements. That's how we approach those problems. Let competition and the loss ratio set these rates. The loss ratio's enough to be a good determinant in rate regulation.

MR. DUNCAN: There's no doubt that loss ratio is the primary determinant in the actuarial lore and everything that we work with. However, loss ratio is not well-understood by the consumer, and his perception is that the higher the loss ratio, the better the product. I don't feel that loss ratio alone should be the only consideration that a regulator makes or that a carrier, for that matter, makes in deciding whether to increase something. Certainly plans that have limited benefits on them are going to have lower loss ratios, and that's understood, but that may not be the perception in the consumer's mind. The amount of benefits that are actually being provided to the consumer is rather important here, too. How many people are getting benefits out of the policy as opposed to what the loss ratio turns out to be? Is it appropriate for that particular form to be rewarded just because it has a high loss ratio? Again we're discussing the concept of looking at the carrier's book of business rather than focusing on the loss ratio of one or two forms. We talked about durational rating, and again that creates a misconception of what loss ratio is all about for that particular forum. It provides a risk classification. It's a short-term measurement. It's not really a measurement over the long term, and the consumer can easily be confused by what loss ratio is meaning at that particular point in time. Again the consumer ought to be aware of what the administrative services being provided under the contract are, not just what the loss ratio is showing on the policy form. So, I would encourage the carriers to look at loss ratio not only from their own point of view as to how much a premium rate ought to go up, but also what does it show about how they're managing their business and what kind of a return they are giving to their consumers? I would be saying that it's not the only determinant, although I recognize that it's a primary determinant.

MR. HARTNEDY: I think we've lost track of what insurance is really supposed to be doing. I didn't have time to address that in more detail in my comments. But what is insurance? I think as an industry we've lost track of that.

MR. DUNCAN: I want to react to the concern of carriers about guaranteed renewability and some of these other things, that they get themselves in a bind because individual states don't react to them, no matter how good their presentations are, and that they may wait and wait, and they don't get any response. Either someone in the state doesn't know how to handle them or the state just decides to stonewall them. I think we're going to have that with us for some time. What we're trying to do is put a little more integrity in the whole process here as a package. I can't speak

for the other states, but I do know that we have a strong department in California. I turn rate filings around within 30 days if the material is presented properly, and I think if we can get that kind of a feeling out there in some of the other states as to the crisis that exists in this market, maybe you'll get better response to it. I even suggested to the task force group at one point that deemers ought to be put in there such as 60 days for approval of forms and rate filings so that you know where you stand on these things. I don't know whether that politically will go over in the other states, but I think it's something else to think about.

MR. GILE: Regarding the question whether loss ratio should be the only determinant, typically it's the only one that you normally see in a rate filing. I would submit that a very important variable that is very rarely seen in rate filings but should be in a large number of them is credibility. I'm not just talking now about somebody looking at a bunch of numbers and waving his hands and saying, this is not credible or this is credible but, rather, having one say I'm going to assign 60% credibility to this, and here's the reason why I'm doing it. I think that there should be more and more of this done in actuarial memoranda with rate filings. It's something that I, as a regulator for 13 years, saw in maybe one or two companies. It is extremely rare. I think it is a subject that should be addressed.

MR. HARTNEDY: That gives us a question to address in our next debate. These are all issues that are current now. I hope by the way we formulated our discussion between Bob and I that it caused you to think about issues that are very pertinent to the accident and health business right now, right today.