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REGULATORY ISSUES FOR INDIVIDUAL HEALTH POLICIES

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Panelists: MARK E. LITOW
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Recorder: JOHN A. HARTNEDY

- National survey results indicate impact of health rate regulation on insurance companies.
- What is the public impact of health rate regulation?
- Results of a survey of actuaries regarding proposed health rate filing guidelines that include:
  - Higher loss ratios
  - Guaranteed renewability
  - Rate caps
  - Optional prefiling

MR. JOHN A. HARTNEDY: I'm Vice President and Chief Actuary of Golden Rule Insurance Company. The primary thing that I'm involved with is traveling around the country talking to regulators and legislators about good legislation and regulation. Sometimes it seems I'm having virtually no impact whatsoever. Our primary topics are small group access and guaranteed loss ratio. I've talked to a lot of people, including our agents, and I enjoy it. The agents are absolutely hungry for information, which has made our activities rewarding.

We also have Don Racheter, who is a political scientist with a Ph.D. from the University of Iowa. He's executive director of the Public Interest Institute. Don's on leave from the Central College in Iowa to perform his executive director responsibilities. He is a very active consumerist. Just a couple of the consumer groups he's a member of include the Iowa Consumer League and the Consumers Union.

Mark Litow, a member of the American Academy of Actuaries, is a partner with Milliman & Robertson. He has worked in the accident and health field for 16 years. He is a member of the Council for Affordable Health Insurance and has done a great deal of testifying at the legislative and regulatory levels to achieve good regulation.

The primary thing that we are going to talk about is a document entitled "Guidelines for Filing Premium Rates for Individual Accident and Health Insurance Companies." What I have is the March 26, 1992 Accident and Health Working Group's suggested revisions to the exposure draft of December 10, 1991. A number of you may have received the December exposure draft. There aren't that many changes in the March 26 draft.

I will also be referencing a panel discussion that was held in Toronto last October at the Society of Actuaries annual meeting. We had seven different questions that members of the audience voted on after a panel debate. There were 52 actuaries

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involved in that voting. I will be passing along the results of that poll as I discuss the various points in the guidelines. We broke the vote down by: Blue Cross/Blue Shield, consultants, regulators, stock companies, mutual companies, and other. The other category included people who didn't want to identify themselves.

Let's address the proposed guidelines. The guideline provides for what I will call guaranteed renewability. The guideline has omitted optionally renewable and conditionally renewable for major medical.

The new renewability classification is called "qualified renewability." A company can cancel the business, or a portion thereof, only if it cannot meet the financial obligations of all of its individual accident and health (A&H) policyholders and if the commissioner approves. Then the company is out of all individual A&H business for five years.

The point is the guidelines, call it "qualified renewability." I refer to it as guaranteed renewability. Note the impact of the words "can't meet the financial obligations of all your individual accident and health policyholders." It seems to me that if you have a very profitable and substantial individual life line, then you can clearly meet the obligations of your accident and health policyholders even though this latter line may be losing a substantial amount of money. If you cannot meet your financial obligations, then the commissioner may approve cancellation. This goes way beyond small group reform, where at least the company has the option to pull out of the business and then it's out of that business for five years.

Twenty of the actuaries at the Society of Actuaries meeting in Toronto said we should have guaranteed renewability, and 32 said "no." The only groups of actuaries that favored guaranteed renewability were the four consultants by five to four and the regulators by two to one.

Please note that the only groups that even slightly favored guaranteed renewability are those that are not actually in the business. Sorry, Mark.

But consider some of the comments that were made. Even for those that said "yes," the primary comments were that it should still be only one of the options. Some said it should only be required if you have file and use of rates. Regulatory control and interference should be limited if you're going to have guaranteed renewability. So even though 20 voted "yes," there were an awful lot of conditions placed on it.

Among those who voted that there should not be guaranteed renewability, the primary reason was that it would inhibit the market. It would inhibit the ability to make changes, for example, to increase the deductible. It's not fiscally responsible to have guaranteed renewable policies and it could endanger solvency. The frequent opinion was that it should be an option.

Brad Giles, actuary for 13 years in the Wisconsin Department of Insurance, said that he had never seen an individual policy canceled. I find that somewhat surprising (over a 13-year period), but it supports my own position that guaranteed renewability is not really an issue in the individual market. I firmly believe you need the leverage of being

able to not renew your block of business because of the attitude of some of the regulators. I'm very sorry to say that, but we have had to use such leverage to get appropriate rate increases approved in certain states.

We did cancel a few hundred policies in Massachusetts with a $100 deductible, because we could not get a rate increase approved. I'm sure that doesn't surprise anybody who is in the business in Massachusetts.

As I look back on that, I believe we made a mistake. I wished we would have never canceled the business. We may never live that down, even though it was a small number of policies and it was due to regulator unreasonableness (trying to force us to unfairly subsidize Massachusetts business with our other business). But, what we have found out since is that regulators now are routinely so unreasonable, that if we take them to court, we get our rate increases. I don't believe that we have lost in court in any state on any rate increase. And we have taken a number of regulators to court on rate increases.

I'll give you just a little bit of background on Golden Rule. Our portfolio loss ratio in Exhibit H is over 60% and that includes a substantial amount of new business. You all know that the lifetime is 55% so we are very definitely in excess of the minimum lifetime requirements. We also are solvent. We do about $600 million of premium. We have $110 million of capital and surplus. Plus, we have lost money from operations only one year in our 50-year history, and that was in 1988. That makes us rather unique.

The reason I gave you this background is to tell you that there is no reason to turn down a rate increase from a company that's running loss ratios well above what has been accepted and approved by the insurance departments, and the company is on a very solvent basis. Nonetheless, we've had considerable trouble in certain states with rate increases. Unfortunately, you need the leverage with some regulators; then you can nonrenew your business. I genuinely feel very sorry to have to say that to you because of the state of regulation today.

Another point in this guideline is rate caps. Over 12 months, the maximum increase is 30%, and it cannot exceed 50% over 24 months, except with the approval of the commissioner. If you use optional prefiling (I'll define that later), the maximum increase in 12 months is 20% and 35% over 24 months, except with approval of the commissioner. At the Society of Actuaries meeting last year, 12 people voted for rate caps and 40 people voted against them. There should not be rate caps. There wasn't a majority in any group that favored them, including the regulators. Even for those that said "yes", it was made very clear that you need exceptions, for example, for trend. For those that said "no" to rate caps, the prime reasons were: (1) let the marketplace set the rates; and (2) you've got to protect solvency.

Can you imagine rate caps in combination with guaranteed renewability? As an actuary, you need to think about whether you have a responsibility to your management to recommend that the company not sell the major medical line under those conditions. You have abrogated responsibility for the surplus of your company to regulators if you have rate caps and guaranteed renewability. It just may be irresponsible to do business under these conditions.

But somebody did say caps would be fine, provided you could cap medical costs. Interesting observation. It's pretty difficult to cap the rates when our benefit level is undetermined. The benefit level has to do with utilization, technology, cost shifting, providers charges, etc. There are no caps on these! So you cannot cap what the insurance industry charges. A few people said you can cap increases for the optional prefiling (guaranteed loss ratio). It would make more sense to have a penalty for not taking timely annual rate increases. One person said that you can't have rate caps because of deductible leveraging in high deductible policies.

Golden Rule used to sell $5,000 and $15,000 deductible policies. The prime reason we stopped selling them was regulation. Because of deductible leveraging, we routinely filed for larger increases on these high deductibles than on the lower deductibles. Often the departments would turn the requested increase down. They weren't looking at the loss ratios for these deductibles. Then we'd go to the state insurance departments and explain it time and time again. And these deductibles generated small premiums. We could not afford the expense on these blocks of business of going to departments and explaining deductible leveraging to them every time they changed staff. Yet, that's the real insurance business -- catastrophe rather than first-dollar coverage.

Should durational rating be permitted? Twenty-three actuaries voted primarily because of equity. The majority in the Blue Cross/Blue Shield and the stock companies voted "yes." Twenty-nine voted "no", which was the majority for regulators, consultants, and mutuals. The usual reason was that abuses must be addressed.

In the guidelines, under optional prefiling, there's a requirement that old forms must be combined with new forms if the company has allowed any replacement of the old with the new form. The point being, a company should not be able to cherry pick its own business and then leave an unhealthy closed block by itself. That's a good rule. I really don't understand why it's only connected with optional prefiling.

The guidelines provide, if claims count on a closed block gets below 200 in a 12-month period, then that block must be combined with another block of the same class and type for rating and monitoring. Class is not defined yet in the guidelines. Type is: medical expense, medical indemnity, loss of income, and specialty. That seems appropriate to me. Small blocks that are closed would not be rated by themselves.

Another possibility that is not in the guidelines is to require the combination of all policies of the same "type" that are later for rate increase purposes. This would not mean the same rates but only the same rate increase. So whether a block is closed or not, the older policies would be grouped or have new sixth duration policies added each year.

At Golden Rule, we do make sure that rates on our old blocks are reasonably in line with our new blocks. An older block would normally have higher rates than a newly underwritten block. A small closed block will get standard rate increases regardless of how high the loss ratio gets. We have blocks over 100% loss ratio that still get only standard rate increases, and we fund the losses out of surplus.

An important provision in the guidelines is optional prefiling, also known as guaranteed loss ratio. Forty-seven actuaries said we should have optional prefiling and only five said "no." The most frequent comment was that it should be "optional." Also rate increases should possibly be limited. It should be disclosed to the consumer. It's for the good of all. One person asked why the regulators are so concerned about their own authority and objecting to this?

Optional prefiling, once elected, requires the company to meet its cumulative expected loss ratios. If the loss ratios are not met, then you must set up a regulatory liability. If your regulatory liability gets to be too large, you must file a corrective action report with the commissioner and indicate what you're going to do about it. You can always refund the "regulatory liability" and then you'll never have to get into a debate with the commissioner about what you do with this money. The advantage to the company is that you get to file and use your renewal rates.

The guidelines propose rate caps for optional prefiling that are only 20% in any 12 month period, with a maximum of 35% in any 24 months. Rate caps, when you're guaranteeing to make refunds to policyholders, do not make a lot of sense to me. The policyholder is already amply protected.

There are a lot of monitoring requirements for optional prefiling, including corrective action plans, if you're cumulative loss ratio falls out of line. Be sure that your system can produce the information you want.

They do say that prefiling has to be picked initially. That is not practical. In the very first year that you begin to sell a product you could get to the end of the calendar year and have virtually a zero loss ratio, because you began to sell late in the year. It would not make sense to have to set up a regulatory liability at that point. It could be a serious surplus drain to you to have to do it. You would probably violate the minimum requirements for regulatory liability, and you would have to file a corrective action claim. You should not have to pick optional prefiling initially. They also say that optional prefiling should be on all forms of the same type. In other words, if you're doing major medical, you would have to do optional prefiling on all of your major medical. Again, I don't see the necessity for that kind of a requirement.

Higher loss ratios are proposed in these guidelines. Among the actuaries at last year's annual meeting attending our panel, 22 voted for higher loss ratios. The regulators all voted "yes." The mutuals voted seven to six "yes." Thirty actuaries voted "no," which was the majority for stocks, Blues, and consultants. Under those that voted "yes," the usual reasons were that we need lower administrative costs and lower commissions. Some people said that the increases had to be moderate. Under those who voted "no" to higher loss ratios, the concern was solvency and that the marketplace should be able to set what rates should be.

The guidelines propose a 60% loss ratio for "qualified renewable" major medical versus the 55 that we're used to. And that's only if average premiums are less than $1,900. If premiums get up to $2,483, your loss ratio will be 65%. There aren't many major medical average premiums that on average are below $2,400. The loss ratio is being raised closer to 10 points. If you don't want it raised that much, then you cannot write policies for family coverage or older people. That's a very

unfortunate impact of this regulation. This also ignores the fact that a number of people who need this coverage need it on a transitional or short-term basis. Right now we happen to be a company that does not financially underwrite; for example, you can be low income or unemployed. These are the people without insurance. If you have to meet a 65% lifetime loss ratio, you don't want these short-term people. They will make it difficult for you to pay a reasonable commission, recover your issue cost, and hit a lifetime loss ratio of 65%. So what do you do? You avoid the primary market for individual major medical, which is the transitional need. That's one of the drawbacks of driving up the loss ratio. Let a competitive market take care of the loss ratio. This is not going to have much effect on my own company, because we are running our whole portfolio in the low 60s already. But I still do not recommend it. We would have to tighten up our underwriting because we'd be cutting it a little bit too close.

The next question was, should small group laws apply on the individual side? Seventeen actuaries said "yes." The only majority that said "yes" was the regulators. The main reason was consistency. Another person said, "Only if individual is sold in the small group market." Thirty-one said "no". The prime reason being there's enough regulation in the individual market as it is.

On the very first page, they give the definition of what this regulation is supposed to cover, which is everything except Medicare Supplement, long-term care, employer/employee groups over 25, and employer/employee groups under 25 if there is other regulation. So if the state does not have small group regulation, then your small group, your associations, and your individual will be subject to the rules that I have laid out here.

The next question we addressed was whether the loss ratio should be the prime basis for determining a rate change. Twenty-four people said "yes." They spoke in terms of objective standards. The mutuals and the consultants were on the "yes" side here. Twenty-seven people said "no." They said there should be other things like credibility and solvency. I've heard the solvency argument used a number of times. When I am filing on one form, in one state, for a rate increase, what they approve or disapprove is going to have very little to do with my solvency. If they think I've got a solvency problem, they don't need to be looking at my rates in one state on one form. They need to be doing an examination and looking at the impact countrywide.

I've run into this excuse in Florida where we have a lot of business. We're primarily a major medical writer. We have a million of premium a month on one form. We asked for a 30% rate increase. They horsed around with this for months. It was costing us $300,000 a month. We're sitting on $110 million of surplus. Even the way they handled it would not endanger our solvency. Whatever they do isn't going to make or break our solvency. You can make an awful good case for not doing business in the state because of the negative impact their regulating technique has on profit. But you can't make a case for the fact that they will make or break solvency by whatever they do with that rate increase on one form in that state. If you're a multiline company, the impact is even less. Solvency is not a good argument for getting additional information. By the way, we have guaranteed loss ratio in Florida now by law. I suggest you seriously consider using it if you have individual major medical.

In addition in this fine guideline that they have produced, the very last of five purposes is to broaden the availability of health insurance to the public by encouraging insurers to participate and compete in the health insurance marketplace. Some of you laughed, but that purpose is in there. It is listed as number five, which is in the proper place the way they drafted this. In other words, the consumer's needs have been put at the bottom of their list, because when you listen to these guidelines, there is no way that they have the consumer in mind. The consumer should be at the top of the list. They are asking us to estimate future rate increases, provisions for inflation, aging, and selection. What are they going to do with this information? They might as well set the rates. And if you have been dealing in Florida, that is exactly what is happening to you. Yesterday, somebody told me that they filed the rates at two different times in Florida. One time the rates were too low, and the other time the rates were too high. They asked Florida what they had in mind. On the one set, Florida told them approximately a 20% higher rate. So they filed a 20% higher rate and it was approved. That's Florida.

The regulators are trying to limit renewal conditions and commissions (hopefully this latter limitation has been eliminated). If you have a thousand claims or more, you will do your rating and your monitoring on a statewide basis. They also added a line in here that the commissioner can request additional information. That means that regardless of the extent of monitoring that this requires, if they want anything else, they just ask for it. Certainly they can come in and look at anything through the examination process, but that doesn't hold up rate increases or allow the regulators to see traits. I'm concerned about supplying this information to regulators. What are they going to require you to do? You already know that Florida is going to require you to levelize your premiums, this is, to raise them. This certainly is going to cut down on complaints to the Florida department for two reasons: (1) if they make us raise initial premiums, there will be a smaller future rate increase, so their life will be easier; and (2) if you raise initial premiums, you will have less people insured, therefore you will have less complaints. It will certainly work to the regulators benefit.

In addition, after two years, this guideline is retroactive. It will apply to everything you have out there. Think about what happens if you begin to phase down the size of your major medical business. You have a very substantial block out there (one hundred million in premium), and you have a 56-57% lifetime loss ratio that you originally filed, and was approved. This was the basis up until now for your rate increases. Now you have only $10 million in premium left. Two years comes to an end and that whole block now has to reach a lifetime loss ratio of 65%. And it will be guaranteed renewable. You can run that $10 million of premium at a 100% loss ratio until it is all gone. Lose money year after year and you will never get that entire block to a 65% loss ratio. The only thing that you can reasonably do to show fiscal responsibility, (now think about this folks), is cancel. You would be irresponsible to do anything else! I would hope that when you do that, you would offer the people coverage under a new policy form that you have or get them coverage. But with these regulations, you have to consider that. I'm very sorry to have to stand here and say that. I am very much against canceling business, but think about that. You had better check all of your lines of business. It could put you out of business if you don't. Mark, do you have any comments on the impact of regulation?

MR. MARK E. LITOW: None!

MR. HARTNEDY: Just as I expected.

MR. LITOW: Well, regulation in the individual market seems like a topic that has been around forever. It's getting to be about as general and as unclear as the term discrimination. Take for instance, the phrase that benefits must be reasonable in relation to premiums charged. What does that mean? I used to think that meant that you had to meet the minimum loss ratio and show that as a part of the rate filings. Well, I don't think that is true anymore. In some states you have to show that the rates cannot be excessive, and also that they are not inadequate. Some states stipulate benefits must be meaningful; in some states benefits can be meaningless. You have inappropriate and appropriate rate increases. Some states redefine what risk classification means. It seems like we are at the point of encountering everything you have ever dreamed of but were afraid to ask. That's what that term means. A lot of states are starting to turn the terms around and say that premiums must be reasonable in relation to benefits. I used to think that didn't mean anything, but I have been in situations where I had to testify and there can be quite a distinction.

Now, that doesn't mean that there is not a role for regulation, I think that there is a very important role for regulation. But let's just think about what the purpose of regulation is. I think it is to balance things that are overly aggressive, such as insurers, and agents; it serves to facilitate the market and keep it stable. There are plenty of examples of regulation being too little or too much. Look at the airlines and all of the problems that they have there. I think if we compared airline rates and how much it costs us to fly here, we would find some unbelievable differences. I know it costs more to fly to Chicago from Milwaukee than it costs to fly to Miami from Milwaukee.

Look at the savings and loan industry and what has happened there. That is an example of too little regulation. But then look at the budget deficit, which of course, is driven by all kinds of regulation. Look at the congressional checking account scandal. Look at health care innovation in foreign countries, most of them get their innovation from us, because they have national health systems in place. So I think we need to focus on the balance -- the balance between rules, and the balance between incentives for programs.

Now with that in mind, we did a study of the individual medical market to look at what the balance was. That study focused on a period from late 1988 to early 1990. The focus of the study was to find how many companies were in the individual medical marketplace, and what is the market share by type of company and type of business. Now this study covers all business sold to the individuals, so it can be individual, it can be one life group, or it can be association franchise. And it certainly was intended to show what was going on in terms of the balance between regulation and the market forces.

Now what were the main conclusions of the study? I will go into some detail on that. The first one is that the states that exhibit more regulation have a higher rate of uninsured, a lower growth rate, and a decline in the insured rate. Also the states with regulation exhibit less competitiveness. The individual marketplace in 1989 was shifting away from individual into association/franchised groups. Now certainly, that

is changing with so much small group regulation going on in various states. It may end up shifting back in the other direction depending on what happens. And the guidelines that John talked about are trying to prevent that from happening and will probably just encourage people to become uninsured. Also the profitability is really a main focus of companies that are leaving the market.

Now if you look at the number of companies in the market in Table 1, the study did show that even though it focused on 1988-90, we did go back and ask companies if they had been in the market and how long, or if they had never been in the market. So we were able to determine how many companies were in this market at various time intervals. As you can see, from 1980-86, there was at least some growth, although very small, in the number of companies in the market.

TABLE 1
Number of Companies in the Market by Year

Year	Number
1980	183
1983	189
1986	193
1989	177
1992	170*

*Estimated

But suddenly, from 1986-90, as you may recall, we went through a bad underwriting cycle. John mentioned that 1988 was the only year that Golden Rule lost money. I would be surprised if there were many, if any, companies that made money in the 1987-88 time period in this marketplace. The other frightening thing is the estimate of 170. It is my estimate, not a number that comes out of the survey. The people who come to these meetings and come to workshops on individual major medical can't believe how small the crowds are getting. And this, by itself, is an indication that people are pulling out of this market. So my estimate is that we are down to 170. Now there are a couple other things in that number that are pretty frightening. The Blues make up a little over 60 of that 170, and I think all of the Blues are in that market. So you have basically 110 or so commercials that are in this marketplace today.

Now let's take a look at the composition of the various groups that make up coverage in the United States -- the under 65 population (Table 2). You have four basic groups: the uninsured, the employer market, the public coverage (which includes Medicaid), and (what this study covers) the private or the individual market.

You can see from this table that the uninsured rate is increasing, the employer coverage is dropping, the public coverage is escalating quite rapidly, and the private market is in a slight decline. Now, if you think about where we are on affordability and other issues, it is probably not very surprising that this is happening. Health care costs are escalating much faster than the consumer price index, forcing more and more people into near poverty levels, which is the reason for the public increase. And with the regulation of individual markets not able to fill the gap, and employers complaining about costs that they are trying to cut, and of course, with the economy

TABLE 2
Under-Age-65 Population

Category	Number of People		
	October 1988	March 1990	April 1992*
Uninsured	33.3	34.4	37.0
Employer Coverage	139.4	140.8	138.0
Public Coverage	26.2	26.2	30.0
Private Coverage	20.1	19.6	19.5
Total	219.0	221.0	224.5

*Estimated

in the situation that it is in, more people are unemployed such that the result is an increase in the uninsured levels.

One other thing that I always think of when I look at this table is, what is the government's philosophy towards medical care and just programs in general? I always go back to what the general philosophy is, and I think of Senator Durenberger, who is supposedly the insurance guru of the Senate. He stated it well a couple of years ago (and I don't even remember which bill it was that passed at that time in the Senate). He said, "This is a good bill because it provides four times more benefits to the consumer than the government takes in revenue." And that is what the government's idea of a good bill is. Social Security started in 1935, and if you remember its philosophy, it was to give out five times as much in benefits than it took in revenue. I don't think that helps the consumer one bit if the consumer doesn't understand the costs, but the consumer is paying for it. And that's just not true for insurance; I think that is applicable in general.

Now, the study also focused on how many companies were actually selling a significant number of policies in the state, and we picked 250 out of 500, 250 because there are 250 working days in the year and 500 just to double it (Table 3). So this shows the number of companies in a state that were selling a significant number of policies and if you go to the 250 column, you will see that there are 19 states, 7 + 12, where there are less than 10 companies selling 250 policies in the state. If you go to the 500 column, there are 24. I think that is a pretty serious comment on the number of significant players in states.

Now another thing that we did as a part of the survey was to define competitiveness of the states. We did this by essentially taking the number of policies in that year, made the adjustment for companies that were missing from the survey (which incidentally, we believe that on a nationwide basis, we have nearly 95% of the in-force and on a statewide basis about 85% of the in-force) and made an adjustment to that to reflect (besides missing companies) economic conditions in the state and the uninsured in the state. We basically made a partial adjustment for each of those to try to put everything on a level 20 playing field. We tried a number of different formulas wherein all states jumped around in results between formulas, but there was not a great difference. States might generally jump from 10th to 15th or 7th, but they didn't jump from 10th to 40th place or anything like that. The five states that

TABLE 3
Summaries of Companies Issuing
Significant Numbers of Individual Medical Policies

Number of Companies	States with Given Number of Companies Reporting Issues of at Least N Policies	
	N = 250	N = 500
26-30	4	0
20-25	6	3
10-19	22	24
5-9	12	11
0-4	7	13

were the most competitive came out to be Nebraska followed by Colorado, Iowa, South Dakota, and Kansas (Table 4). The least competitive was Hawaii, which probably has the lowest health care cost in the United States, and there are a lot of reasons for that which I won't get into right now. Hawaii was followed by Rhode Island, Idaho, District of Columbia, and New York.

TABLE 4
Relative Competitiveness by State

Most Competitive	Least Competitive
NE	HI
CO	RI
IA	ID
SD	DC
KS	NY

One thing that went through my mind as the results came out was are there any surprises in the states? States that we were getting the most complaints and comments on generally had a difficult regulatory process. These include Minnesota, Massachusetts, Florida, New Jersey, Pennsylvania, Washington, South Carolina, and Georgia. Those eight states got the most comments. Generally, of those eight, six of them were in the bottom half, and most of them were pretty near the bottom. The only real surprise in the study was Florida, which ended up in the teens somewhere, and South Carolina ended up in the twenties. In Florida, I think companies just tend to stay there in spite of the problems they have, because they see it as a market with potential.

Another thing we looked at in the study was rate authority, and we divided this generally into four categories: explicit and implicit rate authority and explicit with implicit lack of authority (Table 5). We had calls from states such as South Dakota complaining that they do have such authority, even though we show them as not having authority. We also were recently in a battle with Michigan. Michigan thought it had rate authority, although the court initially has determined that it doesn't. There were two states noted in the study that were acting as though they have rate

authority, even though they supposedly didn't. They were Washington and Oregon, and certainly South Dakota, Michigan, Idaho, and several other states now act like they have rate authority, even though according to a legal reading of the statute, they do not. More and more states are thinking that they do have such authority.

TABLE 5
Number of States by Rate Authority

Type of Authority	Number of States
Explicit Authority	15
Implicit Authority	6
Explicit Lack of Authority	5
Implicit Lack of Authority	25

Just to summarize a little bit, the main regulatory problems found in the survey essentially are: mandated benefits, timeliness of rate increases, the approval process, and the policy form and regulation. Profitability was mentioned in conjunction with all of these things, and certainly they are interrelated.

Now, where do I think this is taking us and what is the value of this study? I think we need to look at what the correlation of the survey findings are with our current health care environment. If you look at where our current health care environment is, we certainly have problems with affordability and with access. In other words, we have problems essentially with the uninsurable, and we have problems with the people who are too poor to provide coverage. And how are the regulators going to solve these problems? I think the regulators right now are focusing on certain things such as access and saying if we get access for everybody, it is going to solve the problem. First of all, even our constitution tries to focus on balance, and many of the things being proposed, if you think about them, really don't achieve a balance.

The Council for Affordable Health Insurance is designing charts to simply show scores of the current systems and the proposed systems. If you give a 10 for each one of the categories, quality, affordability, and availability, that will get a 30. There isn't any way that will happen. What we have to obtain is a positive direction, so if we score a 15 today, maybe we can get it up to 20. If you look at most of the proposals out there, I think that they will take it from a 15 down to a 12 or 13 or perhaps even less. For example, if you have national health insurance, you may have automatic access to coverage, but you don't have the access to treatment. Look at Great Britain, look at New Zealand. We have to make sure that we can find these things, and I think that this study in a sense can lead to that conclusion, even though it is focused on regulation. We need to focus on the balance of these issues.

So what I am saying is that regulators should be facilitators, not dictators, of the way that any issues are resolved. That should include economic factors. If we can do that, we can modify the system and push it in the right direction towards a balance. And I would ask all of you to convey that and in the talks that you give, or presentations you make, or papers you write. Try to focus on pushing the system in the right direction as opposed to letting the regulators push it into extinction.

MR. HARTNEDY: You've heard the two mild-mannered presentations, now we'll get to the real crux of the matter with a real strong opinion with Don.

DR. DON RACHETER: What John was trying to say in a polite way is that I am known to be a bomb thrower from time to time, but fortunately they are only verbal bombs.

I was asked to be a part of this panel because of my training as a political scientist (and I would add that I minored in economics), and because of my 16 years of teaching and studying the regulatory process in American political life. This past year, while on a leave of absence from my academic position, I have been serving as executive director of the Public Interest Institute, a nonprofit, nonpartisan "think tank," which, as the name implies, tries to look at the public interest. As John has also mentioned, I am active in a number of environmental, consumer, and taxpayer associations.

In my capacity as the director of the Institute, I was looking at some of the issues that we should be studying, and education was a high one on our priority list because 60% of most state budgets go toward education. In the state of Iowa, insurance is a very big industry, and therefore, that is something that I have also taken a close look at this past year and tried to apply my generalized knowledge of the regulatory process to that specific case study. Also, because we are in an electoral cycle and a lot of the people running around attempting to become President of the United States are talking about various socialized medicine schemes as a way to buy votes, I've been paying more attention to insurance.

I think it is important to state at the outset that overregulation, rather than helping the consumer, may be counterproductive, driving many firms from business, thus reducing the employment of actuaries, something that I hope you can appreciate. But, more importantly, from my point of view, it could reduce the availability of health care coverage for many citizens.

I will just jump in and comment on the point that John made in his remarks. I had an opportunity to testify down in Houston at the meeting of the working group of the National Association of Insurance Commissioners. The first thing that I noticed was in their five "purposes"; "helping the consumer" was the last one. It followed things like making life easier for the regulators. I got up after the break, and since they really weren't having a public hearing, I thought I would put my two cents worth in, and I said, "This is backwards. You really should put consumers first, because that is the point of this. You don't want to be flat out hypocrites." Well, they have had a couple of meetings since, and they have produced two different drafts. I had a chance to go back to Seattle a couple of days ago, and sure enough, "consumer availability" was still dead last.

Now that was not something that was going to cost anybody any money. If they would have just taken it from to Point E to Point A, it would have been a nice thing that they could have done for consumers. But did they do it? No, that would be too much trouble, and bureaucrats don't want to make trouble for themselves.

A second observation that I would make is that these issues have been labeled "technical." It was being considered by the actuarial task force of the National Association of Insurance Commissioners as if it was some kind of numbers-crunching problem, rather than a public policy issue. There is a lot of debate, discussion, and disagreement about what should be public policy. I think the reason that it is being disguised as a technical issue is because these people who are advancing socialized-medicine and greater regulatory schemes know that if they talked about it in that language that they would lose because of the repeated failures both here and abroad of such schemes. Therefore they are trying a "back-door approach," kind of sliding it by as noncontroversial.

A third fundamental truth that I have learned about government regulation in the 16 years that I have been studying it is that the "crises" that we are told have to be solved by additional government regulation, have inevitably, when they are traced to their root causes, are then found not to be problems of market failure, but rather to be problems by existing interventions in the market by government. Yet, instead of calling for repeal or elimination of the government intrusions which caused the problem in the first place, the "reformers" inevitably called for more regulation to deal with the symptoms of the problem, rather than addressing the fundamental cause of the situation and the original intervention.

I take as my suggestion for protecting the consumer, the statement of Milton Friedman (and I am sure that he got it from somebody else, but I read it in his book), that the best guarantee against abuse of the consumer is not the existence of a regulatory body, but the existence of multiple providers of the good or service in question so that the competitive process will force the providers to look out for the interest of the consumer.

Look at the situation we are in. We have a great deal of regulation as the two previous speakers have documented, and yet we have a problem, do we not? That's why everybody is talking about this. That's why we are having sessions like this. That's why there are infinite, it seems, sessions at the NAIC meetings to debate endlessly these regulations and proposals for yet additional regulation. If they would get back to basics, get back to competition and the desire to get or keep business on the part of your company, that is what's going to compel the providers to attend to the needs of the consumer, the people for whom I am here speaking.

I think we do need laws and I take issue with what Mark said here when he talked about balance of regulation. I think we don't need regulations as much as we need public policy statements in the form of laws, debated on the floor, in the open, so we can see who is being bought off and paid off and whose interests are being served. Fundamentally, let's pass a law that says we are going to this or this as a society. Then, let's make the 240 million Americans enforce those rules, rather than some bureaucrat who may be too lazy, or may be bought off, or paid off, or is looking ahead at a job (the revolving door phenomena), or whatever, who will only slap the people who violate them on the wrist. We have laws against force and fraud; we should have greater access to the courts so people can sue and get triple damages, get class action judgments, etc. to put the money back in their pocket, if in fact, somebody has defrauded them or has not dealt fairly with them.

Beyond the point at which government tries to ensure a level playing field, to prohibit force and fraud dealings between consumers and providers, it is either acting as big brother or it is trying to act as centralized economic director, and history shows us that they have botched both of those roles repeatedly. No one can know our needs and wants as well as we ourselves can. Even if they did, even if they somehow were magically made into angels when they took that government paycheck, they do not have the right in a democracy to force us to follow their ideas about what's best for us. They have only the right to remonstrate with us, to follow their advice as to what is in our best interest. In a truly free society, people have the right to fail, as well as the right to succeed. It seems that the goal of many regulators is to take all risk out of life, and that of course, is to take all life out of life. Why do we allow people to do bungee jumping, parachute jumping, stock car racing, and all sorts of other things that are dangerous to our health? Because we claim to be a free society and that is a part of your right to take risks. If you are smart, of course, you insure yourself against risk, in the true sense of the word insurance.

There's another way that the government could help us is if they really wanted. You know the government is a big enterprise and it has accumulated a lot of data. It has accumulated data, for example, about which companies can provide the best washing machines for the Army, Navy, Air Force, Marines, etc. Why doesn't it publish it? Why do I have to join a consumers union in order to get *Consumer Reports* that tell me which are the best products? Well, if you look into it, you'll find that the government refuses to release that kind of information because of pressures of special interest groups that don't want to be exposed as the best or worst washing machines on the market. I see giving us information as a legitimate function for government. If they leave us free to choose, again to quote Friedman, "We would be better off."

As I suggested before, we see government is not very good at managing a complex society's economy, through centralized dictate. Adam Smith suggested that when a free price system is allowed to operate, it appears the money will be guided as if by an invisible hand to advance the good as a whole. In terms of health care, we have a model with three key variables, as Mark eluded to a moment ago: quantity, quality, and cost. He said you can't get 30 out of 30, or as I would put it, you cannot maximize all three of those variables simultaneously. You can maximize two of the three, so if you want to hold down the costs of health care in our society, either the number being cared for or the quality of that care is going to suffer, irrespective of what they claim before the fact.

Because the Russian, the British and the Swedish health care systems have been exposed as failures, we are told now to look north to our neighbors in Canada as the salvation for socialized medicine. What we are not often told is how Canada is living off the research and development (R&D) efforts of the American health care industry, how health care there is being rationed by standing in line, and how some people die before they get to the head of the line, and how Canada's hospitals have been living off of their existing capital for the last 20 years. More Canadian hospitals are now gradually exhibiting the obsolescence and decay found in the British national health service hospitals.

While the Canadian health care system continues to enjoy favorable press coverage in the United States, it seems certain that the system's deterioration will cause Canada to consider significant reforms before the end of the 1990s. Over 65% of Canadians now purchase private, supplemental insurance, and some analysts now predict that Canada will reintroduce private health insurance within the next five years.

We Americans now have, I would say, the best health care system in the world, even with the excessive government intervention. It would be a grave mistake for us to throw it away, chasing after false promises. Do we really want the same government bureaucrat that brought us the savings and loan disaster, the post office, and Conrail to run our health care?

Dr. Roberto Calderon, a radiologist in Managua, Nicaragua reminds us, based on his decade of first-hand experience with socialized medicine, of the five reasons why Marxist medicine cannot work: (1) patients generally cannot choose their own doctor, (2) the doctor can't choose his patients, (3) the doctor gets paid at the end of the month, regardless of what, or how well he did, (4) the patient doesn't get consoled, and (5) the patient doesn't get well. We are moving down the road here towards socialized medicine. Inevitable problems are creeping up. That's why we are talking about them here in this panel.

Again, instead of removing the existing government intrusions, we are told over and over and over again, even at this meeting by some of the speakers, that we need more regulations to solve the problem; we need socialized health care or we need pay-or-play, which is just an inevitable step down the road to national health care, because they never make the "pay" part at a market clearing level.

We find government spending accounts for about 42% of the total health care expenditures in our society, and 1,843 of our nation's 6,780 hospitals are already government owned.

Another area of the problem is the tort law system that has caused doctors to practice defensive medicine thus escalating their malpractice insurance premiums, and of course, that gets passed on to the patients in the form of higher prices.

We have a tax policy that favors the use of third-party payers who have less incentive to hold down costs. We have a court system that is soft on crime, which results in overvictimization with its attendant health care costs. We have cost containment efforts in Medicare that have resulted in greater recordkeeping requirements, and their attendant costs. We have state government mandates to the insurance companies that prevent individuals from obtaining cheap, no-frills policies, which they may want. We have certificate-of-need requirements, that reduce the introduction of labor-saving technology, and reduce competition, which can lower costs. Several states interfere with private attempts to manage cost by creating preferred provider organizations. And perhaps the biggest way in which current government regulation contributes to higher than necessary health care costs is through occupational licensure. Physician assistants, midwives, and nurse practitioners can often provide excellent routine care at much less cost than MDs can. They are prevented from doing so by state coercive efforts through the licensure process.

Well, by this point I hope you're asking yourself, why do these counterproductive and anticonsumer practices persist? I would submit as a response to you, as a student of the regulatory process, that in public policy debates there is a fundamental inbalance because consumers become unorganized and providers are organized.

You have concentrated benefits and diffused costs. When you have a hearing before a legislature or a bureaucratic body that's considering greater intervention, who shows up to testify? The special interests do. It's in their advantage to do so. Most of the taxpaying citizens and consumers are unaware that these proposals that are dressed up in "public interest language" are anything but what they claim. And even if they were somehow to figure it out, they would go broke very fast, spending thousands of dollars to fly in and testify before these bodies to save a few bucks for a rip off by the system.

Another important reason why these counterproductive and anticonsumer situations continue to exist is because the government regulators' jobs and promotions are at stake. Abolition of their counterproductive intervention in the market would mean these folks would have to go out and compete for a livelihood rather than rely on the coercive power of the state to guarantee that there will be ever more work for them to do.

And if you think about it, the best way to get ahead in a bureaucracy is to expand your own empire so that you can be promoted to become the new supervisor of all these new workers that are needed to handle the increased work load. (And I might add, just parenthetically, that I have been an administrative officer for the Department of Defense for several terms, and I continue to be a government worker on a part-time basis as a reserve officer. I served as an inspector general for four years and found plenty of abuse without looking very hard for it.)

Now some bureaucrats, in advancing these positions, have mistakenly convinced themselves that what they are doing is truly in the public interest. Others, I submit, are cynically manipulating the system for their own benefit.

In Iowa, for example, I recently learned that our insurance commissioner's office has included a provision in an Omnibus code revision that would give them the power to regulate insurance renewals as well as first-issues. They represented this to members of the legislature as merely a restatement of the existing situation, when in fact they should know very well that in 1989, not that long ago, when they advanced the claim that they had renewal authority, they were sued by one of the providers. They were going to take it to court, but they got an opinion from the attorney general of the State of Iowa that says you do not have this regulation authority, and they backed off. And yet a couple of years later they're trying to slip it by as noncontroversial -- "just restating what we're doing."

I think that if we could cut through the smoke screen of self interest and adopt deregulation plans, advanced for example, by the National Center for Policy Analysis and the American Legislative Exchange Council, we would go a long way towards improving health care for all Americans while cutting costs. The idea would be for each citizen to provide for their own needs with private, affordable insurance, which

would increase business in your industry and increase the need for additional actuaries.

It is in your interest both as a consumer and as an actuary to learn the truth about the costs of overregulation, the misleading claims that are being advanced that these are "merely technical issues" and not policy issues, and the often hidden self interest of the bureaucrats and the reformers.

MR. HARTNEDY: You need to write to the NAIC Life and Health Actuarial Task Force in order to give your opinion about what they are trying to do. You're a professional. You're the expert in these areas. Many of the regulators are trying to set social policy and that is not their job. That is the legislators' job to address in a public forum, as Don spelled out very clearly. The regulator is to carry out the law as passed by the legislature. If you read these guidelines, you will see that it is loaded with social and public policy. That is not their role!

MR. S. MICHAEL MCLAUGHLIN: I have a question, but I want to state first of all I'm speaking as an individual health actuary who regards himself, although with a consulting firm, as being very much in the business.

MR. HARTNEDY: I deserve that Mike, but I couldn't resist the comment.

MR. MCLAUGHLIN: I probably would have said that in my previous capacities as a rate filing actuary in an insurance company. And, in fact, I go back about 10 years to a filing I remember I did on an individual major medical policy where I was filing rates that asked for a 60% loss ratio. And the question that I have pertains to that. I want to state also that I'm not defending regulation in this industry at all. But I took a look at the 60% loss ratio and kind of turned it around to a 40% cost ratio or expense ratio. In 1982, the company I was with had about a 40% ratio that we felt we needed for expenses and profit. And we're still sort of talking about the 40% expense ratio. In fact, if that should be squeezed to 35, we would have some hardship. And I think about that quite a bit. We've got home office expenses. And those are going up at some rate, perhaps some rate related to the CPI. But medical costs are going up at a much higher rate than the CPI. And so our premiums, the part of the premium that's needed to cover benefits, going up 15% or 18% or 20% a year. It's doubling every three or four years. But I don't think that our home office expenses are going up at that rate. And so why shouldn't home office expenses as a percent of premium be coming down? This applies to commissions as well. If we have an average major medical premium of $2,400 a year, $200 a month, should our commissions in fact be going up at 15% or 20% a year with medical costs? And shouldn't commission expenses as a percent of premiums be coming down?

These are sort of rhetorical questions. I'm not sure if there's any one answer. John, I wonder if you've done any analysis of the expense that you're company is experiencing? Mark, have you seen the expenses that the industry is experiencing? And is there anything that we have done or can do to improve the efficiency with which we deliver financing of health care to our individual policyholders? It just seems that in the 10 years that I've looked back, we haven't gained very much in terms of bringing that expense ratio down on our own.

MR. HARTNEDY: One of your questions that I can answer the quickest is whether we looked at expenses at our company. The answer is, yes, we have. We don't need quite as much as you're describing, because we tend to run at a lifetime loss ratio that probably hits 65% at least. But I think that should be set by the competitive market. I'm not sure that the costs have stayed as low as you've described. I don't challenge CPI. But the things we have done -- second surgical opinions, usual and customary criteria, managed care, and increased regulation -- have created a lot more costs for our industry.

We need to remember that major medical is primarily a transition product and therefore has poor persistency. If we push up loss ratios by regulation, rather than by competition, companies will have difficulty recovering acquisition costs unless they financially underwrite, that is, eliminate low income or no income people who are between jobs. That is counter to what we need to do, especially with the number of uninsured growing.

The most practical solution to reducing insurance administrative costs is to stop selling low deductible plans. If a person can afford to pay the premiums that we charge for individual major medical, they can probably afford a $1,000 deductible policy. We are primarily in the small claims paying business and that's inefficient. Until we're willing to go out in the marketplace and push those deductibles up substantially, then we aren't going do much about the costs that you're talking about.

MR. LITOW: I'll address your question Mike. I think it's a big problem from the bureaucratic perspective that they say they can administer these plans or whatever benefits at 3%, 4%, which of course, is a grossly understated number. The private industry costs are too high. So I think we do need to address that and address that pretty carefully. As far as the administrative costs, I think that probably has come down over the years. I think if you look at commission scales 10 or 12 years ago, commissions are a little bit lower in general then they were. As for administrative costs, underwriting probably has gone up more because companies now are doing blood testing and so forth. So those costs have not come down as much. Plus, of course, you've got a certain percentage of premium expenses in here for taxes and license fees. You have claim expenses that are based on where your claims and loss ratios are. So those really aren't going to come down. But I think overall that area probably has come down a little bit.

The problem really has been the loss ratios, as John commented in his speech. Now most companies on major medical are running 65-70% or higher. Most companies are losing money. And the problem I see with the minimum being increased has nothing to do with administrative expense. I think, from an administrative expense standpoint, the industry can handle it okay. I think the problem is that a lot of the regulators take your loss ratio to date and divide it by 55%, minus one and that's your rate increase. And they don't even allow you projections at all, or while they allow you projections, they don't trust your trends. They don't trust your projections into the future. They don't allow you to put in an aging increment. So the way I see it raising a 55% to a 65% is going to cause companies to end up at 75% or 80% under the current regulatory process. And that's what I see as being the big problem. I mean if you could really target a 65% and realize it, then I wouldn't see a problem with that.

MR. HARTNEDY: As part of that I would like to direct a question to Donald because I heard him express an idea at breakfast. What is the solution for consumers? What is the solution in the health care market? You talked about that. And I believe your proposal would address the level of expenses.

DR. RACHETER: Yes. One of the ways that I mentioned that there are already interventions in the market is the differential between the tax treatment of employer-provided plans and individual plans. Maybe if we could level the playing field by creating a tax-free medical savings care account-type of situation, where instead of buying expensive, low-deductible, first-dollar or deductible policies like we currently do, we could get back to the true function of insurance, which is to provide against catastrophic care major medical costs. By having a $3,000 deductible policy, employers or individuals (if they want to) could provide for spending on routine health care costs (even expanded beyond what is currently allowed). Let them set up their individual savings account, a medical savings account, and put $3,000 a year into it. That's the amount below the deductible. And then when they need eye glasses, dental work, routine exams, mammograms, or whatever, they can take it out of that fund, pay for it, and they would retain title to any monies that would be carried over. If they're very frugal and they shop carefully, and they manage their account well, they're going to build up funds over time that would be theirs, not their employers. You know, under current law, if the employer does what I'm talking about, at the end of the year, the money reverts to the employer. So there's a great incentive for the employee to "use it or lose it," which is very counterproductive. And there's been some discussion in *The Wall Street Journal*, *The Washington Post*, and other places about this kind of a proposal. That will be very simple, and back off from the current disjunction that's in the law. Let people have the incentive to save, to be prudent on their own.

MR. HARTNEDY: The reason I asked you to comment about that is it puts us in the $3,000 deductible business. It takes a major chunk out of administrative expenses. That's why I thought of it based on your question, Mike.

MS. ALICE ROSENBLATT: I guess I have a couple of comments to make as opposed to questions. I'm a little bit disappointed actually that the panel discussion wasn't a little bit more balanced. It focused on the needs of commercial carriers and didn't address what's going on, from a regulatory point of view, and in the Blues plans, which are very, very different.

Mark, I think you said it was 60 and the commercials represented 110. But I think if you were to look at it on a lives and short-term basis, the Blues plans would represent a greater number of lives than those 110 commercial carriers. And the regulation is very different. For example, in Massachusetts, we're regulated differently than any commercial carrier. I know John and his company have had lots of fun in Massachusetts. We just finished. Blue Cross/Blue Shield of Massachusetts just finished an April 1 rate filing of 800 pages. So I submit that many of the commercials do not know what regulation truly is. In about a month, we will start a public hearing and that public hearing will last about 20 days. There will be 20 days of testimony by people from my company and the interveners. About a month after that we may finally get a rate increase with an effective date of September 1. If you look at what our past history has been, for Blue Cross/Blue Shield of Massachusetts in terms of

rate increases filed versus rate increases approved, we have never yet received 100% of the rate increase we sought. Now Massachusetts is the extreme; other Blues plans go through some of these problems. But I think it's important that we're a society of actuaries; we're not the Health Insurance Association of America. We do spend some time talking about that.

Mark, my other question for you, in terms of percent of lives covered, would be, did your survey include any HMOs whatsoever? Because many of the HMOs are now entering the individual market. And I think it's important that we think about what regulatory standard the HMOs have versus the Blues plans and versus the commercials. And again, in some states there are three different types of reforms.

The other comment I want to make is at the general session, the speakers were pleading with us as actuaries to think outside of the nine dots, think outside of the box. We can't continue to resist some of these public policy efforts. Small group and nongroup are so close together. Again, for example in Massachusetts, small group applies to groups of 1-25. A group of one is not a lot different than the nongroup marketplace or the individual marketplace. So we need to think about the public policy issues or we may end up in a place where we as individuals don't want to be; we, as actuaries can avoid getting there. But sometimes we can't put our self interests as our number one criteria. I have submitted comments to the NAIC. My guess is that my comments were quite different than what some of the people representing commercial carriers may have submitted. But I would agree with John. I think we all in this room should submit our comments. And I would also ask everybody to think outside of the nine dots.

MR. HARTNEDY: HMO comment Mark?

MR. LITOW: Yes. First there are counts on the Blues in the survey. Again these are only one-life issues. The Blues had about roughly 20% of the new issues, and about one third of them are in force. Certainly the Blues rate filings are unbelievable. I deal with a few Blues, but not too many. I think the same general direction applies, it's just that the Blues have it even worse in their particular states. Plus the Blues are in a tough political situation.

The study also included HMOs. This is for 1989. There were roughly about 1000 insurers in the survey and about 575 HMOs. We covered all the HMOs because we did it through Interstudy. The HMOs are in there, but they are a very small part of the group.

MR. HARTNEDY: A comment on the Blues. You're right Alice. Your comment is well taken. I didn't even think in those terms and I apologize to you. I am reminded though of Illinois where the Blues were basically being regulated straight out of business and running out of surplus. And these are comments from a very good regulator in Illinois, who made these observations. They finally became a mutual company to survive. And it was an action strongly supported by the regulators there because of some of the difficulties that Alice talked about.

She raises another good point. I've been very negative. We've got to watch our public policy statements. I do spend a lot of time traveling around talking to agents

about things that will truly address the problems. Those things include the medical IRA and tax equity. Those are excellent ideas! We've got to speak out, not just complain about things (and I'll grant you that's what I was doing). We must offer real live solutions. We're professionals. We have very good knowledgeable opinions about what ought to be done. And I think we need to share those more with our public, whoever that public is. We've got a lot to share.

MR. BRADFORD S. GILE: I'm the regulator that John mentioned who was with the Wisconsin Insurance Department for 13 years. And I must say, when I read the NAIC rate filing guidelines, I was appalled. My company writes $185 million of premium a year and individual health insurance in 12 states. We typically sell to self-insured farmers. I don't know what is going to happen if individual health insurance goes down the tubes. And I think it is going to. I think there's very little question that it is going to. Where are these people going to obtain insurance? I submitted my comments to the NAIC Life and Actuarial Task Force. Unfortunately, that's not the only place where we have to look. We have, on the one hand, small group reform in every state pounding on the door, trying to pull the individual carriers in with the small group carriers. In addition, in the state of Minnesota, there is a law which has not yet been enacted, but soon will be because it's supported by the governor and the Democrats and the Republicans. It deals with insurance reform and has as its stated legislative intent to do away entirely with risk classification in pricing. Now if you don't think this is serious I think you better start thinking again. This would do away with age rating, gender, geographic location or any other variable. My question is not do you think individual health insurance will go out of existence, but when?

MR. LITOW: Well, I'll put in a plug for the Council for Affordable Health Insurance, because that's why that was formed. Insurance companies have joined together because it is a survival issue. There's no question about it. And there is a very real threat, don't believe there isn't. But I haven't given up Brad.

MR. WILLIAM C. WELLER: I encourage you to submit comments on these guidelines. But remember that the regulators are reacting to complaints about the size of rate increases, especially on closed blocks. Policyholders don't write and complain about a 10% or 15% rate increase. So if you can include with your comments some examples of things that you have done as a company to try and control rate increases on closed blocks of business, it would be very helpful. That is going to be very effective for those of us who are lobbyists and are in there trying to work to get these guidelines into a format that will be effective. Then we can point to the positive things that the industry is doing, not just all the negative things that they hear in the complaints. As such, if you're a Health Insurance Association of America (HIAA) member, you will get a copy of our comments.

We have presented what we think is a framework for a solution that reduces the amount of regulation which is based upon the size of the company. It allows the regulator to focus more on those companies that appear to have behavior problems from the point of view of complaints about premium to whether or not they're getting the correct amount of information from an actuarial certification. In addition, it is oriented towards a more national approach on a block-of-business basis as opposed to the state-by-state type of approach.

MR. HARTNEDY: I hate to just openly and publicly support things that are said by the HIAA but I guess I have to in this instance. The idea of regulators addressing solvency and consumer complaints I think is right on. That's where they belong. They make very little contribution in the area of rate regulation.

MR. WILLIAM J. BUGG, JR.: I've been working with the Academy's Committee on State Health Issues. And we've been working with the NAIC Actuarial Task Force and the working group for a number of years now on the rate filing guidelines and other health matters. I want to make a comment on Mike McLaughlin's questioning expenses. It's our perception that one of the reasons behind the increase in the ratios has to do with the point you were making Mike. That is, as increases have occurred, the expenses shouldn't have been increased nearly as much. Well, it should be remembered that there's a lot of A&H business out there that is not inflation sensitive. They haven't had these premium increases. Aside from that, there's some other items that have served to increase expenses, some of which have already been mentioned, for example managed care and underwriting. Also, persistency is a factor. I get a sense that policies are not persisting as well as they did in the past. Consequently, the acquisition cost is a bigger item in the equation.

But aside from that, the Academy's Committee had suggested in Indianapolis last year to provide facts in this very area, and that a survey of expenses be made. And, in fact, such an attempt has been made, though the results of it have not been revealed. A survey was made of about 25 companies of which about half submitted data. We don't know what this data looks like, or how it will be used. Hopefully it will have some effect. But the results haven't been seen as yet. In fact, we had suggested that they look at expenses from some point in the past and the present to see how they have changed and to see whether that 40% includes a cushion that has been created. To reinforce the comment that Bill Weller made, I'd say that in addition to making comments, it's been my observation and experience that you should have tangible suggestions on language also. For instance, say, "I'd like to see such and such section rewritten," then give them the words. I think you'll have a better chance of getting your thoughts incorporated in the document if you do so. Don't just make some observations or criticism and leave them to work out the language. That leaves a bigger gap. This doesn't mean they will accept your language. But if you write language that you'd like to see, I think you'll have a better chance of having it incorporated.

MR. HARTNEDY: Very helpful comments.

MR. STEVEN W. PATRICK*: This statement is mine personally. I heard about a gradual Insurance in Salt Lake City. But most of my experience has been with Blue Cross's move toward less regulation. I think this is appropriate. But Don mentioned the coercive power of the state. And I think in mentioning that he hit on the essential difference between government and all other social institutions. I think this is important for people to understand, if we are ever to stop the encroachment of

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progressively progressive regulation. The essential characteristic of government is that of all other social institutions, it has the authorized power to initiate force. Think about government compared to anything else. The proper definition distinguishes the thing it's defining from all else. And if we say, what is government? What makes government? It's the power to initiate force. And that's why government has to be so limited. So what I'd like to say is that in the end, once you grant government to be in the economy at all, you have opened the door for continual pressure to expand this mistaken use of power. You've granted the bureaucrats the right to be in your business and in your lives. I say this as the ideal understanding. And I'm saying this also in the hopes that some people here will try to understand this as they go along through the years. Because I think the more people who understand the essential difference between government and other social institutions, the more likely we are to survive.

MR. HARTNEDY: If we don't offer real solutions, then we're going to be out of business as Brad said. We have to be objective, looking beyond individual insurance company interests. Tax equity and medical IRAs are a significant part of the solution. It's time for us as professionals to speak up about these issues for the benefit of our customers.