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# THE Actuary

## Forecast 2000 forum generates substantial media coverage

by Robert L. Brown

The recent Forecast 2000 forum on the environment held in Toronto dealt with such issues as increased taxes and higher insurance premiums to cover costs of natural disasters. The forum generated a lot of positive worldwide media coverage and brought more focus on the actuarial profession, despite the somewhat negative tone the survey projected.

In discussing the results, based on a survey of casualty actuaries, a positive pro-active stance was emphasized with the media.

In particular, it was our contention that through insurance premiums, the business sector will see real economic incentives and rewards for being responsible corporate citizens with respect to pollution control (e.g. reduced premiums for safe, inspected storage facilities). Furthermore, we stressed that actuaries have an essential role to play in assessing the economic value of the pollution liablity risk, both in setting equitable premiums and also in assisting the courts in adjudicating penalties in cases of damage or injury.

Before the July 11 Forecast 2000 seminar, actuaries with a particular interest in the topic were polled on a series of relevant questions. In this case, the response was from 332 property/casualty actuaries (out of 1200 polled). Questions varied from the effects of a catastrophic natural disaster to concerns about environmental pollution. The results of the survey, which acted as the focal point

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## Continuing education: The debate goes on and on

by Burton Jay

Should actuaries have a formal program for continuing education? This question has been asked, studied and debated at least since the early part of the decade. For many years, accountants, physicians and lawyers of many states have had continuing education requirements to retain their license to practice. Many other professions, including some groups of life insurance agents, require their members to participate in continuing education activities or in some way recognize those who do. Where are the actuaries?

The topic was on the agenda of the Society's Services to Members Policy Committee as early as 1983.

In 1984, a joint task force representing the actuarial bodies in North America was formed to consider the question. In a September 1985 report to the Council of Presidents (COP) the task force recommended that each founding organization of the Academy adopt a similar continuing education recognition program. The Conference of Actuaries in Public Practice (CAPP) was already in the process of adopting a program similar to the one envisioned by the joint task force. That program would have recognized – with an asterisk or other designations in the organization's yearbook – those individuals who fulfill the required hours of continuing education and submit documentation to the organization's administrative offices. The American Society of Pension Actuaries has also had such a program for a number of years.

Another type of program involves specified continuing education requirements to retain one's professional designation. The Joint Board for Enrolled Actuaries recently implemented a program that members must fulfill to retain their Enrolled Actuary designations. The COP deferred action

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### In this issue:

# Why small-group medical insurance has failed

by Richard L. Vaughan

September's *Actuary* contained an excellent summary by Drew Davidoff of renewal rating for small-group medical business. Among the techniques he describes are age, sex, and area rating, experience rating using credibility, experience rating using tiers, examination of the diagnoses in the claim file, and initial and reentry medical underwriting. Related techniques include industry rating, durational rating, more refined dependent classifications, and the periodic closing of old risk pools and opening of new ones.

Those of us who work with small groups alone or in trusts and associations have seen these strategies evolve in response to market pressures. We consider them necessary refinements in the management of this line of business and have convinced program sponsors and insured employers of their necessity. Armed with these techniques, some of our trusts have flourished, and some of their underwriters have profited.

Yet small-group medical insurance has failed.

- It has failed those employers who cannot obtain insurance because some known medical condition promises near-certain future losses.
- It has failed those employees of such employers who started work in good health and for whom group insurance is the only practical protection against ruinous medical expenses.
- It has failed those group insurers who, through mismanagement, bad luck, or a commendable reluctance to abandon their policyholders, have suffered heavily from cumulative adverse selection.
- It has failed those employers whose groups are still good risks but who cannot obtain coverage at reasonable rates because of the thinness of the market.
- It has failed those sponsors whose association group programs have entered a spiral, lost their carriers, and been forced to terminate.
- It has even failed those employers – and their employees – fortunate enough to have insurance. Their insurance will pay claims incurred through the end of the policy term. But it gives no peace of mind, the purported benefit of any insurance. A single medical condition, arising within the group, could at any moment make it uninsurable to a new underwriter and only acceptable to the present underwriter through forbearance or inattention.

Small-group medical insurance has failed because insurers have wasted their time refining its superstructure while its foundation is built upon sand. They have misapplied a product designed for large groups with stable employment. They have ignored principles long understood to underlie any voluntary insurance mechanism. They have refused to innovate and they have lost the pride they once had in earning an honest profit while satisfying real individual, and thereby social, needs.

## Fatal flaw

The contract insurers offer has a fatal technical flaw. It tries to insure the consequences of events that happened before the policy term, and it avoids insuring the consequences, beyond that term, of events that actually occurred within it. It defines coverage in terms of when a medical service is performed rather than when an accident occurs or an illness first becomes manifest. It is an "expense-incurred" policy form rather than a "true occurrence" form.

Our rating techniques, which are age, sex, dependent status, industry, and area, distinguish among groups according to claims potential even before any accidents or illnesses produce a stream of medical expenses. These would be reasonable predictive variables for a true occurrence form of insurance. Their use neither contributes to, nor reflects, the defects in the small-group market.

The remaining techniques are more pernicious. Some have the overt objective of rewarding and attracting "good risks;" others, of surcharging and avoiding "bad risks;" but all separate those small groups still in good health from those with predictable future medical expenses. The resulting large rate differentials make coverage unaffordable for the highest-rated groups and deny the expectations of many employers, on joining a trust or association, that their rates would be "pooled" and that they would somehow "follow the fortunes" of the entire trust.

Insurers should not be blamed for following these "pernicious" rating strategies. Given an expense-incurred policy form, they are rational responses in a voluntary market. If an insurance contract promises benefits based on the future performance of medical services, and some readily available information helps predict the extent of such services, then a reasonably fluid competitive market will force an insurer to use such information or risk ruin.

A technical problem – contractual in this case – suggests a technical solution, requiring marketing, legal, and regulatory adjustments and the rethinking of many established procedures. But the effort is necessary. We in the brokerage and consulting community, who by training and experience are "of" the insurance industry but not entirely "in" it, are extremely disappointed that the leading national insurers have made no effort to solve this problem and have in many cases abandoned the small-group market.

## What form could a solution take?

One possibility is social insurance, whether it be "National Health Insurance" or the "mandated employee benefit." Because it is coercive, social insurance can be made to work, to a point. But social insurance tends to freeze relationships and methods at one moment, deciding any further innovation through political rather than market processes. It distorts economic decisions and may require coercive intervention at other places in the economy, such as controls on prices charged by providers and suppliers.

Social insurance has an important role in making medical care available to persons unable to purchase it themselves, and no humane civilization would want otherwise. Such a social floor of coverage is not intended to protect accumulated assets and is therefore conditioned on need. Those with assets or income to protect their insurance would greatly prefer the

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## *Small group insurance cont'd*

private market, if it can be creative and flexible enough to do the job.

If someone fails to protect his or her assets with insurance, no one expects the public to replace any lost assets. But what if there is no insurance available for events that have already happened, or for the full costs of new occurrences? What if there is no insurer venturesome enough even to attempt to act as an insurer? Then who can blame small employers, and the politicians who represent them, for trying to devise social solutions? In such circumstances, does not our professional objectivity compel us to acknowledge, not that socialized insurance is efficient, creative, or desirable, but at least that it is feasible?

We must seek a private solution if we do not want this market or the large-employer market to be socialized.

### A proposal

For example, imagine a revised group insurance contract providing full extended benefits for conditions arising during the term of coverage; no benefits for preexisting conditions; all benefits determined by a schedule in effect on the date the condition arises; extended benefits applying only to a list of treatment and/or secondary conditions explicitly stated in the EOB at the time the initial condition arises; and preexisting exclusions applying only to a similar list explicitly stated at time of underwriting.

The full extended benefits would make this policy a true occurrence form, providing meaningful coverage of all consequences of medical conditions arising during the policy term.

The complete exclusion of preexisting conditions – complementary to the extended benefits – would make nearly all groups insurable.

The schedule would make extended benefits feasible to the underwriter by factoring out the risk of inflation from the runoff of any particular medical condition. In compensation, the schedule could be as generous as desired, certainly more so than the common 80% U&C plan. It would normally be updated annually by each employer, applicable to new conditions only. Partial inflation-indexing could be offered for an additional premium. A schedule would make each insured a more interested participant in the medical marketplace, since his or her marginal savings from a less expensive provider would be 100%, not 20%, of the difference in charges.

### Extended benefits

Determining extended benefits and preexisting exclusions by explicit lists would avoid disputes over the cause of the medical condition giving rise to any given expense.

Together, the provisions would create a group contract with some features of the old "per cause" major medical plans and scheduled base plans. Its new administrative requirements would be largely an adjustment to, rather than a replacement of, the procedures already required for small-group medical business. Among its more interesting actuarial consequences would be the following:

- Nearly all groups would be acceptable risks, and at standard rates.
- Rates would still vary by age, sex, dependent status, industry, and area, though with different relativities than at present.
- Rates for a given benefit schedule would not change with trends in unit costs but would continue to change with trends in incidence and utilization.
- Technological trends would be accommodated by adding new procedures to the benefit schedules, with corresponding increases or decreases in rates.
- The credibility of claims experience would decrease. For a single small group, it would be essentially zero. Neither credibility nor tier rating would be useful in rating individual groups.
- Examination of the claim file would yield little information of any predictive value for the following policy year.
- Prospective experience rating would still be appropriate for entire trusts, though with reduced credibility. It would still help capture the effects on claim costs of variables not recognized elsewhere in the rating process.
- Renewal rates would change by the product of three factors: trends in incidence and utilization; adjustments to estimated expected claim costs based on additional experience; and changes in the benefit schedule controlled by the employer.
- Dividend and retrospective experience-rating structures would not need to be changed. The detailed formulas would need adjustment only to reduce the credibility of experience, adjust expense and risk charges, and estimate incurred claims in accordance with the new contract form.
- Reserves for annual statement purposes could be calculated in aggregate in the same present manner, except for assigning incurral dates in accordance with the new contract form.
- Reserves for experience-rating could be calculated as at present except for a change in incurral dates, or could be calculated seriatim using a table of estimated expected runoff expenses for each outstanding medical condition. When enough data had collected, the aggregate of these seriatim reserves could be adjusted to its probable ultimate value using "incurred loss development," as is common for casualty lines.
- When an employer changes from a conventional plan to the proposed plan, he will almost certainly be obligated to pay the runoff of any preexisting conditions not covered by the new plan – though he probably could pay them on the new schedule. A reserve table would allow the new insurer to assume this liability for a fixed extra premium, or offer to pay the runoff claims on the new schedule on an ASO basis.
- In principle, the pure premium component of pricing for the proposal plan would resemble the average claim cost for a large mature conventional group plan with the same age distribution and the same benefit schedule, discounted to reflect a longer payment tail. Expense and risk loadings would need adjustment.
- Employers could no longer expect select-period discounts. Rates would start and remain at essentially mature levels. Promotional literature would need to acknowledge this but emphasize the value of the extended benefits, to educate those employers in good health accustomed to moving from carrier to carrier at low first-year rates. For any employer who had been through a difficult renewal or rejected for or dropped from coverage, the value of the plan would be self-explanatory.

The foregoing is just one possibility! The headline over Davidoff's article stated "Small-group renewal rating – companies must become more active." True! U.S. insurance companies need to experiment, to accept business as well as insurance risks, to negotiate with regulators, to give new products a real try in the marketplace, to persevere until the problem is solved. Otherwise, the problem will no longer be theirs to solve.

**Richard L. Vaughan is Vice President, Marsh & McLennan Group Associates.**