SOCIETY OF ACTUARIES

Article from:

The Actuary

September 1989 – Volume 23, No. 8

The Newsletter of the Society of Actuaries
VOL. 23, NO. 8
SEPTEMBER 1989

THE Actuary

Small-group renewal rating – companies must become more active

by Drew S. Davidoff

Increasingly keen competition for small-group medical business has caused many carriers – both life/health insurance companies and Blue Cross/Blue Shield Plans – to drastically alter their approaches to renewal rating of small-group business.

Whereas I tend to define "small group" business as under 50 lives, among various insurance carriers the small-group market segment ranges from under 10 lives to under 200 or more lives. While portions of this article apply to whatever definition of small groups a company has, it is especially geared toward the smaller-sized groups of under 50 lives.

In the past, many companies – particularly Blue Cross/Blue Shield Plans – treated small-group business as a single risk pool, with the same set of rates (employee-dependent or single-family) applying to all groups, regardless of their age-sex composition, morbidity experience, or new business vs. renewal status. In the case of life/health insurance companies, geographic factors, as well as age and sex factors, were typically applied. This approach to rating reflected the six basic rating principles: adequacy, reasonableness, competitiveness, equity, coordination with operations, and simplicity. However, simplicity was given far more weight than equity.

Built into this approach is the inherent disadvantage that each year the better-risk groups will tend to find coverage elsewhere, while the

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Tests for actuarial soundness for OASDI and HI

by John C. Wilkin

The 1989 Annual Report of the Board of Trustees of the U.S. Federal Old-Age, Survivors, and Disability Insurance (OASDI) Trust Funds (usually referred to as the 1989 OASDI Trustees Report) was released on April 24. Notably, the Board of Trustees removed the concept of "close actuarial balance" from the Report over the objections of Chief Actuary Harry C. Ballantyne. This is the first time that the Chief Actuary of the Social Security Administration has attached qualifying language to the Statement of Actuarial Opinion since it was made a part of the annual reports in 1981 (which was accomplished largely through the efforts of the then Chief Actuary, Dwight Bartlett).

The trustees justify their action by stating that they do "not want to put undue emphasis on the concept of 'close actuarial balance' by continuing to report on whether the actuarial balance falls within an arbitrary range of values" and that the test "might inappropriately influence the decision as to whether and when changes in the program's financing or benefit provisions are needed in the future."

Ballantyne (in a footnote printed in the Report) stated his belief "that 'close actuarial balance' is a valid concept, that it is generally accepted by the actuarial profession in evaluating the actuarial status of the OASDI program, and that it should be included in the report, continuing the practice in effect since the late 1950s" and that if "the concept were continued this year, it would show (using the alternative II-B assumptions) that...the combined OASDI program (deficit equal to 5.1% of its cost rate) is just barely out of close actuarial balance." In his Statement of Actuarial Opinion (attached to the Report), Ballantyne urges the trustees to reconsider their decision.

These two statements typify two schools of thought that have been developing over the last few years. One school wants a stronger test – which would be generally accepted by the actuarial profession – that could be used to determine the actuarial

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In this issue:

HIV infection cont'd

as the epidemic moves through various population segments. Not enough is known about the current prevalence of infection, the prevalence of various risk behaviors, and the probabilities of HIV transmission associated with those behaviors and with various stages of the progression of HIV disease in infected individuals. Also, and we may hope very significantly, various therapies are beginning to lengthen the survival of persons with AIDS (PWAs) and to defer the onset of AIDS among some infected persons.

With the increasing use of drugs to fight AIDS and HIV infection, the financial implications for the nation's healthcare systems become increasingly significant. Actuaries and others are grappling with these implications and with the overall problem of caring for PWAs.

It is important to get better estimates of the prevalence of HIV infection, both to improve the accuracy of projections of AIDS cases and to get a clearer picture of the size of the healthcare needs of HIV-infected persons who do not have AIDS. The importance of HIV-antibody testing for purposes of prevalence estimation, control of the spread of infection, and (relatively newly) treatment of infected individuals is becoming more and more widely recognized. Surveys are being conducted in various population segments. A national cross-section survey with reasonably unbiased results may be difficult or impossible to accomplish.

Life and health insurance companies have tested a great many individuals, many or most of whom do not belong to the population segments being tested by others. Laboratories testing for insurers have been making public some of the resulting data. These data benefit both the insurance business and the public at large. The more such data can be released (subject, of course, to strict confidentiality controls), the greater will be the benefit.

Renewal rating cont'd

poorer-risk groups will stay. This adverse selection process leads to the classic "assessment spiral" of yearly rate increases. Once a company reaches this stage, not only is it difficult to make money, it becomes difficult to break even on this block of business, no matter how high future rates are set.

The solutions

Over the past five to 10 years, companies have responded to this problem in various ways, including all or some of the following (where not previously used):

- Demographic rating
- Experience analysis
- Medical underwriting

Demographic rating, including at least age and sex rating, enables a company to determine rates in such a way that groups with more favorable risk characteristics (i.e., a lower average age or a higher percentage of males) get lower rates, while those with less favorable risk characteristics get higher rates. The rates may either be locked in for a year or vary month to month as people enter and leave the group.

Experience analysis can take several forms. One form is to apply the company's experience rating formula, typically applicable to large groups, to small groups as well. Over the past 10 years, the size of the group to which the experience rating formula applies has been declining. Although the smallest group to which the experience rating formula applies now is typically 50 lives, some companies use the formula below 50 lives. Although a credibility factor of less than 100% is normally applied to a group's own experience, and this result is then coupled with some overall pooled experience, the key is that the group's own experience counts to some degree in determining future rates. The tendency – largely marketing-driven – has been to give more credibility at a given number of lives than is truly warranted based on pure statistical considerations.

Another form of experience rating is known as "tiered rating." Under this approach, an overall rate (perhaps demographically adjusted) is determined for the entire small-group pool, and then each group is assigned to a certain tier – either above or below the standard level – based upon its own experience. A loss ratio approach is the most common for assigning groups to specific tiers. Although companies use differing numbers of tiers, three to six tiers is fairly standard. The difference in rates from the lowest to the highest tier can be as low as 30% or as high as 100% or more. Often, carriers limit the number of tiers by which a group can move – either upward or downward – each year. Although many companies will move a group only one tier per year, others will move groups more than one tier. Some companies limit downward moves (to a lower rate level) more narrowly than upward moves.

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Seminars on exams

Georgia State University will sponsor examination preparation seminars between October 2 and November 3 on the following courses:

110 140 162
120 150 165
130 151 EA2
135 160 210

For further information, contact Robert W. Batten at his *Yearbook* address, or by telephone at (404) 651-2736.

* * *

The University of Waterloo will conduct examination preparation seminars between September 27 and November 4 in Waterloo and St. Louis on the following courses:

140 161 220 361 441 562
150 162 320 362 445
151 165 342 364 522
160 210 343 440 542

For further information, contact F. G. Reynolds at Box 773, Waterloo, Ontario, N2L 3C1, or by telephone at (519) 886-5232.

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The University of Toronto will conduct examination preparation seminars for the November exam period in various locations on Courses 120, 130, 135, 140 and 150. For more information, contact Professor S. Broverman at his *Yearbook* address.

Renewal rating cont'd

Under a different approach to tiered rating, some companies use diagnostic cost groupings. Here a company analyzes the diagnoses of the claimants in the group in one year, using this as a predictor of future experience, and then assigns the group to a tier based on the diagnoses. Although significant administrative costs are associated with this method, some companies believe it to be cost-effective.

With regard to medical underwriting, it has become fairly common among carriers to increase the number of lives above which a group will be written on a guaranteed issue basis. Thus, by requiring medical underwriting on more groups, a carrier's morbidity experience should improve because more "bad" groups will be either declined or rated up. Some companies now allow a group to be medically underwritten upon renewal to gain a more favorable rate.

I have described three major approaches – demographic rating, experience analysis, medical underwriting – that carriers have implemented to better manage their small-group pools. Other methods also have been tried.

Summary

Whereas life/health insurance companies tended to lead the movement toward a more active role in rating small groups, many Blue Cross/Blue Shield Plans have also made substantial changes. This is a significant departure from the Blues' long tradition of "community rating," which treated all groups the same.

With regard to the six rating principles mentioned earlier, companies clearly are making a concerted effort to give more weight to "equity" and less weight to "simplicity." Any company involved in small group will need to manage its pools in a more active fashion than would have been the norm five or 10 years ago.

The message is clear: Companies will have to become more active in managing their small-group pools, or they will not survive in the small-group market.

Drew S. Davidoff is a consulting actuary with Milliman & Robertson, Inc. He specializes in health insurance consulting and has worked extensively with Blue Cross/Blue Shield Plans, life/health insurance companies, and benefit plan sponsors.

MEC-ing sense out of TAMRA

Features Editor Deborah Poppel recently spoke with Cary Lakenbach, Vice President and Actuary at American Financial Systems (AFS), about TAMRA: the U.S. Technical and Miscellaneous Revenue Act of 1988.

Lakenbach has worked in several insurance companies, most recently as head of life insurance product development at Connecticut Mutual. His current company, AFS, is a consulting firm focusing on the nonqualified benefits marketplace.

***Poppel:** Why was TAMRA, the recent tax law, passed?*
Lakenbach: The law was meant to limit the use of life insurance as an investment vehicle. It was especially targeted to deter the use of single-premium life insurance as a vehicle to avoid taxes on income taken from an insurance contract.

***Poppel:** TAMRA created a beast called a "Modified Endowment Contract (MEC)." What is a MEC, and how is it different from all other contracts?*
Lakenbach: A MEC is a life insurance contract where, to put it simply, the premiums paid in exceed the premiums that would be necessary to pay up the contract in seven years or less.

***Poppel:** How is a MEC taxed differently from a non-MEC?*
Lakenbach: There are three primary areas where an MEC is taxed differently from a non-MEC. First, distributions are assumed to be made out of income first, then principal. Consequently, taxation occurs earlier.

Second, loans are considered distributions, including loans used to pay premiums.

Third, distributions made before the policyholder is 59.5 years old are subject to a 10% penalty tax. This penalty tax never disappears for corporate policyholders, except under very limited circumstances.

***Poppel:** Are there any circumstances when purchasing a MEC is appropriate for a customer to do?*
Lakenbach: There's not necessarily anything wrong with owning a MEC, particularly within the corporate marketplace. MECs are treated like non-MECs in two respects: Death proceeds are still income tax free, and the inside build-up continues unabated. It's when you get distributions that the treatment is radically different.

I like to think of a MEC as a "cash-rich" contract. One reason that a corporation would want to buy a cash-rich contract is that it has a quicker positive impact on its income and balance sheets. Said another way, the more cash-rich the contract is, the less of the cash is going out to fund insurance. Usually, the corporation doesn't care about access to the cash – it has other fully deductible credit lines or other sources of capital.

***Poppel:** How does a contract become a MEC?*
Lakenbach: A contract becomes a MEC if it fails the "7-pay test." This test compares the premiums paid into a specific policy to "7-pay premiums" defined in TAMRA. If the accumulated policy premiums in any of the first seven policy years exceed the accumulated "7-pay premiums," the policy is a MEC.

***Poppel:** What policies are subject to TAMRA and must pass the 7-pay test?*
Lakenbach: Basically, policies entered into after June 20, 1988, are subject to TAMRA. Policies issued before June 21, 1988, are grandfathered and are therefore not subject to the 7-pay test.

***Poppel:** If a policy is grandfathered, is it never subject to the 7-pay test?*
Lakenbach: A policy will lose its grandfathering if it is "materially changed."

***Poppel:** What is a material change?*
Lakenbach: Pretty much what it sounds like – a material change in the provisions of a contract. The most common kind of material change is an increase in benefits, although the law defines certain increases that are not considered material changes. If there is a material change, a new 7-pay test period begins, whether or not the contract changed was grandfathered. Keep in mind that even if a policy is subject to the 7-pay test, it will not necessarily become a MEC.

***Poppel:** Could a material change actually prevent a contract from becoming a MEC? For example, if a term rider is added to a contract the year before it is expected to fail the 7-pay test, does*

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