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EDITORIAL

Rate making under pressure

by Janet Carstens

Periodically, a friend or acquaintance outside the actuarial profession will ask me how insurance premiums are determined. Although I find it much easier to respond when I am asked about health insurance (my area of expertise) rather than property and casualty or life insurance (for some reason, these questions occur more frequently), the answer is not always easy to relay:

> Well, premiums are a function of utilization and cost of services, expenses, and family status. Average costs per category of service are based on what a health plan has negotiated with service providers (e.g., physicians and hospitals). These costs are, in turn, affected by general inflationary trends, new technologies, the cost of malpractice insurance premiums, government regulation (e.g., limits on Medicare and Medicaid reimbursement), etc. Utilization assumptions often are based on average experience across an insured population, adjusted for trend, new technologies, government regulation (e.g., mandatory maternity stays), the aging of the population, etc. Expenses reflect the health plan's cost structure, while single and family rates reflect the health plan's premium rate structure.

Assuming I have held the individual's interest to this point, I then go on to explain that once the actuary has estimated appropriate rates, the health plan may, of course, make further adjustments based on competitive forces, government-imposed limits on premium rate increases, or other business reasons.

Political economist Uwe Reinhardt, quoted in the Feb.17 edition of *The Wall Street Journal*, presents an interesting perspective on how premiums are determined in the health insurance market:

> They (HMOs) have been going for market share, feeling that they need to be big. They compete to see who can offer the lowest premiums, to the point that the marketing people set the rates and the actuaries are sent out of the room. Then they pray to God and their medical directors that they can keep expenses low.

While this is a strong statement, it reflects reality in certain insurance markets today where market share has become a primary concern. What should an actuary do in these situations?

First, the actuary must meet professional demands for the work performed. The actuary can seek guidance from actuarial literature, including the Actuarial Standards of Practice (ASOPs), practice notes, journals, and other publications. Sometimes guidance can come indirectly. ASOP No. 31, adopted in October 1997, relates to documentation in health benefit plan rate making but may provide some guidance on the rate making process itself. Other ASOPs, such as those related to reserve adequacy and data quality, also may provide useful information. Collectively, these ASOPS along with other actuarial literature provide guidance related to establishing adequate premium rates.

State and/or federal regulation such as minimum loss ratio requirements for individual policies and federal and state small group reform legislation may provide guidance as to the limitations the actuary must work within when establishing premium rates.

Finally, the actuary has a responsibility to appropriately communicate to his or her client or employer the components considered in the rate making process and the implications of deviating from the recommended premium rate levels. There is nothing wrong

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ratio less accumulated claims. The interest rate would be statutorily determined each year; adjustments would be allowed for dividends and claim reduction expenses (e.g., access fees). For example, dividends below 5% of premiums could be treated as claims, while dividends over 5% could be treated as a reduction to premiums. After all policies in a pool terminate, a final benefit reserve would be calculated, and this amount could be transferred to either the state or the policyholders.

The NAIC and individual states are addressing some of the issues raised in this proposal. They're doing so in a variety of ways, such as limiting rate differentials between classes of policyholders, making it difficult to enact large rate increases, establishing high risk pools, and improving portability of coverage. Also, HIPAA makes it more difficult to cancel coverage in all states. What seems to be missing is a unified approach that simultaneously protects policyholders against large rate increases while encouraging companies to stay in the market.

I believe that if the above proposal was enacted, some insurers would be willing to provide guaranteed renewable major medical policies and that insureds would receive meaningful, long-term protection. By pooling all policies into one rate base, insurers could only charge select rates for the first few years after enactment (or after they entered the market). Then as each year passed, rates would rise so that all insureds, even newly selected ones, would be paying rates that would allow prefunding of the high costs that will come as insureds become nonselect. Under the second part of my suggestion, if states gave up the right to approve rates, insurers could charge appropriate rates and thus be more likely to stay in the market.

So, for now, as I join the ranks of the uninsured, I look forward to the day when insurers again offer meaningful medical insurance to individuals with long-term needs.

Richard Lake was vice president and actuary with the former Washington National Insurance Co., Lincolnshire, Ill.

Dealing with the puzzle (continued from page 3)

offer maternity benefits for groups of any size in the 2-14 range or for no groups at all in that range; they cannot choose to offer maternity benefits only, for example, for groups of five and up. (Federal law mandates maternity coverage for groups of 15 or more.) Participation and contribution requirements are the only permitted rating variables; they can vary by several factors, including group size, benefit, and marketing method (direct versus agent sales). Our older group law still exists and provides for, among other things, 120 days' continuation of coverage (mini-COBRA) and a conversion policy. Conversion policies — with their minimum benefits and potential cost of 200% of normal individual policy premiums — don't seem to make any sense under HIPAA's portability requirements. This has caused us to question whether the conversion policy requirement should remain.

Arkansas' alternative mechanism

Our comprehensive health insurance pool (CHIPS) covers federally eligible individuals (those covered by a group health plan for at least 18 months) whose coverage, including COBRA but not conversion policies, has terminated with no other eligibility for coverage. Our rates are 150% of unloaded new business rates (gross premiums minus profit and marketing costs), or about 112.5% of actual market rates.

Trying to support the marketplace

An amazing number of new laws have been passed that affects the future of small group health insurance. HIPAA may be the most dramatic, but it's just one among many laws and regulations implemented in the 1990s. Coordinating all of it has been difficult at best. Some of the law was good and needed; portability and guaranteed renewability, for example. Other parts, such as guaranteed issue, were destructive; costs are being imposed, and some companies already have decided they will not play, so they are leaving the small group market.

We hope our group rating law, adjusted for HIPAA, will help support the Arkansas market. We want to hear your ideas.

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with the actuary being "sent out of the room while the marketing people set the rates" as long as the actuary has properly communicated the results of his or her work and the implications of adjusting the recommended rate levels.

In this issue, actuaries address this principle from their own perspectives. Richard Lake describes his experiences with the premium rate setting process for individual health insurance coverage and his suggested solutions to the perceived issues. We also gain a legislator's perspective into compliance with small group reform legislation through an article by John Hartnedy. Happy reading.