SOCIETY OF ACTUARIES

Article from:

The Actuary

April 1998 – volume 32 - Issue 4

The Newsletter of the Society of Actuaries

Vol. 32, No. 4

April 1998

The Actuary

Seeking answers

A health actuary views the dilemmas of individual policies

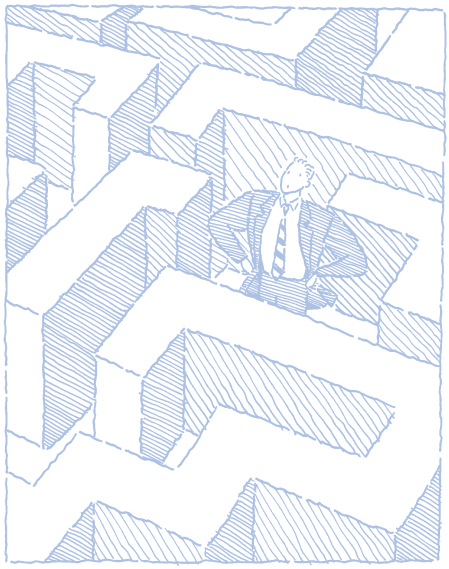
by Richard Lake

I am a health insurance actuary living in interesting times. I have watched all three of my former employers sell their medical lines to other carriers. Now, as I contemplate what to do next with my life, providing health insurance for my family becomes top priority.

I have always viewed my own insurance as a long-term relationship between myself and the insurer. For life insurance, I expect the company to be there 20 to 50 years from now to pay my claim. For disability insurance, although I hope I'll never make a claim, I still expect the company to be there until I retire. For casualty insurance, which many view as short term, I still expect the company to be there long term, and I have stayed with the same insurer for 30 years.

So why do I view medical insurance differently, and why have I joined the ranks of the uninsured? Medical insurance is still a long-term need, since Medicare does not kick in until age 65. Individual medical insurance is likely to be underwritten for the policyholder's health, just like life or disability insurance, and since health can deteriorate, there is an incentive to buy coverage while you are still healthy. But unlike life or disability insurance, some individual health insurance policies for persons under age 65 may be cancelable. And unlike some other types of insurance, health insurance has more than a few cases of sky-high rate increases in its recent history.

For casualty insurance, I don't worry about finding insurance because there are many insurers. I don't worry about becoming uninsurable because this is somewhat under my control (e.g., I don't drink and drive, walk on the roof, or smoke in bed), and assigned risk pools are available for auto insurance. For life and disability insurance, contracts are generally not cancelable by the insurer, so all I have to do is pay my premiums. Yes, premiums on some contracts can increase, but historically these increases have not been extreme. However, with medical insurance, even if my policy isn't canceled, I can be subjected to dramatic rate increases, even if I never submit a claim. I have seen premiums as high as $30,000 a year for a family.



Why rates mushroom

Why are medical policyholders subjected to the possibility of large rate increases?

The reason relates to how medical insurance is bought. Because the purchaser may not understand how health insurance premiums are determined, price often becomes the key decisive factor. Sure, other factors such as the Best's rating, customer service, stability, and benefit differences enter in, but unless the price is in the ball park, all other factors become irrelevant.

Individual life, medical, and disability insurance may be underwritten for

(continued on page 4)

Inside this issue

Seeking answers (continued from page 1)

health where allowed by state law. Those in poor health can be rejected, have their premiums set higher, or have some conditions excluded from coverage. Thus, those who become insured at the lowest rates have been medically selected and are expected to have lower claims. Medical insurance claims in the first year after selection can cost half or less than the claims expected for nonselect persons. In later years, expected claims will rise because some insureds will suffer a decline in their health and become nonselect.

Insurers have learned that to offer the low premiums that buyers want, they only have to initially charge enough to cover the claims and expenses for select insureds. Then, as insureds become nonselect, premiums can be increased to cover the higher claims. Generally, insurers increase everyone's premium, select and nonselect alike, because the insurer does not know which individuals have become nonselect (it is expensive to underwrite each year).

Individual medical insurance has a very high turnover rate. In the first year, as many as 35-40% of policyholders will let their coverage lapse; lapse rates in later years are 25-35%. Much of the turnover results from a family member changing jobs. Employer-based group medical insurance is generally a better buy than nonemployer-based group or individual insurance, so most people beyond the select period will opt for employer-based insurance when it becomes available. People who are employable tend to be healthier than people who are not, so those who drop their individual policies for group health coverage are generally healthier than those who keep their individual policies. Those remaining in the individual pool will include both select and nonselect insureds, and many in the select group will shop around for new coverage because the company has increased their premiums to account for the nonselects' higher claims. Since healthy people are likely to qualify for another insurer's select premium, they can lower their premium by changing insurers. The remaining insureds will be less healthy, and their higher claims will result in the insurer increasing premiums. As premiums rise, more healthy people will leave, resulting in higher and higher rates.

The cancellation catch

Why are individual medical insurance policyholders subjected to cancellation?

Medical claims are subject to medical inflation which is unpredictable and significantly higher than general inflation. This means that medical premiums must rise frequently. In most states, insurance departments reserve the right to approve rates; this sometimes results in companies becoming unable to charge adequate premiums because of either delays in the rate approval process or laws that force unsound rating practices (no matter how socially desirable they might be).

No insurer wants to find itself forced to stay in a business where revenues can become inadequate overnight through a combination of inflation and regulatory action or inaction. Thus, insurers selling individual insurance make their policies cancelable by calling them nonrenewable for stated reasons only, with one of those reasons being that the insurer is canceling all like policies in a state.

Many insurers serve the individual market with group insurance policies, but, when allowed by state law, they may underwrite each individual's medical risk rather than the group's. Because of group conversion laws, these insurers cannot cancel coverage, but because group premium rates may not be subject to the same approval process in these states, insurers can charge adequate premiums. Unfortunately for the insured, the forces that led to rate spirals still exist. While the insured might still be eligible for coverage, he or she might not be able to afford it.

A proposal

So what would make me consider buying health insurance?

Bill Bluhm, in his award-winning paper "Cumulative Antiselection Theory" (SOA 1980-82 Triennial Prize), provided a model for the rate spiral process. The paper strongly suggests that medical insurers should, in a policy's early years, charge extra premiums that would be set aside as reserves for use in later years to pay the excess claims of insureds who become unhealthy. This could result in affordable premiums for those who suffer a health decline, while all insureds would have meaningful long-term medical insurance protection. However, prefunding has been unsalable in a voluntary market because it results in noncompetitive first-year premiums for individual insurance. This leads me to offer a two-part suggestion for the individual market.

First, insurance laws could remove the option of giving price breaks to those in the select period. This could be accomplished by requiring that all individual policies that are medically underwritten for health be pooled for rating purposes and be subject to the same rate table. Premiums would vary only for approved demographic characteristics (age, sex, occupation, tobacco use, etc., but not duration), for benefit differences using appropriate actuarial adjustments, and for legitimate expense differences (commissions, underwriting, and other market expenses).

Next, states could give up the right to approve rates on guaranteed renewable major medical insurance but require that insurers disclose a guaranteed loss ratio for each policy form that is currently being issued. This loss ratio would be required to be equal to or greater than any current applicable minimum loss ratio for that state. Insurers would be required to maintain this loss ratio through claim payments and benefit reserves, with such maintenance being for all forms in the health pool combined and not form by form.

The required benefit reserve would be calculated as: accumulated premiums multiplied by the guaranteed loss

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.

John Hartnedy, life and health actuary, Arkansas Insurance Department, is a member of the NAIC Accident Health Working Group and the Innovative Products Working Group. His e-mail address is *john.hartnedy@mail.state.ar.us.*

Rate making under pressure (continued from page 2)

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.