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LOSS RATIO ANALYSIS

Moderator: FRANCIS T. O'GRADY. Panelists: PAUL JANUS, CHARLES HABECK

1. What does "Loss Ratio" mean?
2. Who uses which "Loss Ratio" tests?
3. What do states currently require? Why are multiple standards appropriate?
4. Is the use of "Loss Ratios" a valid test of product choice from the consumer's viewpoint?
5. Is there a correlation between "Loss Ratio" tests and proposals relative to Life Insurance cost disclosure?

MR. FRANCIS T. O'GRADY: The first question on our agenda, "What does loss ratio mean?" made me wonder if one of our predecessors in the actuarial profession may not have been clairvoyant in giving us an answer to this question. The gentlemen I referred to was a distinguished professor of mathematics at Oxford by the name of Lewis Carroll. Lewis Carroll is of course much better known for his work as an author than as a mathematician and particularly for his masterpiece 'Alice in Wonderland'.

You may recall a scene from that story in which Alice joined the March Hare and the Mad Hatter at their tea party. At one point, the March Hare admonished Alice by saying "then you should say what you mean" to which Alice replied "I do, at least, at least I mean what I say — that's the same thing you know." As with Alice, many actuaries know what they mean when they say loss ratio — and mean what they say, but unfortunately all do not mean the same thing.

Because of prior commitments the March Hare and the Mad Hatter could not accept invitations to appear on this panel so our tea party today will be hosted by three knowledgeable actuaries on this subject who really mean what they say — I think.

First we have Charlie Habeck. Many of you are probably familiar with the article Charlie wrote for Best's Review two years ago called 'Coping with Minimum Loss Ratio Regulations.'

Our second panelist today is Paul Janus. Paul is pinch-hitting for Will Burgess who was not able to attend because of illness. Paul is Chief Actuary of Banker's Life & Casualty and will present Will Burgess' remarks.

Last, but not least, is Bob Shapland. Bob is with Mutual of Omaha, and agreed to join our panel yesterday after I had word that Will would not be present. Bob is an expert on this subject and will give us a hand answering questions and joining in on the discussions. While Alice

couldn't be here today either we are fortunate to have Kathy Corbett who will serve as recorder for this session.

As indicated in the program, Joe Pharr's paper, 'The Individual Health Insurance Loss Ratio' is to be discussed at this session. I will read the abstract of Joe's paper as a reminder to those who have not looked at it recently.

The principle objective of this paper is to remind actuaries of the rather significant misconceptions and distortions commonly encountered in the use of individual accident & health loss ratios. These ratios are used routinely in periodic filings with regulatory authorities, communications within the health insurance industry and discussions among insurance company management groups. Much of the distortion is traceable to the actuarial approach used to reflect active life additional reserve changes in the loss ratios for level premium business. A typical pattern of incurred loss ratios is projected over a reasonable lifetime of a block of level premium individual health insurance policies. These ratios then are modified by 1) changing the active life additional reserve method, 2) adjusting the interest rate assumption inherent in the additional reserves and, 3) using realistic assumptions as to interest mortality, withdrawal, morbidity and underwriting selection in the reserve calculation.

We have set aside some time later in the session in which I will ask if anybody has any discussion of this paper he wishes to present.

There was a concurrent session on the topic of loss ratios at the meeting held in Minneapolis a few weeks ago. That session was moderated by Monte Hopper, who opened the session with a quote from the poem by Sir Walter Scott which was a little more elegant than the one I recited from 'Alice in Wonderland.' The panelists were Spence Kopple, Paul Hansen and Jim Hunt. Through the kind cooperation of Virginia Johnson of the Society's office I was able to get the tape of that session and found much of it to be of interest. I particularly liked Spence Copple's opening statement in his discussion which is short, so I will read it. Spence says "When Monte Hopper first asked me to participate in this panel I hesitated for several reasons. First, I'd much prefer to be in San Diego. But even more than that, I felt that the topic of loss ratios is a very difficult one to discuss. To my knowledge no other concept in actuarial literature looks so deceptively simple and yet is quite as complicated as the concept of loss ratios. A loss ratio is the relationship between benefits and premiums under a policy. Because it sounds so simple everyone thinks he understands it. As a result, unfortunately, it is one of the most misunderstood concepts actuaries have had to deal with."

MR. CHARLES HABECK: Let me begin by attempting to put my contribution this morning in some kind of perspective. I have a quotation also from a famous writer whom I shall not name, but if anyone can tell me the name of this person I will provide two hours of free consulting time.

"Each one who discusses loss ratios may imagine himself to be the first to discuss loss ratios whereas he is always the last term of a preceding series even if the first term of a succeeding one, each imagining himself to be the first, last, only and alone, whereas he is neither first nor last nor only nor alone in a series originating in and repeated to infinity."

This may overstate the case slightly but I think it expresses our debt to the past while recognizing that what we may say today will not be the last word on the subject of loss ratios and that, of the others who speak, many will not be actuaries.

The first question on our agenda is "What does loss ratio mean?" There are two general ways of looking at loss ratios that I would like to explore in my response to this question.

The first way is to consider the loss ratio an absolute measure of the claim experience for a given block of health insurance business during a certain exposure period. This absolute measure is often called the actual loss ratio. The second way of looking at a loss ratio is to compare it to something else.

First, let us examine the actual loss ratio to discover what pitfalls may be met when one tries to interpret particular experience results using this measure of performance. This loss ratio appears in various forms in the insurer's accounting statements. Its meaning in each case depends on how much confidence can be assigned to the amounts estimated for each of its ingredients.

The elements comprising the actual loss ratio can be classified by the degree of actuarial judgement that enters into their calculations. For this discussion three classes seemed convenient. Class 1 loss ratio elements are those about which there is little difference of opinion. These are ledger items like premiums collected and claims paid. Class 2 loss ratio elements may involve a calculation but little or no actuarial judgement is applied to the result once the basis for the calculation has been decided upon. These elements are derived by tabular methods. Examples include disabled life claim reserves and additional policy reserves. The unearned premium reserve usually involves this same kind of straightforward calculation. Class 3 loss ratio elements require considerable actuarial judgement for their proper estimation. A good example is the calculation of the claim reserve and liability when done by the use of developmental methods or lag studies. Questions arise as to how many months of payments should be used to develop the completion factors, how to adjust for seasonal trends, how to allow for inflation, and what to do in the early marketing stages of the product before sufficient loss data are available. Also in Class 3, are estimates of incurred but not reported claims and reserves for deferred benefits or extended benefits, if these items are not part of the lag study results. In order to derive the proper meaning for an actual loss ratio the actuary must confirm the validity of each loss ratio element in all three of these classes.

Two basic questions must be asked. The first, what method was used to obtain this value and the second, how does this differ from what was done in the past. A starter checklist might include questions like the following.

Class 1, or ledger items. How does the company book premium received? Is the insurance service account concept utilized? Are premiums paid directly to the insurer or is there an intermediary (branch office, savings and loan association or a third party administrator)? Have premium rates been increased during the accounting period? Has this been

done on all policies in all states? Finally, in a few cases, are premiums shown before or after dividends?

When is the claim considered paid -- when the draft is dated, when it is mailed, or when it clears? What is the claim payment lag? Is there any sign of a speed up or a slow down? Was there an arbitrary claim payment cutoff date for convenience near the end of the accounting period? Is there a third party paying claims? Have there been any changes in payment procedures? Have key personnel been on vacation or leave or been replaced? Have there been any system's problems?

Class 2, or tabular items. What reserve tables are used? Were these tables assumed in the gross premium calculation? Are they still appropriate? Are the tables based on actual company experience? What method is used for policy reserves? Has there been any change in interest assumptions? How are unearned premiums determined? How does the system handle due and unpaid? In each instance how does current practice compare with that of the past?

Class 3 or estimated items. What retrospective checks have been made? Have results been adjusted for these? What adjustments for the effect of interest if any? How much tinkering is done with the claim reserve after the completion factors have been applied to the paid claims? Is there a special rule or technique for estimating the incurred claims for recent exposure periods? In general, has the method been applied consistently over the years? Have biased estimates tended to perpetuate the bias or is the method self-correcting? Have premium changes been taken into account?

With this kind of approach, one can develop a fair idea of how much confidence can be placed in the stated loss ratio figures for a given block of business. Obviously, if the actuary or other observer is outside the company merely reading published reports, the obstacles to be overcome can be massive.

Once there is a feeling of confidence in the actuarial loss ratio it may be possible to find out what it means. This process typically involves a series of comparisons. Not all such comparisons are valid. It usually makes some sense to compare this year's loss ratio to last year's, unless you're comparing 1979 to 1978 without adjustments. It sometimes makes sense to compare your company's loss ratio to another company's or to the average for intercompany experience. It is most valuable to compare an actual loss ratio to an expected loss ratio if each can be estimated properly. Finally, an actual loss ratio may be compared to a minimum loss ratio established by regulation. In fact, this may be a necessity. However, the results are not always meaningful and are open to ambiguities.

I want to talk about only one of these, the comparison for a certain calendar period of the actual loss ratio as confirmed above and the expected loss ratio based on the assumptions contained in the gross premiums and the actual distribution of business. This is the only comparison that tells you how you are doing with this product.

Note that the expected loss ratio that I mean here has little or no direct relationship to the anticipated loss ratio that was stated in the premium rate filing. This is because in most cases that anticipated loss ratio is determined by the use of a model distribution of issues by age, sex,

deductible benefit period and so on. Since in the absence of subsidies, expected loss ratios will vary for each such exposure cell any deviation from the assumed model will result in a change in expectations. Furthermore, the rate filing loss ratio covers the life of the policy or a cohort of policies. The expected loss ratio used for analysis relates to one or more calendar periods of exposure.

To obtain an estimate of the expected loss ratio for comparison to the actual, an exposure cell first must be created to correspond to each sub-division of the exposure that needs to be defined. If age, sex, family composition, year of issue, policy size and various benefit features can be identified, then a distinct, expected morbidity assumption for each such cell can be applied that will recognize these characteristics. Likewise for each cell the gross premium can be found and applied. From these results expected loss ratios can be determined for each cell and for various subsets of cells grouped as desired. The combination of results for all cells is the aggregate expected loss ratio for that exposure period.

At this point the actual loss ratio can be compared to the expected loss ratio. The comparison can be carried to any degree of refinement that the data allow including analysis by geographical area, state or even agency or production unit. Of course the volume of business must be large enough to merit credibility.

The process just reviewed has always appeared straightforward in theory, but in practice numerous difficulties arise. A good example is the requirement by more and more states that their own experience be shown separately from that of all other states. Many companies have found their system unable to give them this kind of information. Getting actual loss ratios by policy duration is another problem for many companies yet a few states call for this breakdown too.

It is somewhat ironic, considering the resistance to more regulation, that many filing requirements of this kind, if met, would help the insurer manage the business better. Also the problem of gathering exposure and payment data is not a function of the size of the company. Better information systems seem to be needed by companies of all sizes. These systems will in turn allow health insurers to better educate their various publics as to how they are really doing instead of having it the other way around as it now appears to be.

The second question is "who uses loss ratio tests?" and I have just made a list of various users as a survey-type response.

Insurers use loss ratio tests in all aspects of their operations. The actuary of one large health insurance writer counted at least six different loss ratios produced in periodic reports used by the various departments of his company. The difference involved the elements of premiums, claims and reserves. The various loss ratios emerged at different stages of the statistical process. Many companies distinguished first-year loss ratio from renewal loss ratios, separating both premiums and claims. These ratios usually appear on a cash basis using ledger items only in their calculation. A first year cash loss ratio may indicate a questionable situation to the underwriting and legal departments but it doesn't give the actuary much useful information.

Reinsurers use loss ratio tests in the definitions of the risks that are to be exchanged. Such tests can apply to accounting adjustments on coinsured plans or can be set for risk assumptions on stop loss arrangements. Self-insured plans need good estimates of their loss ratio for the same reasons.

Agents study loss ratio results. In one situation I recall the agent studied his company's annual statements and concluded that his territory had been allocated too big a share of the increase in the claim reserve. This element had been allocated based on claims paid in each territory, however very rapid growth in premium volume was being experienced in Florida and Arizona. He reasoned that agencies in these states should receive higher increases and he was correct. The company changed its method.

Insurance departments review loss ratio results at critical points, such as when new or revised premium rates are filed or when there may be a solvency question. Only a few departments appear to be set up to apply continuing tests promulgated in the interest of fairness to the policyholders. But these tests may be seen as valid only for policies with sufficient volume or history to make the experience trends unmistakable.

Consumer advocates are currently using loss ratio tests to demonstrate the need for better consumer information through tougher disclosure rules. They would probably like to bring about greater standardization of health insurance products so that individual purchasers can make direct comparisons of gross premiums.

Auditors became concerned about health insurance loss ratios on those products whose earnings had been restated on the GAAP accounting basis. These products include the more permanent ones that are non-cancellable or are guaranteed renewable. The main question raised by the accountants relates to the concepts of loss recognition and recoverability of the unamortized expense asset. Even where premium rates may be increased the actuary may find that a realistic projection of loss experience will show that recovery is impossible and that even renewal costs cannot be met because of the reduced margins.

Consulting actuaries examine loss ratios for various reasons especially when they have nothing else to do. They even prepare papers and talks on this subject. Trends in loss experience for the non-can market may be studied for instance in the aggregate or for individual companies. A look at the 1979 Argus Chart shows that Provident Life and Accident had a loss ratio in 1978 of about 30% on their non-can business. While Paul Revere's loss ratio on this line was 63%. Also the premium growth of these two companies was quite different. Yet what can the outside observer conclude if anything, without additional information?

In another case I found (again by reference to the Argus Chart) that a particular company's health reserves had jumped considerably in one year's time, much more so than the premium growth would make reasonable. Since they sold the cash value disability policy (which was booming then), I deduced that the reserve on the cash value feature had begun to take off. When I called to inquire about it I learned that the Company had acquired a fairly significant block of mature policies with high additional

reserves. The observed reserve increase had nothing at all to do with the premium refund features of the disability policy.

One more story and then I'll be done. As a follow-up to some pricing work we did on disability income I routinely obtained copies of the company's A&H experience exhibit from the State Insurance Department in order to chart the progress of the plan. The figures in this exhibit seem to show excessively high loss ratios for the first two years they sold the policy in the 65-75% range with no additional reserve impact as yet. I contacted the actuary at the company and expressed my concern that our morbidity assumption had been too low for that plan. His answer was something like this "Don't worry about it, those ratios are wrong. Pay no attention, they don't mean anything." Although I did not pursue the question I learned not to be credulous, but I decided not to be cynical either. In the context of their own elements these figures had a meaning, but not to an outsider.

In summary, let me once again emphasize the need for the user of loss ratio data to carefully examine the context of those data to investigate the sources and trends in each element of the loss ratio. Perhaps these considerations will explain why some departments want both cash and incurred results and they want experience for their own jurisdictions. They may also explain why there are no easy answers for the investment brokers nor for the consumers nor for the congress.

In the construction and interpretation of loss ratio experience the possibilities for ambiguity are manifold. It is important for us as actuaries to make our meanings clear in any discussion of this controversial concept. All we need to do is look around out there to realize that no one else will do it for us.

MR. WILL BURGESS (Presented by MR. PAUL JANUS): "What does loss ratio mean and who uses what loss ratio tests?" My own reaction to "What does loss ratio mean?" brought forth a very fast answer: "Not very much. And the slower answer was: "Not very much." Frankly, my own opinion of loss ratios is that they have some meaning, they mean something to the actuary and the company in aggregate for a block of business in that they tell the company, if they are calculated properly, what margins there are for commissions, for overhead, for profit. They have some varied meaning to the regulator, in that if they are calculated and viewed properly, they begin to give the regulator some idea of what this particular product is providing to the consumer, used by itself the loss ratio can be a very misleading indicator. Actuaries, regulators, especially on the federal level, and the press have gotten into the habit of using the current loss ratio, this year's loss ratio.

The early companies which were organized to issue accident and health (A&H) insurance expanded into various lines of casualty coverage. The present multiple line casualty companies grew out of this introduction of A&H business. A&H insurance was, until 1947, actually classified as a casualty line in the annual statement blanks. It originally followed the casualty pattern of renewal. Policies were typically issued from one to five years, they could be cancelled during the term and they were rewritten by the company at the end of the term. This evolved to renewal provisions which did not give the company the right to cancel the policy during the term but still allowed the company to non-renew it at each

premium due date. When viewed as a short term product, the current loss ratio made some sense. The loss ratio stood by itself for the very short period that it was being considered.

The casualty approach did cause regulators to view this current loss ratio as a yard stick to measure the reasonableness of benefits and premium and much of the legislation that was set forth in the early 50's was based on this kind of yard stick. However, today a current loss ratio is an inadequate and misleading measure of the experience and value under a class of policies. The issues involved are fundamental to responsible premium development. Unfortunately many regulators and consumers do view current loss ratios as a measure of the reasonableness of benefits to premiums. Why? For one thing, it is available in the annual statement and the policy experience exhibit. Except for data supplied at specific requests of the regulators or various other consumer bodies or data supplied at the time of rate filing, there is no other data available on easy basis to the regulators or to the consumer agencies. It takes time for a state insurance department with a limited staff to go through the A&H policy experience exhibit of companies writing A&H in their states and to zero in on the current loss ratio which might be low. It provides a means of opening a dialogue with companies as to the reasonableness of benefits to premiums on specific forms.

In 1978 the NAIC appointed a task force on the uniform reporting of A&H business. This task force was charged with developing recommendations for changes in the various blanks so that A&H reporting schedules were consistent. The Industry Advisory Committee to the task force conducted a detailed review of the manner in which A&H is reported in the various blanks concentrating on areas where there were obvious accounting differences. The committee concluded that Schedule H should be the best vehicle to use in achieving the uniform reporting on A&H. This led to completely revising the format of Schedule H. To achieve uniformity the new format was incorporated appropriately in the life, A&H, fire & casualty, fraternal and hospital and medical blanks. In formulating this revised format, the principle was followed that instead of using additional reserves or active life reserve in determining earned premium, any changes in additional reserve would be used as a deduction from underwriting gain.

The A&H policy experience exhibit was revised to conform with the changes in Schedule H by providing loss ratios defined as incurred claims plus increase in policy reserves, as a percent of premiums earned. The effect of including the increase in policy reserves in the numerator rather than the denominator of the loss ratio is to dampen the effect duration has on the loss ratio curve and thus flatten the curve. Because of this leveling effect, a better relationship is presented with the ultimate loss ratio to be experienced.

Another reason for treating the increase in policy reserves in the numerator, or as an expense, is that this is the part of the pie or premiums that is either paid to or set aside for the benefit of the policyholder and should be reflected in reports which show what portion has been provided for the policyholder. The premiums are the entire pie, what the policyholder paid for his coverage.

At the NAIC meeting in June 1979 the recommendations of the industry advisory committee were adopted and were effected in the 1979 annual statement.

Cumulative loss ratios rather than current loss ratios are also viewed as yardsticks to measure the reasonableness of benefits to premiums. However, these are also inadequate and misleading measurements. They do include the sum total of all the experience to date under a class of policies and as such are viewed by many consumers and many regulators as a measure of the reasonableness. They provide a better means than the current loss ratios of opening dialogue with the companies as to the reasonableness of benefit to premiums but they are not the end themselves.

A more meaningful loss ratio is the anticipated loss ratio, the ratio of benefits to premiums over the entire period for which rates are computed to provide coverage. This provides to the regulators, the consumers and the insurers an estimate of the portion of the premium dollar which will be used for benefits. By determining these loss ratios at periodic intervals, estimates can be made of the adequacy and reasonableness of the premiums based on such analysis and policy forms can be selected for in-depth profitability analysis.

"What do states currently require and are multiple standards appropriate?" Earlier, broadly stated state requirements as to the reasonable relationship between benefits and premiums could be met by declaring that such a relationship was reasonable for a specific policy form. In a number of states it was also necessary to meet a specific benchmark loss ratio most commonly set at 50%. This is still generally true but there are a number of exceptions and the exceptions are growing.

Current minimum loss ratio regulations set more demanding standards. Some of the characteristics of the current trend are: 1) specified loss ratios may vary by benefit type, renewability, issue age range or initial filing versus rate revision, 2) actuarial support for loss ratio estimates may be required and, 3) the definition, or lack thereof, of loss ratio may vary from state to state. Some of the states with specific loss ratio requirements follow.

New York requires a 50% loss ratio for individual health with some exceptions, a 60% loss ratio for franchise health and a 65% loss ratio for group and blanket insurance with an exception for groups of less than 50 at inception. For individual health, the minimum loss ratio is 45% for specified perils or short term coverage. Also it may be 45% for accident only and 40% for combinations of accident only with specified perils or short-term coverage. For issue ages 60 and over the minimum loss ratio is 60%. The individual health benchmark is also increased when rate increases are effected for existing business but no target loss ratio is specified. In New York the company is required to submit anticipated loss ratios. This is defined as the present value of all expected future benefits excluding dividends divided by the present value of all expected future premiums. The anticipated loss ratio must meet the minimum standard, and must be provided to an insured either at the time of application or upon policy delivery. It is to be included in a required disclosure statement which includes a brief summary of the policy.

Michigan has minimum loss ratio standards which vary as follows: 1) 65% for issue ages 65 and over, 2) 60% for collectively renewable or optionally renewable business, 3) 55% for guaranteed renewable or a non-renewable for stated reasons, 4) 50% for non-cancellable coverage or individual accident insurance and, 5) 55% for all other insurance. Exceptions may be considered if a reasonable relationship between benefits and premiums can be demonstrated.

Actuarial support and recent experience are required with all rate filings. In Michigan the anticipated loss ratio means the ratio at the time of the policy filing or at the time of subsequent rate revisions of the present value of all expected future benefits excluding dividends to the present value of all future premiums, less dividends, based on a credible premium volume, over a reasonable period of time with proper weight given to trends and other relevant factors.

Pennsylvania requires at least 50% as the anticipated loss ratio on new filings (45% for industrial policies) as well as an actuarial memorandum. For rate revisions, the minimum loss ratio is 60% (55% for industrial policies). Considerable statistical support must be submitted to back up rate increases.

The anticipated loss ratio is defined as 'anticipated to be accumulated over the entire period of coverage.' The Pennsylvania regulations provide that the department will examine a request for rate increases on an individual basis as appropriate. It is realized that there are many factors relative to a determination of a reasonable loss ratio for any given coverage. A minimum experience period of three years will be required prior to approval of any substantial rate increase.

Florida uses a 65% loss ratio test for the life of the contract. A short range test covering three years of experience requires a 55% benchmark for all individual A&H policies. For policies that contain accident-only benefits, an anticipated loss ratio of 55% is considered reasonable; 45% on industrial A&H; and 40% for industrial accident only. These tests are applied to existing business when rate increases are filed. New filings have the same requirements and expected loss ratios must be given by policy year for the first ten years. Actuarial support is required.

In Indiana the minimum anticipated loss ratios are internal guidelines used to establish the presumption that benefits are reasonable in relation to premiums. They are 50% for specified disease, accident only and non-cancellable, 55% for all other policy forms and 60% for all policies sold to persons age 60 and over. The anticipated loss ratio at issue is defined as the present value of future benefits divided by the present value of future premiums.

Massachusetts has a similarly complex loss ratio guidelines as well as New Hampshire and several other states are beginning to adopt similarly different guidelines. Each of these states has gone a slightly different route with a slightly different definition of loss ratio, or a slightly different definition of anticipated loss ratio. The NAIC has attempted to develop a model regulation with the help of an Industry Advisory Committee and that has helped to some extent. Some states have adopted that, or are beginning to but there is still the individual stamp on each state's

regulation. It is clear from these regulations that many of the states use these as the sole guideline.

The proliferation of these requirements has been greatly compounded by the individual differences in requirements among the 50 states. Because of the interest in this subject on the part of many states an HIAA sub-committee commenced work on the design of a vest pocket model guideline dealing with the general subject of the relationships of benefits to premiums which were used in a few instances as feeler offers to states contemplating regulation of this nature.

In June 1977 the NAIC Life and A&H Technical Sub-Committee began discussions on the subject. The HIAA Sub-Committee resurrected the draft of the vest pocket model guideline as a starting point and it evolved to the NAIC guidelines for filing rates for individual health insurance forms adopted by the NAIC in December 1979. The salient features of these guidelines are that the guidelines require rate filings when new forms are submitted for approval and when rates are revised. Any rate filing must include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the anticipated loss ratio which is defined as the present value of expected benefits to the present value of expected premiums over the entire period for which the rates are computed to provide coverage. Interest shall be used in the calculation of these present values only if it is a significant factor in the calculation of this loss ratio. Each rate submission must include a certification by a qualified actuary that to the best of the actuary's knowledge and judgement the rate filing is in compliance with the applicable laws and regulations of the state and that the benefits are reasonable in relation to premiums. Filings of rate revisions shall also include 1) a statement of the scope and reason for the revision, an estimate of the expected average effect on premiums and the anticipated loss ratio for the form, 2) a statement as to whether the filing applies only to new business, only to in-force or both and the reasons, 3) a history of the experience under existing rates, and 4) the date and magnitude of each previous rate change. Insurers shall maintain records of earned premiums and incurred benefits for each calendar year for each policy form on the same basis as required for the A&H policy experience exhibit. Data for the calendar years prior to the most recent five years may be combined. Section 1E of the report described relevant factors which are to be used in evaluating the experience data.

Section 2 of the model regulation states that with respect to a new form under which the average annual premium is expected to be at least \$200, benefits are presumed reasonable in relation to premiums provided the anticipated loss ratio meets prescribed minimum loss ratio standards. The minimum loss ratio varies according to the type of coverage, renewability and the expected average annual premium. The use of these characteristics as variables in minimum loss ratio standards and the actual standards were determined and agreed upon after extensive deliberation and discussion within the HIAA sub-committee. Other interested members of the health insurance industry and the NAIC Technical Sub-Committee also participated.

The minimum anticipated loss ratio is 60% for optional renewable policies with an expected average annual premium of at least \$200. This is the situation which requires the highest minimum anticipated loss ratio. Lower percentages apply for other types of renewability classes more

restrictive on the insurance company reflecting the higher contingency margins needed. Lower percentages also apply when the expected average annual premium is less than \$200, reflecting the higher portion of the premium dollar needed for expenses that don't vary with the premium. For guaranteed renewable and non-can business, higher minimum loss ratios are specified for medical expense plans than for other types of coverages, reflecting in general, the higher underwriting claims and commission expenses usually associated with disability income.

As an example the minimum anticipated loss ratio standard for a guaranteed renewable policy with an average annual premium of \$200 or more would be 55% for a Medical Expense policy and 50% for other types. For an average annual premium of \$100-199 the percentage would be 5 points less, and for an average premium of less than \$100 an additional 5 points less.

The minimum anticipated loss ratio is 60% for Medicare Supplement plans regardless of renewability and annual premium. This is consistent with the recommendation of the NAIC Medicare Task Force.

A notable feature is the use of a double test for a proposed rate change on the existing business. Both tests would have to be met. The first test is performed by computing the ratio of the present value of the projected future benefits to the present value of the projected future premiums. This must produce an anticipated loss ratio at least as great as the prescribed minimum loss ratio standard for a new form. The second test is performed by computing a loss ratio based on combining past experience and projected future experience. This must also produce a loss ratio at least as large as the prescribed minimum loss ratio standard for a new form.

With respect to rate revisions which apply to new business the anticipated loss ratio must be at least as great as the prescribed minimum loss ratio standard for a new form.

The guidelines don't prohibit rates that would produce lower anticipated loss ratios than the prescribed minimum loss ratio, however, such lower anticipated loss ratios would require justification based on the special circumstances that may apply. Several examples are listed in the model regulation. One of the factors requiring special consideration reads: 'forms issued prior to the effective date of these guidelines.' The NAIC Technical Sub-Committee discussed this very thoroughly and decided that such forms required special considerations but should not be excluded from the guideline. For example a company might have a block of business which had developed favorable experience consistently for many years prior to the effective date of the guideline. A problem could exist if the experience on these forms is deteriorating but the company has dissipated all the profits generated by the favorable past experience. The guidelines would give the commissioner authority to allow a rate increase based on a lower anticipated loss ratio than the prescribed minimum in order to keep the company in sound financial condition.

The guidelines include a checklist of things to provide and minimum requirements as to the documentation of rate filings. The objective of this checklist is to provide a meaningful and flexible but uniform approach to these filings so that the filings would benefit both regulators and health insurers.

The proportion of premium required for expenses cannot be determined by a simple overall index, nor can the proportion remaining to provide benefits to the policyholder be determined in that way. However, the minimum standards given in the NAIC guidelines, which relate premiums to benefits over the entire period for which rates are computed to provide coverage and vary by type of coverage, are a measure of service to the policyholder. They are standards that appear reasonable and room is allowed for justifiable deviation. They tell the regulators and insurers that, viewed cautiously, certain rates may be presumed reasonable and expected to return at least a certain percent to the policyholder while others will be subject to greater justification.

The reasonable NAIC guidelines adopted last December will now hopefully begin to be adopted by individual states. This would provide some uniformity in reasonable loss ratio requirements which would be a welcomed relief to the proliferating loss ratio requirements of the individual states.

"Do loss ratios provide a valid test of product choice for consumers?" The answer simply is "no." Loss ratios are one test of product choice for consumers but a very poor one, then only in attempting to relate the reasonableness of benefits to premiums on a broad basis. Because of the many factors which are involved in the determination of premiums for health insurance and hence should be involved in the determination of reasonableness of benefits to premiums, the use of any statistical device must be examined carefully to ascertain whether proper consideration has been given to these factors.

Expected claims should be estimated for that particular individual who is buying the insurance with a consideration of the trends and underwriting practices as well as past experience and assumptions made for the expense of developing, selling, underwriting issuing and administering the policies and for taxes paid to Federal, state and local governments. In the aggregate, at least, lapse rates are very important to the calculation of health insurance premium, and interest rates must be assumed over the period covered by the premiums.

A reasonable margin must be built in for the profit and for fluctuation in unpredictable variations which may be encountered. The premiums should maintain reasonable equity among classes of policyholders and consistency among various plans of coverage. They must also recognize the intense competition among health insurance. Important in viewing loss ratios as a valid test of product choice for consumers is recognizing that every consumer is different and is looking for a different product for a different purpose. It is very possible, in the aggregate, for a company with a lower premium rate to also have a lower loss ratio for the same coverage. That may be true because of the geographical mix of its business, the persistency rates which it has achieved compared to another company, or the age mix of the business. The higher the age, the higher loss ratio is possible because higher premiums are possible. One looks at a particular company's loss ratio as a measure of what value it is providing. It will provide no benefit to the consumer in determining what value he is getting for his particular purchase.

A consumer purchases a policy for a particular point of view, for a particular period of time. Lapse rates really don't play any great role

in his particular choice. He doesn't care if Joe lapses his policy. That's his choice. He knows he's going to need the insurance for 2, 3, 5 or 20 years. The loss ratio standard provides some very misleading gimmicks or misleading interpretations. A Major Medical policy with a very high deductible will develop a much lower loss ratio than a Comprehensive Medical Expense policy. A long term disability policy with a seven day deductible will have a much higher loss ratio than the one with a 180 day deductible. A company which specializes in one activity versus another may be penalized by a comparison of loss ratio as a value measurement. As I said before, even if the benefits are identical, the loss ratio that one company is achieving on its block of business in the aggregate may not be indicative of the values to the particular policyholder.

Some companies underwrite differently. Some issue guaranteed issue policies and others have rate classifications and therefore sub-standard rates. Obviously, the standard and sub-standard policyholder will be better off by buying a policy from the appropriate company in spite of each company's loss ratios which may differ. The company that issues guaranteed issue should have a higher loss ratio, other things being equal because it has fewer underwriting costs, yet that would not be the best buy for the standard policyholder.

All of this may seem obvious to us here but it doesn't seem to be obvious to the press or to a number of regulators who perhaps have not had an opportunity to think through the problem and the attempt of the NAIC task force and the HIAA advisory groups to provide a reasonable means of attacking the problem from a regulation standpoint. There is still an educational need as far as the press and other regulators are concerned in terms of press releases and talking about loss ratios as buyers guides.

Is there some correlation between loss ratio standards and cost disclosure standards that exists in life insurance? The answer is "yes" and "no." Yes in the sense that they both attempt to apply a statistical measure. No in the sense that life insurance cost disclosure develops a cost per \$1,000 of insurance, whereas a loss ratio is saying-for the premium you pay what percentage of it are you going to get back in benefits. There is a significant difference. If life insurance companies were measured on their current or cumulative loss ratios they would suffer greatly although if they were measured on their anticipated loss ratio over the life of the policy they would show a very favorable result. I don't suggest either one of those but it does illustrate why these two types of measures are different. If a measure which develops the average premium that a person would pay for specific benefits were calculable and it is very difficult to do for health insurance, it would be preferable to the loss ratio standard.