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RECENT DEVELOPMENTS IN HEALTH INSURANCE MINIMUM LOSS RATIO REGULATION

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1. The NAIC Minimum Loss Ratio Guidelines

   a. What is the background of the guidelines implicit in the industry committee report from which they were derived? What is the thinking and actuarial basis underlying the varying ratios?

   b. Are the guidelines sufficiently equitable and flexible to make reasonable provision for expenses, margins and any other considerations:

      1) By class of business?

      2) By average size premium?

   c. What problems arise because of retroactive provisions in the guidelines?

2. Loss Ratios Viewed from the Regulatory Side

   How satisfactory are loss ratio guidelines as a regulatory tool? What regulatory problems or deficiencies exist in relation to loss ratio guidelines from the viewpoint of the regulator?

3. Recent Developments in Certain States

   What are the problems and implications for the health insurance industry arising as a result of recent regulatory actions or proposals in:

   a. New York?

   b. Washington?

   c. Other states?

MR. SPENCER KOPPEL: Our first speaker today is Will Burgess. Will is Vice President and Senior Actuary at Bankers Life and Casualty. He has had 30 years of experience with Bankers, one of the largest writers of individual health insurance. Will has been heavily involved with the actuarial, risk, and benefits aspects of government and industry relations for the last ten years. He was also heavily involved in the development of the current NAIC Guidelines from the very start to the finish. Will is going to give us some background on the NAIC Guidelines with his indications of how they should and can be used.

MR. WILLIS W. BURGESS: 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 benefit loss ratio test most commonly set at 50%.

Current minimum loss ratio regulation sets 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 vs. rate revision.

2. Actuarial support for loss ratio estimates may be required.

3. The definitions, or lack thereof, of "loss ratio" may vary from state to state.

The proliferation of these requirements has been greatly compounded by the individual differences in requirements among the 50 states. For this reason, the HIAA became involved several years ago with guidelines for the filing of rates and for the reasonableness of premiums in relation to benefits, in many of these states.

Because of the interest in this subject on the part of many states, an HIAA subcommittee commenced work on the design of model guidelines dealing with the general subject of the relationship of benefits to premiums, which were used in a few instances as "feeler offers" to states contemplating regulations of this nature.

In June 1977 the NAIC (C4) Life and A&H Technical Subcommittee began discussions on the subject. The HIAA subcommittee resurrected the draft of the model guidelines as the starting point for discussion, and it evolved in to the NAIC guidelines.

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 indicate and describe the calculation of the "anticipated loss ratio", which is defined as the ratio of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are expected to provide coverage.

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 type of coverage, renewability, and the expected average annual premium. The use of these characteristics as variables in the minimum loss ratio standards, and the actual standards, were determined and agreed upon after extensive deliberation and discussion within the HIAA subcommittee, the NAIC (C4) Technical Subcommittee, and other interested parties, and exposure both to state regulators and the health insurance industry.

The minimum "anticipated loss ratio" is 60% for optionally renewable business 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 clauses more restrictive on the insurance company, reflecting the higher contingency margins required. 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 noncancelable business, higher minimum loss ratios are specified for medical expense plans than for other types of coverage, reflecting in general the

higher underwritng, 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 five points less, and for an average annual premium of less than $100, an additional five 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 and the standard included in the Baucus Amendment.

The table of benchmark loss ratios used as the initial test of reasonableness of premiums involves several dimensions, which do not encompass all possible nor all reasonable dimensions, nor do they provide for changing economic conditions.

The guidelines don't prohibit rates that would produce lower anticipated loss ratios than the prescribed benchmark loss ratio standards. However, such lower anticipated loss ratios would require justification based on the special circumstances that may apply. The guidelines give the following examples of coverage requiring special consideration:

(a) Accident only;
(b) Extraordinary expense;
(c) High risk of claim fluctuation because of the low loss frequency, or the catastrophic, or experimental nature of, the coverage;
(d) Product features such as long elimination periods, high deductibles and high maximum limits;
(e) The industrial or debit method of distribution; and
(f) Forms issued prior to the effective date of the guidelines.

One of the factors requiring special consideration reads: "forms issued prior to the effective date of these guidelines". The NAIC agreed that such forms required special consideration but should not be excluded from the guidelines. For example, a company might have a block of business which had developed favorable experience consistently for many years in the past prior to the effective date of the guidelines. 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 loss ratio standard.

Despite the caveat in the guidelines covering "forms issued prior to the effective date of the guidelines", there is a significant feeling within the health insurance industry that the caveat is not strong enough and wrongly puts the insurer at the mercy of the regulators on business issued prior to the effective date of the regulation. It is changing the rules in the middle of a game where stakes are high. Charlie Habeck will touch base briefly on this in his remarks.

The proportion of premium required for expenses cannot be determined by any simple overall index, nor can the portion remaining to provide benefits to the policyholder. However, the benchmark 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,

renewability and average annual premium) are a measure of service to the policyholder. They are standards that appear reasonable, and room is allowed for justifiable deviations.

They tell the regulators and insurers that, viewed cautiously, certain rates may be presumed and expected to return at least x% to the policyholder, while others will be subject to greater justification.

It is of concern to health insurers that rates producing lower anticipated loss ratios than the prescribed minimum loss ratio standards in the guidelines be given full consideration based on proper justification and any special circumstances that may apply. As with all commodities and services provided by private enterprise, prices must cover all appropriate costs and provide a reasonable investment return on the risk capital involved. In a regulated industry, prices higher than this would be unfair to consumers while lower prices would be unfair to sellers and could lead to discontinuing of their efforts. The ultimate test of the fairness of any premium level is whether or not it reflects appropriate costs.

MR. KOPPEL: Our next speaker is John T. Gilchrist. John is Life Actuary with the California Department of Insurance. John's responsibilities include financial examinations, and examinations of all non-routine A&H filings for rate increases, and rate filings in general. John tells me he is the one to blame when your request for a rate approval is denied. John will now give us the regulator's view on the use of loss ratio guidelines.

MR. JOHN T. GILCHRIST: These comments are personal in nature and are not intended to represent the views of the California Department.

By the nature of his calling, the regulator is required to look at outstanding problems from a point of view different from that of the company actuary. Both must put first and foremost the necessity for the company to be solvent and for premium rates to be adequate; but thereafter their viewpoints diverge. The company actuary is involved with competitiveness, reasonableness and saleability. The regulator is involved with public opinion, consumer concerns and dissatisfactions, and what the consumer considers reasonable and equitable. The viewpoints need not conflict, no adversary relationship is necessary, and I think it is well within our actuarial expertise and competence to arrive at an equitable balance.

Much of the concept of rate regulation revolves around the concept of loss ratios. These have much to commend them, in that they indicate how much benefit the policyholder is getting for his dollar. It is a clear and readily understood measure, and one that I think makes sense to the public. A policy with a 60% loss ratio is preferable to one with a 40% loss ratio. Many actuaries may not agree, and maybe from a technical standpoint it is not really so, but no measure seems to be available which is as clear to a policyholder. The ratios of actual to expected are useful but it is quite difficult to see what meaning can be derived by the public, or actuaries, for that matter, from one company's ratio of actual to expected being 110% vis-a-vis another's 120%. So it looks as though loss ratios are here to stay.

The phrase "loss ratio" does not have unique meaning. It is useful to keep in mind that some loss ratios cover the entire policy lifetime, others just a year. The actuarial approach is the former, the public's the latter. Therein lies much misunderstanding. Sometimes I even wonder if our actuarial

training has left a blind spot. It is very difficult to understand other viewpoints when one's training is in present values of future events, asset shares and so on. We may have overall reasonableness, but have we not lost equity between policyholders, or forgotten to include it?

To illustrate, a plan may well have a select period, with losses as percentage of premium of say 30%, 60% and 100% by year. Or, by virtue of aging, a first year cost before selection of say 50% of the lifetime level premium. There can be gross overcharges by duration for some years, with undercharges in later durations. Promises to repay the overcharges have a somewhat dubious value. A seventy year old Medicare policyholder cannot be expected to get excited over the prospect of substantially increased payouts when he reaches 85 or 90, especially when premiums are going to be increased along the way. The numbers may be sound but we really cannot expect the public to buy such a package.

Medicare Supplement plans are a relatively simple example of what is happening. For example, one company requested a rate increase even though they had experienced no claims, just because Medicare deductibles had gone up. Some filings use the reasoning that since actual to expected was 150%, rates should be increased 50%, even though the actual was only 30% compared with an expected of 20% of premium. Another filing showed loss ratios by year of 10%, 28.7%, 35.3% and 42.9% and wanted an immediate and substantial rate increase. All of these may have good actuarial reasoning behind the requests, but as a policyholder would you be satisfied? The policyholder says that he wants a reasonable return on his money now, we tell him to wait, and I doubt if he believes our promises.

It seems to me that the policyholder should receive benefits each year commensurate with his premium payment. These benefits do not necessarily need to be claim payments, but in some tangible fashion, something that he can see and understand rather than vague actuarial formulae. We do not seem to be doing this. It would seem that our actuarial talents should be directed toward a levelling of benefits available each year. Premiums are now loaded to be net level, and then there is an expense loading, and neither load is of noticeable benefit to the policyholder. There is even a hidden double loading as the load for net level is also loaded further for a percentage of expenses.

From time to time various suggestions have been made on how benefits can be levelled. Some of them are:

(a) Provide for preliminary term of one year or less, the reserves to be available to the policyholder in benefits or cash. Does this remind anyone of Elizur Wright?

(b) Provide for participation through dividends. Illustrative dividend schedules may give the policyholder a little more hope for getting something back in the future.

(c) Eliminate the level premium principle, and return to yearly or trienially renewable term plans.

(d) Provide for a guaranteed return every few years of a percentage of premium less claims on each policy.

(e) Redefine reserves as a percentage of premium, varying possibly by first year and renewal, less incurred claims rather than the present tabular basis. On termination, possibly some return of the reserve could be made to the policyholder.

Actuarial ingenuity will surely suggest many more approaches. A fresh approach to the problem, incorporating the public's conception of equity seems to be required to be brought into our actuarial deliberations.

A further responsibility of the regulator is one that is seldom voiced, maybe even seldom considered by regulators, and that is to keep it simple. Vast arrays of data can be requested, the preparation of which involves enormous cost. Then the regulator has to spend all kinds of time studying the submission. Then questions, more data and more study time, almost ad infinitum. Also sometimes overlooked is that when a regulator asks for information, he will get information. If a schedule is to be filled out with numbers, it will be filled out with numbers, maybe randomly generated, but nonetheless numbers. I wonder at the projections, asset shares, incurred losses, loss reserves, expense allocations, all broken down into such minute parts - all that time and labor and expense. The policyholder must bear the cost ultimately. Cannot we as actuaries tame the monster of technical sophistication and produce a measure of the fairness of a premium that does not require such a burden to be placed on a helpless public? I think we all have a real challenge for our abilities, and a very real obligation to the public to meet that challenge, and I cannot see why we should not be able to do it.

MR. KOPPEL: Our last panelist is Charlie Habeck, a Health Insurance Consultant with Milliman & Robertson in Milwaukee. Charlie has been affiliated with M&R since 1964, and has written a number of articles on health insurance with emphasis on the regulatory impact on marketing and on pricing. Charlie is going to give us a handout which is an especially valuable bibliography of available material on loss ratios and then present his views on the usefulness of each as well as the workability of the NAIC guidelines.

MR. CHARLES HABECK: Loss ratios! Last year this same topic was discussed in San Diego in June and in Minneapolis in May. This year we go at it again. I have the feeling that there is nothing new to say on the subject. It is almost a case of deja vu. Almost, but not quite.

I am going to begin in the same way I did last year. Then I shall go over the items in the reading list. After that I'll spend some time on the problem areas I see with the NAIC guidelines for rate filings and with loss ratios in general as a regulatory measure.

To allow the proper perspective on the scope of my contribution to this discussion of loss ratios, let me paraphrase the words of a famous writer:

"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 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.

Now if you look back to last year's transcript in the Record for San Diego, you will find that I offered two hours of free consulting time to the person who could identify that quotation, adapted as it is to refer to loss ratios. I now repeat that offer. But with an extra 52 minutes tacked on. This extra time represents 43.6% of the original two hours. This result appears reasonable, in my opinion, since 43.6% is the aggregate rate increase put into effect this year on the Prudential C.H.I.P. policy.

Let's begin by looking at the material you have received by now. First, there is a reading list for loss ratios. The other two pages relate to the Life and Health Compliance Association. They meet next month in Kansas City as you can tell from the back page. This association specializes in compliance problems. I am told that they have developed a summary of all the loss ratio requirements of the various states. I can't tell you any more since I am not a member. The reason I include this material is because it may be of interest to some of the western companies that may not have heard of it.

Most of my allotted time will be spent going over the items in the reading list. I am tempted to say that everything you need to know about loss ratios is contained in this list -- but I know that it's not true. There are 12 items in the list.

(1) Habeck, Charles, "Coping with Minimum Loss Ratio Regulation." Best's Review (L/H) 79 (May, 1978), 19+. Discusses various state requirements (at time of publication) and definitions of "loss ratio," including marketing and actuarial implications. May be out of date in places.

This is an article I wrote for Best's in 1978. At that time the volume of loss ratio regulation was increasing rapidly with wide variation by state. Most of my information came from HIAA bulletins, but I called the insurance departments of about eight states just to be sure of the facts. Two of these states were omitted from the final draft because changes had already occurred or were in progress. The need for more reasonable guidelines than the use of a single loss ratio test was becoming apparent. It was pretty obvious even then that the days of selling Medicare Supplements with 80% first year commissions and 25% renewals were coming to an end.

(2) Concurrent session: "Individual Health Insurance" (Chicago, October, 1978) in Record, Society of Actuaries, Volume 4, Number 4, pages 891-906. (Frankovich, Houghton, Thexton, Shapland). This discussion contains a progress report on the NAIC rate filing guidelines (Thexton), problems associated with reserves (Shapland), and presentation of paper on the 1974 Medical Expense Tables (Houghton).

Ernie Frankovich was the moderator of this session. Peter Thexton spoke on the background of the NAIC loss ratio guidelines. He noted that flexibility was one of the goals. A number of questions were raised.

Bob Shapland discussed reserves. He pointed out some key differences between life and health "environments". He saw certain inconsistencies between current reserve methods and more realistic reserves. He called for a new definition of the purpose of active life reserves. One of his main points was that reserves must be made to better fit the marketing characteristics of the product, including its underwriting and pricing. He describes some tests that show the possible range.

Paul Barnhart commented at this session that "in the United States there is a decrease in confidence on the part of regulatory authorities in the professional competence and judgment of actuaries". He contrasted this trend with that in Canada. (Note that this theme reappears in Item (5) where the term "manipulation" is used more than once.)

The final speaker, Tony Houghton, presented his paper on the new A&H reserve tables. He took up the question of inflation and how to provide for individual differences among products and companies. This session constitutes an important reference on the subject of loss ratios.

(3) "Health Insurance Policies: Why It's Hard to Pick a Good One." Changing Times 32 (December, 1978): 6-11. A simplified explanation of "loss ratio" appears on page 9. Author states that loss ratio does not "tell you which kind of policy is best for you", but concludes that "all other things being equal, you're better off with the 60% contract (than with one with 50% loss ratio)."

This article is one of the better prepared, popular treatments of the health insurance industry that one is likely to see. I got involved briefly when one of the editors called me -- he had seen my article in Best's -- and asked what a proper commission would be for an individual health insurance policy.

I replied that as I was an independent consultant, I could not provide an opinion on a controversial subject of that nature. Besides which, I couldn't think of a short answer that would be quoted accurately. I referred the writer instead to the annual statements of insurance companies as filed with the state departments. I was impressed with the scope of the final result but I'm not so sure that a loss ratio in excess of 100% deserves the praise it is given.

(4) Pharr, Joe B., "The Individual Accident and Health Loss Ratio Dilemma". Transactions, Society of Actuaries 31 (1979), pages 373-387. Discussions by Claude Y. Paquin, W. H. Odell, and E. Paul Barnhart, page 389-406.

Joe Pharr's paper seems to be a real breakthrough on this subject. The author contrasts loss ratio patterns under varying sets of assumptions and provides illustrations of the range that is possible. The need for a uniform definition is perceived.

In his discussion Claude Paquin takes exceptions to this perceived need for uniformity, because, he says, it means more regulation, something we do not need. Bill Odell takes up the factors that affect loss ratios, classing some as "spurious" and others as "service" factors. Annual statement requirements are also discussed by Mr. Odell, as well as the difficulties of adjusting for interest.

Paul Barnhart states here that the anticipated loss ratio method used in the policy filing must be the guide for subsequent loss ratio calculations; present values must be used, for instance, if they were used originally to define the qualifying loss ratio. He further shows how the active life reserve adjustment can be made unambiguous: it may simply be omitted from the calculation of both the cumulative actual loss ratio and the expected loss ratio.

This paper may have had some effect on the draft of rules to implement the Baucus Amendment (Item (9) below), although Joe Pharr, in his closing response

to the discussion, clearly states that he did not intend to imply that "valid measurements of experience loss ratios require determination of active life reserves on realistic bases", (page 406). He points out that in more than one state there is an interest in relating data filed in statements to that contained in premium rate filings.

(5) NAIC "Guidelines for Filing of Rates for Individual Health Insurance Forms". Adopted by NAIC in December, 1979. May be in process of revision at this time.

I would like to come back to this reference later. Note that the guidelines, when submitted for adoption, included an attached letter from Bob Shapland which brough out the harmful and inequitable effects of retroactive application of the guidelines. I hope it is not premature to mention that certain revised language has been proposed to reduce this problem.

(6) Trapnell, Gordon R. "Use of Loss Ratios in Regulation of Health Insurance Policies," published in draft form (65 pp.) as Appendix B of Cancer Insurance: Staff Report, Office of Policy Planning, Federal Trade Commission, 1980. Thorough, especially the treatment of benefit ratios (=loss ratios) from consumer viewpoint. Some useful theoretical concepts, plus list of pros and cons of NAIC loss ratio guidelines. You may not agree with all conclusions.

This report, which came out at about the end of 1980, appears to be a fairly broad treatment of the loss ratio concept. At more than one point there is mention of "only a handful of expert health actuaries" in existence. The author finds this situation disquieting (and so would I if I thought it were true). There are echoes of Mr. Barnhart's earlier statements in regard to the questioned veracity of the actuary in today's regulatory environment.

The report stresses effective recognition of interest and cites the impact of the reserve calculations. Here is where a question raised by Ernie Frankovich in Item (2) comes in: Is it considered "manipulation" to strengthen or otherwise increase the policy reserve or the claim reserve as part of the calculation of required premium increases?

Mr. Trapnell devotes several pages to the NAIC loss ratio guidelines. He draws certain conclusions. For one thing, not enough data is required from insurers. In addition, he calls for publicly accepted actuarial standards, standard methods and techniques, unbiased calculations of present values, use of actual data, provision for uncertainty, etc.

He concludes that "the necessary ingredients for an effective regulation of minimum lifetime loss ratios do not appear to be in place." The result, he says: Implementation of the guidelines is unlikely to have much economic impact. He does allow that the guidelines are an important first step and represent a major improvement in the current regulation of health insurance policies.

This report is a good example of how too much significance can be attached to loss ratios in and of themselves. It seems to propose that regulatory bodies become vast data repositories, entrusted with both collection and analysis of these data. In his conclusions, Mr. Trapnell also suggests that the first step is to define the purposes of the regulation before deciding the method to achieve that purpose. He notes that if cost reduction is

desired, it can be achieved better through product standardization. This theme is repeated fairly often in consumer-oriented reports; it seems to ignore the true underlying marketing processes.

(7) Concurrent session: "Loss Ratio Analysis" (Minneapolis, May, 1980) in Record, Society of Actuaries, Volume 6, Number 2, pages 417-433. (Hopper, Koppel, Hansen, Hunt). The purpose of this discussion: to look at loss ratios from many different perspectives. Key considerations are taken up.

In this session Spence Koppel pointed out the complexity of the subject. He noted that "the typical statutory wording that requires the benefits to be reasonable in relationship to premiums cannot be interpreted solely as being based on the loss ratio". He also saw the loss ratio as a screening device. He warned of the consequence in the marketplace of arbitrarily high loss ratio standards.

Paul Hansen spoke on the practical aspects of meeting regulatory requirements. He dealt with the problems of smaller companies and the services he provides, both for their internal use and for filing purposes.

Jim Hunt discussed, among other things, the results of product standardization for Medicare Supplement plans in Massachusetts. He gave evidence of the not unexpected marketplace reaction. He further stated that "regulation of rates by loss ratio analysis is a hopeless task except in the one or two states that have a significant actuarial staff". He said it was too complicated. This session also took up the concept of anticipated loss ratio, effect of interest, monitoring experience, etc. The adversary relationship between regulators and insurers was noted once again.

(8) Concurrent session: "Loss Ratio Analysis" (San Diego, June, 1980) in Record, Society of Actuaries, Volume 6, Number 3, pages 843-856. (O'Grady, Janus, Habeck).

Topics for this session were like those for Item (7). Charlie Habeck got into the basic concepts, starting with the ingredients of loss ratios. He discussed users of loss ratios. Paul Janus took Will Burgess's place and gave background on how loss ratios have been used and how they are basically a casualty insurance concept. Changes in the 1979 statement definition of loss ratio were discussed. Current state requirements were listed, but once again, it is likely that some of these are now out of date.

Finally, the NAIC guidelines were described and discussed. The speakers seemed to agree that loss ratios do not provide a valid test of product choice for consumers.

(9) Federal Register, Volume 46, Number 13, pages 6296-6307, January 21, 1981. Proposed federal rule-making to implement Medicare Supplement certification program (so-called Baucus Amendment). Contains detailed definition of loss ratio in 403.224, plus other items on filing requirements, continuation of certification, decertification, and various procedural matters. This rule is not yet in final form.

Many of us have been asked to submit comments on the proposed rules. In my response, I noted that the data requirements appear to exceed what the law calls for. Also, it appears that a GAAP benefit reserve (but without the margins for adverse deviation) is described in 403.224 (b)(2). This just means that one more reserve basis must be maintained, along with all the rest.

I asked specifically about data splits. For example, a large company will try to sell the same product, to the extent possible, in many states, some of which won't have "qualified" programs of Medicare Supplement regulation. But if this product qualifies where there are proper standards, what is its status where there are not? It appears that experience would have to be kept separate. Other problems may occur if the rules do not provide for some kind of state regulatory "spillover".

It may be of interest to you that there is to be a "Regulatory Flexibility Act," supposedly passed in January of this year, which allows special treatment for companies with small premium volume. Such treatment is also allowed but without much emphasis in Section I.E.1. of the NAIC guidelines.

(10) Study note: "Individual Health Insurance Loss Ratios," for Part 10(G), SN 10 GB-302-81, Education and Examination Committee of the Society of Actuaries, 1981. Consists of two sections:

(a) "Individual A&H Minimum Loss Ratios Plus Expense: A Reasonable Total" by Herbert Orenshein, A.S.A.

(b) NAIC "Guidelines.." same as Item (5).

In this new Part 10 study note Herbert Orenshein very sensibly looks at the bigger picture. His purpose is to "analyze the expense item, establish the criteria for a reasonable profit margin and balance the equation with the loss ratio." His conclusion is that "a fair loss ratio range under current conditions would be 50% to 52%".

The author seems to be making the general point that the insurers are not ripping off the public. He lists at least five ways to jack up the loss ratio, none of which is desirable or even meaningful. One way is to sell on a guaranteed issue basis, but the resulting subsidization will drive out the healthy lives. A bigger benefit package will raise the loss ratio, but this may not be appropriate. Moving the administrative costs to an employer or service organization is another way; there is the implication that group loss ratios are not necessarily as high as they may seem.

(11) Study note: "Reserve Strengthening", also for Part 10(G). This study note is listed in the 1981 Exam Syllabus but it is not yet available.

This will be an important study note, since reserve strengthening considerations should be consistent with the guidelines for filing of rate increases. The question will have wider impact in that an insurer's reserve adequacy and continued solvency are also involved. There is no state that I know of at this time that calls for reserve strengthening at the time of premium rate increases or sets forth a method. I have found that most companies do not strengthen at such times. In fact, some say that if they would, they might be accused of manipulating loss ratios. Only a few contend that a strengthened reserve is clearly called for.

(12) Typical approaches to state regulation through minimum loss ratio standards can be found in current rules for these jurisdictions, among others:

Florida	New York	Washington
Michigan	Pennsylvania	
Minnesota	Tennessee	

At this time I shall comment on the NAIC guidelines. My comments will be brief, and I hope, not redundant.

(1) The guidelines are workable. We can live with them.

(2) More weight should be placed on actual to expected loss ratios as revealed in early warning monitoring systems so that disaster can be avoided before the minimum loss ratio has been reached and exceeded.

(3) The retroactive applicability features of the guidelines should be modified to maintain equity for the parties to the original insurance contract. It has been suggested that a simple minimum loss ratio differential can be established and tolerated so that new issues and existing business can be treated properly, measured from an announced effective date for the guidelines.

(4) Reserve strengthening methods should be considered more fully as to their acceptability.

(5) The guidelines should be considered guidelines and not rules; many exceptions should be expected, given the marketing diversity and product differentiation that the industry and public now enjoy.

In closing, let me point out, if you haven't realized it already, that I am not an expert on loss ratio analysis. I have no independent opinions on the subject. I work with a number of companies that have from $2 million to $5 million of annual premium on a variety of individual health contracts. I do not know how I would make interest adjustments, nor how I would allocate interest by plan code for these relatively small exposures, and I would prefer not to learn. I suppose one would have to use the investment year method, but I think I'm too old for that.

Let me simply ask the regulators for these two things:

(1) Please don't expect actuaries to apply a highly refined tool to obtain a relatively crude result, when a simple tool will do the same job. We don't have the time!

(2) Please don't push for product standardization; it is contrary to the spirit of the marketplace and would surely turn us all into vegetables!

Thank you for your attention.

MR. JOSHUA JACOBS: States of Washington and Tennessee have specifically mentioned group insurance. Would the members of the panel describe what they expect to happen with group insurance? For one thing, we never reach loss ratios this low anyhow, so the whole thing seems rather unrelated and I don't understand why these two states and possibly others, have made specific reference to it.

MR. BURGESS: The industry is quite concerned about the proposed Washington regulation. I think that Washington could well be a bellwether for imposing group insurance loss ratio standards. Washington tries to differentiate by size of group and in the discussion that took place at the NAIC (C4) meeting last week, Washington backed off somewhat to indicate that their real intent was not to regulate independently negotiated group contracts, but rather the

group rate manual. I am afraid that even though the loss ratio regulation up to this point, including the guidelines, clearly did not intend to encompass group insurance, that we are going to have more and more states raise this question. I would like to ask John Gilchrist, based on his experience as a California regulator, and his discussions with other people within the NAIC, what he foresses as the possibility that the loss ratio regulation will be expanded into the group area.

MR. GILCHRIST: There are some provisions already in some of the proposed state regulations. California itself has no provisions and no control of many of these rates and we are very restricted as to the type of rate filings which we can consider. So California is really not a representative state. The Washington regulation applies to every individual or group disability insurance policy which is delivered or issued for delivery in the state and to group policies held by a master policyholder in another state, as to which solicitation for the purpose for coverage is made to persons within this state. The proposed Washington regulation does cover group policyholders.

MR. WILLIAM B. DANDY: How do the proposed guidelines treat rate increases on existing business issued prior to implementation of the guidelines? Also, for coverages that tend to increase with inflation (e.g., Medicare Supplement and major medical), to what extent would you be permitted to build in both inflationary trends in future benefits and anticipated or "automatic" rate increases due to such things as increases in Medicare copayments and deductibles?

MR. BURGESS: The guidelines have two tests for rate increases. The tests consist of a propsecitve as well as a combined retrospective and propsective. For example, and again as I pointed out earlier, the guidelines have benchmark loss ratio standards that are presumed reasonable. In other words, the intent of the guidelines is that if the policy form (the combination of the renewability provision, the type of policy, the average annual premium) meets the loss ratio standard, then it is presumed reasonable. So, as far as a rate increase is concerned, it has got to pass two tests. The combined past plus future has to exceed the standard if it is presumed reasonable, and the future only has to pass the test. Now this is what has caused problems as to the retroactivity, because there are policies which were issued in good faith prior to the effective date of the guidelines and you have go to include all that past experience. The intent of the guidelines was that this was certainly something that should be taken into consideration by the company and the regulators when they are analyzing these rate increases. The industry is quite concerned that retroactivity not be applied. On the other hand, we had a discussion of this at the NAIC (C4) meeting last week, and the regulators are concerned that any past guidelines not be ignored. In other words, in essence when a policy is issued, the guidelines that were in effect on that date should be taken into consideration. They shouldn't be ignored. Some of the people in the industry are saying ignore the past experience because we have spent this money. You had some guidelines that governed at the time you issued those policies. You're not going to be able to ignore these completely. There is a proposed change in the guidelines relative to the retroactivity that's to be discussed at the next C4 meeting in June, where this will be given more intensive discussion. The intent of the guidelines was that they would be flexible enough so that the insurer could take the period for which rates were provided and apply the anticipated loss ratio over that entire period. In effect, one actuary may build in inflationary increases, medicare deductible increases, etc., and another not. The period over which rates were computed to determine coverage would encompass the entire period over which he actually had computed rates. Another actuary might say, "inflation being

what it is, I can't cover rates for any more than three years, and therefore I am only going to build it in for the next three years, and determine the anticipated loss ratio to the end of that period". The regulators are concerned about the length of time over which rates are computed to provide coverage. They are in effect saying they don't want any manipulations as Charlie pointed out in his discussion. Inflation being what it is, how can you as responsible actuaries calculate a rate over anymore than a reasonable period for inflation? The intent of the guidelines was that it provided flexibility.

MR. CRAIG F. LIKKEL: Could someone on the panel give us an update of the current status of the Washington regulation and specifically are they still planning to include under the regulation, accidental death and disability benefits attached to life policies?

MR. BURGESS: I would like to take a little of your time and really give some of the aspects of the Washington regulation because, as many of you know, it is so far-reaching, and so radical in so far as rate regulation is concerned.

In November 1980 notice was given that the Washington Insurance Commissioner intends to adopt rules concerning the establishment of minimum loss ratios, reserve standards and filing requirements for group and individual health insurance policies delivered in the State of Washington. A hearing was held on these proposed rules January 20, 1981.

This regulation would apply to every individual or group health insurance policy delivered or issued for delivery in Washington and to group policies held by a master policyholder in another state "as to which solicitations for the purchase of coverage thereunder are made to persons within this state if the cost for such coverage is borne in whole or in part by the person solicited".

The fundamental purpose of the regulation is to promulgate minimum loss ratio requirements. The regulation "seeks to protect the policyholder further by requiring a premium and risk stabilization fund". This fund would "enable a company to weather adverse claims experience and . . . reduce the number and size of rate increases".

Prior to the use of any premiums the insurer would demonstrate to the satisfaction of the Commissioner that the policy will generate minimum loss ratios, that adequate reserves "as well as premium and risk stabilization funds" would be established and maintained for the payment of future claims, and that the insurer "has a surplus and cash flow commensurate with the marketing objectives of the company". The Commissioner could request such a demonstration at any time during the life of the contract.

The minimum required anticipated aggregate loss ratio would never be less than 60% for individual policies, 65% for riders attached to individual policies and 75% for group policies.

The anticipated aggregate loss ratio is defined as the aggregate benefits to be incurred under the policy divided by the aggregate premiums to be earned. The calculations to determine this loss ratio are to be made over the period for which the actuary contemplates the premiums will remain adequate (called the calculating period). However, that period is not to be less than 2 years unless the policy is for a lesser duration and not renewable.

The aggregate benefits are defined as the anticipated amount of benefits incurred, plus any anticipated increase in reserves, plus any anticipated increase in the premium and risk stabilization fund.

The premium is defined as the total gross amount payable directly or indirectly by the insured for the purpose of purchasing insurance less any dividends or experience refunds paid to the insured in the form of cash or a reduction of premiums.

The single year ratio may never be less than 50% for individual policies and riders and 65% for group policies. A single year ratio is an anticipated aggregate loss ratio with a calculating period of one year.

Certificates issued as a result of solicitation of individuals by mail or mass media advertising would be considered group policies.

Group insurance issued to 20 lives or less would be considered individual insurance. Group insurance issued to 100 lives or more would be considered group insurance. Group insurance issued to groups of 21-99 lives would develop minimum loss ratios proportionate to their size ranging from 60% at 20 lives to 75% at 100 lives.

The Surplus Account would include "an unsegregated premium stabilization fund" whenever the single year ratios, as calculated for each policy year, increase over the calculating period. The purpose of this fund is also to level out the experience to approximate the anticipated aggregate anticipated loss ratio in each year and thus "to reduce the need for rate increases as well as to enhance the solvency of the insurer." The fund would be calculated upon the difference between the anticipated aggregate loss ratio and the single year ratios. The fund would be drawn upon to support the premium income in the ultimate years of the policies when the experience exceeds the anticipated aggregate loss ratio.

The Surplus Account would include "an unsegregated risk stabilization fund" set aside for adverse fluctuations in the level of claims payable, in addition to reserves. Such fund would reflect the actuary's opinion as to its adequacy, the company's ability to withstand adverse fluctuations, anticipated cash flow, the presence of reinsurance for this and other products, the anticipated company growth, current management practices and objectives, as well as any other factors "which may significantly influence its ability to fulfill its obligations to its policyholders".

The insurer would furnish an estimate of the size of the premium and risk stabilization fund to the Insurance Commissioner at his request. Calculations of its composition by type of risk and amounts intended for increasing single year ratios would be available.

No filing for a rate increase would be issued unless adequately supported by an actual to expected analysis of the emerging loss ratios. The expected loss ratios would be those calculated when the earlier premiums were filed for approval. Calculations would be made to clearly show the effect on the loss ratio of the change in actuarial assumptions.

A filing of a rate increase would not be made prior to the end of the calculating period unless the emerging experience falls beyond two standard deviations of the expected experience assumed by the actuary in his calculations, and such adverse experience has already or would shortly exhaust the premium and risk stabilization fund.

Only the experience from the policy forms in question as exposed within the state of Washington would be used in these calculations, unless foreign experience would significantly improve the credibility. Any foreign experience submitted would be shown separate from the Washington experience.

The loss ratios calculated in compliance with the regulation would be applied "consistently and equitably to all the policy forms, benefits, issue ages, years of issue and other classifications employed by the insurer".

Any compensation in the form of commissions, bonuses and other renumeration which exceeds 40% of the first year premium may require a justification to the Commissioner that the premium is not excessive and that the policy would be in the public interest.

The Actuarial Memo filed in support of premiums would present in tabular form, the calculation of loss ratios for each year the premiums are expected to remain adequate, as well as an aggregate loss ratio for all years involved.

The great potential impact of these proposals on the internal management of a health insurer brought forth extensive comments at the hearing. Some of the pertinent comments follow.

Compliance by companies (and implementation by the Washington department) would be very difficult and costly.

The initial impetus for drafting the regulation was the Baucus Amendment, relative to Medicare Supplement policies. Apparently there was some concern about a perceived logical inconsistency in establishing minimum loss ratio benchmarks in compliance with Baucus while not providing similar standards for other than Medicare Supplement policies. However, Medicare Supplement insurance has presented a unique regulatory problem. Two of the pertinent reasons for this are:

(1) Medicare Supplement insurance is closely linked with an enormously complex bureaucratic government program whose beneficiaries find it very difficult to comprehend.

(2) It is marketed solely to elderly citizens who can be especially vulnerable to unscrupulous practices.

For the state of Washington to impose similar regulation on all health insurance is the real inconsistency.

Each type of individual health insurance is not like every other type. Varying premium structures, claim frequencies, renewal provisions, marketing techniques and other factors are essential elements in considering whether benefits are unreasonable in relation to premium charged. This is recognized in the NAIC Guidelines, but not in the proposed Washington regulation.

The practical effect of the 60% minimum loss ratio requirement is likely to be an increase in the average premium and average size of policies sold, as companies attempt to lower expenses as a percent of premium. Marketing efforts would be directed away from low benefit/low premium products, depriving many persons (particularly low income persons) of the useful, desirable and reasonably priced products they want or need.

Creation of the premium and risk stabilization fund would require higher premiums, to accumulate the funds, and higher rate increases once the fund has been depleted.

The question was also raised about federal income tax treatment of the fund. It very likely is not deductible as a required reserve on guaranteed renewable policies under the Life Company Tax Act. Also, it may not be recognized by the states.

What are the standards by which to measure the relationship of surplus and cash flow to marketing objectives? Even if they existed, they should not apply to separate forms, but only to the whole company or perhaps to significant lines of business.

The proposed minimum loss ratios are much higher than the NAIC benchmarks. They are inconsistent with industrywide expense ratios.

Single year loss ratios are inadequate and misleading measures of experience. The anticipated loss ratio defined in the NAIC Guidelines is a much more meaningful loss ratio.

The proposed regulations contain the requirement of calculating the standard deviation of the expected experience in order to compare the relationship of the actual to the expected experience in a mathematical, statistical basis. Very few companies will have the data to perform this kind of calculation. Many small companies don't have mathematical statisticians or actuaries on their staffs, and they would have to hire more consulting services. How would service to policyholders be improved by such a requirement?

By requiring that the premium and risk stabilization fund be exhausted before rates can be increased, Washington says that only disaster justifies a change.

Experience by form, in Washington only, would be credible only for a few companies.

It is unwise to try and put surplus, reserve and/or solvency standards into a rate regulation. Rates, reserves, and surplus may depend on each other, but the subject is too complex to cover in a single regulation. Only company management has the overall responsibility and knowledge to set such policy and make practical judgments.

Despite the radical nature of this proposed regulation and its great potential impact on the internal management of health insurers, considerable interest in some of its concepts has been expressed by the NAIC (C4) Life and A&H Technical Subcommittee. It is recognized that the promulgation of benchmark loss ratio standards is only the first step to effective regulation of this nature. The next step is to develop effective monitoring guidelines. The proposed regulation attempts to do this directly, emphatically, and drastically through the premium stabilization fund. This fund attempts to level out the experience to approximate the anticipated aggregate loss ratio in each year and "reduce the need for rate increases as well as to enhance the solvency of the insurer."

At last week's meeting of the NAIC (C4) Technical Subcommittee, this regulation was discussed at length. The Subcommittee asked appropriate committees of the Society and Academy to initiate studies on the subject.

This subject, this regulation, is not going to go away. Some of the concepts were discussed last week at the C4 meeting. There is a need for developing effective monitoring guidelines. To answer your question specifically, it

is my understanding that there have been some modifications in the proposed Washington regulation. There was a requirement that the regulation would apply to accidental death and waiver of premium benefits included in life policies. My understanding is that this is being changed. Another change was made regarding commissions. The original regulation stated that "any compensation in the form of commissions, bonuses and other renumeration which exceeds 40% of first year, will require . . ." It is my understanding that that's going to be changed to ". . . may require . . ." As far as I know, these are the changes of substance that Washington is contemplating in their regulation. Buy it's my understanding that this is still very much alive in the state of Washington.

MR. KOPPEL: Charlie, as a consultant to a lot of companies with $2 to $5 million of premium volume, what is the impact of the variations of loss ratio guidelines as well as policy form approval guidelines, and differences between states? What happens to the smaller company when those things occur? How do they cope with all the variations?

MR. HABECK: In general, the effect of loss ratio regulation has been to discourage smaller companies in certain states where they don't have adequate premium volume to justify compliance efforts. What they are doing is trying to simplify their product line so that they are selling either a 55 or 60% loss ratio product in all of the states. There are some exceptions, for example, the state of Michigan has caused some concern with the mandated Medicare Supplement benefits. There are other things besides the loss ratio requirements that have, shall we say, discouraged companies from staying in certain states. One state's minimum standard caused one of our clients who was in about 35 states simply not to revise their individual health insurance portfolio since they would have had to change almost every plan. They did not think it was worth it. But the variation hasn't proven to be that great of an obstacle where the company really had a commitment in a state. I think Minnesota's requirement for minimum coverages under their Comprehensive Act of 1976, causes some concern where companies were not selling major medical at all and yet they had to come with the pre-approved plans. The general approach that we have taken with meeting the loss ratio requirements is to use a simple array of past experience (three to five years) and project maybe two years into the future. All of this may be very artificial. It is not satisfying to spend a lot of time on something that you know might be negotiated downward. The first time I ran into this was with a smaller company, not a small life company, but a small company in the health area. They prepared a 23 page filing to one of the northeastern states, and it was simply rejected. It called for a 60 to 80% rate increase and the state in question said they would allow only 40%. They had to go through the same process about four years later and they decided to keep that state's experience separate. At that time, they went through the filing process again on the renewal basis. I said since it didn't work before, do something simple. The state in question wanted their experience mingled with other states and they would only take the aggregate rate increase for all of that business. That's the kind of thing that discourages smaller companies from trying to do something very sophisticated in the line of demonstrations for getting filing rate increase approvals.

MR. KOPPEL: Are we going about it in the wrong way? Is loss ratio really what we ought to be regulating? Some suggest that perhaps there are other measures that would accomplish what we are trying to accomplish, which is health insurance at reasonable costs, through other means such as regulation

of profits, regulation of expenses, or something of that nature. Has anybody been thinking along that line?

MR. WILLIAM L. HEZZELWOOD: I am a great believer in free market economies, and I do not think that we need rate regulation. I do not think that we need loss ratio regulation in health insurance any more than we need rate regulation or loss ratio regulation in term life insurance. Why aren't there minimum loss ratio requirements for term life insurance? It certainly makes sense, it makes as much sense as it does for major medical insurance. We do not need these regulations. What we need is an environment in the marketplace that permits buyers of health insurance coverage to come together with sellers of health insurance coverage where there is full disclosure of the benefits and costs on the part of the sellers so that the buyers can choose what products they want to buy. I think that if our insurance departments place more emphasis on helping the buyers to become better buyers so that they are not, as Mr. Gilchrist said, so helpless, there might be a better approach than regulating profits and regulating loss ratios and regulating premiums. The companies that cannot compete simply will not, and the ones that can will offer competitive products at a price that people are willing to pay.

MR. JOHN O. MONTGOMERY: I wish you could convince all of the people who are protesting their premium increases in California of that fact. The fact is that you have companies that go in with loss leader health insurance products and then, in a year or two, increase the premiums by 200%. Then the next year by 300%. It is just a waste of money for the policyholders, it is a big ripoff.

In the complaints that we have received in California, the largest single source of complaints has to do with automobile insurance. The second largest, and almost equal, is health insurance. The public is very much upset about health insurance. There is a great deal of clamor, and it is because all of these operators are going around doing the things that they are doing in California with health insurance. We would like to have no regulation because it would take a great deal of work off our hands, but the problem is that the public is very much upset about health insurance, and if something isn't done soon about it, I am sure there will be measures introduced into the legislature.

MR. HEZZELWOOD: I would like to suggest that if this is a big problem, that the insurance departments do something that I am not aware that they have ever tried. Why don't they publicize this information? Why don't you publish in the newspaper a list of the insurance companies and how many complaints have been registered against each one and so forth. That is the role in which I see insurance departments being most valuable, in disseminating information to the insurance buying public and so that they can make intelligent informed decisions.

MR. MONTGOMERY: The way we operate in California is not the way some of the other states do. First of all, we have complaints and we know the companies that are involved, and we want to give those companies a chance to clean up their act. So we go to those companies and ask them what they are going to do about it. And then they work on it, and after a period of time (usually six months to a year) if they haven't fixed things up, it is very likely that we will publicize. We have a number of companies on probation. We wish the companies would correct their own problems, because

it is not good publicity for the industry. Even so, if they won't do anything about it, then they should be publicized.

MR. BURGESS: While we are on this line, I think we all have to work toward a more reasonable relationship between regulation and industry. The example heard from Charlie is where, in good conscience, a competent actuary develops a full-blown actuarial memorandum to try to justify the rates to the insurance department. Then the insurance department plays games and manipulates the company actuary. I am saying that there are departments that have from time to time done this. No matter what you send these departments you are not going to get anywhere with them. On the other hand, there are some company actuaries playing games with the rates. Somewhere along the line we have got to try and work together between the industry and the regulators and try to come up with reasonable standards. I would like to think also, that we don't need rate regulation, but unfortunately, it is here. It has been here as long as I have been in the business. Benchmark loss ratios have existed at least since 1953. The casualty business was a forerunner to the health insurance business and that is where this thing started. I would like to believe there is a simplier way of regulating rates and rate filing and loss ratios, but I have not found one yet and I think as long as we have the present environment, let's try to get a device that is as reasonable as possible. The purpose of the NAIC guidelines was to develop standards of reasonableness, not standards of unreasonableness, so at least if anything qualified on that basis it did not have to go through anything more extensive. If you could justify exceptions you could justify the rates. On the other hand, I think the regulators' point is extremely well taken. It was never intended that the guidelines in themselves would be the end. There have to be effective monitoring techniques to them.

MR. KOPPEL: We are just about out of time. Will, I wish you would take just a few seconds to describe the current status of New York's loss ratio regulation, and then we will close with that.

MR. BURGESS: New York is another example of a quite significant regulatory development. In January, 1981 amendments to Insurance Department Regulations 62 and 34 were promulgated. The amendments establish minimum standards for Medicare Supplement insurance and set certain requirements and limitations with regard to the advertisement of such insurance.

Some of the features of the amendment to Regulation 62 which apply to Medicare Supplement insurance policies are:

(1) Establishment of a 65% minimum anticipated loss ratio for all individual and franchise policies issued to persons over age 65.

(2) Establishment of a 75% minimum anticipated loss ratio for Group Medicare Supplement policies.

(3) A requirement that insurers annually file experience data for policies issued to persons aged 65 and over. This data will be monitored by the Superintendent to ensure compliance with the minimum loss ratio standards.

It is anticipated that insurers will be filing Medicare Supplement policies for approval by the Insurance Department prior to June 21, 1981. This is the

date when insurers are required to comply with the minimum standards for Medicare Supplement insurance. The legislation and regulation applies to policy forms sold on or after this date.

In addition to establishing standards which appear to meet the requirements of the Baucus Amendment, the amendments establish a system of monitoring experience data. If the Superintendent finds that the minimum loss ratio standards will not be met over the past and future lifetime of a policy form, the Superintendent will notify the insurer that a plan for assuring compliance with the minimum loss ratio standards must be submitted. The insurer's plan may utilize premium reduction, dividends, benefit increases or any combination of these or other methods such that the loss ratio standards can reasonably be expected to be achieved. In most instances, benefit increases may not be included as part of the plan without offering the alternative option of appropriate premium reduction.

A minimum loss ratio requirement is another way of stating a maximum expense ratio allowance.

Elderly policyholders often require much more attention than those of younger age. If enough margin is not available to the insurance company to pay to its agents a commission sufficient to motivate them to offer the product for sale, or if a direct response insurer is not allowed a margin adequate to permit it to advertise its product, the products will be unavailable to the public.

Senior citizens have plenty of free time. Often, they are very much alone. Unfortunately a degree of senility and loss of memory affects a segment of them, and this proportion increases with age.

They write long letters to their insurance companies. They expect thoughtful and sympathetic responses. These are expensive. Those within reach of a local or toll-free telephone call of the company expect detailed explanations over the phone.

Many companies find that it costs more to operate in New York than in many other states. With the minimum loss ratio at 65%, 5% higher than the nationwide minimum in the Baucus Amendment, many individual health carriers are concerned that they will not be able to operate at a profit in New York. At a 65% minimum loss ratio in any state, many feel they would not be able to operate at a profit.

When there is a premium increase, the minimum anticipated loss ratio is to be increased "to reflect reduced acquisition and other expenses". This assumes that the company has not any inflationary problem with expenses or costs and that the only reason for the rate increases is an excessive loss ratio. It ain't necessarily so. If Company A markets a product with a $10.00 premium and a 65% loss ratio and Company B markets the same product but with an $8.00 premium, Company B should be allowed to raise its premiums to $10.00, if necessary, provided that it meets the 65% minimum loss ratio standard.

If the Superintendent finds that the minimum loss ratio standards will not be met, he is to notify the insurer that a plan for assuring compliance with the standards must be submitted. "In most instances, benefit increases may not be

included as part of the plan without offering the alternative option of appropriate premium reduction."

In many cases, benefit increases may be the most logical and effective way of achieving the desired loss ratio at the least administrative cost to the insurer.

Premium reduction programs will involve computer programming, systems analysis, and related activity. For a relatively small block of business, such activity could be expensive. The ongoing expenses of billing, accounting, record-keeping, statistical analysis, and claims administration are unaffected. A reduction in premiums increases the expense ratio when an attempt is being made to increase the loss ratio at the same time.

Individual health insurers which write Medicare Supplement insurance are watching to see how individual states establish standards to comply with Baucus. Hopefully, each state will give the matter careful consideration and not try to equal or outdo New York.