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RECENT DEVELOPMENT 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?

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?

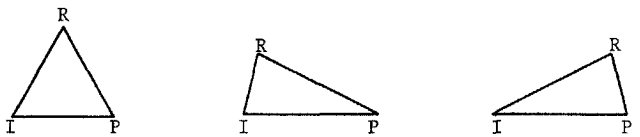
   c. Other states?

MR. E. PAUL BARNHART: Expansion of regulatory activity in the area of loss ratio guidelines has accelerated enormously in the past five years or so. There are several reasons for this. First, as you all know, is consumer pressure and interest. Secondly, the simple fact of a rising frequency and size of rate increase filings. More and more of the state insurance departments have realized that they need some kind of basis, some kind of guideline to follow because of the ever-increasing frequency of the filing of rate increases. Thirdly, the threat of federal intervention. Many of the state insurance departments have felt obliged to take a more positive stand on premium rates and regulatory supervision of rate increases because of the possibility of this intervention.

Various states over the past five years or so have been adopting conflicting and inconsistent rules. This has led to a need for the NAIC Model Rate Filing Guidelines which first came out two years ago. This had to be done. It was a necessary step in order to try to salvage rapidly disappearing uniformity and consistency to the extent that it still survived anywhere in

the United States. Our purpose here is to discuss these developments and their implications and to become current about what is happening now and where things are headed.

I would like to suggest some philosophical background and basis for what we are talking about. Here are several little triangles and they are all labeled RIP. I know what you are all thinking: It stands for "rip-off" or maybe Rest In Peace.



Seriously, R stands for Regulator, I stands for Industry, and P stands for Public. As you can see, the Regulator is appropriately positioned up there on high, benignly smiling down upon the Industry and the Public. I suggest that the left triangle is the one that correctly portrays the relationship that should exist. It should be an equilateral triangle with the regulator, the industry and the public all partners in a total effort of providing adequate health insurance for the public at reasonable rates. Reasonable for the industry, to cover legitimate expenses and a reasonable profit and contingency margin. Reasonable for the public, in that the public can obtain adequate insurance at reasonable rates that provide a fair benefit return.

Sometimes the shape of the triangle gets distorted, and occasionally the middle example prevails in a state where the regulators and the industry get a little too close to each other, and the public is out there on the long arm of the triangle. We are all aware of what can happen when this situation occurs. Regulation can be too lax. It is possible when there is indifference to rate levels and to the question of whether the public is really getting a fair and reasonable return for its premium dollar.

The triangle can get distorted in the other direction, as in the diagram at right. If consumer interests become too predominant and if regulators feel they have to take too much of an adversary relationship with industry, a situation can develop where the regulators and the public are too close together, and the industry is the victim of being out there on the long arm of the triangle.

So this is a good philosophical base for approaching the subject we are discussing, i.e., loss ratio and rate regulation. The goal, the ultimate goal to be sought, is the equilateral relationship where there is a balanced relationship among the three parties, and the legitimate interests of all parties concerned are being protected and recognized.

Our first panelist is Frank O'Grady with Metropolitan Life. Frank will speak about Topic l.a.in the program, the NAIC Model Rate Filing Guidelines which were developed from a draft that originally was prepared by the Actuarial Committee of the HIAA.

MR. FRANCIS T. O'GRADY: Shortly after the model guidelines were presented to the NAIC, the Technical Task Force asked the HIAA to make a broad distribution of the guidelines developed by the Individual Actuarial Subcommittee of the HIAA so that we could get broader discussion of them.

In response to that request, a letter was drafted addressed to the chief individual health actuarial officer of a large number of companies writing individual health insurance.

This letter gave the purpose of the guidelines as follows:

> "The purpose of the guidelines is to respond constructively to the efforts of a number of insurance departments which have expressed concern over the appropriate level of individual health insurance loss ratios and over ways of measuring actual results compared to rate filings."

The Individual Actuarial Subcommittee of the HIAA had over a period of years become aware of the concern of many insurance departments about having a meaningful basis for reviewing rate filings. The Subcommittee also was aware that to meet the need, some insurance departments were independently developing guidelines. These proposed guidelines which the Committee had seen were, in addition to lacking in uniformity, not always definitive or else contained requirements that many companies would find difficult, if not impossible, to meet.

The Subcommittee recognized that rather than responding in a negative way by criticizing the shortcomings of these proposals, it would be in the best interests of the companies, the regulator and the consumer to develop a model guideline. During the early stages of development, the guideline was used as an atlernative proposal for any insurance department proposal which was not found acceptable. After its finalization, the guideline was proposed to the NAIC for consideration as a standard to be used in all jurisdictions.

From the beginning, the Subcommittee recognized that the task it had assumed was not a simple one. The goals and objectives of the companies and the regulators are not always the same and in certain cases could even be considered to be in conflict.

Thus it took several years of work and numerous drafts before a final work product was produced. To again quote the exposure draft letter mentioned above: "Nevertheless, we believe that these proposals will satisfy the substantive concerns of the insurance departments and will permit a fair and equitable presentation by the companies which can be given prompt consideration without excessive work or expense to the companies."

Against this background then, let us examine what requirements were included in the final proposed guidelines. Section I of the guidelines gives the general requirement for filing rates.

Part A, Section I indicates that a filing of any form affecting benefits requires an accompanying rate filing if rates are affected.

Part B of Section I indicates broadly the required contents of a rate filing. It includes a definition of "anticipated loss ratio" in terms of present

values "over the entire lifetime for which rates are computed to provide coverage". This phrase was a new one that was intended to give flexibility with respect to medical expense filings in a time period when projections of inflation were necessary. Part B also requires an actuarial certification.

Part C of Section I more completely defines additional requirements with respect to rate revisions. Considerable flexibility for the variety of company practices was intended to be built in, although this may have the effect of making both submissions and examinations more difficult.

Part D of Section I refers to the Accident and Health Policy Experience Exhibit as being the basic form and content of the experience data requirement. Other data is acceptable, but the Policy Experience Exhibit is essential because it is a required part of the Annual Statement. With respect to forms no longer issued and which may have separate rate filings, separate data must be available, although the data might otherwise be combined with other data in the Policy Experience Exhibit. It was recognized that this requirement might increase some company record keeping.

Part E of Section I lists some of the caveats which are appropriate in analyzing experience data.

Section II of the guidelines gives specific values for the minimum loss ratios and the general methods of determining whether premium rates meet this standard.

Part A of Section II shows the minimum loss ratios. These vary by coverage, by renewal clause, and by "average premium". The intention here is to provide an adequate margin for expense for a wide variety of forms and to provide contingency margins appropriate to various renewal clauses and types of coverage.

Part B of Section II describes the standards with respect to the filing of rate revisions. In this part, one part describes a new test devised by members of the Individual Actuarial Subcommittee. It takes account of not only the anticipated future experience under the form but also the actual past experience. The intention was that for forms with a credible volume, the total lifetime loss ratio, including the experience actually developed and the experience anticipated, would meet the proposed standards of reasonableness as specifically set forth in Part A. It was believed that use of this test would help satisfy the growing department concerns with respect to forms which develop extremely low loss ratios over substantial periods of time, while protecting companies from adverse decisions based on select period data which is unrepresentative of ultimate experience.

This test, Part II B 2(b), will probably serve to moderate the request for rate increases for some forms for some companies.

It should be pointed out that this requirement of the original proposed guideline has been controversial, and after subsequent deliberations, the Individual Actuarial Subcommittee has drafted a modification of this requirement which has been submitted to the NAIC for consideration. It has also been called to my attention that there is another proposed revision that is being submitted to the NAIC at its meeting next week.

Part C of this section of the guidelines lists examples of circumstances when loss ratios lower than those given might be appropriate.

The part of the guidelines that involved more debate and discussion than any other was the table of proposed minimum loss ratios which is included in Part A of Section II. The dilemma facing the Subcommittee was the reconciliation of the need to satisfy the desire of the regulatory authorities to have a relatively simple table with the industry's need to have a range of loss ratios recognizing the multiplicity of products, benefit packages and marketing methods which are not only currently in existence, but have existed in the past or may exist in the future. Setting a minimum level of loss ratios implies, of course, the establishment of maximum expense levels. The extensive and detailed intercompany studies needed to develop expense levels for all the different kinds of individual health insurance products were not available. Furthermore, based on a time lag known to exist in preparing the intercompany morbidity studies, it was recognized as impractical to initiate a study with any hope of early results (assuming we could even get the needed contributions for such a study).

The Subcommittee thus had to work with what was available. This was mainly the expense information of the member companies represented on the Subcommittee.

After reviewing this limited experience and relying heavily on the actuarial experience and expertise of its members, the Subcommittee arrived at the recommended loss ratios. The table that was finally adopted in the proposal is in a two-way format--by type of coverage and by renewal clause. The types of coverage are "medical expense", "loss of income", and "other". The renewal clauses are "optionally renewable", "conditionally renewable", "guaranteed renewable", and "noncancellable".

While not shown in the table itself, provision is made for the variation in the size of average annual premium of a given form. These levels of average annual premium are provided for policies with (a) at least $200 of yearly average annual premium; (b) $100 but less than $200; and (c) less than $100. These specific levels were based on the actual expense experience of the several companies on which the Subcommittee had gathered data on an informal basis. The loss ratios shown in the table vary from 45% to 60%. After making the adjustments allowed for average annual premium, the loss ratios can get as low as 35%.

Overall, it was felt that these minimum loss ratios were reasonable in relation to the risk involved (as represented by the renewability provision and type of coverages) and expenses actually incurred, including the average annual premium.

The abbreviated format of the table necessarily meant that certain facets of the business which were critical to some companies were not recognized in the table itself. This consideration gave rise to Part C of the guidelines. Part C actually consists of two sections. The first deals with coverages that require special consideration and the second with other factors which also warrant special consideration.

While Part C was meant to cover as many as possible of the special situations of which the Subcommittee was aware, it is likely that some may have been missed. It is hoped that the regulators will recognize this is so, that those given are only examples, and that the list is not all inclusive.

Now that the guidelines are off the drawing board and have been cleared with the NAIC, they are ready for "field" testing.

MR. BARNHART: The guidelines, as you have explained, clearly intend flexibility in regulatory administration of Part C, as well as the table and the deviations for small average size premiums. All are intended to emphasize the intended use of the guidelines on a flexible basis, and my question is this: How likely do you think such flexibility in practice will occur in view of the limited staff and frequent lack of sophistication in many insurance departments?

MR. O'GRADY: I think there is a possibility that some of the regulators, in view of short staff and the need to have something specific in place, may very well just look through the guidelines, see the table, and then use it in all cases. And, of course, flexibility is in the mind of the beholder. What some regulators may think is a great deal of flexibility may look like a very rigid stand to some of us who actually do rate filings. There may be an educational process we will have to go through. While we would like to see the regulators adopt the guidelines in total, we very likely will face the situation of specific states that will pick and choose. Part of the process of getting flexibility will be to go through an educational process. We all will be involved in getting this flexibility established.

MR. BARNHART: It would appear to me that uniformity is so far not being realized even though these model guidelines have been promulgated. Can you give us a brief rundown of what states appear to be substantially adopting the guidelines with very slight, if any, deviations and what states appear to be substantially deviating from the model guidelines?

MR. O'GRADY: Actually, the guidelines have been relatively slow getting off the ground. At the Society meeting in New York last month, I asked the Commissioner from Utah what he thought the prospects were of getting the guidelines moving a little quicker. He was quite optimistic about it. He gave the need to handle more pressing matters as the reason for this slow movement in the adoption of the guidelines, but expected more action on them in the near future. With that prologue, the states that have to date either adopted the guidelines or are in the process are Utah, Arizona, Tennessee, Kansas, Virginia, and South Carolina. However, the adopted or proposed guidelines in these states actually are variations. Therefore, we are not yet getting the uniform adoption we had hoped for.

MR. BARNHART: Our next panelist is Bob Shapland of Mutual of Omaha. Bob has some concerns and worries about this matter that he will share with us. He will speak on topics 1.b. and 3. in the program.

MR. ROBERT B. SHAPLAND: There is no question that the intent of the guidelines on the part of both the actuaries in the NAIC and the actuaries in the industry was that the guidelines be only models or benchmarks as an initial test of the reasonability of premium rates. Everyone recognized that when limitations on expenses are set through loss ratio regulations, you get into a very complex field. Expenses depend on many factors that must be recognized by the regulator if he is going to regulate fairly--thus the inclusion of flexibility provisions that Frank mentioned. These are provisions that say lower loss ratios can be recognized if justified. Now, as a practicing industry actuary, I ask myself if these intentions will be carried out in practice. There are two possible viewpoints. One is that regulators

recognize that loss ratios have serious limitations. One has to be flexible in administering them, and loss ratio regulations can only eliminate the clearly abusive cases. I believe there will be many insurance departments for which this viewpoint will be accurate.

On the other hand, I believe there will be many states looking at loss ratio regulation completely differently. They will look at loss ratios as absolutes. If they have a 50% loss ratio standard, for example, they will take the position that it is improper to allow anyone to have a loss ratio lower than that. Even if they feel there might be some justification for deviations, they are going to ask themselves how one determines the validity of a deviation. Should they accept the word of the actuary of the insurance company that his expenses are greater than allowed for and automatically give approval of a deviation? Or what level of proof should they require regarding expenses and their necessity? Because of budget limitations, many states lack the actuarial talent to deal with these questions.

Also, the insurance department actuary is subject to the direction of his superior, who in turn is subject to political pressures. This may preclude flexible administration of loss ratio regulations. In addition, some regulators may have a gut feeling that they should be putting pressure on the insurance industry to cut back on expenses. The regulators may feel that insurers are spending money unnecessarily and about the only way they can deal with this is to adopt higher loss ratios, avoid allowing deviations, etc. A final problem he may have is the feeling that if he does allow deviations to one company, he must allow them to others, and the whole system will break down.

One aspect of the NAIC model is that it does not recognize many of the cost factors affecting prices. Doesn't the regulation, therefore, implicitly tell non-actuarial regulators that these cost factors are not important? Let's look at some of the expense factors that are important but have not been recognized or have been only partially recognized in the NAIC model. The first one has to do with premium size. In order to examine this, I put down some very rough assumptions as to first-year and renewal expenses, some of which are percentage of premium expenses and some fixed expenses as follows:

ASSUMED EXPENSES

	First Year		Renewal Years	
Type of Expense	Per Policy	% Premium	Per Policy	% Premium
Selling Expenses (Advertising, Commissions, Agent Training, etc.)	-	50%	-	10%
Underwriting and Issue	$30	-	-	-
Home Office Administration	10	5	$10	5
Claim Administration	4	-	4	-
Premium Taxes	-	3	-	3
TOTAL	$44	58%	$14	18%

Then I calculated, without interest and using a four-year average policy life, the loss ratios insurance companies could afford, depending on their premium size as follows:

AFFORDABLE LOSS RATIOS BASED ON A FOUR-YEAR AVERAGE POLICY LIFE

Annual Premium	Affordable Loss Ratio
$ 50	29.0%
100	50.5
150	57.7
200	61.3
500	67.7

We tell regulators through the NAIC loss ratio regulation that there is a 10% deviation to go from policies above $200 down to policies below $100. My calculations indicate it may be as much as 38% -- quite a difference.

An ignored factor affecting expenses is persistency. We all know that persistency varies by product and by the type of client served. For example, disability insurance sold to professional people may have much better persistency than medical expense policies sold to those at the other end of the economic spectrum. I do not think the regulator wants to deprive those segments with poor persistency of insurance via this regulation. Let's look at the effect of persistency. I took the previous assumptions at the $150 premium level and calculated the affordable loss ratios using an average policy life of three, four, and five years as follows:

EFFECT OF AVERAGE POLICY LIFE ON AFFORDABLE LOSS RATIO

$150 Annual Premium

Average Policy Life	Affordable Loss Ratio
3 years	52.7%
4 years	57.7
5 years	60.7

You can see there is an eight-percentage point swing. So a company operating in the poor persistency markets is behind the eight ball in meeting loss ratio standards.

What are other areas not dealt with adequately in the NAIC model? One would be financial risk differences. The regulation indicates that the only benefit difference is between disability insurance and medical insurance. But isn't there a difference between accident only disability versus accident sickness disability? Isn't there a difference in risk taking between short-term and long-term disability, and between white-collar and blue-collar risks? And, on the medical side, aren't there risk differences between hospital indemnity insurance versus low deductible major medical versus high deductible major medical? Does the table realistically reflect the differences in risk by renewal agreement? Is there really a five-point difference between one renewal agreement versus another?

Another area involves underwriting costs. If I underwrite a policy on a fully selective basis with medicals, MIB reports, and so on, I am allowed the same expenses as if I issue a policy completely nonselective. Variations in claim administration costs are also ignored. Some forms involve simple and single claims like a hospital indemnity policy with one claim proof. It is very simply audited and paid. Other forms involve simple but multiple claims (for example, one which pays out-of-hospital drug benefits). Still other forms involve complicated and multiple claims (for example, disability policies).

How about company size? We all know there is efficiency in size in many areas of expense. The size of the company not only affects many costs per policy, but also the volume of sales per product developed. It costs a lot of money to develop a product, and small companies might not have a chance to sell too many policies. A large company like Mutual of Omaha may sell a million policies. This has to affect the loss ratios a company can afford. The model also ignores the fact that sales costs differ between direct writers, agency writers, and brokers. How about the time and expertise of the salesman? Does that count for anything? Shouldn't the regulator recognize that the salesman needs to be compensated fairly for his time and expertise, and this is not the same percentage for all products and clients?

What will happen without the recognition of all these factors? Regulators could drive small companies out of business, deprive certain classes of risk of the availability of insurance or possibly eliminate certain types of benefits and products altogether. What is the solution? Frank mentioned one of the important solutions as being continuing education of regulators by industry actuaries. This recognizes that current loss ratio regulation is an oversimplified solution, and expenses are much more complex. We have to do this in our daily activity with regulators, at hearings, or any way we can. All of us in the industry have an obligation to do this. Another solution would be to start from the base of the new regulation and expand it to include a more complicated table. Or, have the NAIC and the industry work together to develop a formula or information to improve utilization of the deviation provisions. The deviation provisions allow the regulator to take into account actual expenses and risks, but he has no tools to enforce that provision.

I have one additional thought on this subject that is different from the others. It involves my worry about inflation. I worry about inflation because it increases our expenses. If we can currently afford a 50% loss ratio under a policy, that same policy being renewed 10 years from now might generate expenses of 100% or even 200%. Therefore, if the industry is going to remain solvent, the regulator must recognize continually decreasing loss ratios. But this flies in the face of political reality where the pressure is on the regulator to increase loss ratios. Therefore, I would like some consideration given to building into the regulation factors that would automatically change loss ratio standards with inflation. Then the regulator would not have to go through a political process to do it.

The next section that I am covering concerns the retroactive problems of the regulation. Those who have been close to its development know I have been very vocal about this. There are at least three retroactive aspects of the regulation. One is that there is nothing in the regulation that says these new loss ratio standards apply only to policies issued after the effective date of the regulation. This means that a company operating in a state with

a 50% loss ratio standard may now be subject to a 60% loss ratio on its old policies. Even though the company issued its policies in the good faith that its 50% expenses would be allowed, years later the regulator comes along, pulls the rug out from under the company and says the old policies are now subject to a 60% loss ratio. Maybe next year it will be 70%. This seems unfair to me. But there is another side of this coin. As I said previously, loss ratios should automatically change because of inflation. So, if loss ratios need to be dynamic in nature, you have to allow for changes in loss ratio standards that are implemented prospectively against in-force business. I might note that one insurance department actuary wrote us a letter stating he had asked his attorney general whether it would be legal to adopt a higher loss ratio for in-force business, and the attorney general said no.

The next retroactive feature has to do with the adoption of a completely new formula for the determination of the rate level to be charged in the future on in-force policies. The new formula brings into effect--for the first time in most states--the past experience in determining what you can charge in the future. I believe many companies have been operating on the premise that rate increases are based on future premiums and claims as offset by their policy reserves. Now there is a new formula being applied retroactively which says if past experience generated excess funds, you must return the money through inadequate future rate increases. I have prepared the following chart which depicts an example to show mathematically how this works:

	Premiums	Claims	Policy Reserves	Loss Ratio
Past	$10,000	$ 3,000	$1,500	45%
Future	10,000	9,000	1,500	75
Total	$20,000	$12,000	0	60%

Old Formula Rate Increase (RI) on 50% Loss Ratio Basis:

$$(\$10,000 + RI).50 = \$9,000 - \$1,500$$
$$RI = \$5,000$$

New Formula Rate Increase on 50% Loss Ratio Basis:

$$(\$20,000 + RI).50 = \$12,000$$
$$RI = \$4,000$$

Under the old prospective formula where credit is given for the active life reserve, one derives a $5,000 lifetime rate increase. Under the new aggregate formula, one derives a $4,000 rate increase. So the new formula says you are going to get $1,000 less than you thought under the old philosophy.

There is a third aspect that is retroactive. For the first time, interest is incorporated in the calculations. Up to now many insurance companies have been operating on the basis of loss ratios calculated without interest. This is a retroactive application since it applies to prior issues. Let's see what the impact of throwing interest in the calculation is. I have produced the following figures by adjusting the previous ones for interest at 5%:

	Premiums	Claims	Policy Reserves	Loss Ratio
Past	$12,500	$ 3,900	$1,500	43.2%
Future	7,500	6,600	1,500	68.0
Total	$20,000	$10,500	0	52.5%

New Formula Rate Increase on 50% Loss Ratio Basis:

($20,000 + RI).50 = $10,500
RI = $1,000 (discounted)
= $1,350 (non-discounted)

Using interest, one derives a rate increase of only $1,000 on a discounted basis and $1,350 on a non-discounted basis. So the regulation takes one from a $5,000 rate increase down to $4,000 because of the formula and then on down to $1,350 by throwing in interest.

MR. BARNHART: Bob, in allowing downward deviations from guideline loss ratios because of expense factors, higher than normal lapse rates, etc., wouldn't the regulator feel obliged to establish some measure of expense limitation, such as a limit on field compensation or a limit on underwriting expense? Wouldn't that be an almost inevitable development to accompany what you have proposed by way of recognizing expenses, lapse rates, and so forth?

MR. SHAPLAND: Yes, I think so--to the degree that a regulator feels he needs to regulate. Not imposing limitations on any of the factors we use and just accepting whatever the company wants to do would not be regulation. That is why the regulator needs the results of some expense studies so that he can do his duty.

MR. BARNHART: I think one of the difficult problems we have to grapple with is just how, as a practical matter, some of these considerations can be dealt with. In the atmosphere of regulation based on loss ratio guidelines and with the atmosphere that we have actually existing, the question is, how will we face up to some of these matters?

Our third panelist will give us a viewpoint from the regulatory side. Bob Nuding who is chief of the A&H Rating Section of the New York Insurance Department will speak to us on topic 2., loss ratio regulation from the viewpoint of the regulator.

MR. ROBERT C. NUDING: How satisfactory are loss ratio guidelines as a regulatory tool?

They work! I would begin by stating that I am not too familiar with the minimum loss ratio regulations of states other than New York. So, the following remarks reflect only the New York Insurance Department's position as well as I can convey it.

The first formal expression of New York's minimum loss ratio standards appeared in our Regulation No. 62, promulgated in 1972 and 1973. A review of those standards suggests that the Insurance Department had considered the essentially conflicting right of policyholders to receive a fair benefit return on their premium dollars with the right of insurers to receive

sufficient funds to cover claims, expense, and provide a fair profit. This consideration is reflected by the fact that the loss ratios for certain "low" premium coverages were lower than for others (e.g., accident only). The higher loss ratio required for policies issued to persons aged 60 and over reflected a belief that a higher standard was both desirable and feasible by reason of expected lower sales expenses and higher claim costs.

The most recent change in our minimum loss ratio standards occurred in January of this year, when the Eighth Amendment to Regulation 62 was promulgated. This amendment established certain minimum standards for Medicare Supplement and other insurance issued to senior citizens. Two critical features insofar as loss ratios are concerned are:

1. The minimum loss ratio on policies issued at age 65 and over will be 65%.

2. A practical monitoring procedure was established, providing for future premium rate adjustments on a timely basis.

In addition to the several reasons supporting a requirement of higher loss ratios just mentioned, it should be noted that because Medicare fiscal intermediaries determine "reasonableness of charges" upon which supplementary payment is subsequently based--and the federal and state benefit standards tend to reduce the diversity of such supplement plans--administrative costs may be further reduced.

On several occasions recently it has been suggested that a more active interest in actual expense studies should be taken by the Department, because of the impact of inflation upon insurers who are caught between rising expenses and inflexible loss ratio standards. Concern has been expressed that worthwhile health insurance products have been or may be proscribed because current loss ratios are not sustainable in the future, given the trend of higher expenses.

We would be very interested in any objective industry studies pointing toward this conclusion. But we do not now have either the manpower or the in-depth expertise to perform such studies ourselves. I would offer several comments bearing on our current thoughts. For a number of years, the inflation of claim costs under unscheduled benefits has appeared to exceed the inflation of expenses so that no reasonable case has been made to justify a downward adjustment of loss ratios. Even for fixed benefit policies, in the absence of proof to the contrary, we would assume that the combined result of discontinuance of issue of "obsolete" forms, past and future lapses, company growth, the long-term increase in investment yields, and probably economies in data processing, would render academic a discussion of inadequate expense margins arising directly from our loss ratio standards. There are some benefits which, by their nature, would require higher expense margins but which provide fragmentary coverage and may not be issued in New York. If there are substantive arguments that should be heard, there will be an opportunity to bring them to a forum, since the Department will be commencing extensive review of Regulation 62 soon, with a view to resolving the problems and curing the deficiencies referred to in the agenda.

The first and most distressing deficiency from our viewpointt, as I am sure it is from yours, is the inability of many, if not most, insurers (at least in New York) to keep certain health insurance forms on a self-supporting

basis. I refer primarily to individual major medical coverage. Given the trends we see and the benefit provisions in the policies extant today, we see no reasonable alternative to planning for annual, or at the most, biennial increases, to keep them at moderate amounts and to minimize destructive lapsation.

The second deficiency came to our attention late in 1978 as a result of forces at work outside our Department. You will recall that testimony in Congress brought to light abuses and potential abuses against the elderly in the provision of "Medicare Supplements". In work performed in compliance with a request from the House Select Committee on Aging and later with the Office for the Aging and the Consumer Protection Board of the State of New York, it became obvious that "anticipated" and "actual" loss ratios were far apart on policy forms issued to senior citizens by five companies doing business in New York. Agreements were ultimately reached that provided refunds in some instances as well as premium reduction, and in other instances provided for dividends. In a broader sweep of all company forms in the early spring of 1980, 27 insurers were queried as to why they should not adjust premiums either retrospectively, prospectively, or in both ways.

Without going into all the details which are not complete even now, it is enough to say that when Regulation 62 is next amended, some provision will be made for downward adjustment of premium rates on any form when it becomes obvious that the "anticipated" loss ratio will not be met both over the future lifetime and the entire lifetime of the block of policies. Our preference would be for a procedure involving self-monitoring by each insurer, with a plan of action initiated by the insurer through some objective formula, if one can be found, and agreement reached as to its application.

It has been asserted that insurers were put in a no-win situation when we in the New York Department demanded refunds of premiums to holders of policies which did not meet our loss ratio standards, because we did not allow these insurers to recoup past losses on forms with poor experience. Our reply has been that the disclosure of an anticipated loss ratio implies an obligation to achieve that loss ratio if at all possible. This obligation is not met by asserting that monies have been lost on other forms which cannot be recovered. Further, in order to avoid creating many of these "losers", this Department is prepared to approve moderate premium rate increases before minimum loss ratios are achieved, when studies of actual to expected experience or experience by duration indicates more drastic increases would be needed if action were delayed. Furthermore, we have only required refunds under policies issued to senior citizens wherein it seemed clear beyond any reasonable doubt that the experience would never approach the minimum loss ratio standard and large numbers of persons would not live long enough for prospective action to take substantial effect.

I would like to emphasize a point made earlier. We are not oblivious to expenses when loss ratio standards are established or enforced, but we do not think such standards would amount to much if any individual company could veto minimum loss ratios by claiming their particular expenses, "allocated" or otherwise, cannot be recovered and still meet the required loss ratio. It was, is, and must continue to be our aim to provide, through minimum loss ratios, some reasonable cap on expenses, within which administrative procedures and contracts can be established by each insurer without fearing unfair competition from other insurers who might overspend to gain more business.

I strongly urge those of you who believe that meeting the need for good health insurance in the individual market is an important goal, to give serious consideration to finding ways in which minimum standards can be reached, or exceeded, with a minimum amount of interference (or harassment) from regulators. It may be that with effective self-monitoring, with initiatives for action originating with the insurers rather than with the regulators, forms could be approved more quickly (at less cost?). I further urge you to have specific proposals in mind and on paper when deliberations begin.

Concerning the 65% loss ratio standard, the Department was aware that there would have to be some changes made, and in doing so, we opened a small door to some increased business if you are interested in going after it. It has been stated to us that you cannot go after business between ages 60 and 64 because you cannot recoup expenses and still meet a 60% loss ratio standard because the business will terminate at age 65. The 65% loss ratio standard at age 65 and over replaces the previous 60% loss ratio standard at age 60 and over. This means that if you are in the business of issuing disability income today up to age 60 and meeting a 50% loss ratio and you are not writing any over age 60, you can now do so and meet only the 50% standard.

MR. BARNHART: In the upcoming review of Regulation 62 by the Department, will the Department be including consideration of the NAIC model guideline itself? If so, what aspects of the NAIC's present model guideline present problems or deficiencies insofar as adoption in New York is concerned?

MR. NUDING: We on the actuarial side of the regulatory apparatus have been looking at the loss ratio standard for some months. Our initial inclination was to not adopt that sort of a loss ratio scheme. We (and I cannot speak for the lawyer and consumer advocates) are, however, looking at the size of the premium more in the terms that if a valuable benefit is brought to our attention as being unable to be sold because of the size of the premium, we will look at it on an individual-case basis. The best examples are those policies, not too many of which seem to be available, having super-high individual major medical maximums with very high deductibles which necessarily produce substantially lower premiums.

There also may be certain very short-term policies that we will look at. We have, in a preliminary working draft submitted to our superiors, introduced a paragraph stating in effect that we regulating actuaries would have the authority to make exceptions to those minimum loss ratios for selected instances. We were not inclined to make an adjustment in terms of all low-premium policies. I mentioned earlier in regard to fragmentary benefits such as cancer insurance that there is no indication at this time that anyone in the New York Department has changed his mind as to the impropriety of cancer policies by themselves in the state of New York.

MR. BARNHART: I want to highlight the comments Bob Nuding has made concerning early rate increase action by companies so that they do not risk letting things drag to the point where they need a large rate increase. I was quite interested in his comments about the ability of companies to make rate increases based on, say, select-year, actual to expected loss ratios or actual to expected claims. Do you think most companies filing in New York understand this? That is, that this route is available to them?

MR. NUDING: I have been with the Department about three-and-a-half years, and for every rate increase we have approved during this period (the majority

of which are very high, two-digit increases), we have emphasized, come earlier, come often, for smaller amounts. There is a direct correlation between the speed with which you get an approval and the smallness of the increase asked for.

For the last seven or eight years, some companies have marketed individual policies that anticipate an increase each year. These companies prepare for the increases in advance, and they get their approvals very rapidly from us. There is one case of a smaller company with a loss of time form that came to us after only three years of issuing the form. Their loss ratios were well below 50%, but they were able to show some very persuasive evidence that the number of claims arising in the first, second, and third years already were well in excess of the expected and the original assumptions. They received a modest increase of 15%, which they were pleased with. I want to emphasize that we have told everyone who has filed for large increases in the last three-and-a-half years to come in often. I do not have any answer to the question of how small an increase you can effectively ask for and still cover the expenses of asking for the increase.

MR. BARNHART: I want to call on Frank O'Grady again concerning the proposed State of Washington regulation. This is not a regulation that has been adopted, but it is pending.

MR. O'GRADY: Briefly, the proposed Washington regulation is not the NAIC model. At the recent Society meeting in Anaheim, Will Burgess presented an excellent summary of the proposed Washington guideline as well as the objections to it that were made at the public hearing held by the Washington Insurance Department. Some of the highlights in Will's report were:

1. The guideline would apply to group as well as individual insurance. The NAIC model applies only to individual insurance.

2. 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.

   Thus even though the basic purpose of the guideline was to establish minimum loss ratios, it actually goes far beyond that objective and requires things like a risk stabilization fund. It is not clear from a reading of the regulation how such a fund would be developed or at what level it would be set.

3. The minimum required anticipated loss ratios would never be less than 60% for individual policies and 75% for group policies. These are higher than those in the NAIC guidelines.

Hearings were held on this regulation in January, 1981. Because of the strong objections raised, the Department will not promulgate the regulation at this time.

One point this regulation demonstrates is that when a regulator decides to issue a minimum loss ratio regulation, he finds it is difficult to confine the regulation to that one topic without considering a number of related topics.

MR. BARNHART: Bob, I believe you had a couple more comments relating to topic 3.

MR. SHAPLAND: My comments are observations regarding regulations in general and how they lack uniformity. I see many things taking place that show we will not have uniformity. I will give you some examples. One Frank just spoke of would be higher loss ratios in the State of Washington. Virginia has just introduced a proposal that contains one more premium size category. Premiums of $1,000 or more would have a 5% higher loss ratio. Then there is the concept just mentioned regarding risk and premium stabilization funds. In addition, there are a couple of states that do not recognize deviations. I am happy to hear that New York, which is one of those, is considering deviations. Another state that specifically utilizes a minimum loss ratio and does allow deviations is Pennsylvania.

There are some states that do not allow amortization of initial expenses. When a policy is filed, these states apply one loss ratio standard. Subsequently, when a rate increase is filed, the loss ratio standard on renewing policies is higher. Those states include Pennsylvania and Kentucky. For example, in Pennsylvania there is an initial 50% loss ratio standard, but under a major medical policy, the first year you ask for a rate increase a 60% loss ratio is applied because you are filing under a renewing policy form. Kentucky has a rule that you must have a 65% loss ratio after the third policy year if filing for a rate increase. There are a couple of states that have recognized the retroactive problem under the rate increase formula. Kansas has adopted a regulation which eliminates this retroactive feature. The current Arizona proposal also eliminates this feature.

Another type of variation taking place is limitations on the level of rate increase allowed independent of loss ratios. Kentucky has a limit of 100%, and New York has a limit of 60%. The year following the 60%, you cannot have more than 35% and the next year not more than 25%.

MR. JOHN O. MONTGOMERY: I am with the California Department of Insurance. I have a number of things here. First of all, I want to point out that at our meeting of the Technical Subcommittee in San Francisco, the Subcommittee expressed the intent that there would be no retroactive increase in loss ratios. In other words, we do not intend that these loss ratio requirements be applied to business that has already been established with some other loss ratio requirement. For instance, California has had a 50% loss ratio requirement for some 25 years, and new standards should not apply to forms issued under the 50% requirement.

MR. SHAPLAND: Should there be a change in the model to make that more clear?

MR. MONTGOMERY: I believe we discussed that at our meeting in San Francisco, and I think there will be some changes. I also want to comment on the matter of persistency and its effect. I brought this up at our meeting in Anaheim, too. In a situation where a company rewrites its business to perhaps a benefit scale that offers a little more benefits or different arrangement of benefits, then replaces forms that have been issued on some series prior to this but replacing only those currently insurable, so those left in the old group represent a closed block of business with rapidly deteriorating experience. Then the company comes in and asks for a big increase in rates on this block. I believe we should consider that replaced block of business--even though the benefits are slightly different--as a prior antecedent of the currently issued policy and combine them all together for experience purposes. Otherwise there will be great problems with this practice. In connection with this, I might point out that in California we have a rather complete system of consumer complaints, and one-third of all our complaints relate to health insurance. Of those, half are with regard to premium increases. There is a tremendous head of steam building up in California with respect to this. People are complaining to the legislators. Incidentally, in California we do not have any statutory authority to approve premium increases. We can make recommendations, but if a company wishes to make a premium increase, it can effectuate it because we have no statutory authority. If the resulting experience turns out to not meet our reasonable standards, then we can ask the company to reverse it. And on a premium increase, the people who are in better health can find better buys elsewhere and leave. Thus the experience deteriorates rapidly. So we are getting a lot of complaints from the policyholders, and I think it is just a matter of time before the legislature gets riled up enough and we have action there to give us statutory authority. Does anyone want to make any comments to what I have said?

MR. SHAPLAND: I might point out that I have previously raised the question of closed blocks of business--not accruing funds to take care of deteriorating policyholders and the fact that the NAIC model does not deal with this. Possibly the NAIC should deal with this problem.

MR. MONTGOMERY: I feel definitely that this will have to be done through the NAIC and our model regulation may have to cover this situation.

MR. SHAPLAND: If renewing policies are issued and those policies go through an aging and deterioration process, then the insurers have to accumulate funds to take care of that process or the insureds are thrown into a deteriorating pool. Unless all companies are forced to set aside certain levels of funds, competition keeps them from doing it under many kinds of policies.

MR. NUDING: The retroactive question was never in the minds of the New York actuaries since regulatory changes in New York only apply to policies issued after the effective date of said regulations.

With respect to complaints, I want to say that all the complaints about individual health insurance premium increases come to my desk. I answer most of them. Hundreds of letters are sent out every year explaining to the complainants that our law requires that premiums be neither inadequate nor excessive, so we have to approve increases by statute when they are justified. We have introduced the 60%, 35% and 25% successive annual increase limits on an administrative basis subject to whatever legal challenges might be mounted.

MR. GERALD S. PARKER:* I have a couple of comments to make. We sometimes think the regulators do not give any consideration to the capital cost of being in business. If you are not earning at least the rate of inflation on your total capital, you are actually going out of business pretty fast. In our business where we have to develop new products so frequently, the cost of a new product can run anywhere from $50,000 to several hundred thousand dollars depending on how complex the changes are, how much computer work you have to do, and how much actuarial work is involved. You have to consider whether you are ever going to get that back and what you can earn on other investments. It is necessary for regulators to know about this and to be reasonable in their consideration of expenses if insurers are going to stay in this business.

A second problem I have is that it has been our experience that many regulators (particularly in the states where they do not have qualified actuaries) do not have any understanding of the effect of selection and the difference between select and ultimate experience. In effect, there are states that want you to reach your benchmark loss ratio in the second year. If you do that, you will be out of business pretty fast. The only way I can see that you can convince some of these people that that is not the way to do it is to tabulate loss ratios by policy year from issue. But you will find that is extremely expensive and lack of credible exposures in many cases makes them fluctuate widely. I do not know what the solution to this is, but if someone could come up with a good, cheap computer program to do policy year loss ratios--which nobody wants for anything except for convincing the regulators--he could sell it to many of us.

MR. JOSEPH W. MORAN: Frank O'Grady referred to the Washington proposal as sweeping in group health insurance as well as individual policies. That is not unique! There have been other proposed regulations that have attempted to prescribe maximum loss ratios for group policies.

The approach taken seems to imply that the mere use of a group policy mechanism for issue of the coverage somehow or other realizes gigantic expense savings that would not be realized if the same coverage were provided under individual policies. That is not always the case, particularly if you are dealing with a mass-marketed program where the insurer may actually have a choice between the use of individual policies or a group policy.

I wonder whether the rationale for distinguishing between group policies and individual policies for minimum loss ratio purposes is incorrectly oriented entirely toward employer-employee group policies and whether adequate attention has been given to the fact that the dividing line between group and individual is becoming more blurred all the time.

MR. NUDING: In New York we think our loss ratio standard applied to group is so low that it does not have any practical effect in the marketplace. We are now considering, at the request of the industry, suggestions for a bill that will liberalize the life and health statutes Sections 204 and 221 of the New York insurance law which would allow greater flexibility in issuing group policies. I am sure, somewhere along the line, we will have to deal with the question of the loss ratios that you raised. At the same time, not all is

*Mr. Parker, not a member of the Society, is Vice President, Health, Guardian Life Insurance Company of America.

good news. We expect to do something about New Yorkers being insured under policies issued in other states that are not connected with true multi-state employers. On the consumer's side, we are very disturbed since the public perceives, rightly or wrongly, that group insurance is a more economical product than individual insurance. Great masses of people get sales brochures for policies issued through the mail in which they are told they will have low group rates. In some instances this makes certain members of our Department very upset since some of the loss ratios on those group forms are lower than our required minimum anticipated loss ratio standards for individual policies. They are paying at something between 30% and 35%. The minimum loss ratio on individual policies is 50%, and the minimum group requirement is 65%.

MR. MORAN: Do I infer correctly that you do not feel there should be a distinction between employer groups and association membership groups?

MR. NUDING: No. Right now there are limitations in New York that effectively prevent some of the types of "group insurance" that are being issued in other states. We will have to face the question of recognizing a lower loss ratio for some forms of group if we liberalize our laws.

MR. MORAN: Even if you do not liberalize the New York law in this respect, you say you would propose to regulate minimum loss ratios for coverage that is solicited in New York for New York members of a nationwide organization under a group policy issued elsewhere.

MR. NUDING: People in the Department who are working on the task force would like to get more business issued in New York. Their idea is that by liberalizing the ways in which insurance can be marketed in New York, the companies will in gratitude agree to limitations on solicitation of New York residents who look to us for protection. Currently we have to tell them, sorry, we do not have regulatory authority. You may live in New York, but you are not protected by our Department.

MR. MORAN: Some nationwide organizations based outside New York will not consider it progress to have solicitation of their New York resident members restricted.

MR. BARNHART: I think it is true, Joe, that many members of the public, state legislatures, and even insurance departments think that merely because something is written under a group master policy it will suddenly be capable of sustaining a higher loss ratio. I might also mention that there are certain companies in our industry which improperly advance that notion. Some advertise on television, for example, saying that if you are a Viet Nam veteran, you qualify under such and such mail order group policy. They also tell us that because of that, low group rates are available when, in fact, nothing of the kind is true.

MR. W. DUANE KIDWELL: In looking at the loss ratios Frank referred to, we should be concerned with their distribution. As an actuary, I can accept those ratios as being reasonable, but as a consumer, they look like a rip-off. I was recently reminded that if we considered taxes and distribution costs in the price of a pound of roast beef, we would find we were only getting 30¢ worth on each dollar spent. In that light, as a consumer I could accept those loss ratios. From the broader citizen's point of view, we may have a difficult educational process. We may also have trouble training our

agents properly so that they can explain why we can only return 50¢ to 60¢ on the dollar for individual contracts. Frank, did the NAIC committee address whether or not loss ratios should be made public on individual policies or whether they are strictly for regulatory purposes?

MR. O'GRADY: That consideration never came up. We were aware that New York has this requirement. We restricted ourselves to developing a proposal in response to the different insurance department loss ratio proposals that were being made and which we found satisfactory.

MR. KIDWELL: In Canada we must certify to the superintendent of insurance each year that the loss ratios being experienced on a particular form are consistent with those assumed in the pricing. If the experience is materially inconsistent, plans for corrective measures must be included.

MR. SHAPLAND: My reaction to disclosure in general is that it would be unfair to our industry (which is competing with other industries) to disclose its raw material ratio if the other industries did not have to. The public is not going to understand that number, and they are automatically going to assume we are ripping them off even if every other industry has a lower ratio than we do.

MR. RALPH E. OLSON: Frank O'Grady enumerated six states which have the guidelines. I believe Florida also has adopted these guidelines. They have required us to file some loss ratio projections on the last couple of health products that we have developed.

MR. SHAPLAND: That would have to be a new development because neither Frank nor I are aware that they have loss ratio guidelines in a form where they vary by renewal agreement and type of coverage.

MR. OLSON: The copy that we were able to obtain from the Florida Association of Life and Casualty Insurers did have a table similar to what was referred to earlier. Florida also required us to make projections of our loss ratios.

MR. MONTGOMERY: We have not adopted the standards of the NAIC guidelines yet in California because we are awaiting the outcome of some legislation. Right now we only have the authority to apply standards of reasonableness to individual medical expense policies, and this legislation would expand it to individual disability income and mass-marketed and franchise business. At that point we intend to go ahead with using those standards of reasonableness.

MR. JOSEPH J. BUFF: My point specifically concerns individual disability income coverages with long-term benefit periods and long elimination periods. The particular problem these coverages present, especially for small companies, is determining what the claim costs will be when calculating gross premiums. I think everyone knows that these kinds of coverages are subject to random fluctuations. You can see it in the loss ratios from one year to the next. In trying to quantify that, a few months ago we modeled one of our policies which was marketed for about four years. It involved about 3,000 policies or about $1,000,000 worth of premium in force. We found the annual loss ratio was subject to remarkably broad confidence intervals. The claim costs, especially for the 90-day elimination period, were almost impossible to measure with the amount of data we had due to statistical

variance. This means that the only way to successfully price this kind of coverage for a mutual insurance company is to throw in a very large dividend margin and then, as experience actually develops, adjust dividends up or down. We need to know that the rates are going to be adequate while, from a marketing viewpoint, we want to be able to continue to pay some dividends. While one can take a look at experience for the last three years, there is some possibility that that experience may understate the "actual" underlying claim cost table by 15% for a 30-day elimination and by 50% for a 90-day elimination. I would like to ask Mr. Nuding how he would react if a company filed a long-term disability income policy, arguing that because of these problems it needs to put in a dividend margin on the order of 25%.

MR. NUDING: Our regulation says we cannot allow this right now. Regulation 62 states that the minimum loss ratio is 50% for such a policy, and this does not allow a 25% margin for dividends. As I previously stated, Regulation 62 is being reviewed. At the proper time, you should bring these types of arguments forward.