RECORD OF SOCIETY OF ACTUARIES
1981 VOL. 7 NO. 2

INDIVIDUAL ACCIDENT AND HEALTH RATE REGULATION ISSUES

*Moderator: ROBERT B. SHAPLAND. Panelists: NOEL J. ABKEMEIER, ROGER C. DAY**

MR. ROBERT B. SHAPLAND: I am an actuary, with Mutual of Omaha, who has been fairly active in the regulatory scene. Others on this panel are Noel Abkemeier from Allstate, whom I chose because he is Chairman of the HIAA Individual Actuarial Committee, which has, over the years, been the body of industry actuaries that has worked with the regulators in developing rate regulation standards, and Roger Day, who is Insurance Commissioner of Utah and has been active in the NAIC, including past chairmanship of the (C1) Committee. Also, Roger's state was the first to adopt the 1979 NAIC model.

The first item on the agenda has to do with the legal basis and history of rate regulation, in order to give some background on how regulation came into being.

Generally, rate regulation began after the 1951 NAIC Uniform Policy Provision Standards were adopted. Those standards did not contain provisions regarding rate regulation, but many states added a provision that said the Commissioner may disapprove a policy form if benefits are unreasonable in relation to premiums. There are approximately 33 states that have adopted this provision. Then, in 1953, a subcommittee of the NAIC made a report on its findings regarding the reasonableness of benefits in relation to premiums. I want to read a couple of statements from their report.

"No loss ratio should be fixed as an absolute minimum for any policy where automatic disapproval is to follow." It goes on to say, "Any proposals should go no further than to serve as a benchmark, which would create a possible presumption that benefits are unreasonable." In other words, even back then, the actuaries who dealt with this issue understood the shortcomings of loss ratios--that loss ratios have to be flexible, that loss ratios should only be used as an initial benchmark or a flag mechanism for showing that a premium might be unreasonable, and that ultimately reasonability should take into account all factors that affect costs in the pricing of insurance.

In 1979, the NAIC adopted a new rate filing guideline that will be discussed later. Over this period of years, the states had taken various kinds of action. Generally states did not initially adopt official regulations, but such activity is now increasing, maybe geometrically. New York, one of the leading states, adopted its Regulation 62 in reference to rate regulation in 1973. Right now, according to our records, there are less than two dozen states that have official rate regulations. There are only a few, and this is just in the last year or so, of course, that have adopted the new NAIC model or variations thereof. In addition, several states have hip-pocket rules that they follow.

In Canada, general rate regulation started in 1975 when the superintendents adopted a guideline that contains two requirements. First, it calls for loss ratio disclosure. Companies are required to disclose their loss ratios

*Mr. Day, not a member of the Society, is Commissioner of Insurance, State of Utah, Salt Lake City, Utah.

in applications, advertising material, and policies. Second, it calls for actuarial certification that the experience that is developing is not significantly inconsistent with that anticipated. Or, if the experience is significantly better than anticipated, the actuary has to state the reason and what corrective action the company is going to take. The guideline goes on to specify the loss ratio information that the actuary must examine before he certifies.

Going on to the next section of our agenda, we consider the purpose or need for regulation. The first subsection asks if the purpose is to avoid companies' charging excessive premiums.

MR. NOEL ABKEMEIER: Although I would be infinitely happier if there were no regulation of health insurance rates, I recognize that there are some justifications for regulation. The product we are selling is intangible and it is difficult for the customer to fully evaluate the product he is purchasing. Products available in the market are quite varied, and the relative value of the product differences is elusive. For new policies, the form which such regulation should assume is to require professional actuarial certification that the benefits are reasonably related to premiums and that the premium scale contains sufficient policyholder equity. This should be supplemented by regulations which require accurate advertising and disclosure of policy benefits. The package is then tied together by competitive forces in the marketplace.

Any concerns about excessive profits, unnecessary expenses, or inefficient marketing or administration should be addressed by market competition. No company could afford to be far out of line with high premiums, nor would there be a shortage of companies willing to lead the price competition. Thus, competition in an informed market should be sufficient.

MR. ROGER DAY: There are certain practical implications regarding the way in which benchmark loss ratios facilitate the regulatory process in avoiding excessive premiums and how they make it feasible to carry out the statutory burden assumed by the requirement that benefits be reasonable in relation to the premiums. We have administered that requirement in the State of Utah on an exception basis. That is, we look at insurers that are out of line compared to the norm for similar products for the industry as a whole. But it is difficult to enforce the requirement of reasonableness unless some standard has been provided. Part of Bob's concern in this area is that the standard will become a very literal indicator.

The standard has to be thought of as an indicator of value, but not the absolute indicator of value. From the practical standpoint, regulation is appropriate. We have had companies with policies approved by us that generated 7% loss ratios. Our first indication that this was occurring was in consumer complaints. After reviewing the filed loss ratio information, we rescinded our policy approval. The limitations stated in 1953 are still appropriate because there could be factors in the context of either the market as a whole or the company, or that particular product, that would allow the unreasonable presumption to be rebutted. But, it is important to have some organized and systematic target that defines reasonableness for the regulator and identifies some of those factors.

In surveying states as to how they were implementing their current guidelines, there seemed to be two basically opposed schools of thought. Some

states, perhaps those with the largest actuarial staffs, were taking the regulation very literally and enforcing it affirmatively across the market for all companies. Smaller states with lesser staffs seemed to be following the exception-based method of enforcement. It is also possible that an insurance commissioner may not know precisely what his staff is doing, and therefore, the kind of discussion we are having today is useful in letting people understand what benchmark loss ratios are all about. It means establishing a benchmark that is going to be adjusted by the full context in which a company or product is operating.

MR. SHAPLAND: One thought that comes to mind is that the pressure of inflation, the loss of our markets to group and government programs and competition are effective forces in avoiding excess profits, and that regulation is unnecessary for the majority of the companies. There are always exceptions to the rule, but regulation is an expensive process and I wonder if it is returning a fair value.

MR. DAY: One thing that is important to recognize is that competition is less effective for individual products than for the group marketplace. There are several conclusions to be drawn from that. One is that we at the NAIC level will be doing all we can to facilitate the entry of individuals into the group marketplace in order to help them meet their health insurance needs. The elimination of some of our current barriers may be effective in achieving this objective. The other consideration is that there are some real limits as to how effective competition can be in individual products. The lack of product standardization makes competition difficult. Without more product standardization and general recognition of certain value parameters, competition will not emerge as an effective regulatory force.

MR. SHAPLAND: The next item has to do with whether or not the purpose of rate regulation is to avoid inappropriate benefits.

MR. ABKEMEIER: An inappropriate benefit in relation to premium is one in which the customer will generally have little to gain through the purchase. An example would be a small benefit, such as the Medicare Part B deductible of $60, which bears a premium of $50. Little benefit is derived when a claim is filed because the benefit is just $10 greater than the premium and in the years where one does not file a claim, the entire premium is spent.

With adequate disclosure, the typical customer should be able to make an intelligent decision not to purchase such a product.

For companies willing to market such a product, the consumer oriented elements in the news media and activist organizations would present the possibility of adverse public relations. The combination of disclosure and concern for public relations should provide sufficient protection so that regulation is unnecessary. Any regulatory attempts to address this issue fall pretty quickly into subjective arguments, which simply heat up the argument, rather than resolve it.

MR. SHAPLAND: If a regulator feels it is necessary to protect the public against buying inappropriate benefits in relation to premiums, then the regulator needs to develop some kind of measuring stick. Let's look at some examples. All of us would agree that if you had a Medicare Part B

supplement benefit of $60 and had to charge an $80 premium for it because of the administrative costs of handling all of the small claims involved, that is an unreasonable benefit in relation to premiums. We would agree even if the loss ratio were 90% or 100% since it has nothing to do with the loss ratio. What if that $60 benefit only costs $30? Now there is a question of the utility value of the insurance and whether the public should have that product available at that price. Finally, let's take the example of $1,000,000 Major Medical policy with a $100,000 deductible. Such a policy might be designed to coordinate with a group program with a $100,000 maximum. This policy might have a premium of only $30 because of the small claim costs, but maybe $25 of that has to go to expenses and only $5 to claims. In other words, maybe only a 15% or 20% loss ratio is involved and that is the highest loss ratio the insurer can afford because of the cost of issuing the policy, billing the premium, paying claims, and so on. Here, it would be reasonable to provide only a 20% loss ratio. The public is not going to have this kind of coverage available unless the regulator allows the 20%.

MR. ABKEMEIER: Just because it is reasonably priced doesn't mean it is something that belongs in the marketplace. Whether or not it should be offered should depend upon the insurer's judgment as to whether the product would be accepted in the marketplace without adverse public relations.

MR. SHAPLAND: The next item on the agenda has to do with whether or not one of the purposes of rate regulation is to avoid deficient premiums or, in other words, if it is an attempt to assure solvency. In the context of loss ratio regulation, I have not seen this take place. I have not seen any proposal that a maximum loss ratio be set so that insurers stay solvent. On the other hand, insurance departments are no doubt concerned when they see insurance companies with high loss ratios. But as far as the regulations are concerned, they have not dealt with this issue. Regulators need to be concerned with this issue because continued inflation is going to cause economic problems for insurers.

MR. ABKEMEIER: Not only have regulations not assured solvency, they have often had an opposite effect. The imposition of high loss ratios at issue may cause a company to slash its contingency margins, thereby increasing the probability of loss for the insurer on a product which is adversely affected by inflation.

Similarly, the refusal to grant rate increases until cumulative losses are demonstrated erodes the insurer's surplus. Therefore, regulations may assure deficient premiums.

MR. DAY: There are some other reactions that are likely to occur first. The availability in the marketplace of certain products could be affected and companies could be forced into a defensive posture resulting in less than full integrity in their marketing and disclosure practices with the regulator. An example is the filing of new policy forms every year before the experience is fully developed on the old ones in order to avoid compliance with the benchmark loss ratios. The whole process can become meaningless and threaten availability if loss ratios are set too high or enforced too literally. This would occur before any insolvency threats arose from high loss ratios, but either would be unfortunate from a public standpoint.

MR. SHAPLAND: The next item on the agenda has to do with whether or not rate regulation is intended to assure fair treatment of policyholders when implementing rate increases under level premium policies. It is my understanding from dealing with the development of the model regulation, that this is indeed part of the concern of the regulator. The purpose of the level premium system should be fulfilled through the rating process and it should not be overcome or obviated by rate increases that don't take into account the fact that a level premium system was in place. On the other hand, there is some disagreement regarding the purpose of a level premium policy, especially one that provides inflationary-type benefits like Major Medical insurance. Is there such a thing as a level premium under an inflationary-type benefit, and if there is, what is the function of rate increases versus the initial premium rate in funding future costs?

There are several changes facing insurers and insureds as they go through life under a policy form. First, they experience aging. Second, if the form is underwritten, they face health deterioration. Third, if there are rate increases, the good risks can be driven out while the bad risks stay and this produces a deteriorating pool of risks.

If the public is to be protected against these factors which affect insurance prices and affordability, regulators and the industry must figure out some kind of a funding system to avoid the adverse aspects of these factors. The NAIC model deals with this in one fashion, which we'll be discussing later, but there are other ways of dealing with this problem. We're going to leave that subject for now and cover it when we get into the technical areas.

Another subject is whether or not rate regulation should become involved in assuring equitable risk classification or premium levels among various policyholders.

MR. ABKEMEIER: Each customer deserves equitable treatment, and it is appropriate to carry the requirement of a reasonable relationship of benefits to premiums down to the lowest practical level. This also calls for requiring that a person's risk classification be maintained in order to preserve the initial equity. The actuarial certification of rates should encompass reasonable equity among the policyholder groups by age, sex, or other characteristics which significantly affect relative costs. Also, the actuary should be applying a consistent interpretation of "reasonable relationship of benefit to premium" among various forms so all segments are treated equitably.

MR. SHAPLAND: Fair equity has not been defined and is very judgmental. Also, when insurers price a product they need to temper equity with simplicity of the rate structure, marketability of the rate structure, risk sharing among the various policyholders, and affordability. I have seen very little public argument that the lack of a price differential, reflecting a cost differential, is unfair and anybody pricing products should have to take into account cost differences. In fact, some citizens seem to be fighting for uniform prices, even if there are cost differentials. So, right now some of the pressure is actually in the opposite direction, and I see very little public pressure for internal equity.

MR. DAY: That is an area where the development of professional standards that provide the foundation for professional certification will probably

be increasingly important. It would be a misapplication of loss ratio standards, which are essentially a screening device, to go to the level of detail necessary to have a definitive statement of equity. Increasingly, regarding the issue of equity, the NAIC will rely on professional certification. That may represent an attempt by regulators to get the ball out of their court, while at the same time, having appeared to be responsive to a politically sensitive issue. It also goes beyond that. One of the issues that must remain of concern to all parties is the ability to conduct the insurance business--maintaining an adequate spread of risk within any universe of insurance being written. If cost-based pricing is pushed too far, the availability of insurance will ultimately be destroyed. Some degree of risk spreading is clearly required. However, excessive risk spreading is unacceptable since it can lack a sound basis and adequate underwriting. This simply reinforces the fact that what we are dealing with is a reasonableness test and there cannot be any absolute determination in a general public sense.

MR. ABKEMEIER: There are many questions as to what is a reasonable way to spread risks or to balance out premiums. Bob mentioned that affordability of coverage is one component that might be used in determining what the premium level should be. The premium structure is not really a way to attack the question of affordability. It should be handled with product design. The insurer should not be allowed to charge a flat premium for all ages for a benefit whose cost varies greatly by attained age. An example might be Medicare supplement insurance which is sometimes offered at the same premium throughout the entire age spectrum. It is more appropriate to charge each insured his appropriate level, rather than have the younger group subsidize the older group.

On his second point, the public's willingness to overlook logical price differentials does not necessarily reflect a deep consumer acceptance of the potentially "unfair" discrimination. Consumers could merely want to overlook unfairness when it favors them. Also these often are part of a much larger "equal rights" or "equal treatment" issue.

MR. SHAPLAND: Our next topic deals with subsidization via rate regulations.

MR. DAY: I suggest that a subsidization requirement would be contradictory to most of the insurance laws in the various states since it fails to recognize that the voluntary marketplace cannot meet all the needs--the social needs in particular--of those who would seek access to it. What needs to be created is an explicit system capable of meeting that need, that will include participation by the insurance industry and equal participation by those who perform the same function as the insurance industry--that is, self-insurers and others--at the state level. The consequence of not doing that is to continue to run the risk that national health insurance will finally be implemented, which would be a far greater concern than the effect of subsidization at the state level through an organized system. The NAIC has had various models, most of which are not in a finished form, for addressing this issue at a state level. I suggest that implementing a state pooling mechanism to meet the needs of citizens that cannot be met in the voluntary marketplace would be advantageous. The losses ought to be financed from behaviors that represent adverse health risk. Other states might have trouble doing this, but in the state of Utah we propose to provide ours out of tobacco and liquor taxes.

Although it is ideally appropriate to charge the assessment against all the different providers of insurance, I'm not sure how practical it is because it is difficult to identify the self-insured.

We must avoid eroding the marketplace in the states enacting state pools. For some reason the State of Utah has had more self-insurance of health insurance as a percentage of the total market than most other states. If there is an unequal social burden and unequal competitive standards, the marketplace and its consumer protection elements or solvency protection elements may be destroyed. My hope is that the linkage of this kind of questions to the tax policy and the deductibility of health insurance benefits as a business expense, will be the vehicle that will overcome the risk of preemption and allow an equal spreading of the burden.

There is one other area of subsidization that was not mentioned. That is, requiring more strict loss ratios for one group of customers than another--such as in the Medicare supplement area. Loss ratios are being pushed up high for the older insureds and that is not appropriate for the insurer who is in that market. If profitability is limited, the insurer may look for additional profits from other business, which is not fair to other customers. Or, it can have the counterproductive result of discouraging insurers from operating in that market.

That reinforces the need for the use of benchmark loss ratios in order to avoid Federal enactment of more stringent single indicator total value type loss ratios, as we had in the Baucus Amendment. If the Baucus Amendment made you nervous, its implementation is going to scare you to death.

MR. SHAPLAND: One alternative to meeting social problems like uninsurable risks would be for citizens in a state to agree that it is a need to be met by all taxpayers, not just those buying insurance. This political question is being avoided by limiting the taxation to hidden assessments through insurers.

The next item on our agenda has to do with whether or not loss ratio disclosure is a proper form for rate regulation to take.

MR. ABKEMEIER: Although it is required to disclose the anticipated loss ratio on the policy or sales material in some cases, such as in Canada and New York, this is not an appropriate disclosure item. It is acceptable as a tool for technical discussion between the actuary and the regulator, but nothing more. It is not for the customer's use because it in no way presents a coherent view of the product in question. It is more subject to misinterpretation than to proper understanding. The raw number does not reflect the differences in premium size, renewability, marketing method, or other features which contribute to the determination of a proper loss ratio. The ratios could encourage, for example, making a more expensive purchase in order to attain a higher anticipated loss ratio. The purchase should be made on the basis of underlying characteristics, that is, premiums and benefits, and not the loss ratio, which is merely a symptom--and often a false one.

MR. DAY: I would concur that it is subject to misinterpretation by a consumer, but it is still a useful indicator. If there are reasons why a loss ratio is low or has been low, in spite of the benefit levels and the level of premium, then the consumer is able to make a valid decision upon receiving the reasons. I do agree that it is subject to misinterpretation and excessive

emphasis will cause problems, but that does not mean that it should never be shown. As a means of beginning to channel competitive pressures, it is a useful tool. The same kind of concern exists with cost disclosure in life insurance. They are never an absolute indicator by themselves. In most cases, the more a consumer knows and the better informed a consumer can be, the more likely it is that competition will be an effective force by itself.

MR. SHAPLAND: We are going to move to the technical issues now. The first has to do with methods of determining rate increases under level premium policies. As I stated earlier, the NAIC has adopted one approach to determining a fair premium increase under a policy that uses a level premium funding method.

In essence, the NAIC adopted a formula that says when calculating a revised premium rate, it is necessary to take into account both the past and the future experience and compare the aggregate loss ratio with the minimum loss ratio. In essence, this says that if you have a low loss ratio in the early years, compared to the minimum loss ratio, you will give back the funds generated by that low loss ratio in future years through premiums that generated higher than minimum loss ratios. The regulation goes on to utilize a second prospective-only loss ratio test. Its purpose depends upon one's interpretation. Its basic purpose is to keep you from using negative funds generated from early high loss ratios to justify low future loss ratios via the previously described formula. There is a question regarding the second formula concerning whether or not active life reserves are a part of this prospective-only loss ratio test. In other words, I don't think it is explicit in the adopted formula whether the future claims that are divided by future premiums are reduced by some active life reserve. Some of the discussion to follow and the differences in what I say versus what Noel's going to say have to do with our difference in interpretation in this area.

I see some problems or shortcomings in the NAIC approach. First of all, there is no responsibility placed on insurers for accumulating early funds to offset the aging and health deterioration process. Therefore, the burden of deteriorating experience falls on the policyholders and not the company. Let me explain this. There is no minimum standard for accumulating funds. If a company sets a premium rate to be competitive, or on any other basis, that accumulates no early funds, it is not held responsible for any funds. Under the lifetime loss ratio formula, if it has a high loss ratio the very first year, then no funds are accumulated under that formula to offset future experience and the company can file for rate increases to take care of the aging and deterioration process. Another problem is that even if a company does accumulate some funds under this formula because of initial low loss ratios, it can delay rate increase activity and use up those funds with little risk. For instance, if it had a 40% loss ratio for the first few years and then the loss ratio rose to 80%, the 80% would just eat into the 40% for awhile and the company could wait until the fund was exhausted and then justify a rate increase of 100% or 200% because of the then current and projected loss ratio. Another problem is that the formula puts insurers in a "can't win" position. Or, if it is not a "can't win" position, it at least creates the need for larger risk charges than would normally be included in insurance premiums. I question whether the adopted loss ratio levels take this into account. This problem stems from the combination of both formulas. If you have favorable experience you are forced to give the margins back

via inadequate future rate increases. But if you have unfavorable experience you cannot recover your losses. So, instead of an insurer being in the business of taking a risk--a risk of both a profit and a loss--profits have to be given back but losses must be kept. As long as there is a sufficient risk charge margin in the minimum loss ratios, a company can still survive, but it is a serious deterioration from the economic environment of the past.

MR. ABKEMEIER: The NAIC model handles the cases you refer to. Aging is handled by the inclusion of the active life reserve in the benefits. It is not precise, but it leans heavily in the right direction. Also, the competitive edge derived by undercharging is limited by the way the NAIC formula does not let an insurer recoup significant back losses. Also flexibility is only available on a closed block of business. The option to undercharge, therefore, is foreclosed.

Concerning your feeling that insurers are hit by one side of a "can't win" situation if good experience must be carried forward to offset future poor experience, I do not share the concern.

Holding gains to cover future deficits does not appear inapproporiate insofar as the assumed loss ratio was calculated by the insurer in the aggregate over the same period. The insurer should be concerned with the overall cost, not the timing.

The observation that there is a "can't win" situation must be kept in perspective. The insurer's function is to spread risk and make a fair margin on the risk. With a moderate contingency margin in excess of the profit and timely filing of rate increases, the insurer should be able to attain a profit.

MR. SHAPLAND: My perspective on rate regulation and the actuarial management of health insurance stems from my belief that the future is so nebulous that all of these calculations and projections are somewhat meaningless. Realistically, health insurance has to be operated more on a casualty type year-to-year basis. Using lifetime loss ratios in the face of inflation and unknown future expenses and claims is an attempt to do things that actuaries do not really have the capability of doing. But, aside from that, if active life reserves are included in this prospective formula, in many cases they are unrealistic reserves, because reserves are not modern. Also, regulators allow two-year preliminary term. So, can insurers reduce their obligation for funding by adopting two-year preliminary term versus net level reserves? Another question is, aren't the reserves for solvency purposes and not equity purposes? Also, reserves up to now have never included any accumulation of funds for the wearing off of initial selection. The competitive pressure on rates, especially for Major Medical policies, is such that without some kind of mandatory funding process, insurers from a competitive standpoint are not going to be able to charge for funding. There are concerns on the part of regulators about closing off blocks of business and cycling through rate increases for a deteriorating block of insureds. The only way to avoid that kind of a situation is to mandate funding.

There is at least one alternative to the NAIC approach. That would be to require some kind of minimum aging and selection funding under individual health insurance. This would be independent of any solvency reserves and

would put insurers at risk for accumulating these funds. It would use a prospective-only formula which would allow the insurer to charge a premium in the future to meet future claims as offset by the minimum funds that the insurer is held accountable for--whether enough premium had been charged in the past to accumulate those funds or not. If the insurer did not realize those funds, then the shortage would have to be taken out of surplus. If the insurer has charged a price that generated funds in excess of those required, a profit has been made.

This system would increase the policyholder protection against this cost spiral situation.

MR. ABKEMEIER: The situation you just described totally protects the policyholder in the case of adverse experience. The NAIC guidelines incorporate this protection by requiring that the future experience satisfy the loss ratio guidelines after recognition of the active life reserve. The insurer also has the potential for profit if the business develops favorably over the long run. I think the NAIC model again has done what you wanted, but it takes close attention and prompt action by the actuary.

MR. DAY: Another element that could be raised for discussion is whether or not loss ratio benchmarks should be applied on a state-by-state basis. If an insurer had to rate on the experience within a state where the experience is not fully credible--is not reflective of the underlying risk or administratively practical--there is a potentially serious concern that the NAIC has not been willing to admit. Maybe Noel's committee should consider this to see what can be done.

MR. SHAPLAND: We have definitely seen indications by some states that they want to look at their own experience. And if their experience is better than the national average, there's political pressure on them to say, "You've got to have lower rates in our state." But if they see experience worse than the national average, then they keep quiet about it. I know one state that had a regulation (I don't know if it is in force anymore) that says the rate in the state cannot be any higher than the rate charged in any contiguous state. If every state had a rule like that, we would have chaos.

Our next subject has to do with the extension of level premium principles to non-level premium policies. The reason this subject is included is because the NAIC formula applies to all policies. There is no statement in the NAIC model that the formula is for level premium policies only and does not apply to step-rated or nonrenewable policies.

I personally believe there is a place for the casualty rating approach in health insurance. In this approach, you sell a policy, set the rate for only one year, and then reset the rate for each subsequent year so that each year is a separate entity unto itself, such as in automobile or homeowner policies. The insurer is not held accountable to give back what was gained in any previous year. There is a proper place for this in step-rated and nonrenewable policies. There are serious problems from a practical standpoint if level premium regulations are applied to nonrenewable policies. If a policy only lasts for six months or even one day (air travel insurance for example), and the premium rate that is charged in the future will be dependent upon past experience under that form, the form could be discontinued if past experience was favorable and a new form could be sold to avoid profit carryover.

MR. ABKEMEIER: The concept of a non-level premium policy is not unique. It may have all the characteristics of a level premium policy except that the profile of planned premium payments is different. The mechanics and rationale of rate maintenance are no different once the appropriate adjustment is made for the nonexistence of active life reserves and the premium relativities for the various attained ages are recognized. The methods described are adequate for the insurer and equitable for the policyholder. The casualty method produces a selection-based profit immediately and the life insurance method spreads the profit over a longer period, which is more appropriate. By the way, there are some limited cases where moderate past losses can be recouped under the model but not under the casualty method. The business can be properly and profitably managed with the lifetime methods developed in the model. I must agree, however, with your criticism of crediting past favorable experience on a block of single premium business against future business. This business lacks the characteristic continuity between past and future premium payors. Whereas on other business you are generally assessing or rebating to those customers who produced the deviation, on single premium business this becomes a subsidization of one customer by another. This interpretation fits within the flexibility of the NAIC model.

MR. DAY: It is important to recognize that a casualty methodology has more danger of providing an incentive to skim. Therefore, emphasis on heavier kinds of regulation would support the spreading approach, allowing for more self-regulation.

MR. SHAPLAND: The next item on the agenda has to do with whether or not regulation should guarantee the maximum future expense charges of an insurer.

MR. ABKEMEIER: The application of the NAIC guidelines creates a maximum expense margin at the same time it creates a minimum loss ratio. This causes problems over the long run if expenses inflate at a rate in excess of claim costs, and therefore, cannot be covered by the percentage increase in premium. There are two immediate remedies which must be made available to the insurer. First, if the original anticipated loss ratio exceeded the minimum in the guidelines, the insurer should be allowed to move down to the lower benchmark limit, if necessary. The insurer simply had demonstrated compliance with the benchmark at the time of filing and had not guaranteed the higher loss ratio. At the time of issue, the actuary certified the reasonable relationship of benefits to premiums and would do so again. The regulation also should be willing to permit measurement against a loss ratio lower than the minimum permitted at the time of the original filing if the changed circumstances justify it. Any other approach would be unrealistic in the uncertain inflationary environment, particularly in relation to policies providing benefits which are little affected by inflation.

A corollary to this is that the loss ratio guidelines must be viewed as dynamic and not static. Certain factors, such as the $100 and $200 breakpoints, must be revised regularly and other dimensions adapted to changing circumstances. Perhaps the benchmark percentages may become obsolete and require revision.

MR. SHAPLAND: I see serious practical problems if this is not done. For example, consider a policy that provides indemnity benefits. Benefit costs are not subject to inflation in this case. The insurer might assume that the expenses over the policy life, based on current costs, are going to be 40%. It is conceivable that with continuing inflation, expenses later could become

100%. The practical solution is for the regulator to recognize this and allow companies to reduce their loss ratio to 40%, 30%, 10%, or whatever is required by the expenses brought about by inflation. But, I see that there are political pressures and regulators may have trouble allowing this.

MR. DAY: Implicit flexibility is probably an inadequate protective standard for the future. When we revise our current regulation, we ought to consider making the flexibility explicit to provide increased security. What we are talking about are guidelines and mechanisms useful for screening, and to some extent, consumer education. We do not believe we are going to stop the effect of inflation through these requirements, nor that it should be absorbed exclusively by insurers, instead of those they represent.

MR. ABKEMEIER: We have been talking about flexibility within the guidelines, and that is the most important message. We must utilize the flexibility wisely not only to accommodate our own specific products' needs, but also to guarantee that the guidelines maintain their desired breadth. This will be the most sensitive part of the guidelines in day-to-day practice. It is an area where we must consciously avoid abuse so punitive restrictions are not imposed either formally or informally. This is the most important point. Without flexible interpretation, the guidelines are deadly. Total objectivity must be maintained by the actuary to keep this channel open.

MR. FRANCIS T. O'GRADY: Commissioner Day, there are only a few states that have adopted the NAIC model. From your experience in the NAIC, do you anticipate more states adopting it?

MR. DAY: I would say, yes. The main area of emphasis recently has been the need for Medicare supplement regulation, especially before the Federal government has a chance to set preemptive standards. I suspect after the Medicare supplement issue is resolved, the states will again consider adoption of the NAIC model. The level of activity has also been a consequence of the work of the (C4) Subcommittee. These have been very important projects that may have been more significant in terms of their own state action. There is also some discussion concerning a revision of certain elements of the model, which will bring back some renewed interest.

MR. JOHN BRAGG: I would like to make the following three points regarding the NAIC guidelines for filing of rates for individual health insurance forms. These guidelines are the basis for regulations which have been adopted in several states. I notice some failure to understand the guidelines in the industry and in some states which have adopted them. In particular, there is some failure to understand that rate revisions for an existing block of business are to be based on the "aggregate loss ratio," which is the sum of the accumulated past experience and the expected future experience. There is a continued tendency to base determinations on the accumulated past experience only,but this is not required by the regulation.

Second, a strong case can be made that past experience which predates the adoption of the regulation should not be taken into account. Such experience can probably be considered as combined with other experience, and moot.

Third, I would like to point out that the guidelines apparently do not require the compulsory use of lapse rates when determining "anticipated loss ratios" or the future portion of the "aggregate loss ratio." Of course, the

historical lapse rates do indeed come into the picture when considering the past accumulated portion of the "aggregate loss ratio." For future calculations, the use of lapse rates appears to be somewhat optional.

MR. ABKEMEIER: In those states adopting the NAIC model, I am confident they are going to use a prospective interpretation. Regarding lapse rates, the requirement is that the actuary provide a projection and that implies the use of lapse rates. So, I have no doubt in my mind that it is an appropriate item to be included. Regarding the nonretroactivity aspect, this particular item is being pursued in discussions with the NAIC right now. Generally speaking, they are in agreement with the idea that you should not go back prior to the effective date of the regulation in the state.

MR. SHAPLAND: One problem this discussion has brought to mind is that the future is so nebulous that an actuary cannot predict it with any accuracy. The NAIC formula brings into account a future lifetime projection which may be 50 years or more. There are practical problems in justifying the premium to be charged tomorrow based on a long-term projection that is subject to speculation. I expect this subject to produce controversy between the regulator and the Home Office actuary.

MR. EARL HOFFMAN: We operate a fairly small individual health line with several small blocks of business. Therefore, when we file rate increases we have to use our nationwide experience. Now we are faced with a problem where various states have different criteria for proving rate increases. This has been complicated by the fact that some states have approved the NAIC model but many of them have not and still use the retrospective method only. How would you suggest companies like mine, with small blocks of business, cope with this rather chaotic situation?

MR. SHAPLAND: Recognize these and other complications which are producing increasing expenses and withdraw from this line of business if the resulting expenses create losses.

MR. HOFFMAN: I might add that we have also been concerned with the equity problem of having one set of benefits with different rates all over the country.

MR. SHAPLAND: You have to ignore this level of equity or you are in trouble. If you start concerning yourself with it, you would not apply any rate increases or you would have to go with the smallest rate increase every single time.

MR. ABKEMEIER: Practically speaking, you determine what your country-wide rate should be and you target for that. When you do experience a few little pockets of problems in one state or another you bend a bit, and perhaps have a little bit lower premium there, but country-wide you aim for whatever you think is right.

MR. SHAPLAND: Yes, and the next time we need a rate increase we try to get back to the national rate level by filing a larger rate increase to bring those states back to the national rate level.

MR. PAUL PEYSER: Is that increase based on the need for that state or based on national experience?

MR. SHAPLAND: It is based on national experience. There are only a few states that ask for state experience when filing rate increases. And they usually do not demand that state experience be used in determining their rate level.

MR. WILLIAM BLUHM: What we have seen companies do is recalculate the experience as though the rate for that state had been charged nationwide. In that way, there is no subsidy of the lower rate states from the other states.

MR. SHAPLAND: We adjust our loss ratio experience to a common rate base across the country so that you can see what the experience would have been at some common rate base. Then, we project from that and determine our needs for those states that have the common rate base. Every other state would have a lesser or greater rate increase based upon their current rate level.

MR. WILLIAM HALVORSON: Commissioner Day says he thinks of actuaries as being consumer advocates or protecting consumer interests. I thank him for making that statement and recognition. I want to point out that we are also great advocates of our management and stockholders, and believe we have a social responsibility to the entire public--not just consumers. We are always in the middle trying to balance all of these claims on us. That is an appropriate place for the professional actuary to be.

MR. DAY: You have mentioned that you think the actuaries as a profession have a responsibility. They have a responsibility and quite an opportunity while issues are being explored. I notice that Noel and Bob do not agree on a number of issues and I think that is the way it is in the actuarial profession. We do need to have more forums for discussions of principles and practices in this area. The Baucus Amendment now refers to actuarial principles and practices and the Academy of Actuaries is going to be trying to fill that void and will get all the input possible to help the regulators, stockholders, and the consumers to understand this very complex issue. I think this is the broad issue of this whole meeting. How can the actuary in the profession be useful?