RECORD OF SOCIETY OF ACTUARIES
1982 VOL. 8 NO. 4

REPORT OF THE COMMITTEE FOR ACCIDENT AND HEALTH VALUATION PRINCIPLES

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The panel will discuss the purpose, rationale, and conclusions of the Committee for Accident and Health Valuation Principles. Discussion will also cover the comments received and any modifications to their original draft report.

MR. ROBERT B. SHAPLAND: During my panel's portion of this session, we plan to first give you some background information as to why our committee was formed. We will then discuss the policy reserve aspects of our report, followed by the claim reserve aspects of our report and a synopsis of the comments we received on our exposure draft. We hope our presentation is followed by lively discussion and questions from the audience.

Several years ago, the NAIC (C) Committee Technical Task Force was considering new policy reserve tables as well as new rate filing guidelines. Both of these topics raised questions as to the need for a better understanding of policy reserve principles. These questions arose under the proposed tables because the tables did not utilize inflation, health deterioration after issue, etc., in their determination. The questions arose under the rate filing guidelines since a rating philosophy was incorporated thereunder wherein low early loss ratios created liabilities for future rate inadequacies. The (C) Committee also saw some problems related to claim reserves. It therefore asked the Society of Actuaries to appoint a committee to deliberate on policy reserve and claim reserve principles.

One of the first things our committee decided was that it would limit its deliberations and findings to very basic principles. While we realized that our report would have limited practical value for regulating actuaries, we felt that it would be inappropriate to move to practical solutions before the underlying theoretical principles were agreed upon. We visualize therefore that our report is only a first step and that additional work needs to be done to carry these principles into practices. In this regard, there is a new committee of the Health Section which I am to chair which is going to study rating and valuation principles. It is assumed that this committee will take the next step.

MR. SPENCER KOPPEL: The Committee focused on the shortcomings which it felt existed in the traditional approach to individual health insurance policy reserves as follows:

1. That approach did not incorporate the examination or testing of many environmental factors, beyond aggregate morbidity and interest, which impact on future income and costs and therefore on the required reserves. The factors ignored include:

    a. Selection.
    b. Secular trends.
    c. Effect of different underwriting standards.
    d. Inflation.

e. Persistency.
f. Regulation.
g. Other governmental insurance programs.
h. Gross premium levels.

2. That approach did not imply any differences for variations in renewal and rate revision provisions except for noncancellable and guaranteed renewable policies.

3. That approach did not deal adequately with the impact that rate revisions on in-force policies should have on the level of required reserves.

The Committee studied the effects of these factors on required levels of reserves. We also discussed the relationships that statutory reserves have to surplus, policyholder equity, GAAP reserves, and the general concept of conservatism.

Based on these studies and investigations, we developed six major findings.

Finding #1:

Policy reserves are a natural outgrowth of rating principles applicable to renewable policies which call for an income stream which does not match the timing and/or amount of the expenditure stream.

It was felt important by the Committee that recognition be given to the fact that two otherwise similar-appearing policies may have entirely different rating philosophies. Two guaranteed renewable medical expense policies, one of which was rated to cover benefits for a long period of time and the other only for a short period should not have identical reserve requirements.

The Committee recognized that there is no one "correct" rating practice but felt that the reserving practice must be considered in conjunction with the assumed rating practice in order to properly manage the business and the development of statutory results.

Finding #2:

Reserve standards should recognize, implicitly or explicitly, all factors impacting on revenues and costs.

In its studies, the Committee became aware that situations might very well exist in today's economic and product environment wherein significant distortions are created if one ignores the effects of various factors.

Some of the effects are illustrated in the report and were mentioned before. This does not mean that these examples are all-inclusive. The existence of non-underwritten products and the impact of mass marketing with its attendant very high initial cost are other possible factors. Each should be reviewed and analyzed when determining the appropriate reserve standard.

Finding #3:

Under the current statutory concept, reserves should be the conservative amounts which, together with future revenues, are needed to meet anticipated future costs. It is the function of surplus to cover costs in excess of those conservatively anticipated.

The Committee debated the purpose of reserves. It felt that reserves should not be set so high that they guarantee that they will be sufficient to cover future excess costs. Rather they should be set so that for reasonably conservative assumptions, they will be adequate. Said another way, there should be a high probability that they are adequate. The amounts in excess of reserves which are necessary to establish a near 100% probability are represented by surplus. The Committee did not feel competent to establish the exact level (or levels) of probabilities which are appropriate. About the best we would all agree on was that it would be greater than 50% but less than 100%.

Finding #4:

There is a distinct difference between establishing conservative statutory reserves and reserves under GAAP which are based on the "release from risk" concept.

One way of explaining this would be to mention that the GAAP reserves are set so that they represent the most probable amount needed; they correspond to a reserve which has about a 50% probability of being adequate, save for some conservatism built into the "release from risk" margins.

Another explanation is that the primary objective of GAAP statements is to accurately portray profits -- for statutory statements, it is to assure solvency.

Finding #5:

Since "statutory" reserves are intended to contain conservatism, standards or principles regarding such conservatism must be established before appropriate tables can be adopted.

As I mentioned before, the Committee did not feel adequately prepared to discuss the degree to which conservatism is appropriate or the principles of conservatism themselves. While this sometimes proved a handicap, we soon realized that it was not essential to the development of health reserve principles.

When principles of conservatism, which would logically transcend all lines of business, are developed, these principles would then be used to establish the level appropriate for specific cases of health insurance or for the entire class of health policies.

Finding #6:

One goal of statutory reserves is to conservatively measure liabilities and corollary solvency. Therefore, such reserves do not necessarily reflect policyholder equity in insurance assets for determining premium rate revisions.

Perhaps because of the parallels to life insurance methods currently in use, persons feel that statutory reserves might bear some relationship to policyholder equity. While this could be made true by incorporating "surrender values" into a policy, in the absence of such requirement it seems totally inappropriate. The reserve which is established for solvency measurement will not, except coincidentally, bear any relationship to the policyholder's equity.

Our Committee expended a great deal of time and effort in initial conceptual discussions which led to the exposure draft. It was a large educational process for each of us in several ways.

1. We learned much about the various ways individual health actuaries view their company's health business as to the methods of rating and reserving.

2. We learned much about the interrelationship of various factors on the resulting reserves.

3. We learned that there were many conceptions with respect to the current reserving practices which have little or no foundation when principles are considered.

All in all, it has been a very enlightening experience.

MR. SHAPLAND: Prior reports and findings on claim reserves have usually looked only to policy provisions on the basis that claim reserves represent future claim payments for which the insurer is already irrevocably committed (even though such payments may be contingent on continued disability or medical treatment). In examining claim reserves and policy reserves, we felt one should start from basics in allocating premiums, claims, and expenses to past vs. future experience.

For example, portions of collected premiums are allocated to the future via unearned premium reserves. Additional portions of past premiums are allocated to the future via their recognition in policy reserves. Furthermore, future claim payments are allocated to the past via claim reserves or to the future via their recognition in policy reserves.

We felt that any division between past and future should be theoretically consistent for premiums and claims based on the applicable rating principles. We have made no attempt to define "past" vs. "future" since this would vary depending on the purpose of the accounting statement. Therefore, this definition is somewhat up to the regulator.

Assuming that the statutory statement will continue its indirect methods of measuring solvency conservatively, it is possible that this theoretical consistency in allocating premiums and claims to the past vs. future based on rating principles will not be attained in practice. If this is the case, we hope that there will be a clearer understanding as to the difference between the theoretical and practical and the reasons therefor.

Rating principles are those that establish the timing and amount of revenues in relation to expenditures over the life of a policy. For some policies, these principles are needed to determine the level of renewal premium adjustments. Some examples that may help illustrate the impact of rating principles

may be helpful. Under step-rated major medical policies subject to annual premium adjustments, one must decide how to fund for health deterioration after issue. Premiums could be loaded in early years to cover this deterioration or companies could assume that premium levels will be adjusted each year to cover the then-current deteriorated costs. In the first instance, one would set up deferred premiums via policy reserves to cover the shortfall of future premiums in covering deteriorated morbidity costs. Or, if no portion of premiums was deferred to cover future deterioration, then claim reserves representing the excess future claims would be set up to maintain rating principle consistency in allocating premiums and claims to past vs. future categories. On the other hand, if premiums were to be adjusted each year to cover current deteriorated costs, then policy or claim reserves would not be involved.

One must also look to rating principles to maintain correct accounting treatment of premiums and claims regarding the claim liability that arises during the 30-day grace period following the statement date. One must first determine if those claims in excess of offsetting premiums are to be met by past premiums or concurrent premiums. The applicable rating principles would be used for theoretically determining if there should be any allocation of such claims to earned premiums via claim reserves or, alternatively, if policy reserves should be set up.

Finally, one of the biggest question marks facing the industry stems from policies where benefits for continuing medical treatment cease if the policy lapses. Assuming that insureds who are currently receiving treatment are unlikely to lapse, the question arises as to whether or not claim reserves should be set up for those continuing claims which will exceed the related continuing premium. It is our position that this question is theoretically resolved by looking to rating principles. If "past" earned premiums are meant to cover such continuing claims, then claim reserves would be appropriate. On the other hand, if future premium revenues are to be assessed to cover such claims, then claim reserves would not be necessary. This example is similar to the earlier health deterioration example except that here I am examining the recognizable current and continuing claims as opposed to future new claims that will appear at a higher frequency or severity because of health deterioration.

In closing, I might note that our findings do not preclude defining "past" claims and thus "claim reserves" as representing those for which an insurer is already contractually liable as of the accounting date. However, such a definition would theoretically call for the allocation of premiums to past vs. future categories on a consistent basis taking into account the underlying rating principles.

MR. FRANCIS T. O'GRADY: A number of written responses have been received in regard to the Exposure Draft which was distributed to the Society's membership in January, 1982. In addition, the Committee members and particularly our Chairman, Bob Shapland, have had a number of informal verbal discussions on the draft, both on a face-to-face basis and by telephone, with knowledgeable health insurance actuaries and other interested parties. A number of the respondents, particularly those who have been heavily involved in individual health insurance, were complimentary of the Committee's work since they recognized the difficulty and the importance of the task that was assigned to the Committee. For those compliments we are most grateful. These same respondents, while being generous with their compliments, did not

hesitate to express their feelings about what they felt were shortcomings or inaccuracies in the draft report. Every comment or suggestion received was carefully reviewed. The revised report incorporates many of them.

The Committee chairman has replied in writing to every member who has submitted a written discussion of the report. In his usual meticulous way, he has given the Committee's position on each item.

Rather than detail every item on the list of comments received, I will give a short overview and then refer to a few specific items.

One type of comment made or implied by several of the respondents was that the Committee Report does not give enough guidance on the handling of the practical problems encountered in valuing health insurance benefits for the Annual Statement and related purposes. The Committee recognizes this but, as Bob Shapland has pointed out, the charge to the Committee was not to produce a "how-to" manual.

Our job, as we saw it, was to examine principles, and that is what we have done. Again, as Bob pointed out, it will be for some successor committee or task force to take these principles and convert them into practices.

Another general area that received a number of comments was the terminology and definition of terms used in the report. We know that this is something which presents difficulties in the discussions of many actuarial documents. While the Committee felt that nothing it said was misleading, it has made a number of changes in the interest of technical accuracy.

One comment of interest was from an actuary who is a regulator. He chided the Committee for not including any discussion of the regulatory point of view and for presenting only the industry outlook. Bob has very properly responded that our report was intended to be an intellectual discussion of principles and that we did not intend that there be any implications derogatory of regulations or regulators.

Another comment made was that the conclusions reached in the report did not follow from the discussions. In its many hours of discussions and its various drafts, the Committee carefully considered the supporting data it should give, within the context of a Committee Report, for the findings it was presenting. We are satisfied that we have done so, particularly after making the changes suggested by the Society members who were interested enough to comment on the draft.

MR. E. PAUL BARNHART: I have quite a few problems with the Committee's Exposure Draft on Statutory Reserve Principles, but I will limit my comments here to the section on "Claim Reserves" (pages 17-24 of the draft).

The treatment given to "claim reserves" appears to me to display very basic and serious confusion between the proper role of policy reserves and the proper role of claim reserves. Such confusion is evident throughout the entire section. The treatment repeatedly seeks to rely on claim reserves to address functions that are appropriately, and quite adequately, served by policy reserves.

In the initial paragraph, the draft identifies "claim reserves" as the "value of claims yet to be paid out which are to be funded (my underscore)

by past premiums (earned premiums) . . ." and goes on to assert that "future claim payments are allocated to claim reserves or policy reserves based on the applicable 'rating principles'." In the opening sentence of the section, it says: "Claim reserves stem from both the interplay of rating principles relative to the timing of claim payments and contract provisions." These introductory assertions set the stage for continuing confusion.

"Rating principles" have a great deal to do with proper determination of policy reserves, but have absolutely nothing to do with the determination of claim reserves. The function and purpose of claim reserves is very simple. It is to provide for the estimated unpaid liability represented by claims that have already been incurred as of the date of valuation. This unpaid liability will be what it will be, quite independent of whatever "rating principles" may be related to the block of business, and quite independent of whether such liability is to be "funded", eventually, from "earned" or from "unearned" premiums; or whether, in fact, such liability will ever be "funded" from premiums at all, or rather, perhaps, from surplus. How can the value of the unpaid liability in existence because of claims already incurred possibly be altered or affected in the slightest way by "rating principles" or by the question of how such liability is to be "funded"? The policy reserve may be heavily dependent on such considerations, but not the claim reserve.

A single consideration establishes the existence and the extent of liability for incurred claims; that is, the question of when (and whether) each claim is incurred. This question is answered wholly by the contract provisions, including, of course, applicable laws and court decisions that may modify or interpret such provisions. If it cannot be clearly determined when and whether a claim has been incurred, then the contract provisions themselves, or legal interpretations of those provisions, are badly in need of further clarification. But resolution of this question has nothing whatever to do with "rating principles" or with "funding". Either a claim has been incurred or it has not been incurred, and only proper determination of a date of incurral can decide this. Once it is decided, from correct incurred dating, that a claim has been incurred on or before the valuation date, then provision for any unpaid liability with respect to that claim is properly included in the claim reserve (including, obviously, claims incurred but unreported). Any existing provision, as of a date of valuation, for future claim liability with respect to claims not yet incurred is properly included in the policy reserve.

One may fairly inquire whether it really makes any difference. After all, what is most important, and what the actuary ultimately gives his opinion on, is the adequacy of the reserves "in aggregate". I suggest that it makes a great deal of difference, for at least the following reasons:

1. Ongoing testing of the methodology used with, and the adequacy of, the claim reserve depends upon comparison of the claim reserve with the eventual paid run-out on those claims incurred on or before the valuation date. Use of the claim reserve to value liabilities other than those arising from such claims already incurred surely muddies up the testing, and for no discernable reason, since the writers of the draft fail to explain why they cannot adequately address all other such liabilities through the policy reserve.

2. Some of the comments I have heard arguing in support of the writers' apparent view favoring a modified role for the claim reserve appear also to argue that claims reasonably can actually be assigned incurred dates consistent with such a modified role. It is very unclear from the draft whether the authors likewise espouse such modified incurred dating. This should be discussed, and lack of clear discussion of this key point is in itself a serious weakness of the draft. If such modified incurred claim dating is to be followed, then we are really in big trouble.

   a. Does this then mean that the insurer involved will actually admit legal liability for claims on such a modified basis of determining dates incurred? Or would it still intend to deny claims that have not been incurred in accordance with contract provisions or appropriate legal interpretation of such provisions? If it still intends the latter, what will its position be if a claimant's attorneys can show that the insurer is actually both dating potential future claims and reserving for such claims on a basis inconsistent with contract provisions, determined instead by actuarial "rating principles" or actuarial questions of "funding"? The claimant will have a pretty good case.

   b. Following up logically on the modified claim reserve and associated dating theories proposed, we could easily have similar claims incurred (with different insurers) under equivalent contract provisions, but dated to fall under different premium payment periods and even in different years, all dependent on "rating principles" which may not be determinable at all from the contract provisions. Presumably, they are then "determinable" at the discretion of the actuary or the accountants or the auditors, under theories or "rating principles" perhaps widely at variance from one insurer to another, or even from one policy form to another within the same insurer.

      Surely those responsible for regulatory examination of the adequacy of insurers' provisions for incurred claim liability have a right to expect reasonable consistency throughout the industry as to appropriate rules for incurred dating of claims. Such consistency can only be realized through recognition that contract provisions alone along with such legal interpretation or modification as may be required, determine whether and when a claim has been incurred. Otherwise the whole matter quickly becomes chaotic.

   c. Similarly, the gathering and reporting of incurred claim experience, such as in the Society's periodic morbidity reports, become a seriously inconsistent, muddy affair; highly suspect at best.

      The same must be said of the historical experience that insurers must compile and submit to regulators in connection with rate filings, particularly rate increase filings. Serious distortion in the direction of overstatement of historical experience can emerge under the treatment, and associated dating, of claim liability as proposed in the draft.

3. There is also increased opportunity for deliberate mischief under the proposed treatment, and I have seen it happen. Some years ago, I was dismissed by one client company whose management intended to file for the largest rate increases they could possibly get away with, the object

being to "freeze out" policyholders by prohibitive increases deliberately designed to provoke massive lapsation. The company wanted to accomplish this goal by setting up the highest possible unpaid claim reserves, in order to display the highest possible incurred claim loss ratio for the most recent statement year. A second consulting firm was hired, whose estimate of the unpaid claim liability was virtually the same as mine. Consequently, a third firm was hired, willing, apparently, to cooperate with management strategy. The resulting claim reserve was nearly double my own estimate. Massive rate increases were subsequently filed and the deliberate objective of massive lapsation was largely realized.

An important safeguard against such mischief making is to keep the function of the reserve for claims incurred but unpaid strictly within its clear traditional bounds. All the other "contingent" situations described in the draft can be addressed through the policy reserve. The difference is critically important, especially if incurred dating is to be rendered consistent with the claim reserve principles and philosophy.

4. Every example cited in the draft which argues for a modified role for the "claim reserve" is one that can be addressed appropriately through policy reserve principles.

   (a) The case of "calendar year" major medical contracts under which all covered expenses must actually arise while the contract is in force (page 18 of the draft). Here, expenses unincurred as of a valuation date are properly dealt with under the policy reserve, either through the unearned premiums or through additional reserves.

   (b) The case of future medical treatment that is a "near certainty", because the insured is highly likely to maintain his coverage in force (page 19). Again, such an unincurred liability is appropriately addressed through the policy reserve. From the text of the draft, with respect to both examples (a) and (b), I find it difficult to discern just what point is being made, other than that the writers appear to be proposing that all such liabilities be covered either by claim reserves or policy reserves according to the "rating practices", rather than in accordance with contract provisions.

Under example (b), if the "rating principles" presumably dictate that the "near certain" claim should also be given an incurred date prior to the date of valuation, along with covering it under the claim reserve, we have a situation analogous to the following dating of a death claim:

> Mr. Z has an ART life policy that renews on January 1. On December 1, Year N, he learns that he has no more than six months to live. He surely renews the policy, and indeed dies in April of Year N+1. If we accept the theory apparently suggested, including corresponding dating, that this claim may be viewed as "incurred" before December 31 of Year N, we have a death claim dated December 1, Year N, even though the death actually occurs in April of Year N+1.

I have never heard of anyone dating death claims by such a bizarre rule. Why should anyone even suggest that health claims may reasonably be dated under such a principle?

(c) The case of claims incurred during a grace period. This again is readily resolved on the traditional, historical basis: If such a claim has been contractually incurred as of the date of valuation, it should be covered by the claim reserve. If not, it should be covered within the policy reserve.

As to policies which are actually within a grace period on the date of valuation, premiums due and unpaid are customarily set up as an asset with respect to the premium period existing as of the valuation date, and the appropriate portion of that due and unpaid premium is also treated as unearned. To the extent any further establishment of liability is deemed appropriate, because the overdue premium may in fact never be paid, this is again a problem to address in relation to policy reserves, not claim reserves.

On page 18, the draft concedes that "future claim payments related to past occurrences that the insurer can't avoid by contract termination have been historically relegated to claim reserves." This "historical" practice is a sound one indeed, and if the authors intend to suggest a new or modified role for claim reserves, surely the burden of proof as to why the role of claim reserves should be redefined falls heavily on the authors. I do not see where the slightest case for any such redefinition has been offered.

MR. SHAPLAND: We have knowingly left a question mark regarding the recognition of claim payments via claim or policy reserve accounts since the dividing line between "past" and "future" could be defined several different ways. We have left this definition to the regulator. I would think it would be acceptable to adopt a rating philosophy wherein an insurer establishes current premium levels to cover continuing claims for anyone who became sick during the exposure period even though such continuing claim payments were contingent on continued in-force status. And if one did so, how would one know which continuing claims were intended to be paid from past premiums if one recorded the incurred date independent of when that sickness began?

MR. ANTHONY J. HOUGHTON: I would like to speak about this same subject plus give some examples and relate them back to the draft and to pricing principles. I also have some other comments regarding your draft.

Regarding the particular question Paul brought up, it is subject to differences of opinion. I disagree almost entirely with his approach and I would like to explain why. I will speak in terms of several different types of benefits which are commonly sold. For example, one policy is the "per cause" major medical which has a deductible, such as $1,000, and then a benefit period of two or three years. It is the practice of most companies, once the deductible has been satisfied, to charge the continuing claims of that benefit period back to when the deductible was started or satisfied. It would be important under their pricing principles to set up their claim reserves accordingly.

We know that the request of the Intercompany Committee regarding major medical experience tells people submitting claims for, say 1975, that they should include the payments made through 1976 and, in addition, include an estimate of those amounts still pending. Presumably that one-year delay and the additional estimate covers more than services accrued before December 31, 1975. We know that many of these contracts will state that once you start a benefit

period, it is required that you continue to make premium payments to continue coverage. Nevertheless, I know of many companies who have that contract language and code their claims back to the beginning of the deductible. For those companies, even though they could conceivably lose some liability because some decline to renew, this is a correct coding practice consistent with their rating. And anyone who uses intercompany statistics on major medical would have that assignment of incurred date as their data base.

On straight hospital, it is the request of the Intercompany Committee to include payments incurred in, say 1975, made through 1976. Thus, this also includes confinements which begin in one year that last as long as a year later. I do not know of any contract that allows insurers to stop paying for someone continuously confined, but there could conceivably be such a policy provision. There are certainly a number of policies which state that if you are readmitted to a hospital within 90 days or 180 days for the same or related condition, it will be considered a continuation of the claim for purposes of the maximum at least. Under some of those contracts, if you had lapsed between one confinement and the next, you might not be able to collect the continuing benefit. Under those circumstances, I am not sure how each company assigns the incurred date for the second confinement. I know some of them charge it back to the first period and some do not.

Under a disability income policy, someone with five-year maximum benefit, 30-day elimination might be disabled for two years. If he goes back to work and then becomes disabled again within six months for the same or related condition, it will be considered a continuation of the same claim. I know a number of companies will charge those reopened claims back to the original disability date. That is the way they rate and that is the way they set up claim liabilities and data base even where the contract states that the second period is not covered if the policy is not in force.

Another example would be a cancer plan that says in order to collect cancer benefits, the policy must be in force at the time the service is rendered. A person could have a covered hospital confinement for 12 days and then undergo other treatment not compensable under the policy. If he is readmitted to the hospital 50 days later for the same cancer, many companies would code that second confinement back to the original cancer treatment date while others might only code it back if it is within 30 days. I would suppose in the case where the company was coding back only within 30 days that it was using its own data base for the purpose of pricing and this might be consistent with their pricing theory as mentioned in the exposure draft. That might or might not be satisfactory from the insurance department's point of view. The companies which have a more conservative stance on cancer policies may be requiring a one-year separation from treatment before they would charge it as a new claim.

Also, let's consider a nursing home plan. You could conceivably have a policy that says in order to collect your continuing nursing home benefit, you must pay premiums while confined. If you had someone confined in a nursing home for two months as of December 31, he would have to pay the premiums day by day in order to collect future benefits. Even though the company knows, on the average, he will stay there for two years, would they ignore the last 22 months of benefits because the policyholder had to keep his policy in force to collect? Suppose he has to pay $10 a month to retain the policy in force and collect $2,200 in benefits. Not reserving for the benefits after December 31 would be unsatisfactory from an insurance department's standpoint.

I do not think there is any way to include a liability like that in an active life reserve because many of these policies are not guaranteed renewable or you may have only a few policies in force at the time you still have many claims remaining.

Finally, there are other situations that require a benefit to be paid beyond the policy provisions such as certain state laws. In Illinois, they require that no termination (even a voluntary one) be prejudicial to a claim which originated while a policy was in force. So there is a question as to whether, for a claim which is continuous in nature, stopping premium payments would really deny a person benefits. Because of that, the conservative approach, which most companies actually use, is correct and the policy language is irrelevant. It is relevant in deciding if someone should be paid but irrelevant to the actuary establishing a liability.

In summary, if I were establishing the claim liability for nursing home policies and one policy said that it must continue in force month by month in order to collect benefits while another one said that once you were in the nursing home the full benefit would be paid regardless of continuing premium payments, I would not differentiate between the two.

Going back to the exposure draft, many of the comments that were made are valid on a theoretical basis. Certainly your pricing, claim reserves, and active life reserves should be consistent. Also, the most actuarially sound reserves would take into account all the factors mentioned such as lapses, selection, etc. However, I am wondering about the practical application. We have enormous problems under GAAP where we try to utilize underlying assumptions by going back to the original assumptions made many years ago when the policies were issued in order to set up the reserves which are specialized for each company. I do not see how, on a statutory basis, it would be possible for an insurance department to go into a company like Mutual of Omaha and look at the policies issued over a 30-year period and determine what the pricing assumptions were back at the time those policies were issued. What were the lapse assumptions, the select factors, etc.? The regulators would have great difficulty in accepting reserves which were three times or one-half those of another company with similar policies. While theoretically there is merit in all of these principles, they will be almost impossible to apply. Factors such as lapses, selection, underwriting, etc., are equally applicable to life insurance. I do not understand how someone would be able to have different evaluation standards for all the different life insurance companies and their different plans based on their separate lapse experience, underwriting, etc. I do not see how a Northwestern Mutual could have significantly different statutory reserves than a Bankers of Iowa because they underwrite differently.

Assuming it were possible to do this for a company with actuarial expertise and for the insurance department to spend enough time to validate the results, when you start thinking of some of the very small companies in the country and the enormous number of policy forms which are outstanding, the cost, even if it could be done, might be exorbitant. We have enough problems getting people to use almost any reasonable standard and when you consider the new disability tables, different underwriting standards, the different definitions of disability, two-year his-occupation vs. five-year his-occupation, male vs. female, white collar, blue collar, short elimination, long elimination, you would multiply their task many times over and above the large tasks they have now. We are lucky to do a good job with the standards we have been using for the last 25 or 35 years.

MR. KOPPEL: While I will not debate the difference between Tony's and Paul's philosophies, the conclusions of the exposure draft as to aggregate reserves cover both concepts. That is, if you apply the principles of the exposure draft in calculating claim reserves and policy reserves, the same aggregate reserves will be derived whether a company determines the claim reserve portion using Tony's philosophy or Paul's philosophy.

MR. HOUGHTON: How can you be sure of that? Suppose you have only 100 nursing home policies in force and eight of the insureds are in the nursing home. How can you be sure your predetermined active life reserves will cover the liability of those eight people?

MR. KOPPEL: That is like asking, how can you be sure that the reserves of any company, policy or claim reserves, will be adequate for their particular situation if they have only 100 policies in force? Clearly, you cannot but the concept is there that will work in aggregate for all companies based on their underlying pricing principles.

I am not sure that I agree wholly that there should not be some differentiation between the statutory reserves of one company and another, especially regarding rating practices. If you take a guaranteed renewable major medical expense policy of one company that was rated on a level premium basis and that of another company that was rated on a step-rated basis and say they must have the same reserve because that is the only way we can regulate, monitor, and audit the reserves of the two different companies, I would have a great deal of difficulty with it. I agree that, practically, you cannot take every nuance of factors when you are determining statutory reserves just as you cannot do it when you are calculating GAAP reserves. One tends to ignore many factors explicitly but not implicitly by determining that they do not make that much of an effect on the aggregate result. All we are saying is that these are things that you should consider when you establish reserves.

MR. WILLIAM SCHREINER: I fully support Mr. Barnhart's earlier comments regarding the confusion between claim reserves and policy reserves. The source of part of the confusion is that there is no definition of claim reserves in the paper. I found that very surprising and think it would be important to be included.

MR. SHAPLAND: Bill wrote to us and gave us good input. In answer to his comment, I believe that the revised draft responds to it.