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HEALTH INSURANCE FINANCIAL REPORTING ISSUES

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Current financial reporting topics related to both group and individual health insurance. Included will be discussions on:

- Standards of practice for health actuaries
- Deficit Reduction Act of 1984 (DEFRA) requirements for health and welfare plans
- Qualifications for health certification
- Internal management reporting needs
- New state reporting requirements

MR. RONALD M. WOLF: If the actuarial profession doesn't have specific standards of practice in the health insurance area, does it have any standards of practice at all? Yes. The authority for writing and promulgating specific standards of practice rests with the American Academy of Actuaries. The main functions of the Society of Actuaries are research and development and education. The Academy has the main responsibility for promulgating standards of practice through its "Recommendations and Interpretations." Recommendations are specific standards of practice, and Interpretations usually consist of clarifying comments.

One aspect of these existing standards is that their promulgation has been largely due to an outside pressure. Examples of this include the life insurance financial reporting principles -- as a response to the accounting profession and its Audit Guide -- and pension plan principles and practices -- as a response in part to Employee Retirement Income Security Act of 1974 (ERISA).

These existing standards of practice contain brief and limited references to health actuaries. So, is the Academy doing anything about standards of practice for health actuaries?

The answer is yes. It is my privilege to currently serve as the Chairman of the Academy's newly formed Committee on Health Actuarial Principles and Practices. My committee is a standards writing committee. Our main charge is to draft standards of practice for health actuaries.

This new standards writing committee has been in existence now for approximately six months. We began as a subcommittee (on professional practice of health actuaries) of the broader Academy Committee on Health. I was chairman of this subcommittee. We were directed to consider the subject of standards of practice for health actuaries and prepare a report thereon. The report went to the Academy Board; they liked it and, in turn, authorized our committee to become a full Academy Committee with standards writing authority.

The committee has increased its staff from five as a subcommittee to eleven as a full committee. We consider that health insurance is unique in that it cuts across many areas of practice: life insurance companies, property and casualty insurance companies, Blue Cross plans, Health Maintenance Organizations (HMO's) and Preferred Provider Organizations (PPOs), individual and group contracts, consultants, company employees, and government employees. Also, actuarial practices that have developed in the health area to date are quite diverse. My committee's response to this diversity has been twofold:

1. We have tried to make our committee membership as diverse as possible. We have consultants, company actuaries, individual and group specialists, one federal government actuary, one state insurance department actuary, and one Blue Cross actuary. We are seeking to add a property and casualty actuary.

2. We fully intend that the standards of practice, which we will draft, will not be hard and fast rules but will be a list of considerations that a properly practicing professional would consider and reject only for specifically documented reasons.

Additionally, we have discussed four main areas of health actuarial practice where the drafting of standards may be in order. These are claims reserves, benefit design, rating and surplus.

It is the committee's consensus that many health insurance companies or plans that get into financial trouble have not done a good job of measuring their claim liabilities. A list of things to consider in calculating such liabilities is clearly needed. Such a list may include analysis of development of prior estimates, volume changes, contractual definitions, benefit changes, and trend rates.

The subject of rating is sensitive. There are some legal, antitrust implications of which we will need to be careful. Currently accepted practice varies widely. Nevertheless, it is our current opinion that "things to consider" can and should be drafted.

At the moment, we don't think that benefit design will be a fruitful area for us. The issue is too broad and significantly nonactuarial. The design of benefits is really part of the rating function. We believe that it is not the actuary's responsibility to determine whether benefits are legal. We may consider an Interpretation where the actuary is advised to check with other personnel to see if benefits are legal, if pricing is consistent with underwriting, and if procedures are in place to generate needed statistics for the benefits involved.

Surplus need is an important issue for many health care plans. A problem may arise in an insurance company where health is not the only line of business. Nevertheless, some published standards for actuaries practicing in this are are needed.

We will draft a preliminary outline of Recommendations and Interpretations under the three subjects of claim reserves, rating and surplus. The drafting of actual standards will come later. We will take this outline to the Academy Board for their review and comment before proceeding.

The Deficit Reduction Act of 1984 (DEFRA) provides for a series of "safe harbor" limits for tax deductible contributions needed to fund health and welfare plans. In other words, if contributions are equal to or less than the safe harbor limit (which varies by benefit), deductibility will not be questioned. However, DEFRA then provides for tax deductible contributions in excess of the safe harbor limits, if these contributions are certified by a qualified actuary (as determined by Treasury regulation).

The bill also requires that actuarial assumptions are to be reasonable in the aggregate, a provision similar to ERISA for pension plans. It then indicates that Treasury regulations may prescribe specific assumptions to be used in all actuarial calculations. The Academy has always been opposed to any setting of assumptions by the Treasury in pension plans, for example.

The reference to "qualified actuary" provides the profession with a new qualifications issue to consider. This is an issue with which the Academy is just beginning to grapple. However, the Academy already has a standing Committee on Qualifications; the issue will not be addressed by a standards writing committee.

The determination of contributions in excess of safe harbor limits may present an opportunity for our new health standards committee to develop an actuarial standard specifically for this situation. The Treasury is not rushing ahead to draft standards or qualifications in this area and enforcement will be on a case by case basis. Nor does the Treasury appear to be particularly interested in some outside help from the Academy. While this issue does present an opportunity to be proactive rather than reactive, there is no burning need to draft specific standards immediately.

My committee has tentatively decided that we would address this DEFRA issue as part of our general standards drafting process. We plan to draft broader standards, with perhaps some specific references (perhaps Interpretations) to the DEFGRA safe harbor issue.

In 1984, the Academy completed a process whereby health service corporation actuaries who were not formerly Academy members could pass a qualifying examination and thereby come under Academy auspices. At the same time, Recommendation 10 was developed to delineate the responsibilities of health service corporation actuaries in signing statutory statements of actuarial opinion. My standards committee was

involved in the finalization of the Recommendation. It is another example of how the Academy is increasing its emphasis on standards of practice.

Some of you may have seen the brief Academy slide show entitled "Standards of Practice -- Who Needs 'Em?" I maintain that we owe it to ourselves and our profession to see that we have soundly drafted standards of practice. If we do not draft them for ourselves, we can abe assured that in the future someone outside our profession will draft them for us.

MR. WILLIAM L. BOGARDUS: Group health insurance is a difficult business to successfully manage. The earnings are cyclical and often are not predicted easily. Competition abounds both from within the life insurance industry and from such outside organizations as Blue Cross and Blue Shield, third party administrators (TPAs), HMOs, and self-insured employers. The business rewards those who manage it well and punishes those who do not. Each year as the results are compiled and analyzed, there seem to be companies that consistently do well and others who consistently struggle. The quality of the management reporting is a key ingredient to the successful management of the business.

To assist in the management of group health business, certain internal information is essential. That information can be extracted from a management information system. There is a finite amount of data that can be captured relative to a line of business, but an infinite variety of ways that data can be compiled into reports (or management reporting) intended to create order. If the management information system is sophisticated enough, one can supplement standard reports with ad hoc reports to meet the needs of the moment.

History -- For many years, the financial reporting for group health insurance was guided by the state insurance departments' requirements. This reporting was designed to insure solvency and to insure that the company is sound enough to fulfill promises made to policyholders. The details required to complete this reporting dictated the level of details contained in the internal accounting records. This annual process took most of January and February and took time away from the important part of managing our business. Because of the once a year time of these results, many of us supplemented the results with monthly loss ratio reports for our major market segments and possibly by coverage. This helped us to keep tabs on where we were throughout the year and was the basis of rate increases as they became necessary. These monthly loss ratios, however, didn't always correlate with the year-end results because of unexpected items: unusual expense levels, experience refunds or dividends different than expected, or unplanned claim reserve increase.

Improved Sophistication -- Over the last several years this has all changed, and the financial reporting to management has been expanded greatly. There are several reasons for this:

1. The poor results that many of us have experienced, especially during the last couple of down cycles, has required information for explanations and also for determination of what course to follow to turn the situation around.

2. Management has heightened awareness of just how volatile the business is and how much control can be exerted over the underwriting and pricing and, therefore, the financial results. There is a relatively short time frame between actions and results, and meaningful actions are being taken daily; therefore, the factors entering into those decisions need to be monitored regularly and adjusted as necessary.

3. The management of group health business has evolved to include elaborate plans and goals and the need to monitor progress towards those goals.

4. Data processing capabilities are available to assist in compiling timely and accurate results on a frequent basis.

Goals -- Most of us manage our business toward the attainment of specific goals. These might be as simple as to do better in the level of new business or the amount of new profits than last year.

More sophisticated goals, such as earning a specific return on equity (investment) over a cycle, and attaining or retaining a certain market share also are used. Whatever the goal is, the measurement of progress against that goal is important. It helps to emphasize good performance if adequate progress is made and should help to identify deficiencies if things aren't going as planned.

Most management reporting is centered around either profits or the growth in the size of the in-force block.

Segmentation of Business -- Many years ago, all business was similar, and we felt comfortable in reporting the results only in total or with only a few breakdowns, such as creditor, regular nonrefunding, and regular refunding.

Now, one of the first questions that we have to ask ourselves is how many and what categories do we want to break our business into for reporting? There is no one correct answer, and the answers will vary from company to company. As a guide, separations are often advisable where different actions can be taken as in:

1. Pricing

2. Underwriting requirements, restrictions, and latitude

3. Compensation to producer

4. Flexibility in types of benefits offered or required

5. Expansion of contraction considerations of markets or products

6. Rewards, monetary or other

In order to help with visualizing the possibilities, I will go over some examples here. It may be appropriate to treat some of these as primary breakdowns and others as secondary. One may find that some combination of categories will work best for the primary segmentation of the business.

CATEGORIES	EXAMPLES
Group Size	Less than 50 lives 50 -- 100 lives 100 -- 250 lives 250 -- 1,000 lives 1,000+ lives
Pricing or Financing	Package plan -- Multiple employer Trust (MET) Nonrefunding Refunding -- conventional financing Minimum Premium Administrative Services Only (ASO)
Regional Territory	Northwest Region Southeast Region . . .
Group Sales Office	St. Louis Atlanta . . .
Producer Category	Letter House Broker Other Broker Agent Other .
Geographic (State or other)	Northern California Montana St. Louis area . .
Claim Office	Fort Wayne Chicago . . .

CATEGORIES	EXAMPLES
Duration	First Year Second Year . . Ultimate
Benefit Package (or options)	Dental Long-Term Disability (LDT) Medical Cost Containment Package Contains a PPO option
Industry (or industrial categories)	Insurance Companies Light Manufacturing Hospitals . .

The possibilities are unlimited. There easily can be more combinations of segments than there are groups in force. One needs to retain as much detail as possible yet summarize at a high enough level so that the information is meaningful.

In our reporting, we prepare monthly profit reports in thirty or so segments that represent a combination of group size and pricing and financing vehicles. Our monthly sales activity is also reported for most of these categories. Additionally, we prepare quarterly sales and profit reports for each of our group sales offices. We also have the capability of preparing reports of profits for most of the other breakdowns identified earlier on an ad hoc basis. This is possible because our financial database includes all the components for monthly results for each of our individual groups.

Increase in Size of Block -- One of the important goals that many of us have is to attain a given growth in our block of group health business in force. There are several ways that we can measure the size of the block of business. Some possibilities are:

1. Number of groups in force

2. Number of employees insured (or persons insured)

3. Premium income

4. Equivalent premium income

5. Service fee income

For any of our market segments, one of these measures may be more meaningful than another, and therefore, more than one of these measures may be used across our entire block. However, when combining all of the market segments together as a composite, one common measure

must be used. Equivalent premiums (premiums that would have been received if all groups were insured on a conventional funding basis rather than minimum premium or ASO), are a common measure in the industry, especially when making comparisons between companies.

As a part of measuring the change in the size of the block of business in force, there are at least two commonly followed components. These are new business and terminations. Of these two, new business gets a lot more emphasis in most companies. There are sales goals, campaigns, bonuses, contests between offices, and leaders. This emphasis on sales is very important, but if the real goal is for growth in in-force business, one must not loose sight of the impact of terminations.

Reporting and Analysis of Earnings -- Tracking and understanding the sources of profits is an extremely important management function. The management reports covering profits are the primary tool by which this can be done. Profits should be summarized for the primary business segments. Support information also should be available to help explain the results and provide assistance in identifying areas where corrective action is needed.

We are referring to earnings reported on a generally accepted accounting principles (GAAP) or similar basis fairly reflecting the results for the period in question. These results need to be reported in enough detail so that they support categories of business that can be acted upon.

In preparing financial reports, comparisons are often necessary in order to better understand the results. Some common comparisons are with a prior period, with the current year's business plan, or with the pricing assumptions used in the premiums or refund formula.

Once we have the results for the current period for each reporting segment, we have gone a long way towards understanding the earning dynamics of the business. However, within each reporting segment, we can look at the components of the earnings to see if the results are different than we were expecting and why. The balance of this provides more discussion.

Premiums -- There are several reasons that the premiums are different than expected. The analysis performed for new business and terminations should go a long way to explain any deviations. Other factors that may need review are the level of rate increases on existing business and premium changes through plan changes. Lately, we have seen significant movement to higher deductibles or other plan changes to reduce the cost to the employer.

Benefits -- Benefits represent about 80 percent of the disbursements, and therefore, it is advisable to perform more analysis in this area than in any other. The inflation and utilization rates of increase experienced in the claims are key. These can be compared to the factors used in the pricing. Large claims can undergo special analysis to identify any fluctuations that may be occurring and to see if there are any large claim management opportunities. These large claims may also

result in polling losses or gains in the application of the refund calculation. With the introduction of the various cost containment and PPO options, special analysis to quantify the effectiveness is desirable. For segments of the business that include initial selection, durational analysis may be indicated.

Commissions, Expenses, and Taxes -- These items are important to the competitiveness and profitability of the group health business. One needs to monitor how these items are doing compared to prior years and the pricing margins. Expense budget control has been a part of management responsibilities for many years. Combine these expense reports with units of output, and you have productivity measures that can be tracked from one time period to another. If one can get the pricing margins for the various expense areas and relate these to the actual expenses, the result is the start of a profit center analysis.

Experience Refunds/Profit Margins -- With experience refunding business there is a commitment to return any excess premiums to the policyholder. This only occurs after the insurance company has recovered all of its costs and has extracted the required risk and profit charge. To the extent that experience is bad, there is a loss on the application of the refund formula. Conversely, in times when there is good experience, deficits will be recovered and fewer new deficits will be generated, all resulting in larger than normal earnings. Reporting the results of the refund calculations, with sufficient detail to monitor the deficits and the use of the risk and profit charge, will go a long way toward explaining the current financial results. This also may help the manager to predict what is in store for the business in the near future and may allow timely corrective action.

Investment Income -- Since the underwriting profits in the group health business are relatively small, the level of the investment income is important to the overall profit picture. There are two aspects of the investment income that can be monitored and possibly controlled. The first is the yield rate earned on existing investments and on new investments. This rate can be monitored against past performance and against any outside norms. The second aspect is the level of the money actually invested. Are all the available funds invested? How is the cash managed? Are premiums received on a timely basis? How about the float until the benefit checks have cleared the banking system? Any reports that can help to identify weaknesses in these areas are desirable.

Federal Income Taxes (FITs) -- The FIT picture is much clearer now than it has been in the past. But it still is desirable to monitor the FIT level and to pay attention to how it is allocated to the group health block in total and to the reporting segments.

MR. ROBERT RUDERMAN: Bulletin 85-273 pertains to the reporting of certain information. Chapter 4-58 prescribes the methods and information necessary for the filing of rates.

Bulletin 85-273 has been promulgated further as an addition to Chapter 4-59 in the Florida Rules and Regulations. It's the result of Senate

Bills 176 and 697 which were passed in the 1984 Florida legislature. This is the labeled intent of the legislature in these bills:

> Whereas the legislature finds and declared it to be of vital importance to the state, that rapidly escalating health care costs be contained to insure continued access by its citizens to adequate health care, and
>
> Whereas the Legislature finds the greatest obstacle to health care cost containment to be that the market for health care goods and services has not performed as other economic markets due to the lack of meaningful price competition between providers, the lack of educated consumers and purchasers, and the lack of reliable data upon which to base meaningful comparison of charges by providers for services rendered.

The rule is the method for getting information to produce a consumer guide, which was one of the things required by the legislature. As a result of this rule, the items included in the guide will be premium and benefit comparisons, information about premium increases in the prior year, loss ratios by annual statement category, and an indication of what insurers write what kind of insurance.

The purpose of the guide is to allow Florida consumers to make more informed decisions about purchasing insurance and to give them guidelines about various subjects related to health insurance.

We have set up seven categories and asked insurers to report information on policies they are selling in each one: basic hospital/surgical, major medical, disability, hospital indemnity, cancer, accidental death, and medicare supplement.

Making comparisons between policies in these areas is difficult. A few states have already tried with consumer guides. I didn't find them of much use to consumers. I'm not sure that the Florida guide is going to be better, but it's a little simpler. We plan to provide this guide annually with further intent to produce a report that will show the top ten writers in each of these categories in Florida.

We're also required to produce a comparison of physician charge data. The legislature originally asked for a voluminous amount of information, asking us to produce a list of charges for all procedures by various areas in Florida, and also by physician specialty. We took it upon ourselves to reduce the amount of data significantly in the first year of publication to what will probably be the top twenty-five procedures by area, and not be physician specialty. We sent out a questionnaire last December to ask the companies what they could provide. Most of them could not provide data by physician specialty. We have recently submitted a recommendation to the legislature that physician specialty be permanently left out of this report.

It is the legislature's intention to allow an individual to see what the average price is for specific procedures performed in a given area, and

by a particular type of physician. There's some question in my mind of whether this guide will actually do that. It might just encourage physicians whose charges are lower than the prevailing average to raise their rates.

The guide will encourage consumers to be more aware of costs and to start thinking about them. When consumers start thinking about cost, our cost spirals will begin to be reduced because patients will start talking to doctors before they go through any procedures, and the effect will be to keep costs down.

The third part of the bill asks for us to collect data on cost containment measures. We asked insurers to estimate the savings from the various different measures; the sentinel effect of deductibles and coinsurance, preadmission testing, and mandatory or optional second opinions.

The rating rule draft distributed on May 7, 1985, follows the National Association of Insurance Commissioners (NAIC) model, but it has a number of significant differences. We hope the rule will eleviate the concern we feel about some practices.

The assessment spiral arises for a group of insurers holding a particular policy on which premiums may be changed over the years. Generally, the policy is sold for a few years before experience begins to develop. When the experience is examined, it is either good or bad. The insurer will not do anything unless the experience is very bad. Raising rates will upset the field force as well as the policyholders, but in many cases it's necessary to raise them. Many insurers take that policy off the market and begin to sell another similarly priced product. The spiral then begins. There are two types of individuals who are insured and faced with a rate increase: healthy and unhealthy lives. Many of the healthy lives will leave the plan for newly underwritten policies at lower rates. The unhealthy lives are stuck. The policies remaining in the group than have a much higher percentage of unhealthy lives, and the experience will worsen. Claim costs begin to rise rapidly, and the company may have to ask for another rate increase.

The Florida Insurance Department bases requests for a rate increase on recent experience (one to three years). The result is to grant larger increases to a reduced number of policyholders under the block. We finally end up in the position where there are a number of unhealthy policyholders faced with large rate increases. In many instances, they could experience 100 percent rate increases for two or three years in a row; they can't afford their premiums, and they can't afford not to be covered. This is not the position they expected to be in when they were once healthy and took out their policies.

The second problem deals with group insurance, particularly with small group insurance. The situation occurs when one or more members of a group experiences a large claim, usually claims that are expected to continue for a long period of time, such as heart problems or cancer. Many insurers faced with a competitive group market will price them-

selves out of the market if they raise their rates for all their small groups. To help alleviate this problem, insurers have developed a system referred to as tier rating under which a certain portion of the small groups, which have had the bad experience, are given a higher rate increase than the healthy groups. In some cases, these rate increases have been as much as 100 percent per year for three years in a row. Some companies have been put out of business because of their group insurance premiums.

The third problem is, fortunately, not very common. Bill mentioned the phrase "corrective action." When results are worse than expected, we have to do something about it. In our rule, we have used the phrase "correction action" to apply to policies where the results are to good. Generally, insurers have been willing to examine the results and request rate increases where necessary, but they don't pay much attention to policies where actuaries have overestimated the rates. There are many cases where loss rations are 50 percent less than expected, yet a request for a rate decrease or an offer of extra benefits is rarely made without encouragement from the Insurance Department. To maintain equity, it is necessary to recognize these plans and make appropriate adjustments.

Another major reason for the rule was to quantify the requirements of the Department to speed up the process of filing and let everybody know what the rules of the game were.

There are a few differences between our rule and the NAIC model. The NAIC model addresses the problem to the assessment spiral by requiring a company to account for all past experience when asking for a rate increase. The amount of the rate increase will be buffered significantly, so it is hoped that many of the healthy insureds will not have an incentive to move.

One problem with the NAIC and the Florida rule, which follows the NAIC in this manner, is that the rule will not help today's unhealthy insured; it will only help the currently healthy person who eventually will become an unhealthy person. It will take three to five years before we see any beneficial effect from this section of the rule. Experience is only counted from the effective date of the rule.

On the other hand, our requirements regarding group filings should allow us to make immediate progress with a second problem -- group insurance is not mentioned at all in the NAIC model. There are a number of companies that are vehemently opposed to group insurance being in the rule on the basis that the competitive atmosphere in group insurance is sufficient. The Insurance Department believes that competition is insufficient, even on the large employer/employee groups where the Department believes the competition is significant. It only takes one bad guy to force a rule which will apply to all the god guys; we can't make rules apply to just a few.

The corrective action plan speaks for itself. It's a significant change from the NAIC model. In some ways it does look a little bit like th New York rule. Although companies think it's going to be a lot of extra

work, it is hoped it won't be too much extra work. When you're making your review for the rate increases, it should be just as easy to make your review for the rate decreases.

There are a number of other significant differences between the Florida rule and NAIC model. These differences were all hammered out in a meeting representing a healthy slice of the industry. The committee believes that the loss rations are slightly different, and the formulas for adjusting them are slightly different. We have also added some categories necessary in Florida. For example, Florida is concerned with its aged population. Sales practices in Florida have not been perfect, and many instances of unfair tactics have been documented. We have added a section to the rule that that requires a higher loss ratio when 50 percent of the policies are sold to individuals over sixty-five.

MR. KERRY A. KRANTZ: What is your philosophy on averaging? Policy A has a loss ratio of 95 percent and Policy B has a loss ratio of 35 percent. If you have the same amount of premium and number of policies and claims, the two policies together would have a loss ratio of 65 percent. If it were one policy form, the loss ratio would be acceptable under the guideline of having at least 65 percent so that the benefits are reasonable in regard to the premiums. However, if we look at the two policies separately, in one case the company would be forced, because their loss ratio was too low, to consider decreasing their premium rates in order to have a more reasonable premium with regard to the benefits. With a high loss ratio, they might be forced to go after a rate increase -- undesirable because of the assessment spiral. What's wrong with just having a 95 percent loss ratio on one, 35 percent on the other, and simply accepting the fact that sometimes you win, sometimes you lose, but on the average you come out fine? Are we trying to get to the point where all forms have a narrow window for their loss ratios?

MR. RUDERMAN: Yes, it would be nice if we had a narrow window. From the consumers standpoint, some people are paying a premium that's much too high, and some people are paying one that's much too low.

Under the new rule, we make rate adjustments easier and more timely. Suppose you file a loss ratio expectation of 35 percent in the first year, 45 percent in the second year, 55 percent in the third year, coming to a 55 or 65 percent loss ration over the lifetime of the policy. If you find that in the first year you've experienced a 45 percent loss ratio instead of the 35 percent you expected, we will now allow you to adjust rates in that first year even though your loss ratio is not above the 55 percent required for the policy.

On the other hand, if your loss ratio comes out to be 20 percent, and you were to reprice the policy today, you would come up with a premium significantly lower. We would then ask you to lower the premiums on that policy, again in this timely manner.

Where two policies are small blocks of business, which have been around for a while and are not being sold, you can combine similar

types of policies for loss ratio purposes, as long as you continue to do so thereafter.

MR. WOLF: Do you see any possible problem with insurer withdrawal from the Florida market because of this?

MR. RUDERMAN: Some insurers may decide to withdraw from the market. There will still be enough companies to be competitive and to offer all the products necessary for the Florida consumer.

MR. WOLF: Is this consumer guide going to be available free of charge to the public?

MR. RUDERMAN: Yes.

MR. JAY BOEKHOFF: I'm familiar with several programs that have applied tier grading for small groups. Companies frequently have a philosophy in their tier grading that renewal business will gravitate to a rate level that's higher than new business because of wearing off of preexisting conditions, underwriting, and so on. As long as this is within reason, is this methodology acceptable to the Department?

MR. RUDERMAN: In the rule, we're asking companies for an explanation of what they intend to do on renewal -- a description of the procedure. Most procedures that are nondiscriminatory will be acceptable. However, we realize that renewal should cause higher rates, and that discrimination there is acceptable.

Some very disturbing practices are when there are no written classification systems. Each small group is reviewed by a committee. They review the current claims. For example, this claim is expecting $200,000 of losses each year for the next four or five years: therefore, we'll give the group a 100 percent increase in premium. It's basically by the luck of the draw that these companies increase premiums.

MR. WOLF: Would you explain equivalent premium?

MR. BOGARDUS: It's basically the premium you would have charged a group if you had sold a conventionally funded plan to that group. For example, let's take the 150 life employer, where you might have a couple different funding vehicles to charge that employer. One might be a purely conventional group. The other choice might be some minimum premium plan where you charge the policyholder only, say, 15 percent of that to cover your expenses, risk, and profit. The balance is put into the policyholder's bank account. Then you're paying claims out of his bank account. You'd treat the same amount for both of those policyholders as the amount of equivalent premium.

MR. PETER A. GERRITSON: One of the sources of earnings for experienced rated policies is the excess of deficits recovered over deficits added or deficits generated for the policies. That isn't known until the refund is done after the policy year is over. How do you get a handle on that during the policy year? Do you have a computer that calculates

these deficits policy by policy each month, or do you have other methods?

MR. BOGARDUS: We perform a refund calculation for each group each month for the partial policy year with which we're dealing. We can have a deficit recovery or an increase in deficit from the end of the month of April to the end of the month of May, and May's financial results, which will be part of the overall results that we have. We will have an "accurate" refund liability at the end of both of those months. We have to make judgements on the factors that might affect that group, determining what the refund liability might be currently, possibly using last year's refund formula and some factors that make a best estimate of what this next year's going to look like. We are in the process of developing a new approach that will be dynamic and will use the same refund calculation process at the end of each month.

MR. ANTHONY L. MCWHORTER: In Rule 4-58 you ask for Florida-only experience at least for the last several years. In our company, that's pretty heavy and laborious from the standpoint of collecting the data.

How successful has asking for the Florida-only data been? What have you gleaned from this request that you've been able to use?

MR. RUDERMAN: We really haven't had much trouble getting the Florida data, particularly on a collected and paid basis. The Rule was originally written asking for earned and incurred, and in this draft, we've changed it to collected and paid because the method of splitting that reserve is usually just a percentage anyway. We find that experience in Florida is different on certain policies, and if the amount of premium on the form is significant, than we should be looking at Florida data. It seems the way to go, especially when looking at medical plans where you're talking about area rating anyway, and you do have to keep the information separate. We get information from everybody already on Florida premium and claims on Schedule T, so the information is available.

MR. WOLF: The management information system that you contemplate certainly needs some computer capabilities. Have you been able to do any of this with personal computers (PCs)?

We hear more about large catastrophic claims, which have an enormous amount of charges with them -- premature infants, serious accidents, and others. Usually you would go through some sort of pooling process. Would you describe that?

MR. BOGARDUS: With the expansion and capabilities of computers, you can use an awful lot of personal computers to do a lot of things. We don't use a personal computer. We have all our data in a database or flat files. With our mainframe, we can down-load those files to a Virtual Storage Personal Computing (VSPC) capability, which uses the mainframe, but is in PC type language and is rather user-friendly. With some of the currently available software, you can move things from a big data file down to a PC and I'm sure it won't be long before this

data will be summarized, sitting on your desk where you can work with it.

In our refunding blocks of business, we sell a pooling concept. We will trade a client for X percentage of premium during that policy year. We will not charge any claims per person above a certain dollar. For example, for 3 percent of the premiums, we won't charge any claims in excess of $70,000 on any one person that we paid during the twelve-month, policy-year period.

In our more manually rated blocks of business, those blocks are large enough to support any claims that we've got for our business. If the blocks are smaller than a certain level, you may want to pretend that you've got some pooling (even within those nonrefunding blocks of business), in developing your rates going forward.

MR. BOEKHOFF: It's been my experience that management information systems usually are tied to accounting systems. Does your company go back and restate 1984, particularly with regard to the actual incurred claims versus your estimates of them; do you recommend that approach; and are you aware of other companies that do that?

MR. BOGARDUS: We do not restate 1984. We might, in arriving at our claim reserve across the entire block or by some segment, get an idea of how much we've misstated the results for a particular block, but we don't spend any time doing that. We trust the fact that the current claim reserve, even though it might be plus or minus three or four percent, is the right number. We use resulting reserve increase for rating actions, whether it be for individual groups or blocks of business.

It would be fairly time consuming to do something like that, and considerably more so if you're trying to arrive at the rate increase for a block of policies in which you're completely unsure of what your incurred claims were for a period of time. You could return six months later and get a better idea. Maybe it would be appropriate to do something like that to be setting your premiums prospectively. I'm not aware of what other companies are doing one way or another in that regard.

MR. GERRITSON: We do frequent restatements of earnings. We find it helpful in management reporting, because if there's any carry-forwards from the claim liability being overstated or understated, it can affect how much you're earning in a particular accounting period. Without it, we found we couldn't make much sense out of segmented management reporting, we couldn't tell what the block was doing once we restated the beginning liabilities.

MR. JOHN D. BOHON: It seems that pooling would play a big role in how you assess regional office results if you had, say, a half million dollar claim in that particular period. Do you employ some pooling concepts when you review the regional office results?

MR. BOGARDUS: We do not. We let the chips fall where they may. Even within our blocks of business mentioned, we have product managers associated with each of those blocks. There is some concern by those product managers that their compensation might be adversely influenced by one large claim and that we should have some pooling. We could establish, for example, a pooling product line run by an actuary whose job and compensation might relate to how well the pooling levels are set and priced. At this point, we have not moved in that direction.

MR. BOHON: Do you allocate expenses by regional office?

MR BOGARDUS: Yes. We take each component -- you can think of the statutory statement but we put them all on a GAAP basis -- whether it be investment income or federal taxes and general expenses. We take the general expenses and break them down into a hundred different categories and allocate those to the groups each month on an incurred basis. To the extent that a group office has a higher than normal amount of commissions, that will be reflected in that office. To the extent that the office is located in a higher rent district than some other office, that probably won't be as adequately reflected as it ought to be. Our refund formula at this time is not refined enough to have variations if the claims are paid in San Francisco, Atlanta, or wherever. We end up with an average cost of paying those claims, irrespective of it's location. Correspondingly, the cost of the regional group office is treated the same way.

MR. BOHON: What variation do you have in the expense allocation formula, and if there isn't any, why do you do it?

MR. BOGARDUS: We have variation by size of group, by complexity of the benefits, by the funding method involved, by the claim level for that specific group, and the premium levels for some of the items.

MR. BOHON: It looks more like an experience rating formula then a true cost allocation.

MR. BOGARDUS: That's probably true.

MR. BOHON: Do the regional people who are getting their compensation adjusted using these results accept this?

MR. BOGARDUS: They do because the refund calculations influence the level of refunds that are paid in these various offices. If you're using basically the same allocation formula for our expenses as you are in your expense charges in the refund calculations, there's a lot of consistency there, and your results shouldn't be adversely influenced. I'm not saying that all of them accept it. Anytime you try to compensate people on financial results when they don't understand each little piece, and where some allocations were made, you always have room for argument.

MR. WOLF: With the aging of the population and some changes with how people over age sixty-five are covered through medicare, how does that impact your financial reporting system?

MR. BOGARDUS: We carry premiums and claims by some coverage levels, so we have an idea of some of the coverage segments. To the extent that we have deterioration of a group because of some kind of an aging problem process, the entire group will show that something is going on. However, it won't identify the aging process as the cause of the problem.

MR. WOLF: In other words, you don't have some way to measure experience for people over sixty-five, for example, or to indicate who the primary coverage provider is?

MR BOGARDUS: We do not at this point.