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ISSUES RELATED TO HEALTH INSURANCE RESERVES

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o An overview of recent developments related to health insurance reserves. The session will discuss the concepts included in several recent papers and committee reports on this topic. In addition, the status of proposed model valuation legislation will be reviewed.

MR. DONALD M. PETERSON: We have a twofold objective for this session. First, and of lesser significance perhaps, is to continue the discussion initiated at the 1985 Annual Meeting in New Orleans regarding two Society papers and two Academy Committee reports. The papers were "Reserve Principles for Individual Health Insurance" authored by Bob Shapland, Frank O. Grady, Gary See, and Spence Koppel; and "A New Approach to Premium, Policy and Claim Reserves for Health Insurance" by Paul Barnhart, both of which are published in *TSA* XXXVII. The first Academy report was that of the Health Subcommittee of the Standing Technical Advisory Group to the NAIC Life, Health and Accident Standing Technical Task Force on Structure for Consideration of Health Coverage Valuation Standards. Committee members were: Bill Odell, Jack Bragg,

Will Burgess, Charlie Habeck, Tony Houghton and Jim Olsen. The second Academy report was from the Academy Committee on Health: Subcommittee on Liaison with the NAIC Accident and Health (B) Committee. This committee was chaired by Paul Barnhart and its members included: Bill Bremer, Scott Bucher, Mike Kazakoff, Jim Olsen, Frank Rubino, Pete Thexton and John Wagner. This report contained proposed model valuation legislation.

The November 1985 session in New Orleans was assembled belatedly, was not mentioned in the preliminary program booklet and, frankly, was rather poorly attended. However, since there was proposed model legislation involved, and an apparent divergence of opinion among respected health actuaries, interest in the subject heated up quickly. It was the lead article in the winter issue of the Health Section News, and the lead article of the January 1986 issue of the Academy's Actuarial Update was a point/counterpoint discussion of the subject by two of our panelists: Bob Shapland and Paul Barnhart.

Second and of more significance, at this time we have a revised model valuation bill. So regardless of debate concerning valuation principles, we now have proposed standards to scrutinize. I am sure, however, that the panelists will address the proposed valuation legislation from their views of the actuarial principles involved.

Our first speaker is Paul Barnhart, chairman of the committee which developed the proposed model legislation. Paul has his own consulting firm in St. Louis, and is a past president of the Society. The second speaker will be Bob Shapland, Vice President and Actuary for Mutual of Omaha. Our third speaker will be Bill Odell from the actuarial consulting firm of W. H. Odell and Associates in Winston-Salem.

MR. E. PAUL BARNHART: I'll be referring to pages in the report to the NAIC from our subcommittee which is dated May 27, 1986. This revised report is the result of the subcommittee's reviewing quite a number of letters received in connection with the American Academy of Actuaries discussion draft that was mailed out in December 1985. We received a total of 43 letters, a near record. The largest number of letters ever received on an Academy discussion or exposure draft was 46, so we came close. The usual response to a discussion draft

is six to ten letters. Not only were there 43, but several of them were quite thoroughly thought out. We got some that were 8, 10, 12 pages long, so we had a wealth of comment to study. The subcommittee spent two days in early April 1986 reviewing the comments in these letters, and we found them extremely useful. Many of them had excellent criticisms and suggestions that we found to be very valuable to us. As a result, the new draft has been substantially revised from the December 1985 discussion draft, and virtually all of the revisions, except for a few minor editorial ones, have been made in response to the letters we received. We appreciated the letters, and I think our subcommittee was very responsive to the many suggestions and comments that were made.

There are a few key things that need to be understood if you're to fully appreciate the way the subcommittee has tried to approach this. First of all, we felt that we should take an evolutionary approach, not a revolutionary approach. We felt that we should work from the base of the existing NAIC model regulation and only make changes where they appear to be clearly necessary or where there is a broad base of support within the profession for the changes. So, our approach has been evolutionary -- working from the existing standards and retaining many features that are in those existing standards.

Second, we believe that the NAIC will not abandon regulation of health insurance reserves or its minimum reserve standard philosophy. We think that will still be true, even considering the advent of the valuation actuary concept. In its adoption of both of these guidelines that I have mentioned, our subcommittee, to be quite candid about it, specifically rejected the approach to minimum reserve standards taken in the paper written by Bob Shapland and his former Society committee. We could not agree with that approach because we felt it was basically revolutionary, basically called for deregulation, and basically called for dependence on what we felt were rather subjective rating principles that seemed to us to be entirely too fluid and too poorly defined to serve as a basis for health insurance minimum reserve standards. I expect Bob will have something to say about that in response shortly.

Now, where compelling problems and needs were perceived by our subcommittee, we felt that there were some areas where substantial change was called for in

the existing NAIC model regulation. One of these is in the area of what we have called Type C benefits where there are now, in effect, no minimum standards. If contracts of this kind are priced on a level premium basis, the existing standards do call for tabular reserves, but there are no promulgated tabular reserve standards with respect to coverages like major medical. In this area, we feel that specific tabular standards are not feasible; that there is simply too much change, too much variation, too many trends, too many pressures on the cost of benefits under contracts of this kind. So, our conclusion was that tabular reserves in the traditional mold simply would not serve the purpose with these cost-sensitive types of benefits which we've classified under Type C in our proposal. We felt that here was an area where a radically different approach to reserving had to be evolved. In other cases where problems and needs do not seem to urgently call for a basic change of direction, or where there seemed to be a clear lack of support throughout the profession, we followed the policy of staying as close as we could to the existing minimum standards.

I have one more general comment about this May 27, 1986 draft. This draft was just presented to the NAIC Actuarial Task Force meeting in Boston, which adopted the recommendation in paragraph 4 on the first page of the report to be submitted to the Task Force's parent NAIC committee. It adopted this report as a revised basis of exposure and extended for an additional six months' exposure with regard to this current draft. So this draft is now adopted by the NAIC as a basis for continued exposure, such exposure to extend to the NAIC's December 1986 meeting. At that time this draft will be reconsidered, either for adoption of some version of these standards or possibly for still further exposure. It depends on how things develop over this six-month exposure period that's beginning now. This session is really the opening phase in the continued exposure and discussion of all these ideas.

Now, let me review some of the key changes that we have made. I'm going to zero in on three or four key changes that we made as compared to the December 1985 discussion draft. Page 14 of the May 27, 1986 copy deals with claim reserves, one of the areas where we made a quite significant change. We do not feel that we have changed our view or our philosophical approach to incurred dating and the question of what constitutes incurred claims; but we have

nevertheless substantially changed the draft at this point. The December 1985 draft contained, in paragraph II.A., a definition of "incurred date." We have stricken that entirely, and in its place is the opening sentence at the top of page 14, "Claim reserves as of a given valuation date shall be established for those payments that the insurer has been obligated to make in accordance with its contracts, as a result of such contracts having been in effect on or before such valuation date." We have deleted entirely what we had in there before, which was an actual definition of incurred date. We think this basically says what we said before, but it says it in a way that provides increased latitude of interpretation. The actuary responsible for valuation has a little more latitude of judgment in what he regards as "incurred" in this considerably more abbreviated statement.

Also, in the December 1985 discussion draft, we had an appendix attached which gave quite an assortment of illustrations of incurred dating. We have abandoned that entirely. We felt that it seemed to imply to everybody that what was needed was a comprehensive bible of definitions of incurred dating in connection with all kinds of combinations of contractual provisions. We didn't want that. We also found that it seemed to imply to some readers that all of these illustrations were of actual contracts in force; they weren't meant to be that either. They were intended to be hypothetical, but we found they were causing more confusion than clarification, and we deleted them entirely. I might mention here that we were particularly influenced by one letter we received from Tony Houghton. He pointed out some good examples of exceptions to the kind of fully defined dating rules we were attempting to put together. His letter was enough to persuade us that we should abandon this idea of a complete and precise definition of incurred claim dates. So instead of that, you've got one simple sentence on page 14 that pretty much spells out the basis of incurred claim liability so far as the minimum standards are concerned.

So much for the key change that has been made in the claim reserve area. One thing needs to be emphasized: the letters that we received covered an amazing spectrum of divided opinion. We had letters ranging all the way from very strong support of what the committee had proposed to letters equally strong in opposition to it. And what this means is that we have a big problem of communication within the whole health actuarial profession as to what "incurred"

means and how one ought to go about determining what claims and what claim payments are going to be included in a proper valuation of incurred claim liability. I think this, in turn, means that in publishing experience tables or in using any kind of claim cost tables, there's a clear need to explain the dating basis that underlies a given set of tables. The range of opinions on this varies enormously. We have no kind of consensus here; we have widely varying interpretations of what constitutes incurred claim liability and how it's to be approached and evaluated. That means that we've got to be much more clear and specific than we have in the past in setting out the basis of any set of experience tables or statutory tables of claim costs, etc., so that we can really know what the assumptions were that went into the determination of any particular table of claim costs. We need to keep in mind that we have a very serious communication problem within our profession as to what we're really talking about when we speak of "incurred" claims.

Next is the area of unearned premium reserves on page 15. We had proposed a kind of modified net unearned premium approach. We felt that our approach was appropriate and fair in regard to determining what should be recognized as a minimum standard when it comes to unearned premium reserves. But we received mostly objections on one side or the other to this. We had a few letters that proposed a purely net benefit type of unearned premium reserve; others strongly advocated the existing standards, unchanged. Again, there was quite a range of opinion, but mostly dissatisfaction with what we were trying to propose in that December 1985 draft. What we've done under III.B. is to go back to the existing standards. We've stated it a little differently because the existing standards specify the minimum basis for both contract and unearned premium reserves together as being mean reserves; however, in no event may the aggregate reserves on contracts subject to active life reserves be less than the aggregate gross unearned premium reserve on those contracts. We stated it a bit differently because we didn't want to continue to state it in terms of mean reserves. We think that most companies probably do not value using mean reserves. Essentially what's said here is meant to be a return to the existing NAIC minimum standard so far as unearned premium reserves are concerned. This is another area where we feel we have made a quite basic and quite significant change from what we had in the December 1985 draft.

Let's move on to benefit ratio reserves. Here I have an apology to make to several authors of papers in the *Transactions*, because in our zeal to work on this problem and come up with a proposal, we completely neglected to give proper credit to some of the authors who have written papers relevant to this subject. One of them is George L. Hogeman, who in 1973 published a paper in the *Transactions* that provided the actual model for the benefit ratio reserve concept that we have proposed. George's paper had to do with generally accepted accounting principles (GAAP) reserving. It was an aggregate approach to GAAP reserving, using loss ratios and estimating the value of benefit net premiums in the aggregate through using a ratio to the gross premiums. George's technique was the source and the model for what we propose, and we neglected to give him credit for that. That omission has been corrected, and he is mentioned specifically in Appendix C to these new standards as being the gentleman who first published a description of the method that we have adapted and proposed. It's not exactly the same as what George Hogeman proposed in his paper, but it's a rather specific adaptation of what he published back in 1973. At the end of the text part of Appendix C, we have also acknowledged three other authors whose *Transactions* papers have provided some useful and valuable discussion of the relationship between health insurance reserves and loss ratios.

On benefit ratio reserves, again we received letters with views that cover the spectrum from one extreme to the other. A number of letters expressed considerable concern about the subjectivity of this proposed reserve. That was a deserved "touche." In our December 1985 report, we placed a lot of emphasis on objectivity, and this was deservedly thrown right back in our faces. We think in practice this will be less subjective than it appears on the surface. While we still emphasize objectivity, we feel that objectivity has to be tempered to fit the context of the problems that are being addressed. We don't think objectivity must be observed at all costs, no matter how arbitrary, fixed, or unrealistic the result might be. We continue to feel, in dealing with these cost-sensitive Type C benefits, that a completely objective specific tabular minimum standard just will not work. It does not do the job, in our opinion, and we've given reasons for that in the report and commentary section of the report.

A second difficulty expressed by a number of letters concerns what appears to be an inverse or illogical result. Because of the use of retrospective experience, if past experience is favorable, the calculated reserve increases. If retrospective experience is unfavorable, the reserve decreases. This certainly appears on the face of it to be illogical, but we do not think it is illogical if you keep in mind the basic purpose of the reserve. It's to measure prospectively the excess of the future unincurred claim liability over the expected benefit net premiums to be received by the insurer. All of these contracts are subject to rate increases; policies under which the rates may be changed. Because of the cost-sensitive nature of the benefits, we think the rates will need changing frequently. We feel that any sensible kind of evaluation of the prospective liability has to take heavily into account the probability of rate increases and the question of how adequate those rate increases will be. We do not think that can appropriately be done without taking into account the retrospective experience. We think it's necessary, given the regulatory philosophy about reasonable rates. It's necessary that a contract lifetime view be taken here, and difficult though the task may be, the actuary involved has to be prepared to project the expected future contract liability in the context of expected frequent future rate increases. We don't think you can get away from that context.

Some of the letters received express the view that there really isn't any liability here, given the fact that the insurer can change rates and that loss ratios are not guaranteed. We nevertheless feel that the insurer is obligated to try to respect the regulatory view of what are reasonable premiums. Those who do not see any obligation here are a little like the person who says, "Promise her Arpege, but give her anything." We think that is what's involved in the view that there's no obligation on the part of the insurer to try to honor its own declared anticipated loss ratios in valuing this prospective liability.

Another problem that came out in the letters and other discussions we've received is a very casual attitude about tabular reserves on these policies. For example, in one of the letters the comment is made that an insurer does not bother to adjust its tabular major medical reserves when it obtains a rate increase. The reasons given are expediency and simplicity. The letter goes on

to say that under that situation the tabular reserves carried on level premium major medical contracts simply become a kind of premium stabilization fund. We feel that that totally fails to perceive the nature and purpose of these reserves, namely to measure prospective contractual liability. One of the serious problems in trying to follow present tabular reserve standards is the absence of specified minimum standards. This leads to indifference and to a very casual attitude about tabular reserves on these kinds of contracts. We think there's liability here, liability that needs to be measured and needs to be taken seriously. The prevailing practices with respect to tabular reserves just don't work and lead to indifference, carelessness, and disregard of the real purpose of reserves.

While we have retained the concept of benefit ratio reserves as developed in the December 1985 discussion draft largely intact, there are some changes incorporated in the May 27, 1986 report. The following are the most important ones:

1. Page 16. Under section IV.A., there are some important changes in the general requirements as to contract reserves, especially with reference to group insurance.

2. End of page 17, top of page 18. In paragraph D.2.b., an important change is the determination of aggregate benefit ratio reserves on the basis of "contract groups," rather than "contract forms" as in the December 1985 draft. "Contract group" is defined and illustrated in the glossary in Appendix B.

3. Page 18. In the definition of R, the "anticipated loss ratio," provision is made for multiple values of R with respect to successive revised premium time intervals, as a minimum standard. This is an important change.

4. Page 20. In paragraph F, it is provided that the adequacy and reasonableness of benefit ratio reserves be reviewed yearly, rather than at maximum intervals of 3 years as provided in the December 1985 draft.

As a final comment, Appendix A contains some clarification as to specific minimum standards with respect to interest and mortality (page 23 of the May 27, 1986 report).

MR. ROBERT SHAPLAND: I will present some of my views regarding statutory reserve standards for health insurance with special emphasis on analysis of the latest draft proposal by the American Academy of Actuaries Subcommittee.

In approaching the development of statutory reserve standards, I believe there are theoretical, practical, and valuation actuary responsibility considerations. I feel that the foundation or starting point in developing statutory standards is the theoretical accounting and actuarial principles regarding proper revenue and expenditure recognition and matching. Thus, rating principles and practices are the keystone of reserves. The practical considerations which then come into play include conservatism as viewed by the NAIC, the viability of the rating principles in use that establish the theoretical reserves, and the administrative expense and other practical problems generated by valuation standards. Finally, one must decide whether reserve standards should allow the valuation actuary a large range of flexibility versus placing restrictions thereon via the use of minimum standards. It might be noted that the proposal calls for the valuation actuary to increase reserves where minimum standards are determined to produce inadequate reserves, but it does not allow the valuation actuary to reduce reserves below the minimum standard except for benefit ratio reserves. This move to allow the valuation actuary to set reserves below the valuation standard in one area of reserving may be a good step forward but consistency would call for allowing the valuation actuary to set reserves below the formula standards in other areas as well.

Some of the foundation for the proposal is seen to be contract provisions and anticipated loss ratios. Further, it appears that the proposal assumes that there is some universal agreement that rating practices stem from contractual provisions and anticipated lifetime loss ratios. I feel this is an incorrect assumption.

Let's look at an example where three insurers are developing a major medical policy where the deductible, stop-loss, and maximum benefits are determined on a "per cause" basis but medical expenses are only covered for treatment received while the policy is in force.

The first insurer might decide on using step-rated premiums with the level set each year to cover the claim payments arising from treatment that year and to produce its loss ratio that year independent of prior years' loss ratios.

The second insurer might fear that such a rating system would be dangerous because it would rely on continuing policyholders' premiums to cover ongoing treatments related to accidents and sicknesses incurred in previous years. This insurer might also see an inequity in setting premium levels for a given year which cover claims related to accidents and sicknesses incurred in prior years and charging those premiums to new enrollees as in the previous case. It might also see that such a system could lead to a dangerous cumulative anti-selection rating spiral. Thus, this second insurer might set premiums each year to cover all claim payments stemming from accidents and sicknesses occurring in that year no matter when the treatment is provided. And, premiums each year would be calculated independent of prior years' loss ratios.

The third insurer might fear financial problems even with this second approach. Perceived anti-selection spirals under the second approach could be seen as calling for the loading of early premiums in order to create funds to cover deteriorating costs. Several approaches could be taken in establishing loading levels as well as fund release procedures. Further, different perceptions could be involved regarding the extent to which the insurer intends to place limitations on the level of deteriorated morbidity that will be recognized in renewal rate calculations versus the level that will be charged against reserve funds and/or surplus.

For each of these insurers, its rating practices, not contract provisions or target loss ratios, would call for different claim and/or contract liabilities. Incurred date coding would differ between the first and the other companies. Balancing reserves would be inconsistent with the rating practices of all three companies, but contract reserves consistent with the rating practices and

perceived deterioration guarantees of the third company would be called for. However, in those states where NAIC rating formulas placed limitations on these insurers' renewal premium calculations, additional liabilities could arise reflecting any future losses the NAIC rules impose.

Regarding NAIC rules which assume a "lifetime" approach to loss ratio rating, only some states have adopted this concept. And even in those states, initial loss ratios lower than those filed generate future revenue shortfalls only to the extent that they call for future loss ratios which, together with renewal expenses, exceed 100% of future premiums. Given renewal expenses that may be as low as 10-20% of premium, prospective liabilities are seen to be unrelated to retrospective assets or funds calculated via the use of a filed loss ratio such as 55%. Also, the use of a disappearing preliminary term calculation is seen to have no theoretical foundation.

If one decides to ignore expenses in calculating contract liabilities and also assumes that some lifetime loss ratio will be achieved, then it is elementary that retrospective reserve calculations will produce the same answer as prospective reserve calculations. However, one should not be misled by the simplicity of the resulting retrospective calculations. The complicated prospective calculations cannot be avoided since they are needed to establish the lifetime loss ratio used in the retrospective calculations. These calculations could include assumptions regarding claim costs by age and duration, persistency, inflation, future rate increases, etc. And, the relationship between future premiums and future claims would be controlled by renewal rating practices or formulas.

In other words, complicated prospective calculations have to be made in any event and could be used as the basis of the contract reserves without going to the work of adding retrospective calculations. Setting forth a retrospective calculation which is disregarded if prospective calculations show that higher or lower reserves are justified seems superfluous.

With this starting point, let's take a look at each of the three types of proposed reserves in light of the theoretical, practical, and valuation actuary flexibility considerations.

CLAIM RESERVES

I believe that from a purely theoretical standpoint, claim reserves are best defined as representing the future claim payments of an insurer which are to be funded by past earned premiums. Future claim payments which are meant to be funded by future earned premiums would be accounted for under contract reserves. Claim reserves calculated on any other basis for statutory purposes would call for a second set of reserve calculations for renewal rating purposes.

The main area where there is controversy regarding which claim payments fall under claim reserves versus contract reserves is where ongoing medical benefits stemming from accidents or sicknesses occurring before the valuation date are payable only if the policy remains in force. Here, the practical consideration of conservatism would call into question reliance on future premiums in paying continuing claims related to a past accident or sickness under individual policy forms. Such funding would be less questionable under group insurance, especially where large groups are involved. This same practical consideration would come into play if one were to rely on future premiums to pay ongoing claims not subject to in-force status.

Under the proposal, the valuation actuary is charged with setting adequate claim reserves. Little guidance is presented, however, regarding the recognition of rating principles or practical considerations in determining adequacy. As previously noted, the proposal calls for contract language to control the establishment of claim reserves. Where ongoing major medical claims are subject to maintaining an in-force status, the proposal relies on this in-force status requirement as being a determining factor. I have trouble with this rule.

While contracts with these provisions state that the company does not have to pay ongoing claims related to past accidents or sicknesses if the policy lapses, those contracts similarly call for the company to pay such claims if the policy does not lapse. And, I presume that many policies involving ongoing illnesses don't lapse. I believe the important questions under this type of contract are whether past or future premiums are meant to cover ongoing claims

and whether the rating practice in this regard is viable and produces the proper level of reserve conservatism under NAIC accounting. In this regard, the proposal seems to be a very liberal one. It assumes the viability of a rating plan which creates, in and of itself, deteriorating blocks of business.

I propose an alternative practical approach to claim reserves. Here, claim reserves would cover ongoing claims for accidents and sicknesses that commence before the valuation date except where the valuation actuary demonstrates that it is reasonable to utilize future premiums as an offset to such ongoing claims. An example of the latter would be large group cases where termination of the group contract eliminates liability for ongoing claims. Here, however, the actuary should recognize the liability which arises under terminated group contracts because of claim continuation and/or conversion provisions.

UNEARNED PREMIUM RESERVES

From a theoretical standpoint, I agree with the statement made in the subcommittee's original draft that unearned premium reserves should recognize the liability for claims, claim adjustment expense, and other administrative expenses related to the unearned period of coverage. From a practical standpoint, some margins for conservatism should be included. This conservatism should be larger where a fast-growing company, a new product, or new underwriting standards are involved which increase the risk of premium inadequacy. From the standpoint of valuation actuary flexibility, one must ask whether a fixed formula should be set forth versus allowing the valuation actuary to determine the probable claims, claim adjustment expense, and other expenses related to the unearned period. While I could support valuation actuary flexibility, such a step should be accompanied by delineating the theoretical and practical foundation for setting adequate reserves.

The subcommittee has proposed the adoption of a minimum standard of the unearned valuation premium where there are contract reserves involved and unearned gross premiums where no contract reserves are involved. The proposal goes on to call for an overall test where the unearned valuation premiums and contract reserves together must be as great as the unearned gross premiums. No foundation for this proposal is set forth. I do not understand why a large

amount of contract reserves on non-cancellable disability policies should have some impact on the level of unearned premiums on medical expense policies.

And, from both a theoretical and practical standpoint, I don't understand why the proposal ignores claim adjustment and other administrative expenses related to the unearned coverage period.

From a practical standpoint, the proposal therefore not only lacks conservatism but seems to be inadequate. It also creates administrative problems by setting forth different standards for policies with and without contract reserves and by further calling for an aggregate unearned valuation premium plus contract reserve test against gross unearned premiums. Also, the proposal may engender unfavorable tax consequences. From the valuation actuary flexibility standpoint, the valuation actuary is precluded from setting reserves smaller than the minimum even in those cases where the expected loss ratio is considerably below the target loss ratio and gross unearned premiums are called for.

As an alternative, I suggest consideration of setting as the valuation standard the unearned gross premiums unless the actuary can demonstrate that anticipated claims, claim adjustment expense, other administrative expense, and a reasonable margin justifies lesser reserves. And, if contract reserves are in use, the unearned premium reserves would also have to make provision for any contribution to the contract reserves called for by the insurer's valuation practices.

Before going on, I might say a few words about due and unpaid premiums. I believe there is a practical consideration regarding the collectibility of due and unpaid premiums. I feel that the probability of collection must enter into the valuation of due and unpaid premiums if they are to be recognized, especially regarding individual and small group contracts. I do not understand why insurance companies should be allowed to book a profit on premiums that are due and unpaid when the chance of realization of this profit is small because of a small probability of collection.

CONTRACT RESERVES

From a theoretical standpoint, in measuring solvency, contract reserves represent the shortfall of future revenues in meeting future expenditures. From a practical standpoint, margins should be included in such reserves to cover deviations between actual and expected costs and to defer profits so that they are realized on a "release from risk" basis. I feel that the valuation actuary needs considerable flexibility in establishing these contract reserves because of the vast array of coverages, risks, and rating practices in place that impact on the necessity and level of contract reserves. This in turn calls for considerable guidance via stated principle and practice guidelines.

Regarding the subcommittee's proposal, the theoretical foundation is unclear. Somewhat arbitrary tables for some policies have been proposed while completely different benefit ratio reserves have been proposed for others. From a practical standpoint, I have seen no analysis or demonstration of whether or not the proposal produces reasonable reserve levels. From the valuation actuary flexibility standpoint, the valuation actuary is called upon to strengthen all reserves which are inadequate but can set up less than the formula reserves only where benefit ratio reserves are used.

I see several problems with the subcommittee's proposal as follows:

1. There are inconsistencies between tabular and benefit ratio reserve standards. Under benefit ratio reserve standards, the foundation is the assumption that there is select and deteriorating morbidity, while these morbidity patterns were not assumed under tabular reserves. Under tabular reserves, there was evidently no attempt to study or assume deteriorating claim costs in the calculations. Further, the subcommittee did not assume that the lifetime loss ratio concept applies to forms calling for tabular reserves, since the benefit ratio test is never applied. In other words, in those instances where the benefit ratio reserve would be greater than the tabular reserve, this does not call for strengthening reserves. Also, the proposal does not allow for the release of tabular reserves when the valuation actuary determines they are excessive. Finally, persistency

experience is allowed to affect benefit ratio reserves per policy but not tabular reserves.

2. Many states and companies are not operating on the lifetime target loss ratio basis. Instead, they view anticipated loss ratios as an individual year-by-year goal with no long-term concept involved. They set premiums for a one-year period to produce the target loss ratio and then move on to new premium levels the following year to meet the next year's target loss ratio. The fact that past experience was favorable or unfavorable in relation to the past target loss ratio has no impact on the calculation of future premiums. This management of insurance business which individualizes each year's risk is similar to the management of universal life and casualty insurance. Under one-year rating for health insurance, benefit ratio reserves are inappropriate just as they would be for these other kinds of insurance.

3. Benefit ratio reserves do not fully solve the "deteriorating block of business" problem. That problem can only be solved by mandated funding requirements and compatible premium loadings which would generate the mandated funds.

4. The subcommittee recognized some of the shortcomings of the NAIC lifetime loss ratio rating approach in its initial draft and should not support the universal adoption of this approach via mandated universal reserve requirements related thereto. If subcommittee members feel that the lifetime rating basis should be the only allowable one, then they should attempt to achieve that goal via rate regulation and not indirectly via valuation regulation. Promoting rating principles via valuation standards is "putting the cart before the horse."

5. Under benefit ratio reserves, the actuary adjusts reserves based on prospective net premium valuation. This occurs via the use of revised lifetime loss ratios. Elsewhere, both in the report and in other actuarial literature, there is reference to the use of gross premium valuation. Thus, there is conflict regarding whether contract reserve adequacy is to be measured on a net or gross prospective premium valuation basis.

6. The benefit ratio reserve, which is a prospective liability, has been equated to a retrospectively determined asset. There is no theoretical foundation for such an equation.

7. The preliminary term calculations appear to be impractical since they call for experience tabulations and claim reserve calculations which are not made by many companies.

8. Combining of forms is allowed in calculating benefit ratio reserves without any requirement that those forms be combined for experience rating purposes. This allows negative reserves on some forms to offset positive reserves on others where the negative reserves will not be used to justify greater rate increases on the positive reserve forms. This combining therefore produces results contrary to the premise of benefit ratio reserves.

9. No analysis was undertaken as to whether or not the preliminary term proposal produces reasonable results.

10. Under the definition of "leveling premiums," there is a call for reserve calculations which can be inconsistent with the proposed standards.

In order to get a picture of the relationship between the proposed benefit ratio reserves and the liabilities calculated on a prospective gross premium valuation basis, I set up a scenario under an annually step-rated major medical policy. Claim costs by age were determined, and select and deteriorating morbidity trends were superimposed thereon. Further, I assumed that resulting claim costs and premiums increased 6% each year because of inflation. Premiums did not increase however because of health deterioration. Gross premiums were calculated for various issue ages to produce a 60% lifetime loss ratio within this health deterioration scenario. Also, persistency and interest were used in the calculations. Given this environment and rating practice, I calculated both the benefit ratio reserves for various issue ages without any preliminary term adjustment and the prospective gross premium valuation reserves. These calculations showed that the benefit ratio reserves were extremely conservative. For example, the gross premium valuation calculations produced negative

reserves for the first nine policy years. These reserves became positive and increased somewhat after the first ten years but maintained a level considerably below the benefit ratio reserves. The ratio of prospective gross premium reserves to benefit ratio reserves reached its maximum at the last duration for the youngest issue age, and this ratio was only 66%. I believe these calculations indicate that further analysis is needed in establishing benefit ratio reserve levels and that a preliminary term adjustment method could be used that is much more simple to implement and which does not have any vanishing point (if benefit ratio reserves are determined to be a reasonable approach in some situations).

Of course, given a different scenario where gross premiums are adjusted each year to cover the claim costs for that year and to produce the target loss ratio each year, prospective gross premium reserves are negative at all durations.

In summary, I agree that contract reserves require valuation actuary attention and reserve setting independent of any promulgated standard. Given our complicated environment and the vast array of rating plans being used that impact on contract reserves, I recommend that any valuation proposal be consistent by eliminating minimum contract reserve formulas per se for all policies. On the other hand, I would have any regulation set forth more detailed information and/or rules regarding valuation principles and practices, with rating practices playing the key or determining role. Under forms operating on the lifetime loss ratio basis, starting out with benefit ratio reserves has merit provided the reserves involve reasonable recognition of renewal expense margins. This could apply to step-rated and level-rated forms. In all cases, minimum reserves would be based on prospective gross premium valuations which include minimum margins for contingencies and/or deferral of profit based on release from risk. Assumptions regarding future premiums would be consistent with the rating practices in use in determining them if those rating practices were legal and viable. Calculations ignoring inflation in benefits and expenses or the impact of aging and health deterioration would call for justification.

While a fallback on guideline reserves could be adopted when actuarial data needed to make sound valuations are not available, these guideline reserves should be developed on a conservative basis appropriately recognizing rating practices, aging, health deterioration, persistency, renewal expenses, interest, and profit based on release from risk.

In closing, I want to commend the subcommittee for taking a giant step forward in expanding the responsibility and flexibility of the valuation actuary. Even greater flexibility should be considered accompanied by appropriate restrictions on valuation principles and practices to help ensure attaining NAIC objectives.

MR. W. H. ODELL: The proposed standard specifies a prospective test. The primary purpose of these comments is to introduce a possible framework within which such a test may be made. Two other topics of importance to both the general subject at hand and the prospective reserve test in particular, namely claim reserves and a pervasive fundamental problem, are also addressed. Some of the advantages of the proposal are presented. The comments are therefore organized under the following headings:

I. The Prospective Test
II. Claim Reserves
III. A Fundamental Problem
IV. Advantages of Proposal

I. THE PROSPECTIVE TEST

American Academy of Actuaries Recommendation IV.F. in the May 27, 1986 exposure draft provides the test criterion and its general framework.

The criterion is that the value assigned to policyholder obligations must exceed by an appropriate margin the excess of the present value of future benefits and expenses over the present value of future gross premiums.

The general framework is that the valuation premium is taken as the gross premium and the value of each actuarial parameter is based on current

experience (as opposed, for example, to experience available at the time the policies were issued or to statutory minimum values).

The work clearly begins with a review of the contractual relationship between the insurance company and the policyholder. Further, it may be considered necessary to consider in the test whether the company can meet levels of performance not guaranteed by these contracts. Examples of such additional levels of performance are those related to premium rate filings which may indicate that: (a) the company expects a certain loss ratio or (b) in some states the company has obligated itself not to perform certain actions such as obtain rate increases unless the loss ratio reaches a certain level.

Beyond that we are faced with a plethora of vexatious questions. One example of a related group of questions is with respect to guaranteed renewable medical expense coverages which are non-inflation proof, how do we deal with possible technological and monetary inflation of medical expenses which will impact on claim cost? Should possible related increases in premiums be considered? Also, over what period should our calculations extend? (Note the word "life-time" in the proposed standards.) Another example of a series of questions revolves around contractually guaranteed increases in benefits. Benefits contractually defined as a function of the Consumer Price Index are an example.

The task of cataloging and organizing the issues and mapping our work may well be as challenging as performing it.

These preparatory functions have already been addressed. A couple of years ago a group of actuaries, Messrs. John M. Bragg, Willis W. Burgess, Charles Habeck, Anthony Houghton, Jim Olsen, and myself as chairman, were asked by the NAIC (EX5) Life, Health and Accident Standing Technical Actuarial Task Force to prepare a document listing the items which would have to be addressed in order to develop a statutory minimum valuation standard along traditional prospective lines. This document, referred to below as the "Report," was prepared in our capacity as the Health Subcommittee of the Standing Technical Advisory Group to the NAIC Life, Health and Accident Standing Technical Actuarial Task Force and submitted to the NAIC on April 29, 1986. The work was also presented at the meeting of this group in the fall of 1985 in New Orleans.

The information contained in the report can be utilized directly for the task at hand which is the prospective test of the proposed minimum standard. The table of contents of the report lists the questions which we must consider in making a prospective calculation.

For our prospective test, (a) the values of the actuarial parameters are to be based on perceptions at the time we make the test (whereas the report presumed those values would be set by regulation), and (b) we will take the valuation premium as being equal to the gross premium (whereas the report presumed the traditional calculation of the valuation premium). For your reference the contents of the report are published in the Society of Actuaries *Record* of the New Orleans Annual Meeting (Vol. 11, No. 4).

In this short session we will not even touch on all the items which must be considered in making a prospective test. Rather let us look at three subjects which pervade these calculations:

A. Simplified preliminary calculations.
B. Reserve period.
C. Future claim payments.

A. Simplified Preliminary Calculations

The bewildering array of questions makes it appear difficult to begin our actual calculations. However, again using guaranteed renewable non-inflation-proof medical expense benefits as an example, the best way to begin will often be with simplified preliminary calculations. We might consider initially just one or two of the most important policy forms. Our calculations would assume no premium increases. They would assume no increases in claim costs arising from technological inflation or monetary inflation. This procedure has a number of advantages:

1. It can probably be completed before an intelligent decision as to future premium and claim cost level scenarios can be made.

2. Very often we would want in any event to see a satisfactory result of this simplified calculation regardless of the results of calculations using other values of the premium and claim cost parameters.

3. The simplified calculation provides a good starting point and basis of comparison for more refined calculations.

We might then proceed by introducing changes in future claim costs which we perceive to be realistic and compatible with realistic inflation expectations. Among other things, this will tell us the extent to which present premium levels can withstand such claim cost increases. We may then introduce comparable future premium rate increases that we believe are consistent and appropriate in light of the premium rate increases which have been obtained in the past on the policy forms being tested, any restrictions on the ability to obtain future rate increases, etc.

Next, variations might be introduced into the values of the other parameters. Then the remainder of the work can be planned and executed.

Commencing with simplified preliminary calculations provides early-on information which usually has to be obtained in any event and which will assist in planning the remainder of the work.

B. Reserve Period

The task of determining the reserve period, the period over which the reserve calculation is to be made, is a crucial one. It has not received the attention it deserves.

One cannot, as far as I know, calculate present values without articulating the period over which they are calculated.

The proposed standard requires that the test extend over the "lifetime" of the policies. For test purposes, it would appear that that lifetime encompasses the period of time over which any of the policies being

tested, identified by policy form number in force at the date of the test, will be in force.

Notice how much simpler the question of the reserve period becomes when it arises in the context of a test of reserve sufficiency rather than in the context of a minimum valuation standard. For example, if the term *lifetime* were used in a statutory minimum prospective standard, then that standard would have to prescribe, for purposes of the calculation, the maximum valuation premiums and minimum benefits over the entire period. This in turn would open up a Pandora's box.

As you will notice from the report, the difficulty of writing into a minimum valuation standard the levels of future premiums and claim costs to be considered over any future period of substantial length is onerous indeed. However, in performing a prospective test the actuary is applying appropriate procedures which will serve as evidence upon which to formulate an opinion. In this context, it is both needful and appropriate to consider different hypotheses and particularly those which seem realistic in the circumstances of the particular case. This is vastly different from establishing hypothetical values which can serve as minimums for setting reserves for the entire industry.

The matters of the reserve period, premium levels and claim cost levels are all interrelated. They appear to be more easily addressed in the context of a prospective test than in the context of a prospective minimum standard.

C. Future Claim Payments

To determine what claim dollars will be paid out, we must go to the terms of the contract. Actually, this may have almost nothing to do with how the contract defines a claim. To take an extreme hypothetical example, even if there was a policy that said "the expense of each day in the hospital constitutes a new claim" and further said "the policy will pay only expenses of claims while the policy is in force," we would still have to address the question of the future payout of claim dollars. To argue

that there is no liability today for expenses on account of future days of hospitalization because we do not know whether or not the policy is in force is specious. We are after a realistic determination of the future claim dollars which will be paid.

Our concern here is with whether or not the claim dollars will be paid as opposed to whether or not the recognition for that obligation should be classified as a contract reserve or as a claim reserve.

The proposed standard indicates:

1. The prospective test should be on the aggregate policyholder liabilities, contract reserves and claim reserves.
2. There is to be consistency between contract reserves on the one hand and claim reserves on the other. The two elements must be determined by consistent methods.
3. The actuary should review dating practices.

It is appropriate at this point to note an important advantage of a regulatory standard which utilizes a retrospective calculation with a prospective test as opposed to a minimum standard based on a prospective calculation.[1]

Consider the degree of difficulty of quantifying three very important parameters: reserve period, premiums and claims, for a retrospective standard, a prospective test, and a prospective standard.

1. For a retrospective standard, the reserve period runs rather obviously from issue; the premiums and claims are those actually experienced.
2. For the prospective test, a reserve period running for the lifetime of the block of business can be handled rather easily. This is due in part to the fact that various techniques or estimation in different scenarios can

[1] In this and following discussion, standards are presumed to be quantitative (i.e., with objectively determined parameter values) as opposed to qualitative (i.e., "good and sufficient").

be employed with respect to the premium and claim parameters. Also, this is done in the context of the particular situation at hand.

3. However, with the prospective standard, we encounter a great deal of difficulty with all three parameters because we seek to define minimums that will apply to many types of policy forms under many circumstances to all companies. Such a task is difficult in the extreme.

The parameters are quantified with less difficulty for a retrospective standard with a prospective test than for a prospective standard.

II. CLAIM RESERVES

Claim reserves (liabilities for losses and loss adjustment expenses, loss reserves, claim reserves and liabilities) are a more important part of the actuary's work than active life reserves if importance is to be measured in terms of propensity to contribute to insolvencies, misunderstandings, confused and confusing rhetoric, and difficulty of actuarial calculations.

The proposed standard does not prescribe specific methodologies. The standard does provide general guidance. This guidance (a) does not contradict present practice, and (b) will not itself be contradicted if any one of a range of practice approaches is prescribed at a later date. These characteristics are highly desirable in a standard to be adopted at this time since expeditious development and clarification of fairly precise practice or regulatory standards for determination of these amounts is unlikely.

Here is a simplistic approach to the claim reserve part of a prospective test (or to a retrospective calculation for that matter). Consider a dollar quantity which we have determined is the expected value of a possible day of hospitalization of a particular insured life on a particular day which falls after the statement date.

First, is any provision for this quantity (regardless of classification) required? Can the insurer by a unilateral action avoid any obligation to make the payment represented by this dollar amount? To take extreme examples:

1. For a guaranteed renewable individual health insurance policy, the answer is clearly No.

2. For a group insurance policy which provides the insurer the unilateral right to cancel all coverage at any time with no obligation to make payments for expenses arising from any services rendered after that cancellation date (even those arising from an illness in progress at the cancellation date), the answer is probably Yes.

If the answer is No, a provision (of one classification or another) needs to be made in the financial statements; if the answer is Yes, then probably no such provision need be made.[2] "Claim costs . . . are recognized when insured events occur" according to accounting literature, FASB Statement 5 and FASB Statement 6.0, without regard to line of business and whether the contract is long-term or short-term.

Second, should this dollar amount be classified as a contract reserve or a claim reserve? Answers to this question (which is often confused with the first question) present a diversity of practice and considerable confusion.

Whether a provision (regardless of the classification thereof) is required is much more important than the question of whether the provision is classified under one heading or another.

The preceding statement must be tempered because of actual practice problems such as:

1. When the reserve system is first established for a block of business, whether particular dollars of claims expense are classified under one heading or another will affect the emergence of profit, and

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[2] Two important cases are: *Calvin S. Sparks* vs. *Republic National Life Insurance Company*, June 10, 1982, 132 ARIZ 529, and *Time Insurance Company* vs. *Commissioner of Internal Revenue*, March 10, 1986, 86 T.C. No. 20.

2. Claim dating practices and the reserving system must be kept in line, and so on.

It is important to look to the contract at hand. For example, with respect to a reinsurance contract, it is the reinsurance contract rather than the direct contract that should govern our deliberations.

Why do both questions (a) whether or not a provision should be made for the hypothetical quantity, and (b) given such a provision should be made, whether that provision should be classified as a contract reserve or claim reserve, seem so much less troublesome for other property liability lines than for health insurance? I believe there are two reasons for this.

1. With respect to most other property liability lines, there is generally no contract reserve.

   There is generally a match within each time period between the premiums accrued to that time period and the claims arising during that period.

   For example, under an auto policy, calculations are usually made as though for a policy year (and also for any portion however small of a policy year), the premium for the policy year (or the portion thereof) is exactly matched with the claims arising in the policy year (or the portion thereof). Therefore no contract reserve is required.

   But in health insurance, this matching over time periods which are subsets of the term of the policy often does not take place. For example, under a level premium health insurance policy running for five years, the calculations may reflect increasing claim costs. Hence, contract reserves are established in the early policy years to pay for policy claims in the later policy years. This immediately gives rise to the question of whether claim payments in the later policy years are covered under the contract reserve or they have to be provided by the claim reserves.

   Well, the underlying calculation should clearly indicate what the designers of the product had in mind. Unfortunately, this is not always the

case. Even when it is the case, it is not always easy in practice to isolate this question from the host of others that impinge on a practical situation.

The presence of a contract reserve for health insurance introduces an element of confusion in determining whether a provision for our hypothetical quantity is to be classified as a contract reserve or as a claim reserve.

2. With respect to most other property liability lines, the term of the contract is generally easily determinable from the contract itself. Also, the reserve period will generally be the contract period.

Most property liability policies are so worded that we can pretty easily conclude they have a contract term of one year. The period over which reserves are set is the same year. As noted above, the contract reserve will usually be zero. When we consider the claim reserves, we only have to consider the amount of such reserves we would establish at the exact end of the policy period.

As of the end of the reserve period, it is usually a matter of the amount of claim dollars which the company has become obligated to pay by the contract which has now run its course but has not yet been paid. Once our reasoning for determining claim reserves at the end of the contract period is worked out, we can very easily make the calculation as of an earlier date falling during the contract (reserve) period. The matter becomes more complicated in practice than it sounds. However, the reasoning is much simpler than often found with health insurance. If every individual medical expense non-inflation-proof health insurance contract were a one-year term policy, would we really have the difficulty that we do in determining which claim dollars should be provided for as of any date and whether any such provision should be part of the contract or of the claim reserve? I doubt it.

Consider again a block of individual guaranteed renewable medical expense non-inflation-proof policies that have been in force for a period of time

> and will doubtless continue in force for a period of time in the future. To ask the question, "for what claim dollars is the company liable today?" does not, I believe, get us to the answer. It is dangerous to answer a very real problem (such as whether or not a company is solvent) by the answer to a hypothetical question. So, next we ask what provision needs to be made given that a certain number of contracts will continue in force next year and a certain number for the following year, and so on. The questions begin to become blurred and, not surprisingly, so do the answers.

If the reserve period could be easily determined from the respective policy forms, the work would clearly be much easier. However, for this to occur, certain matters relating to the use (or more accurately, misuse) of our language need to be addressed.

One of the advantages of the proposal is that it leaves the way open for future improvement in the wording of contracts and legislation. This in turn paves the way for logical determination of the reserve period and, hence, for making the job of determining the company's liability much easier.

III. A FUNDAMENTAL PROBLEM

The story of Babel presented in Genesis was so much a part of our religious upbringing we take it for granted, as we do the air we breathe, and forget its importance.

"The first cause of absurd conclusions I ascribe to the want of method; in that they begin not their ratiocination from definitions; that is from settled significations of their words; as if they could cast account without knowing the value of the numeral words one, two, and three." [3]

Hence, is it any wonder that many have perceived absurdities to abound, considering the state of phenomenology in health insurance? "The Greeks had one

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[3] This quotation and those in the following paragraphs are from *Leviathan*, Chapter IV, by Thomas Hobbes.

word for both speech [which I assert includes the written word] and reason; not that they thought there was no speech without reason, but no reasoning without speech; . . . . Without [speech] there had been amongst men neither commonwealth, society, nor contract, nor peace."

Our forefathers sought constitutional guarantee of the freedom of speech not because they enjoyed hearing other people talk or even enjoyed hearing themselves talk (although that may have been partly true) but rather because without such freedom there could be no freedom of thought.

Our government, our business intercourse, our contracts depend on the quality of our speech.

That some of the most learned minds have devoted significant portions of their life's work to questions of language, definitions, and classification, as well as the reverence in which the work of these minds was held in less literate times, are ample evidence of the importance of these arts.

There is ample evidence of the lack of application of them to the field of health insurance.

Two examples of absurdities:

1. Two different things designated by the same word. Consider the following individual policy form:

    a. The company raises premium rates every year; this had been anticipated when the policy was sold; the company attempts to match the cost of coverage of each year with premiums collected in that year; the policyholder has the unilateral right to renew the coverage each year.

    b. The company has never raised premium rates on the policy; nor does it plan to do so; this had been anticipated when the policy was sold; the company matches the cost of coverage over the lifetime of the policy to premiums which are level over the lifetime of the policy;

again the policyholder has the unilateral right to renew the contract.

These two situations are completely different. Yet they bear the same label "Guaranteed Renewable." They are often sold, it is believed, in an identical manner.

One of the concerns of the people who prepared the report mentioned earlier is policies of the first category being sold as though they had the attributes of policies in the second category. We labeled these the "non-level premium policies" sold as "level premium policies."

2. The same thing designated by different words. Consider a policy with respect to which the company cannot change premium rates. This has been described in two different ways:

   a. "The company cannot change the premium rates on your policy."

   b. "The policy is noncancellable."

   Even if one could find a dictionary in which our policyholders could learn that "noncancellable" means the insurance company cannot raise the premium, the use of two different appellations for the same characteristic is at best a fruitful source of misunderstanding. (As we are well aware, the confusion is compounded because one of these appellations also is used to designate another characteristic and, to raise the confusion to a still higher order, that other characteristic is also designated by a third appellation.)

Do such absurdities have an impact on actions of companies and policyholders? Yes.

As a result of the first example cited, while some companies have worked diligently to provide ample value to their policyholders and return to their shareholders, other companies have marketed their non-level premium products as though they were level premium, with rate increases following, which were

planned by the company and unexpected by the policyholder. And it is for the same underlying reasons that it is difficult to apply present reserving systems to these situations.

And these actions lead to serious consequences, such as rate regulation of health insurance which appears to be more oppressive than for any other line of business, and endeavor to regulate by decisions made today results which will accrue to a block of business over literally decades in the future. (Of course, the regulation has not corrected the problems which it was designed to correct; it is depriving the consumer of long-term premium health insurance products. Like most regulations, it does not solve the problems which gave rise to it but only creates new problems. However, that is another subject.)

One of the advantages of the proposed valuation standard is that it will make it easier for us to recast our future speech as regards health insurance into a more rational form. This is because the proposed valuation standard is tied only loosely if at all to the irrational speech of the present contracts and present legislation. With the proposed standard in place, it would be more feasible to effect improvements in the speech of the contracts and legislation.

It is too much to hope that any reserving system can bring complete order, peace and harmony to a situation due in no small part to the fundamental causes discussed in this section of the remarks. However, it is to be hoped that the proposed system can work effectively to this end. In this regard, its open-endedness referred to previously is another important advantage.

IV. ADVANTAGES OF PROPOSAL

A number of advantages of the proposal have been noted. These are summarized here for convenience.

1. Open-Endedness -- The proposal is so written that it will be relatively easy in the future to address some of the items it covers in more detail. This can be done by additional regulation without changing the regulation implementing the proposal.

2. Freedom of Speech -- "Freedom of Speech" is one way to designate the attribute of the proposal in that it goes a long way toward liberating us from the linguistic morass of present contracts and legislation. It goes a long way toward freeing us to restore rationality to the definitions of the words we use and to restore rationality in our thinking and contractual relationships.

3. Clarity of Specifications -- This item is closely related to the first two. The proposed standard provides for clearer definition than a prospective standard might be expected to in today's environment. This does not mean that the proposal uses definitions which are simple. It means they are not as complex as other alternatives and are freer from the definitional problems caused by current health insurance language than present standards.

4. Ease of Application -- A retrospective standard with a prospective test avoids the problem of a prospective standard of attempting to define and quantify minimum (or maximum) values of each valuation parameter in such a way that the specified value is applicable to all policy forms, issued by all companies, in all circumstances. The retrospective standard with a prospective test utilizes retrospectively known results and prospective valuation parameters based on a specific situation and not shackled by predetermined values.

These are significant advantages.

MR. STORM JOHNSEN: I'm Chief Actuary for the Insurance Commissioner in the State of Washington. I am also a member of the NAIC Actuarial Task Force. The concern I have is that I would like to see how this question came about. What is the origin of the question that we're discussing? I think the origin of it is a dissatisfaction with the health insurance reserves on the part of the regulators. Paul, please correct me if I'm wrong; I believe that some years ago your committee received a charge from the NAIC Actuarial Task Force to explore this problem and possibly come up with a draft, which you now have returned to our NAIC Task Force and which we have approved for exposure. I

don't know whether this is, therefore, an NAIC Actuarial Task Force exposure draft or whether this is an Academy Liaison Committee exposure draft.

As far as the problems that the regulators are concerned with, I perceive those as two problems. There are other members of the Task Force in the audience; perhaps they would enlarge on this. One of the problems is of lesser importance, but it has to do with reserves in the select period. By the select period I'm talking about the second, third, or fourth policy year. There are many companies that have difficulty getting rate increases in the early years of a policy. One of the underlying reasons for that is that they are not holding reserves in the select period. The second problem, a much more basic one and a much bigger one, is the fact that there are no reserves held for the ultimate years as we see it. There are senior citizens out there whose policies get so expensive when they are age 75, 78, and 82, that they can no longer afford to maintain their policies. There are many solutions to this and I'm not current on the present draft, but the underlying problem is that the senior citizens are not able to maintain their policies. One solution to this is to mandate level premiums starting at age 65 for all health insurance. Now that would solve that problem. It would probably create some other problems. Unless we address this problem, I think the senior citizens are going to. The senior citizens, at least in the State of Washington, are a very powerful group, and they are introducing legislation. We have an example on hand, House Bill 1462, that went through last session dealing with long-term care insurance. There are several items in that particular bill which are not favorable either to the industry or to the senior citizens.

Paul, could you please comment on what I'm talking about with the origin of this exposure draft?

MR. BARNHART: There's one thing I want to make very clear in response to Storm's comment. This is an NAIC exposure draft. It's not an American Academy discussion draft. Our role is to assist the NAIC in a charge directed to us by the NAIC Task Force, and we regard this as being an NAIC exposure draft.

MR. ODELL: I'm mindful of the regulators' concern about a valuation standard, and this is very reasonable and it's important. In my remarks I mentioned that one of the difficulties we're having is extremely heavy -- perhaps oppressive is too strong a word, perhaps it isn't -- rate regulation. I pointed out that one of the consequences of that rate regulation is that consumers are not able to get the products they could have without that regulation. I would say that the senior citizens who can't afford to pay the premiums are in that position at least partly because of rate regulation. Years ago, the only law on the books was that benefits could not be unreasonable in relationship to premiums. We priced policies over the lives of the insureds expecting to pay out at least 40% of the premiums in cash and knowing we might well pay a great deal more. Thoughts of rate increases were remote. Along came rate regulation and those numbers were raised to 50%, 60%, 65%. Then someone said you can't use loss ratios anymore. You have to use the present value of future benefits to present value of future premiums. With that kind of a test, with a coverage running for life, if the cash payout, the true loss ratio, is 65%, then the test calculation might produce a ratio as low as 50%. Now we change the relationship between premiums and benefits and end up perhaps with a cash payout, a loss ratio, of 80% and a present value of future benefits to present value of future premiums of 65%. Now, as a result, when one does rate filings in that kind of environment, it is very difficult for a number of reasons to price over the lifetime of a product opining that we expect to pay out 80% of the premiums in cash and still expect to stay solvent, knowing we can have some very adverse swings in experience. We are forced, as a practical matter, to look at shorter lifetimes for rates. This rate regulation is having a tendency to push your pricing down to one-year term, and the person who purchases a policy today may not be able to afford the higher rates which are bound to pertain to this policy 20 years from now when he is a senior citizen. Of course, this is a bit off the main subject of the proposed valuation standard.

MR. SHAPLAND: I'd like to be the devil's advocate for one second. If the perceived problem of the people at the older ages is that they've gone through health deterioration and therefore the company is now charging them a higher rate because of their deterioration, the only way to solve that problem is through rate regulation that requires insurance companies to charge more money

in the early years and to set that money aside and release it later on. And so, the solution is not reserve regulation; it has to be preceded by rate regulation which requires that kind of a funding system. Then the reserves follow. I don't think you solve the problem by having a reserve standard that's trying to solve something without solving it first by the rates that have to be generated to do it.

MR. ODELL: I agree that the solution, if it is rate regulation, is to force higher rates.

MR. MARK E. LITOW: We've been going over this discussion for more than a year, and I think the 43 responses that your committee has received, Paul, are an indication of something which myself, and I think Bill Odell's message, really hit at. We have two problems here. One is that we have minimum standards for regulatory purposes, and second, we have reserving principles. It seems to me that we're trying to set up minimum standards before we have any agreement as to what the reserving principles should be. Bob Shapland's paper also tries to address what these principles should be, and one thing that I pleaded for before and I'm going to plead for again is that I really think we need a committee to follow up on Bill Odell's report to set out what these principles are -- define term period for reserving purposes, define all these other things and get discussion on that, and then we can get back to minimum standards, because the two aren't necessarily related. Paul, you have a valuation standard for tabular, which is not necessarily consistent with your Type C contract, where you're trying to set up this benefit ratio reserve which is sort of on a GAAP basis. So, I really urge that we follow up on Bill Odell's report and try to define some of these terms before we get back to minimum standards. I'd be interested in your comments on that.

MR. BARNHART: Mark, I think basically what you're saying is true and I agree with it, but we don't think minimum standards can afford to wait that long. We think standards have to be addressed. We think the basic and longer term problem that you're describing of reserve principles is a very important subject, and I think we've discovered it's all the more important because of the wide divergence of opinions on the subject. But, meanwhile, we feel we can't simply set aside statutory minimum standards and not address them. We do

see what we are doing as an interim step. That's why I was emphasizing evolutionary. As work goes on in developing reserve principles and working toward consensus on that subject, I'm sure these standards will be revised accordingly in due course. But meanwhile, we just can't set aside the problem and not address it while we're debating and researching all the rest of that. It just won't wait.

MR. SHAPLAND: I can't comprehend the difference between prospective valuation and prospective test. I don't understand why there's any more need for delineating the processes, etc., for prospective valuation than there is for a prospective test. You seem to make that differentiation.

MR. ODELL: I will try. Let's go over to life insurance. The Standard Valuation law is your prospective minimum standard. Recommendation IV.F. specifies your prospective test. The two are different.