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**ACTIVE LIFE RESERVES FOR
INDIVIDUAL HEALTH INSURANCE**

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- o This session is a discussion of alternative approaches to the design of reserve standards to include those topics discussed in several recent papers and committee reports.

MR. TED L. DUNN: Mr. Peter M. Thexton is Actuary of the Health Insurance Association of America (HIAA) in Washington, D.C. Mr. William J. Bugg is Vice President and Chief Actuary of American Family Life Assurance Company in Columbus, Georgia. Mr. John A. Maurer is a consulting actuary with Maurer & Tobleman, Inc. in Galveston, Texas. I am Vice President of Provident Life and Accident Insurance Company of Chattanooga, Tennessee.

This session will be referring to the May 27, 1986 draft of "Reserve Standards For Individual and Group Health Insurance Contracts" and a May 27, 1986 "Report and Commentary on Responses Received Concerning the December 1985 Discussion Draft on NAIC Reserve Standards for Individual and Group Health Insurance Contracts."

MR. PETER M. THEXTON: I plan to discuss the reason or the impetus behind the development of the proposed health standards and who is sponsoring this development. To answer this question, I am going to go back ten years.

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My experience with the subject of individual health valuation standards over the last eleven years has put me in touch with several of the industry and professional committees which have been investigating, thinking about and writing about the subject. I have not restudied all of my files, but I have done enough research to gain a broad understanding of some of the impetus and trends underlying the new studies.

In the middle of 1975, Mr. John Montgomery, as chair of a predecessor of the NAIC Life and Health Actuarial Task Force (ATF), appointed a new advisory committee, with Mr. E. Paul Barnhart as chair, which first met with the ATF on August 6, 1975. Mr. David Robbins, Vice President of the HIAA, was asked to be a member of the Barnhart advisory committee, as he had been a member of the advisory committee to Task Force 4 in the early 1960s, and he passed this honor to me as the newly hired actuary of the HIAA. Of course, the subject of individual health valuation standards really begins in 1965 and perhaps much earlier when the Task Force 4 report set the standards which are now generally accepted by the industry and generally acceptable to the health insurance regulators.

The principal concerns of the regulators, as expressed at that first meeting in 1975, were (1) new experience tables for reserves, (2) reserve changes when rates change, (3) the reserve structure, (4) surplus considerations, and (5) annual statement lines of business.

The Barnhart advisory committee met seven weeks later, and its report to the ATF three weeks after that expressed the advisory committee's overwhelming concern with the adequacy of premium rates and the need that "valuation standards should be viewed and developed in the context of their use as accounting measures of premium rate adequacy."

After that, the Barnhart advisory committee addressed the subjects of experience tables, especially for disability, as the primary concern and a variety of structural valuation concerns: renewal provisions, medical expense coverage special needs, federal income tax requirements, annual statement blank changes, deficiency reserves, coverages without specific valuation standards, credible internal data.

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The ATF responded in December, 1975, by formally asking the Society of Actuaries (SOA) for help in constructing new tables. The Barnhart advisory committee had made a general recommendation for revising Schedule 0 of the Life Blanks to be more meaningful, but the recommendation was not effected then and has not been effected since.

In March, 1976, the Barnhart advisory committee met again. Its report to the June meeting of the ATF showed primary concern with testing disability claims and policy reserves and constructing new tables. Additional subjects, in order, were coverages lacking specific valuation standards, standards for cancer benefits, policy reserve adjustments when premium rates change, claim reserves and claim incurral dating, and standards of reasonableness of premiums in relation to benefits.

At the same time as the Barnhart advisory committee was preparing recommendations, there was a separate advisory committee on accident and health (A&H) nonforfeiture values, chaired by Mr. Ernie Frankovich. Its first report in March, 1976, reflected its immediate and primary concern with the interrelationship of solvency and premium adequacy with respect to return of premium health insurance policies which have cash values. It recommended re-evaluation of reserve standards for these forms before addressing the nonforfeiture question.

The December, 1976, report of the Barnhart advisory committee discussed at length the problems and parameters in revising the loss of time valuation tables. It then commented briefly on the meaning of anticipated loss ratio and commented very extensively on the question of when claims are incurred under various coverages and contract provisions. The report reiterated the importance of premium adequacy. Finally it made initial recommendations for return of premium plans and observed that the tables, which have since become the 1974 Medical Expense Tables, should be exposed and considered as a new valuation standard.

During 1977, the Barnhart advisory committee continued to meet, and its report to the ATF at its December, 1977 meeting emphasized again that rate adequacy is

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fundamental to solvency, reserves must presume such adequacy, and valuation standards must recognize the use of reserves as accounting measures.

The recommendations in the full report were not unanimously supported by the Barnhart advisory committee, and proposed new tables were not ready but promised for the summer of 1978. The report was accepted for exposure.

During 1978 and 1979 I have no record of Barnhart advisory committee activity. A SOA committee was struggling to make sense of data in preparing new disability valuation tables. The 1974 Medical Expense Tables were being exposed. The HIAA was preparing new guidelines for filing individual health insurance rates. The 1980 CSO tables were under construction. Other consumer and regulatory concerns occupied everyone's time.

In 1980 the Barnhart advisory committee was reconstituted as a liaison subcommittee under the Health Committee of the American Academy of Actuaries (AAA) but with a more general charge. Some of the members were the same, but activity over the next several years concentrated on revising the NAIC Model Rate Filing Guidelines. A SOA Committee was investigating health valuation principles. In the meantime, the NAIC had its own concerns.

The NAIC has been concerned for many years with how to protect individually insured persons with current medical conditions from excessive rate increases, especially on closed blocks of business. It has felt that, while current and reasonably projected financial experience fully justified the increases, the companies could have planned more effectively, combined experience under similar blocks, and taken other steps to anticipate and moderate their financial needs. The regulators wonder, why shouldn't an insurance pool be expected to maintain the same average or lifetime insurability standard compared to the universe as its anticipated standard at issue?

The NAIC actuaries believed that not all instances of substantial deterioration of experience were victims of circumstance. They believed that some were self-induced, though perhaps not planned. There were no specific accusations, of course, and no dramatic examples surfaced publicly. The subject continued to smolder.

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During the 1970s there was a growing dissatisfaction with tabular reserves based on "level" premiums which subsequently had increased to several times their original level so that the originally or currently projected tabular reserves did not seem reasonably related to the reserve amounts needed. The regulators (and some companies) were also reluctant to include, in already high rate increases, amounts for future building of reserves, amounts which were perceived as accruing to company profits on lapses which were engendered, at least in part, by a succession of such premium rate increases.

Adoption by the NAIC of the new Rate Filing Guidelines in 1979 made it immediately apparent, at least to some actuaries, that a potential liability had been created wherever those guideline principles govern renewal rate review.

These concerns were among the reasons for Mr. William F. Bluhm's paper, "Cumulative Antiselection Theory" and Mr. John B. Cumming's paper, "Regulatory Monitoring of Individual Health Insurance Experience," both published in *TSA*, Volume 34, 1982. They also gave rise to the 1980 and 1982 initial rate filing proposals of the Washington State Insurance Department. They were significant considerations leading to the 1982 draft proposals of the SOA Committee on A&H Valuation Principles, discussed at the 1982 SOA annual meeting in Washington, D.C. These proposals were later revised in the form of the 1985 paper by Mr. Spencer Koppel, Mr. Francis T. O'Grady, Mr. Gary N. See and Mr. Robert Shapland, published in *TSA*, Volume 37, 1985.

At its October, 1983 meeting, the ATF accepted the offer of the AAA Subcommittee on Liaison with the NAIC Accident and Health (B) Committee chaired by Mr. Barnhart to prepare a proposal for new standards. In April, 1985, a first draft got fairly broad circulation among actuaries as part of the *Transactions* by Mr. Barnhart published in Volume 37. The October, 1985 draft to the NAIC responds to many comments and is the document which the HIAA has distributed to all member companies and the AAA distributed to all members in December, 1985.

In December, 1983, the ATF asked its Standing Technical Advisory Committee (usually called the Greeley Committee) to prepare a paper discussing alternative health valuation principles. This task was assigned to a subcommittee

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chaired by Mr. William H. Odell, and the resulting paper is the second document distributed by the HIAA to all member companies in December, 1985, and being distributed at this Kansas City meeting.

The ATF projected some action for June, 1986. It has received comments from companies and the AAA and recognizes the need for mature thought, consideration, discussion, etc. A revised draft of the Subcommittee's report was presented at the June NAIC meeting with a recommendation for further exposure until December, 1986, and the extension has occurred. The AAA will distribute the revised draft. Those who had intended to prepare comments but failed to send them may find that they are still valid and should definitely write. This issue is not settled either way.

What is the point?

1. Unlike traditional life and annuity insurance reserve standards, health insurance reserve standards and methods are viewed by health actuaries primarily in terms of their utility in measuring annual earnings and the adequacy of premiums, not company solvency and solidity. This requires a standard which should closely track experience.
2. Health regulators are less concerned with inadequacy than they are with excessiveness and with unfair discrimination between similar classes. This does not necessarily lead to the same standard as an adequate experience standard.
3. This conflict, or potential conflict in objectives, which is somewhat subtle, has not existed for life and annuity insurance, so it is new, unfamiliar and unwelcome, at best, to traditionally trained life actuaries.
4. I am not sure what we do about it, but both industry and regulatory actuaries need to open up the conflict and work on a consensus of goals.

MR. WILLIAM J. BUGG JR.: Early last year I heard about the proposed Minimum Reserve Standards for Accident and Health Insurance being

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developed by the Subcommittee chaired by Mr. Barnhart. My company, American Family Life Assurance Company of Columbus, Georgia, writes large amounts of guaranteed renewal A&H business. By some accounts, we write more than any other company in the country. Since A&H products account for over 95% of our business, we were and are quite interested in and concerned with minimum reserve standards as they apply to individual A&H business. Therefore, as soon as I heard about the proposed Standards, I called Mr. Barnhart to ask for a copy of the Standards being prepared in order to analyze the effects thereof and to submit comments.

Georgia, our state of domicile, currently has the gross unearned premium as a minimum reserve standard. The current NAIC model law for individual A&H reserves, or a variation thereof, has been enacted in only 13 states by our count. The remainder either have no minimum standard or have the gross unearned premium standard. Nonetheless, we have elected to hold a net unearned premium reserve with additional active life reserves, or contract reserves as they are called under the proposed Standards, calculated on the two-year full preliminary term method. This has resulted in a total reserve of some 3.5 times that of our gross unearned premium.

In the calculation of the contract reserve, we have followed the alternative valuation procedure under the current model for products which have no minimum standard other than the gross unearned premium. We use claim costs developed from studies of our own experience, and we reflect decrements from both death and voluntary lapse. In fact, when we measure our own lapse experience, we cannot distinguish between the death and the voluntary lapse since we have no benefit associated with death. The interest rate used is that permitted by life insurance minimum reserve standards. A mid-terminal reserve is calculated with unearned premium being equal to one-half the net annual premium used in calculating the contract reserve. During the first two policy years, the unearned premium is based on the adjusted net premium used in calculating the terminal reserve in those years. Since the calculation of the unearned premium assumes an annual mode, deferred premiums are calculated for all policies with modes other than annual.

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I have been associated with American Family for nearly three years. My prior experience has been largely in the group and pension fields. Thus, I am no authority on reserve methods and practices for individual A&H. However, our auditors who have a number of insurance clients tell us that we are one of the few firms they know of which calculates its individual A&H reserves using decrements which reflect voluntary lapses as well as death. Having given you this background, you can see why we are so interested in the proposed Standards.

In an attempt to measure the effect of the proposed Standards, we selected a sample of our in force cancer policies and valued them using several different methods. The sample selected with reserves calculated on our current method is as follows (Amounts in Thousands):

Benefit Level	Tabular Two-Year FPT with Lapses
4	\$ 47,783
5	5,418
6	47,402
14	4,252
15	7,334
17	26,301
Total	\$138,490

Benefit level is a coding approach we use for valuation purposes to represent a different generation of products, and generally each higher level represents a product with a larger benefit. The sample, which represents about 40% of our business, was chosen because we were already doing some analysis of the block, and the additional testing we had in mind could be easily handled.

Our analysis tests the results of applying the proposed Standards to existing in force business, although we anticipate that any minimum reserve standards would be applied only to policies issued after the standards are adopted. However, we feel that this approach would be indicative of the ultimate effect of the proposed Standards. Certainly, there will come a time when the majority of the policies in force would be valued on the new standards.

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Our first test was to calculate reserves using the current method but modifying the decrement assumption to reflect deaths only. The results are as follows (Amounts In Thousands):

Benefit Level	Tabular Reserve Two-Year FPT with Lapses	Tabular Reserve Two-Year FPT without Lapses	Percentage Increase
4	\$ 47,783	\$ 65,139	36%
5	5,418	8,330	54
6	47,402	71,580	51
14	4,252	6,044	42
15	7,334	11,199	53
17	26,301	40,100	52
Totals	\$138,490	\$202,392	46%

Notice that this test reveals that the overall reserve level is raised by 46% when the decrement assumption reflects deaths only. The increase by benefit level varies from 36% to 54%. Naturally, this increase got our attention. Continuing our analysis, we then proceeded to calculate reserves using the proposed benefit ratio method. For this test, we assumed that actual experience would be reflected by the morbidity, decrement and interest assumptions used in our current tabular reserve calculations. The results are as follows (Amounts in Thousands):

Benefit Level	Benefit Ratio Reserves Disappearing One-Year PT
4	\$ 72,636
5	8,721
6	70,928
14	8,300
15	11,667
17	44,987
Total	\$217,239

Since the adjustment made for first year expenses is graded to zero over a four year period, the benefit ratio reserve as proposed becomes, in effect, a full net level reserve after the first four years. This led us to label the proposed method "Disappearing One-Year Preliminary Term." We have made a comparison of the benefit ratio reserves to full net level reserves. In calculating the net level reserves, the total decrement assumption for deaths and voluntary lapses used in our current tabular reserve calculations was applied. This comparison is as follows (Amounts in Thousands):

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Benefit Level	Benefit Ratio Reserves Disappearing One-Year PT	Tabular Reserve Net Level With Lapses	Percentage Increase
4	\$ 72,636	\$ 73,081	1%
5	8,721	9,266	6
6	70,928	73,521	4
14	8,300	9,181	11
15	11,667	12,650	8
17	44,987	56,042	25
Totals	\$217,239	\$233,741	8%

Benefit levels 14, 15, and 17 are newer blocks of business and have more business in the first four policy durations. Thus, the first year expense adjustment is more pronounced for these cells. Very little business is written now in Benefit Level 4, and the benefit ratio reserve is all but equal to the net level reserve where voluntary lapses have been used in the calculation.

Comparing the results, removing the lapse decrement will increase the contract reserve from \$138 million to \$202 million. The benefit ratio reserve is even higher, \$217 million, nearly as high as the net level reserve with lapses which is \$234 million.

We questioned why the expense adjustment could not be the same as that under the two-year full preliminary term. You could eliminate premiums and claims for the first two years altogether and start development of the reserve in the third year. Of course, the benefit ratio would have to be adjusted upwards to reflect the two year reduction in the funding period. This adjustment would produce the reserves shown here in the third column compared to reserves under the proposed benefit ratio method (Amounts in Thousands):

Benefit Level	Benefit Ratio Reserves Disappearing One-Year PT	Benefit Ratio Reserves Two-Year FPT
4	\$ 72,636	\$ 47,783
5	8,721	5,418
6	70,928	47,402
14	8,300	4,252
15	11,667	7,334
17	44,987	26,301
Totals	\$217,239	\$138,490

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Upon review of the results, you will recognize that the modified benefit ratio reserve is equivalent to the tabular two-year full preliminary term method provided that voluntary lapses are reflected in the calculation. Thus, the two reconciling differences between the proposed benefit ratio reserve method and the current minimum standards method are the procedure of adjusting for the first year expenses and the decrement for voluntary lapses. Of course, in actual application additional variance would result from the difference between *emerging experience* and *assumed experience* since the benefit ratio reserve method would reflect actual experience.

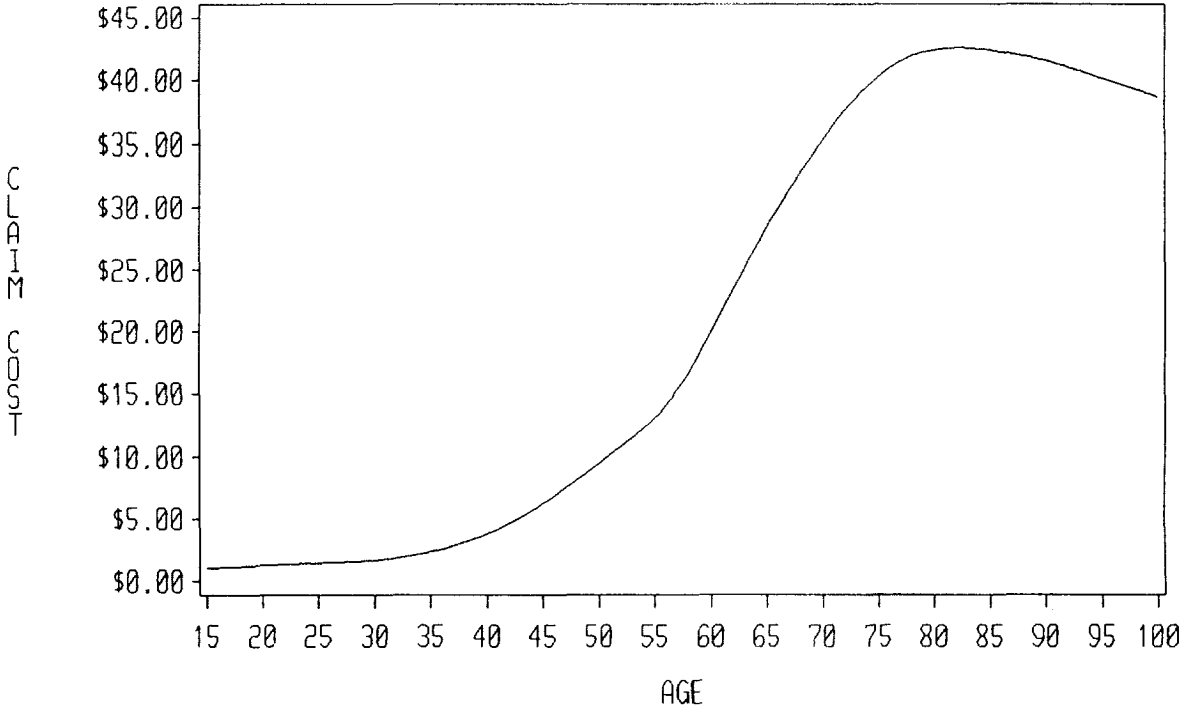
I certainly believe that statutory reserves should be established by using appropriately conservative assumptions for morbidity, interest, and decrement. However, the issue in my mind is what constitutes an appropriate degree of conservatism. As our analysis reveals, ignoring the voluntary lapse decrement results in a nearly 50% increase in our reserves. This would be in addition to other elements of conservatism already included through the choice of other assumptions. In my opinion, this results in a degree of conservatism far beyond what is needed.

Incidentally, the cancer claim cost on which the reserves in our analysis were calculated has a steep slope between ages 40 and 80, as shown in Graph A.

A&H reserves are affected by many variables, one being the slope of the claim cost curve. Mr. G. Scott Bucher, another member of the Subcommittee working on the proposed Standards, was kind enough to perform some testing of the effect of voluntary lapse assumptions upon reserves for plans having disability benefits. Mr. Bucher generated reserves for the two following benefits:

1. Lifetime Benefit -- Accident and Sickness (If sickness disability commences after attained age 49, the benefit is to age 65 subject to a minimum 2 year benefit period.)
2. Two year Benefit -- Accident and Sickness (If disability commences after attained age 63 but before attained age 65, the 2 year benefit period is still applicable.)

CANCER CLAIM COST BY AGE



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CLAIM COST

GRAPH A

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In each instance the plan is renewable to age 65. The slope of the claim cost curve for the two year benefit is steeper than that for the lifetime benefit. Graph B shows the claim cost curve for the two benefits.

The calculations were performed for a male issue age 35, preferred occupational class and a 90 day elimination period.

For the illustration shown, the 1985 CIDA Table was used with 6% interest. The termination rates used are as follows:

1. Statutory Mortality Only (1980 CSO)
2. Moderate Terminations (10.6% -- 1st, 11.9% -- 2nd graded to an ultimate 4%)
3. Heavy Terminations (30.0% -- 1st graded to an ultimate 7%)

The reserves for selected policy durations are shown for each plan in the following two exhibits:

LIFETIME BENEFITS

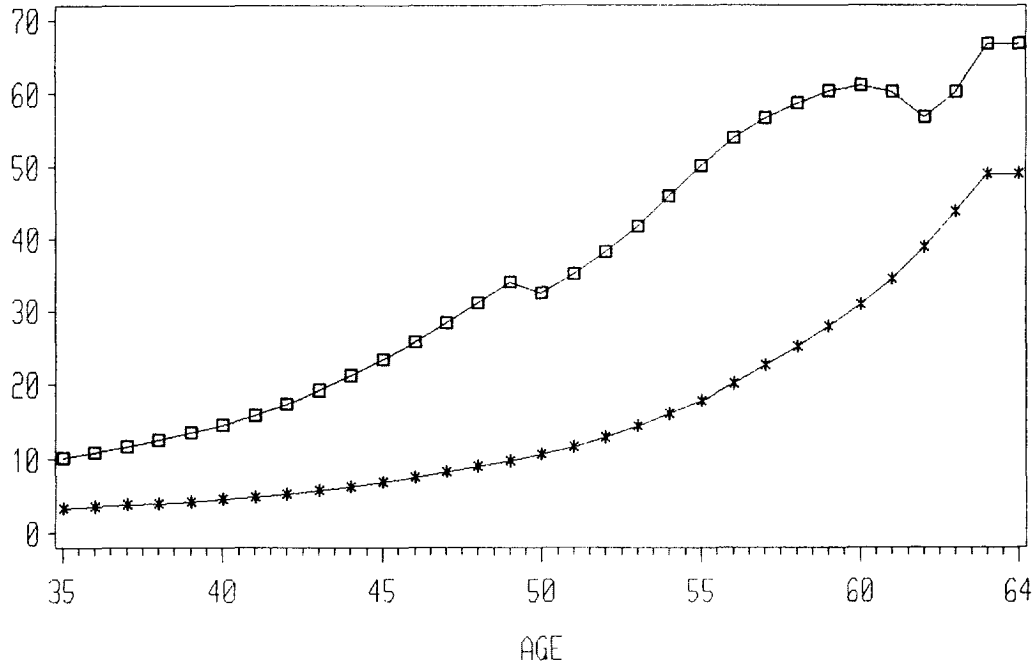
NET LEVEL PREMIUM TERMINAL RESERVE FACTORS Per \$100 Monthly Income Renewable to Age 65/Male/Issue Age 35/90 Day Elimination 1985 CIDA, 6%

Terminations: Duration	1980 CSO	Moderate	Heavy
1	\$ 7.72	\$ 5.95	\$ 3.33
2	15.61	12.90	7.35
3	23.64	20.42	12.03
5	39.94	36.35	22.71
7	55.99	52.31	37.16
10	78.02	74.50	63.42
15	98.51	98.08	100.29
20	94.55	99.65	105.98
25	49.41	56.65	64.81

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CLAIM COST

DISABILITY CLAIM COST BY AGE



GRAPH B

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LIFETIME = SQUARE
2YR = STAR

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TWO YEAR BENEFIT

NET LEVEL PREMIUM TERMINAL RESERVE FACTORS
Per \$100 Monthly Income
Renewable to Age 65/Male/Issue Age 35/90 Day Elimination
1985 CIDA, 6%

Terminations: Duration	1980 CSO	Moderate	Heavy
1	\$ 3.27	\$ 2.29	\$ 1.08
2	6.66	5.01	2.41
3	10.18	8.02	4.01
5	17.58	14.61	8.11
7	25.35	21.66	13.75
10	37.45	32.79	25.16
15	56.72	52.07	48.31
20	68.75	66.78	64.20
25	59.38	60.80	61.15

For the plan with a lifetime benefit, notice that the reserve with a lapse decrement is lower in the early durations and that the higher the termination rate, the lower the reserve. However, the situation reverses itself in later durations, and the reserve with a lapse decrement becomes larger. For the lifetime benefit the crossover point is around the 15th policy year. The same pattern occurs for the two year benefit except that the crossover point occurs later, somewhere just short of the 25th year.

An analysis of our cancer reserves by policy duration reveals a similar pattern. In an attempt to analyze the overall effect on a block of business, I have built two models of in force business. The first model reflects the moderate termination assumption used in the reserve calculations previously mentioned. The second model uses the heavy termination assumption previously mentioned. In each case it was assumed that 1,000 policies were sold each year for a thirty year period. Then the business in force was valued first using reserves with both a death and lapse decrement and then a second time using only a death decrement. The results for the model built assuming the moderate termination rate are shown below.

In this mature and stationary situation, the lifetime benefit reserves would be about the same whether a lapse assumption was used or not. For the two year benefit, the death-only reserve is 8% higher.

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AGGREGATE RESERVES Moderate Terminations Compared to 1980 CSO Terminations

Lifetime Benefit			Two Year Benefit		
		Percentage			Percentage
Moderate	1980 CSO	Increase	Moderate	1980 CSO	Increase
\$699,000	\$706,000	1%	\$401,000	\$432,000	8%

The results for the model built assuming the heavy termination rate are shown below.

AGGREGATE RESERVES Heavy Terminations Compared to 1980 CSO Terminations

Lifetime Benefit			Two Year Benefit		
		Percentage			Percentage
Heavy	1980 CSO	Increase	Heavy	1980 CSO	Increase
\$137,000	\$170,000	24%	\$ 66,000	\$ 92,000	40%

This reveals a greater difference where the in force is subject to heavy termination. In the case of the lifetime benefit, the mortality-only reserve is 24% higher. It is 40% higher for the two year benefit.

For a young company where business in force is not mature, where the business is growing fast, or where lapses are even higher, the difference between using and not using a voluntary lapse assumption becomes even greater.

Developing minimum reserve standards for A&H insurance is an extremely difficult task because of the great diversity of products and the many variables involved. Some new ideas have surfaced in the proposed Standard, in particular, the benefit ratio reserve. I have attempted to give some insight into the nature of the benefit ratio reserve and the relationships between it and the conventional reserve methods, namely the two-year full preliminary term and net level. I have also attempted to highlight the effect of lapse rates upon A&H reserves. I believe that a minimum reserve standard in this day and time should recognize the existence of voluntary lapses by allowing a lapse assumption in the calculation of individual A&H reserves.

I would also point out that the proposed Standards are intended to apply to group A&H insurance as well as individual A&H insurance, and those people who work in the group field should take a close look at the proposal.

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I want to acknowledge two of my staff members at American Family, Mr. Dan Skelley and Ms. Daisy Lee, who carried out the actuarial calculations of the various cancer reserves shown, and to Mr. Bucher, our recorder for this session, who developed the reserves shown for the disability benefits.

MR. JOHN A. MAURER: When Mr. Dunn called requesting that I serve on this panel, I asked him for the makeup of the panel and what would be expected of me. During our discussion, it was agreed that my role would be to present a position contrary to what the Subcommittee had recommended. This morning I discovered that the Subcommittee has a revised draft of its report in which a number of changes have been made. Naturally I felt that the revised draft would probably encompass all of my written suggestions submitted in response to their October, 1985 draft, and I really would not have much to say. Just a brief scanning of the revised draft indicated to me that my fears were largely unfounded. So I will proceed with what I had intended to say anyway. If the Subcommittee has, in fact, responded to my suggestions in the right way, then I am sure it will tell me.

The one aspect of the Subcommittee's report which I find most troublesome is the notion that claim reserves should be established on the basis of what the insurance company would have to pay if the policy terminated as of the valuation date. The implication of this treatment is a premise that some contingency will occur which will prevent the insured from continuing his coverage in force beyond the company's valuation date. If coverage does not in fact terminate, the company will certainly be liable for benefits which become payable beyond the valuation date even though the claim itself may have originated prior to that date. In the absence of death or non-renewal action by the company, one has to assume that an insured who is in claim status will keep his policy in force. To establish a claim reserve standard which ignores this fact of life, is, in my opinion, contrary to the fundamental principle that a company place a sound value on its liabilities.

The question of proper claim incurral dating is a very important aspect of establishing adequate claim liabilities. It is the determining factor as to whether or not you will be reserving for those expenses relating to claims occurring prior to the valuation date.

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In my remarks I am trying to use terms that would reflect the different treatments. These terms, I believe, have been used by the industry for quite some time. I am talking about a "claim incurred" reserving system versus an "expense incurred" reserving system. I define the claim incurred reserving system as that type of system which tries to measure the ongoing payments that will result because of a particular illness or accident occurred prior to the valuation date regardless of when those services were actually rendered. An expense incurred reserving system is that type of system which establishes an incurred date based on that date on which a particular covered service is rendered. The expense incurred dating convention has been used primarily in employer/employee group insurance and properly so because, in those cases there is usually no pre-existing requirements in the coverages, and when the business goes from one company to another, the other company picks up whatever tail would be involved in the ongoing lags. So those are the two distinctions I am trying to make in defining what I consider to be a proper claim reserving system.

In an earlier session, one of the speakers recommended very strongly that, whenever a claim reserving system is developed, in most cases the claim incurred dating convention ought to be used. One change that the Subcommittee did make in its revised draft was to go from disallowing what I consider to be the correct method to allowing it. The next step is to require the correct method.

In the initial draft of the Subcommittee's report, and it may have backed away a little from this, much is made of sticking to the contract language since "no more appropriate and more objective arbiter of the issue can be found." I suggest that the Subcommittee consider the entire contract. The right of the insured to continue his policy in force by timely payment of premiums is as much a part of the contract as the benefit provisions. Under guaranteed renewable policies, this right is clear and unequivocal. Even where the company reserves the right to non-renew, the insured has the contractual right to keep his policy in force until such time as the company has actually notified him by mail that his policy will be non-renewed as of a specified date. Unless the company has actually taken such action, the Subcommittee's recommendation is illogical and imprudent. In other words, I do not think you

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ought to be able to set your claim reserves on the basis that the policy is not going to be in force unless something has actually happened that will, in fact, cause that policy to terminate.

The claim incurred method recognizes events that have occurred prior to the valuation date and assigns a value to the expenses associated with that event, regardless of when services are actually rendered. The event has occurred and the liability exists. The expense incurred method recognizes only the expenses for services performed prior to the valuation date. Thus, at any particular point in time, the claim incurred method will develop a higher claim reserve and a higher cumulative loss ratio than the expense incurred method. A retrospective benefit ratio reserve calculation, of course, will yield a higher contract reserve in connection with a lower loss ratio associated with the expense incurred method. However, the reserve scheme recommended by the Subcommittee will come nowhere near picking up the claim reserve shortfall generated by the expense incurred method in most circumstances. For first year business, none of the shortfall will be recognized. The Subcommittee's own illustration indicates that only about 26% of the difference is accounted for in the third statement year and, even after 6 years, only 38% is recognized. Should the cumulative loss ratio under the claim incurred method at any point in time exceed the "anticipated loss ratio," the understatement in total liability would be even more severe. If loss ratios are developed according to the expense incurred method, this unfortunate situation could well be masked for a period of time and corrective action unduly delayed. If I may paraphrase the Subcommittee, it is my opinion that those who expect the contract reserve to assume part or all of the role of recognizing claim liability may well be underestimating current liabilities by failing to recognize and take seriously the role of the claim reserve.

The benefit ratio reserve method, based as it is on the difference between an "anticipated loss ratio" and actual experience, is likely to produce illogical results. Firms experiencing adverse actual to expected loss ratios will put up lower reserves than those experiencing satisfactory actual to expected loss ratios. One would logically assume this to be the reverse of what actually should happen. The Subcommittee suggests that actuarial intervention will occur in the form of raising or lowering the anticipated loss ratio with

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appropriate strengthening or release of reserves following such action. In my opinion, the Subcommittee is overly optimistic in assuming that the application of sound actuarial advice will overcome the inherent weaknesses of the method and meet the desired goals of the system.

For example, does one or two years of adverse experience indicate inadequacy in the original claim cost assumptions or just a temporary period of bad luck? The answer to this question will certainly have a considerable influence on company action. But this determination, even if proven to be correct by future results, is not the end of it. If claim cost assumptions are determined to be inadequate, does the company strengthen reserves by dipping into surplus or does it assume that the business can be returned to self-sufficiency through the imposition of future premium rate increases? These are judgment calls which will be made based on a company's view of its competitive position and the persuasiveness of individual members of management. In my opinion, the benefit ratio reserve technique recommended by the Subcommittee is too subject to illogical results and charges of manipulation to be workable as a general statutory reserve standard.

I suggest to the Subcommittee that a valuation standard akin to that called for in the development of benefit reserves under GAAP accounting would be a better approach. Such reserves can be developed based upon claim cost assumptions used in pricing the product. These claim costs, including selection and trend factors are routinely supplied to the states in actuarial memoranda. Reserve factors based on these assumptions can easily be made part of the memoranda as a filing requirement. These reserve factors would be applied to in force as is done currently for level premium forms. Thus, reserves would be independent of fluctuations in experience, and the factors would remain unchanged until either a premium rate increase was filed or a gross premium valuation indicated that loss recognition was necessary. In the case of a premium rate increase filing, it would be up to the actuary to demonstrate that the current reserve factors are still appropriate or to introduce necessary strengthening. While no reasonable reserve standard is going to guarantee the financial soundness of a health insurance operation or completely counteract inadequate pricing or mismanagement, I believe that a GAAP-like approach will serve the purpose of

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emphasizing the need to set aside funds in the early years and will avoid the major problems associated with the Subcommittee's recommendation.

MR. STORM JOHNSEN: I am associated with the insurance commissioner's office in Washington state. I will pick up on something that Mr. Thexton referred to earlier. Mr. Thexton was talking about the reserving for closed blocks of business where substantial premium rate increases may be required because of deteriorating claims. The highest such premium rate increase that I have seen is 600%, so they are not small. Consider the senior citizens, in particular, who may not be able to afford this coverage and cannot go out and purchase other coverage. There are a number of those premium rate increases that are denied in my state. The reason for that denial, at least in many instances, is that a company is shifting the healthy insureds from one form to another form.

The way it works, for example, is that in 1982 the company has Form No. 1 approved in our state, and it proceeds to write business on that form. Then in 1986, the company comes out with another form very similar to Form No. 1 and has it approved. Form No. 2 has some improved benefits, etc. Then in 1986 and 1987, the company proceeds to resell that new form to those insured whom it previously sold Form No. 1 to, except of course that no reselling is done to those from whom they have had a claim. This results in excessive incurred claim experience under Form No. 1. So, in the granting of a premium rate increase under such a form, my insurance department has required the combining of experience under both forms. If experience is combined in that manner, then it results in a better basis, we believe, for such premium rate increases.

In the previous session I expressed a concern of my insurance department. The reason for this concern is the number of complaints that we receive from senior citizens. My interpretation of their complaints is that the premium rate structure of policy forms is of an annually renewable term type where the premium rates increase from year to year and ultimately reach a level which the senior citizen cannot afford. I think that Mr. Odell then said in counter to that, "Well this is a result of the action of the regulators in many instances forcing the companies into an annually renewable term type of a premium rate structure." I am sure that in many instances that is true. However, I would like to take that two steps further. We came out with a regulation in

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Washington at first in 1981 and then later promulgated it in 1983. The underlying reason why that regulation came about was that many companies, maybe 25% to 35% of total companies, did not abide by the rules that were in the NAIC model regulation existing in the late 1970s. We had public hearings with a number of companies, and we had informal hearings with other companies. These public hearings pointed out the fact that further regulation was, in fact, needed particularly in the area affecting senior citizens.

There is one other point I want to make. I would like to suggest that while the regulatory actions in many instances may have contributed to a movement toward an annually renewable term type of a premium rate structure, I believe that the underlying problem is one of marketing. Formerly, I was in product development in a private company for 20 years, and the eternal question is, will I have something I will be able to sell? To do that, my premium has to be a dollar less than anyone else's premium. I think that is the underlying problem causing the movement toward the annually renewable term type of a premium rate structure.

I will be glad to answer any questions about this.

MR. E. PAUL BARNHART: I have a question for Mr. Maurer and then possibly a comment or two depending on the response to my question. You were speaking of a claim incurred basis of determining claim liability and an expense incurred basis. Were you meaning to suggest from that comment that you feel our Subcommittee's proposal amounts to an expense incurred basis of determining claim liability? I got that impression. I just want to clarify your comment.

MR. MAURER: That is a correct impression.

MR. BARNHART: Then that is an incorrect impression on your part. It is not an expense incurred basis of determining claim liability. It is a claim incurred basis. The difference is the contractual context in which that is determined. You mentioned that an important consideration is to take the entire contract into account. We heartily agree with this statement. The one point that you emphasized is that one needs to consider the probability of the policyholder renewing his policy thereby keeping the policy in force. It is

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our opinion, and we think that this has been the actuarial understanding of the distinction between claim reserves and contract reserves for many years, that the probability of keeping a policy in force into the future and the liability associated with that falls properly into the province of contract reserves.

There can be some problems about the breaking point between the two, but I think our answer to your comments in that area is that the question of liability associated with keeping that policy in force by the insured into the future is the responsibility of contract reserves.

On the other hand, I think that claim reserves have always been intended to cover the liability for claims incurred but not paid as of the valuation date. So, we are not at all suggesting that the liability be ignored as you seem to be suggesting. Rather, we are saying that we need a better definition of the point at which claim reserves leave off and contract reserves pick up.

MR. MAURER: Mr. Barnhart, I do not know if we have a misunderstanding of what words mean or if I misread the Subcommittee report, and I am referring now to the draft prior to the revised one passed. I really have not had enough time to review the revised draft very closely. In the earlier session, you mentioned that you had made a significant change in the revised draft from requiring an expense incurred basis to now allowing a claim incurred basis. Again, the claim incurred basis recognizes the anticipated payments that a company feels it will have to make given that a certain event has already occurred. An accident has occurred, a major illness has occurred, something has occurred which is going to cause medical care to be rendered and expenses to be incurred over a period of time beyond the valuation date. My position is that those expenses are properly included in the claim reserve and not in the contract reserve.

MR. BARNHART: Basically we would agree with that, Mr. Maurer, and I believe that is what our earlier draft said as well. Claims or benefits that a company is going to pay as a result of events that took place before the valuation date are basically a responsibility of the claim reserve. But we think that when you get into the question of the probability of renewing the policy into the future, that clearly and traditionally becomes the province of the contract reserve. But our intention always was to be proposing a basis of

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claim reserves that is on a claim incurred basis. The intent was never an expense incurred basis. I must say that your comment to that effect is the first one I have heard expressing that interpretation. The proposal all along has very definitely been on a claim incurred basis, so far as the claim reserve is concerned.

MR. MARK E. LITOW: I have two questions; one for Mr. Bugg and the other for Mr. Thexton. I do not have any questions for you Mr. Maurer because I agree with everything you said, and I want to let you know that I had the same interpretation as you had of what the Subcommittee's initial draft of its report said. Mr. Bugg, I found your comments very interesting. I wish you would comment on what you would recommend for inclusion of voluntary lapses and interest rate on a statutory basis versus what you would use on a GAAP basis. Mr. Thexton, I read the HIAA's comments with very much interest, and I did read the revised draft of the Subcommittee's report. I saw where two of the HIAA's items seemed to be addressed and the other five were not. I am wondering where the HIAA is planning to go now from here after the exposure period and if it is planning to do some testing with respect to the issue of tax deductibility of reserves and some of the other items not covered by the revised draft.

MR. BUGG: It may be possible to use the same voluntary lapse and interest assumptions for statutory and GAAP or, if you want to build in some conservatism for statutory, perhaps you could use 80% or 95% of what you used in your pricing or GAAP assumptions.

MR. LITOW: Do you feel there ought to be a difference between the two? Or would you essentially promulgate the same assumptions for GAAP and statutory?

MR. BUGG: I think you need to review the overall results as to what you are doing if you put conservatism in the interest assumption, conservatism in the morbidity assumption, and conservatism in the lapse assumption. What does this produce in the aggregate? You have to have some cognizance of the overall effect. It is not a black and white situation. It takes judgment. Is 10% enough conservatism? Or 25%? I do not know if there is an answer to this question.

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MR. THEXTON: As to what the HIAA is going to do now, we have not made a plan. We do not have a scheduled meeting of the actuarial subcommittee. I would expect that we are going to involve more group people because the group aspects of the proposed Standards have not been discussed very thoroughly. We asked the ATF if it wants us to do anything but, as I feared and expected, it did not respond to that at all. I will have to call the NAIC actuaries individually and ask them what they want us to do. Anything that I suggest that we do, they will say, "Yes, go do that." I am not sure just how we will proceed at this point.

MR. DUNN: I will make a comment to pick up on what Mr. Thexton said. There will be a group disability table prepared. It is supposed to be ready for review later this year. The tabulation of the data is being done on the computers at Swiss Life, in Switzerland. Mr. John Miller recently went over to Switzerland to try to massage this data and get it back so that the SOA committee which has been established to prepare this table can in fact look at the results and get something ready to be sent around for some comments. It is still anticipated that this information will be available later this summer, hopefully, or in the early part of the fall.

MR. MICHAEL L. KELLEN: My question is for Mr. Maurer and Mr. Barnhart. I got the impression from your response, Mr. Barnhart, that we only have a problem with semantics here. I have an example. Let us say that there are two companies: Company A and Company B. Both have the same experience except for two clients, one in each company, and let us say that both clients have an AIDS claim. In both companies that AIDS claim is reported before December 31, 1985, and we are looking at claim reserves at the end of 1985. Let us assume that in Company A the client dies before the end of the year, but in Company B the client survives beyond the end of the year. Company A has not paid the claim by December 31, 1985, however, which amounts to \$100,000. In both cases the contract language states that the policies must be renewed in order for the claim payments to be made. The existence of that claim for Company B somehow is going to be handled by the contract reserves. Suppose that Company B is going to pay \$100,000 on this AIDS claim in 1986. How is that handled by the contract reserves? I do not understand. I agree with Mr. Maurer.

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MR. MAURER: I do not know how it is handled by the contract reserves. I think I understand how it is attempted to be handled. This is one of my problems with the whole construction of the Subcommittee's recommendations. I think the Subcommittee is trying to use the contract reserve to measure a liability that can more properly be measured on its own as a claim reserve. And the Subcommittee tries to offset that, I believe, by increasing the contract reserve through the benefit ratio reserve mechanism of having a lower loss ratio because the Subcommittee has not recognized it as a claim reserve. Therefore, lower incurred claims lead to a lower loss ratio so that when the Subcommittee takes the difference between its anticipated loss ratio and the lower cumulative loss ratio applied to earned premiums, a higher contract reserve results.

MR. KELLEN: I think that at the end of 1985 both companies would have identical retrospective experience, and I think they would establish identical contract reserves.

MR. MAURER: They would not because Company A, which recognized the \$100,000 as a claim in 1985 would have a higher incurred loss ratio than Company B, which did not recognize the \$100,000 as a claim. This occurs because the claim reserve increase associated with the \$100,000 claim goes into the incurred claims and builds up the incurred loss ratio for Company A.

MR. KELLEN: I have another question regarding Mr. Barnhart's comments on the distinction between contract reserve and claim reserve. What about disabled life reserves where clearly someone must continue to be disabled in order to receive benefits? Are we going to abandon the traditional method of establishing claim reserves for disability and put it in the contract reserves?

MR. MAURER: My understanding of the initial draft of the Subcommittee's report is that if the contract required that the policy be in force whenever a disability claim payment was due then you would, in fact, hold as your reserve only what is now determined to be accrued disability claim liability. You would not be holding, as a part of the claim reserve, any unaccrued liability. However, the contract reserve would operate to at least attempt to pick up that difference. It would do so because the lower claim reserve results in the

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lower incurred loss ratio, which results in a larger difference between anticipated, and actual loss ratio, which results in a higher contract reserve requirement. That is my understanding of it.

MR. BARNHART: I would like to clarify that a little more. In the Company A and Company B example that you described, Mr. Kellen, if Company A in fact recognizes the \$100,000 as part of its incurred claim liability at December 31, 1985, then its incurred loss ratio would be increased, of course, by that amount. Then the calculation of the company's benefit ratio reserve would be reduced by that same amount. In the case of Company B, the claim reserve would be \$100,000 less at the end of the year, and the benefit ratio reserve would be \$100,000 higher. In other words, Company B's aggregate reserves are identical in those two cases.

The key question here for Company B is whether the \$100,000 can be presumed to be covered by the company's assumptions that relate to the rates it is and will be charging. In other words, will the rate that the company is going to charge next year for the entire block of policyholders, cover that expected liability? Does the rate fall within the general rate adequacy of the company involved? Ultimately, that is the question, really. What rates are covering that anticipated future liability? How is the company handling its rating? Has it charged a rate this year that contemplates covering that \$100,000 out of this year's aggregate exposure, or is it contemplating rates next year that will cover that?

To answer the question as simply as possible, the mechanics at the end of the year with regard to the one case where the person dies and the other case where the person survives, produce the same aggregate reserves. The claim reserve will be higher and the benefit ratio reserve will be lower, or vice versa.

As for the other disabled life question raised by Mr. Kellen, we do not know of any company that writes such a contract, and because of that we probably should never have had the hypothetical illustration in the original Appendix B in the first place. We are really not aware of an insurance department that would approve a disability policy on the basis that your policy must be in force on each day that you are disabled. We do not know of such a plan in existence,

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and we think that this was part of the problem with our attempts to make hypothetical illustrations. We have disposed of that entire appendix.

So I think the only real difference here, between the current discussion draft and the prior discussion draft is that by eliminating those kind of hypothetical illustrations and overly specific illustrations which never go far enough, we are now simply stating what the incurred claim liability is intended to cover. Simply stated, these are the claims for which the company has become obligated to pay as a result of contracts being in force up to that valuation date.

The place where we are providing more latitude, that was previously absent, is to leave to the judgment of the company and its actuaries whether or not something like this \$100,000 AIDS claim that Mr. Kellen mentioned, should be regarded as an incurred claim under its contracts. We are not trying to answer that kind of a question for everybody. It is a matter of interpretation of the contracts in their entirety, and based on that interpretation, when should claims be considered incurred. Either way, it is still a claim incurred approach.

MR. MAURER: Mr. Barnhart, I have a question about your response to Mr. Kellen's question regarding the \$100,000 AIDS claim coming into the claim reserve or the contract reserve. You indicated that both companies' aggregate reserves would turn out to be the same. Is that also your answer if the policy happens to be in the first policy year?

MR. BARNHART: No. In this case the minimum standard permits the company to use the disappearing one-year preliminary term method.

MR. MAURER: In that situation, the claim incurred technique would give you a \$100,000 higher aggregate reserve than the technique suggested by the Subcommittee which was the combination of the benefit ratio reserve and the Subcommittee's way of calculating the claim reserve?

MR. BARNHART: That is correct. In that instance where the company recognizes the \$100,000 AIDS claim in its claim reserve, the aggregate reserves would be

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higher by that amount for first year business, temporarily. After that year, the aggregate reserves would come together as the preliminary term exclusion disappears.

MR. KELLEN: Mr. Barnhart, I would like to change a few facts in my earlier example of the \$100,000 AIDS claim and get your response. Suppose we consider two policyholders, A and B.

1. Policyholder A is with Company X and Policyholder B is with Company Y.
2. Both policyholders go to see a physician on December 1, 1985 and are diagnosed with AIDS.
3. Both physicians charge \$100.
4. Both insurance companies are informed of such and pay such before December 31, 1985.
5. Both policyholders must pay their premiums to receive any future benefit payments -- even with respect to ongoing illness/injuries otherwise payable under the contracts.
6. Policyholder A dies on December 10, 1985.
7. Company X is informed of Policyholder A's death and closes the claim files before December 31, 1985.
8. Both policy forms have 100% incurred loss ratios.
9. Company Y expects to (and actually does) pay \$100,000 in 1986 on Policyholder B.

Now let's go back to December 31, 1985. If I understand the benefit ratio method, both companies would hold the same claim reserve as of December 31, 1985 -- namely \$0. Furthermore, both companies would have the same benefit ratio reserve namely \$0. Clearly Company Y has liability.

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1. Where then does Company Y reflect its liability?
2. Suppose we a) used the benefit ratio method for determining reserves, b) used such reserves to develop incurred claims, and c) used such incurred claims to develop premiums using 1985 and prior experience. Then such calculations as of December 31, 1985 would indicate that Company X and Y should charge the same premiums in the future. Is this reasonable -- especially if Company Y had taken the rating position of requiring the \$100,000 to be paid out of future premiums?

MR. BARNHART: I think considerable clarification is needed in response to Mr. Kellen's very elaborate \$100,000 claim liability question. His nine assumptions bring up an involved assortment of considerations.

First of all, if both companies' blocks of business have 100% cumulative retrospective loss ratios through 1985 (his assumption No. 8), both companies would then appear to have major problems of rate inadequacy and to be in need of immediate and drastic rate increases. How much depends on a comparison of the 100% actual result with the cumulative loss ratio expected for each company and, further, on each company's evaluation of its trends and, in turn, its anticipated lifetime loss ratio and its ability to obtain adequate rate increases in the face of the actual experience. All this may have substantial impact on how each values its benefit ratio reserves at December 31, 1985.

As our Subcommittee has repeatedly emphasized, one cannot answer these questions in a simplistic, mechanical vacuum, and it may or may not be true that either company should actually carry a \$0 December 31, 1985 benefit ratio reserve. Further, each company's unearned premium reserve is a factor in this equation, and Mr. Kellen's assumptions take no account of the unearned premium reserve.

In his final comments, Mr. Kellen states that the benefit ratio reserves are to be "used . . . to develop incurred claims." Such reserves are never to be used to "develop incurred claims." Incurred claims must be determined first, and the appropriate benefit ratio reserve afterward. He further states that

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"calculations as of December 31, 1985 would indicate that Company X and Y should charge the same premiums in the future."

No such inference can be drawn at all. Instead, all the factors that have been previously mentioned, in relation to determination of each company's badly needed rate increase and each company's determination of its expected lifetime loss ratio on the block of business involved, must be taken into account.

The mere short-term mechanics of benefit ratio reserve calculation are no substitute for responsible actuarial management and judgment, any more than is the case presently, under existing NAIC *minimum reserve standards* where the required minimum contract reserve on the type of business under discussion may be simply zero, at all statement dates.

MR. ANTHONY J. HOUGHTON: Mr. Thexton had started to give a history of some of these items. Mr. Johnsen did too, expressing possible dissatisfaction of his insurance department with some of the minimum standards. In 1976, I was somewhat involved in bringing up the question of the statutory guidance on incurred claims. I think it might be interesting for you to know how that came about. There was a company in Indiana which the insurance department determined to be insolvent on the basis that the company's claim liabilities were understated to the extent that, if correctly stated, there would no longer be any surplus. Subsequent examination revealed that there was also an active life reserve problem, problems with rating action, and other problems. But the initial cause for regulatory action was the inadequacy of the company's claim reserve as shown through its Schedule H and Schedule OH analysis. In justification of the claim liabilities that had been established, some of the actuaries representing the company said, "Well, we only established disability income reserves on open claims on which we are actually making a claim payment because we do not consider them to be a claim until they are fully approved and payable by the company; during the elimination period they are not a claim." So they were throwing out all pending and unreported claims for disability. In addition, they had some typical per cause major medical claims with a \$500 deductible. They said, "Well, we thought the claim liability should be only what was accrued to date, nothing for unaccrued." So for all major medical they were throwing out the present value of amounts not yet due on claims.

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Now the coding of claims was traditional, so the way the actuaries were establishing claim liability did not correspond to the coding. Therefore, the insurance department reviewing the situation determined the company to be insolvent. The policy forms were not 100% clear as to what would be required. With regard to the disability contracts, I would say that they were plain vanilla disability policies, and the people would have been entitled to benefits once disability payments were in progress regardless of whether or not they paid premiums. The point never came up because the people never stopped paying premiums. In fact, some people were on waiver of premium with a one year elimination period well before the benefits would begin. It seemed to me and this is the point I raised with the Subcommittee, even if someone wrote a contract that would require premium payments to be made in order to collect benefits, that fact should not be decisive as to whether or not an actuary would be required to set up claim liabilities. It would seem that he would want to set up claim liabilities to reflect the reality of what was going to happen. I thought that it would be helpful for the regulatory authorities to have something in their statutes which indicates that to actuaries.

For many years we have had problems trying to get beneficial rules. A number of the rules appeared to some of us to be rules that might be more harmful than helpful. Maybe we will have to handle it in a different way. Maybe through the standards of actuarial practice we will have to have some more guidance as to how things ought to be handled. I understand that when we brought problems to the exposure draft people, they talked about claim reserves. To illustrate my problem with this, I will give a specific example. There was a company that was having problems with claim liabilities, but all of its policy reserves, which included benefits like return of premiums and some other things, were being done improperly also. It would have been much harder to detect an error in policy reserves than with claim reserves, if for example the company would have been able to structure a contract that said that you only have claim liabilities for accrued benefits and it indicated that the provision for unaccrued benefits would be in claim costs and active life reserves way into the future.

The ability to detect theoretical errors in active life reserves at the state insurance department level in most states is really very limited. The

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insurance department cannot tell the difference. In fact many companies do not differentiate on a disability income policy between ones that have a his-own occupation clause for many years, presumptive disability and a whole series of differences some of which are more dramatic than others. For residual disability benefits some companies will use a straight 1964 CDT or have some very minor, arbitrary adjustments to cover those differentials.

So, I think this is an important subject. If we do not list problems and receive guidance in statutory language one by one as to how each thing ought to be handled, possibly we need to provide through the people preparing professional standards some more descriptive material that would help give guidance so that actuaries will be doing what is the proper thing to make sure that the accounting that shareholders, management, and the public gets is realistic as to what has happened with regard to the different companies.

MR. MAURER: Mr. Houghton, in the development of the 1974 Medical Expense Tables, were those claim costs based on a claim incurred or expense incurred reserving method?

MR. HOUGHTON: We talked to different companies about that. Almost all the material used on say basic hospital/surgical benefits was from the intercompany reports. On hospital benefits, everyone told us that their incurred date was based on date of admission. On major medical benefits, we made surveys at different times and on almost all per cause major medical the incurred date was based on when the deductible had begun to be satisfied or when the deductible had been satisfied. So they were all based on what we call the traditional coding method or incurred claim method. On certain other things on which we hypothesized, say cancer benefits, we did that directly from certain cancer statistics and tried to make some relationships with known cost of hospital and other services. So to that extent, you could not go back to a data base and say we derived it directly from a particular company's cancer claims. But I think on all the basic coverages (hospital, surgical, maternity, major medical), it was based on the companies' procedures at that time. And, therefore, if a company is going to have a different procedure, all those claim costs and reserve factors would have been inappropriate.

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MR. BARNHART: I just wanted to mention that I could not agree more with Mr. Houghton about the needs for standards of practice. It is my understanding that the Health Committee that is charged with developing standards of practice and reports to the Interim Actuarial Standards Board has now under development a standard of practice with regard to incurred claims dating. I do not know what its status of progress is at the moment. I think that the ultimate answer to the kind of problems we are talking about really does rest with standards of practice and not with minimum statutory reserve standards. We had quite a bit of criticism in the letters we received about the lack of guidelines, lack of suggested methods and means of testing and that kind of thing. We felt that such guidelines are not the job of the minimum statutory reserve standards. It is the job of standards of practice.