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NAIC HEALTH RATE REGULATIONS

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- Are loss ratios useful targets or inappropriate measures?
- Is there a simple actuarial answer to the new business/closed-block issue?
- Experience data for reporting (what is needed and what is useful)
- What is trend? For insurers versus insureds

MR. THOMAS J. STOIBER: This session is entitled, "NAIC Health Rate Regulations." I took the liberty, being the moderator, to give a better title to this session. I call it "The Continuing Saga of This Never-Ending Story." We're really talking about the NAIC rate regulation. It's a little known fact that this regulation draft has been in development longer than the current standards stood unchallenged. That current standard took effect in 1980, with the last revision in 1982. This particular NAIC rate regulation we're talking about was beginning to be changed in 1986, was set aside for several years for the benefit ratio reserve and all those discussions, and then became the top priority in 1988 for the NAIC Actuarial Task Force. It's gone through several drafts, with the last draft coming out in the December meetings. That is not the final draft. They will be working on that a little more this year. We're now sort of in limbo. We've been talking a lot about what's happening with the Clinton administration currently and what's going to come out in May. So what happens tomorrow with this, whether this story will ever end, I doubt it. So we'll talk about it, have some fun, and talk a little "actuarialese" to you.

We've assembled a panel here that's going to keep this lively and exciting. We're really honored to have the guests we have. These truly are the experts on this subject matter. Mark Peavy is with the NAIC and the regulator's key person. Prior to the NAIC, he was with the Florida Insurance Department. Jerry Vance is the Blues' representative here. Society of Actuaries and American Academy of Actuaries people, and consultants, are Barbara Lautzenheiser and Bill Bluhm. I come from an insurance company/HIAA background, so we can give you a little bend from that angle also.

I've outlined very briefly what the difference is between the current draft and the standard that you may be used to seeing, and the one you worked with, what I'll call the 1982 standard.

Changes

- Scope
- Lifetime rate maximum -- minimum loss ratio
- Monitoring

New
- Renewability
- Rate increase limits
- Postunderwriting experience rating
- Durational rating/initial rate adequacy
- "Guaranteed loss ratio" – preapproval

There are significant changes. Some say there are ten significant changes. The scope has changed quite a bit. It used to be only individual health insurance. We're talking about medical expense insurance only, and everything except true group, and that which is already regulated through small-group-reform legislation. There is a lifetime-rate minimum loss ratio. When I say lifetime loss ratio, it's gone up about ten points in this draft. There are monitoring requirements. Now it will be mandatory that you monitor this. There will be no more delays in putting rate increases through so that the policyholders do not see these giant rate increases toward the end of their lifetimes.

There are some new renewability features. The optional renewable provision, the ability for the companies to have nonrenewable business, is going to go out the window, to be replaced with what is called a qualified renewable provision. There will be some types of rate increase limits. We're going to have postunderwriting experience rating, which means that the ability to experience rate is going to be limited. The rate that new business is to be charged will have to be within a certain percentage, not too dissimilar from the small-group-reform rating limitations. There will be ±25% within a class of business.

A big item here is the durational rating, which is to address the initial rate-adequacy issue. This was not addressed at all in the previous drafts. The previous drafts were concerned that rates could not be too small. This draft says they can be too small, which leads to problems if they are too small. There is the guaranteed loss-ratio feature, or the preapproval, prefiling, whatever you want to call it, which also is a brand new concept.

We want to concentrate on what I think is the most important actuarial technical facet of this change, and that's the issue of durational rating and its elimination, or near elimination, which is the intent of this draft. We're going to talk specifically of the mechanics and the problems you can run into and the alternatives of addressing this issue. I've listed some of the considerations that are either in the draft, have been proposed, or are still on the table for discussion. We'll go through them briefly to educate you on some of the problems, the pluses, and the minuses of each.

Alternatives to Regulate Durational Rating
- Prefunding via pricing assumptions and method
- Back-end rate spread
- "Choice" via disclosure
- Other
  - Prefunding via certification only
  - Prefunding via maximum durational loss ratio
  - Presumed prefunding via reserve methods
  - Percause claim incurred

The first item is called a prefunding approach. This would be done through some type of promulgated method of calculating premiums by using a promulgated set of assumptions. Bill Bluhm is the stated expert on this subject, and he'll be talking about this topic. Bill is the Chair of the Academy Committee on State Health Issues, and that committee has been working with the NAIC in putting these drafts together. His committee is the author of the current draft on this particular section. Bill heads up the Minneapolis office of the M&R Services. Bill also has a paper pending on this subject, related to how reserves on individual medical business could support this approach.

Jerry Vance will talk about the second issue. This is the approach that's prevalent in small-group-rate reform, where you don't worry about prefunding. You state what the outcome needs to be on the back end, which means that in the later durations, you cannot have rates that are more than a 20% maximum spread between the highest and lowest rates within a class of business. Then there is also a different number between classes. That's quite different than the small-group rate reform, which gives you a 67% spread between the highest and lowest rates. Jerry is with Blue Cross and has ten years of experience with this, covering pricing, funding, reserving, and so on, thereby being quite qualified to speak on that subject.

Barbara Lautzenheiser is going to talk about this from a different bend. This resembles the life insurance approach, where the buyer is allowed to choose the type of durational funding he or she needs. With life insurance, there are dividend illustrations and indexes, and the consumer is somewhat aware of what type of durational pricing policy he or she is buying. Barbara, owning her own business, feels very close to this subject, and she has spoken on this before. Barbara is a Past President of the Society and has given many talks and testimonies before Congress and at both the state and national levels. Prior to 1986, when she formed her company, she was President of the Signature Group.

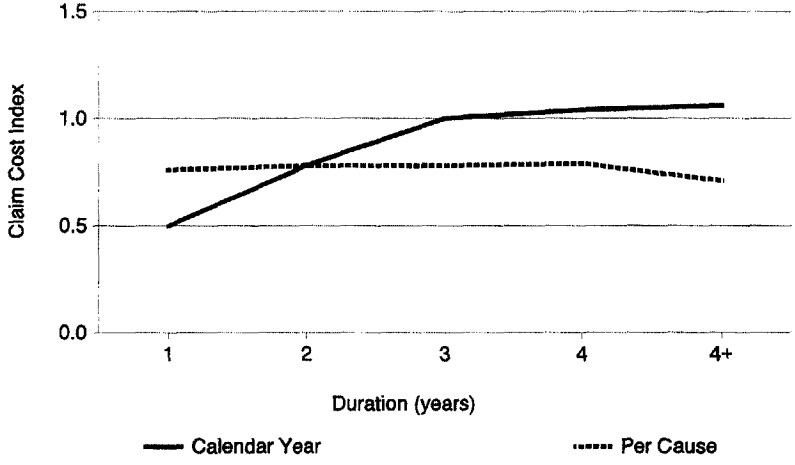
Other approaches are under consideration. There's a prefunding-via-certification approach, which is the same as what Bill's going to talk about, but not putting it in the statutes or the model regulations. This utilizes a type of appointed-actuary approach. Another approach is funding via a maximum durational loss ratio. Those familiar with the Medicare supplement regulations know that's how that is regulated. Companies must not exceed a loss ratio in duration 1; in durations 2 and 3, it's a different loss ratio. It's rather technical, but it takes a little bit of the subjectivity out of it, making it easier for regulators. We're not prepared to present that as that is still under development. A presumed prefunding approach, is where, if we had a reserve standard that required companies to set up reserves as though they were prefunding a first year, companies' actuaries would then set up higher premiums in the first year, so that they could fund this approach and in effect, that would raise the premiums and level the premiums off to eliminate durational rating.

Another approach is the per-cause claim approach, which is something that has been proposed by the HIAA. This essentially says that if companies were required to code claims back to the date that the illness was incurred or the accident first occurred, more claims would be front-ended than they are today. Today many companies are coding claims on the date of the service. So, for example, a heart attack that takes

three years to pay out would have all of those three years funded in a first year by the coding approach. The HIAA has done a little research on this.

Chart 1 shows the difference in the slope of the claims of a major company. If you coded differently, in the first year the claims would be half as large as they would be in the third year under the calendar-year approach. That's the approach of coding on the date of service. You'd see a more level durational cost curve if those same policies and claims were coded another way. In effect, if companies were required to price on this basis, you wouldn't need any of these other approaches. This is a concept that the HIAA is working with. I am the chairperson of the HIAA Actuarial Individual Committee, and I have been for the last four years, through the development of this process. Those of you that know me, know me as the actuary at Time Insurance Company, and have been for the last 15 years, but recently I began working for Coopers & Lybrand's consulting operations in Milwaukee.

CHART 1
Morbidity Selection Curve Individual Major Medical



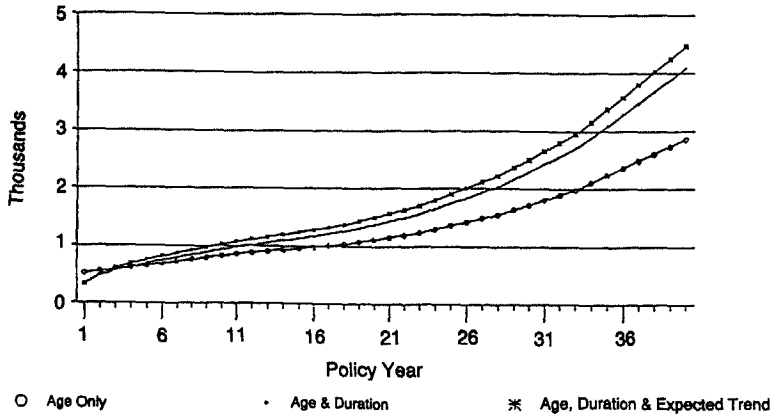
Mark Peavy will let you know what the NAIC is thinking about on all of these subjects and where it is going. He'll have a few remarks, but Mark will be here primarily to field questions and let you know what's happening.

MR. WILLIAM F. BLUHM: I'd like to start by adding one more piece of information. I'm chairing the State Health Issues Committee for the Academy, and that committee did develop, to a great extent, many of the approaches under the direction of the NAIC Life and Health Task Force, but most of that work was done when Bill Bugg was the prior chairman. So he should get a lot of the credit/blame for what's going on.

Chart 2 is a claim cost curve too, but it doesn't stop at an ultimate. In my mind, there's antiselection over time that keeps accumulating. The first curve is age-only, and the second has durational effects. Those durational effects get a little bit wider

each year, as there is a greater proportion of healthy people than sick people leaving the group.

CHART 2
Claim Costs



There's a basic public policy premise that is consistent with durational public-based policy reserves and it goes like this. You're an underwriter at an insurance company, underwriting a homogeneous block of people who are all presumably healthy, and they're all sharing in a risk together. The question is, what risk is it they are sharing in? Are they sharing in the cost of this year's claims for those people? Or are they sharing in the cost that is attributable to a person getting sick or having his or her health deteriorate? If you answer it the second way, if you take that public policy position, then you essentially, in some way, say that that group has to somehow pay for the deteriorated health of that person, even if that's a chronic illness that's going to last for 20 years. You can do that perhaps through per-cause methodologies, or you can do it through, if you know what the additional cost is going to be to that risk, by studying durational effects. Even if you're doing it on a calendar-year basis, you can prefund it. That's the fundamental public-policy premise that this approach is consistent with. If you are willing to assume, at least for the moment, that you're going to insure the deterioration of health of some of those people, the next question is, who really should pay for that? Can you postpone those costs to future generations?

Take the Social Security-type method, which is being used by many Blue Cross plans, having developed community-rated, guaranteed-issue pools, where they rely on future premiums to help control the costs. That is the substance of many of the grouping methods that are being proposed. An alternative to that is to say that each cohort of people, that initial homogeneous group, should pay its own way over its lifetime. If that cohort is going to pay its own way over the lifetime, and if all the people who are in it are going to share in the cost, then you have to find some way of sharing the cost to the people who leave in the meantime. Those people can find coverage elsewhere, because they're still healthy, and they can find cheaper coverage. To me

it's an inescapable conclusion; there needs to be durational prefunding under those premises.

Equation 1 is a present-value calculation, a calculation of a net premium. It's not a net-level premium, because there's a trend factor in it. But it's similar to a net-level premium. It's a net increasing premium, increasing with the trend rate, "T^P."

EQUATION 1
The Mechanics of DBPR

The calculations involved in Duration Based Policy Reserves (DBPR) are fairly straightforward. The starting DBPR calculation has two steps. The first is the calculation of the starting net premium (P_x). This is calculated as the quotient of the present value of future benefits (starting average cost C, times the age factor Y_{x+t}, times the durational factor D_t, times the claim trend factor T_t^C, times the number of persisting policyholders l_t, times the present-value factor v^t, summed over all future years) divided by the present value of an increasing annuity, which is based on the premium trend factor T_t^P. (Note that "$\omega - 1$" as the upper sum is actually "$\omega - x - 1$," but is shortened for readability.)

$$P_x = \frac{\left\{\sum_{t=0}^{\omega-1} C \cdot Y_{x+t} \cdot D_t \cdot T_t^C \cdot l_t \cdot v^t\right\}}{\left\{\sum_{t=0}^{\omega-1} T_t^P \cdot l_t \cdot v^t\right\}}$$

Another aspect of this is that if you buy into the premises, then it says not only do you need reserves on issue-age premiums, but you also need them on attained-age business. Instead of net level or a net-increasing-with-trend premium, you have a net-increasing-with-trend-and-age premium. That's the first step. Just like all reserve calculations, you calculate a valuation net premium (See Equation 2).

EQUATION 2

The previous equation represents the premium value for a premium structure that levels premium by age, sometimes called "issue age" or "entry age" rating. The corresponding attained age formula is:

$$P_x = \frac{\left\{\sum_{t=0}^{\omega-1} C \cdot Y_{x+t} \cdot D_t \cdot T_t^C \cdot l_t \cdot v^t\right\}}{\left\{\sum_{t=0)}^{\omega-1} T_t^P \cdot Y_{x+t} \cdot l_t \cdot v^t\right\}}$$

You then calculate a starting reserve, which is a form of the basic present value of future benefits minus the present value of future premiums. There are explicit

assumptions for the trend in claims and the trend in premiums. You end up with some reserve factors that look like this (See Equation 3).

EQUATION 3

To begin the calculation of DBPR reserves, we start with the starting DBPR reserve (SV), which is merely the difference at any point in time of the present value of future claims and the present value of future premiums. For the issue age case:

$$ {}_sSV_x = \sum_{t=s}^{\omega-1} \left\{ C \cdot Y_{x+t} \cdot D_t \cdot T_t^C - P_x \cdot T_t^P \right\} \cdot l_t \cdot v^{t-s+1} $$

The attained age calculation is similar. Note that the aging factor Y and the durational factor D would typically have a single set of factors for each, which would be used directly. The trend factors T^C and T^P for each year, however, would typically be expressed as compound values of all preceding years' trends.

I divided the durational reserves by accumulated premium factors, because the whole formula and process assumes that the premiums are going to be increasing each year, and the classical sort of version of age only doesn't assume that. The classical version assumes there's never going to be rate increases or future increases in claim costs, and many companies set up their initial reserve factors and never change them, under that assumption. Chart 3 allows me to show you a comparison of apples and apples.

CHART 3
Reserve Factors
Comparison with Classical Factors

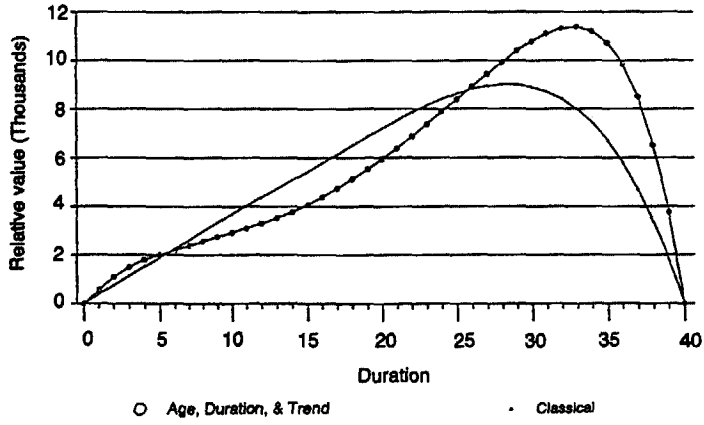
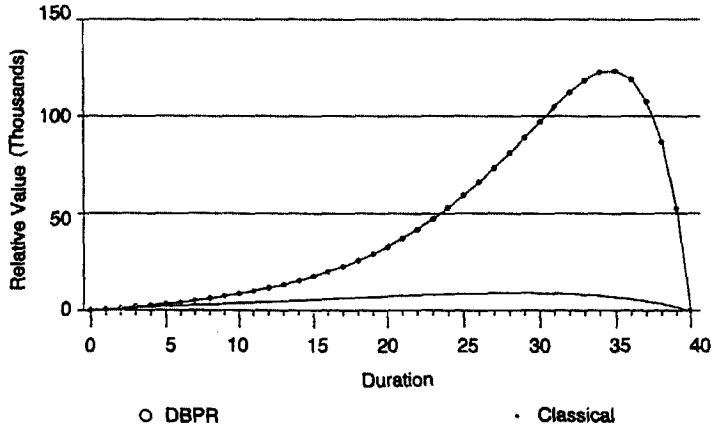


Chart 4 shows what happens when you don't divide by the premium factors.

I was sure there was something wrong with it the first time I saw it, but it is correct. If you take a realistic look at what trend is going to do to claims and premiums, and if you wanted to level things durational, you need to have reserve factors that look like this. As we all know, however, there are very high lapse rates in health insurance relative to other coverages, so it doesn't necessarily mean that you're going to have that impact on aggregate reserves, which look like this. They don't get that much higher, but you can see what the impact is by going back and looking at the reserve factors, and that impact is on that tail end. This is where the chronically ill are, who are still hanging around under coverage, and who everybody in the public policy world is trying to find a way to pay for.

CHART 4
Unadjusted Reserve Factors
Comparison with Classical Factors



The second thing that is unusual about this is that it's sort of a cumulative antiselection argument that says if you have, as often happens, a premium increase that causes larger-than-expected lapses, those extra lapses are leaving because they're healthy and they can find coverage elsewhere. Another aspect of this is to say that those extra people who are leaving, who are healthy, should leave behind their reserves to help pay for the sick people who are staying behind. What it does is factor up all the future reserve factors, so that they're unchanged due to that extra lapsation that occurred.

There are two more formulas.

EQUATION 4

$$CAST_t = MAX\left\{\frac{1-L_t^E}{1-L_t^A}, 1\right\}$$

EQUATION 5

$$DBPR_r = \sum_{t=r}^{\omega-1} \left\{ C \cdot Y_{x+t} \cdot D_t \cdot T_t^C \cdot \prod_{s=1}^{t} CAST_s - P_x \cdot T_t^P \right\} \cdot l_t \cdot v^{t-r+1}$$

The first is developing the factor of actual-to-expected lapses, or persistency. The second is the reserve formula that says your present value of future benefits is increased by that ratio. There are several main things that are different between this reserve basis and the "classical" approach. One is the durational effects; under the current valuation method you are allowed to use lapses, provided you use duration in the same calculation, but this method includes both of them. It also includes trends. I call it excess trends, because what really leverages the whole thing is not so much the trend rates of claims and premiums, but the difference between them. There is also the adjustment for cumulative antiselection.

There should be something explicit in the reserve basis that says you can't ever hope to get your premium increases at the right time, and in the right amount that you want to get. You're going to lag a little bit behind your claim trends. You should reserve something for that, a gross-premium-valuation-type element that creeps in.

MR. JEROME H. VANCE: I'm going to talk about the "back-end-rate-spread method," which is a separate section of the model regulation. Another section of the law investigates the rate spreads that result. If this sounds a little redundant, I'll have to agree with you. It is a little redundant, but it's appropriate in the sense that the scope of this law is meant to apply not only to individual policies, but to any policies that don't come under the small-group-reform laws. That category of policies doesn't often get covered. Due to the similarity of some of the small-group-reform categories of rate spreads, these rules will sound very similar to those. I'm going to first talk about the concepts and objectives of this back-end-rate-spread method, then the mechanics of how it's actually applied, then some practical problems in the process of applying them, and finally, some other related issues.

First, with respect to the concepts and the objectives, it's very similar to the small-group-rating rate spreads. The 67% limitation that we often see between the lowest and the highest rates in the small-group reform is 20% here. For business issued after the effective date of the proposed regulation, we would have the rate spread limited to 20% of the lowest rate within a class. Across classes, the limit is 44% of the lowest rate. All are adjusted for similar risks and for similar benefits, which means that you actuarially adjusted the rates first and then applied the 20% limitation within a class and the 44% limitation. The concept is very similar mechanically to the small-group reform.

Mechanically, the second piece of this relates to business that is in force. What I just talked about, the 20% and the 44% limits, applies to business issued after the effective date. For business in force on the effective date, the values are 67% of the lowest rate. That's the limit of the rate spread, adjusted for similar risks and similar benefits. The rate-spread variation is 100% for across classes and 67% within a class, which is very similar to what you find in most of the small-group limitations.

The third piece of the mechanics relates to substandard business. It simply says that for substandard business, these rate spreads do not apply as long as the ratio between the substandard business and the standard rates do not change. There's not much more guidance, except that substandard business is simply defined as policies issued at higher rates, based on the health status of the insured, and the definition of standard rates in the model regulation is the rates that are available to the majority of the population.

The fourth mechanical piece outlines three other categories of business to which these rate spreads do not apply. These are group conversion business contracts sold without regard to health status or claim experience, and business acquired from a carrier that's either in conservatorship or rehabilitation.

The fifth piece of the mechanics relates to rate increases from one year to another. Again, it's similar to the small-group-reform proposals, but the rate increase limit is 10% plus the change in new business, which is usually meant to be the trend. In most of the small-group-reform proposals, there's a 15% limit plus trend. The idea here being that duration is effectively limited. The rate increase from one year to another is now 10% plus trend.

I invite you to think about how these rate spreads are going to affect the individual market, seeing as this is something new in the individual market filing scene that's going to be imposed along with the loss ratio and other tests that we're accustomed to.

With respect to practical problems, as this is a new area, I'm going to throw out some ideas that occurred to me that might cause some problems. These include: relation of subsidies from one block of business to another; one plan to another; state data classifications; how you're going to divide the business between filings and between states; large-claim pooling; reinsurance costs; and then renewals that occur throughout the calendar year. How are you going to make this test as policies come up throughout the year, keeping in mind the overall 20% and 44% limitations?

The proposed model regulation deals with the practical problem of subsidies as follows: As you can think of this, applying these rate-spread limitations will sometimes cause you to not be able to put in a rate increase that you want and which would otherwise be justified by the loss-ratio rules. You may be required to limit the premium rates for policy form in order to comply. The regulations allow you to create subsidies between plans, first of all, within a given class, so that you make the loss ratio test for the whole class. If that still doesn't work, you can also create a subsidy across classes. The regulations allow several different methods for doing that, which won't be covered here, but may be discussed in the question-and-answer session. The issue of credibility opens up a number of questions. The proposal requires the actuary to address these in the actuarial memorandum. This is similar to problems that we've always had with credibility. The proposal requires the actuary to address, where applicable; the security of policyholders and safety and solvency of the insurers; the extent to which the rate-making assumes and depends on large groups, not individuals; the relationship and equalization of benefits and expenses incurred in relation to premium; making sure that the insurer is not lowering any segment of

policies at the expense of others; and combining and blending of experience, as appropriate.

Other related issues, which are required to be dealt with by the regulation, are the class definitions and the rating characteristics. A class is defined in the regulation as a grouping of policies that has a certain expectation created by either underwriting, marketing, acquisition, or something called fairness, which is to be determined by the Commissioner. This is basically what most of us would use in defining a class. In applying these 20% and 44% limits, I've used the term "related risks" in a number of cases or "similar risks." That has to be defined to some extent and basically the proposal defines similar risk as insureds with the same rating characteristics that are used to determine the rate to be charged. You then have to define rating characteristics, which are defined as demographic or other objective characteristics, as determined and considered by the insurer in the determination of premium rates. You cannot use claim experience, health status, and duration. A number of other practical issues may occur to us.

MS. BARBARA J. LAUTZENHEISER: I have been in actuarial science for approximately a third of a century. In that third of a century, one of the things I have learned more than anything else is that I probably should have spent at least half of that 33 years studying behavioral science, as opposed to studying actuarial science. This is because too often what we do as actuaries is look at what we see in the past, and then adjust it, project it, and say it will probably have a trend factor here and some lapses there. We don't pay attention to what the actual result might be as a result of that. We have to be careful that what we do doesn't have the wrong impact.

For 25 years, I was inside an insurance company, and my sense was that I knew the health insurance business, I knew the life insurance business, and I had a fairly good idea what was going on. But I have to tell you that it wasn't until I went seeking health insurance that I learned it's not too easy to find. There's not a lot of accessibility out there, because there aren't many companies that are willing to sell it anymore. A friend of mine who was looking for some Medicare supplement can't buy it at all because Hillary Clinton is working on the issue, and she can't seem to find a company that wants to sell it.

Nonetheless, if you go looking for it yourself, if you write the checks, if you feel the increases, it makes a big difference. When you're in business for yourself, you are in not only the process of writing your own checks, but you're in the process of your own survival. You have to, in fact, generate enough income to make sure that there is money there to pay the bills. How you spend money and what you spend money on is very important, and what you want left is choice. That choice that you want is for the cheapest thing you can possibly get, as well as for a benefit that will fill just the needs that you have. For instance, you don't want to buy whole-life insurance if your purpose for your insurance is term life insurance. I bought term life insurance to replace my group life insurance until I built up my practice and didn't need it anymore. I did not want to buy whole-life insurance, and I did not want to buy whole-life insurance that didn't have a cash value in it. Unfortunately, opinionated or not, that's the way I feel about the durational rating. As an individual signing the check, I do not want to have to pay for those risks that are going to be out there beyond the time

that I need coverage. My sense is that all of the small employers and all of the self-employed the same way. The vast majority of the uninsured, much of the public-policy problem that we have today, are the small employer's and the self-employed.

Those people are very independent. They don't want to be told what to do, even if what you tell them is in their best interest. They want to make those decisions, based upon their own criteria, and they're going to be very uncomfortable paying more money for something that they do not want. We have very high percentages of people who want to buy these benefits for only a relatively short period of time, for just a term-insurance portion of time. I believe that the Employee Benefit Research Institute (EBRI) has identified that 50% of the uninsured, for instance, only have a four-month period in which they want coverage, because they're moving from job to job. Approximately another 75% only want it for about a 12-month period.

If you want temporary health insurance, you should not buy something that is prefunded with a whole-life concept that doesn't have a cash value to it, but rather something that has a more durational or steeper premium. The key here is that we must have disclosure. These people need to know how to make those choices. They need to have some way of learning what those different choices are. We need to identify what kinds of policies have what kind of premium payments, perhaps requiring some type of regulatory form of disclosure of past premium increases for a company, so that you get some idea of how great those premium increases are. Most people not only want choice but are willing to make those choices if they don't get surprised. It's surprise that people do not like. Part of the public policy problems that we have come from surprise. I remember my very first rate increase. I was told if I'd sign up, and I don't remember what it was for now, I would have a premium decrease. What they meant was a premium decrease below what it otherwise would have been. And I got surprised! People don't like surprise. We need the disclosure side of that surprise.

The last piece that I want to talk about is that I made my livelihood talking about unisex rating. I have been a strong proponent of risk classification, and I am very concerned about both the fairness that comes from risk classification, as well as the solvency that comes from risk classification. Risk classification principles are based upon those items. When we get into subsidies, whether they are from a rate-cap concept, as Jerry has talked about, or they're coming from a subsidy, from a durational standpoint, and I believe the rate-filing guidelines even talk about subsidies, there is a risk classification problem, and we need to address that.

One of my concerns that I haven't had an opportunity to express on the current rate-filing guidelines is that the Actuarial Standard of Practice Number 12 states in the very last point, Section 6.2, "Deviation From Standard," that the actuarial communication disclosing the result of the procedure is an approximate and explicit statement with respect to the nature, rationale, and effect of such use. I don't think we have quantified yet, as our ASP Number 12 requires, what the impact of that thing would be. But I am concerned about anything that subsidizes, because it goes back to my risk classification.

My biggest concern, however, is back to the motivational concept and the behavioral sciences. If you end up with any of these subsidies, particularly with the prefunding,

you're going to end up with premium increases. If you have premium increases, you end up with a decreased affordability; that comes with decreases in the purchases, and it ends up with increases in the uninsureds and increases in the uninsurables. The best solution to eliminating the uninsurables is making sure everybody has them.

How many of you remember the problem about the change that many companies went through when we went from only inpatient benefits to paying outpatient benefits? We did the studies and thought everything was going to be fine because outpatient care was less costly. We forgot two things. We forgot that the hospitals, when they recognized that they weren't making any money anymore on inpatient costs, would transfer their costs to outpatient costs. Second, the public didn't like to go to the hospital. None of us likes to go to the hospital. When the benefits came out on an outpatient basis, utilization went up. We didn't contain costs. We just changed the way it was looked at, and in fact, modified the behavior of the two people who were there or who were involved in that particular equation.

A friend wanted to be an actor all of his life. He was an actuary for a while but wanted to be an actor. He decided he'd go to New York because he was getting old and it was about his last chance to do so. He went to New York and he waited tables, he bussed tables, he parked cars, he did everything he could, and he finally got a bit part with one line in a play. The one line was "Hark! I hear the cannons roar!" He went home and he was so happy. He practiced his sentence. Night after night he practiced, "Hark! I hear the cannons roar! Hark! I hear the cannons roar!" The big night finally came, and he was in the middle of the stage. The play is on and everything is going smoothly. He's just anticipating his part and all of a sudden there is this great big boom. And he says, "Oh my gosh! What was that?" The point of the story is, if we don't pay attention to the behavioral science, the results we receive won't be the results we expect.

MR. MARK D. PEAVY: I'm the senior life and health actuary at the NAIC. When Tom mentioned the title, "The Never-Ending Saga," I thought "The Never-Ending Saga, Part I" could be the individual health rate-filing guidelines. "The Never-Ending Saga, Part II" could be small-group-rating reform. "The Never-Ending Saga, Part III" could be Medicare supplement, and we can go on and on. It seems like that's just the nature of the beast when we're dealing with these complicated regulatory issues. It's just one complicated issue after another.

That's what's made it so difficult to reach a consensus. We had high hopes at the December 1992 meeting that we held in Atlanta. One of the goals of the Life and Health Actuarial Task Force was to expose another draft and have that be a significant step on the way toward some conclusion of this exercise. Before I go any further, let me say that in this effort, there really has been a lot of very good work done. The people on this panel are in a large part responsible for that, and I also want to recognize Bill Bugg. He played a great role as chair of the State Health Issues Committee of the Academy. John Hartnedy of Golden Rule also played an interesting role in expressing his opinions on the subject, and we appreciate that as well. But in any event, in December in Atlanta, we were hoping to expose this document and have it represent something approaching finality, but a number of questions and a number of details came up that we simply could not reach a consensus on. The action that was taken in December was that John Montgomery, chair of

the Life and Health Actuarial Task Force, reported to the B Committee that work was still under way. We were continuing to look at a number of issues, and he identified five principal issues.

First was the durational rating issue, which we've talked about here. I'll just read what it says: "The Bill Bluhm approach is too steep for initial rates. Others have other ideas. Whatever happens, this area must be simple and reasonable, since it will cause moderately higher rates." Well, I'm not sure we've achieved the simplicity part, but I'm also sure that will be one of the topics that will continue to be discussed. What can we do to protect these people at the end of the rating period from getting the huge rate increases that we're too familiar with? Also, in all of what we introduce into the models, we have to keep it simple. You have to understand it when you're filing the rates; the regulators have to understand it when they're monitoring the rates.

The second item that was mentioned was "block approaches as appropriate," and what was meant was that we had to find some way to pool blocks of business so that we could protect those people who find themselves in closed blocks of business from these large rate increases.

The third item that was mentioned was the loss ratios. There is much concern that the loss ratios that were put together many years ago don't represent current conditions, and they want those loss ratios fine-tuned.

The fourth item that was identified was the credibility standards. I get as many calls on this issue as anything else. What represents a credible book of business for rate-filing purposes? I think the regulators want very specific guidance as to what standards to apply.

The last area was expect greater demonstration of initial net-premium development and documentation of trend factors, taking into account inflation versus morbidity factors. In addition to the credibility standards of the rate renewals, I think the task force was saying that it wants a higher comfort level at the time of the initial rate filing.

There were three other areas that were identified as new areas. The task force wants to address disclosure to insureds and product reform, meaning managed care and preventive programs and their use and effectiveness in allowing lower premiums. Finally is the area of deemers, looking for guidance as to what is a reasonable time frame in order to review the rate filings.

Where things stand at this point is that we are going to meet the week after next in Los Angeles. I spoke with John yesterday, and he indicated that he was putting the finishing touches on a revised draft that we will circulate to the task force members next week. We will come to Los Angeles prepared to discuss this subject, as well as in many other pertinent NAIC subjects. The officers want to see some progress, indicating a very strong desire to bring this whole process to closure. They're looking for something by the end of the year. Whether we'll hit that, I don't know. What sort of impact the events in Washington will have on all this, I don't know. But I'm sure it will have some; we'll do the best we can.

MR. STOIBER: What we have here is a rather complex process, a complex regulation for something that started to develop in 1953. From 1953 to 1980 there was one paragraph concerning the regulation guideline. I took this from the *Proceedings* of 1953. "No loss ratio should be fixed as the absolute minimum for any policy where automatic disapproval is to follow. The regulation should go no further than to serve as a benchmark which would create a possible presumption that benefits are unreasonable in relation to premiums charged." There's a list of loss ratios and they were at 40%. That lasted until 1980. We went to the dual loss-ratio test, which gave the impression that the lower the premiums were, the easier it was to get rates approved. That led to the dilemma here, that rates become very steep by duration. That's the issue we're talking about. What I'd like to do is entertain questions first on this element of durational rating. We're trying to say that the NAIC has come to the conclusion that we want to give the assurance to a man when he purchases a policy today at age 45, that the premium he pays five years from now when he's 50 is going to be the same premium that everybody else is buying from that same company at age 50. It is also the same as everybody who bought it 20 years ago at age 30. At least eliminate the severity of the difference, because there can be severities as high as 150%, 200%, and 300% greater rates at the same age when a person is locked out.

Now is there anything wrong with that? This is my opinion, but there's something wrong with that, when the individual who buys it doesn't understand that could happen. Barbara said we should explain it to buyers. If I can speak about the Aid Association for Lutherans policy that came out a number of years ago, that company, I believe, is the only one that did disclosure on this. It had a brochure, and if anybody is familiar with it, you opened it up and in the brochure it said you could buy the same policy at two different rates. One was much lower than the others, but if you bought the low one, it was going to be higher five years from that date than if you bought the other one. That's disclosure.

That's what we're talking about today. It's one thing to say that, and it's another thing to put the back-end-type approach in the rule, like the small group reform does. But, will it really happen? Is that regulation saying, "Just trust us. We guarantee you that ten years from now our durational rates will not have a spread on them?" How do you mechanically do that? These are some of the ideas that have been thrown around. This is why it's been taking so long to do. Does this work for small-group and individual insurance? My question is, if this isn't a problem with small-group insurance, why is it with individual insurance? The point is, it probably is a problem with small-group too, and I would not be surprised to see the small-group-rate regulation come into compliance with this some day. Mark says it's a never-ending story. It may end, and I think the only way it's going to end is if the federal government makes it end.

FROM THE FLOOR: I think I view the perspective almost the same way. I have a difficulty with the durational pricing (I've referred to it as predatory pricing) question. I look at it that way because people who buy in with a cohort of like risks should have like expectations as time goes on. They should not be recategorized into either healthy groups or unhealthy groups. I understand where you're coming from, but somehow I don't see the aspect of disclosure solving the problem. Because putting forth insurance terminology and explanations that make people's eyes glaze over

doesn't offset the seductiveness of a low going-in rate, or a real "gotcha" type rate. I think we need to do something, but I don't know if saying durational pricing should simply be 100% out. The person who bought at age 35, 5 years ago should be paying the same as the person buying today at age 40, and that's kind of the example I use. I think that's the goal. I would like to see that goal, but at the same time, if there are people who have definite short-term needs, perhaps the idea is a short-term policy. Because if that is not done the people buy in as the group gets older and gets rated up, and those who are still in good health opt out and go buy a new policy. So the older group becomes more and more ill, impaired, and expensive. All it does is create an ever-spiraling cost for that older group, to the point that they can't afford it. Then what happens? That's usually when they need the protection the most, and that's when they can't pay the high premiums.

I did go out and buy insurance. I was into consulting for a while. I was looking for a policy that would address my financial concerns. My financial concerns were that I didn't want to pay more than $10,000 in a year for my family's medical expenses. So I was looking for a policy that would say that I didn't have to pay any more than $10,000 a year for my family's medical expenses. There weren't any around.

MS. LAUTZENHEISER: Term stop-loss of $10,000 is what I'm hearing you say.

FROM THE FLOOR: Exactly. Nobody had it. So I got about as high a deductible as possible. I saved money that way. There was a comment on one of the methods being talked about as far as leveling out the effect of durational pricing. Correct me if I'm wrong, but wasn't something mentioned that there was going to be some kind of a minimum on first-year premiums?

MR. BLUHM: That's built into the model. That's how the methodology is implemented.

FROM THE FLOOR: I'm waiting for the very first time a filing comes back to me and tells me that my rates are too low. I've had that happen.

MR. JOHN A. HARTNEDY: In view of some of the things that Barbara said about the short-term nature (12 months or less) of people being uninsured, 70% I believe she said, it seems to me that our market is primarily a transitional or short-term market. I'd like Bill to address, and I'll comment after this, his premise on public policy, the term used, and whether people should share in the fact that they are subject to the long-term risk. A number of employers still do not do a lot of underwriting when employees come on board. We think we're selling a transitional product. People don't buy short term, because they don't know how long they're going to need our product. So they don't buy a short term product, but half of them are gone within 24 months. They knew they needed short-term coverage, and of course, government policies create this with the tax law. You have to be out of your tree to buy individual insurance if you can get it through an employer in any way, because it's fully tax deductible and is exempt from FICA. Individual insurance is a last-ditch transitional type of product. So I see, Bill, your premise of being subject to the long-term risk that the majority of these people are not. Even if they are subject to a risk, they're going to be able to get insurance somewhere else, wherever they're going, because there is still a substantial number of large employers who do not

underwrite. So I don't see that as a fair basis. Also, the number-one problem that we hear about, and I'd like you to address this too, Bill, is affordability. If I remember right, when you presented this, it showed first-year premiums up in the vicinity of 30% plus. We looked at some of ours with the elimination of durational rating and would see some of those kinds of rather substantial increases, to possibly pull the durational rating out. There are other ways to solve the problem.

MR. BLUHM: Are you saying that based on the data that have been presented that a large percentage of people who buy individual insurance are not on the books two years later, and therefore, they didn't need the coverage? To me, a large percentage of people not being on the books means that the brokers have put it somewhere else, and that's exactly what's going on. They were healthy people who found coverage under other insurers.

MR. HARTNEDY: Barbara mentioned a premise that contradicts that, and that's my point. Our market is a transitional market. People who are uninsured for a short period of time, whether it be four months or twelve months. If there were levelized premiums, I don't think we'd see a substantial difference in our persistency rates. People don't buy individual because it's extremely expensive, because they don't get tax deductions for it. What I'm saying is, I don't think your premise is right. Your premise, as I understood it, is that people are buying individual for the long term, so therefore, if they lapse, they should contribute to the long-term risk.

MR. BLUHM: No, that wasn't the premise at all. The premise said to look at the first-year coverage, people who buy their coverage for one year. They're all healthy when they get underwritten, and at the end of that year some people will have developed illnesses, and they are going to cost more money in the future than the rest of those people. The question that I put out was whether that group was sharing the cost of those people's medical costs for that one year, or were they sharing the risk those people got sick? What would the ultimate cost be? If you bought into that latter premise, then the rest of that group shared in that risk, and that's a cost today. As actuaries, we measure it and prefund it in reserves, just like we prefund aging. It's just an aging over time of the policy, instead of the age of the person.

The affordability was your second question. It's a term that's being bandied about. I think affordability is in the eyes of the beholder. The question is, if 1,000 people were all issued this policy, and it cost them each an extra $100 to fulfill this goal and pay all the claims of this group, is that less affordable than if those 1,000 people all paid $100 less, but the one guy who got sick ended up having to pay $100,000? It's the purpose of insurance to share the cost, so that it's more affordable for everybody on the average. It's a question of how much of the sharing you're going to create or not create. What is the insurance risk that you're taking on?

MR. STOIBER: Let me make a comment on affordability, as I hear this all the time. If we get rid of the durational rating, rates will be too expensive. Rates have been going up about 15% a year on individual business for the last six or seven years. Getting rid of the durational rating for probably half the companies out there will mean nothing. Getting rid of it for some companies might mean that they're taking a one-year step into the future as far as trend. They're going to be at those 15% rates

next year. They're just accelerating a bit. For a few companies it might mean jumping ahead two or three years.

So, this is not an affordability issue. I do not believe it personally. To give you a little background, I chair the Wisconsin Risk-Sharing Plan, which I think is the third oldest in the country, and I have been doing that for the last ten years. About five years ago, this question came up of what to charge these 10,000 members in Wisconsin. The law says we have to charge them 50% higher than standard. The question is, what's a standard rate for something that's been in force for five years? What we used to do, I think most places do this, is figure out what standard is, then do a survey of what the street rate is. What's the rate we're charging the customers? Then should we multiply it by 50% when in fact, we're trying to apply this against a population that's already 5-10 years old? As I was explaining this to the commissioner that some companies charge different rates, he said, "No, I don't believe that." I said, "Well sure, that's the case," "Oh, no, that can't be." He said, "Well, find out for me." I said, "Well, I can't find out for you. No one is going to tell me that information." He said, "Well, then write the letter for me and I'll find out." So I wrote the letter for him and asked these companies that were the seven largest writers of individual health insurance in Wisconsin, which is probably fairly typical of the national writers. A couple are local companies and regional companies. Two of them came back and said, "Yes, we do not durational rate." The letter was phrased to the point that said, give us your rates you charge on your plan today, versus the rates that you charge today for policies that were sold five and ten years ago, and also five years ago. The question was not asked, "Do you durational rate?" The question was, "Give us your rates for policies sold years ago."

I personally called each one of these companies and verified this, asking very pointed questions. More than half the companies do not durational rate. So, it's a long comment on affordability, but I just want to keep things in perspective.

We're here to talk about the entire regulation. There's a lot in there, other than just durational rating, and I just thought it would be fun at an actuarial gathering to talk about some of the mechanics. Can this work? Can we physically come up with a premium formula? We have a formula in the regulation now that says you have to use these selection factors against your morbidity table. Can it work? That's why we chose that subject. But we can talk about expense ratios, prefiling, or anything you'd like.

MR. BLUHM: The question was raised about trying to enforce a minimum premium. I got confused, because I thought we had thrown in some hard and fast mechanics or wording in the model. I think what we're referring to part of the purpose in Section 2, is where it says, "the purpose of this regulation is to" and then B2 is "assure that premiums are not deficient, thereby threatening insurers with possible insolvency and jeopardizing the security of policyholders." I don't think we're saying we're going to have hard and fast numbers, but we want to make sure that the assumptions are reasonable, in instances like the durational pattern that was put in is just encouraging that practice.

MR. PEAVY: In the certification section, one of the things the actuaries are required to certify is that the rates that are being charged are no less than the rates you would have gotten if you'd used the same morbidity but leveled the durational effects.

MR. EARL L. HOFFMAN: Mr. Vance, you mentioned some special provisions for conversion policies. Could you share some of the changes that we would expect there, as far as rate filings?

MR. VANCE: Right now, I was simply stating that the rate spreads, as described in the proposed regulation, do not apply to group conversion policies. The proposed regulation doesn't go any further than that.

MR. PEAVY: We have an existing model on conversions that Bill is familiar with. We've done a little work on it and I think the assumption is that this is one of those issues that we would put aside for the moment and concentrate primarily on the major medical issues at this point. So, it just wasn't an issue that has been addressed at this point.

MR. WILLIAM J. BUGG, JR.: Mr. Vance, where does the regulation or the idea that you were talking about exist? Is that just a proposal from the Blue Cross Association?

MR. VANCE: No, this is a proposal in the model regulation that was distributed. It's never been called the back-end approach before. It's the block approach. It was our regulation. It's in Section 6 of the model regulation.

MR. BUGG: I have one thought on the durational issue. From the standpoint of selling business, it's difficult to make a sale, and you like to see those policies stay with you once you have sold them. It's always occurred to me that it would seem a little bit backward if the guy who stayed with you would end up with the higher price. The guy who stayed with you ought to have a better price than the street rate. That's just an observation. The longer the policy stays with you, you've improved your expense position as well, from the standpoint of being able to spread your acquisition costs over a longer duration.

MR. HARTNEDY: As an actuary, it bothers me a little bit that a 40-year-old person who was underwritten ten years ago is simply not the same risk as a 40-year-old person who is underwritten today. If I put them in the same rate, I'm doing a cross-subsidation. I'm not spreading insurance risk. Insurance risk, Webster's definition, not mine, has to do with similar risks, common risks, and equitable premiums. It is the simple definition. That would be my first observation. The other thing is to respond to my comment on affordability that Bill made. Somebody shouldn't have to pay $100,000 because they're left by themselves, and I would certainly agree with that. There are different ways to attack the problem of small closed blocks. A simple way is to require everybody fourth year and later to be combined for the benefit of a rate increase. By that time, most of the differences, not all, that I will grant you are basically well established. It's very simple. I think the thing that bothers me the most about what most people said is that we are going to take the choice away. Tom said half the people don't use durational rating and the other half do. That's a competitive market. If you put disclosure on it, then what's the

problem with that? I am concerned that we are sitting as actuaries and/or regulators, and we're going to tell people that we're going to see that they don't have a choice. There are ways to address closed blocks without taking a person's choice away. There's a way to let them know how a company operates without taking their choices away. Why do we presume to do this? Bill, I heard you say that. I heard that in Mark's remarks. I'm not saying Jerry didn't take the position; he was just relating what it is. But the only one who said anything about that is Barbara. Who the heck are we to take away an individual's choice? That's what everybody up there, except Barb, is talking about. And who are we to do that?

MR. VANCE: I was going to expand a little bit on Mr. Webster. When we say a spread of risk, I take that to mean bringing in people with the same expectation of loss over a period of time and giving them the same price. It's not a year-by-year thing. It's an expectation of the cost they're going to have. If everybody comes in with the same expectation, then as long as they stay within that group, they should have the same price. You shouldn't be reunderwriting these people by letting those who have stayed in good health come back and buy a new policy at lower rates. Because that's really what you're doing here, and that leaves those who are not in good health, who have suffered impairments, paying higher and higher and higher rates. You have just an ongoing recategorization of your insureds. I think that is contrary to actuarial principles and spread of risk.

Now as a matter of choice, there is a very simple solution to this. If someone wants a short-term policy, buy a short-term policy. There are companies out there. They could buy it for three months, six months, or 12 months. But once bought, it would be over soon but they knew that going in. For short-term needs, they could get short-term coverage at a very low price. There's absolutely nothing wrong with that. They know that a year from now, if they want coverage, they have to go through underwriting again. They knew going in and they had the choice. The people who want the longer-term coverage know going in that they have the choice to stay with the group that they entered with.

MR. BLUHM: First, how many people think they really understand the concepts of the durational prefunding that we're talking about? [Majority of room.] That's great. How many think that in a reasonably short piece, you could train agents and the buying public to understand the difference between a durationally rated and a durationally prefunded rating scheme, sufficiently so that they could understand the risks involved? Five? Okay. I agree with the majority of you, and that's my answer. You cannot give people choice and disclose it adequately. My six years with the New York Insurance Department in dealing with the public convinced me totally of that. I never got one complaint about first-year rates. Any complaint I ever got was about rate increases. This process reduces rate increases and raises the going-in rate.

MS. LAUTZENHEISER: I am a broad-background actuary, not just a health insurance actuary. If we go back to basic principles, and say that it is our responsibility, either regulatorily or as an actuarial profession, to take the position that we have to protect people from themselves, we should be making sure that they buy only coverage that funds it for all of their life. We have to eliminate term insurance on life insurance as well. I don't believe that. If I had taken the position that we establish public policy and eliminate choice, I will guarantee you, we would only have unisex rates right

now, and we would have some other problems having to do with risk classification. What happens in the first years is that you select risks? Whether you select risks for an ordinary life contract or select risks for a health insurance contract, they are better risks than they otherwise would be. We tend to think that the buying public is stupid. Remember watching Ross Perot on television doing charts and doing numbers. What a rating he had! The buying public is not stupid; if you give them information (it doesn't have to be in actuarial formulas), an idea of what the purpose of the contract is, some idea of what the increases have been, they can draw those conclusions. They're a lot smarter than we give them credit for.

MR. RODERICK E. TURNER: We're talking about durational rating causing problems; people lapse out because they can get a cheaper price on somebody else's product. Not that I'm saying I do or don't like, I don't think nondurational rating is going to solve the problem. Even if everybody was using the same rating scheme, companies' prices are still going to be cheaper than other companies' prices, because of expense allowances or commissions, or whatever. Someone can do it a bit more efficiently than someone else. If people are healthy, and they can go to that other company and get underwritten and buy that policy, they're still going to do it, whether they are durational rating or not. I'm just wondering if what we're spending all this time and effort on is really going to try and solve the problem that we're trying to address. I'd like to pose that question to the panel. Maybe you're spending a lot of time on something that's really not going to solve the problem.

MS. LAUTZENHEISER: I tend to agree with that. How many of you remember the end of 1972 and what the probability of national health was? The probability of a Kennedy health care plan at a very high level, in late 1972 and early 1973, was a fraction below 100%. Does anybody remember why it didn't happen? No, it wasn't too expensive. It was called Watergate. And from the moment Watergate came on board, our entire Congress was going someplace else. When Watergate was eliminated, the answer was that it was too expensive. At that point in time, I had predicted that we would be moving toward producing a social practice or socialized kinds of insurance, through the private mechanism, and that is what is happening now. The real problem is, until you get to mandatory coverage, which I am not proposing, people will make decisions and make choices, lapse out, and move around anyway, and they're not going to just move from within the company. They're going to move from company to company because they have choice. We are talking about a voluntary market system, which is the reason you need risk classification in the first place. I would suggest all of you go back and read the Academy's Risk Classification Principles and Actuarial Standard of Practice Number 12 and then make some decisions.

MR. PEAVY: To respond to that question, I think the answer is no, we're not trying to discourage movement due to efficiencies. But we are concerned about movement due to rating structures that can't produce a long-term affordable premium. And I think those two items are different.

MR. CRAIG N. SCHMID: I've got a somewhat more prosaic question. It's about what constitutes a class. I think Mr. Vance was talking about that. What are the variations within a class that result, what are the variations between classes? I'm trying to better understand what constitutes a class, in terms of being a rate band

within classes and between classes. The definition of a class was very sketchy in the model regulation.

MR. VANCE: Basically, the model regulation talks about four ways to define a class: underwriting, marketing, acquiring business from another insurer, and something called fairness, as determined by the commissioner. The marketing piece is fairly well delineated; it has to be a separate marketing structure. The people are actually supposed to be different. The underwriting piece is less clear in my mind. The model regulation gives guidance only in that it says underwriting characteristics have to produce more than a 25% difference in expected claim costs. Right now, that's all the guidance that the model regulation gives. That's something that's probably under the heading of practical considerations as far as determining a class.

MR. SCHMID: Are these classes only? If you have a different benefit plan, is that not subject to these, because it's a completely different animal?

MR. VANCE: If you have a different benefit plan, then that's part of the actuarial adjustment.

MR. BLUHM: And then the 20% and 44% rate comparison should be made, but first you have to make the actuarial adjustment between similar risks and similar benefits.

MR. SCHMID: Is there a potential to game the system to avoid the rate bands by creating a slightly different benefit plan? And if so, how is that addressed?

MR. BLUHM: I think that should be addressed in the actuarial certification. Because if your actuarial certification is done properly, then you won't be able to game that. The compliance manual for small-group insurance goes into much more detail in that respect.

MR. PEAVY: There's always potential for gaming, and in the small-group arena, we tried to address that by saying that there had to be reasonable actuarial differences between plan designs.

MR. BLUHM: I was going to say there's another complication that gets into this though, which is rate structure. Because there's a problem where the same company may have some attained-age rates and some issue-age rates, and then we'd compare the age 40, attained-age rate versus the age 40, issue-age rate, or whatever. There had to be a special exception for that, so there is a fair amount of potential for gaming.

MR. LEONARD KOLOMS: At renewal time, the model requires that the actuaries certify that their rates follow the formula, or at least be equal to the rates calculated in the renewal formula. I'm very confused as to when the experience gets into the rate-making process. I don't see how you can have both: how the actuary can certify that the rates are in compliance by using the formula that's in there, with the durational factors, and at the same time reflect the experience to achieve a 65% loss ratio. If it's had unusually bad experience in the past, when does that start getting into the rates that the actuary's charging? It looks to me like the rates for renewals

should be based on experience and not based on the formula. But the statement is in there; the actuary must certify that renewal rates also comply. I'm confused how you can have both happening at the same time.

MR. PEAVY: I don't see why they can't both be minimum standards.

MR. KOLOMS: When do we actually get the experience into this? If the experience demonstrates a 20% rate increase, and let's say we're running 20% above expected because we had unusually bad experience and because of pricing purposes for new business, we're not expecting to continue the bad experience. Let's say we just had a flu epidemic, and as a result of that, claims suddenly shot up. Now, don't they have the right to recover that loss caused by them missing the rates because of that flu epidemic? Is it okay for me to assume in the future that we're not going to have a flu epidemic? Doesn't that produce two sets of rates as a result of that?

MR. PEAVY: You have to decide what the most credible basis is for projecting your future experience. If that was a one-shot deal, then that isn't the appropriate basis for projecting future ongoing experience.

MR. KOLOMS: It is for determining my 65% lifetime loss ratio.

MR. PEAVY: And you have to meet the perspective loss ratio as well. The audience just got a flavor for what it's like to be a regulatory actuary and discuss rate filings.

I just want to point out in all this, that, unfortunately, even though it's been a never-ending saga, many of these concepts that we've been discussing, even durational rating, are just that. The Life and Health Actuarial Task Force has many objectives, and some of them are going to be very difficult, even over the next year, to ultimately resolve. So just keep in mind that the things that we discussed may not appear in hard form when this final regulation ultimately gets through the process.

MR. STOIBER: This was a good opportunity, I think, for all to contribute to the people who have to make these decisions. We have an impression that disclosure will work. If you have any facts on that, or if you have a formula that will prove to Bill that he'll move from majority to minority, I think everybody would appreciate that. That's what these sessions are all about.