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Small-group renewal rating – companies must become more active

by Drew S. Davidoff

Increasingly keen competition for small-group medical business has caused many carriers – both life/health insurance companies and Blue Cross/Blue Shield Plans – to drastically alter their approaches to renewal rating of small-group business.

Whereas I tend to define "small group" business as under 50 lives, among various insurance carriers the small-group market segment ranges from under 10 lives to under 200 or more lives. While portions of this article apply to whatever definition of small groups a company has, it is especially geared toward the smaller-sized groups of under 50 lives.

In the past, many companies – particularly Blue Cross/Blue Shield Plans – treated small-group business as a single risk pool, with the same set of rates (employee-dependent or single-family) applying to all groups, regardless of their age-sex composition, morbidity experience, or new business vs. renewal status. In the case of life/health insurance companies, geographic factors, as well as age and sex factors, were typically applied. This approach to rating reflected the six basic rating principles: adequacy, reasonableness, competitiveness, equity, coordination with operations, and simplicity. However, simplicity was given far more weight than equity.

Built into this approach is the inherent disadvantage that each year the better-risk groups will tend to find coverage elsewhere, while the

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Tests for actuarial soundness for OASDI and HI

by John C. Wilkin

The 1989 Annual Report of the Board of Trustees of the U.S. Federal Old-Age, Survivors, and Disability Insurance (OASDI) Trust Funds (usually referred to as the 1989 OASDI Trustees Report) was released on April 24. Notably, the Board of Trustees removed the concept of "close actuarial balance" from the Report over the objections of Chief Actuary Harry C. Ballantyne. This is the first time that the Chief Actuary of the Social Security Administration has attached qualifying language to the Statement of Actuarial Opinion since it was made a part of the annual reports in 1981 (which was accomplished largely through the efforts of the then Chief Actuary, Dwight Bartlett).

The trustees justify their action by stating that they do "not want to put undue emphasis on the concept of 'close actuarial balance' by continuing to report on whether the actuarial balance falls within an arbitrary range of values" and that the test "might inappropriately influence the decision as to whether and when changes in the program's financing or benefit provisions are needed in the future."

Ballantyne (in a footnote printed in the Report) stated his belief "that 'close actuarial balance' is a valid concept, that it is generally accepted by the actuarial profession in evaluating the actuarial status of the OASDI program, and that it should be included in the report, continuing the practice in effect since the late 1950s" and that if "the concept were continued this year, it would show (using the alternative II-B assumptions) that...the combined OASDI program (deficit equal to 5.1% of its cost rate) is just barely out of close actuarial balance." In his Statement of Actuarial Opinion (attached to the Report), Ballantyne urges the trustees to reconsider their decision.

These two statements typify two schools of thought that have been developing over the last few years. One school wants a stronger test – which would be generally accepted by the actuarial profession – that could be used to determine the actuarial

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status of the OASDI and Health Insurance (HI) programs. The other school wants to eliminate the test.

The controversy surrounding the test has been fueled both by confusion over the traditional long-range test of close actuarial balance and by its weakness in dealing relevantly with the short-range financial situation. (There is no short-range test, other than the implied test that the funds should have positive balances.) The confusion over the long-range test stems from the changes made in the test through time and by the differences in the test as applied to the OASDI and HI programs. Because the long-range test is the only test, its inability to deal with the short-range financing situation is seen by some as evidence that the test is flawed.

The solution to this situation is a separate short-range test. Many believe that the lack of a short-range test contributed to the conditions in which the financial crises of the OASDI program that preceded both the 1977 and the 1983 amendments were allowed to develop. Also, the lack of a short-range test or a target trust-fund level leaves us with little guidance on the appropriateness of the large fund accumulation taking place in the OASDI trust funds.

Well before the 1989 OASDI Trustees Report was released, the SOA Committee on Social Insurance (following the suggestion of Bob Berin, the SOA Vice President who oversees the committee) had been debating the issue. The committee strongly agrees with Ballantyne's statement and, in fact, believes that not only should the old test be continued but also that it should be strengthened.

Currently, the committee has joined forces with the Committee on Social Insurance of the American Academy of Actuaries, chaired by Bob Myers. The committees are looking into a stronger test of actuarial soundness that would be generally accepted by the entire actuarial profession. The committees plan on making a public expression of actuarial opinion on their findings.

The committees see the need for two tests:

- a short-range test for minimum funding requirements to assure solvency (to state when immediate action is necessary), and
- a long-range test for close actuarial balance (to give an early warning that changes will have to be made, even though they may not be effective for many years into the future).

Members of the committees generally agree that the short-range test should not address any aspects of the financing philosophy other than solvency. Thus, the committees would like the test to avoid involving whether or not the system should be financed on a pay-as-you-go basis or on some advanced-funding basis (to level out tax rates, to provide for intergenerational equity, or for any other reason). As such, no test for a maximum trust-fund size would be included in the short-range test.

The committees offer the following tests for determining the actuarial status of the OASI, DI, and HI trust funds:

(1) A trust fund will be considered to meet minimum short-range contingency-reserve funding requirements if, over the first five years of the projection period, the fund ratio is projected to remain above 50%; or, if the fund ratio is currently below 50%, to increase to above and then remain above 50% and, in addition, be able to meet all obligations when due.

(2) A trust fund will be considered in long-range close actuarial balance if the 75-year income rate is between 95% and 105% of the 75-year cost rate.

The fund ratio is defined as the assets of a fund at the beginning of the year expressed as a percentage of the outgo during the year. The income rate for each year is defined as all noninterest income to a trust fund during the year expressed as a percentage of the year's taxable payroll, while the cost rate is defined as the total outgo from a trust fund during the year plus an amount to attain and/or maintain the fund ratio at a particular target level, all expressed as a percent of the year's taxable payroll.

The committees recommend a target fund ratio of 100%, which is judged to provide an appropriate level of contingency reserves. Although amounts held in excess of the 100% fund ratio level improve the financial strength of the trust fund, they are not necessary for the financing of the programs to be considered actuarially sound.

Although there is more than one acceptable method of combining the 75 single-year rates in the projection period into a single 75-year rate in

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order to determine the actuarial balance, the method used should take into account interest earnings of the trust funds, the starting fund balance, and the target fund ratio.

One proposed method for combining the single-year rates is to divide the present value of the numerators (e.g., the dollar amounts of all years' incomes) by the present value of the denominators (i.e., the taxable payrolls). A second proposed method is to determine the arithmetic average of the 75 single-year rates. The present value method was used in the most recent OASDI Trustees Report, while the average method was used in the most recent HI Trustees Report.

Because the committees' goal is to arrive at a test for actuarial soundness that is generally accepted by the actuarial profession, we would be interested in comments on the proposed tests. It may be that more than one test would be generally accepted. We believe, however, that the test will be more effective the more widespread its support and that, once adopted, it should not be changed without a compelling reason.

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SOA Annual Meeting

Plan on joining more than 1,200 actuaries from across the country at this year's SOA Annual Meeting October 22-25 at the Marriott Marquis Hotel in New York City. Anyone who has not received the preliminary program can obtain a copy by contacting the Society Meeting Department at (312) 706-3540.

To plan ahead, below is a list of dates, locations and topics for the 1990 SOA Spring Meetings.

April 5-6, 1990 Health/Pension	Dallas
April 30-May 1, 1990 Product Development/ Financial Reporting	Hartford
June 14-15, 1990 Financial Reporting/ Product Development	San Francisco

Editorial

Refocusing our attention to HIV infection

by Daniel F. Case

The number of AIDS cases reported in the United States during the first 26 weeks of 1989 was up 12% from the corresponding 1988 number. While this increase is much lower than the year-to-year increases of over 100% observed earlier in the HIV epidemic, we cannot expect the incidence of reported AIDS cases to peak within the next year or so. In early 1988 there was a bulge in reported cases, because the Centers for Disease Control (CDC) had broadened the surveillance definition of AIDS. Many cases that did not meet the old, narrower definition were counted for the first time. This reporting bulge, which lasted from late 1987 well into 1988, is still affecting the current period-to-period ratios of reported cases.

In June 1989 the U.S. General Accounting Office (GAO) issued the report, "AIDS Forecasting – Undercount of Cases and Lack of Key Data Weaken Existing Estimates." The report describes adjustments that the GAO made to 11 forecasts by various individuals or organizations (including two forecasts by the CDC). The GAO's adjustments reflected various undercounts (net of overcounts) inherent in the AIDS surveillance data that all forecasters used. In reviewing the CDC's 1988 (Charlottesville) forecast, the GAO adjusted the CDC's best estimate for cumulative cases through 1991 from 285,000 to something in the range of about 325,000 to 360,000.

These GAO adjustments do not mean that we should expect the impact of HIV infection to be significantly more severe than already anticipated. The GAO's adjustments reflect fatal HIV-related illnesses that have been occurring and will continue to occur but are not included in the CDC's count of AIDS cases. These noncounted illnesses include: (1) fatal HIV-related illnesses that are not included in the CDC's definition of "AIDS" for surveillance purposes, (2) illnesses of types included in the CDC's definition, but uncounted because they were diagnosed as AIDS without the use of CDC-required diagnostic tests, and (3) illnesses acceptably diagnosed as AIDS but never reported to the CDC. The GAO described a fourth type of undercount, consisting of illnesses meeting the CDC definition but never diagnosed. The GAO made no adjustment for this last undercount, because it found no empirical data relating to the degree of undercount. In adjusting the CDC's 1988 forecast the GAO noted that the CDC had itself made adjustments for some types of undercount, but not necessarily large enough adjustments.

The main lesson from the GAO report may be that the impact of the HIV epidemic that the nation has been feeling and will continue to feel is greater than the impact previously identified as related to HIV. Certainly, the insurance business is aware that it has probably not been identifying all HIV-related claims. In estimating the past and future impact of the HIV epidemic on overall claim costs, some provision for undercounting should be made.

In addition to discussing undercount problems overall, the GAO report discusses undercounts by transmission category (e.g., heterosexual). It also discusses various trends, such as trends in reporting delays and "hidden" trends in transmission categories. These are worth careful study.

In some respects the forecasting, or projecting, of the financial impact of the HIV epidemic is becoming less difficult. Information on the incidence of AIDS cases, on the length of time from infection (or from test positivity) to AIDS, and on the prevalence of HIV infection in various population segments continues to accumulate. On the other hand, there are problems that continue to make forecasting quite difficult. The average length of time from infection to AIDS may differ from what has been observed among a few relatively small groups of individuals, and it may change over time

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