# The Actuarial Update

VOLUME 15 NUMBER 1 AMERICAN ACADEMY OF ACTUARIES JANUARY 1986


## In this issue



### Enclosures

Included in this month's issue of *The Update* are the following:

- Government Relations Watch
- Special State Supplement
- In Search Of . . .

# Reserve Standards for Health Insurance Contracts

*The point/counterpoint editorials below present two views of issues raised in the discussion draft,* "Health Insurance Reserve Standards for the NAIC," *which is currently before the membership for comment. The draft is a product of the Health Subcommittee on Liaison with the NAIC Accident and Health (B) Committee; the comment deadline is March 1, 1986.*

## Point

**by Robert B. Shapland**

There exists, in my view, the need for further dialogue and a consensus regarding reserve standards for health insurance policies. This debate is not limited to health actuaries; reserve principles and practices are, after all, somewhat generic in nature. The clarification and resolution of issues surrounding health insurance reserves is a process that involves actuaries both in and outside the health field. For the purposes of this editorial, I am limiting my remarks to issues set forth in the discussion draft now before Academy members.

### Contract Reserves

The benefit ratio reserve proposal would establish reserves based on actual retrospective experience. This proposal is inappropriate in many circumstances. For example, many individual health plans are operated on a year-by-year, step-rated basis, with premium schedules adjusted annually (as necessary) to avoid annual prospective loss ratios greater than the insurer's benchmark. Let me label this the "YRT" rating system.

In adopting its loss ratio benchmark (55% for illustrative purposes), the insurer examines expenses, persistency, and intended risk charges. Let's assume its analysis shows that expenses the first year are 100% of premiums, while expenses in renewal years are 20%. Let's further assume that the insurer hopes to realize an annual "5% of premium" profit or risk charge. And finally, let's assume that the projected average

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## Counterpoint

**by E. Paul Barnhart**

In analyzing the viewpoint offered by Bob Shapland, here, it is important not to lose sight of the fact that we are discussing *statutory minimum* reserve standards. It is also necessary to analyze his comments in the full context of the revised statutory reserving system being recommended to the NAIC by the Academy's subcommittee in its totality, as well as in its immediate and direct relationship to existing standards. At times, Shapland's remarks appear to contemplate proposed changes in GAAP reserving principles, rather than statutory principles. And at times he discusses specific topics in isolation from, and out of context with, our proposed system in its totality.

The proposal now before the membership is an integrated reserving system. It cannot be adequately understood by examining various elements in isolation. Moreover, it is an evolutionary revision of existing standards, designed specifically to correct defects and weaknesses of those standards in light of today's needs and problems. We believe that careful evolution, which builds upon the foundation of established reserve principles is the prudent approach, rather than the revolutionary untested ideas that have their genesis in Shapland's proposed new starting point. Let me respond to his comments, point by point.

### Contract Reserves

Shapland asserts that benefit ratio reserves (that portion of our contract

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# Notes and Comments

**Stephen G. Kellison**

## Exposure Drafts: Your Opportunity to be Heard

As 1986 commences, the major initiative involving standards of practice shapes up as one of the highest priority activities of the Academy for the new year. The lead story in December's *Actuarial Update* was a feature article on the appointment of the Interim Actuarial Standards Board (IASB). You will be hearing a lot more about standards in the coming months.

I want to take this opportunity to address one key component in the development of standards; namely, procedures for handling exposure drafts. In fact, the main motivation for this editorial is to underscore the need for greater participation by members in commenting on exposure drafts.

The distribution of exposure drafts for comment is not really a new activity; the Academy has been doing it for several years, and in some cases the response has been outstanding. For example, the recent Discussion Drafts on Standards for Valuation Actuaries generated thirty-seven excellent responses, many of them quite substantive. On balance, though, taking a number of years into account, response to exposure drafts has been spotty, and certain of them would have benefited from greater membership input.

There are several possible reasons why response rates have on occasion been lower than desirable.

1. *"The drafts have been so good, no comment was necessary."*

   Although we might wish this to be true, it is doubtful. Most of our exposure drafts have been significantly improved by comments received, even when the response rate has been low. This reason, in essence, is a cop-out.

2. *"My comments won't really make a difference; the committee's mind is already made up."*

   Wrong. I personally have sat through enough meetings at which comments were being considered to appreciate the great care and attention paid to each and every comment. Members would be surprised at the impact even one comment letter often has.

3. *"I have one comment on one point I would like to make, but I am reluctant to make such a limited comment on such a major draft."*

   There is absolutely no reason to feel this way. Not every comment letter need be a magnum opus. Comment letters have ranged from one sentence to multi-page technical dissertations. Committees have appreciated and considered them all. In fact, the shorter responses may have significant impact because they are easier to digest!

4. *"I simply don't have the time or interest to comment."*

   Apathy, of course, is the most insidious and damaging problem of all. Standards are a vital professional activity that deserve the priority attention of every member. Can anyone imagine accountants not caring what the Financial Accounting Standards Board's pronouncements say or lawyers not caring what the courts and bar associations do in the area of professional standards for lawyers?

As the standards initiative gets going in 1986, I encourage all members to make a New Year's resolution to take a greater interest in standards and to increase participation in the process by commenting on exposure drafts. This will have several salutary effects: (1) Final standards will be improved. (2) Members will be more involved in the process. (3) The standards will have greater stature both within and outside the profession. (4) The standards will become a more useful resource to every actuary in day-to-day practice.

If you have any thoughts on how the entire exposure process can be improved, please send them to me. I will see that they receive attention and consideration by all appropriate parties.

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*Stephen G. Kellison is the Academy's executive director.*

## Letters to the Editor

### Tax Reform Shorthand

December's "Government Relations Watch" states that the Ways & Means Committee adopted a "limit of $7,000 for 401(k) plans, less IRA contributions."

That is somewhat misleading. The 401(k) limit is $7,000, regardless of an IRA. It is the *IRA* limit that is reduced (but not below zero) by *401(k)* contributions. The effect is much worse—it totally eliminates new IRA contributions for most high and middle income taxpayers who contribute to a 401(k) plan.

Albert L. Peruzzo
Chicago, Illinois

*Editor's note: Your comment is well taken. We regret the misleading statement. Simplifying a complex bill into one sentence to fit space limitations has its hazards.*

## CLRS Planning Underway

The Casualty Loss Reserve Seminar (CLRS) has achieved unique public prominence as an authoritative forum for professional discussion of property/liability loss reserving issues. Planning for the 1986 CLRS has begun. At the outset of this process, the joint program committee is seeking suggestions from *Actuarial Update* readers regarding subject matter (general topics, specific issues, current controversies, new reserving techniques, and so on), and guest speakers (individuals who are both able speakers and recognized property/liability insurance authorities). Volunteers to serve as panelists/moderators are, of course, welcome. Please indicate the topic(s) you would be willing and able to discuss. Send all suggestions by March 21, 1986 to Douglas F. Kline, Milliman & Robertson, Inc., 44 Montgomery Street, Suite 200, San Francisco, California 94104.

The 1986 Seminar will be held in Washington, D.C., September 29–30, at the Hyatt Crystal City.

## 1986 Yearbook and Standards

As readers of *The Actuarial Update* are aware (you are referred, most recently, to the lead article in last month's *Update*), there will be considerable attention devoted to standards of practice during 1986.

You are urged to review with care the section of your *1986 Yearbook*, when it arrives shortly, entitled "Procedures for the Development of Standards of Professional Conduct and Practice." This material was revised extensively to reflect the creation of the Interim Actuarial Standards Board (IASB) and was adopted by the Board of Directors at the same time the IASB was created.

These procedures deal with the development of standards and the exposure process; they contain important information for every member of the Academy. Δ

## Checklist of Academy Statements November 1985

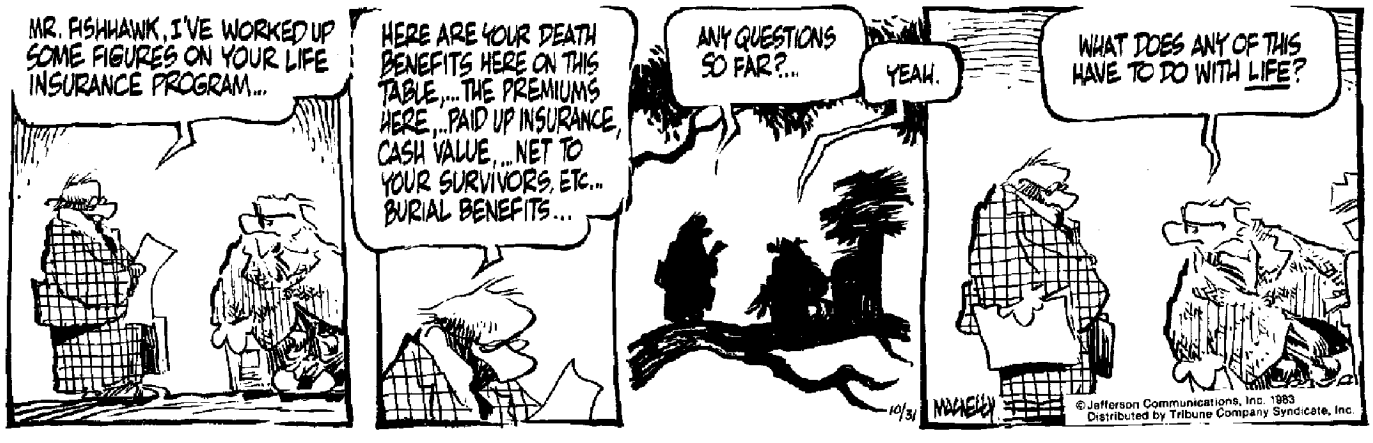
Copies are available from the Washington office.

TO: Pension Benefit Guaranty Corporation, November 5, 1985. RE: Multiemployer plans. BACKGROUND: Statement on notice of consideration involving assessment of withdrawal liability in fully funded plans.

TO: Pension Benefit Guaranty Corporation, November 13, 1985. RE: Multiemployer plans. BACKGROUND: Statement on proposed regulations involving allocating unfunded vested benefits.

TO: Healthcare Financial Management Association, November 18, 1985. RE: Continuing care retirement communities. BACKGROUND: Statement on an HFMA Exposure Draft on Accounting for CCRCs.

TO: Financial Accounting Standards Board, November 22, 1985. RE: Accounting for pension plans. BACKGROUND: Statement in response to FASB Exposure Draft on Accounting for Settlements and Curtailments of Defined Benefit Pension Plans. Δ



**POINT**
*(continued from page 1)*

policy life is four years and that interest earnings are ignored (for simplicity's sake). Given these assumptions, the average policy life expenses and risk charges would be 45% of premiums; the company would adopt the 55% illustrative loss ratio benchmark.

After introducing a plan under these circumstances, the insurer will begin to monitor experience. Claim experience will be projected based on (1) the assumed trend factors that will have an impact on claim experience for the coming year, and (2) the premium level raised, if necessary, to avoid a loss ratio greater than 55% in the coming year. Under this rating system, the retrospective loss ratio experience has no impact on prospective premium levels other than being the foundation for projections of future experience.

Given that the insurer is able to monitor, file, and implement premium adjustments that maintain this 55% prospective loss ratio, it is seen that the insurer will realize a 25% margin in each of the renewal years. Claims will be 55% and expenses 20% for a total outlay of 75%. Of course, the 25% margin is needed to recover the first year loss, as well as realize the 5% profit/risk charge. It might be noted that if actual experience is the same as assumed, the outlay the first year is 155% (i.e., 100% expenses + 55% claims), so that a 55% first-year loss needs to be recovered via the renewal margins.

Given this scenario where the future will produce large margins and my understanding that contract reserves represent the future shortfall of revenues vs. expenditures, it seems that the question is not one of what level of liabilities (contract reserves) is needed, but whether or not regulators are justified in completely ignoring assets (i.e., the recoverability of the initial 55% investment in new business) in measuring the solvency of the insurer. Under level premium plans, regulators have agreed to recognize to some extent the recoverability of the initial investment through modified reserve plans. I believe consideration should be given to such recognition under YRT plans. In any event, setting up contract reserves based on retrospective experience, as proposed, neither serves any purpose nor has any actuarial or accounting foundation.

The preceding example is one of many where the proposed contract reserves are out of sync with actuarial/accounting principles, because the proposal ignores the rating principles and practices being used in determining the prospective premium stream. Other rating plans, such as those called for by National Association of Insurance Commissioner (NAIC) model rating guidelines, are more in tune with the proposal, and thus the proposal could more logically apply where the NAIC methodology is in place. Fortunately, the NAIC guidelines have achieved limited acceptance.

**Claim Reserves**

Given the YRT rating scenario outlined here, one must look to the logical treatment that should be given to the recognition of future claim payments that will be made on claims that have commenced prior to the valuation date for which the company is contingently liable. The contingencies involved can include: (1) the continuation of medical treatment, (2) the continuation of disability status, and/or (3) the maintenance of in-force status.

Given that the future will produce 25% margins, one might argue that only the excess of such contingent payments over these future margins need be recognized. A more conservative approach is probably appropriate, however, especially when the insurer intends that the contingent payments are to be paid by past policyholders when determining future premium levels. The proposal recognizes these contingent payments, but would delegate some of them to contract reserves instead of claim reserves. Especially in the situation where contract reserves are not needed for other purposes, it seems a strained position to label some of the future claim payments chargeable to past policyholders' "contract reserves." This delegation might also make it easier to overlook these claims or offset them with future margins.

Let's look at an example. Given a major medical policy under the YRT rating system described earlier, let's assume that the insurer is liable for continuing medical treatment after the valuation date only if the insured keeps the policy in force. Given this contractual arrangement, many insurers *might* decide that they should not rely on future policyholders to pay for these contingent claims, and therefore choose to charge them to policyholders in force at the commencement of the claim. Reasons for taking this position include policyholders' equity, safety, and avoidance of assessment spirals. In that event, it would appear reasonable to set up a claim reserve that includes these contingent payments.

It should be noted that if an insurer were to charge these contingent payments to "contract reserves," as proposed, the insurer would have to maintain a dual incurred date coding system. Each claim payment would have to be assigned an incurred date of the date of accident or sickness, as well as the date of medical treatment. As outlined in the discussion draft, future claim payments with both incurred dates prior to the valuation date would be called "claim reserves," while those with treatment dates after the valuation date but with accident or sickness dates before the valuation date would be called "contract reserves." I see no reason to adopt such a complex position. I recommend that in this situation only the date of accident or sickness be coded and that claim reserves be established based on the singular incurred date.

**Miscellaneous Comments**

1. While I believe that underlying rating principles and practices should be the foundation for reserve standards, I acknowledge that one should not ignore their relative viability in actual practice. To the degree that there will be a future shortfall in revenues vs. expenditures, it should be

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## Author! Author!

The Casualty Actuarial Society (CAS) is sponsoring a textbook entitled *Foundations of Casualty Actuarial Science*. Intended for use on the CAS syllabus and in introductory college courses, the text will be an anthology of eight chapters (each with author credit): ratemaking, reserving, classification systems, expenses, credibility theory, individual risk rating, reinsurance, and special issues. Anyone interested in writing a chapter should telephone Irene Bass at (201) 953-4184 to receive information on how to prepare a proposal. Proposals must be submitted by May 1, 1986.

**COUNTERPOINT**

*(continued from page 1)*

reserve proposal that deals with benefits vulnerable to strong trends and external influences and therefore prone to frequent rates increases) would be based on "actual retrospective experience." This is only half true. The valuation net premiums implicit in the method are determined from *anticipated* gross premium loss ratios. Hence they are, obviously, *prospectively* determined.

The calculation is directly comparable to retrospective calculation of conventional tabular reserves, but with the important difference that actual retrospective experience is used rather than tabular assumptions. The authors of the discussion draft believe that this basis of *retrospective* calculation, using *prospectively* determined net premiums, is quite necessary, considering the types of benefits involved. This makes it possible for the reserves to adjust continually to reality, while the net benefit premiums, themselves, simultaneously adjust to the reality of changing gross premiums. The proposal also requires that the prospective anticipated loss ratio, itself, be periodically adjusted to reality, viewing reality both retrospectively and prospectively.

The single example that Shapland employs for illustration is a highly artificial and unlikely hypothetical case. Thus, if the insurer is underwriting the business, the first year may be expected to produce select experience. Even though the rating structure is "YRT" and targeted toward a lifetime 55% loss ratio, first-year select business should produce a lower ratio. If the first year in fact produces a 55% loss ratio, the business is probably already in trouble: large rate increases and antiselect lapsation are to be expected.

If the first year ratio is below 55%, our proposed basis produces a positive first year reserve (although the proposed method is modified—a fact that Shapland ignores and to which I will return), as it should. This result is similar to that obtained under a select and ultimate GAAP benefit reserve basis, where higher early-year reserves emerge than under a basis using aggregate or ultimate tabular claim costs.

But let's accept Shapland's scenario and assume that, every year, the loss ratio comes out as intended at 55%. If the assumed reserve ratio is also 55%, then the benefit ratio reserve will remain at zero throughout the lifetime of the business. This is as it should be: the fact that the method will produce a zero reserve in one case where it should, hardly sounds like an indictment of the method, as Shapland implies. Instead, it would appear that the method is working properly. Our proposal does suggest that some conservatism in excess of the minimum standard (the insurer's 55% benchmark, in the example) be considered. Thus, if the insurer initially adopts 57% as a modestly conservative benefit reserve ratio, then in Shapland's scenario, the method would accumulate 2% of gross premium income as a reserve margin, until the insurer makes any adjustment as a result of monitoring the experience.

A comment is in order here as to Shapland's "understanding that contract reserves represent the future shortfall of revenues vs. expenditures." Where statutory reserves are concerned, this only applies if the "revenues" are benefit net premium revenues (plus reserve interest) and the "expenditures" are incurred claims. It seems clear from Shapland's remarks that he is viewing this in terms of gross revenues and gross expenditures.

Shapland observes that "consideration should be given" to the use of modified reserve plans. This comment surprises me, since the proposal under discussion has specifically embodied such a modified reserve method from the beginning. Further, the discussion draft clearly states that this question remains under study by the subcommittee.

Shapland asserts that the proposed contract reserves are "out of sync" because the subcommittee's proposal "ignores the rating principles/practices being used in determining the prospective premium stream." As my preceding comments show, under his own example our proposed method, far from ignoring the insurer's adopted rating principles and practices, provides that contract reserves be *directly based* upon those principles and practices. One key difference, perhaps, is that our proposal takes the insurer's own 55% benchmark to be its adopted policy lifetime *target* with respect to benefit return measured against gross premium income; Shapland appears to view it more as a limiting *maximum*, not to be exceeded in any given year.

**Claim Reserves**

Shapland has repeatedly objected in the past, as he does again here, to the fact that our proposal recommends that a portion of what he calls "contingent payments" (that portion that the discussion draft refers to as claims not yet incurred) be provided for under contract reserves. He has not provided any substantial explanation as to why he considers it so important that they be covered, instead, under claim reserves. He suggests that provisions for such liability under contract reserves "might also make it easier to overlook these claims or offset them with future margins." I submit that the exact opposite is the case. A clear understanding that such liabilities should be recognized and provided for under contract reserves focuses upon their existence and makes it *less* likely they will be "overlooked" or "offset."

Our proposal provides for a very logical, simple, and objective division between claim and contract reserves: Incurred but unpaid claims should be provided for under claim reserves. Future *unincurred* claims, in excess of what is provided for under unearned premium reserves, should be provided for under contract reserves. This approach is a perfectly traditional one. The burden of demonstration must fall upon those who urge abandonment of established views.

Returning to his YRT rating scenario, Shapland observes that many insurers might not want to "rely on future policyholders to pay for these contingent claims, and therefore choose to charge them to policyholders in force at the commencement of the claim." He seems to imply that such claims are not being charged to the "inforce policyholders" if they are provided for by contract reserves instead of by claim reserves. I think he will find, if he will follow through the accounting under each alternative, that they are charged equally to in-force policyholders in either case, since the same aggregate reserve liability is established. Also, it should be observed that if such "contingent claims" are provided for by premiums paid prior to the valuation date on either basis, we are not dealing with "pure" YRT. There is a "level premium" element that is providing for future unincurred claims out of current premiums.

Shapland next informs us that an insurer "would have to maintain a dual incurred date coding system" if "contingent payments" are provided for under contract reserves. I see no need whatsoever for such "dual" dating. The

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# Modern Insurance 1960–1970: Change, Challenge, and Chance Survival

**by Wayne E. Moyer**

The 1960s came in like Chubby Checker's "Twist," took a generation "eight miles high," and left a nation dizzy. Skirts went from poodle to micro, Coke introduced the lift-top can, and FHA mortgages ran 5%. The decade rumbled by with the civil disobedience of the civil rights movement and the outright violence of the anti-war movement. The nation went from a President who would be assassinated to a President who would resign. And before it was all over, the man in the moon became man on the moon.

Architect Philip Johnson had said, "The '60s: we have happenings rather than plays. Art, but no painting. It's a challenge of chaos!" Single wage earner families did not mean single parent homes. There were big city power blackouts, hippies, and TV dinners. Doctors still made housecalls. Clothes that never wrinkled hit a marketplace where married men had an unemployment rate of 2.1%.

*A fixture of the decade: National Guard troops called in by state officials to break up anti-war demonstrations on a university campus.*

Winds of change blew heartily in the 1960s, changes that would irrevocably shape the actuarial profession. In 1960, the age requirement was dropped for the cash benefit program for disabled workers and, in California, Ronald Reagan was criticizing Social Security, suggesting participation should be voluntary. In 1962, two-thirds of the U.S. population owned life insurance, four out of five families were covered, and assets of the 1,500 U.S. life insurance companies totaled $132.5 billion. In 1961, Americans spent $6.7 billion for health insurance and, in February, 1962, President Kennedy urged Congress to create a self-financed system of health insurance for the aged under Social Security. The following month, Kennedy signed a bill designed to permit stricter federal control over employee pension and welfare plans.

Actuaries worried during the decade that their profession might be absorbed into accountancy. The accounting firm of Lybrand, Ross Brothers, and Montgomery acquired an actuarial arm by contracting with the Terriberry partnership and setting it up as a separate division to remedy the accounting firm's actuarial weaknesses. Actuaries questioned the propriety of accountants verifying liabilities of a company whose pension plan was established by the same firm's actuary. At a meeting of the Conference of Actuaries in Public Practice in 1965, an Ernst and Ernst spokesman assured actuaries that some auditors believed merging auditors and actuaries to be highly improper and that their firm (E & E) would make no move in that direction.

1962 gave us a trade ban on Cuban products, and by autumn the world stood still while the American President held world war and a naval blockade over the heads of Russians and their missiles in Cuba. On a more cheerful note, in July 1962, for one day the public was allowed to tour "the room" at Lloyd's, in celebration of the Festival of the City of London.

The strong Democratic government in Washington at mid-decade would give the insurance industry all the impetus for change that it could handle. In 1964, during an Ann Arbor speech, President Johnson first called for a "Great Society," and a year later he instituted "Creative Federalism." That year the President's Committee on Corporate Pension Funds made several recommendations over concern about avoiding pension fund failures. The committee envisioned raid funding of current liabilities and past services and called for portability in private plans. Also urged were employers' plans that were insured against termination.

In '64, the U.S. Surgeon General pronounced the cigarette habit unhealthy, and the FTC set label warning requirements. Lyndon Johnson resumed the Medicare proposals of Kennedy, while half-way round the world, Belgian doctors held an eighteen day strike to protest a national health insurance law.

In 1965, only sixteen actuaries were working in various federal agencies. Many of the 1,600 life insurance companies were small sized, and the number of consulting actuaries was increasing. Many became involved in small companies and began entering the managerial end of business. A 1965 Fortune magazine study found forty-three Society of Actuaries Fellows as either presidents or chairmen of the board in both U.S. and Canadian life insurance companies.

A new chapter for actuaries was begun in 1966 with the first installment of the Medicare program. President Johnson presented the first health insurance identification card to Harry Truman, in

Johnson's words, "the real daddy of Medicare."

Purchases of new life insurance policies hit $100 billion for the first time in 1965. New trends appeared, such as "all-lines" insurance packages, electronic data processing, and the concept of group insurance as a distinct and separate insurance business. *Time* magazine noted in May 1966, "one of the fastest growing credit card items is insurance. Thirty card systems and charge account users now sell and service simple policies from travel and accident to term life insurance. First to try it on a large scale was Los Angeles' Beneficial Insurance Group which teamed up with Diner's Club in 1959. Now, [1966] Standard Oil Company (Indiana) sells auto and travel accident policies and a department store sells term life to charge account customers."

High risk insurance matured in the mid-decade market and at times resembled the old betting atmosphere of centuries past (but minus some of the fun). Jumbo jets and super-tankers became large scale carriers. Lloyd's Underwriters suffered their heaviest loss year in history, 8.2% in 1965. The 1966 marine rate increases helped offset the losses of the preceeding two years.

In the U.S., the January, 1966 fire of Chicago's McCormick Place exhibition center resulted in the second largest payment in insurance history on a single structure ($22.4 million). New classifications for auto and fire in high risk urban areas were developed to serve cities already experiencing racial strife. Riots erupted during the long hot summer of '67 and again in '68. Losses of $100 million were paid on the Newark and Detroit rioting alone. The riots in urban centers were the most disasterous losses for property insurers in 1967, when thirty-six U.S. cities were effected between April and August.

Insurance companies redesigned contracts to supplement Medicare, begun in July 1966, and many individual and "over-65" plans became obsolete. Although hospital use did not increase more than the 5% predicted, hospital costs increased several times that rate. The 1965 authorized rate increases took effect in 1966, and the life insurance industry had a 12% growth over the previous year. Property and liability insurance rose 10%, a record $20 billion. One third of the growth in life insurance that year came from the new Serviceman's Group Life Insurance program begun late in 1965. Policies in force hit the $1 trillion mark after a 7% growth in 1967 when the average U.S. family held life insurance policies worth $16,000 (the average income for two years).

Several states began experimental programs in 1968 to guarantee benefits in automobile claims regardless of fault. The Department of Transportation began a two-year study on auto insurance, and the Senate Anti-Trust and Monopoly Subcommittee held hearings on the automobile insurance industry. The Senate also inaugurated a federal reinsurance plan for state and industry programs that insured property in riot-prone urban areas. Changes based on the first comprehensive revision of the homeowner's multiple-peril insurance program since 1959 were adopted by many states. The new National Flood Insurers Association was instituted in 1968, backed by the federal reinsurance program. As Wilbur Cohen, an architect of the Social Security System, was named Secretary for Health, Education, and Welfare, Part B Medicare payments through private insurers serving as U.S. agents rose sharply.

Property and liability insurers had a break-even year in 1968 with a 100% loss and expense ratio, yet the insurance industry as a whole had an 8% growth that year. Health insurance continued to broaden and the industry maintained another large growth year, a 9% increase over 1968. Policies in force now totaled $1.25 trillion. President Johnson signed an Omnibus Social Security bill increasing benefits by 13% and announced he would not seek re-election. June 1968 ended a fiscal year with a $23.4 billion deficit and began a new year with a record $186 billion budget.

President Nixon urged Congress to stop raising expenditures and cutting taxes at the same time. He signed a tax reform bill in December, 1969, pledged to prevent an unbalanced budget in 1971 and gave a 10% increase to Social Security.

The last year of the 1960s represented both the hope to survive the decade and absolutely no resemblance to the decade's new beginnings. Richard Nixon was elected partly in response to the nation's recoil from the eight years of Democratic influence and to Nixon's "secret plan" for ending the Vietnam war. A month after the new President took office, Dwight Eisenhower died and so, too, did much of the nation's past. The death toll in Vietnam now exceeded the Korean war, and the Saturday Evening Post suspended publication. Prophetically, the magazine that brought Norman Rockwell's calm, warm America into the home slipped from newstands that headlined college riots and closings. While man walked on the moon he had only gazed at a decade earlier, 250,000 people rallied in Washington, D.C. for peace on earth.

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*Wayne Moyer is a free-lance writer and contributing editor to* The Actuarial Update.

## Non-Routine Board Actions

The Board of Directors at its December 4, 1985, meeting took the following non-routine actions.

- Approved the 1986 budget recommended by the Budget and Finance Committee and the Executive Committee.
- Supported the concept of continuing education recognition set forth in the report of the Joint Task Force on Continuing Education Recognition; authorized the president to appoint a task force to develop an Academy recognition program consistent with the joint task force program, but tailored to the specific requirements of the Academy, including a plan for implementing such a program, all to be submitted to the board for its approval at a later meeting.
- Authorized exposure as a discussion draft of a Committee on Health Subcommittee paper on health valuation standards, together with a cover letter describing the context in which the paper was written, with appropriate reference to alternative views on the subject.
- Authorized the president to commit the Academy to joint sponsorship of a healthcare meeting in 1987, provided other actuarial organizations are willing to participate in such joint sponsorship.

**POINT**

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recognized independent of rating principles.

2. I believe that the desirability of simple reserve rules should not be allowed to overshadow the need for reserves attune with basic actuarial and accounting principles.
3. Future major medical claim payments contingent on continuing in-force status may involve higher probabilities of continuation of in-force status than the probability of continuing disability status under disability claims. In fact, where premiums have already been paid beyond the valuation date, continuing in-force status is a certainty. Similarly, the grace period guarantees continuation for thirty days. Therefore, drawing a distinction between these two contingencies as proposed seems illogical.
4. Because of the pervasive nature of the grace period provision, I believe the liability it creates needs to be given greater recognition in any reserve proposal.
5. Many life insurance plans are being managed on a basis similar to the YRT basis, as outlined. If contract reserves based on retrospective experience are appropriate for YRT health plans, wouldn't they be similarly appropriate for YRT life plans?
6. Under unearned premium reserves, if a 60% loss ratio is in use, the proposed minimum reserve becomes 70% of the pro rata unearned gross premium. Thus, only 10% is set up to cover related unpaid expenses not reserved elsewhere. I wonder if any study was made to support such an expense assumption. An alternative system would be to add a constant conservative expense percentage to the loss ratio.

While I concur that setting up reserves based on 100% of the unearned gross is unduly conservative, this conservatism has provided policyholder protection under fast-growing companies with insufficient mature experience to establish the soundness of their actuarial assumptions. Therefore, setting more stringent surplus requirements related to the amount of business in force might be considered if this proposal is adopted.

**Summary**

The starting point in developing health insurance reserves is the recognition of the rating principles and practices in use in conjunction with basic accounting principles. This leads to defining "claim reserves" as the present value of future claim payments chargeable to past premiums, and defining "contract reserves" as the present value of the shortfall of future morbidity premiums in meeting claims chargeable to future premiums. Where future morbidity premiums are adjustable, they would be determined consistent with the applicable rating principles and practices in conjunction with the impact, if any, of retrospective and prospective claim experience.

This is the starting point, and the results would be modified for "NAIC conservatism" and for any invalidity of the rating principles and practices based on current and foreseeable future circumstances. Resulting liabilities would be modified, directly or indirectly, by recognition of the present value of the margins in future expense premiums, which have been adopted to amortize initial expenses taking into account "NAIC conservatism."

While this approach may be complicated if a multitude of rating principles and practices are in use, disregarding the impact of valid rating principles and practices is seen to produce confusing, if not meaningless, reserves. Δ

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**COUNTERPOINT**

*(continued from page 5)*

incurred date, under the example cited, should be the date of treatment. The most prevalent version of major medical insurance that covers expenses on a date of service basis is "all-cause" deductible major medical, with "all-cause" calendar year maximums. Benefits are not determined on the basis of specific accidents of sickness, unless the cause predates issue or is excluded by impairment rider, in which case the question is not the date of the injury or illness, but simply whether it is an excluded cause. One of the significant administrative advantages of such a plan is precisely that it is unnecessary to assign claim payments to specific causes, as must be done with "per cause" major medical that pays benefits in relation to "per cause" benefit periods and maximums. The subcommittee can find no valid basis on which we can or should obligate insurers with all-cause calendar year plans to date claim payments incurred in a given calendar year back to earlier years due to the inception date of a continuing cause. There is no justification for adopting such a rule as a minimum standard requirement.

**Miscellaneous Comments**

Space permits me to respond to only one of Shapland's numbered comments.

Apropos of comment six, I find it surprising that Shapland worries about the wisdom of the subcommittee's recommendation that minimum unearned premium reserve requirements be reduced, yet, in discussing contract reserves, he doubts that regulators are justified in their very limited recognition of the recoverability of acquisition costs. I suggest that minimum reserve requirements would be weakened far more, on balance, from full recognition of recoverable investment in new business than from adoption of our recommended change from gross unearned premiums to the modified net unearned premium basis proposed.

**Summary**

The point of view that Shapland offers here would appear to be that of advocating total abandonment of existing regulatory reserving philosophy and principles in favor of a highly subjective variation on GAAP accounting, under which each insurer is free to determine its own unique reserve requirements on the basis of its own preferred set of "rating principles and practices." Depending on the spectrum of such "rating principles and practices" as might be judged "actuarially sound and acceptable," there is nothing inherently wrong with such a position, but I think an extensively researched and carefully and thoroughly reasoned case for any such fundamental change in regulatory philosophy would have to be fully developed before it could be seriously considered by actuaries or regulators.

Shapland's proposed dependence on subjective preferences as to rating principles and practices, on the part of each insurer, meanwhile comes through to me as a blueprint for *de facto* deregulation: a "non-system" that the Subcommittee on Liaison with the NAIC Accident and Health (B) Committee believes the NAIC is highly unlikely to accept or even consider in the foreseeable future. Δ