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INDIVIDUAL MEDICAL -- STATE REGULATORY ISSUES

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- Loss-ratio requirements
- Getting forms and rates approved
- Compliance and reporting issues

MR. WILLIAM F. BLUHM: Bill Bugg is the chief actuary of American Family Life Assurance Company (AFLAC) in Georgia. He has 20 years of group experience and ten years of individual experience. Most importantly, he was the chair of the State Health Issues Committee after Paul Barnhart's term. He reigned over a good part of the history that took place in the ongoing saga of the National Association of Insurance Commissioners' individual rate filing model.

Bob Cumming is a consultant with Milliman & Robertson, Inc. (M&R) in Minneapolis. Bob is a consulting actuary in the health area. Among his credits is that he won the Part One contest as a student. He also was one of the editors of the textbook *Group Insurance*. Bob will be talking about Minnesota health care reform.

Many of you probably know Morton Hess as the name on the bottom of some important letters from the Insurance Department in New York. Mort is going to talk a little bit about the political pressures and frustrations that he finds with Regulation 62, which is New York's monitoring regulation, and the new community rating law. Mort's background has been with government employers: two stints with the New York State Insurance Department, one with the National Health Insurance Task Force under the Carter Administration, a precursor to the Health Care Finance Administration (HCFA), and ten years with the New York State Employee Program.

MR. WILLIAM J. BUGG, JR.: In the summer of 1988, the AAA Committee for Liaison with the NAIC (B) Committee first met to consider revisions to the NAIC's model for rate filing guidelines for individual health insurance. This process has now been under way for over five years. I was a member of that committee, which was then chaired by Paul Barnhart. I succeeded Paul as chairman of the committee in 1989 and served in that capacity until 1992 when Bill Bluhm took over. So I was a direct participant in the work done by this committee until last fall. It should be noted that the name of the committee was changed in 1991 to the Committee on State Health Issues. I will simply refer to it as the "Academy Committee" or the committee. I have decided to break down the history of the development of the rate filing guidelines into five stages:

1. The first is the development of the first exposure draft by the American Academy of Actuaries (AAA) committee exposed in July 1989.
2. The second stage consists of the time spent discussing the first draft, introduction of concerns from the regulators, discussion of these concerns, and continued drafting and redrafting of language for the guidelines.

3. The third stage is the period during which the task force created a working group of regulators who assumed the drafting.
4. The fourth stage starts when the focus was narrowed to medical expense only and the AAA committee augmented by the Health Insurance Association of America (HIAA), Blue Cross/Blue Shield, and the NAIC prepared a new draft.
5. The fifth stage started last December when the medical expense document was rejected in favor of an all encompassing guideline. The task force again took over the drafting work.

The Academy committee was asked to work on this project after the A&H reserve standards model was revised. Many of you will remember that process took a long time. Under consideration was a new reserving technique, loss ratio reserves. After much debate, this concept was not adopted in the reserve standard.

However, some of its advocates suggested that the rate-filing guidelines be updated and this concept somehow be included. No suggestions were provided as to how this was to be accomplished. Nonetheless, the Academy committee accepted the request to develop a new updated rate filing guideline.

Several meetings were held during the later part of 1988 and the first part of 1989. These early sessions involved a lot of brainstorming of various ideas and approaches. Should regulation vary by renewability clause, type of rate structure, or type of benefit? Should separate guidelines be developed for different types of products? Would limiting expense loads be preferable to regulating through benefit loss ratios? Are there group products that should come under the guidelines, situations which are akin to an individual who pays 100% of the premium. Could criteria be established under which an insurer would be permitted to use rates once they have been filed without getting approval?

Gradually, a structure for revised guidelines was formulated. A draft was prepared for presentation to the Actuarial Task Force at its meeting in Cincinnati in June 1989. The important changes include the following:

1. Scope -- the scope was changed to include coverage offered to individuals under a group policy whenever the group health insurance laws or regula tions of the state require the benefits to be reasonable in relation to premiums for such coverage.
2. Loss Ratios -- the loss ratios were increased to: Optionally Renewable -- 65%, Conditionally Renewable -- 60%, Guaranteed Renewable -- 57%, and Non-Cancelable -- 52%.
3. There was just one set of loss ratios for all products unlike the existing model.
4. No change was made in the renewability.

Along with the increase in the loss-ratio standards, there was a revision in the small premium adjustment such that the loss ratio would be reduced for annual premiums under $2,000.

There was no large premium adjustment. The calculation of the average premium continued to be based on annual mode premiums.

Optional prefiling of rates -- a major addition, this provision permitted an insurer to submit changes to rates on previously approved forms.

Such rates would take effect not sooner than 30 days after the submission, provided all requirements of the guidelines were fully compiled with.

There were a number of requirements associated with optional prefiling:

- Certain experience data was to be compiled annually.
- An analysis of Actual to Expected ratios by duration was needed to determine the need for corrective action.
- A regulatory liability was required to be established, the amount of which would be equal to the difference between cumulative actual claims and cumulative expected claims when actual claims are less than expected.
- In the event corrective action was indicated, a plan was to be submitted to the Commissioner by October 1. A corrective plan might include premium reductions, dividends, benefit increases, or some combination thereof.

The task force reviewed the draft and made several changes:

- The regulatory liability was made into a general requirement not confined to the optional prefiling.
- The annual compilation of data associated with optional prefiling was also made a general requirement.

The optional prefiling provision was certainly the most important element introduced in the draft. While the document was drafted to continue covering all A&H products, this one section was in effect written for inflation-sensitive products which have frequent rate increases, like major medical. If adopted and utilized, it would provide a way to get rate changes into effect quickly. At the same time, it would provide assurance to regulators that a company was staying on top of its business and meeting target guidelines.

Exposure of the draft was made possible by the Health Section which mailed it to all its members in July 1989.

Following the disclosure, the second stage of development commenced with a period of discussion and debate on various sections of the draft.

The committee received and reviewed a total of 32 letters. A summary of those letters was composed and submitted to the task force by Paul Barnhart at the October 1989 task force meeting in San Francisco. The comment letters expressed many different concerns but there were eight items that appeared in most of the letters.

1. A lack of uniformity and consistency in state regulation of A&H premiums.
2. That the single guideline structure in trying to cover all types of benefits and renewal guarantees was attempting to do too much. (They pointed out that

much of the draft had relevance only to those benefits whose future costs are sensitive to ongoing inflation and trends in medical costs and practice.)
3. Inclusion of some group contracts within the scope of the guidelines.
4. Specification of interest rate assumptions.
5. Regulatory liability. (Objections centered on whether or not this liability was needed within the rate filing guidelines rather than within the reserve standards. Other comments suggested that the regulatory liability only apply when the optional prefiling was utilized, which is the way the original draft was written. On this point, the task force later decided to require the regulatory liability only when optional prefiling is used.)
6. The specific guideline loss ratios and average premium size adjustments,
7. Monitoring requirements.
8. Corrective action.

There emerged several dominant issues during this stage. Some of those issues ultimately resulted in proposed changes to the rate filing guidelines, while others were debated throughout the various stages of development of the revised guidelines. The scope was one of these. In drafting the scope, the committee intended that the guidelines cover those policies that had individual characteristics:

1. Individual solicitation
2. Individual underwriting
3. Individual pays "most" of the premium.

There was considerable debate concerning how to include those group policies that had all the characteristics of individual insurance. The Scope section was and continues to be a major issue.

REPORTING OF EXPERIENCE, STATEWIDE VERSUS NATIONWIDE

In the months following the exposure draft, there was discussion as to whether experience data should be reported on a statewide, multi-statewide, or nationwide basis. The task force asked the committee at the Baltimore task force meeting in June 1990 to address this question.

The AAA committee's response was that a basis other than nationwide should not be permitted unless credible. Assuming the experience cell is credible, the insurer should be permitted to report experience on either a nationwide, a statewide, or some other basis for purposes of monitoring loss ratio and other monitoring purposes. The basis to be applied should be stated in the initial filing. This could be changed without approval by the insurance department.

The task force disagreed with the committee's recommendation. Some felt that reporting of data by state must be required; others felt that state data should be provided on all credible cells/forms.

SUBSTITUTION OF ACTUAL CLAIMS RUNOFF FOR IBNR

Some members of the task force felt that the substitution of actual claims runoff for IBNR should be required.

The AAA committee recommended that the substitution should not be required in general. However, they identified two situations where substitution of actual claims runoff for incurred but not reported (IBNR) would be meaningful.

1. When trend factors for projecting future medical experience are based on actual experience, then actual claim runoffs should be used in place of estimated values in determining incurred claims for purposes of developing historical trend factors.
2. When the change in medical claim liabilities and reserves is more than 10% of the claims incurred experience being used as a basis for rate calculations, then the beginning and ending claim reserves and liabilities should be replaced by the actual claim runoffs.

COMBINATION OF FORMS

Combination of forms was another topic on which the task force asked the committee to comment. In general, the committee believed in the concept that each homogeneous block of policies should be self-supporting over its lifetime and that it is inappropriate under this premise to subsidize older issues with newer issues. Therefore, it was suggested that the combination of forms no longer being sold should be a function of the size of the block of business under the form. William Bluhm, using stochastic modeling, determined that when the block of business has declined such that the number of actual claims in a year is less than 200, the business under the form should be combined with similar forms in the same class.

GUARANTEED RENEWABILITY

Concerns regarding renewability arose in spring 1990. Would all policies be at least guaranteed renewable if the prefiling option is used, and the task force asked the AAA committee to consider a guaranteed renewability requirement.

The AAA committee concluded that such a requirement would be counterproductive reducing the appeal of the prefiling option. The task force felt otherwise and finally concluded that guaranteed renewability for medical expense products should be a given regardless of the filing arrangements.

RATE INCREASE CAPS/AFFORDABLE AND PREDICABLE

An issue regarding maximum rate increases was created with the introduction of the prefiling option to the guidelines. Some felt that the prefiling option would not be supported unless there existed a rate increase cap in the guidelines. The task force, concerned about the affordability and predictability of premium rates, asked the committee to place a limit on premium increases.

While the AAA committee did not endorse rate increase caps, it recognized that a limit might be needed in order to gain acceptance from regulators and the public.

A dynamic limit which would reflect the environmental factors affecting rates would be favored; however, such an approach could not be found. What was finally suggested was: a limit of 60% within any 12-month period, and no more than 100% within any 24-month period.

The task force members response was that these limits were too high. Following the task force meeting in Los Angeles in fall 1990, the task force began drafting the guidelines, the beginning of the third stage. An A&H working group was appointed to work on the project.

The working group was initially made up of the states of Illinois, Florida, New York, California, and Oregon. Over time, the members of the working group changed.

Several topics were discussed on a continuing basis. Among them were:

1. Rate increase caps
2. Method for calculating refunds -- an addition to claims or a reduction in premiums
3. Higher loss ratio under prefiling.

During 1991, many important topics emerged which took time away from the effort to revise the rate-filing guidelines such as:

1. Long-term care nonforfeiture and valuation projects
2. Omnibus Budget Reconciliation Act (OBRA) 90 medicare Supplement changes
3. Small-group reform.

Attention did not refocus on rate filing guidelines until mid-1991 when the AAA committee was asked to comment on a set of proposed changes to the model rate regulation in response to a request made by the task force. Once again, requiring guaranteed renewability for optional prefiling and caps on rate increases was proposed.

For the first time, the task force suggested a 65% minimum loss ratio. Instead of rejecting or accepting the specified minimum loss ratio, the AAA Committee put forth a set of principles to aid in the determination of the minimum loss ratio, the focus of which was expenses.

Because of these principles, the AAA committee strongly recommended that an expense study be taken and that the minimum loss ratio be set following the analysis of the survey. The committee volunteered to assist the task force in developing the expense survey questionnaire.

In a response to a proposal that benefit ratio reserves be included in the guideline, the committee stated that there is no appropriate, logical, and consistent way to include benefit ratio reserve methodology in the rate filing guidelines.

The AAA committee prepared a survey questionnaire to be used in gathering data on major medical expenses from insurers. The A&H working group determined that the survey should be broadened to include all A&H lines except Medicare supplement, long-term care, credit health, disability insurance (DI), and group conversions. The survey was conducted in November 1991 and the results were released in August 1992. The results of the survey indicated that total expenses ranged from 36% to

52% of premium, with an average of 42%. Unfortunately, the type of business and mix thereof varied and the data was collected in aggregate.

At the October 1991 task force meeting, the A&H working group put forth three major issues to be included or addressed in the second exposure draft. First, the working group felt that all medical expense policies should be guaranteed renewable.

In situations where the business becomes untenable, the entire block could be terminated. Second, the following caps were proposed by the working group:

	Annual	Over Two Years
Pre-Filed Policies	20%	35%
Prior Approval	30%	50%

Third, the working group called for the minimum loss ratio to be set at 65%. It was not clear whether this ratio applied to everything or just medical.

The second exposure draft was proposed and prepared for disclosure at the December 1991 task force meeting in Houston. Several new elements appeared in this draft.

COMMISSION LIMITATION (NEW)
There was a new subsection that placed limits on renewal commissions. Renewal commissions could not increase more than the increase in the consumer price index (CPI).

VARIATION OF RATES WITHIN CLASS AND BETWEEN CLASS (NEW)
A provision that limits the variation in rates for similar benefits and similar risks by no more than 67% within a class and by no more than 100% between classes was added.

Distinct "classes" may be established only to reflect substantial differences in expected claims experience or administrative costs.

RESTRICTION ON USE OF PREFILING OPTION
A restriction on the use of the prefiling option was added. All forms of the same type must use either prefiling or prior approval.

NATIONWIDE VERSUS STATEWIDE, CREDIBILITY
New language covering the issue of nationwide versus statewide experience and credibility was added. Once the cumulative state experience during the monitoring period reaches 1,000 or more claims, then the state's experience is deemed fully credible.

RISK AND RENEWAL CLASSIFICATIONS

With the introduction of the Houston exposure draft, there were changes to the risk and renewal classifications. Two new classifications were added: the nonrenewable (NR) classification and the qualified renewable (QR) classification. The nonrenewable classification was developed for short-term policies of up to one year. QR was for medical expense. Rates could be changed but cancellation was restricted.

If a carrier elected not to renew any health expense plan except as provided, the carrier may be prohibited, along with its affiliated carriers, from writing new health business in the state for a period of five years from the date of notice to the commissioners.

HIGHER LOSS RATIOS

Higher minimum loss ratios were incorporated in the Houston exposure. Both QR medical and GR medical indemnity were increased to 60%. Loss of Income and Other were increased 5%. Modal loadings could no longer be excluded.

RATE INCREASE CAPS

Rate increase caps were introduced which applied to all rerate filings regardless of whether those filings were under optional prefiling or prior approval.

The maximum rate increase to any policyholder could not exceed 30% within any 12-month period and no more than 50% within any 24-month period.

Other additions and changes made in the second exposure draft were: (1) the addition of combination of forms section -- the combination of forms language was the same as the AAA Committee's proposal submitted in August 1990; (2) Addition of retroactive clause -- premium rates could be revised and filed according to the standards in place prior to the effective date of the revised standards for a period of two years; (3) All rate revisions and filings would be subject to the revised standards after two years following the effective date of the revised rate filing guidelines; (4) Any refunds of premium dividends under the prefiling option shall be treated as deductions from premiums.

At the Houston task force meeting, the task force recommended that the second proposed exposure draft be released for exposure with a solicitation for comments to be received before March 1, 1992. Those comments submitted were to be discussed at the Spring 1992 Zone Meeting in Seattle.

Stage 4 started with the task force's 1992 spring meeting in Seattle. The task force decided to limit the scope of the guidelines to medical expense coverages subject to inflation.

The working group had a meeting in Chicago in May, and representatives from the AAA Committee, HIAA, Blue Cross/Blue Shield Association, and the NAIC were invited. Following the task force's meeting in Washington, D.C., the AAA committee was once again asked to assist with drafting another document. Representatives were: HIAA, Bill Weller and Tom Stoiber; the Blue Cross/Blue Shield Association, Karl Madreki and Jim Swenson; and the task force, Rick Diamond.

A letter was received from the Working Group itemizing certain concepts that were to be followed:

1. The guidelines should apply only to medical expense coverages subject to inflation.
2. Loss-ratio standards should apply on a "block" basis rather than a policy-form basis.
3. Prefunding of durational deterioration would be required.
4. The definition of qualified renewability was to be broadened to:
   a. Incorporate portability for Health Maintenance Organization (HMO) and Blue Cross/Blue Shield coverages as well as that for commercials, and
   b. Include a provision permitting a carrier to withdraw from the market and not renew existing business provided such provision was to include similar conditions as is included in the small group model, and a requirement that alternative coverage must be found for the nunrenewed policyholders.
5. The rate constraint that premiums could not vary by more than 1.67:1 within a class, and the 2:1 between classes should be included as it is included in the small group model.

It was realized that several of these concepts, the within-class and between-class limits, block rating, durational prefunding, and rate increase caps all address the problem of durational rating but from a different direction. The committee was asked to consider the interaction between the several provisions.

Also, the committee was asked to address the treatment of managed care and other claim administrative expenses. How could they be treated as claims for purposes of loss-ratio compliance?

The committee received a formal written request in late June and was given a target date of early September for completion. Meetings were held during July, August and September, and a draft was prepared by the first of October.

A SUMMARY OF THE MAJOR CHANGES

The scope was changed to limit the application of the regulation to just medical expense. The regulation was intended to apply to coverage sold to individuals outside the employer marketplace regardless of whether the form was individual or group, and to small groups if there was no small group regulation.

Under QR, the insurer could not renew provided replacement coverage was found. The insurer was prohibited from reentering the market for five years.

Variation in rates within a class could not vary more than 67% and between classes by 100%. Also, a rate increase for a form could not exceed the increase in new business rates by more than 10%.

A new section was added requiring prefunding of the durational effect. This section described the method to be used.

In the determination of the one's loss ratio, modal loadings could be omitted. However, reasonable constraints were placed on the value of such loadings.

A 60% target was proposed for all renewability clauses, the same level that was used in the draft exposed in Houston. The expense study made by Bob Duncan on behalf of the task force indicated that expenses for the respondents in aggregate averaged 42%.

If rates increased by more than 30% within 12 months, then alternative benefits must be proposed such that the rate adjustment would not exceed 30%. Under the prefiling option, the limit was 20% in 12 months and 35% in 24 months. A table of leveraging factors was included to adjust these limits for high-deductible plans.

Claim expenses in excess of 3% were permitted to be treated as claims for purposes of loss-ratio compliance. Rules for determining such expense were provided.

The required contents for rate filings was redone and expanded. In the drafting of this document, there were a number of areas that were difficult to handle.

SCOPE

It was assumed that small group regulation would be in effect. The document was, for the most part, written with individual pricing concepts in mind. Debate continued about the treatment of associations. As written, it applied to associations.

It was recognized that the filing requirements would be a problem for legitimate association business. It was not likely that the loss-ratio requirements would be a problem.

PREFUNDING OF DURATIONAL DETERIORATION OF EXPERIENCE

Reserve requirements were not addressed in the draft, possibly indicating that this is a matter to be covered by reserve standards.

Attained-age rating and the cash method (typical Blue Cross approach), present some unique problems that require averaging techniques based on anticipated new business distributions, both by age at issue and by calendar year.

The prefunding requirements will result in higher initial rates, but rate increases would be moderated. The need to choose sound claim cost assumptions in pricing is not lessened. If an inadequate claim cost table is chosen, then large increases may still be needed.

The method does require that a claim cost table be available. Many practitioners do work from claim cost tables, but some do not and instead work from projected ratios.

CREDIBILITY

There are contradictory objectives that affect credibility. There is the state regulator's interest in seeing state experience which creates smaller, less-credible cells. On the other hand, there is the desire to look at experience on a block basis. Also, things such as reinsurance, large claims, and small numbers affect credibility. A reasonable approach is needed for spreading risks across as broad a base as possible.

BLOCK RATING

The meaning of block rating was another problem. At one extreme was an approach where all forms would be rated from one rate manual, like having a group rate manual. This would seem to lump all forms within a class together. Rate adjustments for all such forms would be determined simultaneously.

At the other extreme was an approach to continue to rate by form. The rating restraints within and between classes would be viewed from a block perspective. If necessary, a subsidy would be spread across the block.

The A&H working group made several modifications to the document. The loss ratio for GR and QR was increased to 65%. The rating constraints within and between classes were sharply reduced to 20% and 44% respectively. If rate increases, whether for optional, prefiled, or regular filed, exceeded 25%, then benefit modifications had to be offered.

The draft was presented at the December NAIC meeting, noting that there were areas that needed further development, such as the durational-rating concept, block-rating approaches, expense reduction for efforts to control claim cost, and credibility.

The (B) Committee asked the task force to address several issues:

1. Investigate the feasibility of a 65% minimum loss ratio for all lines of health insurance.
2. Investigate the feasibility of linking rate increases to some medical care cost increase index.
3. Prepare clear and concise procedures for combining small and closed blocks of business with actively marketed blocks.

The fifth stage in the development of new rate filing guidelines started at this time. Responding to the (B) Committee's request and feeling that the prefunding provision was too complicated, the A&H working group again took over the drafting work. Working from the AAA committee's draft, an initial draft was made available in June.

In response to the (B) Committee's question regarding whether a 65% loss ratio was feasible for all lines of health insurance, the task force simply changed the scope to once again include all lines except medicare supplement, long-term care, disability and credit insurance, and to require a 65% loss ratio with no adjustment for either small or large premiums. New language was added expressing the position of the task force with respect to block rating and closed blocks of business. The task force wants the rates for new business and closed blocks to have increases, and if the coverage is essentially the same, the rates should be the same. The task force concluded that rate increases cannot be linked to medical care indexes.

Annual rate increase caps of 25% for medical expense and 10% for indemnity forms was inserted. In addition, there were some age/rate-structure constraints. Under an attained-age rating method, the difference between ages could not exceed 1%. Under an entry-age method, only a 15% differential would be permitted between successive categories.

Some arbitrary changes were made to the durational prefunding section. An amount equal to 20% of the first-year cost plus 10% of the second-year cost is to be added to the gross premium. Such additional funding was to be held as a reserve to offset the durational effect.

The task force acknowledged that the draft contained inconsistencies and that some changes were needed. However, in an effort to push forward with the project, it recommended that the draft be exposed asking for comments by September 1. It is interesting to note that two members of the working group did not approve the adoption of this draft for exposure; Illinois voted against and New York abstained.

During the summer, the working group concluded that the draft had too many flaws. They decided to start on yet another draft working from the current model, and another working draft dated September 9 has been prepared. While this draft was a revision of the existing model, it contains many of the features contained in the June draft -- the same scope, rate increase caps, 65% loss ratio with no premium size adjustment. An NC renewable clause was added to go along with GR, QR, and NR; it has the same block-rating language, annual caps and age/rate-structure constraints. The prefunding rate method provisions were removed as was the durational loss-ratio requirements. Also, the optional prefiling provision was not included.

At the NAIC meeting held this past September in Boston, the (B) Committee formed an ad hoc group to assist in the development of the rate filing regulation; it was a five-state group headed by Florida that included Georgia, Delaware, Maine and Connecticut. Apparently, the (B) Committee felt that the task force needed help in order to have a new regulation ready for adoption by December.

At the moment it is unclear in which direction the project will head. Perhaps this is the beginning of yet another stage. The first check point will be the NAIC meeting in December.

MR. ROBERT BRUCE CUMMING: My talk will focus on the individual medical market in Minnesota. Minnesota has passed major health care reform legislation each of the last two years. While the individual market was not the primary focus of this legislation, there have been some significant changes for individual medical coverages.

I plan to cover three topics. First, I will summarize the reform provisions for the individual market. Next, I will discuss some of the compliance issues that arose as a result of these reform provisions. Last, I will cover some techniques and strategies to help carriers get their rates approved in a timely fashion.

INDIVIDUAL MARKET REFORM

Minnesota passed legislation in 1992-93 that reformed the individual medical insurance market. Much of the individual market reform was patterned after the small group reform provisions.

The reform requires that all individual medical policies be guaranteed renewable. This applies both to new issues and renewals. All in-force policy forms that are not guaranteed renewable must be revised. Note that the Department of Commerce in Minnesota has interpreted guaranteed renewable to mean guaranteed renewable for

life. (The Department of Commerce is the agency that regulates insurance companies.) Guaranteed renewable to age 65 is not good enough.

Unlike the small group market, carriers do not have to guarantee issue. This was palatable due to Minnesota's high risk pool. This pool provides individual medical coverage. The premium rates are limited and can be no higher than 125% of the market rates; the pool has no limit on the total enrollment, as in some other states.

Coverage in the individual market must be portable without preexisting condition exclusions. Persons may be subject to a one-time 12-month preexisting condition exclusion when they first enter the individual market. If a person changes carriers, the new carrier cannot apply another preexisting condition, as long is the person maintains continuous coverage.

There are limits on how much premium rates can vary by age, geographic area, and gender. These limits are the same as those applied to the small employer market.

There are new loss-ratio standards. The minimum loss ratio is now 65% and will be graded up over time.

There are limits on the growth in health care costs. These limits are not applied directly to premium rate increases, but do indirectly impact the level of premium rates.

The effective date for this reform was July 1, 1993. It appears that many carriers were not aware of the reform, especially those that have closed blocks of business but are no longer active in the market. I have heard rough estimates that perhaps up to three-quarters of the carriers were not in compliance as of July 1.

RATE VARIATIONS

Individual medical coverage in Minnesota is subject to limitations on how much premium rates can vary. These are the same limits as those applied to the small employer market. Carriers can vary rates by benefit plan and rate cell. Rate cells refer to individual versus family, child versus adult, and so forth.

Carriers also can vary rates by age, health status, and geographic area. However, these variations are limited. Premium rates by age are allowed to vary plus and minus 50% from an index rate. So, the premium rate for the oldest, most-expensive person can be no more than three times the premium rate for the youngest, least-expensive person. Children are treated as a separate rate cell and are not subject to the +/− 50% limit.

Premium rates are allowed to vary plus and minus 25% from the index rate to reflect health status. However, renewal premium rates cannot take into account health conditions that were not present when the policy was issued. Carriers are allowed to vary rates by lifestyle factors, such as smoking status, alcohol use, exercise, cholesterol, blood pressure, etc. These variations are subject to the +/− 25% rate bands. We performed a study of the impact of lifestyle factors on medical claim costs for the Department of Commerce. If you are interested in this area, I would be happy to send you a copy.

Premium rates are allowed to vary by up to 20% to reflect geographic area. Carriers can establish up to three geographic regions with different rates. One of these regions must be the Minneapolis/St.Paul metropolitan area. Also, the rate for any rural region can not exceed the Minneapolis/St.Paul rate. Rates are not allowed to vary by gender.

LOSS RATIO

Individual medical coverage is subject to new loss-ratio standards. The minimum loss ratio for 1993 is 65%. This minimum will grade up 1% a year until it hits 72% in the year 2000.

TABLE 1
Loss-Ratio Standards

Year	Minimum Loss Ratio
1993	65%
1994	66
--	--
--	--
--	--
1999	71
2000	72

The application of the minimum loss ratio has been changed. The original health care reform package, MN Care 92, included some wording that required that carriers hit the minimum by the third year. That is, the loss ratio for the first two years could be less than the minimum. The subsequent health care reform package, MN Care 93, deleted the year-three requirement. The intent of the new law was that carriers would have to achieve the minimum loss ratio every year.

Apparently, the local HMOs in Minnesota told the legislature that it would not be a problem for them to satisfy the minimum every year. The reformists, who are much more in tune with the HMOs than the commercial carriers, revised the law with the intent that the minimum loss ratio be satisfied every year.

With underwriting still in place, if carriers had to satisfy the minimum loss ratio every year, premium rates would start out lower, but go up much faster. There would be substantial rate increases as a block of business aged. Such rating practices would tend to destabilize the market and result in rate spirals. Luckily, some of the regulators recognized these adverse effects. As a result, the Department of Commerce does not require that carriers meet the minimum loss ratio every year. Rather, the minimum is applied on a lifetime basis.

Some players in the market tried to get the Department of Commerce to adopt a duration-based policy reserve standard. Such a requirement would help stabilize the market by encouraging carriers to levelize the durational pattern of claim costs. However, the Department of Commerce didn't seem too interested. At this point, I think the concept is just too new and sophisticated.

With regard to the application of the minimum loss ratio, there are a number of other points to be aware of. First, the minimum loss ratio applies to both the lifetime and future experience. Also, the minimum loss ratio applies to both new issues and renewals. So, on renewal blocks of business, you have to meet the new minimum (65% and grading up) over the lifetime of the block.

As a result, for some old blocks of business, you may never be able to get another rate increase.

Say you have a closed block. The original minimum loss ratio might have been 55%, and the actual experience might be a 60% loss ratio since inception. You can't get a rate increase until your lifetime loss ratio gets above 65%.

The new law requires that the Department of Commerce perform a retrospective test of experience to assure that carriers are meeting the new minimum loss ratios. This test has not yet been fully defined, but the law does require that carriers submit durational experience data. In monitoring experience, carriers cannot include the impact of active life reserves.

POSSIBLE TECHNICAL CHANGES

The next legislative session in Minnesota will probably include a number of technical changes to the current health care reform law. Possible changes and additions to the health care reform law include: (1) a specific loss-ratio compliance test will be recommended; (2) make explicit that the minimum loss ratio applies on a lifetime basis, not every year; (3) for renewal business, the minimum loss ratio will be applied only to future experience; (4) require guaranteed renewability to age 65, rather than for lifetime; and, (5) allow or require active life reserves be included in experience for business with issue-age premiums.

GROWTH LIMITS ON HEALTH CARE COSTS

As part of the health care reform package, Minnesota has adopted limits on the growth in health care costs. These limits apply to health care providers, as well as insurers. The growth limits get more severe over time. For 1994, the limit is the CPI plus 6.5%, which works out to 9.2%. The limit grades down over time to CPI plus 2.6% in 1998 (see Table 2).

TABLE 2
Growth Limits on Health Care Costs

Year	Growth Limit
1994	CPI + 6.5% (9.2%)
1995	CPI + 5.3%
1996	CPI + 4.3%
1997	CPI + 3.4%
1998	CPI + 2.6%

These growth limits apply to health care claim costs, not premiums. In developing rates or rate increases, the claim trend rates need to reflect these limits. In trending the claim experience, you also can adjust for durational effects and deductible leveraging, on top of the claim trend limit of 9.2%.

COMPLIANCE ISSUES

We already talked about compliance issues with respect to the new loss-ratio standards and expenditure growth limits. There are a few other issues that carriers should be aware of.

First, the rate bands apply to both new business and renewal business. So, all carriers must realign the premium rates to satisfy the rate band limits, even on closed blocks of business. As I mentioned previously, I have heard that as many as 75% of the carriers might not be in compliance with this requirement.

The subscriber plus spouse rate must be two times the subscriber rate. This came about as a result of some rating practices in the small employer market. Some carriers were charging rates for spouses which were up to twice as much as the employee rate for the same age. The rate variation reflected that spouses are more heavily female than employees and females are more expensive than males. The Department of Commerce viewed this as disguised gender discrimination. As a result, they now require that subscribers and spouses be charged the same rate.

Another issue that came up, had to do with the variation in premium rates by benefit plan. In the small group market, the variation in premium rates by benefit plan must reflect only actuarially valid benefit differences. That is, you can't load up the premium rates for the rich benefit plans to reflect the fact that the rich plans attract the sickest groups. The Minnesota law says that all rate restrictions applicable to the small group market also apply to the individual market, unless clearly inapplicable. At this point, the requirement for actuarially valid premium variations is not being applied to the individual market.

GETTING RATES APPROVED

With all the health care reform in Minnesota, the Department of Commerce has changed some of their requirements for filing rates and rate increases. I have a few suggestions that might help get rates approved.

First, you should be aware that the Department of Commerce has hired an experienced health actuary to review all the individual rate filings. As a result, your actuarial memorandums are probably getting much closer scrutiny than they have in the past. When filing rates, be sure to include Minnesota-only experience and the number of Minnesota policyholders. The Minnesota Department of Commerce is requiring this information since the loss-ratio requirements apply to Minnesota business only.

In working with the department's health actuary, I have found a few things that can simplify and speed up the rate review process. First, include a complete rate history showing the amount and timing of all rate increases since inception of the policy form. Second, adjust the earned premium for each calendar year of experience to a common rate basis. It is not required to adjust the earned premium, but this information does help to standardize and simplify the review process.

You should address each rating restriction and the impact of that restriction on the new premium rates. Also, the rate changes due to the rating restrictions are supposed to be phased in over a two-year period.

The department doesn't have any formal rules on the amount or frequency of rate increases. However, if you request rate increases more than once a year or request a rate increase over 60%, you may have a more difficult time getting approval.

The following are some things not to do, if you want to get rates approved. Don't accidentally include rate increases in other adjustments. Don't forget to adjust premiums for past rate increases. Don't accidently multiply a leveraging factor by one plus trend. Don't request a 40% rate increase due to rate band limits without providing any support.

I will wrap up with a short discussion of the market reaction. There hasn't been any formal study at this point. However, the people I have talked to are not aware of any major carriers pulling out of the market. Carriers seem most concerned about the guaranteed renewability requirement and less concerned about the loss-ratio standards and rate restrictions. The guaranteed renewability provisions are somewhat scary because carriers could be locked into any future health care reform. They would not be able to cancel their blocks of business and pull out of the market.

If you have concerns regarding the health care reform provisions, the people at the Department of Commerce would really like to hear from you.

In terms of the future reform, there is the possibility of community rating and guaranteed issue.

MR. MORTON B. HESS: As appropriate, I'll have the last word. I don't have a set of prepared comments, but I have taken notes about a couple of the issues that have been raised by the previous speakers and some overall general comments about the difficult relationship between insurance departments and commercial insurers and other insurers, and between the professional staff and political leadership of insurance departments. I should preface all my comments with the warning that the comments I will make represent my own opinion and are not necessarily those of the department.

I'd like to address two general areas that I perceive as having a lot of potential difficulties. I have been struck over the years with the lack of candor and willingness to attempt to truly comply with regulatory requirements. Quite frankly, when I see an actuarial certification, it might as well go in the wastebasket for all the credibility it has. It's the kind that comes off the word processor automatically and is signed "We believe this meets with all the rules and regulations of your state." I know, given the level of intelligence and competence of the actuarial profession, most of these actuaries either have (1) not read our Regulation 62, (2) not read the work that was prepared for their signature, or (3) not bothered to check whether one or the other were actually in compliance.

It's been 20 years since I helped draft the first issue of Regulation 62. It included a new definition of loss ratio being the present value of paid claims divided by the present value of paid premiums over the life of the policy. I still get demonstrations of reasonable reserves that don't even come close to that kind of a definition. It has specific requirements for the maintenance and presentation of claims experience, including reserves, claims, etc. All this does is create considerable delay in processing

the file and significantly reduces the confidence that we can have in the work that is presented by the company and its actuary.

I had to get that off my chest. As a matter of fact, we have a new problem now because of the Committee on Ethics and what have you. Quite frankly, I see presentations where I wonder why don't I go to the Academy and say, "Look, this is what's presented under the signature of a professional actuary. It's a lie." However, over the last year-and-a-half, I've had more problems with political influences in regulation than I have with actuaries. I think this is an unfortunate harbinger of the future of regulatory issues.

Bill mentioned all the rules that were to be put into the NAIC filing guidelines. We have some filing guidelines, but probably because New York has tried to put an emphasis on hiring professionally trained people to review filings. In evaluating our filings, we try to rely more on analysis than on arithmetic. We do have rules in terms of how often and how large of increases can be applied. We also take a hard look at the use of claim and active life reserves that are too conservative to justify increases. They may be appropriate for reserve cases, but they might not be appropriate for reflecting true experience.

In terms of loss ratios and expense levels, I subscribe to kind of a corollary to Parkinson's law, which stated that work expands to consume the time allotted for its completion. I believe that expenses expand to consume the margin allotted for their payment, which doesn't mean that you can increase loss ratios indefinitely and totally arbitrarily. If most states felt that a reasonable loss ratio was 40%, a survey of companies would show that their average expense ratio was 62%.

As a result of the interference of the political animal into regulatory issues, more and more companies will take the path of demanding a judicial review of both law and regulatory action on unconstitutional grounds, and I suspect that more of them will win. Generally in New York, if a company is uniformly rated across the country, we would probably look at national experience. Most medical policies, especially major medical, typically have premiums that vary by zip code or some other variable and are not nationally rated. We would look at both the national and the state experience automatically on those policies.

In terms of combining old and new policies, while I tend to subscribe to the feeling that each class of policy should be self-supporting, we all know that it's a common practice for agents to rewrite their old business onto new forms if people are healthy. Therefore, you automatically create substantially substandard experience on the old forms, which is a variation of durational underwriting for which I believe the regulatory agencies should take substantial responsibility.

If there is one thing that I think the regulatory agency has responsibility for, it is to save the industry from the ill effects of unbridled competition in creating essentially poor public policy results, specifically in the small group area. I know I was not with the department at the time that became widespread. The actuary did recommend that durational and other types of underwriting in the small group area be prohibited. There was adequate regulatory authority to do that, and they should have had no experience within a small group except for factors in the table regarding the age and

geography. Had that been in effect, I believe a good bit of the small group crisis could have been averted. Again, that was a political overruling of the actuarial judgment because some companies felt they could make a lot of money by temporarily undercutting some other company's business. Instead, everybody cut everybody's throat and now we have the Minnesota and the New York experience in terms of limitations on underwriting.

We have had a community rating law in effect in New York since April 1. I don't think any actuary in the department was consulted as to the form or content of that law. We have been asked to pick up the pieces and make it work after it was put into effect. All in all, it has not been as bad as it might have been, which isn't to say it's anywhere near as good as it ought to have been.

FROM THE FLOOR: I've been preparing a filing for the qualified plan for the state of Minnesota to try to bring it into compliance with the age bands. As one of those requirements, our premiums are not to exceed a certain level of the Minnesota Risk Plan. Looking at the rate schedule of that Minnesota Plan, it does not have the same rating parameters set up that we were to follow underneath a qualified plan. The age band isn't three to one. Do you know? Are they going to be changing the rates of that plan to bring it into compliance?

MR. CUMMING: I would imagine they'd have to, but I'm not familiar with that particular plan. Apparently, the rates for the highest age versus lowest age were more than three to one.

FROM THE FLOOR: They were more like four to one.

MR. CUMMING: This didn't include children?

FROM THE FLOOR: Right. It was an age-17 rate versus an age-64 rate.

MR. BLUHM: I'd like to add something if I could. The Actuarial committee of Minnesota Comprehensive Health Association is revamping this premium structure. There were some changes brought out in the law. They haven't done it yet, but I think they're in the process of revamping the rating structure.

FROM THE FLOOR: Until they do that, we'll be one of the 75% of the carriers noncompliant with the qualified plan.

MR. OLIN M. SAWYER: I have a question for Bob on the Minnesota law. I just want to make sure I understand something. If a company has policies in force that can be canceled and is not interested in making them guaranteed renewable for lifetime, its only choice is to cancel them?

MR. CUMMING: That's my understanding. All major medical policies have to be guaranteed renewable.

MS. CHARLENE P. COCHRAN: We do not do business in either New York or Minnesota. With respect to all the work that has gone on in the rate filing guidelines, what is the outlook nationally for states getting on board with that so that we would,

in fact, have to deal with them in other states? My second question pertains to Florida. Do any of the panelists have an update on compliance with that new regulation and what's ahead for in-force business?

MR. BLUHM: The NAIC has appointed the "B" Committee that is, I believe, chaired by Florida's commissioner. Commissioner Gallagher has appointed an ad hoc actuarial task force, as Bill was describing, to work on a separate document to accomplish what they want to do. The Academy committee is going to be working with them. That ad hoc group is headed by Tom Foley, who's the actuary from Florida. I guess there is some feeling that it's likely that Florida will have a big influence in developing whatever comes out of that ad hoc group and it will probably look similar to Florida's regulation, which remains to be seen. We're at the front-end of the process. Does that answer your question?

MS. COCHRAN: That's helpful. We have been studying Florida's developments for, it seems to me, two years or more, and then finally a regulation has unfolded in spite of what appears to me to be trouble complying with it. I was just curious as to what the outlook is.

MR. BUGG: Yes, that is ongoing and we have a draft in late August or September. It was different from the previous one, so you never know exactly where it's going to stop.

MS. COCHRAN: One final comment. I thought it was adopted. I thought it was no longer in the draft stage.

MR. BLUHM: The Florida regulation?

MS. COCHRAN: Yes.

MR. BLUHM: Were you talking about Florida?

MR. BUGG: I was talking about Florida. Are you saying it has not?

MR. CUMMING: It has not been adopted.

MR. BUGG: Yes, that's my understanding. The last document I saw was like several others. It says workshop for meeting.

MS. COCHRAN: I like your interpretation better.

MR. BLUHM: Which is not to say they might not be using parts or all of it on a de facto basis.