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Limited Benefit Plans Loss Ratio Requirements

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Summary: The National Association of Insurance Commissioners has been revising the loss ratio requirements for limited benefit health plans. Panelists discuss the association's work and companies responses to these requirements. Session attendees share their experiences and express their concerns about these new requirements.

Mr. Michael S. Abroe: This is a panel discussion, which means there'll be limited audience participation, but we hope to get some active participation especially at the end of the session when we will talk about how well we think the model law is going to do, and what it intended to do. We will discuss the NAIC model law, the filing of rates for limited benefit individual and group health insurance forms model regulation. I guess we'll call it the model law from now on.

How many years has this been in place? It has taken a long time to actually get through. When they took the final vote, everyone in the audience clapped because this particular thing was over. It's the collective efforts of quite a few regulatory and industry actuaries. We're privileged to have two speakers, Leslie Jones and Sue Rynearson. Leslie Jones is the deputy director for the office of actuarial services at the South Carolina Department of Insurance. She is responsible for managing the activities of the life, accident and health division, and the property and casualty division. Leslie has been with the department since January 1996, and she also serves as the department's chief life and health actuary. Sue Rynearson has worked at AFLAC for the past six years in the area of product development and pricing. She has her B.S. from the University of Missouri at Columbia and is an FSA.

We were going to have a third presenter, Bill Weller, but he had emergency testimony down in California on long-term-care regulation, so he's not here. He did give us a copy of the comments that he was going to make. We will present his

comments on the various aspects of the model law and how well he thinks it's working.

Ms. Leslie M. Jones: I'm going to give you a brief history of the National Association of Insurance Commissioner's (NAIC) project, and how we came to the table. I will give you a conceptual framework that we developed before we actually wrote the model. As Mike pointed out, there were industry folks and regulators all involved in this process. Sue was intimately involved in the process, and she's going to talk about what the model actually does. Shewill walk us through the model. Then our dear friend Bill Weller was supposed to talk about how we did in developing the model versus what we set out to do and the conceptual framework. He was also supposed to do a comparison.

I'll give you a brief history of the model. There was a working group that was looking at limited benefit health plans. It was charged with looking at all sorts of issues pertinent to limited benefit health plans. Those of you who write supplemental plans probably don't like to hear them referred to as limited benefit plans, but, of course, the regulators were dead set on what they should be called. When I say *limited benefit health plans,* I'm talking about what people would typically refer to as supplemental products like cancer insurance, hospital indemnity products, and accidental death benefits.

There was an NAIC working group that was charged with looking at all of the issues associated with limited benefit health plans. One of the issues that they identified was a rating issue. Of course, the regulators all thought that the rates were too high, as evidenced by what? Low loss ratios, right? The rates were at 18% and 20%. We all see them in the summaries that you file in the annual statement. At any rate, rather than take that on ourselves, the Limited Benefit Plans Working Group passed that charge off to the Accident and Health (A&H) Working Group of the Life and Health Actuarial Task Force. We didn't put anylimits on our charge. We just said look at rating issues with limited benefit health plans. When the A&H Working Group got the charge, we already had laws on the books that deal with rating issues for accident and health insurance products. The most notable that's general in nature is the individual accident and health ratefiling guidelines that most of you are probably familiar with.

The A&H Working Group said, "If we're going to be looking at rating issues for limited benefit health plans, we really shouldn't keep our scope that narrow. We ought to look at the full picture because this model deals with loss ratios for all types of plans. We ought to look at the whole gamut of plans." The A&H Working Group started looking at initially the rate filing guidelines that were already on the books. We have fixed loss ratios on the books. We were all struggling with the problems with fixed loss ratios. They don't discourage companies from having high claims because the higher the claims, the higher the rate increase you can file for. What things should be included in the numerator, and what things should be included in the denominator? Should we include reserves, like active life reserves? What about the companies who are doing a good job managing their claims with utilization review and managed care? Of course, they are not able to put that expense component in the numerator.

We got all tied up in all these details with fixed loss ratios, and Jerry Fickus, who was the chairperson of the A&H Working Group at the time, and most of you probably know him as the regulator in New Mexico, said, "Time out. Let's step back and think about what we're really trying to accomplish. Let's not get focused on the details right now. Let's take a clean slate of paper." For a long time,*blue sky* was the operative phrase of the day. We were all saying, "Let's blue sky this thing and see what we can come up with respect to the model." We had an interim meeting in Kansas City, and we all sat down and said we're going to start from scratch. We're going to forget about loss ratios, and we're going to think about what we could do if it were a perfect world. If we could design the perfect model to regulate accident and health insurance rates, what would we do? That's what I'm going to talk about because that was really the conceptual framework that we developed.

One of the first things we looked at is what we want a model regulation that is regulating rates to do? Certainly one thing that we want to do is make sure that premiums are reasonable in relation to benefits. Why do we want to do that? It's the law in most states, right? In South Carolina I'm charged with making sure that premiums are reasonable in relation to benefits. I need to have some sort of methodology to help me do that. Another thing we wanted to do was to promote rate stability. In the long-term-care and the medical supplement market, we hear about these people who are on the fixed income. Suddenly, they were faced with these escalating rates, and they can't deal with that. How do we develop a model that will encourage companies to price the product appropriately up front so we don't have these people hit with these unexpected rate increases on the back end?

People need to know what to expect with respect to rate increases when they buy the product. Another thing we spent a lot of time talking about was the big picture. The regulators who focus on the product side tend to want to not give you that rate increase. They don't want to give you that 50% rate increase when it comes in the door. I'll never forget the day that Cecil Thomas, our deputy for solvency, walked over and said, "Leslie Jones, you've got to give this company that rate increase. I don't care that they misprice the product. They're going under; you've got to give them this rate increase." Of course, you've got to look at the big picture, and we wanted a methodology that would help us do that. We wanted to develop a model that didn't stifle consumer choice. We all want healthy, competitive marketplaces, and that was something we came up with. What is interesting is there were regulators and industry folks participating in this discussion, and everybody was throwing out ideas. It is interesting to see how we ranked these "dos" by priority. We all thought it was important to have, first, a method that would help us have premiums be reasonable in relation to benefits. The regulators thought the second priority should be rate stability, whereas the industry thought the second priority should be consumer choice. Our third choice was that the methodology should help everybody look at the big picture, the rate increase and the solvency piece.

Let's discuss each of those dos. One of the first things that we wanted with respect to premiums being reasonable in relation to benefits is a methodology to help us determine the appropriate level for renewal premiums. We wanted it to enable us to evaluate rate increases. It had to be a method to help us determine

reasonableness, encourage rate adequacy, and determine small benefit payments. When are premiums too high? It also had to encourage fairness in rating. With respect to rate stability all of us had a concern. Given that we were looking at more than just limited benefit plans initially, we wanted to know what was a good methodology for regulating rates. We all wanted to protect against closed blocks because of what happens in a fixed-loss ratio environment when you have a closed block of business. You can justify any level of rate increase, right? Tremendous rate increases can be justified, but are they fair? Is it right? We want to prevent problems before they're created. Of course, we want to encourage rate adequacy and adequate active life reserves, and make sure people are holding appropriate reserves.

Disclosure is an interesting thing that we've all been talking about at the national level. There are many regulators who think that if things are adequately disclosed to the consumer, then that's fine. If a consumer wants to buy a product, it might not be a product that I would buy. If the consumer understands what he or she is buying, and it has been adequately disclosed, who are we to keep him or her from buying it? One of the things we talked a lot about was disclosing the plan for rates. If a carrier is coming in and undercutting the market, the carrier is not setting up premiums that are going to keep the product going without a rate increase for the life of the product. If the rate increase is disclosed to the consumer, then that should be fine. If the consumer knows that in year duration three, he or she is going to get a 50% rate increase, and buys the product anyway, that's fine as long as the consumer understands that.

Public perception of value was a discussion that we had on several fronts. Some regulators believed with respect to limited benefit plans that if the person buys this for a peace-of-mind benefit, then the price that he or she pays is not really relevant. It's for his or her peace of mind. It's what the consumer decides is valuable that's important. If the consumer is willing to pay that premium for that product because it gives him or her peace of mind, then who are we to stop him or her from doing that? We definitely think appropriate disclosure would decrease complaints. Of course, an individual's tolerance for risk will play into things. This applies if somebody knows that he or she is going to get hit—if it's the attained age rating versus issue age rating. Some people are much more comfortable with issue age rating. I'm going to have the same rate my whole life—actually, less, after inflation. With attained age rating, I know that premiums are going to increase as my age increases. People have different tolerances for that.

We definitely wanted to require disclosure that would not allow misleading or false consumer expectations and definitely did not want to encourage dollar-trading products. Does everybody know what we mean by dollar trading? If you're going to have $1,000 in prescription drugs, you sell somebody a $1,000 prescription drug benefit, and he or she knows he or he will buy $1,000. The consumer is just dollar trading. We don't want to cause high levels of claims.

With respect to the big picture, we were talking about looking at a long-term, comprehensive, and holistic approach. In other words, we want to look at both the pricing side and the reserving side. We want the rates to be effective over time

and encourage adequate reserves. With respect to consumer choice, an interesting idea came out of this. If somebody gets an inappropriately high rate increase, and has been paying premiums all this time, why shouldn't he or she develop sort of a nonforfeiture value, as he or she would on the life side, and be able to change companies and discourage companies from socking it to him or her with those rate increases? We wanted to be able to encourage innovative insurance products. We didn't want to harm the market. We don't want to decrease the number of insureds that are out there. We also want to increase competition.

Let's move on to some of the things that we did not want the model regulation to do. We did not want the model regulation to delay rate increases through burdensome requirements. Of course, prior approval is one of those things that tends to delay rate increases, right? We wanted to look at how we could avoid that. We didn't want politics to get into the approvals and rate increase reviews. If you know Senator Al Salvi's (R-IL) policy is in that block of business, and you're approving that 50% rate increase, that makes it kind of tough because you know you're going to be getting a phone call. Don't allow gaming of initial rates or rate increases, and don't create problems that will need to be fixed. Those were some of the "don'ts." The industry and the regulators agreed in terms of what we thought were first and second priorities.

Purposes

First, we talked about what we wanted to do with the model regulation and what we didn't want the model regulation to do. Then we talked about the purpose of having rate regulation. One of the concepts we came up with was wanting to be able to monitor underwriting gain. We want to encourage medical claim cost control. We want to be able to recognize unknown risk. We want to be able to evaluate affordability versus adequacy of the rates. We want to encourage economic and actuarial soundness for the companies. We want to provide the maximum benefit for the consumers, and we want to make sure that the rating methodology that we come up with can be implemented. If we make it too complicated, and nobody understands it, then there's no way we can implement it. It's has to be a feasible methodology that's reasonable. Thinking about the state perspective, we can't afford to have a lot of actuaries, so we have a lot of analysts who are reviewing rates and stuff. We need to have a level where we can tell them to look for these things, and if they have them, then approve it. If they don't have them, disapprove it or whatever. It has to be something that's feasible.

Although we started talking about all types of products, I should let you know that we worked on a model specific to limited benefit plans. Because we had some broad concepts that we think should apply across the board, we understand that the methodology that we came up with may vary depending on the type of product, particularly if the claim costs vary with inflation. We thought that was one of the biggest things. If claim costs don't vary with inflation, then maybe one methodology would work better than another. We wanted to at least account for that. We started specifically with limited benefit plans. We are going to use the methodology that we developed as a basis for evaluating other products, and then modify it as it seems appropriate. Even though this is a model specific to limited benefit plans, if you're in the individual major medical business, this model could be

the template that we use for developing or a rating methodology for those types of products. Long-term care and disability insurance are the same. We're working on those right now.

Some of this concern is specific to limited benefit plans. Of course, the charge is that the premiums were excessive. We had a faction of regulators who were saying they did not think there ought to be any rate control forlimited benefit plans because people don't need these products necessarily. It's not like an individual major medical product in which you have to have it. They want these products. It's a peace-of-mind product, and they ought to be able to pay whatever they want to pay for it. There are excessive expense margins, and, again, that goes back to excessive premiums. Is there insurance risk? That's a big one. If somebody already has a major-medical product that covers what the supplemental product covers, is there insurance risk?

Rate Stability

Of course, we all wanted to promote rate stability. Expenses are increasing at premium rate expense, and this is something that you'll see coming out. If we grant a 50% rate increase based on increases in claim costs, then it's applied to the gross premium. Of course, there's an increase on expenses and not just the claim costs, right? That was a concern for regulators.

What were some of the solutions? We thought about requiring portability by requiring the availability of a fund that could be used to transfer to another carrier at the option of the individual when the carrier implements a rate increase. It is kind of like a nonforfeiture benefit for health insurance. Another possible solution is to apply penalties to the carrier if the requested rate increase is greater than the rate increase stated in a business plan filed with the department and approved by the applicants. This would be a disclosure plan for increasing rates, and as long as you're within that plan, you're all set. If you go outside the plan, then you're going to be penalized for that.

Provide safe harbors for rate increase amounts and disclosure in the business plans. Again, rate increases below a certain amount would have fewer filing requirements. They're talking about reducing burdensome requirements. An idea that came out of that was guaranteed maximum premium rates. Anybody like that solution? No. Another idea was modified community rating constraints, similar to what was used in small group models. We also see exceptions for actions outside of the company's control, such as redefinition due to a change in statute or regulation. If, in good faith, you said this is what my planned rate increases are going to be, but then there was something outside your control, there ought to be some exception for that. Those were all of the ideas that we came up with, and then we formulated that into a proposed recommendation for limited benefit plans.

This is kind of broken up into a couple of phases. On the initial rating, if there is competition, then no initial approval would be required. Again, we were looking at two issues: rates being excessive and rates being inadequate. If there was competition, then we assume that rates would not be excessive. No initial approval would be required. Of course, we struggled with the idea that individual states still

have prior approval laws on the books. They may still have to require prior approval. Of course, there would have to be some way to justify that competition exists. We might require some statement regarding competition in the actuarial certification. If competition does not exist, then we would require initial approval of the rates. There was nothing driving the rates to a reasonable level, and, of course, we're charged with rates being reasonable in relation to benefits.

Credit insurance is a perfect example of reverse competition. You go to buy your car, and they're trying to sell you credit life insurance. They're not going to show you five different products, and you choose the one with the best price, right? They're going to show you one product, and what's that one product? Itwill be the one that pays the highest commission, right? Reverse competition. In that case, lifetime loss ratios may be required. File a claim with the state that shows expected rate increases for at least ten years, and the plan should also be given to the applicant. That's on the initial rate. If there's competition in the market, and you can show there's competition, then you're going to file a plan that says this is my plan for rate increases. It could be zero. I don't have any planned rate increases. It could be I expect to have 10% rate increases every year, right? You're going to file that with the department. You're going to give that to the consumer so the consumer knows what to expect.

You filed the plan. You've said, this is what I'm going to do. Now it comes time for a rate increase. Any rate increase should be filed. That's what we all thought. If the rate increase is within the amount specified in the plan, it may be approved without any penalty. You're doing what you said you were going to do. If approval is granted for a requested rate increase that is outside of the specific amount disclosed, penalties may be imposed. If for some reason you want a rate increase that's higher than what you said you were going to give and what you disclosed, then you may be subject to penalties. Some of the penalties might be we might limit the increase for the expense component and only give you an increase on the claims component. Limit the range of the new business rate to prevent that closed block thing from going on. We might require portability with a fund where the fund is set by the regulation or by the regulator. If you're saying, "I've got to have this because my administrative costs are this and that," then we might require some kind of plan. How are you're going to improve your business practices? We would transfer the block of business to another company, or we might hire an actuary for review at the company's expense, and then we would monitor rates for three years. That was where we started. That was kind of the conceptual framework that we developed for the model. Then we went to work drafting the model, and that's what Sue's going to talk about. She's going to talk about the model that we actually developed, and, of course, you have to understand that this was an industry regulator. Of course, it was at the NAIC, so there was significant industry participation, and many times compromises are made. What we came up with may be a little bit different from the conceptual framework.

Ms. Sue Rynearson: I'm going to talk a little bit about the actual model. I guess the first topic on the additional benefits regulation is, what does the regulation apply to? The main intent, as Leslie pointed out, is it's specific tolimited benefit type plans. This is going to be mainly contracts that cover specific health events,

specific treatment, or specific conditions. Of those contracts, less than 30% of the total initial claim costs are attributable to benefits that might increase with medical inflation. These would be individual contracts, or any certificates that are issued to a trust or association where the employer is not paying a significant portion of the premium. There's actually a drafting note in the regulation. There are products out there that are sold as association plans where there are group certificates, but the intent is that unless the employer is paying the majority of that premium, they should fall under this regulation.

There are several new concepts in this regulation. In many ways, they have thrown out the old loss-ratio concept entirely, and in order to do that we really need to discuss three topics before we get into it. The first one is the issue of planned versus unplanned rate increases. A planned rate increase is one that is disclosed to the insured at the time the policy is issued. That could be a policy that does have some benefits that are affected by medical inflation, and when you sell it you might tell the insured that premiums may increase by 25% every five years. As long as the premium rate increases we're within those limits, and they would still fall under planned rate increases. An unplanned rate increase would be one that was not disclosed to the policyholder. You could have those in two different ways. Say you had said that you were going to have a 25% rate increase every five years, and instead you needed 40% in the first five years. A portion of that rate increase would be considered planned, and a portion would be unplanned. The other way obviously is if you had told the insured that you did not anticipate or plan for any rate increases and then later had some.

The next new concept is that of an equivalent national premium rate schedule. The purpose of this is to allow companies to keep their rates as uniform across the country as possible. Anyone who does state filings knows that you're going to have state variation in rates due to mandated benefits or maybe currently loss ratio requirements, but I think many companies price a plan on a nationwide basis. They're not doing South Carolina's rates based on South Carolina experience. They're doing it really on a nationwide schedule. So the definition of this is that the forms rate schedule is based on a common pool of experience. It does not reflect geographic differences in claim costs. However, it does allow for variability in rates between states because of varying statutory requirements, and, as I said, these could be either benefit requirements such as a mandatory mammography coverage or things like that.

The next concept is a certification of competition. The regulation requires management certification regarding competition at the time rates are initially filed. As long as you can certify that competition exists, then there are really no loss ratio type requirements to meet at initial filing. What this consists of is the completion of an NAIC-standardized benefit worksheet that isn't completed yet which is kind of funny. I think they're still working on that. The idea of that was to give the regulators a common framework so that they see that everyone lists their types of benefits on it. That really was the purpose of that. You also have to provide the names of three non-affiliated carriers who have products similar to yours. With this regulation there is some required disclosure to policyholders. This would be for policies that are noncancelable and do not have the right to modify rates. The

other disclosures need to be made at the time of issue. In most states, you must give the required free-look period. You can do it at the time the policy is received, otherwise you have to do it when the person actually applies for coverage.

If planned increases are anticipated or if attained age rating is used, you must provide the anticipated rate increases for at least two rate increases and at least 15 years. If you plan on telling the insured that you could have a rate increase every five years of 25%, then you must show at least three of those rate increases in the schedule you show them. If you are only going to have a 25% rate increase every 10 years, then you would show the initial rate for 10 years and then the next rate for the next five years, and then you would also show the 20th year because you need to incorporate at least two of the planned rate increases. You must give them a general explanation of the methodology for determining the planned increases. You can't say, I'm going to raise the rates in five years, and do it for no other reason. You will still have to justify that it's necessary. You also have to disclose the rate increases on that particular policy form or similar policy forms over the past 10 years. Now, this is for all plans whether you have planned increases or not. The regulators were very concerned that you might tell the insured that you don't anticipate any rate increases, even though you've had a past history of having unplanned rate increases. They want some sort of disclosure regarding rate increases.

For the filing of initial rates the following information is provided to the commissioner in each state. First, there is a copy of the policyholder disclosure. Second is the management certification regarding competition. Third, detailed information regarding planned increases. If you're going to have planned increases on a policy, you need to let the commissioner know in the initial filing what the driving force is behind those planned increases. You would need to tell them which benefit is affected by medical inflation and give them that information up front. You also have to provide a certification that the initial premium rate schedule and any planned increases are sufficient to cover the initial costs and anticipated trends. It's not enough to tell the commissioner that you don't plan any rate increases and that you didn't put any trend on a benefit that definitely should have trend. That's all going to have to be disclosed up front.

For a filing of rate increases, and for planned increase, you do provide notification to the commissioner. For unplanned increases, the requirements are going to vary depending on whether the plan is filed using the equivalent national premium schedule or the state-specific schedule. If it's filed with the equivalent national premium schedule, you need to give a demonstration of the methodology for determining the rate increase. You also need documentation of the acceptance of the rate increase from your state of domicile and any states with more than 10% of your business on that form. It's a minimum of at least three total states. If you have your state of domicile, and then you have no other states that have more than 10% of the business, then you go down to the next two highest states. This is one of the big pieces of the equivalent national premium schedule. It's really an attempt to keep the rates as uniform as possible. What could happen is you might file a plan with equivalent national rates to begin with and then need a rate increase on it. You get such varied responses to your rate increase by state that,

before you know it, your schedule is very state specific, and this is really an attempt to provide more uniformity in that.

You also need to provide the commissioner information that's consistent with new disclosure requirements for any future planned increases on the form for new sales. Say you design a product and you don't believe there's going to be any significant effective trend on it, and it turns out you're wrong. For all those policies you've sold up to that point, you're going to file under the unplanned increase section forever. However, for new sales of the form, you could actually restate your assumptions and allow the commissioner to know that you do anticipate planned increases for that form at that point.

For state-specific rate schedules you must again provide the demonstration of the methodology for determining the rate increase and also provide sufficient information for review of the rate increase. You have to give new disclosure information if you're going to have future planned increases.

The next section really gets into what some of the penalties are of having unplanned rate increases. I think one of the biggest goals of the task force was to actually incent companies to initially price products adequately. There is one way that they feel that their current loss ratio situation disincents companies. If you have a 60% loss-ratio requirement, and you sell the product for three years, and then you get a 25% rate increase, you don't have the initial acquisition expenses on that 25% incremental premium. So it was felt that the expense margins on that incremental premium should be much lower than they are on your initial premium, and the current system doesn't reflect any difference in that.

One of the goals of this system was to put a disincentive to companies for not adequately pricing the products. There is no loss-ratio requirement on the initial premium for planned increases, but any planned increases have to return to the policyholder at least 75% of their value in benefits. Unplanned increases are calculated so that the accumulated claims plus the present value of future claims are not less than 60% of the accumulated initial premium with a $30-per-policy fee, plus 60% of the present value of future initial premium, and then added onto that is 85% of the accumulated value of any prior unplanned increases and 85% of the present value of any future unplanned increases. If you file a product without the intent of having any rate increases, and then you have one, you're going to be required to meet a 60% loss ratio on your initial premium and an 85% loss ratio on any incremental premium. Everyone felt this was a pretty substantial penalty. You might have originally priced the product to where you would expect a 50% loss ratio, and that doesn't matter anymore. Once you go for an unplanned increase that initial premium has to hit the 60% mark.

There are additional requirements for unplanned increases. Carriers must file lifetime projections of earned premium and incurred claims reflecting the rate increase. These projections have to be updated annually for at least the next three years. The commissioners will be monitoring those results. The main reason for that is they didn't want companies to be able to just claim that they're going to get the 85% on their increment using some kind of high trend that they don't realize.

If the actual experience does not adequately match the projected experience, and your incurred claims are not going to meet the targets, then the commissioner may require benefit modifications, premium adjustments, or other measures so that the company does meet the target.

If you have multiple unplanned rate increases on a product, then the commissioner may require a plan for improved administration or claim processing that's designed to eliminate further deterioration of the block. The commissioner might also force the carrier to offer insureds the option of replacing existing coverage with comparable coverage without underwriting. This would mainly happen if you did have a closed block that had started to deteriorate. Now, if a company has a pattern of misuse of unplanned rate increases, and this would mean that it's on more than one product, not just multiple ones on the same product, then they can actually be barred from the market for a period of up to five years.

I have given a general overview of what the model has. Mike, do you want to go into how we think we did in comparison to what the goals were?

Mr. Abroe: This is Bill Weller's presentation. Has the model done the job or not.

We'd like the audience to give us comments in terms of whether you agree or disagree with what's going on. Bill's answer to reasonable premiums in relation to benefits is yes. There are three main reasons. First, the consumer now makes the decision based upon a set of benefits and initial premium scale, as long as the premiums don't change. Second, competition must exist—this gives the consumer a choice and controls premiums on the high side. Third, economics and/or administrative changes relating to rate increases controls the desire of companies to low-ball for market share. Does anyone want to comment on that?

From the Floor: There is Company A and Company B. This product, whichwill remain nameless, has 7.5% annual medical inflation. Company A, with a good actuary, who wants to do a good job, takes into account the entire 7.5% of medical inflation and prices the product assuming that he or she is going to have 7.5% of medical inflation forever. He or she gets the premium, but he or she is not going to expect any future rate increases. Then there is the low-ball actuary that prices for the smallest. Medical inflation is 8% or 10%. Who are you going to punish? You're going to punish the guy who priced it right, not the guy that low-balled. That's the problem with that.

Mr. Rynearson: If you have 7.5% medical inflation on your entire claim costs, you're probably not going to fall under this regulation because this regulation would only apply to products that have less than 30% of their benefits affected by trend. I think that's the main thing. If you've got that much medical inflation, then it should not fall under this regulation because the regulation specifically excludes products that have more than 30% of their initial claim costs being affected by medical trend.

Ms. Jones: That was one of the issues that we thought might be different for products with significant trend versus those without trend.

From the Floor: What's the initial claims costs?

From the Floor: Initial claims cost is what? First-year claim costs?

Ms. Rynearson: That's something about which there was actually quite a bit of discussion.

From the Floor: You could have a 10-month exclusion for certain benefits and put this on either side of the regulation.

Ms. Rynearson: It was really felt that the initial claim cost was going to be what the actuary's best estimate was of the more or less ultimate claim cost for that benefit without using future trend on it. If you have a 10-month exclusion, you would ignore that exclusion in coming up with the percentages.

From the Floor: If I designed the product that had a maximum benefit of $10,000 lifetime or annually, but was otherwise fee-for-service, that wouldn't fall under this regulation. A medical reimbursement plan that had a maximum benefit of $2,000 but was otherwise a fee-for-service reimbursement and is obviously 100% for a reasonable time period into the future, is going to be subject to inflation.

Mr. Rynearson: I don't think the intent of that is to fall under this. The real things that this should cover do not include long-term care or disability. It shouldn't include any type of major medical or medical supplement. The real intent of this is mainly for supplemental type products like specified disease, hospital indemnity, and products like that. There are also some products that fall under one of those categories that might not fall under this regulation such as cancer coverage that has unlimited radiation/chemotherapy. We did not believe it would fall under this because then you've got a significant portion of medical trend applying to that product. I don't believe your example would fall under this either. It'd be something you'd have to calculate

From the Floor: Do you think that a $2,000 annual benefit product would fall under a major-medical classification?

Ms. Rynearson: That actually was one of the real problems in doing this and in carving out this specific section. We don't know yet what's going to happen with the major medical or what other categories there are going to be. That was a problem when this was being designed. You really couldn't answer where each thing should be because you didn't know what the implications of that were. Do you think we need to have questions on the regulation before we get into this? If anyone has questions on the regulation and how it's intended to work, we might need to bring those out before we get into the "did we make it or not?".

Mr. Abroe: For example, I think there could be a limited benefit medical expense plan that has limits on daily room and board, perhaps $100–200 a day, with maybe some limited ancillary benefit. The actuary there, for example, would need to go through and opine as to whether that limited ancillary benefit makes up more than

30% of the underlying claim costs. If so, it wouldn't fall. If it's less than 30%, then it would fall.

Ms. Rynearson: Part of the problem is I do believe there's going to be some judgment of the actuary. I think there are going to be plans where the actuary could justify it falling under this regulation or not. Right now it's not clear which way they'd want to go. There is still that gray area. With any regulation there are loopholes and problems, and I think that is one that exists in this regulation. There will be products for which the actuary will decide which regulations they fall under, and it will be in their best interest to fall under one versus the other.

From the Floor: What happens if, as an example, you file that for an expected 15% rate increase, and Medicare stops undercharging and their cost-shifting changes or whatever, and medical inflation or inflation on these 30% of benefits is less than that and they don't need the 15% rate increase two years out? Do they get credit for not having taken that 15%? Now they're back to square one.

Ms. Jones: I think again we were trying to avoid the issues associated with trend in this model.

Ms. Rynearson: If the company said that we plan to have a 15% increase in the next five years and then another 15% in the next five years, and if you go the first five years and have no increase, I don't believe you can go back and now get more than 30% in the next five years. It is within those windows. It's not the kind of thing where you can do a 15% increase every five years and not do one for 15 years and then take the whole thing. They really have to fall within those parameters. The main reason for that is not to delay rate increases. They did not want companies telling a policyholder they were going to do one thing and then accumulating that and hitting them with it all at once.

Ms. Jones: People may not buy it. If you look at the example of the two products, one where the actuary has been responsible and priced the 7% trend, and then the other has not, the other company has to disclose a 15% increase every year. This company's going to say, "I'm not planning to increase your rates at all. Your initial premium may be a little bit higher, but I'm not planning to increase your rate."

Ms. Rynearson: To me, there are some problems with the regulation. The biggest one is that even though there is no initial loss-ratio requirement, you're going to have to price your products with that 60% requirement in mind. If I price it to a 40% loss ratio, and I'm wrong, then I'm never going to be able to make a profit on that product because I now have to jump to a 60% requirement on the initial and an 85% requirement on the increment. It was really felt that competition is going to help keep the rates down, but companies are still going to have to look at loss ratios in their initial filing. If you are wrong, and you go into the unplanned rate-increase scenario, it doesn't mean that you're not going to make money on your product. I do still think that the company can make some profit on the product. The real goal of the regulators was to disincent the companies from intentionally underpricing products, and that's what many of the

regulators on the panel feel is happening with just a certain few products or companies.

Mr. Abroe: I wouldn't be surprised if there aren't some changes in compensation structures with companies to recognize noncommissional aspects of unplanned rate increases versus planned rate increases. That's the way in which companies could immunize themselves. I think there are still a lot of things that companies can do within the framework of the regulation.

Ms. Jones: Less than 30% of the claim cost should vary with inflation. It shouldn't be as difficult to predict in that instance.

Mr. Brian D. Holland: I just want to be sure I understood a statement that I think was made. I think someone said that radiation and chemotherapy treatments could be considered the kind of claims that are tied to the cost of the actual treatment. Is that what was said? I was thinking of something like $500 per treatment not being counted towards that 30%.

Ms. Rynearson: In general, there are three types of plans for radiation and chemotherapy in cancer insurance. One might have a cap per day, and that's going to be the simplest one to price. It's going to have the least amount of trend in it. There's another one that has an annual cap. The annual cap might be $10,000. And then there are also some that pay actual charges for radiation and chemotherapy. Of those three benefits, I think I could say that the indemnity type that pay up to a capped amount per day . . .

From the Floor: Pays the cost up to a capped amount?

Ms. Rynearson: Yes, it pays the cost up to a capped amount per day. They are probably not going to have 30% of their claim costs associated by trend. The one with $10,000 a year is probably going to be borderline. It's going to depend on several things the actuary does. Obviously, the unlimited one would have 30% of the cost because that entire claim cost is going to be affected by trend, and that was the intent of it. On the one where you're capping it at a per-day amount, that entire claim cost is not going to be affected by trend because a good portion of the radiation/chemotherapy benefits you're currently paying have already met the cap, and so they cannot inflate anymore.

Ms. Rynearson: It really turns into a big tree, and that's what the actuaries are going to have to look at in determining whether it would apply or not. As another note, no one knows right now whether states are going to adopt this. There hasn't been any real strong feeling from anyone as to which way it's going to go. It just came out at the April 1999 meeting. There really isn't any word on that yet.

Mr. Abroe: And that could go both ways. It depends on industry pressure. It depends on the regulatory environment in that state.

Mr. Holland: Ms. Jones was differentiating between different classes of insurance, talking about major medical type of insurance that you must have, and the other

stuff is just for peace of mind. This is an old, old debate. When I took the health policy course a few years ago, I learned that something like 25-27% of the people in this country were uninsured, and there are plenty of people who manage to survive without having the major medical insurance. If you have enough wealth set aside, then certainly you can. It's a matter of your degree of risk aversion, and there's no magic cut-off point for that degree. That's a whole class of insurance products versus another one in my opinion.

Mr. Garry Reed: In your three examples for your radiation/chemotherapy benefits, I think you're probably right on where they would fall today, but 10 years ago they would have all fallen under this, and the people who sold the unlimited radiation/chemotherapy would be in big trouble with this. It seems to me this regulation sort of disinclines companies from selling any benefits that are possibly subject to any kind of inflation that could somehow get out of hand because of increased technology or for whatever reason.

Ms. Rynearson: Yes, but I actually think it was very much intentional that the companies who sold the unlimited radiation/chemotherapy would fall under this and that they would have a very strong penalty because the feeling from regulators was that consumers did not know what they were purchasing and didn't know what risk was associated with it. They thought they were buying a very limited health insurance policy, and it turned out a big portion of it was affected by medical inflation. I think that was a very big driving force behind this regulation.

Mr. Reed: You're saying you think the regulators thought that when the insurers were developing these products ten years ago, they knew that the trend on this would be 20% because of advances in technology.

Ms. Rynearson: I think they thought that companies should have been a little more careful either in design or in pricing. It is more than likely it was design and not pricing.

Mr. Michael A. Shumate: You keep talking about medical trend, but let's look at our $50-a-day cancer benefit as an example. Let's say that there's a change in medical usage, which there kind of is. It used to be you had chemotherapy. Once a month the patient would get a big blast, and it took 30 days to get over it. Then, the patient went back. Now people get these small doses every day for three weeks, and take three weeks off. There is a big difference. It's not medical inflation. Does it count?

Ms. Rynearson: There is something in the regulation that allows the commissioner to grant a special unplanned rate increase with really no penalty due to either changes in laws or regulations or increased or unexpected utlization that the insurer could not have foreseen. Many companies would have been affected by this. Even the unlimited radiation/chemotherapy might have fallen under this to a point. It's something where the commissioners might make some special rule for it, but there is some room for that. The other thing is we talked about planned versus unplanned, and the bad company has the unplanned rate increase. I don't think that's what anyone intended with this. I don't think there would be any

company out there that will never have an unplanned rate increase. It's not intended to label you as a bad company in any way. The biggest intention of it was to reflect the fact that you have a reduced expense margin on your incremental premium, and that's really where the 85% came in. That really is the biggest piece of that. The first few times you have an unplanned rate increase, it is not such a penalty. It's not supposed to be labeling you as a bad company in any way. That would happen only if you have multiple instances of it, and you've shown a real practice of not taking adequate care on your rates.

Mr. Abroe: Let's move on to rate stability. The potential is there for rate stability if the companies understand this particular model and the changes that this model will bring. Point 2 is there's no value in the expense and risk margins of the premium dollars that are not in the initial schedule. I think he is referring to the 85% rule that states that your fixed expenses and so on won't increase necessarily as your claims increase. Eighty-five percent of the increase should be necessary to be able to meet your additional claims risk. Another point is that there's the increased potential to pool favorable experience and to maintain from one policy form with all the loss ratios for use when another policy form has poor experience. That's one that's not allowed in current loss ratios requirements. That sort of opens up the ability again to pool a line of business more than just look at specific forms.

Point 3 is disclosure. Defined disclosure is better for companies than the need to disclose. Defined disclosure is fair to all companies and improved disclosure is vital when there is no regulation of initial premium scales. Again, this brings all companies to the position of having to disclose in advance what their anticipated planned increases are over the next 15 years.

The regulation should look at how the marketing, servicing, and regulation of insurance should work rather than how a particular aspect of the model needs to be revised to deal with a particular problem. I think I need a little help in understanding what he means by that.

Ms. Rynearson: I think the main thing on that is that it really is a totally new approach. It was a pretty big deal to scrap initial loss ratios. Bill especially felt that the regulators did look at the big picture in doing this, and they really gave up something on initial rates to gain what they felt was the greater good by encouraging rate adequacy and rate stability.

Mr. Abroe: What does everybody feel? I'd kind of like to know. Do you want to disclose and then not have to file for rate increases or do you do what you're doing now?

From the Floor: In terms of disclosure I have absolutely no problem disclosing this with the state because most states will have somebody who's going to understand the implications of that disclosure. The real problem I have with this entire process is the disclosure to the client. The question is, how is the client supposed to use that information? What does it tell the client, other than the fact that these are really cheap premiums, but there might be some rate increases in the future. He or she might ask, can I buy this more expensive product now and

maybe not have rate increases in the future? How is that going to affect the sales process? Quite frankly, I know some really good salespeople, and I doubt itwill affect them very much. It's like some of the other disclosures that we've given policyholders just to engender question after question after question. They don't understand what it means to them. Tell the regulators. Tell the policyholder in general terms, but should we give them the details? What does it do for them?

Ms. Rynearson: You've really hit on one of the reasons why companies don't anticipate using the planned increases. You also need to remember this is a compromise. At one point they did have a maximum premium rate in there, and, as you can imagine, industry was not at all pleased with that idea. It really was a compromise to come up with that, but, as I said, most companies I've talked to do not anticipate or said that they would not plan on using planned increases.

What you need to look at is how it regulates unplanned increases on products where there were none disclosed. That really is the focus of this regulation: what happens when an insured buys a guaranteed renewable product for which he or she might reasonably expect not to have increases and increases happen? I think the key on that was the regulators wanted to keep companies from being overly aggressive in their pricing, and they did want to put the rate increases on a more appropriate level with the expense margin associated with it. That was, I think, one of the two main goals. And whether it did or not remains to be seen.

Ms. Jones: We all had a hard time. We were all very focused on loss ratios, and we struggled with this. You are struggling with this in terms of trying to think of a new concept. If loss ratios don't work, they're broken. What does work? How can we encourage companies to appropriately price products? That's what we were all after. Disclosure was a big aspect of the whole picture. The biggest complaint we get at the insurance department is if I had known I bought this really cheap product that was going to get a 15% rate increases every year, I would never have bought it. It's the unexpected that causes the call to the insurance department, but if that has been disclosed to the policyholder, and they get their 15% rate increase, then they have no reason to complain.

From the Floor: The problem is, though, that that document that discloses that 15% rate increase that they got two years ago is wrapped up in a plastic container stuffed in their safe somewhere.

Ms. Rynearson: It also raises the bigger question of which is better for the consumer? Is it better to price a plan 10% higher today or to price it at 100% and then maybe five years down the road have a 10%, 15%, or 20% rate increase? That's another question. Which is better for the consumer? And I feel the regulators' point of view was that they would prefer that the rates be as stable as possible, and, if necessary, a 5% or 10% increase was the way they wanted it to go.

Ms. Jones: Another more general concept in terms of disclosure is there are many people in the industry that argue that appropriate disclosure should replace regulation. There are many regulators who think that that's true, but I would say

you're arguing against that. You're saying that even if you disclose it, the consumer's not going to read it, and they don't care about it. They're going to stuff it in their safety deposit box. As a regulator, I have to protect the consumers because they aren't smart enough to protect themselves, right?

From the Floor: Appropriate disclosure is absolutely better than regulation, but I don't believe that this information alone will give them sufficient information to know what to do. Do I buy a product that's 20% more expensive or do I buy the one that's less expensive but may have some rate increases in the future? On what basis will they make that decision? If you give them the information to make that decision, it's a different deal. Just telling them that there might be a 15% rate increase in two years is not sufficient information unless they've browsed the *Textbook on Life Contingencies* (Chester Wallace Jordan, Society of Actuaries, Illinois, 1967) and a few other pieces of ancient lore that might help them to figure it out. What's the present value of the difference? What's a value differential on these two products that I can look at, weigh, and say I want to do this versus that?

Ms. Jones: I think you make an excellent point. As Sue pointed out, as she was going through the model, it's not like you can just willy-nilly say 15%. There has to be an actuarial justification for the rate increase. It has to be based on some sound methodology. It can't just be a matter of picking a number out of the hat.

Ms. Rynearson: The additional disclosure of rate increase history on that product is also intended to give the consumer more information. If it's a product your company has been selling for three or four or five years, and you tell them you expect to have a 15% increase every two years, they can look and see what the past pattern has been. I hope that will give them more information. You're right. There's no way to ever get complete information out there because, quite frankly, we don't have complete information. We can't predict the future much better than they can.

Mr. Abroe: These are some of the issues. There are no specifics in terms of the requirements of how that's going to be required in any sales materials. I think there's still a lot of marketing that'll go on in terms of how this information is going to be presented.

Ms. Rynearson: But if we think this is difficult, you can imagine how the long-term-care discussions have gone because that's a product even more averse to having any unplanned rate increase at all. Rate stability is probably the #1 goal. However, we just don't have good data on long-term care to predict the future. There is a real interesting debate on that product.

Ms. Lori A. Nelson: According to this definition, critical illness would fall into that category of long-term care not having a lot of data. It seems like critical illness fits under this regulation. Is that true?

Ms. Rynearson: I believe it probably would.

Mr. Abroe: Yes.

Ms. Nelson: Can you comment on consumer choice? This regulation scares everybody away from even offering it.

Ms. Rynearson: I think the goal of the regulation was to make companies approach new products more conservatively than they normally would. If I come out with a completely innovative product, I still have to certify that I meet the loss ratio requirement. You can justify some margin in your morbidity, but I don't know very many actuaries who are comfortable putting in a very big margin. For products like critical illness, where you have very, very sketchy data on it, the intent of this regulation is to get companies to add a little more margin to their morbidity. So at least you're getting some experience to take a little bit more conservative approach than they normally would. However, you are going to have competition steering you the other way as well, but that really was the goal of this. Whether it accomplishes it or not remains to be seen.

Mr. Abroe: The model regulation talks about new issues on or after the effective date. It assumes there'll be new product filings or so on. What would the impact be on products that are already approved for sale in a particular state? Would there be a refiling under the new requirements or would it be the first rate increase? At that time, you'd file a series of planned increases?

Ms. Rynearson: I think that'd be handled on a state-specific basis. Some states might require that you refile the product to continue the sale. At the time this came into effect, you would have to really make a statement as to whether you anticipate planned increases or not. If you did not anticipate them, then I think you could just go along, business as usual.

Ms. Jones: Those of you who are worried about this new regulation should know that I don't think that there's a big movement on the part of the states to move away from loss ratios. We're as tied into loss ratios as you all are. We were hoping that Tom Foley would be able to use North Dakota as a pilot state, just to see if something new would work. Until we come up with something that can replace loss ratios, we're going to be stuck with this concept that is broken and has some real issues associated with it, unless and until we can be innovative and think about something that will work. We would certainly, as much as possible, like to encourage a methodology that uses market forces, such as competition and disclosure, to help drive rates and help actuaries be conservative in pricing products.

Ms. Rynearson: Not aggressive is probably a better term than conservative. I talked to Tom Foley a couple weeks ago, and he is looking at adopting some version of this in Kansas with even more meat to it, so that's probably not good news. No word on Florida yet, though, but we can always hope.

Mr. Abroe: I think there's a yes for consumer choice for Bill. There was some concern that simply changing the current loss ratio based model could price some products out of existence. The second point is that this approach allows consumers to choose what they want, and allows the failure of those products and prices that don't appeal to consumers. We've talked about this. Here are the next four points:

don't delay increases; don't have burdensome requirements; don't let politics into rate approvals and rate increase reviews. I guess the question is mixed on the last two in terms of not allowing gaming of initial rates or rate increases. Don't create problems that will need to be fixed.

Ms. Jones: That is what you were driving at. There may be loopholes that we haven't anticipated in developing the model.

Mr. Abroe: In terms of the last one, "don't create problems thatwill need to be fixed," Bill comments that the industry sees problems as a result of the excessive regulation while regulators see problems when companies don't understand or don't want to follow the rules. The second point is something like this is new, and it's not likely to be perfect, but the Life and Health Actuarial Task Force of the NAIC is supportive of this approach and wants to make it work. Many companies were also involved and would like to see it work. Dealing openly with what isn't perfect is the best way to avoid creating the unfixable. I would assume on the last point that the issue is that, as problems come up, the Life and Health Actuarial Task Force would handle them in the same way that the long-term-care model works. It's always constantly under revision. That's the idea, I guess.

Ms. Jones: I definitely think that the Life and Health Actuarial Task Force is open to the idea that this model isn't perfect because, as Sue said, there are all these new concepts and new ideas. We understand that we're breaking new ground. There may be issues we never considered in developing the model, and certainly those would need to be fixed, and it would be an evolving, continuous improvement.

Mr. Abroe: Are there any other comments in terms of reactions to the model law and the fact that we shouldn't create problems thatwill need to be fixed?

Ms. Rynearson: It's definitely an interesting topic that's going to affect a lot of our companies if it gets implemented.

Mr. Hobson D. Carroll: I'm sorry. I'm just stuck on this 30% thing again. Can you expand on where that number came from? When I saw the words*Limited Benefits* in the title, I decided that I can design all kinds of what I consider limited benefits that are 100% subject to trend in my actuarial opinion, and would it produce benefits far less than those of many of the hospital indemnity policies that are out there.

Ms. Rynearson: I'm not really sure where the number came from. I thought it was a little high and the intent of this regulation was to apply to products with very little medical trend. I really felt 30% was too high, but I'm not sure. Do you remember exactly where the number came from, Leslie?

Ms. Jones: It was just a compromise. I think we even started at 50%. That's why the name of the model is not limited benefit but, rather, additional benefit. We came up with a definition specific for additional benefit to carve out that piece of the limited benefit health plan. That's an excellent point. We're not even

addressing all of the limited-benefit health plans that are out there because there are many limited benefits that would be subject to more than 30% trend in their initial claim cost. Or, more than 30% of the initial claim costs are subject to trend.

Mr. Abroe: Is there a way of interpreting that 30% as meaning the maximum that cost could increase because of trend? Or is it just for benefits within there that would be subject to trend? That trend could be maybe 5% or 100%?

Ms. Rynearson: How it was supposed to work is that you might have 30% of benefits affected by a 10% trend which would kind of translate into a 3% trend the first year and then 3.3% the next year, etc. That was really how it was intended to work. The entire 30% was affected by trend.