RECORD, Volume 26, No. 3*

Chicago Annual Meeting
October 15–18, 2000

Session 96IF
Controversial Issues in Long-Term Care

Track: Long-Term Care

Moderator: JAMES M. GLICKMAN
Panelists: THOMAS C. FOLEY
TIMOTHY EDWIN HALE
JOHN LEO TIMMERBERG
Recorder: JAMES M. GLICKMAN

Summary: In any dynamic market, issues arise where people have differing points of view. This session provides an opportunity to discuss some of those issues in greater detail.

The panel debates several of the controversial issues in long-term care, including:

- *Substandard underwriting with prudent pricing*
- *Qualified vs. nonqualified plans and the need for Internal Revenue Service clarifications*
- *Rate stabilization and aggressive pricing*
- *Noncancelable products and product features*

Mr. James M. Glickman: First off, I want to introduce Tom Foley. Tom Foley spent 20 years as a company actuary in various life and annuity type of activities before joining the Florida Department of Insurance and then the North Dakota department. He is now in the Kansas Department of Insurance. I am quite sure that Tom will lend credibility to the controversial issues topic.

John Timmerberg is second vice president of long-term-care (LTC) pricing at CONSECO. CONSECO consists of a number of companies including the old American Travelers, and Pioneer. I think he had the Transport business as well, if I'm not mistaken, and I'm sure that some of the issues will prove controversial. Hopefully, John can lend some history to that. He spent two years prior to that at Transamerica in the LTC evaluation area, and before that five years at CNA.

Finally, Tim Hale is assistant vice president and health actuary at Munich American Re where he manages the LTC reinsurance group. He started pricing LTC at MX Life. He should be able to give us a good historical perspective of that experience and he spent a fair amount of time working with continuing care retirement community (CCRC) pricing and their finance health-care components. I'm with the LifeCare Assurance Company. We work exclusively in the LTC reinsurance marketplace, trying to put together turnkey programs and complete reinsurance opportunities for large insurance companies.

The first topic is qualified versus nonqualified issues. What is the current situation and status relative to what issues need to be cited and what opportunities there are in both the qualified and nonqualified side? First, I'd like to give each of our three panelists a chance to just give an impression of where they think the issues are on qualified and nonqualified. Then we'll move into the audience and try to get some questions, comments, and hopefully, disagreements with those things that are being said. Tom, why don't you start?

Mr. Thomas C. Foley: I think this is wonderful that you set us out to be experts and then you always give out nonqualified plans. I mean, I don't have a clue any more than anybody else does about that. I met with the Treasury people last week and we talked about LTC for an hour and the qualified/nonqualified issue didn't come up once. So, I don't know that anybody knows how to resolve it.

Mr. Glickman: What do you think are the major issues that need deciding?

Mr. Foley: I've always objected to classifying policy forms that don't meet the requirements to be qualified as nonqualified, because we don't know whether they're tax-qualified or not. And the key issue, of course, that everybody grapples with is someone who buys one of these policies and goes on benefits is they're going to have to include the benefit payments in their income. And I don't know that we know that. I'm sure there would have to be policies sold since 1997 where the people have to be in claims status and they have to fill out the tax returns. Does anybody know of situations where they've been audited?

Mr. Glickman: To the best of my knowledge there have been several companies and John may have some direct experience with some of the policyholders from American Travelers, where the Philadelphia office of the IRS has sent out audit statements asking why monies that were reported on the 1099 LTC were not shown on the client's tax returns. I have not yet heard of any instance where that happened to apply to a nonqualified policy. It almost always turned out to be grandfathered in qualified policies. Obviously, over the years we will get more that are in the nonqualified mode, since they have been sold since 1997 and presumably, with underwriting, there's some delay in claims occurring. John, are you aware of any situations?

Mr. John Leo Timmerberg: I haven't heard that specific instance come up. CONSECO Senior still offers both qualified and nonqualified. And the sales are, by far, predominantly qualified. As a company, I think we're trying to get agents used to the idea that they should be selling qualified and we're moving in that direction.

Mr. Glickman: What issues do you think are important to determine qualified and nonqualified?

Mr. Timmerberg: Well, some people see it as a fuzzy issue and I think it creates some confusion in the marketplace. So I think it's essentially a clarity issue.

Mr. Hale: I've always had trouble with the hospital indemnity policy at a 90-day cutoff certification for benefits and if I'm selling a 20-day elimination product and begin paying, I think anybody can get certified for 90 days just about, unless you're in a hospital and out of the hospital at this point. So, I'm not quite sure if it's just something I don't understand or if there is more confusion. What qualifies is that I'm paying benefits after 20 days as a direct writer, and as long as I have a 90-day certification, if it's less than 90 days that's fine and if it's more than 90, where is the 20 days that I don't pay benefits?

Mr. Glickman: I think you've brought up an interesting issue. I'll tell you how we've dealt with the 90-day issue and what some of the parameters for consideration are and then hopefully some other people in the audience will give some of their experience. The 90-day precertification issue essentially has 3 issues that are not clear. The first one is if you get a certification for the 90 days, does the carrier have a right and/or obligation to challenge that if it doesn't think that it's truly legitimate? Second, during the less than 90-day stays where there is no certification, but while you're in your elimination period, do you credit the elimination period days because there is no actual payment and there is no prohibition against crediting those elimination period days or do you take the stance that because it's not a 90-day precertified stay that you cannot count the elimination period either because they're not a qualified benefit status?

What we do is take the path of what I'll call marketing-friendly, least resistance, which is, since we're not allowed to pay without a certification, we don't pay if there's no certification. We virtually never challenge a certification because we didn't particularly change our pricing, assuming there would be an offset for those who wouldn't qualify. The third thing that we do is provide coverage for those elimination period days that are satisfied as long as they meet the activities of daily living (ADLs) or cognitive impairment requirements. But if it's a short stay, this will be less than 90 days.

Mr. Greg Gurlick: Jim, I would disagree that people should have assumed there would be no impact when we took a look at it. If everybody looks at their continuance tables, you'd have not only claims less than 90 days that actually have a large percentage of your claims lasting less than 90 days, especially if you're looking at home care coverage. Now if you chose as a company to simply ignore that and pretend that there would be no impact, I'm not sure what your justification for that would be. It would essentially have rate increases for new business. It might be decreasing the benefits that will ultimately get paid and still be charging the same premium. But at the same time, if you take a look at those short stays I think you'll find that the financial impact of that is not huge. We're talking about a lot of claims that are very short in nature, and as a percentage of the total claims they don't add up to a lot.

Mr. Glickman: Essentially what we've assumed, and it follows somewhat along Tim's description, is that we expected virtually all people will be able to get a qualified care provider to certify virtually any stay as being hospital the last 90 days. And unless the carrier is going to take a proactive stance of challenging those

certifications, it's not written that you have to get the majority of people to say it or you really only have to find one provider who you pick who will certify in order to satisfy the Health Insurance Portability and Accountability Act (HIPAA) requirements. And if the company accepts that, then the payments will be made. So we think there will be very little in the way of offset. And with our position on crediting elimination period days, especially since most of the business is sold within a 90-day elimination period among our companies, we expect that most of those payments will provide coverage just as if there were not a 90-day certification.

Mr. Gurlick: It seems to me when I was doing this work a while back, that the number one cause of people going into a nursing facility, for instance, was a broken hip. It is fairly well documented that in most cases it's a 6-week kind of event, and that certainly there may be complications that cause it to go longer, but how often are you going to accept a 90-day certification on something that time continues to prove to be a 6-week event? Somewhere along the line, somebody is going to hold somebody responsible and I prefer it's not my insurance company.

Mr. Foley: So generally what we're saying is we're not doing that, right? The 90-day certification is at the same point that medical necessity was or still is. You can always find somebody who will give that certification.

Mr. Michael S. Abroe: There have been several claim shops that we've talked to where initially the claims manager said, "Yes, we don't expect any savings," but, in fact, they have experienced savings whether they've said that not all providers are willing to certify to 90 days. There are some savings, at least according to several companies that we've talked to, that are resulting from the 90-day limit.

Mr. Timothy Edwin Hale: So if they don't get the 90-day certification, are you saying the company is not going to pay that benefit if they have a 20-day elimination period?

Mr. Abroe: The provider was not willing to certify to 90 days.

Mr. Hale: So why doesn't everybody have a 90-day elimination period for qualified plans and just leave it at that?

Mr. Glickman: Well, actually having a 90-day elimination period wouldn't make any changes or solve any situations unless you were taking the position of crediting the elimination period during a nonqualified stay, and then with most companies having gone to the vanishing style, what would happen is that you'd eventually use up the 90 days and then you'd just be, in effect, denying claims. So there should be some small savings; however, how large or small is another question.

Mr. Foley: It seems to me there's not a relationship between the elimination period. The certification is that whatever the ailment is, or the impairment, it's expected to last 90 days. And if it isn't expected to last 90 days, then it doesn't satisfy the benefit triggers. It has nothing to do with what the earned premium is as far as I'm aware of.

Ms. Loida Rodis Abraham: I really think that the 90-day certification is different from the elimination period requirement. I have heard some claims people say that they're concerned that if they approve the expectation of the 90 day—and they know very clearly as in the example that Greg gave—that it's not going to last 90 days. They're afraid that's going to impact the tax qualification of the benefits for that policyholder, so my understanding is that they may have actually denied the benefit for that reason.

Mr. Foley: Explain to me why that would affect the tax qualification. It seems to me that if you buy a tax-qualified plan, are you saying you buy a tax-qualified plan but you don't abide by the 90-day certification and that may make it nonqualified?

Mr. Glickman: I don't think any carrier is approving claims without the certification. So if you have the certification in the file from a qualified health-care practitioner, that certifies the 90 days. In order to deny it, you would actually have to physically deny the claim and challenge that certification as not being valid. So I don't think that from a HIPAA standpoint, in terms of being disqualified, that that would ever come into play because I doubt the government is going to be in a position to second-guess the carrier allowing the certification from a qualified practitioner because they've defined it up just in terms of that practitioner certifying it.

Ms. Abraham: I know what you're saying, Jim, but because you found a qualified practitioner who basically approved the 90-day certification, according to some claims people I've talked to, that's not enough. In their opinion, even if some qualified practitioner approved it, you may disagree with them and say that's not the way HIPAA will look at it, but that's not their perception of how HIPAA might look at it.

Mr. Glickman: An interesting side effect of taking that position is that you're going to move your claims denial rate up. And as you know, many companies and agents are very conscious as to what percentage of claims are approved or denied. So in practice, I'm not sure that companies are going to be willing to stick their neck out to save on a very small claim, because in my definition we're dealing with something less than 90 days in order to challenge the practitioners designation.

Mr. Foley: I'm not sure we're dealing with something that's less than 90 days.

Mr. Glickman: We were talking about the 90 days in practice. If you challenge the practitioner, you wind up with claims denial.

Mr. Timmerberg: Right, and you were talking about the denial rate. According to many people whom I have talked to, the claims denial rate becomes a big issue. And yet the reality is we paid 100% of all qualified claims. I know it's still being used out there, but I'll go on record to say that this is a bogus measure. It has little relevance and companies, I think, should be taking a position saying exactly that "this is bogus and we need to expose it for what it is".

Mr. Foley: Doesn't that depend on your definition of qualified claims?

Mr. Timmerberg: That's exactly the point.

Mr. Glickman: Well the interesting thing is that the states do require you to file data on claims denials. So whether you consider it a "righteous" denial or a bogus denial, you will not be able to get around the issue that you made that denial. And agents have become sharp enough to read right through 100% of all qualified claims. You gotta come up with a number in the 90s for them to believe you.

Mr. Hale: So what if a company then just deferred claim payment until after 90 days to verify that this was a 90-day certification that actually reached 90 days?

Mr. Glickman: Well, interestingly enough, the law doesn't require it to actually go 90 days, but just requires that it be certified to be expected to go, and, further, if you can't get that certification and it actually does go 90 days, that is proof of the 90-day requirement. But the fact is that somebody could have a 90-day certification and have it only last 65 or 70 days. And that would be fully appropriate to pay, especially if it wasn't really expected to last that long.

Mr. Jim Youngquist: This is for Tom Foley. Are you seeing companies following any nonqualified plans?

Mr. Foley: Yes, but not the onslaught that we were seeing a year ago. A year ago, it seemed like everybody was filing two and three policy series, and almost all the companies would file a qualified version and a nonqualified version. They explained to me that the benefits all have the same premiums, which I never understood.

Mr. Glickman: Let me refine the question. Are there any companies that are new to the market filing policy forms that are nonqualified and qualified or perhaps even nonqualified only? Because I know that a lot of companies that were heavily into the market, pre-1997, felt the need to continue their NQ and Q forms and try to convert their agents over, rather than risk some type of revolt by either significant marketers or marketing groups.

Mr. Foley: Yes, it's possible that there's been a shift away from N to NQ, but it really hasn't hit my radar screen yet. I haven't become aware of that. However, now that I'm thinking, it's been a while. We don't see nearly the number of new forms that we were seeing a year ago.

Mr. Glickman: One other interesting thing that did come out of the broker world survey was the fact that approximately 84% of all business was being issued on qualified forms. That was in 1999. However, of the 16% that wasn't, nearly 75% of it was issued by 3 companies that emphasized nonqualified and one of those 3 companies was a very major company and, therefore, is doing a lot of nonqualified business. So we know there is still some interest and effort around that and, of course, we have California where everybody is required to offer nonqualified

offerings. So I don't think it will entirely go away, but clearly in my opinion it has shifted away from qualified. Ready to go on to our next issue?

Mr. Foley: Is anyone going to answer why the premiums are the same for the different benefits? Nobody wants to speak to that? I'm not surprised.

Mr. Glickman: Does anybody have a nonqualified policy that is not priced higher than their qualified? OK. I actually think that that has been the trend. There have been enough years since 1996 when the law came into play, and the companies have a chance now to revise even filings that they had done just for the HIPAA law. I know that originally when the law came into play we, and many other companies, made no differential between the two because there was a crush to get the policies approved and done and it was much easier administratively to just deal with it with a Q or an NQ without a separate rate structure, but to continue to encourage and to represent some of the cost differentials. Usually not so much in benefits because most companies Qs and NQs, even back then, had the same definitional basis other than the 90-day certification. What was different was the tax position on the tax reserves. You had to use two-year preliminary terms for tax reserves while you were required to use one year for statutory for a nonqualified plan.

So I think most companies have shifted to some differential. The ones who really don't want anybody selling NQ have switched to the largest differential they can justify.

Mr. Glickman: OK, hopefully the next topic will generate some interesting conversation—the concept of taking an aggressive approach to pricing. Now, obviously, companies, especially ones that are new in the market, have to think about how to achieve market penetration and sometimes their approach is to have a lower price than the next company. And as we all know, there's only a limited amount of information available upon which to make some of these pricing decisions, and there's certainly great latitude to develop whatever premium you really would like to justify. Let's ask our three expert panelists what they think of the aggressive pricing issue or whether there has been a retrenchment.

Mr. Timmerberg: I can't comment whether it's still going on in other companies. I don't know. There's a very delicate balance between how you do your underwriting and how your pricing meshes with that. Things are changing continuously as you look at it from one year to the next. I think what we see as obvious mistakes from the early and mid-1990s, was that companies wouldn't put it out on the market if they knew those holes were there. Like you said, CONSECO acquired BTL in December 1996; that included ATL, a J.C. Penny block, Transport, and some other smaller companies that ATL had acquired. Some of the problems we see that are obvious now weren't clear to them at the time, such as age banding, (55 to 59, 60 to 64), using a composite rate for those age bands, and, of course, you look at the business 10 years later, and all the business was sold in the top age. All of it was issued at 64 and issued at 69. They probably thought all their sales were going to be 70-plus.

Another company, LTC, was experimental at the time. It used its cancer policy rates to do its LTC pricing, which probably made sense at the time. It hasn't worked out that way. We all know what an impact that has on your rates in the end, and, of course, there's still a lot of smoke and questions as to how you want to underwrite. Do you want to be extremely strict and have your agents wait six weeks or two months to get a policy issued? Do you want to do minimal underwriting to try and get them issued quicker? Where in the spectrum do you land to get the appropriate mix of agent, service, and risk control? Some people can be doing aggressive pricing now, but they think it's conservative pricing. We'll know in five to ten years.

Mr. Hale: Tom probably sees more of these filings, but regarding aggressive pricing, to me that was basically a casualty attitude —we could just price this product and raise the rate—just like we do in normal health insurance based on one years experience and continue with that as the benefits continue to expand. We've gone from facility-based care to more of the home- and community-based types of care, and this I'm sure will run us right into rate stabilization. I just don't see that companies are going to get anywhere near that aggressive in their pricing. I think they'll try to come up with discounts that help reduce their pricing—try to be niche marketers and have your lower-rated companies be your C-rated companies. Their lapse rates could be higher than an A+ company, because an A+ agent is going to come in and tell them, "Oh no, you have to be with an A company. Lapse that policy." So, I do think there are some things that allow companies to get more aggressive in pricing. Whether or not they pan out, we'll find out.

Mr. Foley: I've had a couple of experiences in the last 30 years that probably push me very clearly in one direction. In North Dakota and Florida, I had to implement the Commonwealth rate increases that everybody I'm sure is aware of for their average premium, which went from 900 to 7,000 over a 5- or 6-year period of time. I had a talk with a lot of the friends and relatives of people who had those policy forms who asked, "What do I do with Aunt Nelly's policy? Her premium next year is $7,000 and she's getting more feeble every day?" So that left a significant impression on me that we should do everything we can to make sure that as blocks age, that that doesn't happen. Second, I've been involved in health insurance, medical expense, for the last 25 years, and I know I can count on one hand the number of blocks of medical expense business that I'm aware of that did not go into an assessment spiral at some point in time. There are four or five blocks I'm aware of where the company has the initial premiums high enough that it they sold them for a significant period of time, closed the block of business, continued to manage it, and now get nominal rate increases year after year. But in every one of those cases, the initial premium was, in hindsight, compared to the marketplace, very high. To put those two things together, I feel so strongly that rate stability is a key element and aggressive pricing, which includes aggressive benefits. I'm going to try to put more flesh on that and underwriting, claim adjudication, marketing, and client knowledge, the whole business. Aggressive pricing is potentially going to lead us to a path where the Commonwealth experience is not the exception, but unfortunately becomes the rule.

Mr. Glickman: Well, let's try this from a slightly different angle. Obviously, there is in every company, pressure put on by marketing to the actuarial and financial areas to make the products more competitive. That's true regardless of where the market's going as a whole. There is always something out there that seems more competitive, that has significantly lower premiums and higher benefits. Likewise, a lot of this is not particularly well-known to us. So do we pick a premium that has a 99% chance of being sufficient or do we pick one that has 50%? Or do we pick one that has 10%, because perhaps the marketing goals are more important than the assuredness that the price stays in place? Likewise, the products that tend to be the most aggressive tend also to wind up with the best persistency. And for somewhat obvious reasons, although interestingly enough, the more aggressive prices are often addressed and justified by using just a slightly higher lapse rate. And by the same token, products that have the highest premiums and the most conservative pricing and the lowest lapse rates will, I suspect, over the long haul, experience higher lapse rates than perhaps they had imagined, just because other products or other agents eventually get to them and convince them that should give up that policy for one that is significantly cheaper.

On the other hand, you have the issue that companies are trying to be more proactive and offer better and newer benefits and we're seeing them in all sorts of ways, not the least of which is one of the interesting positions recently on companies that issued what were nursing-facility-only policies in states that want to pursue enforcing assisted living benefits on them, and whether or not they should be "good citizens" and just provide an expanded definition of nursing facility; thus, risking the viability of the rate structure in the future. Or whether they should say to the state that the only way we can offer these enhanced benefits to this policy is by charging an additional premium, which in most cases will be significantly higher because of the lapsed time that's gone by and the need to fund that benefit at the higher attained age. Anybody have any comments on some of these pricing issues?

Mr. Hale: Well, Jim, first of all, I understand certainly the company's point of view about adding a benefit to a product, and I'd like to question whether somebody would be 3ADL deficient qualifies for a nursing home and is getting care in assisted living, why wouldn't the insurance company pay that benefit just because they're not in a nursing home? Is that what the states are asking? Or are they saying no if they're 2ADL deficient? I think there's a measure that the company could look at now; it used to be doctor-certified. Are they in a nursing home? We pay the benefit.

Ms. Peggy L. Hauser: I think that would be a dangerous precedent if you just paid all those claims because they met the benefit eligibility criteria but not the facility criteria. People don't want to go into nursing homes, but assisted living facilities are nice places to be. And so, if we price this and we said that we were paying benefits to everybody who was 2ADL dependent, our rates are going to be much higher than if we're covering just facility care. So I think that would be dangerous for a company to do.

Mr. Hale: With private insurance, if you go to most CCRCs where they own the health center on a campus, their nursing homes are as deluxe as assisted living is. So if you have private insurance, you're not going to a Medicare or a Medicaid nursing home. You're going to a private pay facility. So I'm not saying you're right or wrong.

Mr. Bruce A. Stahl: One of the victims of an article in the June 22, 2000 issue of *The Wall Street Journal* made the mistake of paying assisted living benefits when they only priced for nursing home.

Mr. Hale: Oh that was out of the kindness of their heart because that's what their rate increases were for, right?

Mr. Stahl: Actually it's true, but it wasn't part of the promise they made when they wrote the contract. And they had a lot of assisted living facility claims that they stopped paying. They wouldn't have had that if they stuck to the definition in the contract.

Mr. Glickman: Well, actually, I think what Tim was getting at is that they may have seen an opportune time to justify since they have frequently come under attack for needing rate increases. They said, "Hey, we'll give this benefit away and this will justify the other rate-increase needs that may be there." Is that what you were getting at as an issue?

Mr. Hale: Yes, because I had read a letter from the company to one of the state commissioners saying that we'll need a rate increase because we are paying these claims out of the goodness of our heart, when, in fact, they had already instituted the rate increase and this was just kind of a way to say we're giving them an extra benefit for that rate increase.

Mr. Stahl: I know from personal experience that they did start paying assisted living before the rate increase. I remember calling them on the phone and being put on hold and listening to them tell their policyholders you're now covered for assisted living. File the claim. This happened long before the rate increases were requested.

Mr. Glickman: Right now, companies are required under HIPAA to pay after Medicare. And there's an issue from most actuaries and their pricing, how much they want to take into effect, the claims that won't get paid because Medicare will be paying them, and, therefore, they won't be eligible for payment under the policy. My belief is that some day Congress is going to look at this issue and say, "We can save X number of dollars if we take the logical position we've taken in almost all other health coverages and make Medicare secondary as the payer." All of a sudden, you're going to have a whole group of policies, depending on how much they put in there for that offset, who are underpriced, and, if it's five or ten years down the road, it's likely that they're underpriced to the extent that they might very well need to put in significant rate increases, perhaps even creating rate-spiral-type reaction to them in order to recover. And, in fact, they're probably covered

under the rate stabilization, which we'll get into next as an extraordinary event, because, again, they were priced for what the conditions are today but not priced for what they will be. What I'm curious about is what companies think they should be doing if they're trying to do this right in terms of taking that into account, or whether they should assume that some day it's going to go away probably well before many of the claims have been paid, so there's no claims impact and whether they're pricing for the assumption that Medicare coordination will not be there when they start paying claims.

Ms. Abraham: That's a tough issue. Because you're right, Jim, that's an issue if you price for it, and if you don't take it into account now, when you could have, because it would make sense to account for a Medicare offset. It doesn't make sense to not account for it. To over-account for it, knowing there's a chance it might go away would be an issue too. So I think to go somewhere in the middle is probably a safer thing to do.

Mr. Glickman: Mike, you do a number of pricings for companies.

Mr. Abroe: Well, the thought that struck me when you were talking about this is the new rate and stabilization requiring the actuary to have reviewed claims practices, and that the pricing assumptions would be consistent with what the company's administrative practices are. And so it's going to require actuaries to become a lot more familiar with what the claims departments are actually doing. Are they checking for Medicare? Even though the language allows them to do it, maybe some claims departments aren't even checking to see if Medicare would cover the claim. Some departments may be checking to see if Medicare is covering the claim and then denying it. I think you can vary quite a bit by company.

Mr. Glickman: It's actually an interesting question you bring up because the certification—and Tom can correct me if I'm wrong—says that you have to certify that under reasonably adverse circumstances your premiums will be sufficient. And the question is, would a presumption of a change in the law that would change pricing assumptions be a reasonably anticipated adverse assumption? Or should you be pricing in the current status and just dealing with other assumptions?

Mr. Foley: It's underlying this whole issue. Let's just talk about this for a couple of minutes. It would be great if we could find a solution. But one of the biggest heartaches I have working for insurance departments is I'm invariably subjected to the consumer assistance people. And I tell you their heart is in the right place. They just don't understand the concept of payments being forced to be made outside a contract. And I can't tell you how many times I've had consumer assistance people come by and say, "Boy I had a great day today because I got Company X to pay Y for an LAN." I said, "Shouldn't the contract indicate that that payment should have been made?" Then they start mumbling. So it's kind of a chicken-and-egg problem because we have situations where companies try to get off appropriate claims. One reaction that the regulatory community has to that is to overcome that by forcing companies in some situations to handle claims they shouldn't. In fact, there are at least two states I'm aware of that have sent letters

to companies voluntarily asking them to take old nursing home policies and include assisted living. Actuarially, that makes absolutely no sense at all. Contract-wise, that makes absolutely no sense at all. And yet, we have that going on in this country. So it's a lack of trust from all sides. I think it would be great, if as company people we would take the high road and understand that what we're going to do is design a product that really meets people's needs now and in the future, and we'll underwrite it properly. We'll price it properly. We'll pay claims properly, and would go out of our way to do everything. I know that the retort you're going to make is, "Yes I can do all that and then some regulator or public policy person is going to make me do this." I mean we have a guaranteed issue in medical expense, so that makes absolutely no sense at all.

Mr. Foley: Somehow we have to get over this hurdle and that's part of the motivation, but why does the rate stabilization have model changes that are designed the way they are? Try to strongly encourage companies to do the right thing, not only now, but in the future, and I understand the marketing people. I've been in actuary, accountant, president, and marketing officer meetings for 30 years and I know the marketing officers generally win. But somehow we have to find a way to take the high road and get away from the nitpicking and try to do the honorable thing.

Mr. Hale: Mike, I think you hit on two issues because everybody tries to attract the younger market, the under-60 market. Will benefits be paid when I need them and can the premiums stay on an affordable level? To me that's the motivation to buy it at a younger age—I have an actuarial background too, and I'm against paying for benefits outside the contract—but ten years ago, we didn't know about assisted living. So ten years from now, those alternate plans, those care plans benefits, could be huge compared to what my nursing home benefit is. So I guess I'm agreeing with you that there should be a way to do this to guarantee the prices; to have this stable measurement for the premiums and still address all the possible benefits that might be paid.

Mr. Foley: If you want something really bizarre there are people in the industry whom I've been involved in conversations with who believe that the whole concept of guaranteed renewable (GR) needs to be reviewed. It especially needs to be reviewed in the context we're talking about now. Nursing home coverage paying an assisted living is a perfect example of that. Let's suppose that we go back to 1985 and that we were all-knowing and we determined that of all the people who we were going to sell to 15% were going to go into claims and that was our intent. That's the way we designed it and marketed it. But over 15 years, it turned out that because of our definition, it's not 15% benefit claim status. What does the concept of GR mean in that context? Does it mean when I bought the policy in 1985, that I bought this anticipating that I was going to be in the 15% claim mode? And if it turns out that I'm in a 50%, well clearly the price is woefully inadequate and we have to have significant rate increases, or if it turns out that because of changes there's only 5%, then we ought to have a premium reduction. So the concept is, how can we design things in such a way so that GR means that 15% is what we pay? That's what the renewability assures me of when I buy one of those

contracts. I must profess I don't know how to do that, but you could have a lottery.

Mr. Foley: I told you that I was really prejudiced by the fact that I worked in medical expense for so long, where we've tried to be all things to all people and we get involved in dollar trading and clearly that system is broken. It is so broken we don't even know where to go. If we do the same thing in LTC, which is where the marketing people are taking it with all these whistles and bells, and trying to provide first-dollar coverage and be all things to all people, I can see LTC going the same path 10-15 years from now. The expectation of all the consumers who buy this, is that, if I need care, and I'm going to define whether I need it or not, then there's going to be money there. There's no way to price that.

Mr. Glickman: Let me ask a question. How much responsibility do regulators take in the process of determining what's too aggressive and what shouldn't be aggressive or should they have any role in that at all? Should there just be a certification process?

Mr. Foley: Well, you're probably talking to the wrong regulator because I'm one of those people who keeps poking my nose around things and if the rates look aggressive to me, then I'm going to write and ask you about it. Chances are most regulators are going to look at what the law and the regulation says, and the law and the regulations say the actuary is going to certify that it meets the 60% loss-ratio end of story. So what should they do? I personally think that regulators need to be poking around. And my real intent is to find out that you know what you're doing. If I find out you know what you're doing and you have some sense of fairness across all your policyholders, you won't get any grief from me. I mean you can do what you want. But if you don't do one of those things or another, then as a regulator I can try to help you see that there must be another way to do it.

Mr. Glickman: Let's move onto the next topic, which is rate stabilization and its effects on pricing. And again, we'll start off with a brief comment from each of our panelists. We'll let Tom lead off with that one, since he's been most intimately involved.

Mr. Foley: Is there anybody here who isn't aware of the changes in the model or regulation or what caused them, where they are? I might just tell you that, hopefully, you're aware that there is a compliance manual that's in the process of being developed that's available at the NAIC Web site; that is *http://ww.naic.org*.

Mr. Glickman: At what level of development is it at this point?

Mr. Foley: We had a seminar in Dallas in September. All sections but Section 20, which is the rate increase section, have been written in some form or another. This will probably be continually updated over the next year. I'm hopeful that we'll have some part of Section 20 written. I can tell you that we're in the process of adopting this in Kansas and would hope to implement this as soon as possible. Some of the trade associations promised me that they're going to contact the

state insurance department and try aggressively to get this adopted. And I think that there's a sense among most of the people in this business that there are some problems with the way LTC has been priced and the way it's been designed, and that there are some affluent companies that are making it very difficult for companies that have a long-term interest, both from the company viewpoint and the policyholders' viewpoint in being able to provide care. They're making it very difficult to do that. I think that's the impetus behind finally getting this thing adopted, and I started raising these issues in 1992 when I was in Florida and the industry looked at me like I was nuts. There's no way we're ever going to do that. And I guess the California problem is what finally got us over the hump. Anyway, I'm hopeful that it'll get adopted and that companies will develop this new attitude of adequacy.

Mr. Glickman: What do you think will happen? Do you think companies will change their pricing perspective? Or do you think it'll be just be status quo until something happens quite further down the line?

Mr. Foley: That's a really interesting question because my whole career I've dealt with fixed-loss ratios. And I don't know how companies are going to react because I think all the pricing actuaries have spent their whole health career with fixed-loss ratios and now, to have that barrier gone. . . I certified for 20 years, but I certified to a loss ratio. That's relatively easy to do. Now if you have to certify to adequacy even though there are all kinds of catchwords in there, I'm hopeful that just the questions are being asked. For example, do I need to go find out what claims people are doing? Do I need to really go find out what underwriters are doing? I can't tell you how many times I've had one-on-one conversations with actuaries in the regulatory arena, talking about rate increases and I'll ask, Why did we get to this block of business and, invariably, didn't we price it right? "No, I'm sorry," that seldom is what is said. But what's said is, "we had this marketing arm and they were too aggressive for field underwriting, and home-office underwriting didn't adjudicate claims." Some of you heard me tell the story about a 40% rate increase. This was ten years ago in home health care (HHC) and it turns out that this company went through five claim managers in a period of three to four years before they finally found one who said, you've been paying claims you shouldn't have been paying. And it turned out that if this was in Florida and the insurers, the HHC agencies and the doctors, all knew of this company so they would send people to buy HHC coverage and then both put them on HHC and the company would pay it. So I'm hopeful that actuaries will now make sure that they know about that and will continue to monitor on an ongoing basis how we pay claims today and how we are underwriting today.

Mr. Glickman: John? What's your view on what you think will happen with the pricing and rate stabilization?

Mr. Timmerberg: Logically, it should force rates higher. I mean you're shifting a risk. If this LTC is viewed as true GR, that implied a sharing of the risk between the policyholder and the company. This new regulation is moving the risk more toward the company and offering the policyholder more rate stabilization, which should

imply higher rates. The idea that you can come in with low-priced products can somehow make up losses with rate increases in the future is not a viable business practice and for companies that are underpricing today, I guess that can be washed through with reserves etc., for a short while. But that does come home to roost pretty quickly.

Mr. Glickman: Some believe not quickly enough. Go ahead.

Mr. Foley: Especially in LTC. You know? In medical expense I agree, but in LTC I think there's a period, which is a lot longer, do you agree with that?

Mr. Timmerberg: If you're reserving properly and monitoring your experience as it develops, then that implies someone is not recognizing what's happening. As I said, you can wash that through with reserves and delay the pain, but the pain is going to show up. I made these comments about a year ago that I thought the market was going to handle this issue on its own, without having a new regulation. Obviously, the regulation is probably going to handle it more quickly than the market will. In other words, companies that are doing this probably aren't going to be around that much longer to continue doing it.

Mr. Foley: Unfortunately, some of us are still doing it. It appears to me that we're masking existing problems with more and more new business, which I think magnifies the death; when death finally occurs, it's going to be horrendous and I wonder if it's not going to be horrendous for our business.

Mr. Philip J. Barackman: I'm wondering if the bar is being raised to a standard at which rates are certified to be adequate under a reasonably adverse development. I'm wondering what the implications are for actuarial memos, which are explicitly if not implicitly the best-estimate-type assumptions. In other words, is there an onus now on the actuary to talk more about margins for conservatism? It seems like every actuarial memo that I look at the interest-rate assumption is whatever interest rates happen to be today, and the assumption is that they'll remain that way forever. That strikes me as a best-estimate assumption. And if the onus is now to certify that rates remain adequate under adverse developments, then I'm wondering if we'll see or need to have more explicit evidence in the documentation of their pricing that those events have been anticipated and things such as grading down interest rates after the length of the initial assets.

Mr. Gary L. Corliss: It seems the question is what would be the effects of the rate stabilization and my own opinion is that it's not going to have any immediate, short-term impact at all on the way that people are pricing. We've had the *Actuarial Standard of Practice No. 18* revised a couple of years ago. There are things that Mike mentioned in there that practicing actuaries should be following. They should be looking at their whole operation for the organization that they're pricing and making sure that all of those assumptions are put into place. I think that the quality actuaries that are doing the work and really studying it are going to continue to do that, and they're going to continue to be in the business. There's always going to be those probably that will be pricing either with somebody with a bigger marketing

arm on them, and I think the net impact is that these companies will get washed out, so I think it has a punitive impact. I really don't see it having a positive impact on the marketplace.

Mr. Stahl: I think it's going to cause the rates to go up, no doubt. I'm viewing this as noncancelable. I don't see how we can do it otherwise. The risk for the company is far too great to have to implement a rate increase in the future. There's something that hasn't been brought up in any of the seminars that I can remember. When you go for a rate increase, you have to use 4.5% interest in your projections. So if we're pricing, say, at 6.5% and we're meeting profitability targets with, say, a 55% loss ratio, and then we have to go and justify a rate increase with 4.5%, the loss ratio may really end up being 63%, 64%, or even higher. And so you're going to be trying to get an increase on expected loss ratio that's much higher than what you were really planning to do in initial pricing. Do you understand what I'm saying, Tom?

Mr. Foley: Sure do.

Mr. Stahl: And it was intended that way, wasn't it?

Mr. Foley: Exactly. I think the message is pretty clear. And maybe that's why I'm at least a little bit surprised that the end filing came to this point and finally came to the table and agreement . And it was pretty universal, at least based on the trades that were at the table, as something we need to do. I think that the reason for that is there continues to be maverick companies out there that may well drag this business down.

Ms. Joan Ogden: Tom, what would your advice be to some of your colleagues in other states who say, "Yes this is really neat. I really like this idea. What we'll do is keep our minimum 65% loss ratio. We'll have the companies file their loss ratios every year and we'll add this on top"?

Mr. Foley: Let me give you two answers. Regarding the conception of what we've done by eliminating initial loss ratios and only implementing the rate increase time, conceptually, there's not a person in this room who didn't understand that in the first five minutes they saw it. I think that it's relatively easy to explain that to regulators in other states and get them to buy off on the fact that they have to eliminate the initial loss-ratio requirement in order to implement this. The unfortunate part is the industry in its zeal to make sure that it didn't leave any stone unturned had put all kinds of complications in this regulation change in order to cover first one thing and then another. The group people wanted it out, so we got two pages of requirements so they could have a little bit out. In the compliance manual, we have maybe ten full pages of examples of how you can indicate that you've had a rate increase. All those things do is complicate this and make it more difficult for nonactuarial regulators and other states to understand how this works. And so my biggest fear is kind of inherent in your question and that is, we're taking something that's pretty simple and I think should be pretty easy to understand and by having all these exceptions, we may end up throwing

the baby out with the bathwater and either having states not adopt it because they don't understand it, or, if they do, misadopt it. Now you know, I've done everything I can to encourage them to call me or e-mail me and we've had seminars. We're going to have more seminars aimed specifically at regulators who try to head that off. In fact, I'll go out on a limb and say that my commissioner would probably send me to a state that wanted to implement it and still require a loss ratio, which isn't to say that that would make any difference, but at least we could go talk to them.

Mr. Glickman: One of the things that I think may be a big issue with this rate stabilization is, who is going to make the first move? Let's say you're in a particular company and you think it's a good idea to do this. It's going to be tough for you to say to your marketing people that even though we think we're priced right now, we need to make some changes because we need to be another notch conservative off of perhaps where we went because of marketing pressures in the first place. This applies even to those companies that have been trying to do a very scientific job of it. Yet, I can't imagine that any company wants to be the one to do that first, because it'll take a lot of flack from its field force.

Mr. Abroe: Well, one of the things that I think will help the actuaries in this is that the Academy is obviously aware of the rate stabilization model law, and it's on the Academy's list for review and possibly updating the standards and identifying perhaps some safe harbors, some ways of dealing with issues such as, what does moderately adverse mean? Provide some guidance to the actuary, so I think that there are some things that are going to help the actuary be able to go back to management and say, "Here are the types of things that, as a company, we're going to have to be dealing with, going forward."

Mr. Foley: I've had two, three companies come to me informally and ask, if we want to implement this, can we do it now? And I tell them that we're in the process of changing our regulations just as fast as we can. If I got a filing tomorrow from a company with a certification of adequacy, I can tell you that I would do everything I could to find a way in our regulation and law to approve that and not make them subject to minimum loss ratio. That would be the problem. I don't know that I'd be able to do it, but I'd try to do it.

Mr. Glickman: Although that works in Kansas, unfortunately, everyone has to work with all the other states and there are very few companies that want to implement a one-state product change in order to accomplish that.

Mr. Hale: Jim, let me make a quick comment too and play devil's advocate. First of all, I'm in favor of the rate stabilization. I think it's at least a good first step to try something that needs to be implemented. But if you look at this from purely a consumer's point of view, basically you're telling me that my initial rates are going up, and my other rates could still go up. And so, although we can argue this as a great consumer bill, where does the consumer see that? I mean their premiums can still go up and if they don't buy now, chances are the rates are going to go up anyway.

Mr. Foley: Well, that's a segue into another topic you want to talk about, Jim. If GR rates are here, and noncancelable rates are here, one of the questions is, where are certified adequate rates going to be? Where are the new rates going to be? Are they going to be closer to GR? Are they going to be closer to noncancelable? Bruce seems to think that they're going to be, if not at noncancelable, at least close.

Mr. Hale: I think it's also going to require state regulators to take a more active role in the regulations than they have in the past, even with staff and budgets pretty short.

Mr. Foley: Let me throw something out for you to think about. The life people and property and casualty (P&C) people have come to the NAIC and indicated that we need centralized review. I'd be less than candid if I told you I don't really have a clue whether they're going to pull this off or not because when we get to the bottom line, it will be a function of whether states are willing to move their laws and regulations to fit some national standard. On the life and PC side, some significant number of states are talking about doing that. You need to weigh in as health companies and say wait a minute. Let me back up a minute. Right now, the thought that's in the source commissioners' minds is that health insurance is a local activity; therefore, this centralized view is not appropriate. There certainly are exceptions to that and LTC is the prime one. So you may want to talk to your associations and follow what's going on, because I agree with you. I think that there would be significant advantages to the industry and to consumers if we had some kind of centralized review because even if this new regulation gets adopted in 12 key states, there may continue to be a significant number of states where the kind of loss ratio mentality will continue which, as we've indicated, hurts everybody.

Mr. Timmerberg: One thing that concerns me about the new regulation is there's no minimum loss ratio. And there's also kind of a retrospective side to the regulation, where past actions have to be disclosed now—for example, if you did a 10% rate increase in 1994 and a 10% rate increase in 1996, all of a sudden in year 2002, you have to disclose that. But when you did those rate increases, you didn't know you would have to disclose them. This raises a question. If there's no minimum loss ratio, but 10 years from now if you have a form that's running at 50% loss ratio, and the state realizes that you have a substantial amount of profit there and some new regulator says, "You're making windfall profits on these people. It's time for you to lower your rates." The new regulation opens the door of retrospective actions, so I don't see how we can be firm in our minds that in the future this no minimum loss-ratio thing is set in stone.

Mr. Foley: I guess I ought to speak to that. It's kind of a leap, although John, I understand what you're saying and I hate retrospective as much as anybody. If you listen to me as a regulator, every time retrospective comes up, I'm on the side of "No, this has to be prospective." And we grappled with this a long time about rate increases, and, in fact, that's part of the reason why the words are in there; that if the company had a rate increase it gets to describe the rate increase. That's why we have ten pages in the compliance manual. We're trying to help everybody

understand how to do that. I think it's important that companies that have historically taken this strategy own up to that, although on the other hand it does have retrospective and retrospective bothers me. So I sure can't disagree with that. And I dearly hope that ten years from now the public policy makers don't do what you're suggesting.

Mr. Glickman: Well, let me ask this. Over the years there's been a lot of talk about noncancelable and whether or not it should be mandated or whether or not it should be an option and whether companies will voluntarily come to the table and offer noncancelable products. And outside of a few specialty situations, such as single pay and some limited pay contracts, I don't think I've seen yet any true, noncancelable annual pay products. What does the rest of the audience think about whether or not this will inspire some noncancelable product designs? Clearly the disclosures about the likelihood and probability of future rate increases have been thrown much more in the consumer's face than they ever have in the past. In fact I think the reason why most companies haven't offered a noncancelable policy where they thought they could even price it reasonably safely at a significantly higher premium than GR, and give their clients the choice between a much higher guaranteed rate or a lower, what I'll call current, practice rate is because one of the implications is that that lower GR rate isn't particularly stable. Does anybody see any changes in that realm, now that the disclosure is much firmer in terms of creating uncertainty in the mind of the client about the level premium rates staying level?

Mr. Andrew M. Perkins: I'm actually not going to answer your question directly, Jim. I'm not sure whether the industry's going to go that route. From observing the disability industry for a lot of years, companies I think tended to price noncancelable disability without any load for the guarantee. They'd price the noncancelable for the same price they'd price GRs. And part of that was probably market pressure, but also, for some period of years they saw a pattern of experience and they thought they knew what the costs were. And the industry and the actuaries were willing to bet that it was going to stay that way forever. It just didn't work out that way. I worry about the LTC industry going the same route, but that's not a prediction.

Mr. Foley: You know, it's fascinating to me looking at disability insurance (DI) because we've gone through that cycle at least six or eight times in the last century—easy underwriting, low premiums, and liberal benefit definitions. DI has gone through that cycle starting in the 19th century.

Ms. Ogden: I wonder if a consumer's perspective on noncancelable versus GR varies according to age. If I'm 50 and buying LTC, I might very much like a noncancelable policy and be willing to pay the higher rate. But if I were 75, I might rather gamble and pay the lower rate, because I could be dead in 5 years. Why pay the higher rate at a guaranteed than when if I make it to 85, my rate won't go up?

Mr. Hale: I think, too, indirectly there are some companies that basically say they have never had a rate increase in the history of their policies. And, effectively, they're marketing themselves as a noncancelable product. They still have the GR in their hip pocket, but I think the industry itself is starting to lend itself to a noncancelable product. And, again, I don't profess to know what that guarantee is worth. But I just wonder what's going to happen if any of these companies did have to raise their rates. None of their agents would know how to market the product anymore because their number one sales option is never having had a rate increase.

Mr. Gurlick: My perspective would be that I hope the industry does not go to noncancelable. If you look at the history and other lines of business it just doesn't look that good. And I think what we're going to end up with is a situation where in the short run, we should have premiums that, essentially, tend toward that noncancelable level. But we aren't going to get the market advantages of noncancelable. We're going to have to rely on what Tim says. Companies are going to be able to point to their records and their history and market that. It's just too early in this industry to actually take the leap and say for the next 40 years we won't increase rates.

Mr. Hale: I find it interesting, too, Greg, that there are a few companies that have given a guarantee of ten years. And I think a lot of regulators are suspicious of it. They feel that's just so you can raise your rates after ten years. And they're saying we don't think we'll ever have to raise our rates. In fact, we're so confident of that, we'll give a ten-year guarantee, and you're even more suspicious of them. But you're asking them to state up-front we don't ever think we'll have a rate increase.

Ms. Abraham: I agree with Greg. I'm very concerned about the noncancelable, but the issue to me is not that we shouldn't be trying to price the noncancelable. I think we ought to be doing that. But, in my mind, we're so focused on what we're seeing today. And the reality is, that the utilization of tomorrow could be very different. I mean we're not talking about how providers are changing or services are changing, or how medical technology could change all this. I don't presume to know what the future is going to be or what the future utilization is going to be. And so when we talk about pricing to noncancelable, what does that really mean right now? It's based on what we know. But is it really what we think, or what we know the pricing of the claims will be tomorrow? Who's going to tell?

Mr. Hale: I agree with you. We always talk about what will a nursing home in the future look like. It might be waterbeds and virtual reality where I think I'm in Palm Springs on a beach.

Mr. Stahl: When California raised the issue of mandated noncancelable, we were all throwing out numbers such as 10% or 20% increases in the rates. But I had a couple other comments. One, going to noncancelable may be the solution for someone like CONSECO that has the history of rate increases because it will

eliminate that as an issue. I don't like that. I think there are a lot of things in this regulation that I don't care for.

Mr. Timmerberg: Well, CONSECO has done rate increases on the American Traveler's block that was purchased. We haven't done any rate increases on products we've priced and filed in Indiana. Is CONSECO directly associated with rate increases? Well, yes, we purchased a block that happened to be in much worse condition than we thought it was at the time it was purchased. I wasn't there when they purchased it.

Mr. Stahl: But I think there's a big difference between this regulation and DI being noncancelable. This has penalties in it that are much more than just financial. This allows the commissioners to come in and review the operations of the insurance company and pretty much take control of it. This is not just a financial issue. And I think the industry is going to be forced to treat it even more cautiously than DI.

Mr. Timmerberg: Another interesting comment I'd just like to throw out is that there were companies in the market in the mid-1990s, and we've done rate increases on some of the products that were sold in the mid-1990s. From what I've seen, almost everything out there that was sold at that time does need a rate increase. Some companies have chosen not to do a rate increase on those forms for their own reasons.

A relative of mine got a letter in the mail from a company that's never done rate increases. He has a nursing home policy that has $110 of daily benefit with inflation coverage. They offered him the option to convert that to a comprehensive policy with $50 of base coverage and a much smaller level of inflation. In other words, they were taking his old rate and converting him to a policy at today's rates, so it's not a rate increase. He called me and we talked about it and I said, don't do that, the company is taking advantage of you. It seemed like a recognition to me that that company knows it has a problem.

Mr. Barry D. Eagle:[*] As a nonactuary, I look at the industry wrestling with a very immature product. This isn't like life insurance that's been priced for hundreds of years or any of the casualty products—car insurance, stuff like that. And yet we're being asked to come up with the final price today. And, as people have said, we don't know what these claims are going to actually be paying for 30–40 years down the road. And it's almost like as an outsider I'm looking and seeing that the industry is being asked to do something that it really has not done in any other field before. Why is this one so different?

Mr. Foley: My sense is the majority of the companies have been pricing responsibly. They have been constructing benefits properly. They have been underwriting. They have been adjudicating claims. They've been trying to do the best jobs they can, but there are some exceptions. There are some companies

[*] Mr. Eagle, not a member of the sponsoring organizations, is vice president of individual health at General Cologne Life in Stamford, CT.

and major companies that, clearly, have been going another way. And I think that something needed to be done. I'm not the pricing actuary who's going to sign this, but looking at it from my perspective, for the bulk of the industry this is going to require a rethinking and some tweaking, but it's generally going to be business as they've been doing it. And if there are some exceptions to that where they have to significantly change the way they do business, that's exactly why we did it.

Mr. Foley: This question is for mutual company representatives Why can't we develop a participating premium structure for LTC?

Mr. James A. Youngquist: Our product is issued out of a stock company.

Mr. Foley: But you still can offer a participating policy if you wanted to?

Mr. Youngquist: Well, now, it's not a mutual company question anymore.

Mr. Foley: Yes, I know. I've done a giant side step.

Mr. Glickman: Anyhow, I'll give you a small answer to that because I have actually been a proponent for the concept of coming up with a noncancelable policy with a dividend scale. Then you could have both a high enough premium that you have expectations of paying out a dividend and you can get all the advantages of what a dividend scale can offer. Likewise, you have probably a lot more flexibility in how you adjust that dividend scale versus actually doing any presumed rate increases. That would be an interesting question for you to address—whether somebody who had a noncancelable policy with a premium and a dividend scale underneath it could change that dividend scale without obtaining approval from the insurance departments first.

Mr. Foley: I have to think about that.

Mr. Youngquist: *Ryan v. New York*. The company has the option to adjust the dividend scale without input from the state insurance departments.

Mr. Glickman: So for those people who think that noncancelable may have some future, they may want to go that route, because it gives them both the advantage of noncancelable and the opportunities of being able to change rates, if necessary.

From the Floor: This may not be real relevant, but I'm curious. Is it possible to have participating policy on the GR basis?

Panelist: Sure.

From the Floor: So if you did that what would be in your projections when you do the current premium and the projected premium? Would you be using the premiums after the dividend or . . .?

Panelist: If you had current practice in guaranteed, you'd take a noncancelable premium and that would be your guaranteed premium.

Mr. Glickman: If it were noncancelable, it wouldn't be guaranteed.

Panelist: But you may be able to back off that and say, "I'm not going to charge any higher than this, but I think this will work."
Mr. Glickman: Let's finish one last topic because I'm sure everybody would like to hear about limited-pay policies.

Mr. Glickman: They're really somewhat of a halfway between noncancelable and, in many cases, they have become very much a major marketing interest to higher income individuals and even to marketing groups. I've been surprised over the last 3 or 4 years that we've probably had at least 12 major companies come out with some type of 10-pay, 20-pay, or paid up at 65 option, in order to deal with this marketplace, while everybody at the same time and many of the same companies are saying this is totally sound to do. We don't want to do it, but we have to. Let's see if we can get a few comments on that.

Mr. Perkins: It strikes me and, again, this is an opinion that basically the industry is playing around with the noncancelable concept with limited pay plans. It's not necessarily all bad in that I suspect at least where the insured is paying the premium, you have an automatic positive selection factor in that someone who knows up-front they're a high-risk individual for an early-term claim is not going to pay a higher premium. They're better off paying a one-month premium and collecting their claim. But the risk is that the experience may change. Will our pricing turn out to be wrong over the long-term after we've closed off accepting new premium? Will all these same noncancelable issues apply there?

Mr. Foley: And then do the continuous payers have to pay for those rate increases for the paid-up policyholders?

Mr. Glickman: Well, Tom, obviously you have taken a very strong position against limited pay policies; in fact, to the extent of actually trying to pursue that with other states. What is your feeling about somebody who prices a limited pay policy as a noncancelable policy variation? Since, apparently, I don't think you're opposed to the concept of noncancelable, if it is a true noncancelable design, then limited pay should just be another way to get at it, right?

Mr. Foley: I'm fearful of the continuous payers having to pay for any adverse experience. And, as a paid up, sometime in the future, that's one problem. And the reverse problem is that the paid-up people are paying a much higher premium than they ought to. So those are the two concerns that I have.

Mr. Gurlick: Would you be able to require companies to define these limited pay plans as a separate rating class, so that it would essentially be a separate forum and they would not be allowed to subsidize between the classes?

Mr. Foley: You know, if everybody would buy into John's concept that he stated a while ago, I would be encouraged to do that. We all know if we have ten blocks of business, chances are at any point in time one or two of those have experience that's worse than what we anticipated. One or two has experience that's better than what we anticipated and then there's this bunch in-between. Now, if everybody would use the good experience to offset the bad and do everything they could not to get rate increases, then I would be far more encouraged to buy into that. But my fear is even if you set it up as a separate block, if it turns out that you sell a bunch of paid-up and for some reason or another it turns out that that experience is really adverse, the continuous payers are going to suffer somehow at some point in time.

Mr. Glickman: But, again, taken to its logical extreme, noncancelable policies, you don't oppose that concept, I assume, or is that not true?

Mr. Foley: I don't oppose it. The most thoughts I have about it now are that I'd like to have a comparable GR policy there so people understand that they're paying the additional premium for noncancelable. And as long as they understand that and are willing to do that, fine.

Mr. Glickman: If a company wanted to market a noncancelable policy with or without a dividend scale, would you feel that you needed to disapprove it because they had no basis of comparison other than other company's policies?

Mr. Foley: It comes back to the same issues that we and you segregate it. How do I know that the continuous payers at some point aren't going to end up paying for the noncancelable? I mean that's the overriding issue as far as I'm concerned.

Mr. Glickman: So the ability to segregate the policy forms is the key issue from your standpoint?

Mr. Foley: Yes. And the ability to treat a block of health insurance as if all your health insurance were pooled. Now, I know pooling isn't going to work. We can't put pooling in the regulation. We talked about that. It's not going to work, but there's a way and you all know that. There are ways to manage blocks of business. I mean that's, historically, how it's done. I'm suggesting that that's a shortsighted way. One of the reasons why consumers and companies are not well-served today is because our knee-jerk reaction all too often is to get a rate increase rather than being able to market as John's saying that we've never had a rate increase and we have this mentality of taking care of everyone.