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A Review of Proposed Changes to the NAIC's Model Regulations for LTC Insurance

by Allan Kanner, Esq.[1]

Introduction

On August 17, 2000, the National Association of Insurance Commissioners (NAIC) approved a new Long-Term Care Insurance Model Regulation to address the problem of rate stability. This effort attempts to respond to abuses such as were uncovered in the *Hanson v. Acceleration Life Insurance Company*[1] lawsuit, in which rates were increased over 700% in a few short years. As is well known, what happened in the Hanson case is not a one-time event, and there are other unsuitable long-term-care insurance (LTCI) policies in the marketplace.[2]

The proposed NAIC changes are a mixed bag, but ultimately they are highly problematic. The good news is that the NAIC has recognized that its earlier laissez-faire approach to pricing LTCI allowed for abuses and that certain regulatory standards and procedures are needed to protect consumers (especially in frequent situations where internal voluntary controls are not scrupulously applied). Beyond that, the proposed regulations are highly problematic.

First, they are a work in progress. *Second*, they fail to adequately address rate instability. *Third*, they do not ensure substantive disclosures. And *last*, they neglect to address marketing abuses.

A. A Work in Progress

The NAIC's proposals are only a work in progress, lacking even a guidance manual, which remains to be drafted. This fact reflects an unfortunate rush to produce rate stabilization rules in time for a Congressional hearing.[3] This has resulted in ambiguity surrounding how the regulations will be interpreted and enforced. This raises questions about their likely impact, if implemented and written nationwide.

For example, § 9.B (2) now requires "[a]n explanation of potential future premium rate revisions, and the policyholder's or certificate-holder's option in the event of a premium rate revision." This could be a good rule to ensure that consumers make informed choices, but a great deal depends on how it is ultimately interpreted and enforced.

Also, § 9.B. (5)(a) now requires "information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state..."[4] Again, this rule only goes to information about past rate increases and not other, perhaps more pertinent, information regarding the known and quantifiable risk of future rate instability for the particular insurance product. Its usefulness again depends on how the rule is interpreted and enforced.

§ 9.B. (5)(c) appears to create an undesirable disclosure loophole for "blocks of business acquired from other nonaffiliated insurers."[5]

This work in progress also leaves much to be answered surrounding enforcement. It is true that NAIC proposals are joint efforts to improve LTCI, and are not meant to cover every scenario. In fact, the drafter notes, p.18 of the LTCI Model Regulation, that advocates are looking to the various state statutes, such as unfair trade practices, to punish persistent practices of inadequate premium filings. But some worry that this may undermine stricter state regulations where they exist.

B. Fail to Adequately Address Rate Instability

The NAIC proposal is unlikely "to guarantee rate stability and level premiums over the life of a policy," as its authors claim. Only two things will "guarantee" rate stability: the use of sound actuarial data and objective limits on rate increases. Neither of these are mandated by the NAIC. In addition,

the new regulations do not address commission rates and the approval of rate increases. The NAIC's idea of pooling bad blocks of business with non-closed blocks also leaves many questions unanswered.

1. No mandatory adoption of sound actuarial data

Rate stability undeniably depends on a sound actuarial foundation. To my knowledge no one takes the position that there is enough good data today to accurately price LTCI. However, the NAIC seems to acknowledge this point indirectly by acknowledging a distinction between types of rate increases.

Specifically, a distinction is drawn between regular "rate increases" and "exceptional increases" § 4.A; § 20. The distinction seems to turn on the cause of the increase. Exceptional increases are linked to new legal requirements, § 4.A.(1)(a), and new actuarial data, § 4.A.(1)(b).

Such increases seem superficially fair, if explained initially to the purchaser and limited to truly unforeseeable developments. However, there is no requirement that these changed circumstances be truly unforeseeable to the actuary. This problem is exacerbated by the fact, noted above, that the insurer is not expressly obligated to identify for the customer known or foreseeable risk factors that could lead to future rate increases.

In addition, the exceptional increase allowed may still be greater than the new facts or law warrant. § 20.C.(1) ("Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits"). Yet there need be no showing of thirty percent extra administrative cost associated with that foreseeable or unforeseeable increase (over and above the existing administrative expenses priced into the original premium).

A sound actuarial foundation is only meaningful if proper underwriting practices consistent with that foundation are adhered to. Remarkably, the NAIC does not seek to improve underwriting problems or even address their abuses. There should be standard underwriting criteria. There should be basic guidelines to be followed, such as requiring attending physician statements (APS) on anyone 75 or over. Right now, companies have a free reign over when to request APS on someone. There should be some *standardized guidelines* to follow. If these criteria are not followed, the company does not get to use this loss in their loss ratio analysis.

Actuarial certifications are already used with new filings and rate increase filings, and most reputable actuaries would follow their profession's existing actuarial standards of practice, which provide in substance that no hidden rate increases are planned. This leaves us in essentially the same position. Some actuaries will sign off on bad policies.

State regulatory ability to adopt appropriate regulations, monitor compliance with those regulations and police fraud is likewise tempered by their responsibility to see that insurance companies remain solvent enough to pay all claims. Too often the company that knowingly or negligently engaged in low-ball pricing points to prospective financial problems of its own creation as the justification for future rate increases.

Unfortunately, state regulators do a bad job of worrying about solvency at the time of initial filing (as opposed to waiting until it is too late and a rate increase is being sought).

2. No objective limits concerning rate increases

Rate stability can also be achieved by firm limits on rate increases. This, in effect, would mean that the insurer would have to cover the risk of its actuarial mistakes from its own capital. The NAIC ignores absolute rules. For example, there should be a ban on rate increases for the first five years and an absolute limit on rate increases in excess of some percent.

There should be some control over how soon a company can ask for their first rate increase. There should be a period of required stabilized rates, such as five years. Then, if any rate increases are needed, they should be limited in amount, and they should also be guaranteed for at least two to three years before asking for another rate increase. There should also be a penalty for asking for too many rate increases.

Why not set firm and absolute limits on rate increases? Clearly price matters. Certain public benefits, such as tax deductions, could be limited to policies from companies willing to accept such limits, which will certainly give those companies a competitive advantage over non-price-restricted policies.

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3. What about commission rates?

Also, what about commission rates? Why not limit the amount of the first year commission to no more than double that of the renewal commission (i.e., if the renewal commission is only 15%, then the commission for the first year should be no more than 30%)? This would allow for more money to be put into reserves at the beginning of the policy and may result in less frequent requests for rate increases.

Also, a company should not be rewarded with rate increases when they hand out large first year commissions while predicting high initial lapse rates.

4. Poor standards regarding the approval of rate increases

Section 20 on Premium Rate Schedule Increases makes some good points, but it does not go far enough. Automatic rate increases ought to be eliminated — the loss ratio concept as currently used does more harm than good.

Also, companies should not be rewarded with extracting profits from rate increases when the rate increase is due to poor underwriting.

Regulators are rarely able to discern that a policy is priced too low (as opposed to being priced too high). More troubling, most states allow automatic (or "deemer") rate increases whenever the company's loss ratio exceeds a certain percentage, commonly 60%, meaning that more than 60 cents of every premium dollar are going to pay benefits.[6] This makes meaningful regulation of rate increases virtually impossible.[7]

The NAIC should recommend that all rate increases shall be approved — no deemers or notice allowed. If a company is not certain that it will get a rate increase, it is less likely to underprice.

It is true that the old loss ratio concept is no longer necessarily a part of the initial price setting process, although it continues to be utilized for rate increases. Some had thought this tended to lead to a lower initial price separate and apart from competitive market forces. This view misses three points.

First, the pressure on initial price due to competition is real. *Second*, as indicated, utilization data is not standardized. *Third*, the problem is that low-ball pricing and rate instability are often accomplished by other non-ratio deceits, such as unrealistic lapse rate assumptions and bad underwriting.

This loss ratio change does little, then, to improve the status quo. Although, strictly speaking, elimination of the loss ratio requirement does allow companies of good faith to set more conservative initial premiums, this ignores the fact that conservative companies in the past repeatedly managed to develop good policies, despite this rule. The loss ratio rule is not the problem and did not cause the fraud; it simply failed to help regulators stop or identify poorly priced policies. Moreover, for companies desiring to get market share by underpricing competitors, this change creates no deterrent.

The limits on expense allowances and profits on rate increases do continue to use the loss ratio concepts, and are a move in the right direction. However, it is not clear why a company that has priced a policy too low (in the case of a non-exceptional increase) should receive any portion of the additional premiums for commission and profit. The first priority should be to stabilize the block of business by identifying some combination of rate increases and/or capital contributions by the insurer to achieve that end; otherwise, a cycle of increases is started.

Forcing a company to dig into its own pocket, instead of the pockets of the elderly who relied on, and paid for, the company's expertise, would provide an even more powerful incentive for companies to charge an adequate initial premium.

Companies already have powerful economic incentives to administer well. In my experience, bad claims practices do not cause increased premiums. Instead, bad underwriting leads to foreseeable claims by people who never should have been in the group in the first place. Currently, most states require the company to honor the claim of someone who did not hide their medical condition at the time of sale. I have seen market conduct exams dealing with the problem of mass denial of claims. This should not change, but the tenor of the NAIC proposal suggests the contrary.

What is troubling is when a company engages in "post-claims underwriting" which now arguably appears to be tacitly approved by the NAIC, or tries to pass the added costs of these claims to the other insureds in the form of rate increases. A company should bear

the economic risk of bad underwriting and bad administration, since the customer has already paid the company for these services in his or her premium.

5. Pooling bad business blocks with non-closed blocks leaves questions unanswered

The idea of taking a bad block of business and pooling it with a non-closed block of business is generally a good idea, although arguments about the triggering events for action could delay its implementation. However, there are some other open questions.

First, do the significant number of policyholders who let their policies lapse get an opportunity to opt in, or is that benefit limited to those policyholders who have continued to pay the increasing premium? *Second*, what rate is to be charged for that new policy? *Third*, who bears the financial risk that the more stable current policy may be destabilized by this change?

The idea of banning "bad" companies from the marketplace has been rejected in numerous other contexts. However, this sort of corporate death penalty will likely suffer from the same enforcement problems that we currently see with lesser sanctions. Most states already have the power to stop approving new insurance products from a bad company or to take the license of a bad company that does not play by the rules.

C. Fail to Ensure Substantive Disclosures

The NAIC's proposals surrounding disclosure also fall short, as are discussed in these sections.

First, the timing of disclosures should be earlier than is currently man-dated by the NAIC. *Second*, disclosures also need to be made more clear, as many consumers of LTCI are elderly citizens. *Third*, companies should also project what the chance is that rates will go up, instead of just acknowledging that a rate hike is possible. *Fourth*, the regulations' current stance on rate increase history disclosure is too vague. *Fifth*, companies should have to disclose why they are increasing rates.

1. The timing of disclosure is too late

The timing of disclosure is less than adequate if it first comes in the policy, as opposed to the application and advertising material. § 8.A (limited to "policies"); § 9. For example, § 9.B. requires only that "an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate." A better rule would put this information and the idea of risk of rate instability up front in the solicitation phase.

In addition, I would also require insurance companies in their billing statements and in their renewal letters to provide meaningful notice of future anticipated rate increases and problems. Currently, regulators are often told that a proposed rate increase is not enough (and that more may be needed), but consumers are not. This is highly relevant to the decision to buy or renew. More important, many policies are sold in one push, and the block is closed before the rate increases begin.

2. There is no emphasis on the unambiguity of disclosures

Little is being done to ensure that consumers have substantive knowledge as opposed to getting a form disclosure. What consumer really understands the difference between coverage that is "guaranteed renewable" or "noncancelable"? § 8.A.(1). The explanatory language following this should also state that the policy is guaranteed renewable if you are able or willing to pay premiums which the company may/will increase. In addition, systemic marketing abuses such as pressure sales are ignored.

Some proposals are just plain silly. Section 9.B.1-4 requires "An explanatory of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision." The only revisions worth worrying about are "increases." Why not call it what it is, a premium rate *increase?* A rate "revision" can be interpreted to mean a rate decrease, too, and we know that is highly unlikely.

3. No disclosure of the chance that there will be a rate increase

Disclosure must be substantively meaningful. Boilerplate language that premiums "may" go up does little to provide meaningful information to the consumer (or independent agent) about the possible range of rate increases and the attendant risk factors. By the same token, limiting the use of some deceptive terms does little to increase consumer understanding.[8]

The signed acknowledgment of potential rate increases without a disclosure of risk factors is less than worthless.[9]

First, is the risk 1% or 50% that rates "may" go up? Is this truly informed? Does the customer know the company lacks adequate utilization data, or that this policy might perform very differently from other policies? *Second*, this would enable a company that was selling experimental coverage to say the customer's consent (as opposed to its intent and undisclosed knowledge at the time of sale) is the only issue and should bar any recovery. *Third*, it shifts blame to agents who can honestly tell the client that this is just legal boilerplate or something similar.

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Fourth, and most important, it begs the question of corporate responsibility.

A better way of reaching this sort of result would be something like this:

I UNDERSTAND THAT MY (MONTHLY/QUARTERLY/ ANNUAL) PAYMENT FOR THIS POLICY IS $_____. YOU UNDERSTAND THAT I CAN ONLY AFFORD (OR I AM ONLY WILLING TO PAY) $____ PER MONTH FOR MY LONG-TERM-CARE INSURANCE. I UNDERSTAND THAT MY RATES WILL NOT BE RAISED BEYOND THAT AMOUNT.

This sort of statement will alert the conscientious company to the limited ability of the customer to pay for future discovered shortcomings in the insurance company's current actuarial analysis.

4. The current standards for rate increase history disclosure are too vague

Section 9.B.5.a provides that information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years for this state or any other state be disclosed. This is very narrow.

In my opinion, a better disclosure would relate to all rate increases, by the issuing company and companies it has acquired or divested, on all prior and current LTCI policies. These and other disclosures should appear on the application. This is more meaningful than disclosures about the risk of rate increases on the contract (as some states require) and/or suitability worksheets (often filled out by agents). There are no substitutes for better information and clearer warning than on the initial application regarding (i) the risk of future rate increases, (ii) the history of rate increases, and (iii) the company's experience with LTCI.

In addition to the three things listed that are to be included in this information, there should be a requirement that makes the company indicate what other LTCI forms the company has in force where the block of business has been closed.[10] If they keep closing blocks and opening new ones (with new forms) a pattern can be recognized. Also, whenever a block of business is closed, the company should be required to notify present policyholders and give them the option to convert to a new policy or drop their policy if they want to.

"Customers are not told the reasons that a company can increase rates.... They are also not told that there is no limit to the amount the premium for the policy can be increased. In most cases, the insurance company's request for increase is approved automatically."

5. Companies ought to disclose why they can and are increasing rates

Customers are not told the reasons that a company can increase rates (if underwriting is poor, if policy was underpriced, if block mismanaged, if actuarial analysis is faulty). They are also not told that there is no limit to the amount the premium for the policy can be increased. (In most cases, the insurance company's request for increase is approved automatically upon the showing of a loss equal to a certain percent.) This is harsh, but isn't that the point?

Also, at the time of renewal, the true reasons for rate increase should be disclosed. The company should also be required to state whether they are contributing any of their own funds to lessen the increase.

D. Fail to Address Marketing Abuses

The emphasis on disclosures misses the point that pressure sales tactics may be occurring and would likely override formalistic disclosures. The relatively high initial lapse rates of between 30-40 percent on some of those policies prior to any rate increase suggests pressure sales tactics are occurring in some cases. Training of agents and setting standards for marketing is always important. But ask yourself this: why do companies put self-serving and exculpatory language on insurance contracts that expressly disavows any responsibility for what was said by the agent during the sales process?[11]

Moreover, why should companies who entice agents with high commissions and promises of "easy

underwriting" be allowed later (when a customer complains about pressure sales) to disavow any legal responsibility for those agents or complicate a straightforward case with such attempts at a legal defense?

Failure to deal with such problems, combined with the proposed § 9.C, will increase the legal protections of fraudulent marketers. In this and other ways, the proposed regulations actually make matters worse.

E. Conclusion

The NAIC regulations are a concession that the traditional approach to regulation in the LTCI insurance industry has failed to protect our nation's elderly from fraud and abuse. In that sense, they are a step in the right direction.

However, they are only a step at best (and likely only the illusion of a step). They will fail to achieve the substantive changes needed to prevent the tragedy that occurred in Hanson, and continues to occur in other cases.

Much more is needed in the areas of rate stability, substantial disclosure, and marketing regulation if LTCI insurance is going to achieve its purpose of taking care of those who had the foresight to purchase it.

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Footnotes

1) Civ. No. A3:97-152 (D.N.D.)

2) My comments are not intended to disparage all LTC insurers, but only those few that have systematically preyed on the elderly. Nevertheless, the problem is not limited to a few fly-by-night companies, and the problem persists today.

3) Jim Connolly, *LTC Rate Model Adopted by NAIC,* NATIONAL UNDERWRITER (8/21/2000):

NAIC President and Kansas Commissioner Kathleen Sebelius said that the adoption of the model was important not only to strengthen state insurance regulation, but also to ensure that regulators can fully participate in Congressional hearings on tax qualified long-term-care policies scheduled to take place next month.

4) This exception is ostensibly justified to prevent insurers from being discouraged from buying bad blocks of business. Fair enough. However, consumers still need to be protected, and there has to be a plan to fix the problem — rate increases or capital contributions or rewriting the block — and this should be disclosed at the earliest possible time to the consumers who may buy the policy and the insureds who are renewing their policies.

5) The 60-40 "loss ratio" concept is a well recognized life insurance regulatory device that appears to have been improperly transposed in the LTCI area. E.g., Gary Corliss, The State of LTCI, D&H ADVISOR (Jan./Feb. 1997), "LTCI is a new coverage. Traditional logic suggests that reserves and capital/surplus requirements should be greater for LTCI than for other more traditional insurance products," E.g., Gary Corliss, The State of Long Term Care Insurance: 1998, supra, "State regulators started way behind everyone else and tried to alter their regulations and practices to fit into a new reality."

Nevertheless, insurance companies attempt to avoid civil liability by hiding behind regulatory rate approval or inaction. The vehicle for this excuse is an improper attempt to move the filed rate doctrine into the insurance context.

6) Allan Kanner, *The Filed Rate Doctrine and Insurance Fraud Litigation,* 76 North Dakota Law Review 1 (2000).

7) E.g., § 6.A.4 (limiting the use of the phrase "level premium" in brochures, policies, and actuarial memoranda to situations in which the insurer has no right to change, or ask for changes, in premium).

8) Section 9.C. provides that an applicant shall sign an acknowledgment at the time of application. . . .that the insurer made the disclosure required under subsection B(1) and (5).

9) Disclosures of buying blocks with intent to raise premiums should be disclosed. Customers should be told if block is closed.

10) Companies are prohibited from using agents with records of violations.