An Exploration of Potential Regulatory Measures Intended to Prevent Individuals at Later Durations of Non-Group Major Medical Products from Receiving Higher Rate Increases than Those at Early Durations

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ISBN: 978-1-59917-176-0

Printed in the United States of America

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An Exploration of Potential Regulatory Measures Intended to Prevent Individuals at Later Durations of Non-Group Major Medical Products from Receiving Higher Rate Increases than Those at Early Durations White Paper

INTRODUCTION

In 1999, the NAIC’s Accident and Health Working Group requested that the American Academy of Actuaries (the Academy) study various approaches states may take to prevent individuals at later durations of non-group major medical insurance products from receiving higher rate increases than those at early durations. This perceived increase in later-duration premiums has become known as the “closed block problem.” In response to the NAIC’s request, the Academy developed a complex model to review four “solutions” that states could potentially utilize. It made no suggestion that one, rather than another, solution was more appropriate for any particular market.

While there have been discussions regarding the benefits that can accrue from selecting one particular “solution” and advocating its adoption across all states, there is a recognition by a majority of regulators that the nuances of various state markets, their different regulatory structures and requirements, and variations in demographics make a one-size-fits-all response difficult, if not impossible. Instead, it has been suggested that this White Paper, which will explore the four options outlined by the Academy and two other non-modeled approaches, should be crafted to assist regulators and other policymakers.

This document is intended to do just that. It will outline the six approaches and provide basic explanations for their appropriate use, and under the “Pros and Cons” section, it will outline the benefits and drawbacks of the approach. The last section, “Considerations,” will discuss the considerations that policymakers must keep in mind in attempting to adopt or implement the various approaches. It may be possible to combine the various proposals described in this document to create additional alternatives.

This document is not intended to endorse any of the various proposals discussed.

ALTERNATIVE APPROACHES

I. Durational Pooling

A. What It Is

Durational pooling is a method that requires a carrier to pool the experience for the computation of renewal business rates of all of its policies within an applicable business segment after they reach a chosen duration.

B. How It Works

Prior to reaching a specific duration (for example, 10 years, or for the purpose of this paper, N years), renewal business rate increases are calculated by allowing each block to be rated on its own experience. Under the durational pooling method, after a policy reaches duration N, the policy’s experience must be pooled with those policies at duration N or greater from all other forms and blocks defined to be included in this new combined rating pool. The experience of this combined group of policies is used to calculate rate increases for the group, rather than using the experience of each block of business to determine separate rate increases.

This method results in the premium rate increases being the same percentage increase for all policies in the durational pool. The percentage would apply to all policies older than the specified duration for all of the pooled blocks. This can reduce the possibility that policies in later durations in one block would need a very large rate increase due solely to the experience of that closed block. It does not prevent large rate increases if the experience of all of the combined blocks justifies the increase.

The effect of this method is to cause some policy premiums to be lower than they otherwise would have been, and others to be higher due to the subsidization of some blocks of business by other blocks within the durational pool.
C. **Pros and Cons**

This method has little impact on new business premiums in the market.

It does not prevent large justifiable rate increases from being implemented, but it does assure that all policies in the pooled blocks receive the same rate increase percentage.

It results in policyholders with the same policy and the same demographics having different rates based on the duration of the policy. This results from policies before N having their rate increase based on the experience of the policy form alone, and policies after N having their rate increase based on the pooled experience of possibly many other policy forms. This may be prohibited in some states.

It should also be noted that having similar policyholders with different rates complicates administration for the insurer, as well as compliance and verification for the insurance department.

While this method ensures that all policies with lengthy duration receive the same percentage rate increase at renewal, risk selection would be encouraged as healthy lives reaply for coverage at lower rates and leave the long-term pool. Additionally, if all long-term policies are included in the pool—regardless of benefits—policies with built-in cost-control strategies (for example, three-tiered copayments) could have higher rate increases than they otherwise would.

D. **Considerations**

Only similar types of products with similar underlying pricing and trend expectations should be pooled. Regulators or legislators would need to develop careful definitions outlining those forms and blocks within segments that may be pooled. The pooling should occur only among forms and blocks with broad yet somewhat homogenous risk characteristics, such as comprehensive major medical policies with similar networks, underwriting guidelines, or other significant rating factors. Homogeneity is critical, inasmuch as each form or block would likely have differing trend experience potential based on its benefit design, underwriting, or network. For example, forms with rich prescription drug benefits would expect to experience different cost increases than forms without these types of benefits. The same is true for forms with a mix of deductibles.

Pooling of durations still in the select underwriting period can limit the effectiveness of underwriting, and minimize the effect of any new underwriting standards a carrier would possibly implement. Thus, if possible, N (the duration at which pooling starts) should be set to a duration beyond the select underwriting period.

Under a durational pooling method, disclosure of the inequity in rates between individuals with the same product and identical demographics but who are in different durations after the durational pooling begins would be important in order to prevent consumer dissatisfaction. Consumers should be provided adequate disclosure of N, the number of years after which all products are pooled. However, while this disclosure is critical, it may also be confusing, and may inadvertently lead to more consumer dissatisfaction, rather than less.

The current NAIC Guidelines for the Filing of Rates for Individual Health Insurance Forms allow carriers to combine forms for purposes of improving credibility of experience. The model, or state-specific language that is based on this model, may need to be modified in order to accommodate blocks of business, as well as subsets of forms, rather than only a single “form” as that term is defined.

It may be necessary to file anticipated loss ratios by duration for each block in the pool so regulators have some means of verifying the variation of the pool’s actual loss ratios versus expected loss ratios.

Rate filing methods would need to be reviewed to assure that they are compatible with the methodology. For example, pricing methods that model unlimited increases in rates at later durations may not be compatible with the restraints placed on the product by durational pooling.

Given that pooling of business is to occur after policies reach their Nth duration, the determination of the year N needs to be carefully chosen to minimize negative impacts on consumers.

Policymakers must determine if restrictions would be placed on rating factors after duration N that are not on policies in durations less than N. (An example is whether state policymakers would permit smokers and non-smokers to have different rate increases.) The rules for determining the common rate increase percentage after duration N would need to be developed. Rules would also need to be developed to determine how the lifetime loss ratio calculations should be handled under this
method. This would include the development of the appropriate rating methodologies, which may require assistance from the Academy.

This method should only apply to new business written after the effective date of the law adopting it.

While this method may smooth the rate increases between old blocks, the rates and rate increases could still be larger than new-business rates and rate increases, thereby causing older blocks still to have higher lapse rates. And it does not guarantee that rates or rate increases for individuals after year N would be the same or less than individuals prior to year N. It would therefore create many rate levels based upon issue date and duration, because each calendar year of issue would have a different rate increase percentage after year N.

This method creates many different rate tables for the same policy after individuals reach duration N, which would require that companies develop the system capabilities to handle these variations, and that insurance departments develop the expertise necessary to verify that rate tables are correct and that consumers are appropriately assigned.

Policymakers must determine whether companies can use a duration of N less than that determined by the state on an optional basis, and if so, what the rules would be for using it.

There is a distinct potential for inequitable subsidization, as there would be no equity in rates between individuals with similar benefits. This may lead to high lapses in year N in the newest block, if rate increases for people reaching N are greater than those less than N by a significant amount.

II. Individual Medical Pool (IMP)

A. What It Is

This approach allows an eligible insured who is covered by an individual major medical policy, and whose rates have increased beyond a trigger level after a specified length of time, to move to a separate state-authorized program—the individual medical pool (IMP). The IMP would offer policies with premiums that are limited to a fixed percentage above current market rates, and whose rate increases are limited to the average increase in the individual market in that state. Insured individuals are eligible to move to the IMP if they purchased their major medical coverage after the effective date of the IMP, they have been continuously insured for a specified number of years, and their current premium rate exceeds the benefit adjusted IMP rate. Losses of the IMP are assessed to the carriers in the individual market in the state, so the program is intended to be self-funding.

B. How It Works

The IMP gives eligible policyholders an option to voluntarily move to a lower-rated policy after specified criteria are met. It is comprised solely of individuals who are eligible under specified criteria and who choose to move to it. The premium rate would be restricted to an actuarial equivalent of a fixed percentage, such as 150%, of standard premium rates for comparable individual products sold in the state. Due to this formulaic method of determining the IMP rates, the IMP’s annual rate increases would mirror the average rate increase in the individual market each year, and the rate increases would not be based on the IMP experience. Since these rate restrictions apply, claims and expenses of running the IMP would most certainly exceed the premiums received, creating losses for the IMP program. These losses would be funded solely by the individual major medical insurers in the state through an assessment method that reflects multiple factors. At least one factor should reflect the volume of business in the IMP that originated from each carrier.

C. Pros and Cons

The rate increases of the IMP-issued policies are based upon the overall increase in the individual market in the state and not on the experience of the policies in the IMP. This is achieved by assessing the IMP losses to the carriers in the individual market in the state. Therefore, rate increases for people in the IMP should be relatively stable, inasmuch as they would mirror overall market costs increases and not policy-specific cost increases.

The IMP approach does not stop the need for large rate increases at later durations, but it does give policyholders an option to move to a rate-controlled product after they meet a specified set of criteria.
The effort required to establish an IMP would be similar to setting up a state high-risk pool. This requires, among other things, establishing a board of directors and hiring an administrator and other professionals required to run the program. It may be possible to piggyback on an existing state high-risk pool program to reduce the start-up cost and effort.

Benefits provided by the IMP may be different than the policy an individual had from previous coverage. There would be no exclusions for pre-existing conditions on the IMP program, but waivers on previous policies should be carried over to the IMP program, as it is a rate-guarantee program and not designed to improve covered benefits.

Companies may still file for justifiable rate increases that may be large. Consumers eligible for the IMP would then have the option to accept the increase offered by the company or move to the IMP, which would have a lower cost and controlled rates.

An assessment methodology would have to be developed and applied to all companies with individual major medical business in the state.

Companies would have to develop a notification procedure to let policyholders know when they are eligible to move to the IMP.

Certain insurers try to minimize lapses by moderating the size of rate increases at early durations. The IMP method would allow insurers to continue this practice.

D. Considerations

The objective of the IMP is to limit the ultimate spread between premium rates at later durations and those charged to new business. This is achieved through a mechanism that gives customers choice, without hampering an individual carrier’s ability to charge appropriate rates based on experience.

Losses from this program would be distributed back to the individual major medical insurers in the state. It is important that this assessment on individual companies be allocated based on at least two factors: first, the number of insured persons in the IMP from each company, and second, the number of lives that company has in force in the individual major medical market. Additional factors may be appropriate to prevent carriers from undue financial benefit if they can rate in such a way as to unduly encourage insured people to move into the IMP.

Eligible insured people (under individual major medical products) should be notified of their potential eligibility to move to the IMP with their rate-increase notices. The price of their current product must exceed the benefit-adjusted price of the IMP product before they are eligible to move to the IMP, so policymakers and companies would need to develop a method to make this determination.

Policymakers must determine if the IMP would be open to policies sold in the state, or to state residents only.

IMP plan benefits should be similar to products purchased in the state’s individual major medical market. Multiple deductibles should be offered to ensure that individuals can obtain coverage comparable to their major medical plan under the IMP. Inasmuch as the purpose of this program is to control rates, not provide additional coverage, any exclusionary waivers attached to an insured’s existing policy should be attached to the IMP policy.

Premiums for the IMP should include variations by age, gender, geography, etc., in the same manner as allowed for other individual plans in the state. Anti-selection would be a problem for the pool without these variations.

The IMP products should be administered by one entity and governed by a board of directors elected by the insurers selling individual insurance in the state. The board should be responsible for selecting the administrator and all other administrative aspects of the program.

A new NAIC model would be needed to define the operating parameters of the Individual Medical Pool, including specific carrier reporting and/or filing requirements and assessment authority, in order to ensure state-to-state uniformity in process and procedural requirements.

The new method would be effective only for business issued after the passage of the appropriate legislation. Business issued prior to that date would continue under its current rating method.
Implementation of this method requires legislative action to set up the pool and to require carrier participation.

The state needs to clarify those policy forms that would be included in determining the assessment allocations, and hence be eligible to have policyholders move to the IMP. Rules would similarly need to be developed to assure that companies allocate assessments equitably across the appropriate blocks of business.

A method for funding the pool in those instances when an individual carrier discontinues its participation in that market must be created. This could be handled by the normal assessment process or by a special assessment on the discontinuing company based upon the number of its customers in the pool after its discontinuance.

Provider discount fee arrangements for individuals in the pool would need to be arranged. This could have a large impact on the pool losses if the provider rates charged to IMP participants are not generally in line with those of the carriers in the non-pool market. Networks would need to be sufficiently broad to minimize the possibility of consumers losing current providers when they move into the pool.

Medical management of individuals in the pool would have similar consequences. If care is not managed to the level of the rest of the market, consumer health results may be less favorable. This could result in higher costs for the pool, resulting in higher assessments.

Cash flow management and accurate determinations of the timing of needed funds, and therefore needed assessments, would be crucial.

It would be important to determine how the assessment is to be included in the company’s loss experience so as not to penalize it for the pool’s experience. The assessments could be included in incurred claims for rate increase purposes, or they could be treated as a separate charge to consumers and excluded from company experience. Tax issues must similarly be determined. Whether assessments will be subject to premium tax, whether pool premiums will be subject to premium tax, whether the pool will be subject to state and federal taxes, and whether assessments will be allowed as an offset to state premium taxes for the companies paying them are critical issues for successful pool operation.

Eligibility factors, particularly in those states that currently have a high-risk pool, need to be carefully developed. Double eligibility for both the IMP and the high-risk pool would be inappropriate.

The suggested requirements for eligibility are based upon a person having a policy in the individual health insurance market for N years, and having a premium that exceeded the average market rate by x%. Both of these factors must be determined. It will also need to be determined if the N year requirement relates only to one company, or to all companies in the individual market. If the latter is chosen, then a break in coverage requirement must also be developed. Residency requirements and whether or not there should be portability for individuals who may later move out of state are critical decision issues as well.

Pricing methods need to be reviewed to determine if any company is pricing in a way that may encourage consumers to move to the pool outside of normal parameters. Retrospective market conduct reviews may be needed if pool participation from any specific company is abnormally high. New methods of pricing may have to be developed that reflect the reduction in losses and the increase in assessments from this method.

Transfer issues specific to individual cases when moving to the IMP would need to be determined. Of particular concern is how a company or the IMP should handle an existing large claim in process at the time a covered person joins the pool, particularly if it was under a case management program from the carrier at the time of transfer.

III. Rate Compression

A. What It Is

Rate compression describes a method in which premium rates for individuals with comparable demographics, geographic location, and benefits must be within a specified high-to-low range, regardless of whether they are in a closed or open block of business. The rate comparison is made between all policies within a specified segment of forms to which the rate compression requirement applies. The effect of this is to cause rate increases on some policy forms to be artificially lower than their true experience levels, so the resulting rates stay within the specified high-to-low range but then cause a corresponding increase in rates for other policy forms to subsidize these reduced rates.
B. **How It Works**

Renewal business rate increases (after the first renewal) are calculated based upon actual experience of the policy form. Under this method, these rate increases would still be calculated upon actual experience, but a rate comparison between the carrier’s blocks of business would need to be done. Premium rates for persons of like demographics, area, and benefits would be compared between forms. If any of the rates were outside the rate compression limits, the carrier would have to make adjustments to bring those rates within the high-to-low range. As a result, some forms would need to have their rates raised while others would be lowered to maintain the overall needed premium income for the carrier while staying within the allowable bands. These comparisons are done by each company. No comparisons are made between companies.

C. **Pros and Cons**

Once a policy form reaches the maximum allowable rate compression limit, the rate increases for this form are limited to the average rate increase applied to all blocks of business for the company. This should eliminate a small closed block with poor experience from getting significantly larger rate increases than any other block of business for that company.

Given that the policy form may be rate-constrained by this method, all people with similar demographics on that form would have the same rates. This ought not to create the administrative problems created by durational pooling, when people on the same form have different rates based upon duration.

Rate compression would require newer entrants to subsidize older blocks of business in order to maintain the allowable rate differential. The magnitude of the allowable high-to-low differential chosen may result in modestly or significantly increased rates (and therefore decreased affordability) for newer entrants, or may cause individuals to drop coverage entirely.

Some current rating methodologies may not be allowed, or may be restricted, under this method.

No new consumer disclosure would need to be developed for this method.

No separate pool or other administrative mechanism would be required.

No additional corporate assessments would be required.

After a company stops writing individual major medical business, this method may not provide the protection from larger rate increases as the remaining business winds down. The smaller blocks may all then need large rate increases.

This method may make selling old blocks of business difficult and, therefore, result in cancellation of all policies if a company wishes to exit a market.

As a result of employing this method, coverage being actively offered in the individual market will be more expensive than that which is currently offered and could lead to higher uninsured rates. Even modest price increases in the individual market can result in higher uninsured rates, as the individuals are paying the full cost of coverage without the benefit of employer contribution or tax deduction, unless the individual is self-employed. Today, the vast majority of states do not require rate limitations due to health-status differences. Therefore, this approach would differ from the current practices of the majority of states.

D. **Considerations**

Definitions must be developed to outline which forms and blocks within a market segment would be subject to rate compression. The compression should only occur among forms and blocks with broad yet somewhat homogeneous risk characteristics.

Rate compression is performed so rates are within the required range, exclusive of benefit differences and predefined allowable characteristics. These would follow the state allowable rating characteristics, such as age, gender, and area.

An annual filing of a certificate of compliance may be required. This would provide regulators with a signed statement of compliance. The company should have a methodology statement available for the regulators to show its process for compliance.
The high-to-low range chosen for this method can have an effect that varies from negligible to dramatic, as illustrated in the following table:

<table>
<thead>
<tr>
<th>Relatively Narrow Range</th>
<th>Relatively Wide Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Similar rates for all policyholders</td>
<td>Rates similar to current rates; potentially wider variations among policyholders</td>
</tr>
<tr>
<td>Higher new-business rates</td>
<td>Small impact on new-business rates</td>
</tr>
<tr>
<td>Smaller durational rate increases</td>
<td>Little or no limitation on durational rate increases</td>
</tr>
<tr>
<td>Could discourage people from purchasing coverage</td>
<td>Not likely to discourage purchases</td>
</tr>
</tbody>
</table>

If this method is applied to products that are priced using durational rating, it would minimize the effectiveness of that rating method due to the ultimate compression of rates.

A new NAIC model regulation may be necessary to define what types of forms are to be combined for purposes of rate compression, and to discuss what types of rating factors could be excluded from the compression tests.

This method requires a calculation of the value of benefit variations between plans. The state would therefore need to develop capabilities to verify these factors when doing rate calculations. Some state risk pools already do this type of calculation and may be a resource for the state.

Policymakers must determine the appropriate compression band widths. It may be possible to start with a wider band than ultimately desired, with a transition to the final band over time.

States should apply this method only to business sold after the effective date of the law. Retroactive application would result in a significant disadvantage to companies with large blocks of older business, compared to new companies with no older blocks to subsidize. In addition, if states consider retroactive application, the effect on rates could be dramatic to policyholders at the date of such a change. It would then be necessary to develop methods to minimize this impact on consumers, and might also be necessary to determine if new companies entering the market are to have minimum rate levels to prevent the disadvantage to existing carriers in the market. In addition, a state adopting the rate compression method for business sold before the date of the law could expect an increase in its uninsured population.

Expertise would need to be developed to assure that company pricing methods do not encourage gaming of the system. Rate filing methods would need to be reviewed to assure that they are compatible with the methodology. For example, pricing methods that model unlimited increases in rates at later durations would not be compatible with the restraints placed on the product by the compression bands.

Rules may be needed to include all business sold by a company and any of its subsidiaries or affiliates in the compression calculation to avoid gaming of the method by using other affiliated companies for new business.

IV. Pre-Funding
A. What It Is
Pre-funding operates on the premise that each issue-year cohort of policies must be financed with premiums and claims from that cohort. Reserves are set aside at early durations when loss ratios are low to fund claims at later durations when expected loss ratios are higher.

B. How It Works
Policy forms must be priced assuming that no increases other than trend would be allowed going forward. This means that the effect of selection due to the underwriting process cannot be reflected in lower early-duration premiums. The anticipated result of this method would be to have rates only increase by age and trend each year for all policyholders. However, if a company could demonstrate that it under or overpriced its overall cost assumptions, adjustments would be allowed to be applied evenly to all policyholders on the form in question.
To do this type of pricing, significant reserves must be set up from early-duration premiums. These reserves must come from additional premiums charged on top of the premiums normally charged by methods used today that do not use pre-funding.

Modified pre-funding methods allow for some additional specified amount of increase each year over and above age and trend.

C. Pros and Cons

Theoretically, in the event a carrier discontinues sales, the in-force business should be self-supporting, and future rate increases should parallel new-business rate increases no matter how small the block gets. This occurs, however, only if the product was originally priced appropriately and does not need any adjustments based on incorrect initial assumptions compared to actual experience.

This method does not provide for any direct recognition of high policy-acquisition costs, which results in a combined ratio that varies less over time than the medical loss ratio.

The intent of this method is to prevent a rate spiral. Its use, however, does not guarantee this result, inasmuch as rate changes must still be allowed for variation from priced for experience. Nor is any relationship specified between renewal premiums and market premiums; blocks can be closed as easily as without pre-funding.

This method requires establishment of large reserves. The size of the reserves depends upon the slope of expected loss ratios by duration, which may vary widely by carrier and by block of business. These additional reserves increase prices for all policyholders. It is possible that these reserves may not be deductible by the carrier for federal income tax purposes. This is a critical issue, as it may place the carrier in an untenable financial position.

A carrier that started a block of business at a rate below market could sell business for a short period of time, and then, by terminating the entire block of business, walk away with all of the excess reserves required for pre-funding. This is most possible when a rate set below market is still above the actual claim costs in early durations due to the existence of the excess pre-funding reserves.

If a company underpriced a product and had to file for a rate increase over and above age plus trend, the increase would be magnified by the need to increase the pre-funding reserves and to correct for the underpriced claims experience expected in the future. This would result in larger rate increases than non-pre-funding methods.

In states that do not currently use any form of pre-funding in their rating methodologies, the increase in current market rates that would result from a transition to pre-funding could be very large. This could result in a significant increase in the number of people exiting the market.

Current RBC formulas may not be appropriate for this method. Adopting this method would require that a new RBC method be developed.

This method can result in higher initial premiums and could therefore increase the numbers of the uninsured. Even modest price increases in the individual market can result in higher uninsured rates because the individuals are paying the full cost of coverage without the benefit of employer contributions or tax deductions, unless those individuals are self-employed.

D. Considerations

It would be difficult and probably impractical to determine a method to transfer any reserves built up by a policyholder with one company if they move their coverage to another carrier.

Federal tax code changes may be needed to allow companies to use this method. In addition, new reserving methodologies would need to be developed by the appropriate actuarial organization and approved by the NAIC before it could be widely adopted and used.

This method could not be applied retroactively. If it were to be so applied, it would require extremely large inputs of capital, which could threaten company solvency. This could encourage carriers to cancel business rather than attempt to transition to pre-funding.
The pre-funding method is extremely sensitive to changes in pricing assumptions and variations of experience from those assumptions. Very small changes can cause very large changes in the reserves needed. Without a strict standardization of assumptions, this method is extraordinarily susceptible to gaming; however, the capital needs to meet these assumptions may be unrealistic for some companies. Yet even with good pricing assumptions, fluctuations in actual experience can subject the company to radical changes in the financial stability of the product. These fluctuations can significantly affect return on equity, which can impact the way rating agencies review the company, and in turn can affect the ability of the company to raise capital. Because of this danger, significant new guidance would need to be developed by independent agencies regarding the use of the pre-funding method, regulatory review of companies using the method, and rating agency review of companies using the method. This would include the development of new RBC methodology—a relatively long and complex process—and, as discussed above, a determination of the impact of federal tax law around the holding of significant pre-funding reserves.

Given the sensitivity of the assumptions, especially lapse and interest rate assumptions, the state would need to determine how, or if, they should be regulated. It is critical that this regulation appropriately balance the needs of the regulators with the financial solvency of the companies. In addition, it is necessary to determine whether loss ratio assumptions should be regulated in order to prevent gaming, with the same balance considerations.

New actuarial guidelines would be needed to define how actuaries could use and certify to the adequacy of this method under both NAIC and appropriate actuarial requirements.

Consumer disclosure requirements would be needed to explain under what conditions rates could change.

The effect of deferred acquisition costs (DAC) and active life reserves on the company’s financial situation would have to be carefully analyzed. This analysis may prove to be very different if it is being done from the standpoint of a state insurance regulator or a stock analyst or a financial reviewer. The interaction between these requirements would have to be carefully analyzed and understood to determine if this method is appropriate.

Accounting standards would need to be changed to reflect all of the new methodologies developed to be used with this method, and new administrative systems would have to be developed to handle Sarbanes/Oxley issues.

Due to the sensitivity of assumptions, as discussed above, it may be appropriate to develop provisions for “bailing out” companies when their experience varies from their pricing assumptions enough to create solvency issues. There may be some form of guaranty association needed, or possibly direct financial support from the state.

A large amount of new expertise would be needed at state insurance departments, and a significant amount of new staff time would need to be devoted to review all the companies using this method. This would include filings, market conduct, and solvency review. Companies, in turn, would need to develop the systems and staff to accommodate the new insurance department review.

V. Trend Plus a State-Determined Percentage Increase

A. What It Is

Under this approach, premium increases for long-duration policies in closed blocks generally would be limited to amounts that cannot exceed a state-estimated trend factor plus an additional, specified percentage increase. Open blocks would not be subject to these restrictions.

B. How It Works

A closed block policy’s duration would determine whether the policy is subject to: (1) the state’s general rating rules (shorter-duration policies); or (2) the state’s general rating rules, as well as the trend plus percentage increase rule (long-duration policies). Duration is measured in terms of either: (1) whole policy years since issuance, or (2) whole calendar years equal to the difference between the calendar year of issue and the calendar year of the rate increase. A state would need to specify the point at which a closed-block policy is considered long-duration.

Each year, the state sets a permitted trend increase that estimates the average statewide trend increase for all carriers in the individual market (both open and closed blocks). In making this determination, consideration is given to price inflation, changes in utilization, and deductible leveraging (i.e., over time, a constant deductible amount requires higher premiums). Exceptions from this trend estimate can be granted in cases of carrier insolvency.
In addition, a state would need a schedule of percentage increases that may be imposed beyond the trend limitation. The schedule might vary based on submarket (e.g., regular individual, conversion, association, etc.) and duration (e.g., longer durations could be subject to tighter increases). The percentage increase factor is intended to provide carriers with some leeway in setting rates, taking into account the carrier’s particular cost issues. This approach still permits adjustments for case characteristics such as age, geography, and benefit plan design, in addition to the trend plus stated percentage increase limitation.

This method requires cross-subsidies from open blocks and shorter-term closed-block policies to the longer-term closed-block policies, pre-funding of policies, or both.

C. Pros and Cons

This approach has the advantage of ensuring that premium increases for long-duration policies in closed blocks do not significantly exceed the increases that can be justified by average trend factors for the entire individual market. Ideally, more long-duration, closed-block policyholders would renew coverage under this regime. To some extent, determining compliance would be simplified due to the state-published limits on the premium increases permitted for long-duration, closed-block policies.

On the other hand, the higher premiums in earlier durations under this approach necessitated by pre-funding and/or cross-subsidization could lead to fewer initial uptakes and more nonrenewals in earlier years, thereby increasing the ranks of the uninsured.

Moreover, this approach could discourage price competition if carriers feel compelled to impose the maximum allowable rate increases in earlier durations to avoid inadequate premiums in later durations when the stricter limits apply. Furthermore, the approach’s rate caps might discourage carriers from acquiring closed blocks of business from other carriers, thereby resulting in coverage cancellations.

This approach also places long-established market participants at a disadvantage, as their trends could be expected to be higher than the state’s average trend, and could encourage them to withdraw from the market. Similarly, carriers without open blocks that could cross-subsidize to closed blocks might elect to cancel coverage altogether.

To the extent this approach requires pre-funding, the pros and cons described in that section apply here as well, including concerns relating to the federal tax treatment of premium reserves.

In practice, estimating trend is a complicated matter and is very carrier-specific. It is unlikely that a state could determine a trend factor that would be appropriate across all carriers and products. The approach’s simplified trend criteria fails to account for a number of factors contributing to trend, including, without limitation: (1) the impact of new technologies and treatments; (2) cost-shifting from public programs and the uninsured; (3) provider contracts; (4) product type/mix and deductible differences; (5) durational mix; (6) marketing approach; and (7) the imposition of new benefit mandates.

This method could result in actively marketed policies receiving higher rate increases than those in closed block, inasmuch as the open blocks would need to fund the residual costs of the closed business when the state factor does not provide sufficient funding. Even modest increases in new market rates can deter younger, healthier individuals from purchasing coverage, which would increase cost pressures on the individual market pool.

D. Considerations

This proposal could require costly and extensive changes to carriers’ administrative practices. Currently, many carriers do not track duration on a customer-by-customer basis within a block of business. Carriers might determine that the easiest way to track duration would be to create new blocks of business each year. In addition, carriers might need to institute new consumer disclosures to explain why policyholders with similar case characteristics are being charged different rates for the same policy form.

This method has not been modeled by the American Academy of Actuaries to show potential effects on the market.
VI. Closed-Block Pool

A. What It Is

This method of calculating rates requires that the insurer pool the experience for all of its closed blocks to calculate a single percentage change that would be applied to all closed-block policies, even though some closed blocks might otherwise have increases below the average for all closed blocks. This includes all business in the block regardless of the duration of the policy.

B. How It Works

Renewal business rate increases currently may be calculated by allowing each block to be rated on its own experience regardless of the duration of the business in the block. Under the closed block pooling method, after a block of business is closed to new sales, the experience of the block must be pooled with all other blocks of business that are closed to new sales. The experience of this combined group of policies is used to calculate a single rate-increase percentage for the combined group of policies, rather than using the experience of each block of business to determine separate rate increases.

This method results in a single rate-increase percentage that is applied to all policies at all durations that are in the closed-block pool. This method does not impact rate increases for policies not in the closed block pool.

This pooling of policies can reduce the possibility that policies in later durations in one block would need a very large rate increase solely due to the experience of that one closed block. However, it does not prevent large rate increases if the experience of all of the combined blocks justifies the increase.

The effect of this method is to cause some policy premiums to be lower than they otherwise would have been, and others to be higher due to the subsidization of some closed blocks by other closed blocks.

There are two options available for this process. The first would create a single pool for all closed block individual health policies regardless of their benefit structures. The second would allow for the establishment of separate pools for closed-block policies based upon the type of benefits provided.

C. Pros and Cons

This method should have little impact on new business premiums in the market.

The single pool may be simpler for some carriers to administer, thus resulting in lower administrative expenses for rate filing purposes. This may also simplify rate review processes at state insurance departments.

On the other hand, the single pool does not recognize the divergent trends that occur among different types of benefit plans (for instance, plans with large drug benefits versus those with more modest drug benefits). Multiple pools allow for a more appropriate distribution of experience among the closed blocks based upon the underlying risks.

The multiple blocks are less likely to be credible, however, and the administrative expenses of tracking the experience and filing of rate increases would be larger than for a single-block method, but still smaller than current methods of filing on each policy form.

Credibility of the pooled experience is greater than that of each individual block.

The stream of new blocks entering the pool as other blocks are closed serves to mitigate larger rate increases on the oldest duration policies.

The transfer of claims cost from older duration policies in the pool to newly closed block policies entering the pool may exacerbate the exodus of insurable lives from the recently closed block to reenter new business blocks, especially at the first rate increase after the block enters the closed-block pool.

While this method would ensure that all closed blocks of business receive the same percentage rate increase, risk selection would be encouraged as healthy lives reapply for coverage at lower rates rather than remain in the closed-block pool.
D. Considerations

When using multiple closed-block pools, only similar types of products with similar underlying pricing and trend expectations should be pooled. For instance, a highly managed care product should not be pooled with a traditional major medical product. Definitions would have to be developed for what forms and blocks within segments could be pooled. The pooling should only occur among forms and blocks with broad yet somewhat homogenous risk characteristics, such as comprehensive major medical policies with similar networks, underwriting guidelines, or other significant rating factors. This is because each form or block may have differing trend experience potential based on its benefit design, underwriting, or network. For example, forms with rich prescription drug benefits would expect to experience different cost increases for trend than those without this benefit. The same is true for forms with a mix of deductibles.

The very simplicity of the method may be seen as violating insurance principles of transferring cost among individuals of known risk differences.

There may be significant variations year-to-year in rate changes in individual policy forms even where the pool is large.

Using multiple years or national experience from the same carrier may or may not be appropriate if the block is small.

Rate filing methods would need to be reviewed to ensure that they are compatible with the methodology. The method may eliminate some methods that require certain levels of rate increases at later durations that may not be compatible with the restraints placed on the product by combining multiple blocks for rate increase purposes.

Pooling of business is to occur after blocks are considered closed. The criteria to be used in determining when a block of business is considered to be closed must be carefully chosen to encompass all blocks that are effectively closed even though technically still open.

In most states, specific legislation would be required to use this rating method.

Additional actuarial work may be required in order to appropriately combine the experience of policies with significantly different benefit structures in order to calculate a single rate revision for all blocks.

This method should only apply to new business written after the effective date of the law adopting it.

This method has not been modeled by the American Academy of Actuaries to show potential effects on the market.

CONSIDERATIONS FOR IMPLEMENTATION OF ANY OF THE APPROACHES

Under any of the methods chosen, it would be important to determine how to handle acquired blocks of business. Any methodology chosen should not preclude a company’s ability to sell its block of business, and the method should be equitable with respect to the rest of the market.

Prior to instituting any particular method, it would be important to develop consumer disclosure requirements in order to explain both the immediate and long-term effects of the method chosen. In addition, the issue of premiums for Medicare-eligible policyholders needs to be considered, and disclosures crafted for that population as well.

The NAIC and the individual states would need to analyze potential conflicts with existing state and federal laws, and legislative or regulatory changes would need to be made to correct any problems discovered. Potential areas of concern are reserving and accounting standards and rating requirements, as well as interaction with existing state high-risk pool legislation.

Issues with regard to interaction of policyholders moving between states with different regulations would need to be considered. The effect of each of these methods on consumers needs to be considered in all events, but particularly so if different out-of-state options are also available.

Methods for monitoring the ongoing success of any method chosen must be developed. This monitoring would necessarily need to include benchmarks in order to determine if the “solution” is working as intended. In addition, ongoing compliance methodology would need to be developed for companies, insurance departments, accounting and actuarial firms, and for the conduct of audits by both auditing firms and insurance departments. It would in all likelihood be necessary for the
appropriate actuarial organization to develop new or expanded actuarial standards of practice for each method adopted before actuaries can certify that they are using the methods as intended, thereby giving regulators the comfort that companies are applying the methods consistently.

Transition issues would need to be thoroughly studied by each state based upon where they are starting from and the method they choose to move to. One particular transition issue that needs review is how a state could transition individuals from products currently being sold to a new set of products that are priced under the new method. The complexity of transitioning the market from one form of rate regulation to a significantly different one may severely disadvantage either consumers or carriers (or perhaps both), and may have a significant impact on the viability of a given solution.
Headquartered in Kansas City, Mo., the National Association of Insurance Commissioners (NAIC) is a voluntary organization of the chief insurance regulatory officials of the 50 states, the District of Columbia and five U.S. territories. The NAIC’s overriding objective is to assist state insurance regulators in protecting consumers and helping maintain the financial stability of the insurance industry by offering financial, actuarial, legal, computer, research, market conduct and economic expertise.

Formed in 1871, the NAIC is the oldest association of state officials. For more than 135 years, state-based insurance supervision has served the needs of consumers, industry and the business of insurance at-large by ensuring hands-on, frontline protection for consumers, while providing insurers the uniform platforms and coordinated systems they need to compete effectively in an ever-changing marketplace.

For more information, visit [www.naic.org](http://www.naic.org).