

## GUIDELINES FOR FILING OF RATES FOR INDIVIDUAL HEALTH INSURANCE FORMS

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### Section 1. General

- A. Every policy, rider or endorsement form affecting benefits that is submitted for approval shall be accompanied by a rate filing unless the rider or endorsement form does not require a change in the rate. Any subsequent addition to or change in rates applicable to the policy, rider or endorsement shall also be filed.

- B. General Contents of All Rate Filings

The purpose of this guideline, including its Appendix, is to provide appropriate guidelines for the submission and the filing of individual health insurance rates and to establish standards for determining the reasonableness of the relationship of benefits to premiums. Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called “anticipated loss ratio,” of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Interest shall be used in the calculation of this loss ratio. Each rate submission must also include a certification by a qualified actuary that to the best of the actuary’s knowledge and judgment the entire rate filing is in compliance with the applicable laws and regulations of the state to which it is submitted and that the benefits are reasonable in relation to premiums.

**Drafting Note:** Assumptions applying to the future “period for which rates are computed” should be reasonable in relation to the circumstances. For example, if future rates of inflation are a major factor, the period of projection of such rates normally should be short, such as three to five years only. Other assumptions, however, may still appropriately apply over the entire future policy renewal period, particularly in cases where the basic rate structure is one of level premiums based on original issue age.

- C. Previously Approved Forms

Filings of rate revisions for a previously approved policy, rider or endorsement form shall also include the following:

- (1) A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums, including the anticipated loss ratio for the form;
- (2) A statement as to whether the filing applies only to new business, only to in force business, or both, and the reasons therefore;
- (3) A history of the experience under existing rates, including at least the data indicated in Section 1D. The history may also include, if available and appropriate, the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates. Additional data might include: substitution of actual claim run-offs for claim reserves and liabilities, determination of loss ratios with the increase in policy reserves subtracted from premiums rather than added to benefits, accumulation of experience fund balances, substitution of net level policy reserves for preliminary term policy reserves, reserve adjustments arising because of select period loss experience, adjustment of premiums to an annual mode basis, or other adjustments or schedules suited to the form and to the records of the company. All additional data shall be reconciled, as appropriate, to the required data; and
- (4) The date and magnitude of each previous rate change, if any.

- D. Experience Records

- (1) Insurers shall maintain records of earned premiums and incurred benefits for each calendar year for each policy form, including data for rider and endorsement forms that are used with the policy form, on the same basis, including all reserves, as required for the Accident and Health Policy Experience Exhibit. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Subject to approval of the commissioner, experience under forms that provide substantially similar coverage and provisions that are issued to substantially similar risk classes and that are issued under similar underwriting standards, may be combined for purposes of evaluating experience data in relation to premium rates and rate revisions, particularly where statistical credibility would be materially improved by the combination. Once such a combining of forms is adopted, however, the insurer may not afterward again separate the experience, except with approval of the commissioner.
- (2) The data shall be for all years of issue combined and for each calendar year of experience utilized in the rate determination process (but never less than the last three years). For example, for policies originally filed under this guideline, experience since inception would be required because of the utilization of the rule in Section 2B(2)(b)(ii). Here, it is permissible to combine experience for calendar years prior to the most recent five.

E. Evaluating Experience Data

In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:

- (1) Statistical credibility of premiums and benefits, e.g., low exposure, low loss frequency;
- (2) Experienced and projected trends relative to the kind of coverage, e.g., inflation in medical expenses, economic cycles affecting disability income experience;
- (3) The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations. Where this consideration is pertinent, ratios of actual to expected claims, on a select basis, will often be appropriate for an adequate evaluation; and
- (4) The mix of business by risk classification.

**Section 2. Reasonableness of Benefits in Relation to Premiums**

A. New Forms

- (1) With respect to a new form under which the average annual premium as defined in Paragraph (5) below, is expected to be at least as large as the maximum \$X in Paragraph (3) below but not more than the minimum \$X in Paragraph (4) below, benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio is at least as great as shown in the following table:

<u>Type of Coverage</u>	<u>Renewal Clause</u>			
	OR	CR	GR	NC
Medical Expense	60%	55%	55%	50%
Loss of Income and Other	60%	55%	50%	45%

- (2) Definitions of Renewal Clause

OR - Optionally Renewable: renewal is at the option of the insurance company.

CR - Conditionally Renewable: renewal can be declined by class, by geographic area or for stated reasons other than deterioration of health.

- GR - Guaranteed Renewable: renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.
- NC - Non-Cancelable: renewal cannot be declined nor can rates be revised by the insurance company.

(3) Low Average Premium Forms

For a policy form, including riders and endorsements, under which the expected average annual premium per policy is low (as defined below), the appropriate ratio from the table above should be adjusted downward by the following formula:

$$RN = R \times \frac{(I \times 500) + X}{(I \times 750)}$$

Where: R is the table ratio

RN is the resulting guideline ratio

I is the consumer price index factor

X is the average annual premium up to a maximum of I .250.

The factor I is determined as follows:

$$I = \frac{\text{CPI-U, Year (N-1)}}{\text{CPI-U, (1982)}} = \frac{\text{CPI-U, Year (N-1)}}{293.3}$$

where:

- (a) (N-1) is the calendar year immediately preceding the calendar year (N) in which the rate filing is submitted in the state;
- (b) CPI-U is the consumer price index for all urban consumers, for all items, and for all regions of the U.S. combined, as determined by the U.S. Department of Labor, Bureau of Labor Statistics;
- (c) The CPI-U for any year (N-1) is taken as the value of September. For 1982, this value was 293.3;
- (d) Hence, for rate filings submitted during calendar year 1983, the value of I is 1.00.

(4) High Average Premium Forms

For a policy form, including riders and endorsements, under which the expected average annual premium per policy is high (as defined below), the appropriate ratio from the table above should be adjusted upward by the following formula:

$$RN = R \times \frac{(I \times 4000) + X}{(I \times 5500)}$$

Where: R is the table ratio

RN is the resulting guideline ratio

I is the consumer price index factor (as defined in Paragraph (3) above), or

X is an average annual premium exceeding I . 1500.

In no event, however, shall RN exceed the lesser of:

- (a) R + 5 percentage points, or
- (b) 63%.

(5) Determination of Average Premium

The average annual premium per policy shall be estimated by the insurer based on an anticipated distribution of business by all significant criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

The value of X should be determined on the basis of the rates being filed. Thus, where this adjustment is applicable to a rate revision under Section 2B of these guidelines, rather than to a new form, X should be determined on the basis of anticipated average size premium immediately after the revised rates have fully taken effect.

(6) Medicare Supplement Forms

For Medicare supplement policies, benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio is at least sixty percent (60%).

(7) Conflict with Specific Statutes or Regulations

The above anticipated loss ratio standards do not apply to a class of business where the standards are in conflict with specific statutes or regulations.

(8) Forms with Indexing of Benefits

Certain policy forms provide for automatic indexing of benefits in relation to some base that is not subject to control by the insurer or the insured. Medicare supplement plans under which benefits automatically adjust in response to changes in the Part A or Part B deductibles under federal Medicare are a common example. Other possibilities exist, under disability income, major medical and other forms of coverage.

In such cases, the insurer should be permitted to file rates on a basis that provides for automatic adjustment of premiums, on an actuarial basis appropriate in relation to the automatic adjustment in the benefits. While such premium adjustment would thus be considered "pre-filed," to apply "automatically," it should nevertheless be subject to ongoing monitoring of the continuing loss experience and there should be some agreement with the insurer that the commissioner may require, from time to time, renewed justification that the automatic premium adjustments remain appropriate and reasonable.

B. Rate Revisions

(1) With respect to filing of rate revisions for a previously approved form, or a group of previously approved forms combined for experience, benefits shall be deemed reasonable in relation to premiums, provided the revised rates meet the standards applicable to the prior rate filing for the form or forms.

In general, the rule that applies is that any rate revision is subject to the guideline basis under which the previous rates were filed (with consideration of all relevant rating factors: morbidity, expenses, persistency, interest, etc.), and to those regulatory guidelines, if any, that were in effect at the time of the filing. Where there was no written guideline applicable to the prior rate filing, the regulatory benchmark then generally recognized, such as the 1953 NAIC benchmark (1953 *Proceedings of the NAIC*, Vol. II, p. 542), will continue to govern rate revisions of the prior rate filings.

(2) With respect to filings of rate revisions for a form approved subject to these guidelines, benefits will be deemed reasonable in relation to premiums provided both the following loss ratios meet the standards in Section 2A of these guidelines:

(a) The anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage;

**Drafting Note:** Assumptions applying to the future “period for which rates are computed” should be reasonable in relation to the circumstances. For example, if future rates of inflation are a major factor, the period of projection of such rates normally should be short, such as three to five years only. Other assumptions, however, may still appropriately apply over the entire future policy renewal period, particularly in cases where the basic rate structure is one of level premiums based on original issue age.

- (b) The lifetime anticipated loss ratio derived by dividing (i) by (ii) where (i) is the sum of the accumulated benefits from the original effective date of the form to the effective date of the revision, and the present value of future benefits, and (ii) is the sum of the accumulated premiums from the original effective date of the form to the effective date of the revision, and the present value of future premiums, such present values to be taken over the entire period for which the revised rates are computed to provide coverage, and the accumulated benefits and premiums to include an explicit estimate of the actual benefits and premiums from the last date as of which an accounting has been made to the effective date of the revision. Interest shall be used in the calculation of these accumulated benefits and premiums and present values only if it is a significant factor in the calculation of this loss ratio.
- C. Anticipated loss ratios lower than those indicated in Subsection B(2)(a) and (2)(b) will require justification based on the special circumstances that may be applicable.
- (1) Examples of coverages requiring special consideration are as follows:
    - (a) Accident only;
    - (b) Short term non-renewable, e.g., airline trip, student accident;
    - (c) Specified peril, e.g., cancer, common carrier;
    - (d) Other special risks.
  - (2) (a) Examples of other factors requiring special consideration are as follows:
    - (i) Marketing methods, giving due consideration to acquisition and administration costs and to premium mode;
    - (ii) Extraordinary expenses, or, in the case of a rate increase, expenses in excess of those expected under the previous rate filing;
    - (iii) High risk of claim fluctuation because of the low loss frequency or the catastrophic, or experimental nature of the coverage;
    - (iv) Product features such as long elimination periods, high deductibles and high maximum limits; and
    - (v) The industrial or debit method of distribution.
  - (b) Companies are urged to review their experience periodically and to file rate revisions, as appropriate, in a timely manner to avoid the necessity of later filing exceptionally large rate increases.

## **Appendix. Rate Filing Guidelines**

A basic actuarial requirement in the establishment of a premium rate scale is that the benefits provided be reasonable in relation to premiums. This requirement has been incorporated in the statutes of many jurisdictions and in the regulations and operating rules, formal and informal, of the insurance departments of probably all jurisdictions.

One of the principal objectives of these guidelines is to establish a basis for assisting both those filing rates and those responsible for regulatory review of filings in deciding whether a premium rate filing meets this requirement.

The individuals who drafted these guidelines recognized that the guidelines would be applicable to the wide range of products marketed by a diversity of methods under the general title "Individual Health Insurance." For this reason, they decided it would be inappropriate to establish rigid rules or inflexible standards. It should be recognized, therefore, that the guidelines are intended to be only guidelines, and they must be interpreted and applied flexibly.

Section 2A of the guidelines includes a table of numerical values representing loss ratios that "shall be deemed reasonable in relation to premium." This "deemer level" of loss ratio is meant to be the initial guideline test for establishing the reasonableness of the premiums in relation to benefits. Satisfying this test establishes that the premiums are reasonable in relation to benefits. However, premium rates not meeting this test may still have benefits that are reasonable in relation to premiums based on further considerations.

Other parts of Section 2, and particularly Subsection C, give examples of situations where considerations beyond the initial test would be appropriate in determining the reasonableness of premiums in relation to benefits.

Although expenses are not addressed in detail in the guidelines, the variations in loss ratio benchmarks by average annual premiums per policy is clearly intended to provide for the fact that a substantial amount of general expense is not a function of premium but is flat per policy. Thus, the guidelines intend to make realistic provision for actual expenses as incurred. As inflation causes unit expenses to rise, despite the gains from improved productivity through greater mechanization, etc., the possibility of lower loss ratios may have to be confronted for some forms.

One of the purposes of Section 1 of the guidelines is to set the requirements for rate filings. The usefulness of this section is enhanced by showing herein the minimum requirements as to the documentation of these rate filings.

In developing the checklist below, consideration was merely given to pointing out some of the factors that may be involved in calculating the rates, e.g., interest, mortality, morbidity, selection, lapse, expenses, inflation, etc., and spell out how those factors might be used in such calculations. It was felt, however, that this approach would produce details not always necessary to justify or review the rate filing while leaving out possibly essential information.

The checklists are separate for filing of rates for a new product and filing of rate increases.

### **Checklist of Items to be included in Individual Health Insurance Rate Filing Submissions**

#### Rates for a New Product

- I. Policy Form, application, and endorsements required by State Law.
- II. Rate Sheet
- III. Actuarial Memorandum
  - A. Brief description of the type of policy, benefits, renewability, general marketing method, and issue age limits.
  - B. Brief description of how rates were determined, including the general description and source of each assumption used. For expenses, include percent of premium, dollars per policy or dollars per unit of benefit, or both.
  - C. Estimated average annual premium per policy.
  - D. Anticipated loss ratio, including a brief description of how it was calculated.

- E. Anticipated loss ratio presumed reasonable according to the guidelines.
- F. If Subsection D is less than Subsection E, supporting documentation for the use of the proposed premium rates.
- G. Certification by a qualified actuary that, to the best of the actuary's knowledge and judgment, the rate submission is in compliance with the applicable laws and regulations of the state and the benefits are reasonable in relation to the premiums.

[IV. A statement as to the status of this rate filing in the company's home state.]

**Rate Increases for an Existing Product  
for which Rates are Subject to this Guideline**

- I. New Rate Sheet
- II. Actuarial Memorandum
  - A. Brief description of the type of policy, benefits, renewability, general marketing method and issue age limits.
  - B. Scope and reason for rate revision including a statement of whether the revision applies only to new business, only to in force business, or to both, and outline of all past rate increases on this form.
  - C. Estimated average annual premium per policy, before and after rate increase. Descriptive relationship of proposed rate scale to current rate scale.
  - D. Past experience, as specified in Section 2D of the guidelines, any other available data the insurer may wish to provide.
  - E. Brief description of how revised rates were determined, including the general description and source of each assumption used. For expenses, include percent of premium, dollars per policy, or dollars per unit of benefit, or both.
  - F. The anticipated future loss ratio and description of how it was calculated.
  - G. The anticipated loss ratio that combines cumulative and future experience, and description of how it was calculated.
  - H. Anticipated loss ratio presumed reasonable according to the guidelines.
  - I. If Subsection F or G is less than Subsection H, supporting documentation for the use of such premium rates.
  - J. Certification by a qualified actuary that, to the best of the actuary's knowledge and judgment, the rate submission is in compliance with the applicable laws and regulations of the state and the benefits are reasonable in relation to the premiums.

The test in Section 2B(2) is an innovation of these guidelines. It seems appropriate, therefore, that this appendix include an example of how it works.

The first test in Section 2B(2)(a) is the same for a new form, new business on an existing form, or experience on existing business following a rate revision. Suppose that we are talking about an OR form with an average annual premium exceeding \$X, defined in the guidelines, and the new rates are originally set to provide the benchmark loss ratio of sixty percent (60%).

When the new rates are applied to existing business in force and we calculate the present value of future premiums and benefits, we obtain the following results.

Table 1 - Future Projection

	<u>Present Value at Current Volume from next year anniversaries</u>
Premiums	\$30,000,000
Benefits	18,000,000
Loss Ratio	.60

Then we look at the accumulated experience for the past. Suppose it can be summarized as follows: The poor recent experience has prompted the need for the current increase request.

Table 2 - Accumulated Experience

	<u>Prior to 3 years</u>	<u>Last 3 years</u>	<u>From last year end to next anniversary</u>	<u>Total</u>
Premiums	\$50,000,000	\$10,000,000	\$10,000,000	\$70,000,000
Benefits	20,000,000	9,000,000	11,000,000	40,000,000
Loss Ratio	.400	.900	1.100	.571

When the accumulated and present value figures are combined, the following results appear.

Table 3 - Combined Experiences

	<u>Accumulated</u>	<u>Present Value</u>	<u>Total</u>
Premiums	\$70,000,000	\$30,000,000	\$100,000,000
Benefits	40,000,000	18,000,000	58,000,000
Loss Ratio	.571	.600	.580

The test in Section 2B(2)(b) is not met.

With respect to future premiums on the existing volume, the rates proposed must be reduced so that the .58 result is increased to .60. Since the benefits are what they are and the present value is settled, we can work backwards to determine that the total premiums must be \$96,666,667 (\$58,000,000 - .60). Thus the present value of future premiums must be \$26,666,667 and the proposed rates, applicable to new business, must be reduced by one-ninth, with respect to the existing volume. The new table which meets the Section 2B(2)(b) test is as follows.

Table 4 - Revised Combined Experiences

	<u>Accumulated</u>	<u>Present Value</u>	<u>Total</u>
Premiums	\$70,000,000	\$26,666,667	\$96,666,667
Benefits	40,000,000	18,000,000	58,000,000
Loss Ratio	.571	.675	.600

The next rate increase request will depend on how experience develops, if the company wishes to charge the same rates for new business and renewal, one way it could do so would be by reducing the rates otherwise proposed for new business. An alternative approach would be to combine the experience under new and existing business in a similar analysis to arrive at a single rate structure applying to both.

If the early experience under the form was poor, the losses would not be recoverable. Suppose, for instance, that only the last three years and the estimate for the last year-end to the next year's anniversary in the above example existed and the proposed new business rates applied. Then, the following test from Section 2B(2)(b) appears:

Table 5 - Alternate Combined Experiences

	<u>Accumulated</u>	<u>Present Value</u>	<u>Total</u>
Premiums	\$20,000,000	\$30,000,000	\$50,000,000
Benefits	20,000,000	18,000,000	38,000,000
Loss Ratio	1.000	.600	.760

While the present value of future premiums could be increased under the Section 2B(2)(b) test to recover past losses and still meet the 60% benchmark, the test in Section 2B(2)(a) would preclude such an increase.

It is believed that this test will be rather simple to apply, in practice, from readily available records. It will be an effective tool in reviewing the reasonableness of rate increases.

Section 2B, as amended, is not intended to substitute new standards retroactively in place of standards in effect before the date of these guidelines. It is not intended that the rules be changed in the middle of the contract period. On the other hand, the principles of these guidelines may have been implicit in a state's former rules and guidelines.

It should be emphasized again that the tests in Section 2A and 2B have to do with benchmarks, not legal minimums. Section 2C mentions some situations in which lower loss ratios may be justifiable. If, however, a rate submission meets the benchmark standards and includes full documentation as described in the guidelines and this appendix, the requirement that benefits be reasonable in relation to premiums should be considered met.

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*Chronological Summary of Action (all references are to the Proceedings of the NAIC)*

*1980 Proc. I 29, 38, 406, 410, 413, 416-425 (adopted).*

*1983 Proc. I 6, 35, 644, 652-659 (revised).*

*1983 Proc. II 16, 22, 638, 644, 646-655 (amended and reprinted).*