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REPORTS ON TOPICS OF CURRENT INTEREST

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RECENT LEGISLATIVE DEVELOPMENTS

PENNSYLVANIA SALES TAX

A legislative development which attracted particular recent attention was the passage and quick repeal by the state of Pennsylvania of a 6 per cent sales tax on insurance premiums. The passage of the bill was a rapid development coming after a long search for increased state revenues from all possible sources. This search had included passage by the lower house of the legislature of an increase in the premium tax from 2 to 3 per cent. The senate refused to pass this bill because of the effect of retaliatory laws on Pennsylvania companies, but toward the end of February leaders of both houses decided to have it amended to make it bring insurance premiums under the state's 6 per cent sales tax law, apparently in the belief that retaliatory laws of other states would not be triggered by this form of tax on insurance. Amendment and passage by both houses of the amended bill took only two days in spite of desperate hurried attempts to oppose passage.

Strong efforts were made to get the governor to veto the bill. These efforts were unsuccessful, and it became law without his signature after the end of a ten-day period following its passage. It took effect immediately, which meant that under the law the policyholder was liable to the company and the company to the state for the sales tax on all premiums paid from the first effective date, even though there had been no time for notification to policyholders or the establishment of administrative procedures by the Department of Revenue.

Although all efforts to prevent passage of the bill were futile, a campaign to reverse the decision of the legislature began to produce swift

results even before the law had become effective after the end of the period for consideration by the governor. Companies published newspaper advertisements, and some wrote all their Pennsylvania policyholders. Agents became thoroughly aroused and staged a demonstration in Harrisburg. Lawsuits were filed attacking the tax as unconstitutional and asking for injunctions against collection of it. Legislators received messages by phone, wire, and letter from agents, company officials, and policyholders. Commissioners of several states threatened application of their retaliatory laws to Pennsylvania companies.

As a result a bill to repeal the tax retroactively was introduced the day the tax became effective, and the repeal became law with the governor's signature six days later. It provided some current revenue by calling for acceleration of certain existing taxes. Both the passage of a sales tax, never before applied anywhere to insurance premiums, so swiftly after such perfunctory consideration, and the overwhelming character of the campaign for repeal were developments which were rather amazing to those who follow insurance legislation.

VARIABLE LIFE INSURANCE

A bill to authorize the sale of variable life insurance has been enacted in Tennessee, and similar bills are currently before the legislators of Arizona, Massachusetts, Maryland, and New York. Of course, some states have laws authorizing the use of separate accounts that are broad enough to permit the sale of variable life insurance without any additional legislation.

There are also problems concerning the possible authority of the Securities and Exchange Commission to regulate variable life insurance. These are presently being explored. It is hoped that the SEC may hold that variable life insurance is not within its authority to regulate on the grounds that in it the insurance element is predominant relative to the investment element. For such a holding, however, it may be necessary to exclude from variable life insurance contracts with substantial investment elements.

HEALTH INSURANCE AND HEALTH CARE

The House Ways and Means Committee is currently reviewing both the Medicare and Medicaid programs. On March 25 the administration proposed the addition to Medicare of a new Part C, a plan of prepaid group practice along the lines of the Health Insurance Plan of Greater New York and the Kaiser Foundation Health Plan. This plan would also be made available under Medicaid. Under the administration proposal

the Social Security Administration would contract with a private health insurance carrier to provide care for a person eligible for Part C.

In New York an administration bill for compulsory health insurance has been introduced this week. I do not yet have the details of this bill, but it is believed to require coverage by private carriers (all types of private carriers) of all workers and their dependents. Workers would presumably include the self-employed and the temporarily unemployed, the latter to include public assistance recipients and Medicaid eligibles, with premiums for these to be paid at least in part by existing federal, state, and local programs. Employers would be required to provide coverage on employees, with both sharing in the cost. At this point, passage of this bill does not appear likely in the current session of the legislature, which has only a few weeks to run.

A bill for compulsory health insurance of employed persons is also pending in Hawaii.

In Pennsylvania, a bill has been introduced which would create a health agency to regulate the planning and provision of health and medical services within the state. This agency would be empowered, among other things, to regulate both charges made by hospitals and health insurance premium rates.

PENSIONS

At the federal level, an administration bill has been introduced by Senator Javits and by Representative Ayres which would amend the Welfare and Pension Plans Disclosure Act to provide standards for fiduciary responsibility for persons handling employee benefit plans, together with additional disclosure, greater investigatory powers for the Labor Department, and a limit on investments in securities issued by the employer. The bill, a similar bill introduced by Representative Dent, and another bill of Mr. Dent's that would require vesting and funding are all currently before the House Subcommittee on Labor, and hearings are being held intermittently. The interest in these proposals seems currently to be increasing.

In Massachusetts, a bill has been introduced which would require pension plans to provide that benefits vest after ten years' service by an employee.

INSOLVENCY FUNDS

Wisconsin enacted a law in 1969 providing that in the case of a life insurance company a guaranty fund should protect Wisconsin policyholders. This fund would satisfy claims against the insolvent company by paying either death benefits or cash values for each contract. An as-

sessment would be made against life insurance companies admitted to Wisconsin, except for foreign companies subject to assessment for guaranty funds of their own states which provide substantially the same protection to Wisconsin residents. This law also applies to all other forms of insurance.

A bill establishing a guaranty fund with postinsolvency assessments with a writeoff of such assessments against future premium taxes passed both houses, with different amendments in the two houses, of the Washington legislature, but it died in conference committee.

In Maryland a bill which follows the approach of the Wisconsin law, with a number of modifications, has passed one house of the Maryland legislature.

At the federal level, a bill applicable to property and casualty insurance companies is currently in committee. The NAIC model bill for property and casualty companies is currently pending in several states.

POLICY LOAN INTEREST RATE

In New York, a bill to increase the maximum interest rate on policy loans from 5 to 6 per cent was defeated in the assembly after having passed the senate. New York is the only state in which a 6 per cent rate is not permitted.

MISCELLANEOUS

A bill has been introduced in Massachusetts which would change the requirements for Schedule G of the annual statement. Currently, salaries in excess of $5,000 have to be listed; the bill would change the limit test to $20,000, the current provision of the NAIC Annual Statement Blank.

GEORGE H. DAVIS

THE TRAINING OF ACTUARIAL STUDENTS IN THE UNITED KINGDOM

Life insurance companies in the United Kingdom are becoming increasingly reliant on university graduates to fill the ranks of actuarial students as well as other management trainees. As this trend comes at a time when there is increased competition from other callings and industries for those mathematically trained and competent individuals who would make successful actuaries, it is extremely important for the actuarial profession to have a good image within the universities. This is one reason why it is very important to make good use of students during their training period.

A study of the experience of university graduates in the insurance industry has been carried out recently by two university appointments men. This study, published under the title *Graduates in Insurance and the Actuarial Profession*, is based on the results of a questionnaire sent to graduates of the preceding ten years who had entered the industry.

The report is critical of the use made of university graduates by insurance companies, including those graduates who had entered actuarial training programs. I believe the results of the survey might have been subject to some degree of misinterpretation by its authors, perhaps because of the design of some of the questions. I refer particularly to one question which inquired, "Who mainly supervised your training in the first two years?" A large number of the respondents selected the sweeping-up answer choice "No one particularly," a result which was interpreted in the report as evidence of inadequate supervision. In many cases the respondent may merely have meant that he had received supervision from a number of sources rather than from none.

Still, the training programs of the insurance companies are not perfect, and the real question is what can be done to improve them. It is obviously desirable to give as wide training as possible to actuarial students, but there are problems in this approach. If a student moves about too frequently, it will not be possible to allow him to take the degree of responsibility commensurate with his length of training. If he is kept in one department too long, however, the company will be subject to criticism for not offering a sufficiently varied training program.

In any event, it is vitally important to treat university graduates as fully adult. Youth of today are just as responsible and as hard-working

as they were in the past but are much more liable to speak up and criticize existing practices.

In a program recently introduced by my office, each student enrollee is assigned a Fellow of the office as an "uncle." The "uncle" will offer his "nephews" (each Fellow has two or three of these) advice on the syllabus and the pace of his studies. The program is informal and entirely voluntary, but the blend of persuasion and encouragement that the Fellows can offer the students seems to be having good effects.

JAMES B. H. PEGLER, F.I.A.
President, Institute of Actuaries

Hartford Regional Meeting

LEGISLATIVE DEVELOPMENTS OF INTEREST TO ACTUARIES

Not too much has happened this year in the way of legislative developments of interest to actuaries, but a lot might have happened or is still pending. What I have to say, therefore, mainly concerns the latter. First let us consider the federal legislative front and then the state legislative front.

On the federal front, one of the most important issues, at least to home office life underwriters, is the Fair Credit Reporting Act, still pending in Congress and very much alive. It is aimed primarily at inspection reports designed to help with the extension of personal credit, either small loans or instalment purchases. However, it also covers inspection reports designed to help with insurance underwriting, especially life insurance underwriting, and there is the rub.

One thing that the bill says is that, if adverse information is turned up on inspection for insurance and if, as a result, the insurer declines or rates the insurance up, then the applicant for insurance must be so advised. Furthermore, if the applicant puts up an argument, he must be told that he may have access to the inspection report. If the argument still persists, the applicant can then require that the names of those providing the adverse information be disclosed. You do not have to be an underwriter yourself to realize how all this would tend to dry up sources of inspection information and even perhaps inhibit the application for insurance in the first place.

Earlier this month our own Charles Walker testified against these particular features of the bill and proposed amendments on behalf of the Life Insurance Association and American Life Convention. The occasion was a public hearing before the House Subcommittee on Consumer Affairs, which, by the way, was the subcommittee which started the 1969 "Truth-in-Lending" law on its way. It meant business then, and it means business now. I was not present to hear Chuck testify, but I am told that he made an excellent impression and answered all questions convincingly—convincingly to us, that is. We are cautiously optimistic that substantial changes will be made in the bill. The subcommittee has just completed two executive sessions on it, and this amount of deliberation at this stage of the game is itself a good sign.

Next to the situation on the Fair Credit Reporting Act, I would say that the most important federal legislative situation of direct interest to actuaries is that which concerns possible federal regulation of private pension plans. Congressman John Dent, chairman of the House Subcommittee on Labor, has last year and this year introduced two important bills to regulate pensions. One is a revival of the Johnson administration proposal for federal requirements as to vesting, funding, and guaranteeing pension plan benefits. The other is a revival of another Johnson administration proposal for imposing federal fiduciary standards on the administrators of pension and welfare funds.

Senator Javits, acting for the Nixon administration, introduced the latter's version of federal fiduciary standards for plan administrators—nothing about vesting, funding, and guaranteeing pension plan benefits. When the new Nixon proposals were referred to his subcommittee, Congressman Dent put out a press release centered on a remark "Is that all?" Well might he ask. Without a push from the White House, federal pension proposals on vesting, funding, and guaranteeing benefits do not appear to have a chance to be seriously considered this year and, if the attitude of large segments of the business community remains opposed to all federal laws on vesting, funding, and guaranteeing of benefits, probably not next year either or the year after that.

There is a great deal of other federal activity, but, to save time, I will mention three proposals briefly: (1) to increase social security old-age benefits still further and the tax and benefit wage base substantially; (2) to add a Part C to Medicare and to provide an option to utilize group medical practice prepayment plans; and (3) to establish an income maintenance plan for the poor, especially the working poor, on a basis not too different from that recommended by the high-level commission on which J. Henry Smith served so well. This morning's papers report that this Nixon administration income maintenance plan has passed the House of Representatives.

On the state legislative front, I can confirm the report that the New York bill to authorize variable life insurance has passed. We have no doubt that Governor Rockefeller will sign it. That still leaves the need for variable life insurance legislation in a number of other states, but, given time, that should not be too hard to come by. I do not know what to say about the SEC problems which variable life insurance has. I can only say that we are working on the SEC problems—working hard.

The New York bill to increase the maximum policy loan interest rate for new policies from 5 to 6 per cent is regarded as dead. Unfortunately, the bill died under circumstances which leave no assurance that it can

pass next year either, unless we manage to get some of the important outside support which has so far been lacking. While we are not discouraged, or not discouraged too much, all I can say of value is that life companies doing business in New York should make their policy design plans on the basis that we may have the same trouble next year in getting a 6 per cent limit to replace the 5 per cent limit.

More promising in New York are the prospects for the so-called jumbo-jet bill, which is noteworthy in that it would allow life companies to enter the airplane liability insurance field by way of reinsurance and by way of a sort of "no-fault" direct insurance. This is the first step that I have knowledge of by life companies into what has heretofore been regarded as an exclusive casualty insurer domain. It just so happens to be sponsored by casualty insurance interests, who would rather see the life companies provide a solution to the so-called capacity problem than have the federal government do so.

Probably the most important—certainly the most spectacular—state legislative development this year was the passage, and then the repeal, of the law which would have extended the existing Pennsylvania sales tax of 6 per cent to insurance premiums. This was to be on top of the 2 per cent premium tax, making 8 per cent in all. I do not think that any of us have any doubt what this would have done to the sale of permanent forms of life insurance; it would just about dry it up completely. Unfortunately, we are not completely out of the woods yet. Pennsylvania is still without a long-term solution to its very serious revenue problems, and so are practically all the other important industrial states without both a broad-based sales tax and a broad-based personal income tax. Until these important revenue sources are tapped in these industrial states, we can only expect the most serious insurance tax problems ahead at the state and local levels in 1971 and thereafter.

ALBERT PIKE, JR.

OBSERVATIONS ON THE 1970 NATIONAL HEALTH FORUM

"The country has gone through a period of assuming financing is the only problem. We have learned that this is an oversimplification. The additional dollars of Medicare and Medicaid merely highlight and aggravate the deficiencies of our medical care system. Most people now believe we must consider financing and organization as closely related problems."

Thus did Dr. Cecil G. Sheps open the National Health Forum on February 23, 1970, in Washington, D.C. Dr. Sheps, who is director of the Health Services Research Center at Chapel Hill, North Carolina, had chaired a forty-five-member committee that planned and organized the 1970 forum. I should add that his opening remarks were not challenged during the forum.

I first heard of the National Health Forum when Mr. E. J. Moorhead wrote to say that the Society of Actuaries had suggested my name as one who might benefit from attending the forum. I found that the forum was convened annually to consider a single aspect of health care and was sponsored by the National Health Council, a federation of seventy national health organizations. The Council can seemingly claim every major voluntary health agency and health professional association among its members. These include such professional organizations as the American Medical Association and American Public Health Association, as well as voluntary health organizations, such as the United Cerebral Palsy Association.

Dr. Gerald Dorman, president of the American Medical Association, and Dr. William Stewart, the former surgeon-general, were perhaps the best-known professionals among the eight hundred and seventy-five participants. Deliberately invited to give other points of view were seventy-five community representatives. These men and women were given subsidized transportation and accommodations so that they could represent the voice of ethnic minorities, the ghetto, and the "consumer." Some who helped give a consumer point of view were Julian Bond, the Georgia legislator; Edward Martin, president of the Student American Medical Association; Mrs. Johnnie Tillmon, president of the National Welfare Rights Organization; and a well-dressed young black girl who spoke for a Black Panther neighborhood health center in Chicago.

The conference plan was imaginatively conceived. It is one thing to round up eight hundred and seventy-five articulate participants and quite

another to generate something more than emotional reactions to a theme such as "Meeting the Crisis in Health Care Services in Our Communities." The forum was able to move from generalities to specifics by focusing discussion upon three different actual operating systems for providing medical services and upon three proposed financing plans. Each participant then reacted by considering the strengths and weaknesses that each plan might have if put into use in his locality and its effect in his professional area.

The three organizational "models" presented were all operating medical services systems:

1. Dr. Joyce C. Lashof of Presbyterian–St. Luke's Hospital, Chicago, described a neighborhood health center which she heads as project director. The center serves 25,000 low-income black citizens, with ambulatory services for acute and chronic illnesses, mental illness, and preventive care, and dental care. Referral and inpatient services are provided at St. Luke's.

2. Dr. Donald C. Harrington described the Foundation for Medical Care of San Joaquin County, California, which he heads as president. The Foundation was formed in 1954 and now has contracts with 10,000 physicians who render service reimbursed under group insurance contracts with quality, utilization, and fee control exerted by the Foundation.

3. Dr. Ernest W. Saward presented the significant features of the Kaiser-Permanente Plan, a prepaid group practice arrangement. Dr. Saward is an effective advocate for his system of financing and delivering medical care.

Each proposal for solving the "crisis" was first discussed by a panel and then by the participants in small discussion groups. Out of the discourse came an enumeration of the strengths and weaknesses of each plan. Many of us found ourselves agreeing with former Surgeon-General Stewart's conclusion. He had observed that none of the solutions now offered, none of the conventional thinking now put forward, would solve the health delivery problems of the country. He suggested that this was because we still lack the required basic knowledge of how health care delivery systems operate.

Next on the program came the presentation of three proposals for national financing of health care services. Mr. James Brindle opened this section of the program by outlining the goals of the Reuther Committee of 100 proposal for national health insurance; he did not estimate cost or specify how the plan would be operated.

Dr. Russell Roth, the speaker of the House of Delegates, American Medical Association, then presented the "Medi-Credit" plan. Under Medi-Credit each family would purchase a plan of comprehensive medical service insurance at an estimated family premium of $700 a year. There

would be federal tax credits or outright subsidy of the premium for those in low-income groups.

Finally, Mr. Daniel Pettengill, F. S. A., presented a plan that he helped to design and one now endorsed by the HIAA board of directors. The strength of the Pettengill plan lies in its retention of existing insurance arrangements which work so well for a large part of the population. He described minimum benefit standards to be laid down for group medical expense plans and a uniform, federally subsidized plan for poor, near-poor, and uninsurables. The proposal entails a pooling of uninsurable risks, federal subsidy of the plan for the poor and near-poor, and steps to train additional health manpower, to make health planning more effective and to promote ambulatory care.

The response to these three proposals? Mostly a shrugging of shoulders and seemingly profound indifference. The poor and those of ethnic minorities greet large federal programs administered by distant bureaucracies with about the same degree of warmth as is displayed by an Agnew supporter from a small town in Nebraska. Other health professionals, perhaps as an article of faith, still proclaim that a national uniform system of health insurance is inevitable.

Yet, for the short run, most observers appeared not to give national health insurance, in whatever form, a very high priority. Robert M. Sigmond, an economist serving as executive vice-president of the Albert Einstein Medical Center in Philadelphia, noted that national health insurance would not stimulate new health service. He said it would primarily offer protection to the pocketbooks of consumers and providers and probably would have an unanticipated impact on the health care system. But for the immediate term he called attention to the fact that health insurance cannot do much to meet the crisis of access or increase the availability of health manpower. He said that it would do little to bring more services to blacks, Indians, and Chicanos and that, in fact, national health insurance was almost irrelevant to the immediate health care problems of the nation.

Economist Gerald Rosenthal suggested that widespread interest in financing may have developed from the hope that a new means of financing would change the features of the health care delivery system. But he also made it perfectly clear that putting more resources into today's health care system would require rationing of services. He agreed with Dr. Stewart that the medical crisis was caused by our lack of enough resources to improve access. He added that inflation in medical costs may actually reduce the nation's ability to provide services, a reduction that always starts with the poor.

Unhappily, at least from my point of view, forum participants did not have an opportunity for group discussion of financing proposals, because minority group representatives pre-empted the allotted time to offer three resolutions calling for actions that no discussion forum could possibly bring about. The resolutions, one suspects, were a device by which the blacks, Chicanos, and Indians told us that they wished to speak for themselves and to have their point of view recognized. The rhetoric of the ghetto is one of overstatement, which is perhaps unfortunate; I am certain that many were offended by the suspension of Robert's Rules of Order. Yet there was no profanity or physical violence. Once the minorities had offered their improbable resolutions, the issue was forgotten, and the forum was allowed to proceed with the remainder of its program without incident.

Several conclusions reached by most discussion groups as an outgrowth of considering how best to organize medical services are worth reporting:

1. There was agreement that a new partnership is needed at every level in the health care field. The partnership should involve consumers of every kind and at every level, lay control of professional services, and local control of institutions.

2. Improved access to medical services was perceived as an emergency matter to be dealt with before any attention is given to the development of a national health insurance plan.

3. Our nation's emphasis on the free choice of physician or hospital has become illusory in many communities and in many segments of the population who, in fact, have no choice.

4. There was emphasis on the importance of preventive medicine, especially as to measures that could be undertaken by communities and by consumers.

5. Clearly more and different kinds of medical manpower are needed. It is suggested that there be emphasis on increasing the numbers of new medical professionals as well as the establishment of career ladders with upward mobility. Those skillful in dealing with people and with knowledge gained through experience should be allowed to advance to more responsible positions without returning to school for extensive but unnecessary education. This objective will require revision of existing licensure laws.

Pluralism, I believe, is very much the order of the day, there being a strong emphasis on the importance of having each locality and ethnic group work out its own solutions. The consumer is perceived as knowing more about his community than the health professional.

It is my personal view that we have a serious problem of unattainable expectations. We can see that inflated expectations are held by all citizens, expectations that make it so difficult to supply health care satisfactory to most consumers. One hears this in the rhetoric of the blacks demanding an end to the dual system of providing medical care and in the reactions

of the middle and upper classes who bring malpractice suits when medical miracles are not forthcoming from the mortals who practice medicine.

Yet there are realists around who see the true nature of things and recognize that a universal solution does not exist. I found it remarkable that Mrs. Arva Jackson, a black administrative assistant to the governor of Delaware, would end her clear, intelligent analysis of the virtues of neighborhood health centers by quoting H. L. Mencken: "To every human problem there is a solution that is neat, clean, and wrong."

I believe that it would be constructive for the nation and the health insurance industry to stop using the word "crisis" to refer to the bag full of problems present in the financing and provision of health care services. Clearly a major immediate problem is the escalation of health care costs. In my view the inflation in medical costs calls into question many of the traditional cost-control techniques of insurance. Techniques such as insuring clauses and exclusions are completely ineffective in limiting vendor charges for care. Other policy provisions, such as the definition of a hospital or of a physician, may actually strengthen the monopoly position of the vendors. Even limiting reimbursement to usual and customary charges seems at best marginally effective against a raging medical services price inflation.

Dr. Roger Egeberg, HEW Assistant Secretary for Health, talked of the current concerns of the department in a closing address. He supported the view of other speakers who had made it clear that the rising cost of Medicaid was pre-empting health budget funds that might otherwise have funded health research, education, or service programs. He stressed steps being taken to curb rising Medicare and Medicaid costs. These include measures spelled out in proposed "health cost effectiveness" amendments to the Social Security Act, the development of cost-effectiveness measures, and the use of prospective rather than retrospective schemes for reimbursing hospitals and doctors.

Dr. Egeberg called for a working partnership between the private and public sectors. He directed our attention to the value of developing incentives to encourage the use of lower-cost ambulatory health services. He called upon insurers to abandon their neutrality in dealing with hospitals and physicians and believes that we must initiate a continuing dialogue between the private and public sectors.

Finally, I will close with another opinion of Dr. Stewart, who said that many of our health care problems are still not defined well enough to give direction to change. Since a satisfactory solution is one that is acceptable to the customers being served, one suspects that we shall never find a single universally acceptable "solution."

JOHN C. ANGLE