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CURRENT GROUP INSURANCE TOPICS

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Panelists: JOHN W. COONS, RAYMOND F. McCASKEY.

1. Experience rating problems.
2. Group life problems.
3. Long term disability problems.
4. Association group.
5. Utilization of Health Maintenance Organizations.
6. Reinsurance.

MR. WILLIAM A. HALVORSON: The group insurance industry had lots of red ink and frustration last year. The companies our panelists represent were more fortunate. One company actually made a gain while the other had a small loss of $7 or 8 million. To put that into perspective, our panelists represent large organizations so $7 or 8 million is not that big of a percentage of their total income.

We will take up three of the topics this morning: experience rating problems, long term disability (LTD) problems, and utilization of HMO services. Discussion of group life, association group, and reinsurance are left for the two workshops which follow this session.

MR. JOHN W. COONS: Let me first briefly describe how Chicago Blue Cross/Blue Shield's rates, reserves, and solvency are regulated. We operate under the provisions of special enabling legislation, the Health Care Service Plan Act, which requires the Illinois Director of Insurance to regulate all aspects of our operation. This includes rates charged our subscribers, rates or basis of payments to our health care providers, valuation of assets, reserves and other liabilities, and expenses such as the cost of soliciting new business. All are subject to the approval of the Director.

The specific solvency provision of the Act requires the maintenance of a rather nominal minimum surplus of not less than $1 million, but, in addition, we must maintain such additional surplus as is necessary to our financial needs. With 1976 premium income of almost $750,000,000, we currently have about 1 1/4 months of benefits and operating expense in reserve, which is less than the 2 months or more we attempt to build into our rating.

Our community rates for blocks of business such as small group Basic and Major Medical, Direct Pay Under 65, and Over 65 Group and Direct, are updated periodically by formal submissions to the Director with supporting statistical documentation including trend factor data. Incidentally, our small group community-rated block of business comprises about 3½% of our total premium, so the old days of one great big happy family with everybody community rated are certainly not around any more.

For experience-rated groups, we use formulas approved by the Director including base rates and trend factors for initial rating, renewal rating, and for experience refunds. We do require prior experience before quoting on new groups of 100 lives or more. One of our most troublesome problems in recent years has been the maintenance of adequate trend factors. Because we calculate renewal rates for merit groups three or four months in advance of their anniversaries and because the anniversaries are spread throughout the year, the adverse financial effect of an inadequate trend factor is not fully corrected for a period of 15 or 16 months even after we receive approval from the Director to implement a needed increase.

Two specific problem areas with respect to trends were the end of Phase IV controls in May of 1974 and the well-publicized malpractice crisis which surfaced hard in late 1974 and early 1975. Both of these situations prompted us to request specific incremental increases in our trend factors on a projected "guesstimate" basis over and above the traditional projection of the past experience. The Director and his staff have been reluctant to recognize any such trend increases not documented by experience, even though we have pointed out that if our factor proves redundant, our experience refund formula will give the excess back, at least to our merit groups.

During 1975 we had to quantify the effect on our Blue Cross/Blue Shield trend factors of increases in malpractice insurance premiums charged our providers. Two full studies are now available which are almost a year old but still useful.

In April 1975 we surveyed twenty-five of our large and medium-sized metropolitan area hospitals, representing almost 30% of our total Blue Cross benefit payments, asking for the dollars of their prior versus current annualized malpractice premiums and for increases recently implemented or soon to be implemented. The responses totalled $3,465,000 of prior and $11,730,000 of current malpractice premiums, an increase of 238.5%. The $8,265,000 increase was slightly more than 2% of the total expenses for those hospitals as shown in their then most recently filed fiscal year statements, and we assumed their charges would be increased accordingly. A Chicago Hospital Council survey released in January 1976 confirmed the magnitude of these numbers, stating that the increase in professional liability insurance premiums as a percent of total hospital costs have risen 2.3%, from 0.9% in 1974 to a 1975 level of 3.2%.

In July of 1975, a carrier for the Illinois State Medical Society increased malpractice premiums for about 9,000 Illinois physicians by 89%. The rates varied by five categories of risk classification, and by amount of coverage in metropolitan areas versus the balance of the state. We could not obtain in our company the distribution of the risk nor the extent of Blue Shield's services those specific covered physicians might be providing. However, in using an available 1975 distribution of some 17,700 Illinois physicians by 69 different specialty codes, and data published by the American Medical Association which allowed us to estimate average annual provisional expenses for Illinois physicians by type of practice, we arrived at 2% to 3% as the potential increase in the level of doctors' charges. We have not been able, for either our hospitals or doctors, to document any sudden quantum leap in resulting charge levels, but we do believe the situation produced inflationary pressures and helps explain the continuing high level of premium increases observed since then.

Major ... 2-3%

Now, compared to what is facing us this year, the above is almost the "good news"! As of July 1, 1976, the malpractice rates were to have been increased by 267% or 3 times last year's increase. Although the Illinois State Medical Society rebelled and is forming its own physician-owned carrier to provide malpractice coverage as of July 1, 1976, the increase over the current rates will still be 146%. A one-time initial contribution will be required with the July 1 premium which brings the aggregate increase to 235%, not much under the prior carrier's proposal. It is obvious that malpractice continues to be a major inflationary cost concern and we believe we will see major fee increases within the next few months, requiring additional trend on our Blue Shield side on the order of 8%.

Aside from the malpractice question, we do monitor trend data on inflationary and total cost increases monthly and utilization quarterly. Our Blue Cross plan hospitals are required to notify us 90 days in advance of any adjustments in charges. We are then able to calculate each month the approximate dollar effect of these changes based on those hospital's Blue Cross benefit dollars for the prior year. This year to date, through April, we have processed changes for 151 hospitals, with 32 of the hospitals submitting a subsequent second change and 4 of those a third change. At last we found some good news. This year's cost increases for Illinois Blue Cross, as tabulated through April, are down 4% from comparable figures last year. Based on these figures I would project a 12% to 13% trend in cost level for the balance of this year.

For Blue Shield inflationary costs, a monthly tabulation is made of claims paid for major statistical categories of our Usual and Customary contracts, representing about 70% of our total block of business. For twelve different types of service and for inpatient versus outpatient, both the physician's charge and the actual Blue Shield payment are tabulated and averages calculated and compared with prior months. We find pronounced shifts in the month-to-month mix of inpatient versus outpatient services as well as between types of services. We also note that recent charge levels generally seem to show larger increases than the corresponding payments, indicating pressure on us to increase our customary payment levels at a faster rate if we are to keep up with the charges relatively. In the aggregate, however, Blue Shield cost increases year to date appear to be running about 10% or slightly higher. This compares with the 12.7% built into our current trend factors. So again this is some good news, and, considering our concerns for malpractice, we can use all the good news possible.

Utilization figures are derived from a quarterly report by type of contract for subscribers listed within line of business. The incurred basis of the report involves a 3-month runout which may be unique to Chicago Blue Cross and Blue Shield. We hold our statistical books open for 3 months and claims which are paid in the fourth month or later following actual date of incurrence are assigned to the then earliest open statistical month, the third prior month. Current report data is compared with prior quarters, and trends are derived and projected for the various breakdowns and tabulated.

Our reading on current utilization for Blue Cross is about 3% inpatient and 7% outpatient. Again, inpatient claims are 95% to 96% of our total dollars. Our Blue Shield incidence results do seem to bounce around from quarter to quarter but our current reading indicates a level of about 8%.

MR. HALVORSON: Compounding the problem of coping with rising health care charge levels has been the continuing upgrading in the coding of physician services by physicians. Normally, this practice is difficult to trace in an insurance company because utilization statistics are not generally kept. But the practice can be documented in the statistics kept by a prepaid health plan. This upgrading practice contributes to rising costs without a change in the basic coefficient applied to the relative value study (RVS).

Upgrading occurs when a physician records, and presumably delivers, more services at RVS codes which carry a higher unit value. The result is an increase in the average charge per service, without a change in utilization and without a change in the RVS multiplier.

In one plan, for instance, for which the coefficient did not change during the period mid-1974 to mid-1975, the percentage of Brief Examinations, coded 90040, decreased from 41% to 26% of all visits, while the Limited Examination, coded 90050, increased from 51% to 62% of all exams, and Intermediate Exams, coded 90060, increased from 7% to 10%. In all cases, the higher code carried a higher unit value.

In this same plan, for the AFDC category under a MediCal contract, utilization for the medicine section was up 4.3% and the average charge also increased 4.8%, for a combined increase in costs of 9.3% over a one year period, with no change in the RVS coefficient. In contrast, under the surgery section, utilization increased 14%, while the average charge decreased 13.7%, for a net change of minus 1.6% in costs. These statistics illustrate that changes in medical and billing practices are always going on, even with a stable enrollment of 25,000 people. And these changes can account for substantial increases in costs, quite aside from charge level increases.

MR. BENJAMIN R. WHITELEY: Recently, General Motors, at the bargaining table, asked their employees to pay a greater part of their medical care costs. I wonder if Mr. Coons has seen any of that kind of passing along of these cost increases to the employees.

MR. COONS: Many of our plans are fully contributory as the UAW - General Motors contract has provided. These cost increases cause a severe problem for many employers. For instance, we required a $400,000 rate increase on a relatively large group. I understand the controller just about fainted. He said that his company's profit projection for the year was $275,000, which would be completely wiped out by the rate increase.

MR. RAYMOND F. McCASKEY: Based on the experience of the 1970's, most actuaries give some recognition to the impact of the economy on group long term disability insurance (LTD). Despite this shared conviction that such a causal relationship exists, there has been little statistical analysis performed. This situation is due at least in part to the large number of variables involved, as well as the difficulties involved in adequately measuring general economic conditions.

Some evidence of this relationship does exist in the recent Society Intercompany Group Long Term Disability Studies. These studies show significant increases in the rates of disablement and actual-to-tabular ratios during the 1970-1971 recessionary period. It also appears that rates of disablement did drop in 1972 and 1973, but not to the lower levels of the 1960's.

I am confident that when all the data is in, 1974 and 1975 will have produced even higher rates of disablement relative to the past. Interestingly enough, no such clear pattern emerges with respect to severity of claim.

A less apparent, but equally important, observation is that there appears to be a long-term upward trend in rate of disablement underlying the short-term cyclical fluctuations. An in-depth analysis of these trends was provided by Howard J. Bolnick at the corresponding concurrent session in Houston on May 21, 1976. I urge any interested parties to read Mr. Bolnick's discussion in the Record.

My concern today is with the difficulty of properly pricing group long term disability insurance given the short-term volatility and apparent long-term trends. Does the actuary establish premium levels sufficient to cover even the worst years in the economic cycle? Is the historical long-term average experience an appropriate basis for price determination? Perhaps the actuary should revise group long term disability premiums each year based on his expectations regarding future economic developments? The answers will, of course, vary based on the philosophy of a particular insurance company, the competitive climate, and on the company's long-term commitment to the group LTD market. Still, a few basic observations can be made.

Assuming that a long-run premium level that is adequate while still reasonably competitive is a basic goal, an actuary can adopt one of two general philosophies. First, he may conclude that the most reasonable goal for pricing is the composite long-run favorable experience of the group LTD portfolio. Individual years will show gains or losses due to the impact of economic or other variables. In this case, the actuary will concern himself primarily with long-term historical experience with some adjustment to reflect the emerging long-term upward trend in the rate of disablement. The actuary may also find himself under pressure from his company management in a bad year and under pressure from the policyholder in a good year.

Second, the actuary may conclude that since group LTD is characteristically one-year renewable term insurance, the experience with respect to each year must stand on its own. In this case, the actuary must concern himself with the future condition of the economy or any other external factor which might affect the experience of a particular year. The appropriateness of the premiums developed will vary directly with the accuracy of the actuary's economic forecasts. In either case, the actuary cannot rely solely on past experience for his pricing assumptions. Economic factors can affect group long term disability experience in ways other than influencing the rate of disablement, such as the potential impact of inflation. The relative increases in general wage levels and government-sponsored disability benefits can alter the percent of salary actually paid as a disability benefit. Consider, for example, a hypothetical worker earning $1000 per month covered by a 60% of salary LTD program. Assume the group LTD premium for this worker is 1% of salary or $10 per month. Further assume that, if disabled, he would qualify for a Social Security disability benefit of $400 per month. Thus, the effective monthly premium rate per dollar of monthly benefit is $10 ÷ $200 = $.05. Now, if the worker's salary increased by $100 per month, with his potential Social Security disability benefit increasing by only $20, the benefit payable from the LTD program becomes $660 - $420 = $240 and the premium rate per dollar of monthly benefit is $11 ÷ $240 = $.046. On this basis, the effective premium has decreased by more than 8% due to an in-

crease in the potential percent of salary payout while the premium rate remained unchanged. In recent years, rapid Social Security improvements have reversed this example. Thus, the actuary must constantly reexamine his group LTD exposure and premium structure.

Finally, the actuary pricing disability insurance is faced with the fact that many years may pass before the adequacy, or inadequacy, of his pricing assumptions may be confidently established. In the short run, the valuation assumptions developed for group LTD, to the extent that they have been developed in a manner consistent with the pricing assumptions, will make the actuarial price projection a self-fulfilling prophecy. This problem is compounded in that there has been no truly appropriate industry data base for group long term disability. Over the last few decades there have been dramatic changes in benefit level and plan design. The significance of government programs has increased dramatically. The very subjectivity of the concept of total disability combined with wide variances in company definitions, underwriting procedures,and claim practices have hindered the development of a useable data base. In recent years, however, the consistent expansion of the Society's Intercompany Group Long Term Disability Insurance Study has provided us with the beginnings of a meaningful data base. As the caveats contained in this study let you know, the data may not be representative of what can be expected for any particular insurance company. The actuary's interpretation and judgment are still critical ingredients in any pricing formula.

Once an expected claim cost or price is established, the actuary must then concern himself with the potential volatility and credibility of the data that evolves. Relative to most group life and health experience, group LTD is highly volatile, even for the largest groups. The group LTD dispersion table by case size (Table 1C on page 159 in the 1974 Reports) shows that, even for the 111 experience units of over 5000 lives,there is a wide range of actual experience. The experience of most insurance company's entire group LTD portfolios falls far short of being statistically credible.

Similarly, the experience of any particular group policyholder will have little or no actual credibility. I am somewhat concerned over what I see as a trend toward consideration of self-insurance of group LTD by a number of firms. Invariably, the firms have considered the various options using expected claims as a guide. With equal consistency, the very real elements of volatility and risk are virtually ignored. The real key for a decision regarding self-insurance is a firm's ability and willingness to properly finance the occasional period of higher-than-expected claims that will eventually occur. Unfortunately, periods of high claim activity often occur during times when firms can least afford the additional cost of higher claim levels.

In summary, the pricing of group long term disability insurance is still somewhat of an art as opposed to a science. The industry's knowledge and sophistication are continually growing, however. Today, there is definitely a need for group long term disability coverage and this need must be met - carefully.

MR. CHARLES D. GROTH: In your study of the fluctuations related to economic conditions,there has always been a differentiation between blue collar and white collar workers in the long term disability areas. Could you touch on that ?

MR. McCASKEY: Everybody is already aware that experience has been significantly worse on the blue collar groups. It takes a more localized specific situation in a particular geographic area or industry to trigger a major fluctuation in the blue collar market, although it is susceptible to general economic conditions too.

MR. HALVORSON: In the 1969-70 aerospace cutback, it was not only blue collar workers who were causing fluctuations in claim experience, since white collar workers and engineers were also out of jobs. This caused the disastrous financial experience with respect to long term disability in the state of California.

You did raise the question, Ray, as to whether long term disability, as it is now sold, is really insurable. In my own mind, I really have a serious doubt that it is an insurable risk for insurance companies or the insurance industry. There is a challenge here, since experience is so dependent upon economic conditions. It would seem to be a natural area for some governmental involvement, to develop a cooperative effort between government, employers and unions, to try to come to grips with this problem. The need for disability income is real but the ability to prefund it on an insured basis seems to be a challenge beyond our ability to grasp individually. At this point, I don't see the rallying point toward getting at the solution to this problem through employers, unions, insurance companies and government, but I believe we need to find a real solution to this problem.

MR. WILLIAM E. MASTERSON: One element of cost that nobody has talked about is the trend towards large punitive damage suits against insurance companies. To what extent should we be allowing for these increasing costs in the pricing of the LTD product?

MR. McCASKEY: California seems to lead the nation in all sorts of things like this and there really have been a substantial number of problems in this area and they are going to become bigger and bigger problems. My concern is not that we are going to get sued on any particular claim right now, but that our claim adjustors may become a little more liberal and may let a few more borderline or questionable claims slide through. There is really no way we could price for a $5,000,000 or $10,000,000 suit.

MR. HALVORSON: I would like to again refer you to the excellent summary of published data prepared by Howard Bolnick for the Houston meeting.

In his discussion he detects a secular increase in incidence of long term disability, but little change in severity. He calls attention to the fact that the Society of Actuaries LTD studies (1974 Reports) show a ratio of actual recoveries and deaths to that expected under the 1964 Commissioners Disability Table of less than 100%.

Let me read to you the ratios of actual to expected for ages 40-49, 50-59, and 60 to 64, respectively, for durations 3, 4 and 5:

Disability Duration	Age 40-49	Age 50-59	Age 60-64
3	88%	76%	81%
4	80	72	56
5	53	76	103

The above are for 6-month elimination periods, and represent 1962-72 calendar year experience. Actual terminations for these 9 cells totalled almost 1500. In aggregate, these 9 cells average less than 80% ratio of actual to expected.

To quantify these a bit, let me share some relative reserve figures with you, based on some work done a year ago for a major company.

Reserves based on 5% interest and 1964 CDT will be used as the base, and let's assume that this reserve amount was $100 million, to keep it simple.

Three percent interest and 100% CDT termination rates would produce reserves of $109 million, approximately.

Five percent interest and 80% of CDT termination rates would produce reserves of $110 million, approximately.

Expressing this in a different way, and assuming a normal distribution of termination rates, if terminations average 80% of CDT expected, the $100,000,000 reserve would be adequate none of the time. A reserve of $110,000,000 would be adequate 50% of the time. To be 99% confident, the reserve would have to be close to $115,000,000.

Contrary to Mr. Bolnick's observation that termination rates don't seem to be changing, one company's experience that we studied did show marked reduction in termination rates over the years 1972 through 1974, primarily on terminated groups. We do not know if this continued into 1975.

Evidence is appearing that raises the question of the appropriateness of the 1964 CDT termination rates for durations up to at least 5 years for use in reserving for group long term disability. A statement as to "good and sufficient" should give consideration to this apparent fact.

MR. RICHARD B.SIEBEN: To the extent that you observed the deterioration in experience in the last couple of years in the economic cycle, is there any distinction in terms of the amount of the relative impact at the ages over 50 as opposed to the ages under 50 regarding the combination of frequency and duration of claim recovery rates?

MR. MCCASKEY: We see a lot of variation in our own portfolio at the two extremes, the youngest ages and the oldest ages, while the middle-age range does not fluctuate as much. Some early retirement type of disabilities occur at the oldest ages. At the very youngest ages,some of the newest employees who have been most subject to layoff and terminations are responding by becoming disabled.

MR. SIEBEN: Where you have disability retirement as a feature of a pension plan and long term disability coverage that is really covering the permanent disabled retirement, it seems that in terms of economic shifts you have a gain due to the release of a pension liability in the event of a permanent disability over age 50, and you have a loss because you have a disability claim. It seems that our whole approach to funding this type of disability risk is in the wrong place. It is really a premature retirement problem. If you recognize this, it will take much of the weight and the bulk of the dollars out of these economic fluctuations because of the balancing of a gain on one side and a loss on the other.

MR. HALVORSON: The employer should have a strong interest in getting the disabled person rehabilitated and getting him back on the job. However, the employer has very little incentive currently if the person is covered under a fully insured product and if there is no experience rating. We need the employer's involvement and his interest in the employee's rehabilitation. A combination of self-funding and experience self-rating, has a great appeal to a large employer who is genuinely concerned with this problem. If he is using the plan as a vehicle to solve his superannuation problem, then the insurance company is going to sustain excess losses. There should be some way to address this problem in a better fashion than we have been able to in the past.

MR. THEODORE W. GARRISON: I would like to propose a slightly different hypothesis on the credibility of claim results. Any rate scale is less than perfect because there are intangible variables we really cannot measure so as to set the right rate for the right case. But for a large case, 1,000 lives for instance, you begin to see some real results coming from a case after a period of two or three years. In this event I would give some limited credibility to those results.

In rough terms we expect 3 or 4 disability claims per 1,000 lives exposed per year. After a few years there exists an expectation of having, say, 6 claims from a particular case. If you have 10 claims, that might be cause for increasing the rates. On the other hand, if you expect 6 and only have 3, I do not know whether to reduce the rates or not. My own practice in this regard is to look at two things: (1) , the actual-to-expected number of lives that remained disabled; and, (2), the financial results of using the best estimate of reserves for the lives that were disabled. I then average the results of these two actual/expected comparisons and apply a variable scale of sliding credibility that does not give much credibility for a small expected number of claims. If the expected number of claims is 20 or 25, then quite a bit of credibility would be given. This past experience will certainly not hold true if some kind of gross economic disaster hits, such as occurred in the aerospace industry in 1969-70. Short of gross economic disaster, the prior experience as it emerges gives the actuary a chance to improve on his original estimate.

MR. McCASKEY: Bad experience sure appears to be a lot more credible than good experience. That is, when we have a group of 1,000 lives and expect 3 claims per year and you get no claims, I don't have a lot of faith in saying that group is significantly better than average. However, if you had 10 claims, I would worry a lot about that group and attempt to do something other than continue without change. We obviously do give credibility to our larger accounts. We have two general formulas which are not entirely compatible for trying to attempt to determine credibility of a particular case. The first is related to the claim activity on the case for the last five years at most, and follows my belief that bad experience is more credible than good. The other credibility formula we use is based on life years of exposure which is independent of actual experience. It is just a pure function of size. I'm not totally satisfied with either formula. In fact, in all our large cases we use both formulas and hope for consistency. There are no cases where we assign 100% credibility but we do have some extremely large accounts where we have 50% credibility.

MRS. CAROL C. SHALL*: When you are discussing self-insurance with some of your policyholders, do you encourage them to hold active life reserves in the sense that you would talk about a block of individual disability business, as opposed to the group unearned premium reserve, and would that serve as something of an offset to future bad experience?

MR. McCASKEY: If a company is going to fund a group long term disability program, whether it be self-insurance or group insurance, the responsible position has to be to fund for the liabilities as they develop. By this I mean, if a company were to go out of business, funds should have already been set aside to provide for those people who were disabled. To the extent that a company is serious about doing that, they are going to realize the full effects of economic fluctuation. On the other hand, the company that funds the program over the long run with annual contributions will realize that they have to contribute substantial sums of money, maybe more than they can afford, and the whole program may be in jeopardy.

MR. HALVORSON: It is possible to use pension funding techniques for long term disability to develop an entry-age-normal contribution under a 501(c)(9) trust. If any large employer is considering self-funding of long term disability, we would recommend to him the use of pension funding techniques rather than the unit credit one-year-term costs used under group insurance programs.

MRS. SHALL: How much do "own occupation" provisions contribute to what you are calling the increasing trend in disability claims?

MR. McCASKEY: The Society in their study has the definition of disability as one of the variables, and it has shown some fairly substantial differences. I do not rely on that particular variable, however, as shown in Society studies, for estimating the value of that particular clause, because there is a high correlation between the liberality of one clause in an LTD contract, and the types of other benefits and clauses you find in the same contract.

We have had to make assumptions, of course, in our pricing on a rate manual approach. When we examine any particular case, much judgment is used based on occupation to judge the effects of an "own occupation" clause.

MR. COONS: Chicago Blue Cross/Blue Shield is currently involved in half a dozen prepaid group practice situations and one Foundation for Medical Care. Our initial venture into alternate delivery systems was in 1972 with the introduction of our Co-Care Program, a prepaid group practice representative of most HMO operations. Co-Care has grown to a total of 23 group practice facilities in Chicago and surrounding suburbs, offering a complete range of inpatient and ambulatory benefits such as:

Physician's office visits for illnesses, accidents, and consultation

Referral to specialists

Pediatric care through age five

*Mrs. Carol C. Shall, not a member of the Society, is an actuarial consultant for Peat, Marwick, Mitchell and Company.

Routine physical exams every three years from ages 6 to 36, and every year thereafter

Preschool and premarital examinations

Diagnostic, X-ray, and lab tests

Prenatal and postnatal care

Outpatient surgery

Outpatient physical therapy services

Outpatient psychiatric care

Emergency medical care

Care received in skilled nursing facilities and in a patient's home following hospitalization

Traditional Blue Cross benefits are provided when hospital inpatient care is needed

Optional prescription drug benefits are available

We have two similar programs in downstate Illinois, one of the medical groups being attached to the immediate area's only hospital, the other using several nearby hospitals.

The professional services provided by Co-Care and the other programs are priced with the capitation amounts being negotiated with each medical group; Blue Cross/Blue Shield retains the risk on inpatient and out-of-area claims. We expected to review capitation amounts and the rates for the balance of the coverages annually.

Each of the three programs contains an incentive arrangement to discourage unnecessary hospital utilization. The incentive target is 650 hospital days per year per 1,000 members, with a payment under the Co-Care Program of $95 per day for each experience day under target. Amounts less than $95 per day under the same 650 day target are returned to the provider under the two downstate programs.

A fourth arrangement allows our Co-Care members to enroll at one of the Anchor Program group practice facilities, a network operating from a large Chicago hospital and various suburban locations. Capitation rates are negotiated periodically with Anchor for both hospital and physicians' services. Again, Blue Cross/Blue Shield retains the risk for out-of-area claims.

Our hospital incentive arrangement with Anchor is based on a 20% band on either side of 100% of the expected hospital benefit dollars anticipated by our capitation rates. Anchor is refunded the amount by which actual claims are less than 100% of expected, to a maximum of 20% of the expected. Blue Cross keeps any further savings below 80%. However, should the actual claims exceed 100% of expected, Anchor will reimburse us for the first 20% of excess, and we absorb the loss over 120%.

A fifth arrangement with another large Chicago hospital-based group practice involves only our covering the risk on out-of-area and catastrophic claims.

We currently have an application pending with HEW for the formation of a new, separate corporation which will provide the necessary additional benefits beyond our present Co-Care Program to be federally qualified under the HMO Act of 1973. Included are such additional services as preventive dental care and vision screening for children, private room and private duty nursing when medically necessary, unlimited hospital, skilled nursing facility, home health care benefit days, and emergency ambulance service. The target days and incentive dollar arrangement is essentially the same as for Co-Care.

Our one Medical Foundation involvement is with the Foundation for Medical Care of Central Illinois, Springfield. This program provides a comprehensive scope of benefits very similar to Co-Care, but through individual doctors rather than through medical groups. We withhold 20% of the negotiated capitation amounts until settlement for the experience year. The Foundation is on the risk for up to this dollar amount of losses on the whole program.

The 1974 experience used to calculate revised Co-Care community rates last fall revealed inpatient utilization of 610.8 days per year per 1,000 members.

The experience for one very large group, the Chicago Board of Education, with almost 6,000 members enrolled in Co-Care, showed inpatient utilization for the 10-month period April 1975 through January 1976 of 443.3 days per year per 1,000 members.

Unfortunately, we have experienced much higher utilization on our Medical Foundation program than anticipated during that program's first three years. Early enrollments included the employees of a large Springfield hospital and the members of two large rural-oriented county associations with higher-than-normal age distributions. For the experience year ending April 1975, we experienced inpatient days of 1025.8 per year per 1,000 members, and we anticipate a final figure for the year ending April 1976 of close to 1,100 days.

MR. HALVORSON: I would like to discuss the reinsurance needs of an HMO of an IPA type, that is, one that operates on a fee-for-service basis with a risk pool set aside by physicians out of their fees. This type of HMO is typified by the Foundations for Medical Care, which are generally organized by county medical societies and deliver services through private physicians throughout the community.

It has been our experience that such HMO's have limited cash reserves, since it has not been possible to raise more than a limited amount of capital through the dues or membership fees of participating physicians. Even after the HMO's formation, the risk pool funds accumulate at the rate of only 10% to 15% of the physician dollars payable from the plan. The hospitals under such HMO's are the general hospitals in the community, and are unable to participate in risk sharing because of their own financial pressures.

Thus, in the early years of these plans, reinsurance of an aggregate stop-loss or excess-loss nature is needed. The 1973 HMO Law permits an HMO to reinsure 90% of its incurred losses in excess of 115% of income. Reinsurance of this type has not been available. When it has been offered by a limited number of reinsurers, it has been on a paid, not an incurred, basis. Let me elaborate on the problem this causes.

Most HMO's operating in California are registered under the Knox-Mills enabling legislation, soon to be Knox-Keane. As such, they are required to file financial reports on an accrued basis, and to maintain a minimum net worth. If the reinsurer only pays off if cash claims actually paid during the first contract year exceed 115% of income, it is probably obvious that the HMO would be financially insolvent on an incurred basis, and still not be able to recover anything from the reinsurer.

In an illustration based on claim payment lags experienced by one HMO, and with a growing enrollment during the first year, cash claims paid could represent only 40% of the claims incurred during the same period. Running the claims off for 90 days following the close of the first year would bring cash claims up to 91% of incurred claims.

In this same illustration, 54% of the incurred claims were for physician services, as opposed to hospital claims, so that a 15% risk pool on physician services only would provide a margin of safety of 8% of incurred claims. This illustrative HMO anticipates that claims will be 85% of income, and expenses to be 12.5% of income, leaving 2.5% margin for contingency reserves. To avoid any loss, the reinsurance attachment level would have to be at 95% of premium, and as soon as incurred claims exceeded this level, 92% of all excess claims would have to be payable. By adding expected expenses of 12.5% of premium income to the 95% claims, and defining the attachment level in terms of claims plus expenses, then the attachment level for a no-loss situtation could be 107.5% of income. Thus, even with claims plus expenses counted toward the attachment level of 115% of income, the HMO needs at least 7.5% of premium in free reserves to avoid loss.

At this point in time, we can say that the HMO movement is barely off the ground, if at all, and the economics of dealing with start-up costs, inflation, medical malpractice, antiselection, enrollment costs, reinsurance, and health management statistical systems seem almost overwhelming to the new HMO. Federal funds and assistance from insurers can help overcome most of these obstacles, but they cannot solve the reinsurance problem of HMO. Fortunately, some companies are now showing more interest in finding a solution to this reinsurance problem, and we hope the market need for aggregate stop-loss reinsurance can be served.

It also makes sense for the aggregate stop-loss reinsurer to offer individual catastrophe insurance for all of the HMO enrollees. Depending upon enrollment expectations, the deductible level might range from $5,000 to $25,000 per individual, with amounts in excess covered by the catastrophe cover, and excluded from the aggregate stop-loss.