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REGULATORY CLIMATE IN GROUP INSURANCE

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MR. JACK W. ROBERTS: I will be dealing with trends in the regulatory climate in Canada, but in discussing trends and projecting them it is important to establish a starting point; thus, if governmental incursions into the group insurance business as of several years ago such as entry into the pension business, the taking over of hospital and medical insurance and the inroads made by unemployment insurance benefits into the income replacement business were to be considered as trend setters, we might well conclude that it would not be long before we were all out of business. But it seems to me that the federal government, after a period of very enthusiastic socialistic activity has begun to let this activity cool off a bit.

This probably occurred because of a smouldering antagonism of the general public against growing governmental spending - such as is occurring in the United States today - and may be part of the present government's attempt to regain favour with the voters. However, even though the federal government may be lying low as far as our own business is concerned we should not be unaware of the fact that there is a great deal of apprehension amongst marine underwriters that the government may extend the operation of its Fishermen's Indeminity Fund to other classes of business than those for which it was originally designed; thus, if socialistic tendencies are continuing in other areas of insurance coverage it would be foolish to assume that dangers of further encroachment upon our business have disappeared.

The Insurance Corporation of British Columbia (ICBC) was formed a few years ago and took over the auto business in that province and competed with carriers in other property and casualty lines. They were embarking on a course of action which would lead them into the Group Life Insurance Business. I know of no current action in this connection, but it was indeed discouraging to be made aware of the fact that some carriers in Canada were prepared to co-operate with I.C.B.C. by offering to write individual conversion policies upon termination of coverage under an I.C.B.C. group plan.

It's quite possible that the public exposure of the disastrous financial results of I.C.B.C.'s auto insurance operation will discourage expansion into the group insurance operation - but the machinery is there.

You might be interested in hearing about a recently published report of the Sickness and Accident Insurance Committee of the Province of Saskatchewan. This report is dated September 1976. It recommends a provincially run program which will protect income from losses caused by accident and sickness. It mentions cash sickness plans now in place in Rhode Island, California, New Jersey and New York. I would like to quote from the report:

> "For the time being income replacement is to be the objective. However, included in our vision of a final and integrated system is the........ entitlement to full benefits under a plan which will include lump sums for disability and extended death benefits."

Later the report says:

> "We recommend a death benefit for the new program. However, the death benefit award under the new plan does not, at this time, require the recognition of non-economic losses.........
> We recommend, as a beginning, a payment for two years of 66 2/3% of the net earned income of the deceased. Coverage would extend to those under age 65 and the benefit would be payable to the surviving spouse or dependants of the deceased."

The committee had five members and I was pleased to see that there were two minority opinions - that is until I read them.

One member stated:

> "The proposition that compensation be payable at only a percentage of an employee's net income I cannot accept."

And later he says that:

> "The survivor's benefit should be a continuation of the full net income of the deceased, not only a percentage of the deceased's net, and it should be payable for life or until remarriage."

And finally he says:

> "The waiting period suggested is excessive. I don't see the need for a one-day waiting period for accident, and the seven-day suggested period for illness is certainly too long, even with the retroactive feature. Properly administered, a plan should need no waiting period."

The second minority opinion advocated an elimination period of 6 months - but then suggested that an optional attractive policy should be offered through the Saskatchewan Government Insurance Office or under the new plan to cover the first 6 months.

In dealing with the role of private insurers under the heading of existing coverage, the report is somewhat critical of our business because of the lack of uniformity of coverage and administration, and concluded that finally, with private insurance there must be a direct ratio between the amount of premium and the amount of protection! This is quite a profound conclusion, but I was unable to find in the report how a government-run plan was going to get around this difficulty. The report also noted that incurred claims ratios in Saskatchewan were significantly lower than those in the rest of Canada and concluded that residents of that province are subsidizing policyholders in the rest of Canada - shades of Vermont Bulletin No. 27.

This Saskatchewan matter is not yet legislation or regulation, and maybe I have stretched the discussion outline a bit by talking about it here - but I think it may be a part of a trend. What do we do about governmental encroachment on our business? The answer is not simple - we do a better job - we make governmental intervention unnecessary or undesirable - we should improve our images. One thing we do not do is offer coverages which can be criticized as being useless. One such policy examined by the committee had severe limitations and exclusions and created a very bad impression - an impression that might well extend to all of us and one which may be difficult to erase.

When the anti-inflation program was announced by the Federal Government just over a year ago, I had a great deal of hope that regulations and interpretations of the guidelines would be as sensible as they were under a similar program introduced in the States a few years ago, but unfortunately this did not occur. We hoped that there would be special guidelines for fringe benefits because of their anti-inflationary nature, but this has been resisted by the Anti-Inflation Board (A.I.B.). We hoped that adverse mortality and increased expenses would be permitted to be used to justify increases in manual rates or decreases in dividends, but so far the board has adopted the position that only changes in these factors occurring since last October would be permitted to be passed through. My company was recently turned down on a request for an increase in the charges made to group policyholders on conversions to individual policies. The Board took the position that we were unable to show that the deterioration in mortality under converted policies took place during the last year. Therefore, for the present we, must use our old 65 dollars per thousand charge. The Board's treatment of life insurance companies has not been all bad though. We have escaped the necessity of quarterly reporting but, generally speaking, we do have to prenotify any rate changes except for those plans which are strongly influenced by current new money interest yields; rate increases emerging on group business as a result of the renewal underwriting process do not have to be prenotified, provided the carrier has applied for a blanket exemption for certain groups. My company asked for such an exemption a month ago but has not heard anything yet so I am unable to comment on the stance which the Board will be adopting in these matters. The insurance industry in Canada has taken the position that fighting inflation is a very important matter affecting our survival as a business, and has agreed to support the program. My only real complaint is that we do not have separate guidelines for fringe benefits.

In addition to monitoring prices and profits, the Anti-Inflation program has affected the group business in another way. My company was informed that the bonuses earned by our Group Field Representatives was deemed to be indirect incentive pay and thus subject to all the restrictions placed on salaried people. We were able to convince the Board that our sales people were indeed paid on an incentive basis and we were able to get them to reverse the earlier ruling. However, they still think our Group Sales Managers are not paid on an incentive basis.

At the meeting of the Association of Superintendents of Insurance of the Provinces of Canada held in Halifax on September 28th there were some matters discussed which were of some interest to group carriers in Canada. Certain changes in the group rules were recommended, most of which you will be familiar with. The conversion rule has been massaged again and a guideline dealing with credit insurance minimum loss ratios in effect in Ontario was adopted. Manitoba has already followed suit on the credit guideline and it is hoped that if other provinces go along, they adopt the same guideline. The Superintendents have now adopted Group Accident and Sickness rules and have suggested model legislation dealing with continuation of certain coverages on termination of contract which is acceptable to the Canadian Association of Accident and Sickness Insurers. We are hoping that if the provinces move in this direction, they all adopt the same language. Incidentally, we really should be thankful that by and large, in Canada, a great deal of uniformity in regulation exists in the various provinces. It's sure much different from the situation in the United States which no doubt will

be pointed out by my colleagues on this panel. It is too bad that laws which affect our business, such as recent human rights legislation cannot be put into place sensibly as the Superintendents of Insurance have been able to do the job. It is surely not in the public interest to have the price of insurance and the service that can be rendered, so seriously affected by administrative difficulties arising from lack of uniformity among the provinces.

Generally speaking the provincial governments in recent times have been doing a good job - the initiatives that have been taken have been taken in the public interest and have not proven to be too onerous. It is too bad that Ontario's incredibly poorly conceived increase in premium taxes which completely ignored the retaliatory tax implications for Ontario companies doing business in the States had to spoil a pretty good record.

MR. JEFFREY L. GATHERS: Time was, not that many years ago, when the regulation by state government of the conduct of group insurance was not a hot topic. New York had its rate laws for Group Life and its filing requirements for A and H, and many of the states imposed various forms of the maximum Group life amount statute. But the subject was static enough, it could even be described in books and study notes without fear that the content would be out of date before reaching the hands of its first readers. Laissez-faire was the operative policy, particularly in the field of health insurance. When a subject did arise that seemed to warrant legislative treatment, principal recourse could be had to the National Association of Insurance Commissioners (NAIC) which, acting with enlightened regard for the interests of both the states and the insurers, would ultimately set forth a model bill with good prospects for unmodified acceptance by the majority of states.

Since 1970, however, a significant change has occurred. The word trend hardly carries the correct connotation--tidal wave is much more descriptive of the flow of new legislation affecting group insurance in the past five years. Why has all this come about? A simplified rationale points to the growth to maturity of "consumerism" as a political force. And it is easy to attribute the current bumper crop of legislation and its associated compliance problems in the group insurance area to this single development. But is the question of product value for money actually the central issue? Or the fact that it is the much maligned insurance companies that are building the products in question. Partially yes to both, but I would venture that there is not, in fact, a single central issue. Rather, it seems to be that the group health insurance industry has become a point of confluence for all the great issues of the day, including but not necessarily limited to: the health care question, fair employment practices in general and sex descrimination in particular, inflation, and unemployment. The complexity of the subject and the sensitivities of the business community are no longer sufficient to preserve "political immunity" for the group insurance business. The legislatures--the insurance departments--even the courts, have had little political choice but to get involved.

Consider the most recent activities of the state legislatures in group health regulation. The political message from many quarters in the nationwide health care debate is that commercial health insurance is a good thing for those who have it; but then again, to a lesser extent, so is Medicaid. The truest victims of the health care crisis may be those who are unable to obtain either when they need protection the most. In 1974 and early 1975,

the principal manifestation of concern for those in such a dilemma was the requirement to extend coverage to laid-off employees--this, of course, in response to the prevalent recession. Now, though the recession is said to be behind us, legislation is moving even more steadily toward the farther-reaching vehicle of mandatory conversion rights, for even the broadest of Medical plans. At the same time, one of the most insidious "cracks" through which any insured may fall--that occurring at the replacement of one group policy with another, is being affirmatively sealed with "no-loss" transfer legislation.

Other weak spots in the coverage scope of group health insurance relate not to the key economic issues but to the social ones. For example, for years the buyers and sellers of group plans have collaborated to exclude or cover only on tightly limited bases those medical conditions classified as mental or nervous and those due to alcoholism or drug abuse. Many states have already acted to curb or eliminate this type of practice; many more will. Another disabling condition that has rarely been treated like all the rest is pregnancy. The peculiar characteristics of the condition notwithstanding (it is, after all, neither sickness nor accident), the fact that it is characteristic of one sex and not the other seems destined to invalidate most policies that would regard it as unique.

My comments so far, though they have referred to the need for significant modifications in plan design, would hardly suggest a crisis situation--more a case of friendly persuasion by the authorities to help the carriers to do a better job than they were doing before. Whether through our own misguided policies, those of our customers or, as is more frequently the case, a complex interaction of the two in the competitive marketplace, we as carriers have not universally been providing the best coverage to all the people who need it the most. Is it necessarily wrong to be forced to buy something you need but do not want? Is it wrong to be prevented from selling things people want but should not have? The answers to these questions are complex and tend to expose one's deepest political sensitivities. However, as citizens as well as group actuaries, we must acknowledge the helpfulness of well-placed legislation in our efforts to deliver as humanitarian a bill of services as possible. Were it as simple as that, however, the subject of group regulation would still scarcely merit a forum as auspicious as this one.

Where actuaries and other group insurance professionals start shaking our heads is in dealing with the undesirable side effects of the medicine society has decreed we take. A typical group writer, like the one by whom I am employed, may well be licensed in more than 50 jurisdictions. In recent years, news of passed legislation and/or regulation has entered the company at the rate of roughly 200 pieces annually. Even though that translates to only four per year per jurisdiction, it is also close to one per business day. Of course, we are far from lucky enough to have them distributed so evenly. Due to the complexity of a number of the bills, many hours of valuable management time are consumed in planning and executing the necessary steps for compliance, but even this is only after our staff of three full time compliance personnel has reviewed and analyzed each bill or regulation. These facts of course, suggest the single biggest aggravation of the state regulatory scene--an escalating cost that weighs particularly heavily on the smaller group carriers. These additional overhead expenses, which must ultimately be borne by the consumers of the products, decrease the percentage of each premium dollar that can be returned to them in claims and dividends,

a trend which, by itself, is exactly counter to the "consumerism" that supposedly started it all. And it's not just the carriers' direct expense in manpower and paperwork. The costs generated for the administration of expanded insurance regulatory operations, ultimately come from the same pockets. All of this for the privilege of being protected from abuse by a slightly more diligent authority than one's neighbor across the river in the next state. In their fierce protection of their own constituencies and the pursuit of their mission to regulate the transaction of the insurance business, the state authorities have unfortunately been unable, even if willing, to take proper account of the following aspects of the overall problem.

First of all, group insurance has always been a showpiece of the insurance industry for its ability to extend broad coverage to large numbers of people (many of whom may not have been insurable otherwise) and to do so at very low cost. The ability of the carriers to maintain these low costs depends very much on their continued ability to standardize--to "package"--their products, particularly for small groups. Continuation of the current regulatory trends will break down these standardization economies as carriers reach the point of having separate contracts for issue in each of their jurisdictions and the concomitant separate rates and administrative practices.

Secondly, for reasons that may be characterized as "evasion in good faith" many group carriers have in recent years made use of multiple employer trusts to accomplish a number of important objectives, many of which were associated with the avoidance of certain state regulations such as rate minimums or amount maximums. By issuing master certificates to employers nationwide under a single policy, compliance problems are reduced to those associated with the situs of the master trust policy, or so it has been held traditionally. Legislators, in their new fervor to improve health insurance standards, understandably resent the existence of this barrier between themselves and their constituencies. As a result, language is more and more frequently being written into laws which would attempt to regulate the carriers with respect to the employees who are either employed or reside in the state, without regard whatsoever for any other jurisdiction which may actually be the situs of the policy. The same situation occurs, of course, in many instances that do not involve Multiple Employer Trusts. This tendency towards the claiming of extraterritorial sanctions, while as well intended as the laws themselves, can place both insurers and their multistate policyholders in a nearly impossible administrative situation even if neither ever had the slightest intention of avoiding compliance with the regulations of _any_ state.

Finally, administrative requirements, such as the filing of forms and rates for new standard benefits require ample staffing in the insurance departments, but the passage of laws does not. Many times the departments are unable even to issue the necessary interpretive regulations for a piece of legislation before the statutory effective date for compliance. Furthermore, responsibility for making actuarial evaluations of filed rates may be passed to the departments by law, lacking regard not only for the staffing of the department but also for whether the department's information on carriers' rate structures is adequate to determine what the total cost for a new statutory provision even is, let alone whether it might be appropriate for the benefits provided.

It is difficulties of this type that make us think we have a crisis on our hands, particularly if the future calls, as we generally suspect, for more of the same. Are there remedies? I'm sure there are. But we are probably kidding ourselves if we think they will not involve a substantial amount of hard work and compromise by ourselves individually and by our industry collectively.

MR. VINCENT W. DONNELLY: Since the passage of Public Law 15, more popularly called the "McCarran Act," on March 9, 1945, the primary responsibility for regulating the insurance business has rested with the states. Jeff Gathers has helped us understand the changing nature of that state regulation -- from the "light touch" of the early 60's to the "heavy hand" of the 70's. I read recently a statement by a well known figure in our industry that during 1976 there will be some 2500 pieces of legislation introduced affecting the health insurance business -- just the health insurance business! Many of these bills will mandate coverage for specific segments of the population, cause basic changes in what services must be provided through insurance policies, and will tell us what illnesses and injuries we must cover. Add to this the growing fragmentation of such legislation at the state level, despite the efforts of the National Association of Insurance Commissioners, and I think you can easily see why I talked about the potential change in the role of the Federal government. I'd like to explore with you the details of this possibility-- one which you will see is very closely tied to the future of group insurance.

While I do not profess to be a "futurist" it would be my prediction that any changes in the blend of state and Federal regulation of the life and health insurance business will emerge as a direct consequence of developments in the following three areas: first, the trend of state regulation to "frustrate" the economies of group insurance; second, the increasing interest in Federal regulation within the property and casualty business; and finally, the scope of the interpretation of the pre-emption provisions of ERISA. Let's check the current status of each of these areas of interest.

First, the changing nature of a state's regulation of group insurance. Jeff Gathers told us of the trend of state legislation and regulation to become more "consumer oriented" in its intent -- states are no longer restricting themselves to insurance company solvency matters but are now regulating the products themselves (minimum benefits, conversions, etc.). But there is an even more subtle trend emerging in state regulation, and it derives from this first more apparent trend. I am referring to the extra-territorial application of a state's laws. This is a new phenomenon to those of us in the group insurance business sincewe have always operated, with few exceptions, under a system which applied only one state's laws to any one group policy. But the states have been finding, as they expand their regulation to include the contents of our policies, that a majority of their residents are not getting the benefits of such regulation because a majority of their residents are insured under group insurance policies legally issued in another state. When this effect is recognized, the logical reaction of the state's legislators and regulators, as has happened recently in Minnesota and South Carolina, is to make their laws apply to all residents of their state regardless of the state of issue of the group policy providing the benefits. The more the states attempt to regulate the contents of group insurance policies the greater will be the variations in regulation from state to state and the more we will see this trend towards extra-territori-

ality. To the extent this trend "frustrates" the marketing and economies of group insurance, the greater the potential for Federal intervention.

I mentioned the growing interest in Federal regulation within the property and casualty business. Many of you may wonder why that trend has any importance to us. The general public and our Federal and state legislators do not see the differences between the life and health insurance industry and the property and casualty industry that we who are employed in one or the other see so distinctly. As problems emerge in the property and casualty business and as legislative solutions are sought, the eventual legislation seems to be very broad and sweep the life and health insurance business in. Malpractice is a current example -- the states have gone the route of establishing Joint Underwriting Associations and when they get around to drawing up the participation requirements, life and health insurers many times are being included -- witness New Mexico and Colorado.

There are two characteristics of the property and casualty business which will perhaps lead to eventual Federal legislation which will most likely also apply to life and health insurers. Rate-making in the property and casualty business has historically been done by "cartel" and the protection of that right was the primary purpose for the passage of the "McCarran Act" in 1945. As a result of the economic recession during 1974 and 1975, President Ford expressed an interest in "deregulation" on the premise that there existed a great deal of overregulation which was hitting the consumer's pocketbook. Out of this interest there grew a study by the U. S. Department of Justice into the antitrust exemptions given to certain industries, including the insurance industry. In 1975, the Justice Department released its study of the regulation of the insurance industry by the states and concluded that such regulation had prevented the consumer of property and casualty products from receiving the full benefits of competition. Emphasis was placed on the use of "cartels" and the existence of state laws which prohibited the "mass-merchandizing" of automobile insurance. The Justice Department's report proposed, as the only solution to these anti-consumer practices, modifications of the McCarran Act. But, consistent with the lack of distinction between various forms of insurance which plagues all insurance regulation, the proposed modifications in the McCarran Act were to be made generally applicable, thereby sweeping in life and health insurance. So, even though the life and health insurance business has no apparent anti-trust problems, and even though the proposed modifications in the McCarran Act, restricted as they are to the elimination of state regulation of premium rates and state prohibitions of "Mass-marketing," are of little concern to the life and health insurance business, nevertheless we have an important interest in what happens to these proposed amendments if only to make sure that state regulation of our business is preserved (if that is indeed our wish).

Recently another problem of the property and casualty business has led to some proposed legislation which should have an even more important effect on the future of our business. Senator Brooke, back in June, expressed concern with the financial condition of many property and casualty insurers and the effect that the failure of any major insurer would have on the guaranty funds established by the state. He felt that it was necessary to establish a Federal guaranty fund -- and he further stated that if a Federal guaranty fund were to be established, it was only proper that the administrator of such a fund should have the authority to regulate participating companies to prevent insolvencies. However, to subject insurance companies to double

regulation to prevent insolvencies would, in his opinion, be a mistake. Therefore, he proposed a system of "dual regulation" -- that is, insurance companies would have the choice of obtaining either a Federal charter (thereby being subject to Federal regulation) or retaining their state charters (and thereby remaining subject to state regulation). I want to re-emphasize that Senator Brooke's only concern in making this proposal was with the financial condition of property and casualty companies. However, the proposal, general as it was, had some appeal to certain life and health insurers who subsequently suggested to Senator Brooke's staff that they ought to make the "dual regulation" concept more generally applicable. On September 30, Senator Brooke introduced his Bill and consistent with the trend I identified earlier, it did not differentiate between the various types of insurers. I will not go into the details of Senator Brooke's Bill, except to say that instead of simplifying the regulatory picture (which it proposed to do), it seems to further confuse the picture by subjecting life and health insurers to new Federal regulation while retaining the maze of existing state regulation.

Finally, I want to mention one last area which has the potential for changing the regulation of the life and health insurance business -- Section 514 of ERISA. Commonly referred to as the "pre-emption provision," the Department of Labor has routinely interpreted this provision, when asked for an opinion, as pre-empting all state laws affecting employee benefit plans. Although ERISA is referred to as the Pension Reform Act, this is one section of ERISA that has greater impact on the life and health insurance business than on the pension business. I've given you the interpretation of this provision by the Department of Labor. Equally non-surprising is the position being taken by the National Association of Insurance Commissioners (NAIC) -- the protection of a state's right to pass "insurance laws" which mandate coverage for specific segments of the population (so-called Comprehensive Health Care Acts as introduced in Rhode Island, Minnesota and Connecticut) and which establish minimum benefit standards for individual and group health insurance policies. The insurance industry, and primarily those of us associated with group insurance, probably find ourselves somewhere in-between these two extremes. While it is probably safe to say we still support state regulation of our business, there are certain types of state laws which we consider to not be in the public's interests and which we might like to see pre-empted. Jeff Gathers mentioned a few and earlier in my remarks I alluded to a trend towards extra-territorial application of a state's laws which could make all the laws of a particular state highly oppressive. It is quite possible that in the not-too-distant future, we will see either some litigation of the pre-emption provision or the introduction of clarifying legislation. Regardless of the source of such litigation or regulation, our industry must be prepared to have a say in the eventual outcome and a joint task force of the American Council of Life Insurance and the Health Insurance Association of America has begun to identify the possible interpretations of the pre-emption provision and to select those interpretations which the insurance industry should support. Not to be forgotten is the regulation (or lack thereof) of uninsured plans -- any continuation of the significant differences in the regulation, state or Federal, of insured and uninsured plans must be viewed with alarm.

I would say the potential for greater Federal regulation of the life and health insurance business is growing. And probably, with or without our consent, group insurance will be the eventual field of battle. We have

grown very expertise in the design and sale of our product -- so much so that perhaps it is outgrowing the wall of state regulation which has been placed around it.

MR. RICHARD E. JOHNSON: In some states a number of rate increases for Blue Cross/Blue Shield have been denied due to the issue of cost containment. There is a building pressure to extend this cost containment issue into group health insurance. Does the panel have any comments on this?

MR. GATHERS: I would assume, in speaking of cost containment, you are referring to the inclusion of incentives to reduce costs in the policy provisions. Cost containment is in fact being made more difficult in terms of insurance benefit costs due to the diversification of regulation and the minimum benefits which are being specified as required.

MR. DONNELLY: Generally, I feel that if the States is thinking of cost containment, an approach similar to that of Maryland and Connecticut would be more appropriate than approaching the insurance industry.

MR. WILLIAM CUNNINGHAM: Insurance companies are being criticized for only increasing rates and not doing enough to contain costs by working with the hospitals, medical profession and other areas. For example, Blue Cross in some areas is getting a second opinion before surgery is performed.

I have a question for Mr. Roberts. Is there any similarity in the trends between Canada and the United States? Is one country ahead of the other?

MR. ROBERTS: I see a possibility of a trend in the United States. The States got into the pension business before Canada with the Social Security in 1935. Then Canada went into the pension business, the hospital business, the medical business, and finally, the weekly income business through unemployment insurance. The United States got into the pension business and are in the medical business with Medicare and Medicaid. All of these are indicative of trends and, of course, everybody's talking about national health insurance these days. The trend hasn't even stopped in Canada where most of the provincial plans are now providing under the medical part dental coverage for young children.

MR. DONNELLY: I think perhaps we have to sell our story a little bit better from the standpoint of the nature of regulation. Now the States are trying to regulate the contents of our policies. I think regulators are extremely concerned about what is happening within the industry. However, the greater the number of regulations that are passed, the more obvious the discrepancy from one state to another becomes. We do have under consideration the possibility of modernization and we are thinking about going to the NAIC with a new group life definition. Obviously, that ties in with group health insurance in that many states have state laws that say definitions of group coverage apply to health as well as life benefits. We are trying to even out the peaks and valleys in the various states insofar as the way they regulate our business. We think this is the method by which we can hold down this application of state laws on an extra-territorial basis. I want this group to be aware of the fact that we can do much as actuaries. Obviously, we have a lot of input. You know what type of groups are logical for group insurance, and which groups are not.

MR. DAVID S. WILLIAMS: Both in U.S. and Canada we are faced with a veritable explosion of legislation which is under the name, in one form or another, of consumerism. Other industries which have handled problems of legislation seem to have a much more effective lobbying organization than the life insurance industry. In fact, perhaps one of the problems we have is that there are too many life insurance companies and there has been too little lobbying going on. I am wondering if any of our panel is familiar with any initiatives taken to get closer to legislators.

MR. DONNELLY: The American Council of Life Insurance feel they are doing a good job. It is difficult to get an adequate solution - one that is satisfactory to both life insurance companies and the regulators. This is very difficult but I think we are making progress.

MR. WILLIAM S. THOMAS: I would say that the pressure is not only legislative pressure; it is a pressure of the companies. It is a pressure of the industry to get together and understand each other better. For example, the elimination of group life minimum premium was not a move by consumerism; it was a move by the industry. Companies wanted the rules removed so they could compete more vigorously for transferred business. I think the most serious problem we have before we get a national health insurance is that there is a concept that you can revise the delivery care system in the United States by legislating minimum benefits in the group insurance policies.

I think the biggest threat to the business is the ERISA concept with the 501(c)(9) trust whereby a nationwide employer can have a plan and we can administer it for him without paying attention to the regulations that the States have adopted. Now, with respect to national health insurance, I think that we believe that pumping the money into a medical care delivery system as was done in Canada is not going to solve the problems of health care in the United States. You have to revise the system. You have to have more planning, a more systematic process of eliminating extra beds and some provision for reimbursement to hospitals if they eliminate the beds.

MR. ROBERT J. DYMOWSKI: Most of the consulting work that I have been doing the last several years has been with several large Blue Cross and Blue Shield plans. I think the removal of the hospital discount is something Blue Cross/ Blue Shield are recognizing as handwriting on the wall. However, in one particular area where legislation was introduced this year, the State Insurance Department and the Health Department came to the Blue Cross plan for their support regarding this legislation for essentially an equal pricing of hospitals. They wanted to have an arrangement whereby all third party payees would be paying the same hospital rates. Initially, the Blue Cross plan's reaction was negative, of course, because they didn't want to lose the competitive advantage that they enjoyed by means of the discount. Later they decided to support this type of legislation, provided that they got equal consideration in terms of the type of regulations that they enjoyed relative to the companies. In this case, it doesn't mean that Blue Cross will be regulated any less. It means that the industry is going to be regulated more. There is a complete unawareness in many insurance departments as to the meaning of some of the things that go on in the industry. For example, many companies operating in a state provide conversion benefits but there is no law on the books requiring it and they immediately began to think in terms of putting a law on the books. I think that consumerism represents

the misconceptions in many of these departments. We certainly have a very important responsibility as actuaries to educate these people.

MR. CUNNINGHAM: Recently, the Health Service Agency (HSA) designations throughout the United States were announced. How many people in this room are active in that area, are you on the boards or supporting the health insurance association? This is an area which is going to have a great deal of power over the health insurance dollar and medical care dollar in the future.

MR. ROBERTS: The plea for representation on these HSA boards was for companies to have representatives in their state of residence. Since we are a Canadian company, we do not have a state of residence. However, this week I forwarded three names to the Health Insurance Association of America (HIAA) of Crown Life employees working in the States of Colorado, Washington, and Florida, who are willing to appear and act on committees of HSA's. The more insurance-minded and insurance knowledgeable people we've got on these HSA's committees, then the better off we are.

MR. CUNNINGHAM: I am serving on the California Health Facilities Commission Committee. There they have disclosure information on hospitals. Within the next few months there will be quite a large volume of data on hospitals that will soon become available. It is going to be a very voluminous public information report. These are the kinds of things that are starting to be done in answer to some of your questions. We must become more involved in this.

MR. DAVID J. BAHN: I would like to comment on multiple employer trusts. On one hand, these have been used to sell life amounts far in excess of, and sometimes in flagrant violation of, state maxima. On the other hand, they have extended the more liberal group health benefits and the more liberal group health claims administrations, etc., to employers with just two to nine lives on benefits which would not have been available to their employees under individual products offered by many of the companies. The group health has obviously been in the consumer interest, especially when you look at our loss ratios on them.

MR. ALASTAIR G. LONGLEY - COOK: The question of the inequities in legislation between the insured and non-insured plans has been brought up a couple of times. I find it very disturbing that we are seeing many requests for self-insured plans on very small groups, 100-200 lives perhaps, with us carrying the insurance after a large deductible. Do you see any movement toward evening out the legislation on insured versus non-insured because these small groups are being sold a bill of goods? They see some advantages in not having to pay the premium tax or set up the reserves. Do you see any movement of the States to even out the premium tax question and to ensure that these small groups will set up adequate reserves?

MR. DONNELLY: When the National Association of Insurance Commissioners (NAIC) met with the Department of Labor early in September, there was general agreement on only one area. That is, the Labor Department which has basically said all state laws are pre-empted and agree with the NAIC that they should have the right to regulate uninsured multiple employer trusts. They disagree totally with regard to the rest of the uninsured business and also with regard to employee benefit plans and the ability of insurance departments to regulate such plans.

MR. CUNNINGHAM: I haven't heard any comments about whether we should have federal, state, or dual regulation. Does anyone have views on this subject?

MR. DONNELLY: I was rather negative about the Brooke bill. It is interesting to look at the way a federally chartered company would be handled from the standpoint of premium taxes. I believe that was the primary concern of the health and life insurers from the standpoint of it being brought under the dual regulation concept. The reason why I am concerned about the Brooke bill is that it implies dual regulation although Senator Brooke says it is not. Senator Brooke proposed the bill from the standpoint of the casualty business. It is dual regulation from the standpoint that the bill permits states to regulate the contents of our business and the contents of our policies.

MR. GATHERS: The lack of distinction by the regulators between property and casualty companies and the life and health companies is shared by the population at large. One of these areas that is becoming an increasingly difficult problem for us seems to be in the area of co-ordination of benefits with those payable under life and health policies as opposed to those payable under automobile insurance policies. The extra-territorial implications of these problems are particularly knotty because of the lack of uniformity between the auto insurance laws as they are passed. Do you see any near term potential for help either through the industry, either the property and casualty, or life and health, or through any federal regulation?

MR. DONNELLY: I would emphasize that this lack of distinction between property and casualty and life and health is rampant. Everybody seems to be concerned about what is happening in the property and casualty field and we get swept in. We are trying to differentiate when we go to various states but it is an extremely difficult thing. The Department of Justice recognizes that we don't have the anti-trust problem but that we are in the mass merchandising business.