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REGULATORY CONSIDERATIONS IN GROUP INSURANCE

Moderator: RICHARD J. MELLMAN. Panelists: ROBERT H. DOBSON, VINCENT W. DONNELLY, TED L. DUNN, RAYMOND F. MC CASKEY

1. What is the impact of National Health Insurance and Federal Hospital Cost Control?

2. What is the impact of non-discrimination legislation and regulation?

3. What is the impact of recent OASDI financing changes and changes in mandatory retirement age?

4. What is the future of multi-employer trusts and self-insurance?

MR. TED L. DUNN: The health business is the third largest business in the United States behind only agriculture and construction. Health expenditures are expected to be $181 billion in 1978 and are presently rising at about 14% per year. In 1968, health expenditures were 6.5% of Gross National Product, while in 1978 health costs will amount to 8.9% of Gross National Product. Today, the average American works one month a year to pay for health care services. Hospital costs are rising at a rate at least twice the increase in the Consumer Price Index.

On April 3, 1978, Secretary Califano sent to the Cabinet and the White House a Lead Agency Memorandum describing four alternative approaches to National Health Insurance. These alternatives are called:

1. Consumer Choice Health Plan

2. Target Plan

3. Public Corporation

4. Publicly Guaranteed Plan

Three of these alternatives would have put the group health insurance industry out of business, and the other would simply delay its demise.

It is understood that President Carter plans to release a Statement of Principles for a National Health Insurance plan by the first week of June 1978 and will submit a bill to Congress in September 1978. There will probably be some congressional hearings in the fall. Most observers feel that the earliest a NHI plan could get through Congress would be in 1980. Some observers feel a more realistic schedule for passage of a NHI plan would be in 1981, if Carter is re-elected.

The likely format of President Carter's NHI proposal will be that of the so-called Publicly Guaranteed Plan, the fourth alternative in

Secretary Califano's Lead Agency Memorandum. This concept would provide a mandatory public sector National Health Insurance plan. All persons would be automatically covered by the plan unless they opt out of the public program by purchasing qualified private insurance.

Employers who opt for a qualified private insurance plan would be required to provide the plan for all of their employees. Individual employees could not choose to opt out on their own. However, self-employed individuals and persons not connected to any employee group would have the right to opt out to a qualified private insurance plan.

A basic plan of benefits would be provided by either the federal plan or a qualified private plan. The second layer of benefits would consist of a federal reinsurance program which would cover all medical expenses over a specified amount, such as $15,000 per year, incurred by an individual in either the basic federal plan or a qualified private plan.

The federal government would establish the parameters of the basic benefit package, the extent of any deductibles and coinsurance in the basic benefit package, and would set standards for participating insurance carriers.

In addition to the four approaches given in Secretary Califano's Lead Agency Memorandum, it also discusses a fifth variation which is said to be a plan agreed to by Senator Kennedy and organized labor. This approach is something of a hybrid between the other approaches but is quite a change from the old Kennedy-Corman proposal which called for complete government take-over. Its provides for a closely controlled and regulated role for private insurance companies and eliminates entirely the direct federal operation of health insurance programs such as Medicare, Medicaid and Champus.

This variation calls for two consortia in each state (one Blue Cross/Blue Shield and the other all private insurers) which would enroll the entire population. The premiums for the poor, the aged, and the disabled would be paid by the federal government. Employed persons would have premiums paid entirely by their employers. Other persons would be required to buy coverage individually from one of the consortia. All persons would be charged the same premium.

The consortia would administer the program and negotiate reimbursement rates with providers under rules established by the national and state NHI boards.

The Kennedy-Labor approach does make maximum use of the private sector with government funds being used to meet needs which cannot otherwise be met, but it does not permit competition in a free market place, and would greatly alter our ways of doing business. Obviously, under such a scheme we would need few actuaries and underwriters and no sales people for health insurance.

The Carter Bill (H.R. 6575), sometimes referred to as the 9% Cap Bill, is dead.

Congressman Rostenkowski, Chairman of the House Ways & Means Subcommittee for health, has introduced a substitute bill which eliminates certain

features of the President's Bill and puts others on a stand-by basis. This stand-by legislation accepts the health industry's voluntary cost cutting program in lieu of the revenue cutting in the Carter Bill. The American Medical Association, American Hospital Association and Federation of American Hospitals have pledged to cut hospital cost inflation by 2% this year and 2% again next year. The proposed stand-by legislation would automatically go into effect should the voluntary effort fail. A voluntary effort committee has been created in each of the 50 states.

Those opposed to Rostenkowski's substitute Bill include organized Labor, the American Medical Association, the American Hospital Association, the United States Chamber of Commerce and the Washington Business Group on Health. The Health Insurance Association of America supports this bill as do many individual insurance carriers.

MR. VINCENT W. DONNELLY: Welfare -- Social Security -- and Mandatory Retirement.

What do they have in common?

They are all "public" issues.

They are all being "reformed."

They are all controversial.

They all impact -- admittedly to varying degrees -- on the life and health insurance business.

When I think of Welfare reform, I think of an amusing -- and yet not so amusing -- article that appeared in a recent issue of the Washington Post. The author was playing a little game with numbers. He projected the prices of various manufactured goods for the year 2047 using current prices as the base and a 7% annual rate of inflation. His figures showed a loaf of bread costing $134; a subcompact car costing $400,000; a luxury sedan at $2,500,000 (for $7,000 more you could even get white walls). But then he put everything back into perspective by reminding us that everyone would be eligible for food stamps if their gross income was under $700,000!

And this is the system that Jimmy Carter has decided to reform?

They are moving the furniture around on Washington's legislative stage. The props for one debate -- the great energy deliberation -- are being taken away, and the cast for the next reform spectacle -- welfare -- is already rehearsing its lines in the wings. Step aside Schlessinger -- enter Moynihan.

The life insurance and private pension business, as a long-term provider of income maintenance arrangements, should be, and is, concerned about welfare issues and welfare reform. Though our expertise in income maintenance does not extend specifically to welfare, we are concerned about the impact of various proposals for welfare reform on the well-being of our citizenry and on the soundness and viability of our economy and society, and on our business and the future of our business.

The interest of our industry in welfare reform is reflected in the establishment of a Committee on Welfare Reform by the American Council of

Life Insurance. Made up of chief executive officers of member companies, this committee will initially monitor the changing welfare scene. No public policy positions are planned for the immediate future.

I presume that the majority of us in this room this morning make our living in the group life and health insurance business. It might be appropriate to end this brief visit with welfare reform by asking ourselves the following three questions -- and the answers you give may tell you why you ought to be concerned over welfare reform.

Will an enlarged federal role in the public income maintenance sector lead to greater federal regulation of the private income maintenance sector?

Will the ever-higher taxes needed to finance the welfare system impair the ability of corporations to maintain and improve their already expensive fringe benefit programs?

Will an enlarged federal welfare role, on top of the considerable expansion in income maintenance transfers in recent years, dampen an individual's perceived need to provide for his or her own security through savings and insurance and reinforce "let-the-government-do-it" thinking?

With these questions still lingering on our minds, perhaps it is appropriate to shift this discussion to the topic of social security. Those of you who believe that our Social Security system is nothing but a glorified welfare system will not perceive any change in topic whatsoever.

At the top of this program, I remarked that all of the topics we would be discussing this morning would be public issues, in a process of reform, controversial, and of significant importance to the life and health insurance industry. Perhaps none fill the bill as much as social security.

All of you, being well-read actuaries, know that Congress made some wise, but politically dangerous, financing decisions late last year and is now about to renege on them. This being an election year, the probability of Congress doing that is probably close to 100%.

At the risk of being proven wrong in public, it is probably safe for me to say that at least one part of the 1977 reform -- namely decoupling--is unlikely to be changed by Congress. This might be due to the fact that 99% of the members of Congress, just like 99% of all actuaries don't understand the topic and don't want to have to again demonstrate that ignorance. But let's give credit where it isn't due -- Congress will leave decoupling alone because they believe they have done it correctly.

The decoupling changes have their greatest short-run significance in the disability and survivor benefit areas -- especially disabilities and deaths at the youngest ages. This is primarily due to the fact that the "phase-in" of the 1977 law was not made applicable to the disability and survivor programs -- instead the changes take effect immediately. It was recognized by Congress that benefits at the youngest ages were already "lucrative" and that to prevent any immediate correction of that portion of the system would leave the whole system in financial jeopardy.

I'm not completely sure what the effects of these decoupling changes will be on the private insurance business. Under group policies, which typically have a social security integration feature, insurers will be paying greater benefits than they would have if the old law had remained operative. Under individual disability income policies, which typically have no integration provisions, and where the greatest current fear is with the growing inability of insurers to deal with the effects of over-insurance, perhaps the decoupling changes bought us nothing more than time in which to work on further solutions to the over-insurance problems.

Whereas decoupling may have solved a problem at the youngest ages, so the recent amendments to the mandatory retirement age legislation may have created problems at the oldest ages.

The original Age Discrimination In Employment Act was signed in 1967, and it protected persons who were at least 40 years old but under the age of 65. While at that time there was almost no discussion as to why the upper age limit was set at 65, it is now generally agreed that it was selected because 65 had by then become a customary retirement age and the age at which many public and private pension benefits became available. Whether right or wrong, the 1967 Act gave the practice of mandatory retirement its federal "seal of approval" and led to even wider use by employers. In keeping with this practice, group life and health insurance programs either cut off all coverage at age 65 or provided reducing levels of coverage.

Perhaps the employee benefit program at the American Council of Life Insurance is typical of current practices. Group life insurance is provided on a multiple of salary basis up to age 65, after which coverage is reduced 15% each year for five years. Coverage never falls below one-fourth of the amount the employee held just before attainment of age 65.

Group survivor income protection and group long-term disability protection terminate at age 65 (actually LTD eligibility terminates at age 64 due to the existence of a one-year disability requirement. Under the group LTD program, individuals who enter benefit status prior to age 65 will receive benefit payments only through the end of the month in which they attain age 65.

Assuming this insurance program is reasonably "typical," what happens to it as a result of the 1978 amendments to the Age Discrimination In Employment Act? In order to try to get to a logical answer, let's take a look at two provisions of the new law and some commentary which was read into the Congressional Record by Senator Javits.

Section 4(a) of the newly amended Act says that it shall be unlawful for an employer to"... discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's age." This Section remains unchanged from previous law, except that its provisions now apply up to age 70. While there are some exceptions for college professors and federal employees, let's ignore them for purposes of this discussion.

With the extension of this Section to age 70, it would appear that the practice of terminating eligibility under the group survivor income and long-term disability income plans at age 65 will no longer be lawful and will have to be modified so as to permit eligibility up to age 70.

Since both of these coverages are tied to an employee's income, it would appear that coverage could be discontinued should the individual's employment voluntarily terminate prior to age 70.

The extension of the provisions of this Section to age 70 becomes effective January 1, 1979 so there is sufficient lead time to bring an employer's program into compliance.

Section 4(f) says that it shall not be unlawful for an employer "...to observe the terms of a bona fide ... insurance plan, which is not a subterfuge to evade the purposes of this Act." This provision previously permitted the employer to retire an employee below the age of 65 so long as a pension or retirement plan provided for early retirement and the employer was merely observing the plan.

Now the Section has been amended by the addition of the phrase "... no such ... employee benefit plan shall require or permit the involuntary retirement of any individual ... because of the age of such individual." With this amendment, the Act now forbids the involuntary retirement of an employee below the age of 70 pursuant to the terms of a seniority system or employee benefit plan.

This amendment would seem to have little direct application to group life and health insurance programs. Indirectly, of course, by restricting an employer's ability to retire someone, there will be more persons remaining employed and, therefore, insured for life and health.

During the Senate debate, Senator Javits made reference to this Section and specifically mentioned welfare benefit plans. He said, "The purpose of Section 4(f) is to take account of the increased cost of providing certain benefits to older workers as compared to younger workers. Welfare benefit levels for older workers may be reduced only to the extent necessary to achieve approximate equivalency in contributions for older and younger workers. Thus a(n) ... insurance plan will be considered in compliance with the statute when the actual amount of payment made, or cost incurred in behalf of an older worker is equal to that made or incurred in behalf of a younger worker, even though the older worker may thereby receive a lesser amount of ... insurance coverage."

While Senator Javits comments obviously do not carry the force of law, they do indicate that the Congress fully intended to permit the practice of benefit reductions or increased employee contributions at the upper ages in order that employers' costs could be maintained at a reasonable level. In light of this intention, the group life insurance plan described earlier (15% reductions annually beginning at age 65) would seem to be consistent with the "intent" of the Act.

At the time the amendments to the Act were being debated in Congress, some employers expressed the concern that the amendments may increase cost for employee welfare benefit plans, such as life, health and disability programs. As I noted earlier, involuntary retirements are no longer permitted. But when you come right down to it, the real factor affecting costs is the individual employee's decision to either continue working or retire. Surveys of public opinion seem to indicate that most employees, while being appreciative of the availability of an option to continue

working, still plan to retire no later than 65. To the extent this attitude does prevail, the expected added costs will not materialize.

MR. ROBERT H. DOBSON: My subject is the impact of non-discrimination legislation and regulation. We are somewhat limited on time because we want to allow plenty of time for discussion. Therefore, I am not going to waste any time giving both sides of the argument. Those who disagree, and I hope there will be some in the audience who do, are urged to give the other side of the argument during the discussion period.

One more general point before I began: The ideas and opinions expressed in this talk are mine alone and not those of any organization with which I am affiliated.

I will now state my thesis:

Because of the political appeal of non-discrimination legislation and regulation at the state level, the insurance industry will be gradually phased out of existence or come to welcome Federal regulation.

Discrimination has, of course, become a very popular thing to be against. Many actuaries have pointed out that what we should be against is not discrimination itself, but unfair discrimination. Barbara Lautzenheiser, in particular, in her famous article "Sex and the Single Table" emphasizes that the insurance principle depends upon discrimination. We discriminate against those who do not have a claim in favor of those who do.

Two types of discrimination have come under fire. The first is rating discrimination, the second is discrimination in availability of coverages. Other areas of current interest are mandated coverages and the move against discrimination in types of providers for which reimbursement is allowed.

Let me define what I mean when I talk about unfair discrimination in rating. Discrimination in rating is charging a premium appropriate to the risk which is transferred from the insured to the insuring organization. Unfair discrimination is charging a rate which is inappropriate to the risk transferred.

The NAIC model regulation to eliminate unfair sex discrimination was purposely limited to availability of coverages and deferred the question of rating for further study. Some states, in adopting similar regulations, have added their own provisions with regard to rating. I understand that Florida is interpreting their regulation, which is essentially the NAIC model as prohibiting rates which differ by sex. That's why Federal regulation becomes necessary; even identical regulations can be interpreted and enforced differently in different states, and, generally, for the sake of political gain.

Let me emphasize one point which has been made by many others before me, but which I think needs to be reiterated:

We do not eliminate unfair discrimination in rates by charging everyone the same rate; if the risks transferred are different, we increase unfair discrimination because we overcharge one class in favor of another.

Fortunately, the discussions about discrimination in rating have not had a great impact on the group business for a couple of reasons; namely, the premiums are largely or entirely paid by the employer and the rate for the group applies to each of the individuals within the group.

There has been one notable exception to this, however, and that is in the group pension area. The U.S. Supreme Court ruled recently that women cannot be required to contribute more than men to an employer's pension plan. The ruling is based on Title VII of the 1964 Civil Rights act. The Court pointed out, however, that it was the unequal contribution which was called into question. Nothing in the ruling should prohibit equal contributions with each employee left to purchase whatever benefits were available from his or her accumulated contributions at retirement. Further, the Court saw nothing unlawful in insurers considering the female content of a group in determining projected benefit costs.

The "equal pay for equal work" aspect of this raises an interesting question Can we expect to see a reverse discrimination suit where male employees object to the fact that the employer contributes more for pension benefits for female employees? If so, then is the next step a suit by a thirty year old that the employer contributes more for life insurance on a sixty year old? These are questions we can expect to face in the next year or so.

Discrimination in availability of coverages, as opposed to rating discrimination, is another matter. I personally think that the steps taken to improve availability are healthy steps for the industry. This subject has not had a significant impact on the group business, however.

The two related subjects that I mentioned earlier have had an impact, though. These are mandated coverages and specified providers.

Let me start with providers. Laws and rules in more and more states are requiring insurers to provide payment for covered services when provided by psychologists, social workers, marriage counselors, osteopaths, podiatrists, chiropractors, and the like, if practicing within the scope of their license. Although these laws and rules are probably prompted by self-interest lobbying, I do not see a problem, <u>if</u>, and this is a big if, the covered service would have been performed anyway by an M.D. In other words, it becomes important in claims administration to ascertain medical necessity. In the absense of medical necessity, of course, costs go up.

The final area of anti-discrimination legislation that I would like to discuss is mandated benefits. These really trouble me, because the same politicians who are mandating these additional coverages are blaming the insurance industry for failing to control costs. In this category I put alcoholism, drug abuse, and outpatient mental and nervous coverage. I will not argue that there may not be a social need for these coverages and/or a social benefit from requiring them, however. Getting back to sex, we see mandated benefits in the form of disability coverage for pregnancy and required medical coverage for complications of pregnancy.

Whether or not there is a social gain in requiring these benefits, we must recognize that there is an increased risk transferred and therefore that there is an increased cost, which also causes surplus requirements to increase, as pointed out in Bertram Pike's recent paper.

As another example of the way things are going, I recently attended a Zone III NAIC meeting in Biloxi, Mississippi. Somebody told me, and I must admit I'm not sure that it's true, that no one from the District of Columbia was there because Mississippi has not passed the equal rights amendment, and the District will not reimburse them for travel to a state which has not passed it. I personally favor the amendment and am embarrassed that my state, Florida, has not passed it either.

But that's not the point. The point is that a governmental unit is telling its employees that they cannot attend a business meeting in another state, because the people in that state don't hold the same beliefs. Something's wrong somewhere. I don't think our country's founders had that sort of action in mind when they established the procedure for amending the constitution. But I'm an alarmist anyway, so let's drop the politics and get back to discrimination.

What should we do about all of this? First, as actuaries, I think we owe it to our clients or companies to let them know what the trend in anti-discrimination legislation and regulation is. We should be certain that they understand the basic threat to the insurance principle and what the outcome will be if the threat is realized. We should also take every opportunity to oppose each arbitrary and politically oriented bill or regulation as it appears. We should always raise rates when a new benefit is mandated or an old benefit is expanded, even if we don't have specific data available. This, more than anything, should drive home the point.

Secondly, as concerned citizens, we have a responsibility to let our insurance commissioners, insurance departments, legislators, and even our neighbors know what is happening. The commissioners and departments should be concerned about losing their influence through Federal regulation. Our legislators and neighbors should be concerned about the demise of insurance and additional federal control.

In conclusion, we all need to be looking for other jobs.

Thank you.

MR. RAYMOND F. MCCASKEY: The proliferation of new MET's in the 1970's, both insured and more recently the so called self funded variety, and the rash of financial horror stories that followed, have placed MET's in the regulatory spotlight and have cast the MET in a somewhat villainous role. Personally, I see the MET concept as more of a victim than a villain in the events of recent years.

The concept of many smaller groups banding together to stabilize experience, provide uniform benefits, and/or create administrative savings is not inherently bad. In fact, it is quite legitimate. These reasons, however, do not seem to be the prime motivating factors behind the recent rapid development of multiple employer trusts. The key motivation, instead, seemed to be avoidance of multi-state regulation or, in the case of the "self-funded" trusts, avoidance of any state regulation.

Concentrating first on the self-funded MET's, the trigger to the veritable explosion of self-funded MET's on the market was the passage of ERISA, complete with language providing for preemption of state regulation for

certain employee and employer associations. Many self-funded MET's sprang up and claimed they were "ERISA plans", and therefore not subject to state regulation. As problems and conflicts arose, the question shifted to the judicial arena. As decisions are now emerging from the courts, it appears that all but a handful of self-funded MET's do not qualify as ERISA plans and, therefore, are subject to state regulation.

Two court decisions stand out as especially significant in determining the jurisdictional question. These are the Hamberlin vs. VIP Insurance Trust and Fletcher Bell vs. Employee Security Benefit Association. Both cases helped to clarify standards for defining employee welfare benefit plans and employee beneficiary associations.

To oversimplify the results of these cases, the major issues boil down to the following questions: Who created the trust? Who controls the trust and decides on benefits, rates and enrollment standards? Who is the primary beneficiary of the trust? If the answers to any of these questions are something other than employers and/or employees, the trust probably does not fit the ERISA definitions and is, consequently, subject to state regulation.

These court decisions cleared the way for state insurance departments to issue cease and desist orders and thereby halt the activities of the self-funded MET's as unauthorized insurers. The state regulators have not hesitated. Cease and desist orders have been issued in many states and it appears that such orders will continue to be issued until self-funded MET's are virtually eliminated. Thus, it appears that most self-funded MET's are on their way out.

A natural consequence of these events is that many self-funded multiple employer trusts will now be searching for an insurance carrier in order to remain in business. Whether insurers will be found for most trusts is clearly in doubt. The reason self-funded MET's were self-funded was their inability (and often their unwillingness) to meet qualified insurers' standards with respect to administration and underwriting control. To complicate the situation, it is not unusual for the self-funded MET's to have established little or no reserves for existing claim liabilities. I believe it is safe to predict that a few well run and well managed MET's will find insurance carriers. The others will disappear.

This leaves us with the insured MET's. The primary appeal of the MET to the insurer, as noted above, is the avoidance of multi-state regulation. An insurer can operate a nationwide small group program while complying with the regulations of only 3 or 4 states. This, of course, leaves many state insurance departments and legislators with a slightly uncomfortable feeling about their ability to regulate the sale of insurance in their state. Just how intense this discomfort will become and at what point this discomfort will prompt restrictive action on the part of the state regulators is difficult to predict. Thus, a question which must be considered by insurers is, "As the door closes on the self-funded MET's, are the insured trusts next?"

The concern, of course, is that there is a clear need for quality group coverage which can be provided efficiently and economically to all size groups. MET's currently are significantly contributing to insurer's ability to meet this need.

The "utopian solution" to this dilemma would be rational and consistent state laws and regulations that would dramatically alleviate the complexities of conducting a multi-state business. This solution does not appear to be even a remote possibility for the foreseeable future.

It is hoped, however, that the states do move slowly and carefully in attempting to solve the problems associated with MET's, because MET's are in themselves, not the central problem. They are a reaction, a symptom of the underlying problem of complex and inconsistent regulation at state levels. If legislatures and insurance departments simply eliminate the MET's without considering and addressing the underlying regulatory problems, the insurance consumer will be the ultimate loser. Insurers and administrators, if MET's are to be preserved, must work to make their programs as sound and as compatible with the laws of various states as possible. The reduction of abuses and perceived abuses should make MET's less of a threat to concerned regulators.

Balance is the key. MET's are being abused, and changes are needed, but all parties must work diligently to make sure that the cure doesn't kill the patient. With a little proper care and control, MET's just may provide for the efficient distribution of group insurance benefits for a number of years to come.

MR. DUNN: Employers who provide uninsured benefits to employees are not subject to the same state insurance requirements as are insurers which provide insurance coverages to employers. Large employers can design an uninsured benefit plan that is uniform throughout the country without regard to varying insurance laws where extraterritoriality is asserted. Unless the ERISA preemption provision is narrowly construed with respect to uninsured plans, employers can, for the most part, avoid the mandated benefit laws and can, with few exceptions, avoid the state premium tax.

The public has an interest in the loss under self-insured plans of guarantees previously provided by insurance companies to employee benefit plans. The public also suffers, under uninsured plans, in that the state regulatory system designed to regulate insured plans is not available either to protect the public or to assist it in resolving problems of coverage. As costs rise beyond what the employers anticipate, financial failures may occur similar to what has occurred in the uninsured multiple employer trusts.

Section 514 of ERISA attempts to set forth the basic areas of regulatory responsibility as between the states and the federal government respecting employee pension and welfare benefit plans. The statutory language is ambiguous and the precise parameters of the federal preemption are unclear.

A "narrow" interpretation of Section 514 would result in the preemption clause operating so as to preempt only those state laws which are duplicative of the provisions of ERISA (e.g. reporting, disclosure and fiduciary requirements). This would allow existing state insurance laws, such as mandated benefits, other non-uniform laws affecting benefits, extraterritorial laws, etc., to stand.

A "broad" interpretation would have the preemption clause preempt all state laws relating to employee benefit plans.

Currently the issue is being litigated in several cases, at least two of which have reached the level of the United States Circuit Court of Appeals. In these two cases the District Court Judges came to different conclusions, one taking the "narrow" view and the other taking the "broad" view. Regardless of the outcome of either case or others at this level, this issue seems destined to reach the United States Supreme Court before long.

A Joint Task Force appointed by the Group Insurance Committees of the ACLI and the HIAA to review current regulatory problems for group life and health insurance considered at length the lack of parity as between insured group plans and uninsured group plans and the current confusion surrounding the ERISA preemption.

The conclusion reached by this Joint Task Force was that the ACLI and the HIAA should, in conjunction with as many other interested parties as possible, seek a federal legislative change to the ERISA preemption provisions whereby it is specifically stated that state laws mandating benefits and classes of individuals to be covered are preempted. Essential to this conclusion is the continued strong support for state regulation in the areas not specifically preempted.

MR. A. L. COOKE: Under the Kennedy proposal, if the premiums are to be the same for everybody, would experience rating be allowed for groups? Or would a company with good experience pay the same as a company with bad experience?

MR. DUNN: I don't know the answer to that question but I presume there would be no experience ratings for individual employers as we know it today.

MR. TED GARRISON: Under that plan I had the understanding that the government would set one rate to be charged of everyone?

MR. DUNN: As I understand it the premiums for the poor, the aged, and the disabled would be paid by the federal government, and all other persons would be charged the same premium.

MR. GARRISON: I had the impression these same premiums would be set by the federal government and that they would put these consortia in the squeeze position of having to provide specified benefits for the specified premium. It could be an untenable position if the premium set by the government were inadequate. It would be the responsibility of the consortia to presumably in some manner squeeze the providers into accepting reduced fees in order that the consortia stay solvent.

MR. DUNN: I'm really not certain as to whether or not this would be the same rate nationwide or whether it might vary by geographical areas as is provided in some of the other suggestions by Secretary Califano. Obviously he has not presented it to the cabinet and to other federal officials, who are now making comments about these 4 or 5 suggestions. Secretary Califano has obviously not given all the options that are available, he's just given 4 or 5 that they seem to like.

MR. ROBERT LINK: Picking up with that question I guess the question really is: you have 2 consortia in a state and they offer these plans, who decides the universal rate for that state at which the plans are offered, is it the consortia or is it the government or is that not clear?

MR. DUNN: It's not clear to me.

MR. LINK: Then let me go over the question I was going to ask before. The situation as I understand it is one in which everybody is required to be insured at some rate or other, whoever sets it. Are there any elements in that kind of a plan that would have the effect of influencing in a healthy way the trend of health care costs, or do you have just a third party payer situation in double spades?

MR. DUNN: Well that is an interesting question. When these plans get fleshed out there may be some. Certainly Senator Kennedy has been one who has over many years advocated a lot of controls over health care purveyors, and it would be unusual if he advocated something that didn't provide for any controls on that segment.

MR. WILLIAM NEAL: Are there any interpretative regulations on the new retirement age yet? And if not, when are they expected?

MR. DONNELLY: The bill itself requires that the Department of Labor come out with regulations. The last time I talked with the Department of Labor officials working on this, that's exactly what they said. They are working on it, and if you want to guess when they'll come out with anything - it's up in the air at this point - I have not seen any interpretative guidelines and don't expect any for the immediate future, although a portion of the bill has become effective of course already - the part dealing with involuntary retirements. The part "creating the new retirement age" at age 70 becomes effective January 1, 1979. So I would anticipate that they would have to come up with something fairly soon although I expect it at the end of the year probably.

MR. HENRY BRIGHT: Just to clarify one point, the involuntary retirement in a plan is still permitted but not at an age below 65, and as of 1/1/79 it is still permitted but not at an age below age 70. Is that correct?

MR. DONNELLY: What you had before was a situation where if the employer had a pension plan, he could retire someone early, that is before age 65. This is the United Airlines court case that recently came down which said they could do that. That provision that says you can no longer permit a person to be involuntarily retired became effective on the signing of the bill. So I guess my answer is that an employer even now can no longer involuntarily retire someone under the age of 65, and when January 1 comes around he can no longer do it up to age 70.

MR. RIAN M. YAFFE: You spoke primarily about insurance contracts, and I'm just wondering whether the bill addresses itself to insurance contracts or plans or rather to benefits. For example is it possible, do you believe, at age 65 to transfer benefits from one plan to another. An example might be a disability benefit that was provided by a group disability policy prior to age 65, but perhaps at age 65 the benefit or similar benefit could be covered by the retirement plan rather the LTD plan. Does the bill permit this kind of transfer or does it deal with contracts?

MR. DONNELLY: The best answer I can give at this point from the research that I have done on the bill is that it, like ERISA, addresses itself to employer practices. The best feeling I have for the bill is that it says

what an employer can do. Therefore I would think that shifting benefits from life contracts, disability contracts, the retirement plan would be soon caught up with and deemed to be illegal. That's my own personal opinion. I don't think you can move things within contracts. Transfers within funding vehicles is what the employer does.

MR. JAFFE: Maybe I didn't make the thrust clear. As long as the employer was still carrying out the intent of the law and not discriminating by age but was providing the same benefit, it would seem to me it wouldn't be a violation of the spirit of the law. It might become extremely expensive, for example, to provide some type of coverage under a group vehicle, but it might then become more feasible to continue it under a pension vehicle where some funding had taken place over a period of time. That's the kind of thing I'm wondering about.

MR. DONNELLY: Yes, I don't really think the bill addressed the details of the situation.

MR. CHARLES JACOBY: The latest I heard was that Labor intended to get interpretive regulations out in October or November which would be quite late. On the other hand, if it results in their being thoughtful that might not be all too bad. There is a task force at work in Labor. Unfortunately none of them know anything about Group Insurance. We tried to suggest that they should get some help from some competent experts, but whether or not they will remains unknown. The Javits speech you quoted is picked up almost verbatim from the interpretive regulation that was issued by the Labor Department many years ago. Nobody knows what it means, I guess. To start with, nobody even knows what a bona fide plan is. We've been trying to make some points with Labor that, for instance, the maximum need for Life insurance and for long term disability is at the younger ages and so forth ...whether we've been successful I do not know. Nobody knows how to measure this question of cost for younger workers, cost for older workers, benefits could be less if the cost is less, but nobody knows how to define younger workers and older workers, and the labor task force people know that also. I don't think anyone is sure as to the extent to which you can take into account government mandated benefits. They do seem to recognize that you can do this with respect to medical benefits. That is if you had a plan that's offset with Medicare, you surely wouldn't have to provide the same employer benefits at 65 as at 64. Whether they'll buy the extension into considering Social Security Old Age Disability Benefits with respect to other plans is again uncertain.

MR. DONNELLY: Well of course the American Council of Life Insurance took a position at the time of the bill. We got in very late, and it moved very quickly. When it came into the conference committee we were very surprised that it came out. Drawing $27,000 as the level of highly compensated people was the thing that finally broke the jam and let the logs float down the stream. Senator Javits did say that basically things would go on as they had in the past.

MR. LINK: Since Vincent Donnelly alluded to the Welfare Reform Committee of the American Council, my question is: Is there any sign that their activities are addressing the whole question of the causes of the existence of

welfare as distinguished from the questions of how to administer to the need? What I'm thinking of is government policies or other things that may help create the problem, and just to cite one specific example - there are those who believe that increasing the minimum wage exacerbates the need for welfare - are they looking at that side of it and developing Council policies that might be brought forward at the appropriate time - that really say let's not change the system, let's get rid of the need for it.

MR. DONNELLY: Two comments in that regard; of course, the Carter proposal that started off and stimulated all this says let's throw out the current system and put in a whole new one. That of course makes everybody think about basics, and then you start from there. At this point I think the task force of which Bernie Clyman of your company is chairman is trying to just educate insurance executive officers on the entire topic. Risk classification is of course a very massive topic that's being addressed. It's primarily affecting the individual side of our business. At this point I detect in talking with group people that we were the sleeping giants. We were aware of risk classification, we would come to meetings of the Society of Actuaries, and listen to Barbara Lautzenheiser and everybody else and the group people would think, we don't do that kind of thing. We don't really underwrite so therefore we don't have to worry about it. I suggest to this group here, assuming you are primarily group actuaries, that you start running very rapidly. As you are well aware, every topic that starts with individual insurance, when it gets to the NAIC level, sweeps you in anyway and many of your practices, whether or not they are discriminatory. When you come down to preexisting condition limitations and to cutting off disability coverage in a life policy at age 60, these are subject to review, and if you're not there when they start thinking about it, they take it away. So be aware of it - that's my job as part of the Council's activities to keep you up and running on topics that don't necessarily affect you today.

MR. DUNN: Vince can you give a comment with regard to mandated benefits- there's been a conversation with the NAIC regarding this matter also.

MR. DONNELLY: Just to briefly address this - the primary concern of course here deals with group insurance as it is affected by mandated benefit laws and by the laws that require us to cover handicapped children, etc. Now we recognize that a lot of these laws have been passed, model laws have been developed and have been adopted by the industry and the regulators, and what we may be doing here is dismantling something that we have personally assisted in doing. At the same time we recognize that the two group committees recognized in their wisdom that this is an area which if not cleared very quickly could totally dismantle state regulations. This is the issue that we've been carrying to the NAIC. Obviously this would throw out their efforts to establish state health care plans, which is a primary NAIC activity, and it will also throw out all their efforts on mandated benefits, on which they really believe they are being pressured on a state by state basis. As the conversations have gone on with NAIC we have noticed that the commissioners have realized the problem, and we believe now that they really think that we are trying to save the part of state regulations - namely, the solvency part etc., on which they really ought to have stayed in in the beginning. It's the mandated benefits, that have caused them the problems that they are having now and employers are coming out of the woodwork as you know at the ERISA level demanding that the Congress interpret the preemption section to totally preempt all state regulations whether it is of insured

plans or uninsured plans. At this point we are now planning to expand our conversations on two levels - first of all we're going to go to the public, that is to the employers and the unions and see to what degree we can generate their support, and the other thing is that we're going to Congress within the next couple of months. The Javits-Williams bill has now been introduced. It has a section that deals with preemption, it doesn't essentially address the preemption from the Daniels case, which is a pension issue cited, but we will use that as a road to offer our suggestions on preemption of state regulations.

MR. DONNELLY: The self-insurance item is something that we in the group insurance area are all very concerned about. We constantly bring this to the NAIC, I would just refer to the fact that there is another topic that is driving employers to self-insurance and that is that the NAIC in all of its wisdom has decided to take on the subject of readability of policies. This again started in the area of individual insurance. To the best of my knowledge all group insurance is in now. You may want to consider the impact that this has on group insurance business. The thing we've been emphasizing is the self funding aspects. That's just another straw on the camel's back, and large employers may very well consider this the final straw and move to self-insurance.