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REGULATORY CONSIDERATIONS IN GROUP INSURANCE

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1. National health insurance.

2. Federal hospital cost control programs.

3. Non-discrimination legislation and regulation (e.g., pregnancy, handicapped).

4. Multiple-employer trusts.

5. Impact of recent OASDI financing changes and changes in mandatory retirement age on group insurance.

MR. DEANE A. NINNEMANN: Until national health insurance becomes a reality, we can only speculate as to how it might affect group health insurance. At one extreme, group health insurance could be eliminated; at the other extreme, its existence could be guaranteed and its distribution enhanced.

Many Congresses have been faced with a variety of national health insurance bills over the years, and the first session of the 95th Congress has been no different. With some modification, the already familiar bills previously introduced by Kennedy-Corman, the American Medical Association, Long-Ribicoff, and Burleson-McIntyre were reintroduced. However, the bill which the Carter Administration plans to propose later this year will probably be given the most serious consideration. Carter has not yet announced the form of his legislation; however, no fewer than six variations have been submitted for consideration. Four of these were submitted by HEW, one by Senator Kennedy, and one by a faction of the private sector. A brief summary follows:

1. The "Consumer Choice Health Plan" proposal would introduce federal subsidies for the poor, establish minimum standards for private health plans, and initiate health care cost controls through competitive pressures within the health care delivery system.

2. The "Target Plan" proposal would introduce federal subsidies for the poor and federally financed catastrophic coverage for the public at large.

3. The "Federal Health Insurance Corporation" proposal would place the financing of health care under complete federal control and federally mandate that all citizens be provided with comprehensive health care.

4. The "Publicly Guaranteed Health Protection" proposal would also federally mandate that all citizens be provided with comprehensive health care, although it would permit employers and individuals to buy government approved private insurance in lieu of the otherwise automatically provided government insurance.

5. The "Private Guaranteed Plan" proposal would require all citizens to purchase a standard comprehensive health insurance program from either a private insurer or private HMO, although there would be financial incentive to purchase coverage from HMO's. It would require about 20 million Medicaid eligibles to be covered by the private sector, and millions of other Americans would have to improve their private coverage to meet federal standards.

   It is significant that this proposal, which provides for maximum participation of the private sector, was submitted by Senator Kennedy who, along with organized labor, has always insisted on 100% government financing and administration.

6. A faction of the private sector has unofficially proposed a "Building Blocks" approach. It would build on the present system to:

   a. Bridge the gaps in coverage for the uninsured and the underinsured, and

   b. Improve medical cost controls.

   Carter Administration response to the proposal has been quite positive, so that industry observers feel that it will be one of the top contenders for Carter's support.

   The "Building Blocks" proposal includes suggestions for minimum standards in group policies. Some of the suggestions are already being voluntarily implemented. You may be your own judge of the merits of the following suggestions found in the proposal:

   a. Eligibility standards. These would be standardized and liberalized so as to reduce the number of persons in the private sector who are often without coverage. Waiting periods of coverage beyond termination of employment would

be lengthened. Likewise, by modifying the preexisting conditions limitation to provide credit for time covered under any private or public plan which meets federal standards, there would be improved continuity of coverage in the events of employment changes and insurance carrier changes. Dependents' coverage would be provided from birth until at least age 26 as long as the person remains a dependent as defined by the Internal Revenue Code. The full-time employee definition would be liberalized so as to provide coverage for low income persons who are employed but are currently excluded from group insurance programs. Finally, employee contribution amounts would be limited so that more employees and dependents would be covered. And, beyond the group policy, insurers would establish state-wide or regional pools for the purpose of guaranteeing the availability of coverage to groups and individuals who are highly rated or uninsurable; enabling legislation would be required, however, since this has antitrust implications.

b. Benefit provisions. These would be standardized and liberalized so as to eliminate the problem of underinsurance. Deductibles and coinsurance percentages would be limited and, possibly, graded by family income. Likewise, there would be annual limits on out-of-pocket payments. Most types of medical expenses would be covered, including all expenses of hospitals, skilled nursing facilities, physicians, dentists, home health services, X-rays, laboratory tests, medical appliances, eyeglasses, and prescription drugs. Although mental health expenses would be treated somewhat differently than other medical expenses, there would be some minimum benefit standards; incidentally, the President's Commission on Mental Health has said that national health insurance must provide emergency, outpatient and inpatient treatment and, if essential to the patient's treatment, it must also provide care for the patient's support group. Finally, the proposal suggests that some medical benefits, although they may be in the public interest, are simply not insurable events. Accordingly, the federal government should consider making universally available such things as immunization programs, well-child care, maternal care, preventive programs, and diagnostic screening for such things as glaucoma, hypertension, and diabetes.

c. Cost containment features. These would be expanded to better control medical expense inflation. Plans would only provide payment for medical services which are tested

> and approved by the federal government. Likewise, there would be more preadmission testing, second surgical opinions, ambulatory surgery, and coordination of benefits.

President Carter has expressed hope that legislation will be passed in 1980. However, there is very little Congressional support; Congressional leaders are insisting that we cannot proceed with national health insurance until we have enacted health cost containment legislation. There is increased recognition that it is not feasible to have the federal budget finance all of the nation's medical expenses, and neither is it desirable since the private sector's system works admirably for more than 90% of the people. If the private sector is willing to be innovative before there is legislation, the impact of national health insurance could be extremely limited.

MR. HOWARD J. BOLNICK: Deane mentioned that one of the requirements that Congress is imposing, or trying to impose, is that there be hospital or medical cost containment legislation passed prior to national health insurance. That brings up an issue that Bob Maule will discuss, hospital cost control bills.

MR. ROBERT G. MAULE: The problem underlying cost containment efforts is well known. I won't bore you with statistics except to mention just a few. There has been a ten-fold increase in hospital costs in the last twenty-five years. The consumer price index may have increased two and a half times. Hospital cost increases are extremely visible because of published statistics. Hospital costs now comprise about 40% of total medical care costs, a significant portion. In the last few years there have been increases on the order of 15% annually. There appears to be no end in sight in the foreseeable future under current circumstances. It is somewhat ironic that the federal government, which now takes a dim view of the ability of the private sector to control costs, itself has quite a history in influencing cost levels. Going back, the Hill-Burton Act resulted in 15 billion dollars of investment in hospital construction after World War II, especially in rural areas. Government instigation of Medicare and Medicaid programs resulted in substantial increases in utilization of hospital services, perhaps 25% or more.

A variety of vehicles have been promulgated to deal with cost control: the PSRO (professional standards review organizations) were established to review necessity of inpatient confinement, length of stay, and other medical care characteristics with respect to Medicaid or Medicare patients. The old comprehensive health planning agencies (subsequently replaced under the National Health Planning and Resource Development Act in 1974 with Health Systems Agencies) had cost confinement as an important objective. Unfortunately, if we look to history, many times when health systems agencies have discouraged development of hospitals or added facilities, state agencies, which generally wield final judgement, have ignored their recommendations. State certificate of need programs have often been far

more concerned with "quality" of medical care and expanding medical care than cost containment objectives. Looking back historically, it isn't difficult to suspect that the system, as it exists today, will not be able to control costs. Cost containment is viewed now to be a necessary precursor to National Health Insurance.

This sets the stage for President Carter's solution to the problem--the so-called "9% Cap Bill," HR6575. This is a blunt instrument. Basic features of the bill are that total inpatient revenues would not be allowed to increase more than 9% in the current year (in subsequent years there would be a promulgated rate about one and a half times the then current CPI). Adjustments would be permitted if admissions were to increase substantially in a particular hospital. However, there is a corridor and larger hospitals would have to sustain a 15% increase in admissions before the requirements would be modified. Another key feature of the bill is an aggregate 2.5 billion dollar capital ceiling (about 40% of what hospitals are now investing annually). No one has a very clear idea how this amount would be distributed among states, and then to the different localities. This limitation is aimed at solving various problems perhaps outlined best in Secretary Califano's pronouncements. There is a pervasive attitude that we are overinvested in the health care area. Hospital occupancy rates now range between 70% and 75%. A desirable range would be 80% to 85%. Perhaps 100,000 beds should be decertified. It is interesting to note that the cost of a new hospital bed currently ranges between $40,000 and $100,000. That is initial capital cost. Within two and a half years operating costs associated with the bed equal these capital costs, and the operating costs continue. By restricting capital development there would be a two-fold effect: the immediate effect of holding down current capital expansion and the long term effect of reducing operating costs. Nationally there are about 4.4 beds per thousand population. A desirable shorter range goal would be 4 beds and perhaps ultimately, 3.5 beds. (Incidentally, in Washington State, where I reside, the current count is about 3.3 beds per thousand.) Another goal is to force consolidation. A fairly widespread attitude is that the allocation of hospital inpatient treatment facilities is inefficient. The administration thinks this and I suspect many others also agree. There is considerable documentation of duplication in the areas of obstetric facilities, pediatric wards, coronary care units, intensive care units, CAT scanners, radiological facilities, and so forth. It would be hoped that the "cap" would force hospitals to merge and otherwise begin to eliminate duplication.

Another objective is to reduce utilization. A cap on total hospital revenue would force careful consideration about the number of services to be provided.

Another hidden, and very sensitive issue, relates to technology. There is a belief, in some quarters at least, that we are spending too much for the results obtained. To take a hard-nosed economic viewpoint--does the society really want to spend $25,000 for open-heart surgeries? How many

people are affected? Neo-natal care is another example. For newborns I am aware of costs that have ranged up to $175,000. Nevada had the fourth highest neo-natal death rate in the nation. The state spent a lot of money, put professional teams together and developed facilities which resulted in reducing the rate by half. Three lives are saved every month. From an economic standpoint, is this justified? Ultimately society must face questions like these squarely and choose economic priorities.

Finally, another key objective is to obtain better management. The hospitals have been reimbursed retrospectively, on a cost plus basis. With prospective limits, belt tightening could lead to substantial reductions (for example, considering energy alone, perhaps costs could be reduced 20%).

President Carter's blunt instrument generated an enormous response from providers. Shortcomings of the bill were pointed out quickly. In dictating a uniform 9% cap, a recognition is not given to hospital size, patient mix, capital structure, and so forth. There has been considerable congressional activity. At least four committees are involved, two in the Senate and two in the House, each working separately to modify Carter's bill (evidently their staffs are working closely together to obtain a consensus). In the end a cost confinement act with characteristics of Talmadge's bill, "Medicare and Medicaid Administration and Reimbursement Act") may emerge. As a first step, the Act calls for a definition of hospital costs. It is difficult to talk about cost containment until functional costs are known. Hospital data has been scanty and non-uniform. The bill proposes a uniform, functional accounting system, which, incidentally, is also a necessary prerequisite to any prospective reimbursement mechanism. The bill classifies hospitals into a number of categories. There is a wide variety of groupings (size, type of hospital--teaching, rural, urban, etc.). Routine and non-routine operating costs are separated. Non-routine costs include capital investment, education and training, salaries of medical personnel (interns, etc.). Remaining costs are routine. Routine costs of all hospitals in any given subcategory are to be combined and divided by total inpatient days to obtain per diem figure. This becomes a normative reimbursement level. Under the Talmadge bill, current Medicaid and Medicare costs would be reimbursed on this basis. Non-routine costs would be reimbursed on a normal cost reimbursement basis. A very desirable feature of the bill, and one lacking in the Carter proposal, is that it contains financial incentives. If a hospital can provide services for under the per diem reimbursement level it will keep up to 50% of any savings. If actual costs exceeded normative levels by 20% the hospital would sustain the excess.

Other features include a provision for return on equity, required approval of any expenditures by the appropriate health systems agency, and a conversion allowance if a hospital decertified beds. Finally, there are incentives to encourage physicians to accept patients on an assignment basis.

As is, President Carter's bill is dead. At this point no alternative bills will go into effect since providers have formed a coalition (Federation of American Hospitals, the American Hospital Association, the American Medical Association) and have promised to reduce costs, reducing inflation 2% in each of the next two calendar years. My understanding is that the private sector will be given its chance for a year or two to contain costs. After that a cost containment bill would take effect.

I would like to discuss other approaches to cost containment, including prospective hospital reimbursement and budgeting. About five states now have such mechanisms (Washington is one of them, but it is very new there). Of the states that have had such programs for some time, increases in costs over the last two or three years have been well below national levels. It appears that something quite successful is happening. In Washington, even prior to the prospective approach which was instituted just a year ago, we had a strong hospital commission which set up uniform accounting systems for all hospital reporting (similar to the Talmadge bill). In the last two years the commission declined 15 million dollars of requested budgets. Projected total hospital budgets in 1978 are only $4\frac{1}{2}\%$ above last year. We have actually seen the case in which room and board rates have been decreased for some hospitals in Washington, in some cases by 15%.

Finally, I want to discuss briefly what carriers can do in this area. In Kansas City a hospital proposal went straight to the state commission rather than going through the local HSA. Blue Cross indicated refusal to reimburse the additional hospital beds if they were built until there was HSA approval. (This is being litigated.) In Dayton, Ohio the hospital did go through the HSA but the HSA did not approve the proposal. The state overruled this and again Blue Cross indicated refusal to reimburse the beds. (This is also being litigated.) Perhaps for the first time we are seeing carriers flex the muscles of the reimbursement mechanism in supporting the HSA and in supporting cost containment.

Commercial carriers don't have such avenues available to them but there are other things that can be done in terms of plan design. Examples are institutions of deductibles and copays, writing the contracts so that pre-admission diagnostic can take place outside the hospital and get reimbursement, being responsive to the alternate methods of treatment (e. g., nursing home care or home care versus inpatient confinement). Second or even third opinions could be encouraged for surgery. I believe one other important area is in aggressive experimentation with open and closed panel HMO arrangements.

MR. BOLNICK: Thank you. Let's have questions now for a few minutes.

WILLIAM LOVINGSTON: At the end of your talk, Deane, you said that 90% of the people are adequately covered by the private sector. Frankly, I don't believe it. Would you mind expanding on this 90%, starting with 230 million and working down from there?

MR. NINNEMANN: Possibly the statement was taken in a context in which I didn't intend it. I believe the statistic I was using was that more than 90% of the people are in some way covered by private or public health care insuring organizations.

MR. STANLEY L. OLDS: Has there been any agreement on what the starting point is in connection with the private hospital or the hospital voluntary effort to reduce their costs? I recall that they first said they would reduce the level of inflation by 2% per year but later said there was an error in their figures.

MR. WILLIAM CUNNINGHAM: The AHA first said there had been a 2% reduction in the rate of inflation over the previous year. Then about six weeks later they said they had made an error, and instead of a 2% reduction there had really been a 2% increase. That put a lack of credibility into some of the things they were doing.

MR. BOLNICK: There have been a number of pieces of legislation in the past year that will have an impact on group insurance programs written by commercial carriers. We would like to talk about them under two topics: (1) non-discrimination legislation, and (2) the recent amendment to the Age Discrimination In Employment Act.

MR. NINNEMANN: The purpose of non-discrimination and mandated coverage legislation is to reform certain insurance practices which legislators consider as either arbitrarily unfair or contrary to public interests. A review of recent HIAA bulletins indicates that a flood of state legislation is currently being introduced, and the pace is likely to quicken. Non-discrimination legislation includes, for example, requirements that women be treated like men, single people like married people, the handicapped like the non-handicapped, and the old like the young. Mandated coverage legislation includes requirements that policies provide such things as pregnancy benefits, mental illness benefits, coverage for newborn children, and conversion privileges. These laws can be expected to have a significant impact on the insurance companies who write group insurance and on the employers who pay for it.

The most obvious impact may be the added expense of operation, of which the most significant elements are keeping informed, modifying policy forms, and maintaining the administrative flexibility to handle state-by-state variations. An insurance company may attempt to avoid the multiplicity of state law variations by issuing group policies in states with favorable jurisdiction. Such efforts are offset to some extent by an

increasing number of state laws that apply to group policies which are issued outside the state but cover residents within the state.

Although less obvious, the legislation also contributes to restricting growth of the group insurance market and intensifying antiselection. This may be more apparent after considering the following illustrations of types of legislation which may some day be pervasive:

1. We face the possibility of legislation that would require group insurance policies to contain a conversion privilege which would make available individual policies with benefit provisions equivalent to those in the group policy. This would clearly increase the severity of the antiselection which already exists, and the assessed conversion charges against the group policyholder would likely increase.

2. We may see legislation that would require group insurance policies to provide the same benefit package to all employees regardless of age. In conjunction with the recent federal legislation on mandatory retirement ages, this would have important cost implications on nearly all forms of group insurance.

3. We face the possibility of legislation that would require group policies to provide coverage for handicapped people without exclusion of coverage for contingencies related to the handicap. Again, there are important antiselection and cost implications.

4. We may see legislation that would require normal pregnancy to be treated the same as other sicknesses for purposes of loss of time and medical expense coverages. In fact, there is federal legislation to this effect which has already passed the Senate; it has not yet passed the House due to disagreement on the extent to which the expenses of abortion should be treated like other pregnancy expenses. If such a bill is enacted, it would have major implications with respect to the cost of group insurance. The additional cost of such benefits could be more than 25% of premium in groups with a high percentage of young employees, although the additional cost for a typical group would be in the 5 to 10% range. This legislated cost would show up in reductions in other employee benefits, increases in required employee contributions, and increases in employer production costs. For some small employers the additional cost might inhibit the purchase of any plan; on the other hand, small employers whose employees are planning family additions would find it a bargain. Legislation of this type has already been enacted in the State of New York; it should not be a surprise that some insurers have decided to discontinue their small group health operations in New York rather than comply.

The pregnancy legislation is part of the larger sex discrimination issue. It is worth noting the recent U.S. Supreme Court sex discrimination decision concerning a pension plan sponsored by the Los Angeles Department of Water and Power. The court ruled that it is improper to require higher employee contributions from women than men even though women receive benefits of greater value than men. The majority opinion reasoned that "to insure the flabby and the fit as though they were equivalent risks may be more common than treating men and women alike; but nothing more than habit makes one subsidy seem less fair than the other." The possibility remains, no matter how unlikely we think it may be, that the insurance industry will be required to develop unisex tables for all forms of group coverage. The result would be increased incentive for more groups to self insure and increased opportunity for antiselection.

The future impact on group insurance is inherently related to consumer response. More of the large employers will go the self insurance route to avoid the additional employee benefit costs associated with costly requirements in group insurance policies. The circumvention of state regulation will likely lead to accelerated federal regulation. In the small employer market, the legislative trend will inhibit the sale of group plans, increase the level of employee contributions, and increase the severity of antiselection.

MR. BOLNICK: On April 6, 1978 President Carter signed legislation HR5383 that amends the 1967 Age Discrimination in Employment Act (ADEA). The 1967 version of the ADEA protects persons between ages 45 and 65 by making it illegal for an employer with 20 or more employees to refuse to hire, to discharge, or to discriminate with respect to compensation, privileges, and condition of employment because of a person's age. The amendment signed by the President raises the upper age limit of the protected group in the private sector from 65 to 70.

The old law, in Section 4(f)(2) of the Act, permitted an exemption from the general prohibitions against discrimination on the basis of age to bona fide employee benefit plans that are not subterfuges to evade the purpose of the Act. This exception was designed to facilitate the hiring of older employees by permitting their employment without necessarily providing equal benefits under pension, retirement, or insurance plans. This exemption provided the basis for a recent Supreme Court ruling in United Air Lines vs. McMann. This ruling affirmed lower court interpretations that allowed pension plans adopted prior to the enactment of ADEA to require retirement before age 65. The new law clarifies Section 4(f)(2) to prohibit a plan from requiring retirement at less than age 70 after January 1, 1979. The only exemptions from this stringent requirement are for certain executives and for college and university faculty until July 1, 1982. Further, Section 4(f) of both the old and new laws allow for mandatory retirement prior to age 70 "where age is a bona

fide occupational qualification reasonably necessary to the normal operation of the particular business or where the differentiation is based on reasonable factors other than age." For instance, health status could be used, and an employer may still discharge an individual for good cause.

The new law clearly mandates that employers covered by the law allow any employee who so wishes to remain employed through age 70. Raising the mandatory retirement age has obvious and widely discussed implications for pension and retirement plans. While all questions have not been answered, a great deal is known about the effect of the law on the employee pension benefit plans. The new law may also have an effect on welfare benefit plans: group life insurance, health insurance, disability income, and other employer sponsored programs. The possible effect of the law on these plans is neither obvious nor widely discussed. Despite the lack of wide discussion, we will try to formulate some of the potential problems.

There have been few regulations or court cases interpreting the effect of the old law on welfare benefit plans so it seems as though we can expect to wait a long time to discover the effect of the new law. However, employers and insurers should be aware of the potential impact of regulations and court rulings on their welfare benefit plans.

An underlying issue in regulations covering all employee benefit plans under ADEA is the "equal cost" versus "equal benefits" problem. That is, must older employees be given benefits equal in cost to those provided for younger employees or must the benefits themselves be equal regardless of cost? The Wage and Hour Division of the Department of Labor has issued regulations to the old law that require "equal cost" criterion for all employee benefit plans.

> "A retirement, pension, or insurance plan will be considered in compliance with the statute where the actual amount of payment made, or cost incurred, on behalf of an older worker is equal to that made or incurred on behalf of a younger worker, even though the older worker may thereby receive a lesser amount of pension or retirement benefits, or insurance coverage."
> (Code of Federal Regulations, Sec. 860.120)

The questions raised by the new law are basically as follows: Will this regulation be extended to cover welfare benefit plans? Will the courts uphold this interpretation? How will the "equal cost" criterion work in practice on various types of welfare benefit plans?

Since there are no laws, specific regulations, or court cases explaining exactly what "equal cost" means to welfare benefit plans, the "equal cost" issue will not force any immediate changes in welfare benefit plan practices. However, future actions on the part of Congress, the Executive Branch, or the Judiciary could cause profound changes. Let's review these possibilities.

1. Life insurance benefits. Due to the high cost of group term life insurance at older ages it is a common practice to sharply reduce or to eliminate coverages after normal retirement age. This reduction applies whether or not the employee actually retires. (Note that the new law leaves the concept of normal retirement age unchanged. It only affects mandatory retirement age.)

   If these practices are allowed to continue, ADEA would obviously have no impact on group life insurance programs. However, if an "equal cost" criterion is applied, benefits would have to be offered and the minimum amount of benefit may be well defined by regulations. An "equal benefit" criterion would, of course, require an even more costly level amount of life coverage from normal retirement age through mandatory retirement age.

2. Medical benefits. Medicare benefits are available to all covered workers at age 65 whether or not they retire. It is a common practice for employers to provide no medical coverage after age 65 or to continue medical coverage after 65 subject to a Medicare "carve-out."

   Once again, if these practices are allowed to continue, ADEA would have no effect on the cost of medical benefits. However, it seems quite possible that regulations could require that the same total plan benefits be extended to older employees subject to the Medicare "carve-out." This type of "equal benefit" regulation would increase plan costs for employers who currently depend on Medicare to cover all of the age 65 year old employee's medical care cost needs, but it would seem difficult to devise regulations that would fit the "equal cost" prescription for medical benefits.

3. Disability benefits. The impact of "equal cost" or "equal benefit" criteria disability plans, whether short term or long term, involves the greatest uncertainty regarding the cost effects of the new law. These benefits are highly volatile for a number of reasons. First, many disability benefit plans provide higher benefits than retirement plans. If not properly controlled by sound claims administration, disability benefits at the higher ages take on the characteristics of early retirement supplements. This stems from the fact that aging blurs the distinction between disability and bona fide retirement.

   In addition, rates of disability claims increase during an economic downturn. Thus, where disability coverage continues after age 65, the potential for retirement with higher disability benefits serves as an incentive for workers to defer retirement after age 65. Of course, the cost of coverage at higher ages increases dramatically.

> The solution is to limit both the disability coverage and disability payments to age 65 or less, if allowed, or to design the disability program in such a manner that an employee receives the same benefits under the disability plan as under the retirement plan.

The Amendments to the ADEA expand the protection against age discrimination in employment and provide employees with the opportunity to defer retirement until age 70. However, in considering this legislation Congress may have failed to determine its potential impact on business, employee relations, and employee benefits.

MR. CUNNINGHAM: Do you think that because of the social security financing problems there will be an attempt to change either the retirement age or the eligibility age for medicare benefits to 70?

MR. BOLNICK: The recently enacted finance and benefit provisions of social security simply glossed over a large part of the problem of social security. They solved the problem on the short term but the fact still remains that by the twenty-first century the cost of social security is going to increase dramatically. I have seen more and more acceptance of an increase in the retirement age as a sound solution to the problem. Congress is accepting the fact that people are going to be working longer; it may be a number of years, but ultimately I wouldn't be surprised to see the retirement age increased to 70.

President Carter signed into law the "Social Security Amendments of 1977" (HR9346) in December, 1977. These amendments make major changes in the financing and benefits of the social security system. Most of the analysis of HR9346 has focused on its effects on retirement benefits. However, the amendment also has a significant effect on disability and survivors benefits. Changes in the social security disability and survivors benefits affect group life and disability programs.

The major change affecting group programs is caused by the benefit "decoupling" amendment. Prior to 1972 the law had provided that a beneficiary's initial social security benefit payment was based on his or her earnings up to the social security wage base ("covered earnings") during his or her working career. Moreover, increases in the social security wage base were not automatic and necessitated legislation to effect each increase. In 1972 the law was changed to provide for automatic increases in the social security wage base, thus providing automatic increases to initial social security benefit payments. Furthermore, the table of social security benefit payments was also increased automatically as a result of increases in the Consumer Price Index (CPI). This double adjustment for inflation is commonly called "coupling."

The 1972 law also called for increasing payments after the initial social security benefit payment as a result of further increases in the CPI. The new law provides for "decoupling" in that CPI increases will no longer

affect the computation of the initial social security benefit payment. Now CPI increases will only be taken into account to adjust payments after the initial social security benefit payment has been made. The initial social security benefit payment will still, of course, be based on the employee's covered earnings.

Prior to the new law an employee's covered earnings during his or her working career were directly used to determine the initial social security benefit payment based on the application of a complicated set of percentages for various earning ranges. Under the new law each year's covered earnings will be indexed. The result of this indexing will be to adjust each year's covered earnings to reflect the higher social security wage base near the time benefits commence. A set of simplified and much lower percentages will be applied to the higher indexed earnings, producing benefit levels that are roughly comparable to those under prior law.

These changes in the benefit formulas have a number of significant effects on social security disability and survivors benefits. First, the ratio of initial benefits to final income has been stabilized. This ratio is known as the "replacement ratio." The old law had a disturbing tendency for the replacement ratio to increase with time, and increased replacement ratios directly reduce the need for coverage from the private sector. The new law is designed to replace about 55% of a low income worker's final year's earnings, about 43% of an average income worker's final salary, and 30% of income for a worker whose earnings equal the wage base each year. For workers earning over the wage base, the replacement ratio will be further reduced.

By stabilizing replacement ratios the degree of social security encroachment on private plan benefits has been stabilized. Further encroachment will occur only as the proportion of total wages covered by the social security system increases.

Second, under the old law disability and survivors benefits were not equitably distributed by age. Because of the shorter number of years included in the benefit computation period and the lack of indexing in years of lower general wage levels, younger workers received significantly higher benefits than older workers. The new law automatically corrects this inequity with its "decoupled" benefit formula.

It is clear that stabilizing the replacement ratio and equitably distributing benefits by age affect both disability and life insurance benefit programs.

1. Disability benefits. The change in disability benefits will have an immediate impact on LTD programs with a social security offset benefit. The new benefit formula will go into effect as of January 1, 1979. Disability and survivors benefits will not have any transition period (as will retirement benefits). The new social security benefits will be lower than current benefits, particularly

for younger workers. This will cause an increase in LTD benefits. Insurers should therefore take steps to assure themselves that they are compensated for these higher benefits.

In the long run, the stable replacement ratios will mean a stable market for LTD benefits provided by the private sector. The federal government will still be the largest provider of disability protection in the U.S., but its market share will of course remain stable.

2. Life insurance benefits. The impact of the new law on life insurance benefits is similar but less direct. The federal government, through the social security survivors benefit program, is the largest life insurer in the U.S. The new law reduces survivors benefits, especially for younger workers. This increases their need for insurance protection. To the extent that employers feel an obligation to help meet this increased need or unions negotiate for increased employer provided protection, the new law should open new opportunities for life insurance sales.

   In the long run, as with disability coverage, stable replacement ratios should go far towards ending the government's encroachment on the private life insurance market.

It would seem that the 1977 Amendments have a sanguine effect on disability and life insurance benefits. Without further legislated changes, a limit has been placed on the size of the social security system relative to the private system.

KATHLEEN E. BURT: In Oregon a law has been passed requiring pregnancy benefits and it makes the employer rather than the insurance company responsible for treating pregnancy as if it were a sickness. The Teamsters have challenged the law on the grounds that ERISA pre-empts that kind of regulation. The court has ruled for the Teamsters and the state is now appealing. Our company is now in the position of adding maternity benefits to all contracts except those for the Teamsters.

MR. BOLNICK: In New Hampshire there was a hearing on whether or not the state could mandate that pregnancy be covered under an insured plan. It may have been the Teamsters who were suing the state because they claimed theirs was a welfare benefit plan under ERISA and the state should not be able to tell them what to insure. The court ruled that the state was regulating the insurance plan, not the welfare benefit plan, because the insurance contract was a vehicle for providing insurance and was separate from the plan itself.

MR. OLDS: Howard, you discussed the possibility that the social security retirement age may eventually be increased to 70. In those plans that have offered early retirement with little penalty there has been a large number

of early retirements. I question whether the mood of the country really is for later retirement.

MR. BOLNICK: There has been a tendency toward earlier retirement even though workers are given the opportunity to continue their employment. It could be that workers do not want to be forced to retire at a certain age. In order to make age-70 retirement an effective tool for containing social security costs the benefits for early retirement would have to be reduced more than they are for early retirement under the current law; otherwise age-70 retirement may have no effect at all.

MR. NINNEMANN: There has been some research done, particularly among large employers, as to the utilization of early retirement. There is a tendency for employees not to take early retirement because of a fear of inflation. As long as the rate of inflation remains high, and as long as we continue to have pension plans that do not effectively handle post-retirement inflation, I think early retirement will be less attractive.

SUSAN M. SMITH: You may find workers taking advantage of the heavily subsidized early retirement provisions to change jobs since with the new legislation it will be more difficult for companies to keep them out of their employ even though they may be switching at 50 or 55. The costs are going to be much higher than anyone has anticipated if the pension program is front-end loaded. In a 15-year plan where the employees get fairly high benefits after working 15 years, and they decide to tie themselves to earnings at 50 or 55 (and in many industries that's not too far different from what they're going to have at 65), they're going to go into another program and accumulate as much or more pension. It's clear that if the company they retired from early is paying the benefits from age 50, and it's subsidized, then the cost will be large.

MR. BOLNICK: Multiple employer trusts have become very popular vehicles for marketing small group life, health, and disability products. Three variations on the basic MET theme have been developed:

1. Fully insured MET's. These are plans established, administered, and most often marketed by an insurer.

2. Third party administered MET's. These are MET's whose participants are assured of their benefits by an insurer, while an independent third party administers and most often distributes the product.

3. Self fund MET's. These are plans established, administered, and marketed by an independent third party with the participants bearing all of the risk.

Each of these types of MET's has had examples of serious financial difficulties in recent years. Some MET problems have been so severe and

so noteworthy that Congress, the Federal Executive, the NAIC, and State Insurance Departments have all become active in assessing and regulating MET's.

Basically, there are three controversial issues which encouraged the development of these various MET's. These issues still exist today. They are:

1. The onerous task of maintaining a small group product in a large number of states with different insurance laws and regulations. These requirements include different mandatory benefits, rate and form filing requirements, and agents licensing requirements.

2. The ERISA pre-emption of state laws (Section 514 of ERISA) and its resultant effect on employee welfare benefit plans.

3. The effectiveness of and need to regulate independent third party administrators.

Each of these issues has been the focus of some or all of the bodies with a stake in regulating the insurance industry. Let us look at each issue in turn and discuss the regulatory trends.

1. Multistate insurance laws. Insurers generally interpret the status of MET's under state group insurance statutes in a manner that allows legal simplification and a corresponding administrative simplification. Even without a MET an insurer can distribute small group life, medical expense, and disability insurance in any state in which it holds an insurance license. The insurer then must comply with the mandatory benefits, policy form, rate filing, agent licensing, and other laws and regulations of each state. By using a MET most insurers view the contract as a contract issued in the state of situs of the trust rather than the state of domicile of each participating employer. If this view is in fact correct, then the product available through the MET group contract may be sold virtually nationwide by complying only with the requirements of the state of situs of the trust.

   Some states are beginning to question this interpretation of the legal status of MET's. To the best of our knowledge New York, Texas, Wisconsin, and Ohio have required the filing of MET's sold in their jurisdiction. Wisconsin convened a hearing in October, 1977 to gather information on MET's and their legal status. No ruling has yet come out of these hearings. I would not be surprised to find that other states have also begun investigating the legal status of MET's.

   The NAIC task force responsible for drafting the recent model Administrator Statute (which we will discuss below) also

investigated the legal status of MET's under state group insurance laws. They chose, however, not to officially address that issue.

The basic issue to be addressed in all these instances is if and when a MET can qualify as a multiple employer plan under existing state group insurance laws. State laws are rather lax in their definition of multiple employer groups in comparison to, for example, the federal law definition of such groups under ERISA and the old Welfare and Pension Plan Disclosure Act. Since some insurance departments are beginning to view MET's as a means of avoiding regulations in their state we expect to find the states reviewing their definitions of multiple employer groups.

2. ERISA pre-emption of state regulation. Self funded MET's blossomed in the post-ERISA era. Self funded plans claimed that they are welfare benefit plans under Section 4(3) of ERISA and therefore are free from state insurance regulation. This problem became particularly serious with the bankruptcy of two large west coast self funded plans: the National Multiple Employers Foundation and the Hospital Welfare Association Trust. Further, it became obvious that other self funded plans had serious financial problems due to abnormally low rates and unusually high commissions and service fees. There was a regulatory void which needed to be filled.

In April, 1977 a meeting was convened in Washington by the Department of Labor and was attended by the NAIC, various state insurance regulators, third party administrators, and other interested parties. The meeting was more a forum to express opinions than any type of rulemaking session. The Department of Labor did indicate, however, that it was placing a high priority on developing regulations for a position on self funded MET's.

In August, 1977 two court decisions were handed down which have had a substantial impact on self funded MET's. One decision is Hamberlin vs. VIP Trust. In this decision the U. S. District Court for the District of Arizona held that the VIP Trust was not an employee benefit plan under ERISA. This was held due mainly to the lack of separate identities of the administrator and the trustees and the fact that insurance was sold directly to employees without any involvement of the employer.

The other decision, Bell vs. Employee Security Benefit Association, addressed the issues of what constitutes an ERISA plan in much greater detail. This case drew an amicus brief from the Department of Labor and resulted in a lengthy opinion outlining the requirements for a plan being an ERISA employee welfare benefit plan. To be a welfare benefit plan, a self funded MET must be either an "employee representation committee" or an "employee

beneficiary association." The court, agreeing with the Department of Labor, found that a group of employers with no other interest in mind other than the purchase of insurance fits neither category. This ruling has virtually eliminated the legal basis for self funded plans avoiding state insurance regulations. In November, 1977 this decision was upheld by the Seventh Circuit Court of Appeals.

As a direct result of these court cases and the Department of Labor position outlined in its brief filed in Bell vs. Employee Security Benefit Association, a number of insurance commissioners have issued cease and desist orders to certain self funded MET's. These orders charge that the MET's are unauthorized insurers doing business in the state. The list of states taking this route is growing. To date we have seen public announcements from nine states, including Florida, Georgia, New York, Indiana, Illinois, Mississippi, Kansas, California and South Carolina. Other states may well have taken unannounced actions.

By November, 1977 the Department of Labor had completed its promised study of the ERISA pre-emption of state laws claimed by self funded plans. The Department of Labor conclusions put a further damper on any remaining hopes that self funded plans could continue to exist free of state regulations. First, the Department of Labor concluded that ERISA prohibits spending employee benefit plan contributions on commissions to agents soliciting new members for the plan. Second, the actual activities of brokers or agents who solicit the participation of new employers and employees in MET's are not outside of state regulatory authority as the result of any possible ERISA pre-emption.

Lastly, in May, 1978 Senator Javits introduced the ERISA Improvement Act of 1978. This Act affects self funded MET's in two ways. First, it clearly defines "employees' beneficiary association" as described in the Bell vs. Employee Security Benefit Association case, that is, an employee welfare benefit plan must arise from a group with a commonality of interest other than just insurance. Second, the bill adds Section 413 regulating "uninsured welfare plans." These are plans formed by groups of employees with no commonality of interest other than their participation in a welfare plan. The Secretary of Labor is empowered to subject these plans to solvency and reserve standards.

It seems clear that the result of these new regulations, laws and interpretations will be to end self funded MET's. Insurers will find that many of these MET's will be contacting them trying to find a new home.

3. Third party administrators. Many insurers have found that third party administrators (TPA's) can handle a MET package more efficiently than their own home office. This has led to the widespread use of TPA's. The NAIC has recommended a model statute aimed at regulating TPA's. To the best of my knowledge only three western states have adopted the statute: California, Nevada, and Arizona.

   The Administrators Statute is basically a very sound statute. It spells out the TPA's fiduciary responsibilities, sets disclosure standards, requires written agreements between the insurer and the TPA and access to records, and contains penalties for failure to act in a competent manner. The only section that appears to be controversial is the section that prevents contingent commissions to TPA's. It has been my experience that a contingent commission is quite useful in helping an insurer control and properly motivate TPA's.

With the issue of ERISA pre-emption well along the way to being solved the visibility of MET's should subside. However, as we have seen, the issues of the extent of compliance with multistate regulation and the regulation of third party administrators could soon become "hot" issues in their own right.