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HEALTH INSURANCE COVERAGES UNDER FIRE

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1. What are problem areas that have given rise to recent legislative and regulatory activity? What charges have been made against these coverages? Are the charges legitimate?

2. What new or different sales practices are being utilized - buyer guides, cost comparison information, other sales literature? Have these alleviated consumerist and regulator concerns?

3. How have legislative restrictions on product design and sales practices affected pricing adequacy, morbidity experience and the long-range availability of such coverages?

4. What can actuaries do to educate the public and regulators about cost projections and premium adequacy?

5. Is it ethical to market a product with a low benefit payoff, high expense ratio? If so, how can future "low risk-high expense" coverages be presented and filed to minimize such problems?

MR. RICHARD H. DRAKE: When the Medicare program was created in 1965, it was hailed by its supporters as an ingenious solution to the problem of providing suitable health care for a large and unique segment of the population which could ill afford to pay for it through private means. To the insurance industry, it appeared to be a serious Federal incursion into the realm of insurance which promised to lead to further involvement and regulation by the government. Both sides, it now appears, had over-reacted. The benefits provided by Medicare have become diluted over the years so that the portion of the cost of health care to senior citizens which is now provided by Medicare is less than 40%, and there is increasing dissatisfaction with the extent and quality of the Medicare program by its recipients. On the other hand, the insurance industry has found that the threat of unbridled takeover of the insurance industry by the Federal government was premature, if not unfounded, and that there is indeed still a market for insurance sales to senior citizens to supplement the benefits provided by Medicare.

And therein lies the beginning of the tale I have to tell. Let me begin that tale by briefly outlining the benefits providing by Medicare and the way in which insurance companies have found a market for supplemental insurance.

The Medicare program consists of two parts: A hospital insurance program (Part A) and a supplementary medical insurance program (Part B).

Part A covers hospital, skilled nursing facility, and some home health care, as well as certain therapy services. It is oriented towards acute care, and its coverage is based on the concept of a benefit period or

"spell of illness," a period that begins when an individual receives inpatient hospital or skilled nursing facility services and ends when that individual has been out of the hospital or skilled nursing facility for 60 consecutive days. In each benefit period, individuals are entitled to up to 90 days of inpatient hospital care, up to 100 days of post-hospital skilled nursing facility care, and up to 100 post-hospital home health care visits. If the full 90 days of hospital benefits are exhausted during a spell of illness, a beneficiary may draw on 60 additional lifetime reserve days.

Part B, the supplementary medical insurance program, provides coverage for physicians' services, diagnostic tests and x-rays, outpatient hospital services, and up to 100 home health visits per year.

Both parts of Medicare contain cost sharing provisions. Under Part A, the law requires that the hospital deductibles and coinsurance amounts be adjusted annually to reflect the rising costs of health care. There is currently an annual hospital deductible of $204, a daily co-payment of $51 for the 61st through the 90th day of care, and $102 a day for each lifetime reserve day. In a skilled nursing facility there is $25.50 co-payment for care from the 21st through the 100th day.

Under Part B, the beneficiary must pay an annual $60 deductible.* After the deductible, Medicare generally pays 80 percent of "reasonable charges," and the beneficiary pays 20 percent coinsurance. The "reasonable charge" is the amount of the actual charge of a physician or supplier that can be recognized for payment under Medicare. Since actual charges generally exceed the "reasonable charges," beneficiaries are also responsible for the difference, unless the physician or supplier accepts "assignment" of a beneficiary's claim (on the average, only 50% of physicians accept such assignments.)

There are a number of items and services that are not covered under either of Medicare's two insurance programs. These items and services include: Private duty nursing care, custodial care, most prescription drugs, dental care, eyeglasses, eye and hearing examinations, immunizations, routine physical exams, most foot care, and homemaker services. Beneficiaries must pay the full cost of these services out-of-pocket or obtain additional insurance protection to pay the costs.

The Medicare program was never designed to cover the total cost of providing medical care for its beneficiaries. It has been estimated that Medicare paid for only 38 percent of all health care costs for its beneficiaries in 1978. The remaining 62 percent included the cost of noncovered services and cost-sharing provisions of the Medicare program.

Since the enactment of the Medicare program, various insurance organizations have developed and marketed health insurance policies aimed at paying health care expenses not covered by the Medicare program. In 1978, about 65% of the 23 million Medicare beneficiaries spent $4 billion for approximately 19 million policies to supplement Medicare. These policies are commonly referred to as "Medigap" policies but the ones about which I will be speaking are more properly referred to as "Medicare Supplement" policies. I will not be talking about hospital indemnity policies. "Medicare Supplement" policies are designed to fill specific gaps in the Medicare

*Unchanged since 1973

benefit structure. These policies typically offer coverage of some or all of Medicare's deductible and coinsurance amounts and sometimes include coverage of services not covered under Medicare. There are many varieties of Medicare Supplement policies with premiums and benefit structures designed to meet the needs of people with a variety of incomes. A characteristic of most of these policies, however, is that they base their payments on Medicare's coverage and reimbursement structures.

They seldom pay more than the 20 percent coinsurance amount of the "reasonable charge" recognized by Medicare. They rarely pay any of the difference between the "reasonable charge" and the actual amount that a physician or supplier of services might charge. Furthermore, they frequently do not cover a broader range of services than are covered under Medicare. The premiums for these policies are usually adjusted annually to compensate for increases in Medicare's deductible and coinsurance amounts.

Seems reasonable so far, doesn't it? Government sets up a program with desirable deductible and coinsurance features to provide an incentive to the insured to hold back on over-utilization and unnecessary services, and private industry steps in and fills those gaps so that there is no longer any incentive for the insured to control the level of health care expenses he incurs. Disturbing, perhaps, but not much different from the age-old conflict of designing plans which balance the desires of the client against what we think the client should have. So why all the fuss? The fuss arises because some few companies and agents went beyond the point of filling the gaps completely. . . They filled gaps that didn't exist! While duplication of coverage is not a new phenomenon, it aroused the protective instincts of the public, and politicians in particular, when the victims were helpless senior citizens.

Here are a few examples of the abuses which were exposed to the public view in numerous state and Federal hearings, starting around 1976:

- A 67 year old woman who had been sold 17 policies by the same company; she was paying 68% of her income for supplementary health insurance.

- An 88 year old woman who was sold health insurance with premiums of more than $10,000 a year in a one year period. . . premiums more than twice the woman's annual income.

- A blind 94 year old woman who was sold 26 accident and health policies in a 3-year period.

- An 80 year old woman who spent over $50,000 in premiums on 3 policies over a 3-year period. . .

These are merely examples of the abuses which were reported. Most were, of course, true. There was never any doubt of that, and the industry was quick to condemn this sort of abuse. In fact, the Health Insurance Association of America **conceded** the following list of abuses which were known to be occurring in varying degrees of frequency.

A. High pressure sales tactics

B. False or fradulent representations by agents - (I'm with Medicare) or (I'm here about your Medicare)

C. False or misleading advertising

D. Overinsurance (stacking)

E. Replacement of policies which are already adequate (twisting)

F. Inadequate coverages at excessive rates

G. Intentional inadequate disclosure or misstatement of coverages

Many of these abuses, of course, are not peculiar to the over 65 market. The HIAA had long supported the efforts of the various states in enacting legislation that would guard against abuses in the marketing of <u>any</u> type of health insurance. Various state laws and regulations dealing with claims settlement, agent licensing, advertising, minimum standards, replacement and disclosure, the relation of benefits to premium charges, and policy language have all been enacted in various states in recent years, often with HIAA assistance and encouragement.

The HIAA believed that most cases of marketing abuses and outright fraud could be dealt with effectively through the state insurance departments. It urged those state departments to enforce vigorously the penalties provided by state law or regulations. Where penalties were not severe enough to match the abuse committed, the states were urged to strengthen penalty provisions. In addition, the HIAA took the following steps:

1. It urged its member companies to review their marketing practices including instructions to and training of agents to make certain Medicare Supplements are properly marketed in the public's best interests.

2. It increased the efforts of its public relations arm, the Health Insurance Institute, to educate the public in the purchase of appropriate Medicare supplementary coverages.

3. It started working with the National Association of Insurance Commissioners on the development of a buyer's guide for Medicare Supplementary policies. (In fact, this guide - a good one - was finally developed through the joint efforts of the NAIC and the Health Care Financing Administration of the Department of Health and Human Services, and tens of millions of the guides have already been distributed to the public.)

While forces were being marshalled to more effectively protect the senior citizen, there were a few dissenting voices heard. They can be best summarized by quoting a letter sent to the Washington Post in response to an editorial about Medicare Supplement abuses.

> "That story demonstrates what was wrong with the woman who bought the policies—she was foolish.
>
> There are a dozen better reasons to regulate the insurance business than the notion to which you apparently subscribe—that people need to be protected from their own stupidity.

> If such persons need protection, let it come from within themselves, from their friends or families. Otherwise, let them bear the consequences of their own actions. The taxpayer has enough burdens to bear already."

There are many who would applaud the sentiments expressed in that letter, but even King Canute learned that the tide is relentless, and he who tries to halt the progress of the waves (or the waves of progress) gets wet. And public sentiment in this matter did, indeed, represent a tide.

The states, meanwhile, had been busily creating their own responses to what seemed to be an increasing litany of abuses. A number of states concentrated on disclosure requirements and insisted that an appropriate outline of coverage be provided to the senior citizen applying for health insurance. A few created minimum standards for Medicare Supplement policies, so that any policy advertised as a Medicare Supplement could be depended upon to provide a suitable minimum level of benefits. But there was no uniformity among the states, since the NAIC, in its model Minimum Standards Acts, had not specifically covered Medicare Supplement policies.

Despite the action by several states to set standards for Medicare Supplements, there was increasing concern at the Federal level over the lack of real and timely progress to correct the abuses which were being documented with increasing and monotonous regularity. In particular, hearings held by the House Select Committee on Aging in late 1978 tended to bring into sharp focus the national concern over the plight of senior citizens who were bewildered by the problem of providing for their total health care needs. That national concern, however, became transformed into a concern for the way in which <u>insurance</u> was covering those needs. Because some insurance companies and agents had been guilty of improper practices, the insurance industry became a popular whipping boy, and it became fashionable to offer solutions based upon regulating the activities and forms of coverage offered by <u>insurance companies</u> operating in the over 65 market. And for perhaps the first serious time in over a decade, the Federal government found it comfortable to join the parade.

The Federal Trade Commission added fuel to an already blazing fire by issuing a report in August 1978. The report said that one-quarter of the elderly **Americans** who annually spend $1 billion for extra insurance to cover Medicare gaps actually buy unnecessary, costly and overlapping coverage. It pinned the blame on lack of adequate consumer information, unscrupulous sales tactics by some firms, and a lack of uniformity in coverage.

Eventually, the NAIC developed and adopted (in June of 1979) modifications of its Model Minimum Standards for Health Insurance to provide the following specific requirements for policies sold to those eligible for Medicare:

- Minimum benefit standards to insure adequate coverage.
- Distribution of a specific outline of coverage describing benefits and limitations.
- Display of a caption on the policy characterizing the scope and nature of the coverage.

- Distribution of a buyer's guide to make the elderly applicant more knowledgeable about his or her health care needs and how Medicare can be supplemented by private insurance to meet those needs.

The new NAIC Model Minimum Standards also provided for penalties to insurers and agents guilty of improper marketing practices, but the main thrust of the requirements was to insure that a senior citizen could feel comfortable about buying a policy to supplement Medicare, knowing that it would have to be a good one, and that he would get a complete explanation of the benefits it provided, and that he would get a guide to help him evaluate the way in which those benefits filled his needs.

But progress towards adoption of the new standards continued to be slow. Not surprising, therefore, that a trio of bills suddenly appeared on the Federal scene. Despite the diversity of these bills, there were some common elements, and some of them were reminiscent of the NAIC principles.

- Minimum benefit standards

- Penalties for agent misrepresentation

- Disclosure of benefit information to prospective buyers

- Provision for future studies

- Minimum standard for loss ratios

- Some sort of voluntary certification, state or Federal

The stage was set — and at this point Senator Max Baucus stepped into the spotlight. The Social Security Disability Benefits Bill was then being considered. It contained a number of important and badly needed changes in the disability provisions of the Social Security program. Accordingly, the bill provided an opportune vehicle on which to piggy-back the introduction of requirements governing benefit standards and certification of Medigap policies. Senator Baucus introduced an amendment to the bill which contained some of the better and more temperate features of the Medigap bills which had previously been introduced. With minor changes, the amendment was adopted after a spirited but relatively brief battle, and the Social Security Disability Benefits Bill, with the Baucus Amendment intact, became law on June 9, 1980.

The intent of the Baucus Amendment was to help senior citizens identify quality insurance coverage which would properly supplement Medicare (without duplicating it) at a fair price. It attempted to do so by the following means:

1. It established a benchmark of quality for Medigap policies

   - First, benefits meeting or exceeding the model standards adopted by the NAIC in June 1979.

   - Second, loss ratios meeting or exceeding 60% for individual policies and 75% for group.

2. If a state has not adopted a regulatory program at least equalling the benchmark just described by July 1, 1982, a voluntary Federal certification program goes into effect in that state

   - An insurer can submit its policies for review in such a state. . . if it meets the same benchmark standards it would be given a seal of quality.

   - There would presumably be no stigma attached to an uncertified policy in a non-conforming state, since the program is a voluntary one.

3. For states which, by July 1, 1982, have adopted a regulatory program meeting the benchmark standards, the voluntary Federal certification would not apply

4. A supplementary health insurance panel would be created to pass judgment on the adequacy of state regulatory programs

5. The amendment established penalties for misrepresentation as to a policy's coverage or certification status, or the status of the agent, and it provided penalties for selling duplicative coverage or for mailing (or advertising) a policy in a state where it is not approved.

6. A study was required by the Department of Health and Human Services to determine the effectiveness of state regulation and the continuing need for a voluntary Federal certification program.

From the point of view of Senator Baucus and his supporters, this law provided protection to consumers in <u>all</u> states, including those which would not themselves effectively regulate the sale of Medicare Supplement policies, and it offered a seal of quality as tangible evidence of a policy's suitability. Why then, was there opposition to its adoption? Here are a few of the objections raised by the industry.

- More than 30 states, covering over 3/4 of the senior citizen population, had already enacted or introduced <u>some</u> form of Medigap legislation.

- Competitive pressures might turn the "voluntary" certification program into a "mandatory" one.

- Certification (and the seal of quality) would give unscrupulous agents an opportunity to "twist" existing valuable coverage by suggesting replacement by a "certified" policy which might be no better than the one being replaced.

- Consumer education, a key element in the program, was already well advanced through the effective distribution of the "buyer's guide" developed by the NAIC and HHS.

- It was a "foot in the door" for Federal regulation of insurance (anathema to the industry).

A critical consideration in the Baucus Amendment was the inclusion of group contracts. It wisely excluded group health policies issued to employers or labor organizations. These contracts covered most group policies but they were exempted for two reasons:

1. They are usually sold without regard to age or to the availability of Medicare for the insured lives.

2. The most frequent abuses of Medigap coverage have occurred in individual policies.

The timetable is clear. If all states and jurisdictions adopt the NAIC standards (including the appropriate loss ratio requirements) by July 1, 1982, then the Baucus Amendment will not have any effective operative requirements. Indeed, the amendment will have accomplished its purpose by forcing the states to place effective Medigap restrictions in operation. But at this writing, only 5 states have adopted regulations or laws which would seem to fulfill both the benefit and loss ratio requirements of the Baucus Amendment, and only 11 more states have the necessary changes in the works.

Whether the NAIC requirements or the Federal requirements are in effect in a particular state, one point is evident. The Baucus Amendment will have forced the creation of a new minimum standard with respect to loss ratios. And that is perhaps, above all other considerations, the point of most concern to actuaries.

The NAIC had developed, with the help of actuaries, a set of guidelines for loss ratios under individual health insurance policies. These guidelines reflected the variation in desirable expense margins caused by differences in basic benefit characteristics (disability income vs. medical expense), or renewal provisions (**non-cancelable** vs. guaranteed renewable) or premium level (high premium vs. low premium). Under the stimulus of the medi-scare investigations and increased concern for effective standards related to Medicare supplements, the model loss ratio guidelines were modified to include a specific 60% standard for individual Medicare Supplement policies before their adoption in December of 1979.

Few states had adopted any loss ratio guidelines, however. The NAIC Model Minimum Standards, which were receiving consideration by a number of states, did not contain loss ratio requirements. Thus, the Baucus Amendment, while accepting the NAIC Model Minimum Standards as a benchmark for benefit adequacy, found it necessary to go further and require additional loss ratio standards. . . including a loss ratio minimum for group insurance, which had not previously been addressed by the NAIC (or by any other organization) in its models.

The 60% loss ratio minimum for individual Medicare Supplement policies is consistent with the NAIC guidelines and there is a reasonable opportunity for most companies to achieve that standard, given the relatively generous level of benefits required for a policy to be considered a Medicare Supplement. As for group policies, it must be remembered that the Baucus Amendment does not apply to most group contracts, the traditional ones

issued to an employer for the benefit of his employees, or to a labor organization for the benefit of its members. The exemption also applied to most association contracts. And mass marketed policies, solicited by mail and by printed or broadcasted advertising, were considered subject to the individual guideline of 60%. Accordingly, only the more esoteric forms of group coverage would in practice be required to meet the 75% loss ratio standard, and for them it might well be considered a reasonable target.

Since June of 1980, the impetus for the insurance industry has been to encourage the adoption by all of the 50 states and several additional jurisdictions of the NAIC Model Minimum Standard Law and regulation, modified to include the loss ratio requirements of the Baucus Amendment. Successful implementation of this modified minimum standard approach would effectively preclude the application of Federal certification standards in any jurisdiction, and federal intervention in the business of insurance regulation would once again have been forestalled.

So much for the enduring battle between the states and the Federal government for the right to regulate the insurance industry, which might, just possibly, prefer to be unregulated. . . although I would think that no regulation might prove to be a greater curse than regulation by either the states or the Federal government!

What about the basic ethical problem of providing coverage which is essentially low-risk in nature, so that expenses constitute a relatively high proportion of the premium? Admittedly, this is an ever-present consideration, particularly for a company like my own domiciled in New Jersey where there is currently a very great concern over the validity of coverage which produces a loss ratio of less than 50%. But we are talking about Medicare Supplement coverage which, by its design, picks up significant deductible and coinsurance gaps. I would judge that the 60% loss ratio minimum for such individual policies is a reasonable one, and that the availability of adequate Medicare Supplement coverage will not be adversely affected by the Baucus requirements.

Clearly, the administrative requirements of a mandated contract complying with the Baucus Amendment provisions pose a substantial burden for a company which would prefer to avoid such a market. A Medicare Supplement contract will now have to pay special heed to anticipated loss ratio requirements, will have to consider the need for outlines of coverage and the presentation of a buyer's guide, and will have to address with some concern the matter of agent training and control. But these restrictions are, in the final analysis, matters of good business judgment. The very existence of abuses in the area of Medicare supplements suggests that the industry should have been doing a better job, not just to avoid public censure, but to serve its public better! Whenever the industry does its job properly in an area of the public interest, you will not find that subject on the agenda of a meeting of the HIAA, or the NAIC, or the Society of Actuaries! There will be no medals or prizes handed out for having done a job well, but there is a built-in reward in not having to answer criticism. . . it lets you get on with the work to be done.

MR. W. KEITH SLOAN : We have been issuing these policies for several years. There is one small misconception about the loss ratio standard which was actually included in the NAIC's guidelines for loss ratio standards. This

inclusion was a result of the activities of the Medicare Supplement Task Force.

One of the major problems that we have is that none of us have had any facts to work with. Where possible, we should get facts; if not, we should have informed opinions. I would like very much to urge an investigation into these costs, as otherwise we're flying in the dark.

These policies are extremely expensive to administer, due to the large number of claims, and the low size of the claims. I've seen a claim as low as 80 cents, which is hardly an economical way to proceed.

The difference between policies that conform to the Medicare pattern, including Medicare's limitations as to reasonable and customary, and those that try to fill in, is dramatic. In 1979, we developed a fill-in policy. As of the end of last year, our loss ratio was 97%. By contrast, our standard Medicare supplement has a loss ratio of 65%.

We have had our problems with abuses, and one of the actions that we took as a result was to decline anyone over the age of 84, because the complaints just multiply exponentially. However, not all the complaints are valid. In one instance, a nephew hotly complained about our agent who had sold his uncle a policy when he already had fourteen. We refunded the premium, but also asked if all fourteen policies were in force. The check was returned with a request for reinstatement, as none of the fourteen were in force.

MR. GARY FAGG: Most of the regulatory and consumer complaints against credit accident and health insurance are actually a case of mistaken identity. The accident and health side of the credit insurance business has faced guilt by association with the life insurance element of credit insurance. Many of the articles which have been written in the past several years have focused on life insurance with only an aside concerning accident and health. The Consumer Report article in June 1979 is a prime example. Here is an excerpt from that article:

> "Credit disability insurance (accident and health) is considerably more costly than credit life. In many states a common type of policy costs $2.20 per $100 of initial loan per year. CU doesn't have a yardstick against which to gauge the fairness of this cost, as we do with life insurance. However, we suspect that credit accident and health insurance is also grossly overpriced."

There are three major problems which have emerged concerning credit A&H. By far the most prominent concern deals with the perceived loss ratios. Other problems have arisen concerning the pre-existing condition clause in many A&H contracts and the payment of refunds on early terminations.

To understand the problem with the loss ratios, a bit of history is necessary. The credit insurance industry began selling only life insurance. The rates which were charged have proven to be redundant. Accident and health coverage did not begin in any volume until the late 1950's. Traditionally the companies paid the same compensation on life insurance as they did on accident and health insurance. The result has been that credit insurance companies have consistently lost money on the accident and health line of business. For many years this was not a problem from

the company standpoint. Credit insurance companies view the combined products as one line of business. Profitability was not seriously reviewed individually, but on the combined results.

During the 1970's the accident and health experience deteriorated rapidly and significantly. At the same time the life insurance experience was continuing to improve. Faced with this situation, regulators were unwilling to recognize the problem and allow upward rate deviations on accident and health insurance. In 1974 there was a study of credit accident and health experience. The 1974 study showed dramatic increases in claim cost over the prior study made in 1968. The new table was rejected by the NAIC and has never been adopted. Although there were technical flaws in the study due to the available data, the real reason for the rejection was the unwillingness of the regulators to accept the results.

A second major problem has been the fact that credit accident and health has been reserved based on the Rule of 78 unearned premiums. This is one of the few examples in statutory practices where the prescribed valuation basis is inadequate. However, there were not definitive studies on which to base morbidity reserves. The Rule of 78 is simple and understandable. Unfortunately it produces inadequate reserves which result in understated loss ratios. Even with the Rule of 78 reserving basis, the loss ratios have always been defensible. Few blocks of credit accident and health insurance produce loss ratios below 50%. This was the NAIC bench mark until 1979. The loss ratios at Credit Life have ranged from 65% to 80% over the last five years.

The outlook for solving this problem is good. A special study committee of the Society of Actuaries was formed in late 1979. This committee is now conducting a pilot study of credit insurance experience and hopes to have results available for the fall meeting. From this study, an industry study will be designed. The study has been hampered due to the way the industry has maintained its data. Credit insurance is inherently a simple product, and many of the computer systems developed by credit writers have reflected this fact. Many of the companies simply do not maintain the detail necessary to produce a study with all of the detail normally found in Society studies. The pilot study hopes to identify the necessary parameters critical to a valid study. Hopefully, the industry will then begin to maintain data capable of producing valid future studies.

The regulatory trends have been good. The current trend is to set both the life and the accident and health rates at the proper level. While this has meant significant decreases in the life insurance rates, the accident and health rates have been significantly increased. The most recent New York and California regulations are typical of this process. We are moving towards a situation where the two lines of business will stand alone and will be self-supporting.

Lastly the NAIC revised its bench mark loss ratio from 50% to 60% in 1979. Several of the new regulations implemented or proposed since then have incorporated a bench mark loss ratio of 55% or 60%. The proper loss ratio is clearly a subjective matter. The trend to the higher required loss ratios should alleviate at least some of the consumer pressures and provide a more defensible product.

From the product standpoint, the most common insurance department complaints come from the existence of pre-existing condition clauses. Much of the credit insurance written today is sold without any restrictions on pre-existing conditions. This type of product obviously faces anti-selection problems. Until the last several years, the premium differential which was allowed if pre-existing conditions were covered was sufficient for the risk assumed. Traditionally companies have been allowed to charge 10% more if they covered pre-existing conditions. Excluding the anti-selection factor, this rate differential is adequate. However, in depressed economic locations, the anti-selection factor overcomes the rate differential. The result of these trends is that more and more insurance is written excluding pre-existing conditions. Since the coverage is not sold by professional insurance agents, there is a strong likelihood that many consumers will not understand the pre-existing conditions. Needless to say few consumers ever take time to read their certificate of insurance. Therefore, the industry must find a way to properly communicate the limitations of the policies recognizing that complete consumer understanding will never be achieved.

Refunds on prepayment of loans have always been a problem. Many of these problems have been solved in the last ten years. Consumers are more aware of their insurance and of the refund provision. Secondly, the regulatory constraints placed on banks and large finance companies have resulted in almost full compliance by these credit insurance producers. The major remaining problem is third party paper. This is primarily the automobile dealer market. Unfortunately, there are few solutions to this problem. An increased consumer awareness of the refund provision is probably the best way to attack the problem.

One proposal which has yet to be implemented is a buyer's guide. A buyer's guide makes a great deal of sense, but it must recognize the basic expense margins which are available in credit insurance for the administration of the product. Any buyer's guide must be a mass produced type product with no items of an individualized nature. A simple pamphlet specifying the nature of the coverage provided, a clear and concise statement of the limitations of the policy, and a notice to the consumer of the refund provision would solve many of the consumer complaints.

Our major concern as an industry is that our future problems may lie in the solution to the current problems. Adequate A&H rates will be significantly higher than the current rates. These rates may prove unsaleable and may result in anti-selection. Several of the disability income markets, **notably** the mortgage A&H market, have seen rates increase to the point where the anti-selection destroys the product.

Higher required loss ratios, while defensible from a consumer standpoint, are reaching the point which are dangerous to the companies solvency. In New York, the required loss ratio varies from 65% to 75% depending on the coverage and the creditor involved. These ratios are extremely high given the volatile nature of the credit A&H product. Lastly, some of the new products which have been developed to fit the new lending environment are susceptible to consumer misunderstanding. Several areas of the country are now writing critical period coverage. This is simply disability income coverage where the benefit period is twelve or twenty-four months. This means that the credit insurance product will no longer have a benefit period equal to the term of the loan. A second product has been named

truncated life. This is used in the long-term market, primarily second mortgages, mobile homes, etc. Here the insurance sold may cover only the first five years of a loan. Here the consumer will find that the coverage of the policy does not extend to the full term of the loan and will result in misunderstandings.

Overall, the future of the credit accident and health product will depend on the state of the economy. If our current economic conditions prevail during the 1980's, the future of this product is in doubt.

MR. JAMES H. HUNT: I could spend quite a long time responding to Mr. Fagg, but I don't intend to do that. Just let me say that in many respects there is another side, namely, the consumer viewpoint. I know the author of the Consumer Reports article that Mr. Fagg referred to, and also I was consulted on the article. Mr. Fagg is entitled to criticize the author's assertion that the loss ratio on credit disability is too low, but I am not sure that the author is wrong. From the consumer viewpoint, a loss ratio of 65% is too low due to the single premium nature of the coverage. This single premium coverage covers terms of at least five years, and is financed at rates upwards of 20% or 25% annual percentage rate.

I think that a consumer buying credit disability would be unhappy with the fact that no investment income is being used to compute the loss ratios. We find this to be a serious problem that becomes more serious every day as interest rates rise.

There tended to be an assumption, I think, in Mr. Fagg's remarks that whatever compensation rates to the creditor are prevalent, are givens and not to be questioned. There is no question that creditors squeeze independent companies such as Mr. Fagg's for all the compensation that they can. That makes it difficult for the insurer to make a profit, especially in a line as difficult as credit disability. But that shouldn't make these compensation levels given, and it's toward reducing these levels that the National Insurance Consumer Organization has been working.

I think many of us would agree that if you push in on the balloon of credit disability rates that it will come out elsewhere, either in higher prices or in higher finance rates, and I am not King Canute in that respect, either. But each of these can be seen by the consumer and evaluated a lot better than he can evaluate whether credit life or disability is over or under priced. Our goal, then, isn't to be concerned about credit insurers who have a very tough time fending off demands from creditors, but instead to squeeze out the compensation to where it can be seen.

MR. FAGG: The basic structure of rate making is to divide the claim cost by the bench mark loss ratio to produce the gross premium. If there were a set, proper bench mark ratio to use, then Jim would be right, investment income should be considered. But an exact number is not available, but instead we use a broad, general number as 50%, 60%, 70%, etc. Why complicate matters with investment income? The regulators should recognize that the companies earn investment income when setting the bench mark loss ratio.

MR. FRANK J. BUSH: The states have been playing around with regulations for 20 years, and at one point it looked as if each would have its separate regulations. What's the prospect that one day there'll be a workable minimum, perhaps even one single standard?

MR. FAGG: To me, a realistic objective would be about 20 standards. We operate now under 50 different standards, and it's a big problem for us. The credit industry is becoming more complicated than ordinary insurance. It's unbelievable that a simple product could be handled so many different ways. Only five states adopted the old NAIC bill without significant modification. We now have a new NAIC model bill. While the model bill may not get much wider acceptance, there may be 10 or 15 states that will accept it. Many states are adopting the experience reporting forms of the new model, which is a big help. The new forms are much better than the old, and I hope that as many as 30 or 40 states will accept them. This would solve one of our real problems, as now almost every state has their own reporting format. Standardization would mean that we have come a long way.

MR. CHARLES HABECK: I recently ran across a very interesting book. To begin my talk, I'd like to tell you about it. The book is called "Burrs Under the Saddle." The author is Ramon F. Adams. Adams is an historian of the early Western United States. He has written a number of books on this era of our history. I immediately recognized that this was the most authoritative book on horses and the people who ride them since the publication, in 1838, of Jorrocks' Jaunts and Jollities by Robert Smith Surtees.

I have not read through this book and you will soon see why. In the span of just over 600 pages, Mr. Adams carries out a painstaking process of correcting the various errors that repeatedly have crept into the retelling of the exploits of the outlaws and gunmen of the old West. He reviews 424 different accounts and shows where they have gone wrong.

For instance, we learn how many men Wild Bill Hickok really killed singlehandedly that day at Rock Creek Station, and that his real name was Jim, not Bill. We get the true facts about Billy the Kid, Calamity Jane, Wyatt Earp and the James Brothers. Jesse James never did pay off that mortgage for the widow, we discover. But these versions of "history"--sometimes described as "traditional accounts"--die hard, and like all myths, are not soon forsaken.

At this point, I have to say that I read only the introductory material and a few scattered passages before turning to the end of the book to find out where it all was to lead. This was a mistake.

Mr. Adams informs us in the closing pages that unfortunately, just before the book went to press, yet another faulty book about the West had appeared. And it contained all of the same errors that he had just got done pointing out! He found this "most discouraging." In his place, I would have used stronger language, had my expectations been similar to his.

It is from within this frame of reference that I want to take up the topic of cancer insurance. What are the parallels? (1) One could write a book about cancer insurance and its history. (2) One could carefully document all of the errors--and there are a few of them--in the newspaper accounts, staff reports, transcripts of regulatory hearings, and so on. (3) The process could consume the better part of a lifetime. (4) The impact of such an effort is likely to be quite small and, in turn, limited to a very small audience, in contrast to that much larger population that can only be reached via the mass media.

I believe that the history of cancer insurance has already been written and that there is very little that anyone can do to change it. Except in the most extreme circumstances, one could perhaps go to court. Yet the current climate treats as overreaction any insistence on one's right to due process.

The world does not need another discussion of cancer insurance, even if it is less than book length. There is plenty to talk about now, and more is likely to be produced unless a new "whipping boy" can be found.

Just out of curiosity, I tried to find out how big a deal cancer is and whether anyone has a right to be afraid of it. I took a look at Ulrich's International Periodicals Directory at my neighborhood library. Under the heading "Medical Sciences - Cancer" I found a list of 85 medical publications that focus strictly on cancer research and treatment; 85 items, published in 24 countries all over the world. That's how big a deal it is! This intense preoccupation with the cure of this dread disease--if I may call it that--has a direct bearing on the psychology explaining the public's acceptance of cancer insurance products.

It seems to me that the regulators have ignored this psychology entirely in their response to specific objections that relate to cancer insurance. Let me try to identify a few of the main issues that have arisen, and then provide a few comments to test how valid these charges are.

1. It is said that plan design is faulty. This objection refers to the package of benefits offered. Benefits tend to be scheduled. Covered losses usually relate to a period of hospitalization. Fifty dollars a day doesn't cover much.

   These arguments may have some validity, but the problem arises because the consumer does not understand the scope of benefits, not that the package is poorly designed. The design is proper for benefits that are intended to supplement those of other programs. The more appropriate regulatory response in this case is to call for fuller disclosure requirements, and for penalties in the event of misrepresentation. There is currently a trend in this direction.

   The regulators should understand that the product should be considered for what it is, and not for what it is not, regardless of who decides what it "ought" to be.

2. Sales tactics are questionable. The point is made that the prospect does not understand the risk of developing the disease. Therefore, he or she cannot make an informed decision as to the value of the benefits in relation to the premium charged. Data on cancer incidence is presented in a misleading way. These objections can be met by controlling the sales materials, and by penalizing agents or representatives who excessively emphasize the prospect's natural fear of cancer. I say "excessively" because the fear is present in all of us. "No word is the English language is more chilling than cancer" says Dr. Epstein in his book, The Politics of Cancer.

3. Sale of cancer insurance to the elderly. This was the practice that aroused regulatory interest once the scope of the abuse became apparent. The effort to protect the elderly then expanded to include sale of this product to those under age 65. The criticisms have to be granted since the facts are there to support them. The need for additional controls at the point of sale became obvious.

4. Claims procedures are too strict. Some have objected to the required diagnosis by a pathologist, including microscopic examination of tissue, blood or secretion. In some cases this is not even possible. On the other hand, it seems unlikely that a person who is told he has a cancer will not want valid and thorough confirmation of the diagnosis, much less rely on purely clinical observations. Second opinions are becoming a common feature of surgical provisions to avoid unnecessary treatment. This charge does not seem to have much substance.

5. Loss ratios are too low. This objection has been treated at great length in many papers and discussions of the validity of loss ratios, and in fact, whether they mean anything at all, if viewed without regard to the marketing environment. The NAIC guidelines for premium rate filings allow an anticipated loss ratio of as low as 35%, depending on the average annual premium. The developing loss ratio is obscured in most financial reports by the influx of new business, so that aggregate measures tend to be suspect. A loss ratio of 45% in the aggregate can be favorable or unfavorable, depending on the circumstances. There are many facets to loss ratio analysis, such that controversy can arise simply because the parties to it are not always talking about the same thing!

These are the main issues that have been raised. There are also some spurious issues that tend to be irrelevant, but that we can discuss if someone raises one of them. In way of summary at this point, a number of the charges raised against the marketing of cancer insurance appear to be legitimate, but for the most part, these charges can be met through the proper disclosure procedures at the time of the sale.

In this connection, sales practices appear to have changed somewhat where abuse had been present previously. Buyers' guides have been required in some states, using the model form promulgated by the National Association of Insurance Commissioners (NAIC). However, I have not found much in the way of cost comparisons of specific products, since this approach is most difficult to carry out in a meaningful way. There are just too many product types, not all of which are scheduled. Comparison of dissimilar products would serve no useful purpose. (This result also has been found in some cases where supposedly similar Medicare supplement policies were being compared.)

The buyers' guide used in Wisconsin is the NAIC model. It spells out the nature of cancer insurance as a limited coverage, with exclusion of pre-existing conditions. It emphasizes that cancer insurance is not a substitute for comprehensive coverage. It advises the consumer to seek a major medical policy first, although it is more expensive.

In addition, the guide outlines a procedure for the consumer to follow to decide to buy or not to buy. Those eligible for Medicare or Medicaid are told they do not need cancer insurance. Then comes a warning about duplicate

coverage, and how the coordination of benefits feature of the basic coverage may act to reduce benefits under that policy (implicitly, it seems, "blaming" the cancer policy for this result). Some data are given on the distribution of costs along with lists of items that are not covered by any insurance, although once again the guide says only that these are not covered by cancer insurance.

The guide repeats the statistic that "only" one in four Americans will get cancer during a lifetime; it says the odds are against receiving any benefits at all. (There may be a small degree of comfort in these words.) Finally, the limitations are set forth as well as who to call for additional help.

The buyers' guide for cancer insurance ought to alleviate consumerist and regulatory concerns, but like everything else, its impact lies in the hands of the user. Incidentally, the Wisconsin Commissioner of Insurance informed the public of the cancer guide through a letter to the major newspaper in Wisconsin. It is hard to say just how much media effort is required to fully educate the public in this situation.

Product design for cancer insurance seems to be shifting a little toward the inclusion of a premium refund feature of some kind, although I do not detect a strong trend in this direction. There may be a cash surrender at age 65 (with intermediate withdrawal values) or the once-common 10-year rollover type. Obviously, the premiums will be substantially higher; loss ratios will rise too, possibly into the 60's, but reserve requirements will also have a significant effect on reported results. Note that the addition of the premium refund feature produces a different animal from the usual cancer insurance policy.

The comprehensive cancer insurance policy--without internal limits--is relatively rare. I have seen just one of these, and it exhibited all the characteristics of the typical major medical plan in that it needed frequent premium rate increases. Here again, comparisons fail when this type of product is set beside the fixed benefit type, and loss ratios in excess of 100% are praised. The imposition of a rate increase with a comprehensive cancer-care plan makes results even worse.

As to the long-range availability in the marketplace of a cancer insurance plan, I think most companies have become highly sensitized to the image problem with this product. This is unfortunate. It means that the option to market the product has been effectively reduced by actions of the regulatory sector in combination with the media who are always delighted to report controversy (it's their job). However, we are seeing a cop-out in some states where they have decided that cancer insurance may not be susceptible to regulation, and therefore, it must be banned.

The regulatory ban and the regulatory mandate constitute the two extremes in the spectrum of possible actions by the insurance departments. Neither of these extremes is desirable, and neither seems to be a rational answer to the perceived problem.

For instance, it is interesting to note that while cancer insurance is banned in a few states, the Medicare supplement coverage is mandated. This is hard to understand because many of the same charges seem to apply to both products. Both have limited benefits, both are meant to supplement other coverages, both have been involved with multiple sales, and so on.

As a general principle, it can be expected that regulatory activity of any kind will tend to reduce product availability. The effect of a ban is obvious; the effect of a mandate is less obvious, as certain companies withdraw their products entirely from that state rather than comply with the mandate, especially if it means they must enter a market they are not already in.

The last two questions on the agenda are interdependent to some extent. "Is it ethical to market a product with a low benefit payoff, high expense ratio?" I would prefer to say, "Is it feasible to market such a product?" My answer is that you have to start with a need. You can't create the need, you can only create the awareness of the need. If the product meets the need (and the need is legitimate), then the product serves a useful social purpose.

Expense levels relate to marketing methods. If a competing product can be sold for less than yours, due to lower marketing expense, then obviously your own product will not survive without some changes in methods.

The second part of this questions deals with acceptance of industry methods and concepts. The answer is similar to that for the preceding question, and that question is: "What can actuaries do to educate the public and regulators about pricing projections and premium adequacy?"

Actuaries can do a lot, but they can't do it alone. Actuaries must learn to function more effectively in both their internal and external environments. They must see themselves as team members, along with those from other functional units in their companies, and they must likewise learn to appreciate the views of consumers and the role of regulators in the whole process. At some point, actuaries must learn to deal more effectively with the media.

Last year, in another paper relating to regulation, I drew up a relatively simplified list of the concepts that we need to seek agreement on as part of our effort to educate the consumer and preserve the marketplace. Such an effort will have to involve our schools as well as the media. Otherwise, I don't think it will have much long-range impact. Here are some of the things we need consensus on: (There are 10 items in all.)

We need to agree:

1. That the price for a retail product is necessarily greater than that for a wholesale product.

2. That the loss ratio test is not a measure of product suitability in given circumstances.

3. That agents deserve adequate and proper compensation for services performed for both the insured and the insurer.

4. That consumers deserve an insurance product that does what they think it will do, while giving them this protection at a fair price.

5. That "insurance" is <u>not</u> defined as protection provided to "those who need it the most."

6. That government-sponsored or self-insured health programs operate under the same basic principles as do private health insurance programs.

7. That the appointment of experienced and knowledgeable insurance persons to state insurance departments will not compromise the regulatory mission.

8. That regulation should foster competition.

9. That product availability is inversely proportional to the coercion index of the regulation that governs it.

10. That insurance companies are private business enterprises serving public needs, but are not public utilities and are not consumer co-ops.

Of course, these concepts apply more generally to health insurance products, not just to cancer insurance. Broad acceptance will better balance the critical interests of all parties to the social transaction. Such acceptance will also allow market forces to resume their proper role in benefit design and pricing of health insurance products.

MR. SLOAN: I am sorry that Charlie did not mention the call for experience that went out recently. The NAIC's C-4 subcommittee is developing a morbidity table for valuing cancer policies. The call has gone out for information, and any company that can contribute will help the profession considerably.

MR. HUNT: Charlie said that plenty has been said about cancer insurance, and then proceeded to give a fairly lengthly defense of cancer insurance. I will identify myself as one who has had something to do with the ban on cancer insurance in New Hampshire and Massachusetts. And I would like to point out that in Connecticut that the ban was by legislation.

I'd like to comment about a statistic that Mr. Drake used to start off his otherwise elegant review of Medicare supplements. He referred to a widely quoted statistic that, I believe, originated with the Federal government, that Medicare covers only 38% of the elderly's health care expenditures. This has irritated me for several years, and I have tried without success to correct it. I believe it puts Medicare payments in the numerator, and everything else in the denominator. I believe the denominator includes toothpaste, cosmetics that fall under health care, and it must include dentistry. The denominator includes items that no one would expect to find in a comprehensive major medical program. I think that Medicare actually covers better than 70% of the services that it was designed to cover, and I encourage the Health Care Financing Administration to do a little research on this misleading statistic.

MR. HABECK: I would like to respond to the charge that I have made a defense of cancer insurance. I consider this a misconstruction. Last year, I presented a paper to the Casualty Actuarial Society on the impact of regulation on individual health insurance. One member of the audience said "This is the first defense of cancer insurance that I have heard." I replied that I was not defending cancer insurance, I was just trying to discuss it objectively. But this is the response that objective discussion elicits.

The only comment that I have regarding the ban is that there have been bans on cranberries, and bans on saccharin. Now they are trying to ban cancer insurance because they must think it causes cancer. Even coffee is suspected of causing cancer, but I doubt if banning it will get a great deal of public support.

MR. DRAKE: I share Mr. Hunt's discomfort with the 38% Medicare figure. I, nevertheless, quoted it for the purposes of my remarks, but I find no way to relate it to other statistics available from HCFA and which are rather well documented. For instance, short stay hospital claims--stays for less than 30 days--are reimbursed at about 71% of total charges. Physicians charges are reimbursed at about 77% of allowed reasonable and customary charges, or about 70% of total charges. So there must be a lot of extraneous material in the denominator to get the reimbursement level down that low.

MR. ROY GOLDMAN: These three types of insurance--Medicare Supplements, cancer insurance, and credit insurance--are supplemental to other coverages and do fill a need. If the buyer had a complete understanding of what these policies covered, and what he was paying for, then it would certainly be fair to offer these policies, and for some people they would provide a coverage for a real need. Now, it's easy enough to provide a buyer's guide. You can get them for Medicare Supplement plans from the government for 15 cents, or you can print them yourself for three cents. You can pass them out, but I don't know whether anyone reads them. It's a long, involved guide, and I would be interested in knowing how much consumer awareness it really provides.

I would like to ask the panel whether the NAIC Model, and Baucus Amendment, allow insurance companies to offer Medicare Supplement policies that do not cover the minimum requirements of the NAIC Model Bill. Could a plan be offered that covered the deductibles and coinsurance payments of Part A Medicare, if it had proper disclosure, an outline, a buyer's guide, and a 30-day refund privilege?

MR. DRAKE: In my opinion, yes, it can be offered. It cannot **advertise** as a Medicare Supplement, because it does not meet the standards, but it can be offered.

MR. HABECK: The type of plan that you are talking about was included in the Wisconsin Rule 3.39 as Plan 4A. Since the Baucus Amendment has come out, they have had to eliminate that alternative.

MR. GOLDMAN: A plan supplementary to Medicare Part A only would have to have a label on the outline or certificate to the effect that it is not a Medicare Supplement plan. I don't see how this is going to help the buyer, because such a plan most certainly is supplementary to Medicare.

MR. GEORGE CALAT: I am quite sure that Baucus was never intended to outlaw plans that did not meet the minimum requirements of the NAIC model. We have tried to give an incentive to companies to offer only policies that meet the NAIC minimum guidelines, but I do not believe there is any intent to outlaw policies that do not meet them.