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REGULATION OF GROUP INSURANCE AND INDIVIDUAL HEALTH INSURANCE

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MR. DON F. FACKLER: This afternoon we intend to look at regulation - specifically as it relates to Group Insurance and Individual Health Insurance. Regulation, and the threat of regulation, continues to expand. Each year our associations are faced with an increasing number of bills which are admitted for legislative action. For example, only six states introduced more than 3,000 bills in the 1954 and 1955 session; eleven states presented 3,000 or more bills in 1964 and 1965; this increased to twenty states ten years later in 1973 and 1974. In a comparable period between 1972 and 1975, there was a 33% increase in total legislation, while bills pertaining to insurance rose over 50%. A significant number of the insurance bills introduced in 1976 affected the Group Insurance side of the marketplace. Indications are that similar increases have continued to take place. Since insurance is principally a state issue, the industry is faced with a multiplicity of regulatory responses. Each state has its own variation of a "model" bill. However, this does not indicate that one regulatory response is better than many. Perhaps no response - which transaltes into no regulation - is a better response in some instances.

Some will say that the conservative attitude expressed during the last national election will effectively limit additional federal legislation. However, I do not see that it will have any significant impact at the state level or, for that matter, at the federal level.

We intend to define some of the major issues facing the industry and the responses to these issues. Our panelists today are students of the regulatory process. Robert Shapland will first discuss Individual Health. Vince Donnelly will comment on Group Insurance, both Life and Health. This will allow Vince to highlight a distinction between Group Insurance and Individual Insurance, at least the way he sees it, in relation to regulation.

At this point, I present to you Bob Shapland.

MR. ROBERT B. SHAPLAND: I think one of the major issues facing insurers in the '80's is survival of Individual Health Insurance lines, especially medical care; at least, survival as we know it now. We have to survive until the economic or environmental situation improves. Of course, one of the biggest problems is not regulatory. Inflation is increasing costs in medical expense policies very rapidly, and this is compounded by deductible features. Inflation is also increasing Home Office administrative costs. These increases bring about the need for rate increases, and these rate increases may drive out the good risks and leave a deteriorating pool of poorer risks in this type of environment. In addition, extra lapsation from rate increases impairs ability to amortize initial expenses.

Medical care costs are also affected by increasing utilization. For example, testing by doctors is increasing, and increased hospital outpatient utilization is taking place. With good intentions, regulators have been forcing us to

cover hospital outpatient expense on the premise that it would keep people from going into the hospital. Now people are replacing office visits with visits as hospital outpatients.

Another factor is, indeed, regulation. We see limitations put on our ability to raise rates, either through rules being adopted or delays taking place in the insurance department approval process. Another reason for increasing Home Office or administrative expenses is the nonuniformity of benefit rules and regulations. Each state is going its own route telling us what we have to sell, and that nonuniformity is causing increases in expenses. They are also increasing benefits after issue of a policy by passing laws and regulations that require payment of this benefit or that one. Another serious impairment is the increase in risk that is foisted on the insurance industry through the rate regulation process. A formula has been adopted that says: If we earn profits in the early years, we have to give those profits back through losses in the future; but if we have losses in the early years, we cannot recover them.

In summary, I see a building conflict between the increasing demands of regulators with respect to loss ratios and benefits and the inflationary environment. I do not see any change in the trend to multiplicity in requirements at the state level until it is clear that availability and solvency are being impaired, and that realization outweighs political pressures on regulators to do what they are doing.

Let's turn now to various areas of state regulation. Of course, an actuary's first concern is rate regulation. There are many things giving impetus to rate regulation. One of them, of course, is the Baucus Amendment, and states are passing benefit and loss ratio rules for Medicare supplement policies to prevent the federal government from being involved in Health Insurance. If states are passing regulations for Medicare supplement policies, why shouldn't they regulate other types of Health Insurance? So they are adopting regulations that extend beyond the Baucus Amendment. Model rate regulation adopted by the NAIC in 1979 would lead various states to pass regulations or to amend theirs. On the other side of the coin, public reaction to rate increases is a main driving force to rate regulation. Every time a policyholder is disgruntled about a rate increase, he complains to the regulator. The regulator reacts by asking himself what he can do to cut down the size of rate increases. I perceive that regulators also feel some responsibility to hold down medical care costs. They can do this by putting pressure on insurers, and they can put this pressure on by putting a squeeze on profits. We have all heard about abusive cases of extremely low loss ratios and the need to correct for that.

What is my prognosis for the '80's for state rate regulation? I see continued expansion to more states as this public pressure comes to bear on all of the states. For states that already have rate regulations, I see pressure building for adoption of higher loss ratios. I think the economic situation is such that these higher loss ratios probably will not be adopted in many states. I see this pressure creating a desire or an impetus on the part of the state to spend a lot more energy enforcing the rules that they have. But I see a continuation of the nonuniformity of rate regulation. I believe that the NAIC Model will limit the expansion of nonuniformity, but I believe nonuniformity will continue. I think this is evident in the states that have already passed or adopted the NAIC Model. Almost every state has made some kind of modification based on what they think is right.

What is the current status of rate regulation? We went through a tabulation - which might not be 100% accurate - and we found twenty-three states that have formal Medicare supplement loss ratio standards; nineteen states that have standards for other kinds of policies; several states that have informal standards that they are applying; and seven states that with some regularity indicate that they are reviewing our rate filings and asking questions, and so they are regulating rates to some degree.

Before going on to another area, I would like to mention a few of the issues that I see involved in the rate regulation area.

1. Should favorable past experience impact on future rates? In other words, if you have lucky experience, should you have to give that money back? If you have unlucky experience, you cannot recover it.

2. Can insurers reduce their filed loss ratios? In other words, if they filed a loss ratio on a policy form ten years ago at 60% and inflation increases their expenses, are regulators going to allow them to reduce their loss ratio on a rate increase to 55% or whatever?

3. Should insurers pool old and new blocks of business together for rating purposes to avoid the deterioration pools or closed block pools? Should there be funding requirements for Individual Health Insurance to cover the health deterioration process so that insurers cannot go through a deterioration pool for their insureds?

4. Should coverages requiring high percentage expenses be barred from sale?

Another aspect of current regulation (and I see no let up in this area) is benefit regulation. This will continue on a nonuniform basis, again, until availability or solvency is threatened. There are many types of regulation: expansion of coverage provided (midwives), the adoption of minimum benefit standards in general, the expansion of minimum benefits for certain health conditions (mental disease and alcoholism), and requirements to cover certain types of care (out-of-hospital services and second surgical opinions).

I believe this proliferation of nonuniformity has added very significant cost to the insurance industry. At the same time, regulators are telling us we have to cut our expense ratios. State regulators and legislatures must recognize these costs for Federal regulation. For example, we are just now forming a new Medicare Supplement policy, and we have twenty-nine state versions. We recently brought out a major medical policy which required forty-one state versions.

Another area of regulation or law that can have impact on the viability of Individual Health Insurance will be state impaired risk pools, depending on the economic burdens that they put on the insurance industry. Some of the issues in developing state pools are: what level of subsidization should there be under the pool, and if there is going to be subsidization, who pays for that subsidization; also, what level of benefits should these people be able to buy, and what waiting period should they have to go through. I think there are five states that have pools right now, and I see definite need to provide insurance for these people.

A final area of regulation is possible restriction of risk classification, especially dealing with sex. We have bills at the Federal level. For example, H.R. 100 would ban differences in benefits or rates based on sex. There are also NAIC proposals to require unisex ratings.

I believe these attempts will continue to be successful in the employee-related benefit plan areas, because laws there are slanted toward discrimination in employment. I see the educational process winning out in other areas, both at the NAIC level and at the Federal level. I believe we are now educating legislators and others to the fact that the viability and availability of coverage can be dependent on risk classification so that we are not selected against and we can operate in a free enterprise system.

Going beyond that, I see building pressure for refining and defining risk classification. There have been proposals in a couple of states that insurers recognize smoking or drinking habits in a rate classification system. I can see comparative reasons and solvency reasons for insurers themselves to engage in expanding risk classification, especially in areas where the public controls health, not only drinking and smoking, but exercise habits and other health habits.

I would like to urge all of you who are not involved in the regulatory process to get involved. There are many things taking place, and they have impact on our ability to survive. For example, the NAIC Actuarial Advisory Committee met Sunday in this building, and they discussed many issues. There were few people from the industry there to express their viewpoints. There were lengthy discussions on rate regulations and many of the issues I just discussed. There were serious questions about valuation standards and dual standards - one set of regulations or standards for rate purposes and another for annual statement solvency purposes. There are discussions going about non-forfeiture benefits in return-of-premium policies. There are issues like sex discrimination.

MR. VINCENT W. DONNELLY: I am on the actuarial staff of the ACLI. I would like to just make some qualifying remarks. I will be dealing with the subject of Group Insurance. I have spent twenty-one years in the Group Insurance business. Fifteen of those were spent on the company side and six years have been spent with the ACLI. My formal comments will basically build off of my last six years' experience, but I want to emphasize that they also relate heavily to the experience on the company side. One further qualifying remark. I am going to make some comments that, from the Group Insurance side and from the regulators' side, and perhaps even from the Individual side, may get your dander up. I am not speaking on behalf of the ACLI at this session. These represent my own personal thinking, and I hope they will encourage you to react.

Group Insurance is no longer the stepchild of the Life and Health Insurance business.

Actually, Group Health Insurance never has been. According to a recent publication of the American Council of Life Insurance, Group Health Insurance premium income for U.S. life insurance companies has exceeded Individual Health Insurance premium income for more than thirty years, and in 1980, using current dollars, was more than 3 1/2 times greater.

But Life Insurance, and, more particularly, the volume of Life Insurance in force, has always been the real standard by which those in and out of the business have traditionally measured "status" - and by that standard, Group Life Insurance finally achieved parity with Individual Life Insurance in 1980. And, since Group has shown a greater rate of growth than Individual since 1967 (Group volume has increased 4-fold while Individual volume has increased 3-fold), it is expected that future in-force volumes will reflect Group Insurance as an increasing percentage of the total market.

You are probably saying to yourselves, "Why is the relationship between Group and Individual Insurance important, especially in a discussion of the future course of the regulation of the insurance business?" Simply this -- I contend that the regulation of Group Insurance is being conducted as if Group Insurance is merely an extension of the Individual Insurance business. Group Insurance is now a business in and of itself and deserves to be regulated in the future without regard to the historic concepts which will continue to guide the regulation of Individual Insurance.

Since the election of President Reagan last November, we have all heard again and again the new Administration's efforts to achieve substantial regulatory reform will rely on emphasizing more efficient, less expensive and less burdensome regulatory techniques. William Bailey, President, Aetna Life and Casualty, in an article published in the September 19 issue of the National Journal, made the point that ". . .regulatory trends affecting U.S. business as a whole parallel. . .trends underway with respect to insurance regulation." Mr. Bailey is certainly on the right track when he says that our business supports regulatory reform -- but I am here today to try to convince you that a major reformation in the regulation of Group Insurance is necessary if that business, as we like to think of it today, is to survive.

I think it will be beneficial to your understanding of the remainder of my remarks if you operate with a simplified definition of Group Insurance. Every time I refer to Group Insurance, you should try to picture an employer who has purchased a policy of insurance on his employees. Now, I fully recognize that the word of Group Insurance has gone well beyond the standard employee-employer type of group -- however, right now and probably into the foreseeable future, employer-employee groups will be the major source of Group Insurance premium income and will be the primary type of group adversely affected if the current trend in the regulation of Group Insurance continues. It will also make my comments less confusing if you only have to evaluate them with respect to one type of Group Insurance business.

Earlier, I established that the Group Insurance business is a business in and of itself, based upon premium income and volume of Life Insurance in force. But I would be the first one to admit that sheer size alone does not justify different regulation. Probably the best reason for regulating Group Insurance differently is simply this -- it is different from Individual Insurance. As pointed out by Patrick Burns, Executive Vice President, Confederation Life Insurance Company, during a recent speech at the LIMRA Group & Pension Marketing Conference, ". . .different not just in the range of benefits it provides and the manner in which it is delivered to the public, but different for one very important reason -- and that reason is that the buyer is different."

Now, you may also feel that just because the buyer is different does not justify a wholly different regulatory scheme. Well, in order to appreciate the importance of my argument of the different buyer, you have to first appreciate the type of regulation currently facing the Group Insurance business. Laws now on the books in the majority of states tell Group insurers who they may offer insurance to (Group Insurance definitions), what products they may offer (licensing laws), the levels of benefits which must be provided to insured employees (so-called mandated benefits laws), the degree to which Group insurers may discriminate between insured and non-insured individuals (risk classification laws and regulations), and what Group insurers can charge (minimum loss ratio standards). Most of you would tend to view this as a body of regulation limiting what a Group insurer can sell. And you would be correct. Some of you would also have viewed this as a body of regulation which controls what an employer can buy. But you are only partly right on this score. And this is a very important distinction when considering the regulation of Group and Individual Insurance. In the latter case, laws that control what the insurer can sell automatically control what the prospect can buy. Not so in Group Insurance -- because the corporate purchaser has an important alternative, namely, self-funding.

Webster's Dictionary defines "regulate" as "bringing under the control of law..." The point I am trying to bring out is that when regulatory concepts, originally applied to Individual Insurance, are applied directly to Group Insurance, the results are distinctly different. In this case, laws designed to bring Group Insurance under greater control only serve to drive more and more business away from regulation -- that is, toward self-funding. Initially, financial incentives provided the primary encouragement to employers to self-fund, but today the avoidance of what is considered to be adverse over-regulation of the Group Insurance product is a driving factor.

In advancing my theory that Group Insurance needs to be regulated differently from Individual Insurance, I have brought two general arguments to the floor so far -- first, the sheer size of the business and second, the existence of a purchaser who has available an entirely separate risk-taking alternative, namely self-funding. But there are other factors which form the basis of general insurance regulations which, if allowed to persist, will adversely impact on Group Insurance.

State regulation is entirely compatible with Individual Life and Health Insurance. One contract, one state of issue, and one person insured. But state regulation is rapidly becoming a disaster in its current application to Group Insurance. The concept of state regulation is not inherently incompatible with Group Insurance -- it is the implementation of the concept which is causing the breakdown.

Mr. Bailey, in the aforementioned National Journal article, said it best: "Although the basic state regulation framework has remained unchanged, a far-reaching change in emphasis has characterized the insurance regulatory environment in the last fifteen years. This shift, which paralleled the move away from concern with economic matters to concern with social issues in the regulation of business activity generally, began late in the 1960's and continued through the 1970's."

This shift in emphasis from economic to social issues is characterized by three important developments insofar as Group Insurance is concerned -- first, the phenominal volume of laws and regulations it produces. Second,

the nonuniformity of the laws it produces from one state to another. And finally, and probably the most important to the future of Group Insurance, the tendency for legislators and regulators to apply this large volume of nonuniform laws to Group Insurance contracts issued outside their states -- the so-called extraterritoriality issue.

Eighteen states have passed laws relating to Health Insurance coverage of alcoholism treatment. Eight states have passed laws relating to Health Insurance coverage of drug addiction treatment. Eighteen states have passed laws relating to insurance coverage for treatment of mental illness. Five states have passed laws directly relating to mandatory pregnancy and maternity coverage. Twenty-seven states require the recognition of other practitioners of the "healing arts" in Health Insurance policies.

The Group Insurance business could probably survive the "avalanche" of laws and regulations. It could probably even survive the nonuniformity of such regulations, although at great cost. But the extraterritorial application of such a volume of nonuniform state laws will either kill the Group Insurance business or, more likely, kill state regulation of the Group business.

Regulation stressing financial soundness is compatible with Individual Life and Health Insurance. Any business which assures its purchasers of long-term guarantees must also assure those same purchasers of its continuing solvency. But the Group Insurance business has never emphasized long-term rate guarantees. Even when health care inflation was manageable, Group Health Insurance contracts never guaranteed their rates for more than two or, at the most, three years into the future. Today, inflation has forced Group insurers to include contractual provisions which allow a change in premium rates at any time with thirty days prior notice. The financial soundness of any particular piece of business today depends upon the Group insurer's ability to persuade the employer to pay the necessary rate increase.

Laws and regulations which address the solvency of insurers themselves are entirely appropriate and will continue to receive the support of Group insurers. But efforts to interject solvency standards into the actual Group Insurance contracts by means of maximum and/or minimum rate standards, minimum loss ratio standards, non-profit provisions, etc., again ignore the existence of the self-funding alternative alluded to earlier and, therefore, serve only as a detriment to solvency. Recent history shows that increasing numbers of Group Insurance clients are moving to self-funding, and to the extent that adverse financial soundness type legislation continues to be adopted, an increasing portion of the employee benefit business will remain beyond the grasp of insurance regulators.

If I have done nothing else here today, I hope I have convinced you that there are serious flaws in the regulation of Group Insurance and that, without correction, these flaws will further reduce the proportion of the fringe benefit market being retained by Group insurers and, therefore, the effectiveness of state regulation. It is, therefore, in the interest of both the regulator and the regulated to work out a new concept of regulation for Group Insurance, otherwise both will lose.

The $64 question is, "Can an acceptable compromise be reached?" Let's look first at the employer-employee arena. There, the regulation of employee benefit plans, and hence Group Insurance, is being debated under the banner of ERISA preemption. To those of you who work outside the Group Insurance

business, it would appear to involve a debate over state versus Federal regulation. Employers (i.e., Group policyholders) are seeking to throw out all state regulation affecting employee benefit plans. State insurance departments, through the NAIC Central Office, argue 180 degrees in the opposite direction. The Group Insurance business sits right in the middle of this tug-of-war taking the position that some state regulation is worthy of saving while other state regulation (e.g., mandated benefits laws, etc.) must necessarily be preempted if some degree of sanity is to return to the employee benefit field. With policyholders, insurers, and regulators taking distinctly different positions on the future regulation of the fringe benefit business, compromise can be expected. As far as the Group Insurance business is concerned, if compromise comes, it must treat insured and self-funded programs with parity or else Group Insurance will not long survive.

Outside the employer-employee market, the debate no longer takes on state government versus Federal government overtones. Here, I am talking about such Group Insurance vehicles as associations, credit cards, multiple employer trusts, etc. ERISA has no direct application to these types of groups. Let's call these schemes "mass marketing" to differentiate them from the more typical groups (employers, unions, etc.). Those of us in the Group Insurance business know that this is the primary growth area within our business and will continue to be into the foreseeable future -- with one important proviso, namely, accommodating state regulation. Right now this area of state regulation is getting close to chaos. Most states prohibit all but a few of these groups from purchasing Group Insurance, but a few (e.g., Missouri, Rhode Island, etc.) have no such prohibitions. Since the buying public appears to welcome these marketing devices, it is understandable that they spring up in the more liberal states and then proceed to extend into the more conservative states. It is this "spreading effect" which is encountering adverse state regulation. Some states apply their prohibitions extra-territorially saying no Group Insurance scheme can be extended into their state which could not have begun in their state. Other states permit the extension but require that their "residents" receive all the protection of their own laws. Without dwelling on the details, I think you can see that when it comes to "mass marketing", the administrative requirements brought on by all of this confusing state legislation serves as a severe bottleneck to its growth.

So what is the solution? Certainly, states have the right to protect their residents from abusive insurance practices. At the same time, insurers are trying to meet a growing public demand for these apparently cheaper Group Insurance schemes. I think a potential solution lies within the Model Group Life Insurance Definition recently adopted by the NAIC. If a state were to adopt this more modern Definition, it would thereby agree not to apply its own laws to specific types of groups (employers, unions, credit unions, etc.) when they are insured through contracts issued outside their state. Second, the new Model Definition would give the Insurance Commissioner authority to approve the issue of Group policies to so-called discretionary groups provided such groups met some general standards (e.g., actuarially sound, rates which are reasonable in relation to the benefits provided, etc.) stated in the Model Law. And finally, and perhaps more importantly, adoption of the new Model Definition would commit the state insurance department to allowing these so-called discretionary groups to be marketed within its borders even if the Group policy was issued outside that state, provided at least one other state had reviewed and accepted the particular Group policy.

What this all suggests is that state insurance departments are being urged to tear down their prohibitions and accept the concept that if a particular Group Insurance contract is being regulated by another state, it does not need to also be regulated by their state.

If Group insurers want to see this new concept gain acceptance, then they are also going to have to accept the imposition of regulation where none now exists (e.g., Missouri, Rhode Island, etc.). This may be a hard pill for Group insurers to swallow, but if it provides the necessary impetus for the state to swallow an even bigger pill (acceptance of a sister-state's regulation), it probably becomes worth the effort.

In conclusion, I hope that I have convinced you that Group Insurance has a future, but only if significant change in its regulation takes place. Also, I hope I have suggested some potential regulatory solutions.

MR. FACKLER: Thank you both, Bob and Vince, for your prepared remarks. I hope that you are now prepared for some unprepared remarks.

I noticed several similarities between Individual and Group. I heard you both mention survival, which I found quite interesting. Bob was talking about financial survival or regulatory survival. Also, in the Individual marketplace, you noted some type of state pool that might be collectively utilized as an alternative to what the insurance market may be able to deliver. In the Group area, an alternative which Vince pointed out quite emphatically in his remarks was the whole area of self-funding, which is a method by which you can avoid some of the regulatory climate.

MR. STARR E. BABBITT: One of the things you argued about with some justification is saying 'you have to pay'. In Tennessee, the Attorney General has now decided that school guidance counselors are clinical psychologists, so 'you have to pay' them. That is not a function of the regulatory process from a regulator's viewpoint. That was lobbying in the legislature, and I think if the industry got in there and lobbied too, maybe they could get somewhere. Our big fight lately is Credit Life. Try to beat the automobile dealers and the banks - you cannot do it. On Group Insurance, how come everybody is charging the maximum allowable rate for Credit A&H and Credit Life?

Charley Richardson, who resigned from our Department some years ago, in his farewell speech to the Nashville Actuaries Club said, "Until you have worked in an insurance department, you would not believe the things you see." I see things day after day signed by FSA's that I send back and say, "No way." The first thing I look at in an actuarial memorandum is the signature. A lot of those, that is all I have to look at.

MR. SHAPLAND: I hope there was no implication from here that regulators have a definite responsibility to fulfill for people of the states. Obviously, you have a different viewpoint from that of the actuary who is working for an insurance company.

MR. DOUGLAS C. HENCK: I wonder, Mr. Donnelly, if you would care to comment on a recent trend of regulations with respect to Blue Cross and Blue Shield. Various states are beginning to outlaw differentials and are looking at the somewhat archaic justifications for that differential. Where do you see that going?

MR. DONNELLY: The question has to do with the future trend of Blue Cross/Blue Shield discounts, essentially, the hospital discounts they receive, the preferential treatment that their insureds receive. Doug, it is primarily under the control of the Health Insurance Association of America, but everything seems to indicate that a trend is beginning away from Blue Cross/Blue Shield discounts. There are bills introduced in a number of states which have indicated that they are non-competitive, and (the bills) have every indication of going someplace. There is another type of discount that is being discussed and probably will be the subject of a National advertising campaign, and that is so-called cost shifting in the government system. That one is even greater in effect than the discounts. They are both important to the insurance business, especially to the Group Insurance business. I think that when we finally get the public and the legislators educated, we may very well see some trend away from them. It is going to be slow. It will go state by state.

MR. FACKLER: The HIAA has also, within the last three or four months, defined a number of states where Blue Cross discounts still do exist. My memory probably is not precise at this point, but I think there are less than 50% of the states where discounts still do exist. The trend has definitely been for the elimination, or, as in Maryland, waiver of the discount. At least for a period of time while state regulation is in effect, there will be a similarity of rates charged by the providors.

MR. RICHARD E. BAYLES: On the matter of discounts, one of the reasons there is a discount is that Blues have been paying in advance. About regulation, it is not all a one way street, I can assure you. I do think that it is better for both the Blues and the commercial insurance carriers to be working together on this regulation than against one another.

MR. DONNELLY: Dick, I assume you are talking about the non-rate type of regulation. The type of regulation that does not address what we charge as opposed to what we have to provide in the form of benefits.

MR. BAYLES: The Blues are subject to that, and at least we do not have to worry about multi-forms because each Blue Cross/Blue Shield is completed within one's state boundaries. If something is mandated, it is generally mandated for both the Life and Health companies and Blue Cross/Blue Shield. We get the added regulation on our rates, and we get public hearings on those. It is hard enough dealing with it in private, but when you have to deal with it in public, it is quite a show.

MR. DONNELLY: The point I was making was that we are both affected to the extent that regulation, in and of itself, drives people away from the insurance market. There is a rising tide of that type of regulation. You said we should join together. I think we have, essentially, in the past.

MR. SHAPLAND: What is the status of the difference in premium tax between the Blues and the commercial companies? Does that still exist with the hospital discounts?

MR. DONNELLY: I am not sure that there is the differential any longer. Most of the discussion that goes on, at least within the insurance business, is primarily aimed at the discounts, not the difference in premium tax.

MR. FACKLER: I think premium tax (differential) still does exist in many locations, but the 2 or 2 1/2% is somewhat academic in the discussion of discounts. When you are talking 15% to 40%, then you get into something meaningful; but a 2% differential for smaller cases means it really does not exist.

MR. HOBSON D. CARROLL: Mr. Donnelly, you suggested that further regulation with regard to Group Health Insurance, specifically medical, should bring about parity between self-funding situations and insured situations. Do you have any suggestions on what you would like to see in terms of regulation that would bring about that parity?

MR. DONNELLY: The basic activity would have to go in the direction of de-regulation of the insurance product. I think that is the sad fact. ERISA came along and said, essentially, that if the states want to regulate employee benefit plans, they are preempted. When an employer puts in a plan, he can avoid state regulation by uninsuring his plan. ERISA preempts the state from doing anything about this. The insurance business has two alternatives. One is to try to overturn the preemption provision of ERISA to allow states to regulate the uninsured product. While we may all think that is the most desirable direction to go, the plain fact is that it is impossible, because our policyholders, the employers, are going to keep the preemption provision sacred (and they are a very strong lobby and can do this). The problem, therefore, is that the insurance business has to go forward with a public position that essentially asks that some state regulation must be overturned, must be preempted. This is a very delicate situation because the insurance business is primarily made up from the Individual side, which is strongly in support of state regulation. Group Insurance business, on the other hand, is saying there is some form of state regulation that is damaging to us competitively, and as a result, we have to go forward to our organizations - our trade associations - and seek the preemption of some state regulation, while at the same time arguing that we favor state regulation in general. It is the "mandated benefits" type of laws that we seek preemption of, the laws that require us to cover certain types of persons under Group Insurance policies and require us to treat all practitioners alike.

MR. CARROLL: I would suggest that another alternative would be an ERISA type law which describes Federal regulation of the types of benefits that can be provided for Health Insurance. It is my impression that ERISA basically gets into detail with regard only to pensions, so it leaves wide open what employers may do in terms of Health Insurance or health benefits. Do you see that as a backward step?

MR. DONNELLY: Called National Health Insurance?

MR. CARROLL: Well, in a modification it might be. That would put us on a par with them.

MR. DONNELLY: That is exactly why it is a very difficult item to address, because if you argue that it should go into ERISA, you are putting it into the Federal bureaucracy. The other alternative is to seek deregulation and that seems to be the better of two evils. That is the mood of the Group Insurance business at this point.

MR. SHAPLAND: One thought occurred to me while you were discussing Group Insurance and the fact that you have multiple states regulating the same

Group policy. A person does not self-insure under Individual Insurance to get out of regulation. You have nebulous areas where several states are regulating the same policy in Individual Insurance. There are questions about who has authority over the rate of a policy, the state of issue, or the state of then residence? There is also the question of who has control of the benefits of a policy. For example, if they pass a law saying all policies renewed after this date will provide X benefit, is that based on state of issue or state of residence? So there are these conflicts in the Individual area, too.

MR. DONNELLY: I think this is the most critical thing in the area Bob mentioned - that actuaries have to begin to get involved in the regulatory process. I think the process that you have to become more aware of as actuaries is this whole issue of which state is going to regulate. Bob has indicated that it is present in Individual Insurance. It is unbelievable in Group Insurance, and it is growing every day. Take the product that you nicely design to meet the laws of state X. States A, B, C, X, Y and Z all regulate that product. I think the expense factors that you have built into your rates are just going to evaporate very quickly as you try to meet all these expanding state laws under every single policy that crosses a state line. Some cross fifty state lines. I think this is the key issue in state regulation as I see it within the next couple of years. We have got to turn this around in some way. We have got to do it mutually. Insurance companies cannot throw out state regulation, and states cannot just continue in the direction they are going.

MR. WILLIAM H. WETTERSTRAND: Mr. Babbitt is correct. There are some of these real curve ball things that come through, ill-founded rate increases where strange things happen. I think that is what I am paid to do, screen those out, and they make me feel that I am earning my money. Two things are discouraging. One is just the steady stream of twenty or so filings a week for 20% to 60% increases. It seems to be getting worse in the two years that I have been doing this. It must discourage you to come in and ask for them. The other thing, which Mr. Shapland alluded to, is the problem with the closed block of business. I perceive this as a very serious problem. There are times when I suspect that a company is deliberately trying to kill off a block. When you get into a cost spiral, it is rather hard to say that large increases are actuarially unjustified or the premiums are unreasonable when experience is deteriorating. I do not really think that we have the authority to stop that, from a strict actuarial standpoint. I think from a social standpoint there may be an implicit violation of the good faith with which the contract was entered into. I sure wish there was some solution to that problem, particularly on disability income. It can get really bad, because you end up with no denominator, no premium left to spread the rate increase over. You just have claims.

MR. SHAPLAND: I think this deterioration that takes place is a natural phenomenon. You underwrite policies at issue, and as that block of business ages, you have more and more health deterioration. Then the rate increases come along - because of inflation or whatever reason - and that compounds the deterioration process. When companies raise their rates, they might not do it deliberately to force out that block of business, they are just trying to charge a rate so that they do not lose any more money. But the end result might be that they force people out of business. I feel that is one of the very key issues that faces the Health Insurance industry, and something should either be addressed by the NAIC Actuarial Advisory Committee or the new Health

Insurance Section that has just been formulated. I think there has to be a solution. One of the solutions would be mandated funding for the deterioration process, so that you are forcing all insurers in the competitive market to do some funding for this process. Otherwise, the guaranteed insurability has less value, or, ultimately, no value.

MR. FACKLER: Does anybody have a comment or potential solution? I am very concerned, as you are saying, Bob, by that deterioration of a block of business which forces adjustments up and up and does not allow a person to switch to a more favorable block of business in the marketplace from another competitor. This is a continuing cycle.

MR. SHAPLAND: It might be possible if you worked out a model, building in the inflation into the future and the health deterioration and the natural wearing off of underwriting selection. The loading that would have to take place in the early years at today's dollars to cover health deterioration in future dollars might make it impossible. I think it behooves the actuaries to figure out if it is possible, and if it is, we ought to do it.

MR. JOHN O. MONTGOMERY: One-third of all the complaints we receive in California about policies are on Health Insurance. One-third are on automobile insurance, and the rest are divided among all the other lines of business. About two-thirds of health complaints are due to claim settlements and one-third due to premium problems or underwriting. The public is very upset about Health Insurance, and it is not so much the disability income as it is the health care that they are concerned about. We do not get too many complaints on disability income. It is medical expense policies that they are concerned about, and they are concerned about the inflation of medical care costs. I think it would behoove the insurance industry to do some research into ways of confining the costs of medical care. I think this is where one of your big problems is. I think you are going to have to do some research in that area and figure out what you can do to cut that cost. Otherwise, you are in a very bad situation.

MR. DONNELLY: In response to the comment on research: A number of insurance companies have made strong efforts on their own to control health care costs in given areas by supporting HMO's and bringing competition into the providor field. One of the problems that faces the insurance business is the whole idea that the anti-trust laws prevent the insurance business from dealing with the providors. We must deal with them individually, and I think you can appreciate the fact that bringing pressure without dealing through our contracts is a very indirect, and many times impossible, way of controlling the charges that providors make. We do support, in many instances, laws and regulations that provide competition into the health care field. I personally think this is probably the long term solution, but it is not one that is going to turn the health care field around immediately.

The other thing is that the insurance business has been - and this is a voluntary type thing too - interjecting wellness concepts into products more and more. If you cannot get at the providors, go after your policyholders or your insureds and encourage healthier life styles. I have been encouraging actuaries to consider non-smoker discounts. I think Group Insurance actuaries should begin to build into their pricing structures concepts that would encourage people to get a lower premium rate by demonstrating a healthier life style and then hope that you can police it enough to control it. This is what happened in the non-smoker area. If you talked

about it a couple of years ago, everybody laughed. Now, over one hundred companies have it, and if you do not have it, your marketing person is probably yelling and screaming at you to get it developed quickly. Concepts can change. Wellness, and the whole area of controlling providors indirectly, are about the only things we can do.

MR. MONTGOMERY: Another phase that I did not mention is medical malpractice. That has had a drastic effect on the claim costs because now both physicians and the hospitals are submitting patients to all kinds of tests to avoid medical malpractice suits. This has brought the claim costs up dramatically.

MR. FACKLER: That one, and the one that Bob alluded to, whereby "outpatient" is no longer an emergency situation but has really developed into an alternative to your doctor, particularly for sickness as opposed to accident. We see a movement from in-hospital to out-of-hospital. If you plot or look at what has happened in the outpatient situation, you will find that that escalation has been far greater than anything else we have seen.

MR. DONNELLY: One additional comment. One of the sad facts in the Group Insurance area - and most Health Insurance is Group Insurance - is that state insurance departments are getting frustrated with their inability to control medical care costs just as companies are frustrated. You are beginning to see minimum loss ratio standards talked about within the insurance departments and legislatures; the idea is to put pressure on the insurance product. The price of health care to the public is the premium we pay. In order to control the rise in rates, state regulators are trying to put minimum loss ratio standards in our Health Insurance premium rates, not what we pay the doctor. In the Group Insurance area, this is exactly the wrong thing to do. All it does is drive all of the business away from the insurance product and into the self-funding marketplace where state regulators have absolutely no control. Then the price is out of your hands, and it just escalates directly.

MR. MONTGOMERY: I want to mention one more thing on that self-funding market. In California, there is a case that has been going on for years and years involving self-funded insurance and the premium tax. By the end of this year, I think the State Supreme Court will render a verdict on that. I do not know whether it will go on to the U.S. Supreme Court.

MR. DONNELLY: Whereas premium tax used to be the primary driving force behind going to self-funding, it is not any more. The states are passing laws that mandate benefits, and they are easily avoided. When a small 100 to 200 life policyholder finds that maternity benefits, for instance, are mandated in his policy, he avoids it by going self-funding, which is a totally incorrect move.

MR. MONTGOMERY: We know that from personal experience in California. The way Group laws are worded, much of our business is written through Missouri and Rhode Island.

MR. LARRY M. GORSKI: I would just like to relay a few comments about the situation in Illinois Blue Cross/Blue Shield plans and Group Insurance in general. Some individuals in our Department were very frustrated with the rate of rate increases on Individual contracts for the direct pay subscribers and the over sixty-five market. It is felt that limiting rate increases by themselves would accomplish very little. A few people have the idea of requiring the Blues to perform certain good faith efforts in cost contain-

ment. That was finally put into a statute which read that, unless the Blues demonstrate that they are making good faith efforts in cost containment, the rate filings would be denied or deemed unreasonable. At first they were just to be deemed unreasonable with respect to the direct pay plans of individual subscribers, and we did not interfere with the experience rating products. Now the law has been tentatively changed to read not only 'deemed unreasonable' but 'denied', which is really going to cause chaos in Illinois. I have to feel that some day the people in our Department are going to become very upset and disenchanted with the rate of rate increases on Individual products. With the introduction of the new NAIC Model Group Life Law and how it interacts with our Group A&H Law, we will becoming more involved with Group Accident and Health Insurance in general. I foresee the day when that kind of statute might be applied to both non-profit and commercial companies alike. So, I think that the comments with respect to communication between actuaries and insurance departments and legislators are very important today.

MR. FACKLER: Bob, I have one question that maybe you would like to comment upon, and that has to do with the state pools. I think you talked about some problems associated with this, but do you have a solution or recommendation that might apply here?

MR. SHAPLAND: I guess I have views on how I think state pools ought to be organized. First of all, I believe they are a necessary element to keep the Federal government out of Health Insurance. There is a segment of the population that cannot buy Health Insurance because of health impairments, and I think it is good for the state to accommodate those people. But I think the people that wait until the barn burns down to buy insurance should have penalties. I think that they are not meeting their social obligation to buy insurance before they get sick, and there ought to be some penalties for that. One of the penalties would be a significant waiting period for pre-existing conditions. I think states that have very short waiting periods for pre-existing conditions just are not having enough penalty and are going to cause large losses and underwriting problems. I think, too, that there should be some kind of a signifieant deductible, so that you can cover these people for catastrophe but not for the smaller type claims. Then, I think there ought to be a rate penalty, possibly as much as 100% over the standard rate. On the other side of the coin, I cannot see these states that are passing laws that say the rates have to be self-supporting. I do not see how that can work. I think you are just going to go through a deterioration cycle where the rate just keeps driving out the better risks. I think there have to be some losses. Then you come to the question of who should pay the losses. Self-insurers can avoid these losses. If you try to charge them to self-insurers, there have been court suits on the legality of that. I think in the long run, it is better that the state taxpayers take up those losses. That has been the case because they have premium tax offsets. The insurance companies pay the losses, but the premium tax offsets pass the burden to taxpayers.

MR. JINDIH SHIH: In regard to the comments of Mr. Montgomery about cost containment by the insurance companies. Every time we try to implement some cost containment, we see more complaints from the customer. We are caught in between as middle men. On the one side, when the patients get in the hospital, they just want to be taken care of. On the other side, if we question or say we will not pay the physician or hospital bills, we get complaints to the insurance department or some legal action. Without cooperation from either the AMA or ABA, I do not know what we can do.

MR. DONNELLY: I think the sad fact with regard to cost containment of health care costs is that most people in this Country are insured. The plans that most of us as employees are insured under are non-contributory. To the extent that our dependents are insured, we may not be paying either the full or a major portion of that premium rate. We read a lot about health care costs going up. But employers are not passing on the cost to individuals. Deductibles are remaining at $50, $100, so individually we are not seeing our health care costs go up. I think the problem is that we have a strange combination here. We have the press writing constantly about health care costs going up and, therefore, pressure is brought to bear on insurance companies because we are sort of looked at as the people who have the key. We control all the money because we pay the claims. The logic is that we do not control what the providors charge, unless we can get in there and create a competitive alternative. We should create a system to which the people can go for their care, or we can encourage people to become healthier. Other than that, most people are not individually concerned about their own health care costs, because they do not pay them.

MR. RONALD M. WOLFE: In this area of cost containment, would you comment on this proposal that we have heard from the Federal government to limit the amount of cost per person that an employer can deduct as a reasonable business expense, thereby giving the employee a better idea of what his health care costs are and hopefully holding it down that way?

MR. DONNELLY: Ron, I think you are talking about the so-called pro-competition legislation. The first thing is that the insurance business, the National Trade Associations, oppose such legislation. You start from there. Basically, such legislation, instead of aiming at providing greater competition among the providors, really increases the competition among insurers. There is a general feeling in the insurance business that there is plenty of competition in Health Insurance business. You do not increase that to create the impetus to keep costs down. The pro-competition legislation you are talking about essentially tries to create greater competition by saying that you have to have more than one company involved in providing the benefits. I think the general thought among insurers is that is the wrong direction in which to go. It is gaining popularity. There are a number of sponsors of that kind of legislation, and they are well known in the Congress. It is going to be a tough sell for the insurance business to convince people that it is not necessary.

MR. WETTERSTRAND: There are consumers that do complain about costs and do pay the costs themselves. That is in Medicare Supplements. When I approve an increase for Medicare Supplements, I had better go on vacation for a couple of weeks. Fortunately, I do not have to answer the phone calls. When the benefits are rich - 35%, 40% inflation rate per year in prescription drugs and things like that - those people really complain.

MR. FACKLER: Bill, is that largely because they are paying the entire freight themselves, so it becomes an individual basis?

MR. WETTERSTRAND: That is right. It is an individual basis, and there is no alternative for them. There is very little Group coverage available along those lines. We even have trouble with Group coverages for our own state employees. They got very upset.

MR. SHAPLAND: I do not know how viable it would be, but could you put pressure on providors by providing benefits in insurance policies that would only pay the lower charge levels in their geographic area? For example, if there are two hospitals in Omaha, Nebraska, and one is charging $80 for a private room, and one is charging $90, you would only pay the $80, and the public has an incentive to go to the lower cost providor.

MR. WETTERSTRAND: Blue Cross/Blue Shield are heavily involved in a cost containment program in the State of Indiana. Indiana rates do compare favorably with other geographically rated major medical programs, so it has been successful to some extent. I think if you started to restrict the benefits, then you would need a Medicare Supplement on top of a Medicare Supplement.

MR. SHAPLAND: If we write our policies to pay only what the lower cost providors charge, and the public does not get insurance for the extra cost or the higher cost providors, then they have an incentive to go to the lower cost providors. Then there is competition to be one of those low cost providors. In Omaha, my wife worked for a dentist, so I know what is going on in the dental area. There are dentists now that will accept the scheduled benefits of the Group companies around town as full payment. There is now competition, because people know they are going to get their bills paid if they go to a low cost providor, and they are not if they go to a high cost providor.

MR. WETTERSTRAND: Another thing are HMO's that have made very favorable deals with certain hospitals in certain areas. That seems to work occasionally.

MR. CARROLL: I would like to go back to a point that Vince discussed, and I think Bob started to address. We could certainly decrease some cost problems by putting in a tight schedule on all kinds of benefits. The insurance industry has gone out and written low deductible, high limit, "reasonable and customary" or "usual and customary" products, and that has contributed to the problem. How you stop that and put in schedules when another company continues to have a major medical product, is a problem.

MR. DONNELLY: As staff to the ACLI, I have to be careful how I criticize our member companies, but I would say you are absolutely correct. Through the mechanism called competition we have written plans that are now coming back to haunt us. Companies believe that one way to control costs is by increasing deductibles. I think that will work to a given extent, but I am worried when we argue that the government is shifting costs and at the same time we argue that a cost containment device is increased deductibles. I believe that is cost shifting, not cost containment. If a higher deductible makes somebody think about incurring a medical care cost, only then is it cost containment. I am not yet sure that a $100 deductible per year, or even a $500 deductible per year, will serve effectively as a cost containment mechanism.

MR. FACKLER: Thank you. I appreciate your attendance today and especially your comments. I also appreciate the efforts of our panelists. I would like to call your attention to the two workshops which will serve as follow-ups to this session. At this point, this session is adjourned.