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HEALTH SECTION SESSION - CURRENT TOPICS

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Panelists: SPENCER KOPPEL
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Section members should keep an eye out for a section newsletter. The issues have been a little erratic in the past. Please watch the section newsletter for news of our ongoing activities and requests for participation.

We have a prize winner as a result of the call for papers we had for this meeting. The winner is Charles Larimer, F.S.A., who is with Blue Cross/Blue Shield of Illinois. His coauthor, Mike Schionnin, is a student of the Society. Their paper will be available for distribution within a short time.

MR. SPENCER KOPPEL: The tax law of 1984 did have some provisions which affect health insurance in particular. The development of the 1984 tax law included health insurance as an afterthought rather than as a specific coverage. Many of the rules haven't been completed yet, and it is questionable whether anyone will focus on some of these issues. For example, the bill says that hopefully there are standard tables that are supposed to be used. A standard table is one that is required to be used in calculating reserves by at least twenty-six of the fifty states. I don't think there are twenty-six states that require a specific table, and therefore there are probably no standard tables in use. So, the bill says where there are multiple tables available or there are no standard tables, there will be Treasury regulations that will describe what the standard tables are. There are none today and there is no strong activity from what we can gather to establish standard tables.

If there were multiple standard tables then the company is supposed to use the table that generally yields the lowest reserves. It is not clear whether "generally yields the lowest reserves" refers to the entire industry, or to the company, or to the block of business or the policy form in general. It is just not very clear and I have a feeling that it was intentionally left somewhat unclear in that regard. We can imagine that the standard tables would probably include things like the 1956

Intercompany Tables, the 1964 CDT and the 1974 tables that were developed by Houghton and Wolf but there is no clear indication that those will be allowed. What are companies going to do for their 1984 tax returns, both for the beginning and ending numbers? It seems as though companies are using the tables that they used for statutory reserves. There isn't anything else that a company could do under these type of circumstances.

As to the rate of interest for those tabular reserves, for noncancelable (which includes guaranteed renewable policies) where there is no prevailing state interest rate specifically stated for accident and health policies, the regulations say to use the interest rate that applies to a whole life contract in the state on the date in which the accident and health contract was issued. So, for accident and health, you refer back to the life insurance rules.

Regarding the reserve method, the bill requires a two-year preliminary term method for accident and health policies. However, there is a very narrowly defined exception wherein a company could use net level reserves under very specific circumstances. The provision itself is intended to be narrow in its application by requiring "a complete and continuous commitment by the company to the use of the more conservative net level reserve method for its noncancelable accident and health contracts." A company would have to have done the following four things. Specifically, (1) it had to use the net level method in filing its current year's convention statement; (2) it had to use the net level method for filing its convention statement in 1982; (3) it had to continue to use the net level method all the way through from 1982 until the current year; and (4) it had to have all of its directly written accident and health reserves on a net level basis except for de minimus amounts. De minimus is defined as no more than 1 percent of all of its reserves. It talks about "direct" because for reinsurance, the assuming company would follow the ceding company. Therefore, if a company assumed a block of accident and health business and valued it on preliminary term basis, that wouldn't count toward the 1 percent requirement.

The conference report following adoption of the code included confusing language which would have limited the application of this section to policy forms written by the company at the time the code was adopted in 1984. That would have meant that if a company did take this net level election and started filing new policy forms, those new forms would have to be valued on a two-year preliminary term basis. In the "Blue Book," the technical description of the law, the writers suggested that shouldn't apply because if it did, then as a company's policy forms became out of date or as new policy forms of any type were filed, the company would have to use two-year preliminary term.

It would lose the benefits of the net level election and the fresh start provision. No company would take this net level election under those circumstances and, therefore, the law couldn't have been adopted. So, the Blue Book suggests that there will be technical amendments in the 1985 revisions of the tax law that will say it applies to all of the company's business if it qualified under those four points mentioned.

Another question is whether a company can use gross pro rata unearned premium reserves for its noncancelable and guaranteed renewable accident and health policies. The gross pro rata is fine for cancelable policies. However, the code says that the method for noncancelable accident and health policies should be two-year full preliminary term and that the reserve method for other than noncancelable accident and health shall be that prescribed by the NAIC; i.e., gross prorate unearned premium. The question is: Does the two-year preliminary term method include gross pro rata unearned premiums in addition to the mid-terminal reserves? From a life insurance point of view, the minimum reserve would not be the gross pro rata unearned premium reserve in addition to the mid-terminal reserve. It would be whichever is greater, the gross pro rata unearned premium reserve or the mean reserve using the net premium method. However, companies are not clear on this and there has not been anything issued that describes which is appropriate. Some companies are using net premiums and other companies are using gross premiums.

Section 217i of the law allows a mutual insurance company to make a permanent election to treat individual noncancelable or guaranteed renewable accident and health contracts as cancelable for the purposes of the qualification ratio to determine whether or not it is a life insurance company. The election would not otherwise affect the computation of the tax reserves for these contracts. Therefore, the reason for this provision is that a company with larger amounts of individual noncancelable accident and health policies which might have large surplus requirements could elect to become taxed as a property/casualty company. That might provide a mutual company with a lower tax result benefit than if it were taxed as a life company. However, the IRS warns that if a company elects this and the property/casualty tax laws are changed subsequently, the company would not be given an opportunity to elect to become a life insurance company again.

Those are the provisions that are specific to accident and health policies and reserves.

MR. PETER M. THEXTON: These remarks were prepared by Marty Dickler, my colleague at the HIAA.

The proposed taxation of employee health benefits qualifies as a current health topic. Proposals to tax employer contributions are not new. The Reagan Administration proposed such taxation in 1983 and certain influential senators actively supported the idea. However, a strong coalition of employers, labor, the insurance industry, and others were opposed and made their views known in Washington. This coalition, led by the health insurance industry, was able to demonstrate to key congressional committees that such taxation would be bad public policy. Also our legislators had one eye on the 1984 elections so no significant action was taken on this issue in either 1983 or 1984.

With a new Congress, however, the issue is upon us again. The most widely known proposal is contained in the November 1984 Treasury plan

for tax reform. It provides that employer contributions to group health insurance over $70 per month for an individual and $175 per month for a family would be taxable income to the employee. The Treasury proposal is being widely discussed, although other legislative tax reform proposals might also eliminate the current tax preferences for health benefits.

One obvious reason for the emergence of these proposals is that huge federal deficits force the search for new revenues without enacting a "tax increase." You can decide for yourselves whether broadening the tax base is or is not a tax increase.

The notion that taxing employer contributions was good policy grew out of the so-called pro-competition school of thought. Several health care economists have argued that Americans have too much health insurance and are overly insulated from the cost of health care. That has allowed providers of health care to raise their prices virtually without restraint. The economists claim that if employees had to pay tax on employer contributions to health insurance, they would either seek less insurance, or accept more out-of-pocket liability. The larger out-of-pocket exposure on the part of employees and dependents is expected to lead to more shopping among health care providers for services, based on price and quality. The theory continues that if employees and dependents become more astute consumers, then health care providers will be forced to be more efficient and competitive, all of which will control health care costs. Thus the proposal to tax employee health benefits is supposed to be a cost containment device of great potence.

This scenario is rooted in economic theory and may work very well when speaking of general goods and services. It is not at all clear, however, that such reasoning can be directly applied to health care services. It has long been known that when employees face large out-of-pocket expenses, the demand for health care services is reduced. This is reflected in insurance company premium rate structures, and statistical evidence of this so-called deterrent effect of out-of-pocket expenses was provided by the Rand Corporation Health Insurance Study.

Also, Americans are risk averse and wish to be relieved of emotional trauma when illness or injury strikes. While we have observed a trend toward greater deductibles and coinsurance in group plans, it is doubtful that a majority of Americans have reached the point where their out-of-pocket exposure has made them astute consumers. Many seriously doubt that a health benefit tax will accomplish the purpose.

The advocates of the pro-competition approach have generally overlooked its practical problems. Most employers still provide either one uniform plan for their employees or at least one plan for all employees at a given location or bargaining unit. If the employer contribution became taxable and encouraged some employees to want less insurance, an employer probably wouldn't change the plan for everybody to satisfy the desires of a few. If the tax law also required the employer to offer multiple plans, in order for the pro-competition

theory to work there would be other problems. Employees could readily choose a less expensive plan, and avoid some income tax, but for many groups the multiple choice would open the door to adverse selection. That would operate to distort the premiums for the offered plans, and the multiple choice option would often break down long before any cost containment could be realized through the taxation of employer contributions theory.

The cost containment argument for employee benefit taxation was very popular in the 1983-84 legislative session. It is still with us since it is included in the November 1984 Treasury proposal. Cost containment, however, is not the only argument advanced. There is also a theory that taxing employer health benefits will result in greater equity among taxpayers. In the Treasury proposal for tax reform, the present tax preference accorded employer-provided health insurance is said to be unfair to individuals who are not covered by employer plans. That is an interesting argument when one recalls that a few years back Congress repealed a limited deduction for health insurance premiums. In any event, many believe that the Treasury is stretching with this argument. The vast majority of people are covered by group insurance for most of their lives and relatively few have to rely exclusively on individual health insurance for long periods of time. Congress could just as well bring back the deduction it repealed.

Critics of employee benefit taxation have pointed out that the end result will be far more tax inequity than now exists. In any given group where age-rated premiums are not used, the amount of imputed income would be the same for both high and low income workers. As a result, the percentage increase in income tax will be higher for the low paid worker than for the higher paid worker. Clearly taxing employee health benefits is regressive. Social Security taxes will rise, but only for persons who earn less than the wage base plus the taxable premium. Furthermore, the use of nationwide exclusion amounts, such as $70 per month per individual and $175 per family, will mean that employees living in high medical cost areas will be most affected. Those who live in low medical cost areas will pay little or no tax. For these and other reasons, critics maintain that taxing employee health benefits will unleash an avalanche of tax injustice.

Many in our industry are troubled by the proposal to tax employer health benefits for other reasons concerning the ability of the public sector to provide group health coverage on a broad basis as it does today, without evidence of insurability, when ten or more employees are involved. Will the proposal to tax employer contributions damage a system that has worked so successfully for so many years? If employees have to pay income taxes on employer contributions to health insurance, it will not be long before the young and healthy realize that their group health coverage is not the financial bargain it used to be. As they drop out of the group plan, by finding more competitive forms of health insurance elsewhere or for other reasons, the cost of group plans is likely to increase. That will cause more drop outs. Soon low-income employees will become hard pressed financially to remain covered, and they will drop out. When participation in a group plan deteriorates the claim experience often worsens, which will further aggravate the situation. This will impair the ability of insurers to offer

medical expense coverage to small and mid size groups. Furthermore, as more people drop out of group plans, especially low income workers, there will be more horror stories of people becoming bankrupt as a result of medical expenses. Hospitals will see an increase in charity care and bad debts, which will force increased charges to those who are insured. If these events unfold, we may see increased pressure for national health insurance, despite the government's struggle to control Medicare and Medicaid costs.

I have tried to cover some of the major points of employee health benefit taxation in just a few minutes, which is a gross injustice to the subject. The HIAA is preparing a lengthy analysis of the issue, which I would be pleased to send to anyone who wants it.

MR. KURT VON SCHILLING: For the last fifteen years, we have had national medicare in Canada, and, by law, we are not permitted to insure medical and hospital coverages. Canadian insurers provide fringe medical coverages which you would classify as supplementary coverage. We insure drugs, vision care, semiprivate hospital charges and out-of-country insurance. This last item recognizes that Canadians travel throughout the United States and around the world and may incur emergency medical and hospital expenses which exceed the usual and customary charges provided by the provincial medicare plans.

The Canadian insurers are not involved with the problems and concerns that are expressed by my fellow panelists; however, all Canadian citizens are also deeply affected by the escalating health care costs and the government's desire to control them. We are fortunate to have a national medicare plan which provides universal access to health care facilities whether the individual is rich or poor. Most of the forces that escalate your health care costs are also at work in Canada, but we do not have the benefit of the ingenuity and inventiveness of the free market system to control and harness these forces.

Group creditors' disability insurance is a product that has been on the Canadian market in recent years. Today, this product is being offered by all the Canadian banks and the major Canadian trust companies but the insurance is provided through a group contract underwritten by an insurance company.

When an individual borrows money from a bank, he is offered the opportunity to insure the loan against the event that he may die or become ill, and hence he may be unable to repay the loan or make the required monthly payments. You are familiar with group creditors' life insurance which addresses the need to cover the loan in the event of death. Group creditors' disability addresses the need to cover the loan in the event that the borrower becomes ill.

A borrower qualifies for disability insurance if:

1. he is under the age of sixty-five;

2. he is currently capable of performing all regular duties of his principal occupation and he is working at least twenty hours a week; and

3. he applies for the disability insurance within seven days from the date the loan is advanced.

Plan Design

1. Most plans cover up to $1,000 a month.

2. The definition of disability is two-year "own occupation."

3. The coverage period is the amortization period of the loan to a maximum of three hundred months or the attainment of age seventy if that occurs earlier.

4. The disability payments commence if the individual has been disabled for thirty consecutive days.

A borrower completes an application form but does not have to provide any medical evidence. Naturally, this warrants the question how you can write such coverage without any evidence.

Two exclusions control most of the selection. The first exclusion says that if an applicant is subject to seasonal layoffs or suspension of work lasting normally more than sixty days, no benefit is payable for a disability due to any cause if it begins during such a period.

The medical selection is controlled through the use of a preexisting condition which is the second exclusion. This preexisting condition states that no benefit is payable for a disability that begins within six months of the date of application if it is related to a condition for which the applicant has consulted or received treatment from (including taking pills, an injection or other medication) a physician or practitioner in the six months before the date the application was signed. Both of these conditions will control most of the flagrant selection.

It is desirable that as many as possible of the borrowers apply for disability coverage because, with excellent participation, better claims experience can be attained and the effects of selection are minimized. A very simple application process will contribute to better participation rates, which is why a preexisting condition clause was used instead of obtaining medical evidence which then necessitates assessment. An application form can be completed and accepted quickly, and the insurance coverage is automatically in effect. I am aware of participation levels for the product varying from 20 percent to 75 percent.

Under most creditors' plans, the borrower has the option to pay the premium on a monthly basis as part of his loan repayment or to pay a single premium at the time the loan is applied for. Most individuals elect to pay a single premium up front which is included as part of the loan amount and amortized in the payment. The single premium approach provides the insurer with additional premiums to cover the nonflagrant selection.

During the early years, insurance companies incurred losses under this product because they failed to underwrite and price appropriately for the characteristics of the business. Generally, the incidence rates are high - averaging two and a half to three claims per thousand per month - but fortunately the recovery rates are also higher than normal long-term disability (LTD) rates. The average reserve factor per dollar of monthly loan payment is about $7 at inception of claim, whereas the average reserve factor for an LTD claim admitted after a qualifying period of four to six months is about $40 per dollar of monthly disability payment. Most of the difference is due to the difference in qualifying period, but a small part reflects the difference in recovery experience.

I have expressed a concern that the advent of group creditors' disability could have a detrimental effect on LTD experience because group creditors' disability will lead to higher direct and indirect benefits received by a claimant in relation to his earnings. The Society of Actuaries' statistics clearly indicate that disability experience deteriorates at higher benefit levels.

To the best of my knowledge, no accurate studies have been done to determine whether the existence of group creditors' disability has had an adverse effect on general LTD experience. Group LTD writers do not know whether a claimant is also receiving benefits under a group creditors' disability program and to seek such information is not an acceptable practice in the marketplace. The increase in LTD incidence rates that has occurred over recent years is primarily due to the economic environment and the high unemployment rates, but the higher benefit levels attained indirectly through group creditors' disability have also contributed to this rise. LTD recovery rates have also fallen and this special product had an effect on that trend. All of this is indirect, circumstantial evidence, but it is evidence supporting my concerns.

Liberalization of Benefits

Some liberalization of benefits has occurred in Canada but it has not been as extensive as in the U.S. We see a few requests for three or five year "own occupation" periods. We generally decline such requests, which has not hurt us so far in the marketplace. Liberalization in the definition of disability is more extensive in the United States, and may be a function of the market. We are fortunate that the Canada Pension Plan (the Social Security counterpart) provides a disability benefit amounting to about 20 percent of earnings. The 20 percent is a simplification of a complex benefit formula. All of our group LTD plans cover employees from all occupations, whether they are truck drivers, electricians, secretaries, or executives. Most clients wish to have a common definition of disability applicable to all employees. They are content to have a two year "own occupation" definition.

The other liberalization is in benefit amounts. Monthly benefit amounts of up to $25,000 are available in the United States. In Canada, the amounts written are not as high but they can range to $10,000 or $15,000 per month. No detailed studies have been performed to

substantiate that selection by benefit amount is occurring in the same way that it is in the individual term market. I have spent many years in the group area of my company and have not observed any noticeably large LTD claims. My impression is that there is almost no selection by benefit amount.

MR. CARL RICCIARDELLI: My company attempted to control the types of treatment that we would cover, by using the "experimental" rubric. We identified and excluded from coverage those treatments that were experimental or investigational and we thought, in this way, that we could gradually orchestrate the kinds of treatments that we wanted to consider under our contracts. We were pretty successful in doing so. Over a period of time we developed an "administrative" benefit exclusion and inclusion and began to cover organ and tissue transplants - particularly, cornea, kidney, bone marrow and heart valve.

Then we and other carriers had suits brought against us. The attending physicians of some claimants indicated that a particular transplant or procedure that we had identified as experimental was medically necessary. The issue changed from the language supporting our experimental exclusions to language supporting what medical necessity was. We denied a number of claims on medical necessity grounds, as many other carriers did. The issue became larger and goes something like this.

Blue Cross receives a call from the hospital requesting affirmation that coverage is in force. Blue Cross then essentially agrees to the coverage. Some time later we deny coverage as not medically necessary. The outcome of the suits forced us to perform a concurrent review of inpatient stays so that, on an ongoing basis, we could determine and inform the patient and doctor that we judged the treatment no longer medically necessary.

We made some changes in our contracts to specify that our own medical department was the final arbiter of what was medically necessary. We weren't able to sustain this position for a number of reasons. Among them were special requests from large accounts that wanted us to provide coverage for transplants that we hadn't included under our administrative rubric.

The force of large accounts impacted our monolithic decisions about what was covered and not covered. We had coverage offered by competitors and other Blues organizations that we needed to deal with. We had an increased incidence of the major transplants - heart, heart/lung, and liver. We had a proliferation of specialty transplant centers. And, finally, there was a denial of an HMO liver case (not the HMO associated with Blue Cross/Blue Shield of Illinois) in which coverage for a liver transplant was denied. That led to a legislative hearing where many of these medical necessity and transplant issues came up.

The result was a bill entitled the "Experimental Organ Transplantation Procedures Act" effective August 30, 1984. It affected all providers of

health care: health care service plans, medical care service plans, accident and health insurers, and HMOs. The critical provision in this bill was that we could not use the experimental language to deny claims. But the law does permit an experimental exclusion if supported by the Office of Medical Application of Research of the National Institute of Health (NIH).

We then did an actuarial risk analysis of the cost of providing coverage for these transplants. We also did a legal analysis of what our current contract provided.

In our risk analysis, we considered providing coverage for heart, heart/lung, liver, and pancreas transplants. Our medical directors determined that the first three were no longer experimental. Pancreas transplants were determined to be still in the experimental stage.

To gather incidence and cost data, we went to reinsurers and to a rather extensive study done by the Blue Cross Plan of Massachusetts. From that study we obtained the most detailed cost information we had on the incidence of the transplants. The Blue Cross of Massachusetts study indicates the expected incidence of transplants per one million insureds for liver, heart, and heart/lung, from 1984 to 1986. You see the dramatic increase, from fourteen expected transplants in these three areas in 1984, to thirty-nine in 1986 and thereafter. The study also estimated the costs for these procedures. In particular, the 1985 estimated average costs shown here are $285,000 for liver, $127,000 for heart, and $154,000 for heart/lung. Those estimated costs took into account the mortality during the course of subsequent treatments and recovery.

We had to redefine our policy in the light of new legislation. We interpreted our current contract as providing full coverage for all human organ transplants. We could no longer rely on the experimental language because we did not at that time have any support from the NIH.

We developed three riders. The first eliminated coverage for all transplants. The second named the transplants that we had previously identified as covered in an administrative way and excluded all others (heart, heart/lung, and liver). The third simply added coverage for heart, heart/lung, and liver transplants. That combination of riders gave us the flexibility we needed.

For certain blocks of our individual and group business, we decided to roll on the heart, heart/lung, and liver transplant coverage in 1984. For larger groups, we gave options. The critical factor was communicating to the group that their current contract was completely open. They were subject to whatever transplants took place within that group; we could not defend them using our language. We offered them a rider which covered the cornea, kidney and so forth, but excluded all other transplants. Or, they could add coverage on a pooled or unpooled basis, for heart, heart/lung, and liver transplants. The underwriting we planned to include would be a preexisting condition limitation for new entrants. We offered the accounts, on their

anniversary date, the option of adopting one or more of the transplant riders. It would not be until the following renewal date that they would be offered that opportunity again.

The benefit itself names the specific procedures and excludes all others. It provides coverage in the same way as the basic plan would for a period of five days before the transplant and 365 days after the transplant. We cover donor organ transportation expense. We require prenotification by the attending physician of an upcoming transplant and also specify approved facilities. Without these preconditions, there is no coverage. We offer this coverage with an inside limit of $250,000 or $1,000,000. The monthly premium rates for 1985 are roughly $.40 for a single employee and $1.50 for a family. We offer pooling so that for a premium group we would be willing to wall off the human organ transplant coverage and keep it completely separate from the underlying coverage, or we would be willing to fold it into the basic coverage.

We do have reinsurance. We believe there will be significant increases in the cost of human organ transplant in the future. The limiting factor now is the availability of organs. We felt that, in the early years at least, we wanted some protection. We are reinsuring about 75 percent of the risk with several reinsurers.

HMOI is Health Maintenance Organization of Illinois, a subsidiary of Blue Cross/Blue Shield of Illinois and the largest HMO in the state. It is federally qualified and contract interpretations were the same as for a basic plan. Basically, there was no way that we could deny a transplant claim under an HMO contract. As the law provides, we wrote to the Office of Medical Application of Research of the NIH and explained why the transplants we wanted to identify as experimental should be so designated. The response indicated that the NIH had no knowledge of the law, so it didn't make the requested determinations. However, we learned that at the office of HMO, the Surgeon General had determined that HMOs could exclude as experimental heart, heart/lung, and liver except for biliary atresia. So now, we have a position on human organ transplant coverage for HMOs that we can work with. We've decided to create a rider to the HMO contract specifically providing coverage for heart, heart/lung, and liver transplants. This rider will be offered to group accounts along with the options noted earlier for their basic health programs. We will require that each group provide transplant coverage under both basic and HMO options or not at all.

There will be a dramatic increase in available organs. Availability is a limiting factor in coverage and incidence. The costs are likely to go down. Expansions of coverage are likely to be in the xenograft area: interspecies transplants and artificial organs.

MR. SHELDON SUMMERS: I am making some comments for John Montgomery who is the chief actuary for the California Department of Insurance.

An advisory committee to the National Association of Insurance Commissioners (NAIC) Life and Health Actuarial Task Force has

prepared a set of Cancer Claim Cost Tables consisting of four parts:

1. A table of hospital claim costs per $100 daily benefit.

2. A table of claim costs for hospital and other benefits under a "standard plan" as defined in the details of the report.

3. A table of average days per claim.

4. A table of conversion factors to obtain costs for other benefits with different maxima than those in the "standard plan."

These tables were derived from a complete exposure consisting of at least 40 percent of such business known to exist for the years for which data was collected. They have been prepared on an "each-payment" basis. Work is continuing on developing experience on an "all-payment" basis.

The tables were published as an exposure draft as part of the proceedings of the December 1984 meeting of the NAIC. At the March 17, 1985 meeting of the NAIC Actuarial Task Force, a proposed model regulation or law was presented by the HIAA and further changes to the tables were distributed by Mr. William Odell, chairman of the Advisory Committee. At the June 1985 meeting the NAIC will be asked to adopt these tables as a standard for valuation. It is hoped that the proposed tables will also have a table of factors to convert the experience from an "each-payment" basis to an "all-payment" basis.

MR. DOUGLAS W. ANDREWS: If a group creditors' disability plan insured a mortgage that renews every five years where the level of payment can change on each renewal date, and someone is on disability, what level of payment would be insured?

MR. VON SCHILLING: This particular coverage is generally applied to loans, not to mortgages. If you extend it to mortgages, you would insure the actual amount that the client has to pay on a monthly basis.

MR. ANDREWS: So, the amount subject to insurance may increase at a renewal date for someone that is on claim?

MR. VON SCHILLING: Yes.

MR. DONALD M. PETERSON: If a mutual company elects to have its noncancelable business treated as optionally renewable, and it has a stock life subsidiary, that subsidiary is subject to the roughly 8 percent penalty tax on the parent mutual casualty company's surplus. This applied to our company since we are taxed as a casualty company, and we are looking at the possibility of having a life subsidiary. That penalty would make it unattractive. We have tried to get some ruling on it, but we don't expect one for quite a while.

MR. KOPPEL: Does anybody here who is active with the various task forces that are working on that have any idea when the regulations might start coming to light?

MR. PETERSON: We had gotten information that one midwestern company had gotten something written into the law to protect their interests, but we were not able to trace it down.

MR. KOPPEL: None of us can rely on any regulations for quite some time. We are going to be in the position of filing and hoping for the best in terms of making elections. Even on a critical issue we won't know whether we made the right elections in many instances. It might be too late by the time we do know.

MR. O'GRADY: Is there any prospect or idea of the likelihood of taxation of health benefits being enacted in this session of Congress?

MR. THEXTON: We note that Senator Packwood is now the chairman of the Senate Finance Committee and he has not been in favor of this particular concept in the past. In general, support for the bill has come from only a very few senators and representatives who are not currently chairmen or at the top of the committees that deal with this subject. We have a solid basis of support so we don't think that at this time we are in very great danger of the bill being enacted. But you never know what might suddenly happen, so we have to keep our arguments up to date.

MR. DALE F. ETHINGTON: Most of the pooling arrangements that I have seen on individual claims have to do with pooling amounts in excess of a certain amount. What led Blue Cross to choose these three specific types of claims to pool and not to use pooling like they do perhaps on some other types of claims?

MR. RICCIARDELLI: The issue of human organ transplants is an emotional as well as actuarial one. Group accounts would be nervous about providing coverage but, at the same time, sensitive to the backlash that would occur if they did not. The idea was simply to give them an option of incorporating the transplant coverage within its premium or cost structure. But, we also provided the option to pool the risk. From our standpoint, we are going to block it off, look at it separately and pool it anyway. We just felt it gave an additional option.

MR. ETHINGTON: Have you tried it with any other coverages?

MR. RICCIARDELLI: Just those. We regularly offer aggregate and specific stop loss as well.

MR. ETHINGTON: The really emotional claims are the neonatal claims, and they can be even more expensive than some of the transplant cases.

MR. RICCIARDELLI: In the case of neonatal, it comes down to the question of medical necessity and we feel that, as the largest insurer in Illinois, we are a target. For that reason, we can't use medical necessity language to exclude neonatal coverage.

MR. EDWARD W. O'NEIL: What process is used to determine whether

something like a pancreas transplant becomes nonexperimental? Are you using any special reserving techniques for the low frequency of these operations?

MR. RICCIARDELLI: To determine the proper category for transplants, we refer to the physicians on staff who are quite knowledgeable in this area. As to reserving, we are new in this. One of the things we are doing is trying to raise the consciousness of the organization so that, when anyone hears about the possibility of there being a transplant claim, the actuarial department, which is the controlling department in the organization for transplants, is notified. We do not have any special reserving techniques that we are planning. We are gathering information about known and suspected transplants and incorporating it into our figures and transmitting the data to our reinsurers.

MR. O'GRADY: Is there any indication of how legislative activity is proceeding on a national basis? Are we seeing a lot of legislation?

MR. THEXTON: I am not aware of a lot of legislation. We have had a few requests from the attorneys for prices and so forth. It's not like alcoholism or mental illness where requests are much more frequent.

MR. CHARLES J. SHERFEY: The Illinois legislature is considering a law which would require insurers to continue coverage for dependents after the death or divorce of the employee. The way the proposed law is currently worded would require us to continue coverage at the same rate being charged under the group policy. It may be advantageous for us to include individual age rates, or perhaps just age bracket rates, in our policies such as those in group life policies to protect companies and plans against at least the age part of the selection, if a law like this is passed.

MR. THEXTON: California also has such a proposal, but I'm not aware of any other states that do.

MR. VON SCHILLING: We have a similar coverage, and there is a possibility that extended health coverage must be provided to widows. This is factored into the costing, as a disability benefit or a death benefit. In other words, you set up a special death benefit which will generate the required premiums; your variability of the cost by age is the reserving problem. If you make an average cost over the total lives, make sure that you establish appropriate reserves which cover the future costs of the individuals who will die. Otherwise you have a long-term need for additional premiums.

MR. VICTOR PAGUIA: Are there any special issues involved with coordination of benefits on organ transplants?

MR. RICCIARDELLI: It's no more complicated than coordination of benefits normally is.

MR. KOPPEL: Is there anything other than reserving that you get out of requiring pre-notification for claims?

MR. RICCIARDELLI: One of the issues was to make reasonably sure that the transplant is performed in an approved facility. We had a sense that once we, as the major insurer in Illinois, began to offer the coverage, hospitals that perhaps did not have a history of doing this kind of thing would suddenly spring up overnight. We wanted to be in the controlling situation and permit our medical directors to decide on specific approved facilities whose procedures met our standards.

MR. THOMAS L. HANDLEY: When you developed your policy language on organ transplants, was it your intent to cover the artificial transplants and inter-species transplants such as the baboon heart transplant that occurred with Baby Fae in California?

MR. RICCIARDELLI: Our current coverage is for human organ transplants only. It does not cover the class which are called xenografts, artificial and interspecies transplants. However, I presume we will include those some time in the future.

MR. HANDLEY: You talked to the Office of HMO and they have told you that they still consider organ transplants experimental so the HMO doesn't necessarily have to cover them. If that's the case, how do you view it from the standpoint of your Blue Cross/Blue Shield competing with the HMO for the same people in a group? Do you think there is a problem with selection? Maybe there is somebody out there who's worried about the potential of transplant coverage. Blue Cross/Blue Shield is going to get the risk and the HMO doesn't have to worry about it. Have you tried to deal with this issue?

MR. RICCIARDELLI: We just recently got the word on our ability to limit the HMO coverage so it does not include heart, heart/lung, and most liver transplants. The experimental language in our HMO contract now is sufficient to exclude those. We want to develop a rider attached to the HMO contract that would essentially cover those for an additional premium. We are going to develop the HMO coverage in these two different flavors, with and without, and essentially have the basic coverage follow the HMO or vice versa.

MR. THEXTON: Are there any restrictions on credit accident and health plans in Canada? In the U.S. there are at least four plans which are commonly written. Do you have legislation or something that requires only the one-month plan?

MR. VON SCHILLING: Most of the banks offer a comparable product because they are competing for loan dollars, so the one-month is pretty standard. In addition, there is provincial supervision to assure that, over time, a 75 percent loss ratio is attained on this kind of product. That in itself puts a limit on the premium.