RECORD OF SOCIETY OF ACTUARIES
1985 VOL. 11 NO. 1

INDIVIDUAL MEDICAL EXPENSE MARKET: IS THERE A FUTURE FOR COMPREHENSIVE COVERAGE?

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- o Products: design, policy provisions, impact from changes in the health care system.
- o Marketing: traditional and alternative distribution systems, concept of product brokerage.
- o Administration: cost effectiveness, group trust mechanisms, use of technology, regulatory environment.

MR. THOMAS J. STOIBER: Let us look at the history of the individual product and its progression. Before the turn of the century, individual policies were basically accident policies. Sickness policies appeared in the early part of the century, but on an indemnity rather than a reimbursement basis. Hospital-Surgical policies then followed. The major medical comprehensive product took form in the late 1950s. It was important because it introduced the expense reimbursement basis of paying individual medical claims. In the mid 1970s, we took the caps off of those benefits. Now we are in the 1980s and there is no where else to go.

The progression has always been upward because of competition and good financial results. The present situation is not really any different than what happened in the 1920s with the individual disability market, when benefits became overliberalized. We then returned to limited policies. I would hate to see that happen again.

This current upward movement has paralleled personal income growth which had always outpaced inflation. People still need the coverage, probably more than ever.

Is the product too comprehensive? I think there are two answers. No, it is our business to protect people from unexpected costs and to prevent financial ruin with the products high limits and unlimited nature. Yes, it is too comprehensive because, in our greed for more, we have gotten away from insurance principles by allowing our product to become a "prefunding mechanism plus insurance" with low deductibles, low coinsurance provisions, and an open checkbook to providers.

Why do we question the present and fear we have an unsolvable problem? This results from letting the world change without us properly reacting to these changes. We must analyze what the changes have been, determine what the real problems are, and modify the product design to take advantage of the changes and avoid problems.

Changes Affecting Medical Expense Products

Claim cost trends are probably the biggest changes that have occurred. This includes inflation, technological advances, and utilization. Evidence of these trends is most apparent when one examines national health care expenditures. In 1960, we were spending 5.2 percent of the gross national product on health care. Ten years later, it was 7.2 percent and it climbed to 9.8 percent in 1981, 10.5 percent in 1982, and about 11 percent in 1984. The 1984 Delphi study, conducted by Arthur Anderson in conjunction with the American College of Hospital Administrators, predicts the figure will settle at about 12 percent in the period of 1990 to 1995.

In addition to the claim cost trends, we have had a change in those competing for the traditional individual market. We now have multiple employer trusts (METs) and associations.

The demographics have changed. The baby boom has come of age. The over age sixty-five market is now a significant part of the population.

Economics are different. In the 1970s we saw for the first time the price index outpace the wage index.

Our products are quite different. What was once a predominantly level premium product is now an Annual Renewable Term (ART) policy. The guaranteed renewable product is being replaced by state renewability features or even optionally renewable clauses. Benefits which were of a fixed nature are now essentially unlimited, with no more room for benefit enhancement. Affordability is now in question because of the economic and competitive changes.

The provider system is probably undergoing its most dramatic change ever. The providers are becoming competitive with each other, leading to negotiated reimbursements and prepaid expense schemes such as Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO). The Delphi study predicted that 10 percent of total hospital revenues will come from this source by 1995. It now stands at 2 percent. Surgi-centers and minor emergency centers are rising everywhere. Hospital mergers are common place. The current oversupply of doctors will continue.

The distribution system is no longer the same. Banks, retail outlets, and financial planners are now part of the picture. Direct response may play a more important role in the future. There is also government involvement and consumerist movements.

Identification of the Problems

These are the changes. What are the "real" problems.

The first is our industry's improper reaction to the changing influences around us. Our product design not only failed to attack inflationary pressures, but actually promoted them via the "blank check" cost reimbursement basis. An example of this is the proliferation of technology at the insurance industry's expense.

Why has it taken so long to recognize that the comprehensive product is becoming unaffordable to many of our policyholders? The 1984 American Council of Life Insurance (ACLI) Map study found that three out of four people believe that health insurance is becoming too expensive for the average family. When that same question was posed in the 1977 survey, two out of three people responded the same way. We have led ourselves to believe that "more is better." More open-ended products meant higher premiums, more commissions for the agents, larger profits for the companies, and more benefits for the consumer. We have forgotten that we are in the insurance business. We have created a consumer attitude that one must get his money's worth out of his plan. How many people would hope their house burns down or that it is burglarized so that they can get their annual premium back? No one does. On the other hand, how many people have heard their friends or even themselves say, "I had better get that final doctor call in or get those prescriptions filled because I have not gotten my money back yet on my insurance policy."

The reimbursement based medical insurance was intended to reimburse for expenses they would have paid if there was no insurance. There is nothing wrong with this concept. In fact, it should be the cheapest way of covering medical expenses. However, it has not worked out this way! Policyholders are not prudent health buyers. To many, an insurance policy is like a company expense account, with one exception -- the provider of the services, not the buyer, determines the amount spent.

Fortunately, we are now overpredicting inflation trends in our pricing and lower cost products are becoming more common.

A second key problem is persistency. Product design is one of the best places to attack this. I would hate to see the regulators require us to set up a cumulative antiselection reserve. This has been talked about at some of the National Association of Insurance Commissioners (NAIC) meetings.

The third key problem is properly identifying our market and competition. For example, is our client better served by a small group policy, MET, or association policy? Do we offer the client who is between jobs a temporary policy? Does he have a permanent need for individual insurance, as with life insurance, or is it more of a transient need such as with casualty insurance?

There is a need for the comprehensive individual product. With costs so high, the need may be even greater. The country is entering an era of entrepreneurial spirit once again. This increases the need for the individual product. The large group employer is not the only employer in good economic times.

Possible Solutions Through Product Design

An individual product should have these qualities:

1. It should promote the reduction of unnecessary expenses by using cost containment features, educating the policyholder of the cost/benefit relationship, giving the owner incentives to be a prudent buyer, and promoting the notion of insurance over prefunding. It should be flexible to address new medical technologies such as transplants, to compliment the various government mandates, and to respond to the ever present rate increase pressures.

2. It should promote persistency of healthy and unhealthy lives.

3. It should be portable. We should take advantage of the one unique quality the individual product has over its group counterpart. A by-product of this would be better persistency.

4. It should be simple so the owner thoroughly understands what he has bought. This also encourages persistency as well as client/company goodwill.

5. It should encourage better risk buyers.

6. It should take advantage of the uniqueness of the age in which we live, such as the areas of advanced computer technology, high interest rates, and possibly the craze of unbundling the premium.

To meet these qualities in individual product design, the new generation of policies should contain a host of new policy features such as:

1. A fuller payload, such as 100 percent, on diagnostic related group (DRG) based benefits. This would require a company or an outside service committee review before payments above the limit could be paid.

2. A universal life approach to funding the initial costs of an insurance program. It would contain an annuity type funding to cover costs up to a large amount such as one, two, or five thousand dollars at which point a conventional insurance program would take over. It would contain little or no load on the funding element. It could take advantage of the high company interest earnings and possibly get a tax break.

3. Provisions which would reward the policyholder for low utilization. These could take the form of premium reductions,

a lower deductible, or higher coinsurance benefits.

4. Automatic index provisions on rates, deductibles, and coinsurance.

5. A return to level premium plans with a possible modest cash value buildup.

6. Larger benefits if low cost features such as second surgical opinions on selected operations, use of free standing surgi-centers, minor emergency centers, and pre-admission approaches are used.

7. Possible reinstatement of the per cause deductible. This would eliminate many of the low miscellaneous claims that people are now filing.

8. A policy that may go dormant for both premiums and benefits when the need is not there. When a person is between jobs, he has full benefits and while he is working he has very nominal, limited benefits, but his policy still stays in force. It is sort of a guaranteed insurability option without losing the policy.

Inside limits are not an effective feature for an individual product. The client is not always aware of just how comprehensive his policy is. This leads to an unhappy policyholder when he files a claim and discovers the limits of his policy. This also creates agent dissatisfaction resulting in the lapse of healthy lives. The limited policies of the past have given us a false sense of effectiveness because they are and have been profitable. In fact, some companies are making a good living at buying these old blocks. But we must remember that these are supplemental coverages. The pressures to overutilize are not the same as on the more comprehensive policies of today.

I think wellness features will not work for an individual product because they are too subject to antiselection. They are not measurable and are not fully proven to be cost effective. Wellness features may, however, have a place as an underwriting tool. The PPOs that work so well in the group area will not work in the individual market because of the geographic diversity of the marketplace.

<u>Summary</u>

In summary, there is a future for the individual product. We have been missing the bullseye, however, with our current products and, in some cases, even the entire target. If there is anything imminent to fear, it is the possibility of PPO domination, unless there is a law calling for a system where all payors would have the advantage of the negotiated expenses. If the PPO discount negotiations become widespread, cost shifting will go to those markets who have not or cannot negotiate discounts and result in a cost spiral. Further compounding the problem would be the difficulty discovering, measuring, projecting, and therefore, pricing this effect. There is always the possibility of

national health insurance. I do not see that occurring for at least the next ten or fifteen years.

MR. JAY JAFFEE:

The Marketplace

The market for individual comprehensive medical insurance can be divided into four pieces:

1. the self-employed;

2. the unemployed, whether temporary or long term;

3. the employed who have no plan at their place of work;

4. retired persons prior to going on medicare.

I guess there is even a small group of people who are over sixty-five who are not eligible for medicare.

How many of you know your marketplace and your customers? You should examine the applications being received and do some market research.

Will there be a market for individual comprehensive medical insurance? Will HMOs, PPOs and initialed organizations take over the world?

Medical Insurance - A Public and Social Issue

Medical insurance has become a public issue in the last several years. In the New York Times a couple of months ago an article appeared with the title, "Health Care Regulations: Bane? Bomb? Accident?" It discusses what the government has done in the last several years to become involved in this medical process. There has been a complete change in the concept of medical advertising. When I was growing up, you never thought that a doctor would advertise. A look at today's newspapers shows the changes which have occurred. The Wall Street Journal (March 15) published "Doctors Find a Dose of Marketing Can Cure a Pain of Sluggish Practice." The article is about doctors who are now using marketing services to change the nature of their practice. Just a few weeks ago, the Radiology Clinic took out a two page advertisement in our local paper. This would have been unheard of years ago.

The public is now conscious of medical costs. Employers are acutely aware of medical costs and are even telling workers which doctors they should use. A major article on HMOs appeared in Chicago Magazine which is certainly not a state-of-the-art technical journal. It is a very general publication in Chicago, a very upper socio-economic level publication. The Wall Street Journal wrote about the rise in out-patient surgery as firms rush to reduce health care costs. The New York Times wrote about Medi-Gap policy costs. The list of articles about medical costs in papers and magazines is endless.

Today we expect to be cured by the doctor and, if we are not, we begin to question whether the physician is guilty of malpractice. We expect to have access to expensive life-saving procedures and drugs regardless of the costs. We believe, that the right to health care has become the right to good health.

Vertical Integration: Direction for the Future?

Medicine is big business today. We have just heard from Mr. Stoiber what percentage of the GNP is devoted to health care and that it is going to get bigger. This is going to influence the distribution system and the players in the medical care field. Medicine can be a profitable business.

Consider that medicine and health care have become capital intensive businesses. It costs a lot of money to build a hospital. It costs a lot of money to equip a doctor's office. The machines used by a radiologist cost one million dollars or more.

Mass purchasing power and modern management controls can be put to bear on the health care delivery system. This is what it takes to make hospitals and physicians and other health care providers profitable. Vertical integration is probably going to come about because there is an oversupply of health care facilities in many areas. The providers are stressing the need for marketing. The key, in part, to being a profitable health care provider is a steady supply of patients.

Doctors no longer make house calls because of the inconvenience, the lack of facilities, and the liability. This change has affected how we are getting our health care delivered to us.

The barriers and stigmas at all levels against advertising in the health care field have been torn down. This is going to create the need for more advertising and more public relations by all levels of health care providers. I believe that a vertically integrated health care organization can make profits from all parts of the system. They can provide the entire range of health care services. They understand the economies of health care. They understand, for example, that the hospital expenses keep on occurring whether or not beds are filled with patients.

Yesterday's New York Times carried an article in the business section about the pharmaceutical firms and their need to broaden their range of services. They are going to have to provide drugs as they have in the past, but they are also rushing in to provide computer services and management services for hospitals, home health care services, and others.

American Hospital Supply plans to merge with Hospital Corp. in a stock swap. The Wall Street Journal noted "executives of both companies said the move is an effort to provide goods and services more cheaply in the face of pressure by the government and corporations to hold down costs." The health care providers are getting themselves together to be prepared to service the needs of the public and employers.

Another key article appeared in an early February Wall Street Journal, "Hospital Chains Battle Health Insurers, But Will Quality Care Lose in the War." This is an article about the Louisiana-based Humana Hospital chain. I quote from the article, "Humana is the first hospital operator to invade the health insurance field - but not the last." American Medical International, Inc. of Los Angeles recently acquired an insurance unit. Hospital Corporation of America in Nashville, Tennessee, also agreed to buy one. National Medical Enterprises, Inc., in Los Angeles is shopping for one. There appears to be a definite trend toward vertical integration in the health care business.

A vertically integrated health care provider would take over certain services. The insurer role could be taken over. Since the vertically integrated health care provider already runs the hospitals, it could run extended health care facilities because that would get people out of the hospitals. It will provide home health care services because there are many people who do not have to be in the hospitals and can benefit from this. It will have prescription drug and appliance programs. It will own emergency medical clinics. It would get involved with ambulance services. It will run retirement communities for people, and of course, it will own funeral homes. That is the description of a vertically integrated health care provider.

Will independent insurers be able to compete in the individual health care market against vertically integrated organizations? Not if people are getting cheaper benefits at a different type of facility. Unless there is a law to level this out, individually insured customers will possibly be paying more for the same services.

Distribution Approaches

We are facing competition in distribution costs from the different types of groups, such as METs, that are essentially in our same marketplace. A level commission schedule similar to casualty insurance is a possibility. We hear the same thought about ART life insurance. Everybody says that the level commissions avoid the antiselection problem that occurs and yet there are very few doing it.

Will facilities continue to be open to your customers? Will hospitals and other facilities admit your patients if they are not insured by their carrier? Will there be priorities that exist for admissions? What about administrative expense levels? Is your product going to be more costly to administer?

You are going to see more and more organizations develop which enable people to form groups for mass purchasing power somewhat along the lines of METs. I believe people are going to be creative in putting these groups together possibly using some of the individual policy marketplace. There will be a number of insurers left who will do well, providing individual comprehensive medical insurance plans. I also believe the number of companies and the overall marketplace will diminish.

As for direct response, it is not a panacea for changing the cost of

your agency distribution system. It takes special skills which you may or may not have. There will have to be very accurate mailing lists because the marketplace for the product is not all that broad. You are going to have to learn to deal with the customers where there is no agent involved. I think the answer to that problem is going to be a high level of telemarketing. Direct response will require a special set of skills. It may be of importance to a few of you who have special markets.

The public is receptive to changing its thinking with respect to higher deductibles. I always wonder why the excess major medical plan, which is one of the most important that people should have, has never sold well. Other products that have been available to the public on a supplementary basis have done well, such as medicare supplement products and hospital indemnity products.

MR. PAUL JANUS: Is there a future for comprehensive coverage in the individual medical insurance market? What do other experts think? There are almost as many views expressed as can be conceived.

Two studies have attempted to collect the views of the experts in health care and in public policy formation in a manner which allows us to develop a consensus about the future. They are long term in nature, and leave us with many questions.

The first study is Health Care in the 1990s - Trends and Strategies, jointly published by Arthur Anderson and Co. and the American College of Hospital Administrators. The second is a yet unpublished report prepared for an industry association by a very reputable research firm and will eventually be available to member companies. Both studies interviewed hundreds of experts in a very structured format.

The Arthur Anderson Study

The Arthur Anderson report produced thirty-two specific conclusions about the future. The ones most important to individual comprehensive coverage are:

1. The amount of money spent nationally in health care services will continue to grow, even with slowed inflation and more efficient or reduced care. By the 1990s, health care's share of the GNP will be 12 percent (it was 10.5 percent in 1982) and will remain there through 1995.

2. Emphasis in health care will shift to ambulatory services and new delivery systems. Long-term care alternatives will grow.

3. Prospective payment systems will be extended to include physician payments. There will be a decline in fee-for-service payment methods. Doctors will make less money. (How do we design benefits? Can we cover both prospective and fee-for-service payments?)

4. Patients with private coverage will experience payment restrictions, but additional levels of service will be available to those willing to pay. (Does this imply group supplemental coverage?)

5. Equal access to a minimum level of health care is considered a right. However, access for those unable to pay will decline.

6. Medicare will further limit coverage for inpatient care and physician services. However, coverage for home care, hospice care, hospital outpatient services, rehabilitive services and skilled nursing care will be expanded. Catastrophic benefits will be added.

   Overall medicare beneficiaries will pay more through increased premiums, deductibles, and coinsurance. The qualifying age for medicare will be raised. A means test will be implemented by 1990. Mandatory assignment of benefits by physicians is expected.

   (Does this mean an expanded market for medicare supplement ? What is the effect of a means test on the market? Can we develop "level of care " products for senior citizens?)

7. Medicare's share of health expenditures will increase from 16 percent in 1982 to 18 percent in 1990 and 19 percent in 1995. This is due to the aging population. By 1995, persons sixty-five and over will make up 13 percent of the population.

8. Prospective payment DRGs will prevail by 1990. The DRG prospective payment system will continue to be utilized by medicare over the next five years. The use of a DRG system by other payers including medicaid, Blue Cross and commercial insurers is expected as well. However, half of the experts believe DRGs will be replaced by 1995.

   By 1990, only self-pay patients will be paying full charges.

   (Can individual insurers design, administer, communicate, and sell DRG payment systems in contracts? How do you handle geographical and age differences and changing methodologies and still provide ongoing comprehensive coverage? Will we be wasting our time? Should we instead be negotiating discounts with hospitals and doctors? Do we wind up insuring "those few still paying full charges?")

9. PPOs and HMOs will increase market share five-fold and will account for 10 percent of all hospital revenues by 1995. Blue Cross and commercial insurers will experience a decline from 33 percent to 27 percent of all hospital revenues. However, some of the PPOs and HMOs will be insurance company owned or sponsored.

10. There will be greater need for nonacute facilities by 1995, especially extended care facilities and rehabilitation facilities. Substance abuse and psychiatric facilities will also be needed. (How do we underwrite benefits for such care?)

11. Multi-hospital systems will grow significantly to over 40 percent of the hospitals. (Will there be increased competition if they enter the insurance market? This may improve our ability to negotiate fees and restrict facilities where we will pay for care.)

The Insurance Industry Study

Many of the conclusions in the insurance industry study are similar, but some differ in emphasis. They made specific assumptions about the future:

- o overall U.S. population growth of about 18 percent between the years 1980 and 2000;
- o continued growth in the proportion of the population aged sixty-five and over and, especially, the population aged seventy-five and over;
- o continued improvement in the financial status of many of the aged, with many others remaining below poverty level;
- o continued growth in the supply of physicians, resulting in a marked surplus by 1990 and an even larger surplus by 2000;
- o a continued oversupply of hospital beds reflecting diminishing need and the difficulty of dismantling capacity already in place;
- o economic growth, inflation, and employment rates falling between existing "high" and "low" projections, without any major disruption such as might result from a large-scale war or another development comparable to the oil crisis.

The major conclusions of the industry study are:

1. There is a shift away from the traditional view of health care as a social good exempt from market forces and toward a view of health care as an economic good subject to laws of supply, demand, and price. The Anderson report had indicated that people would still view health care as a right, but at a minimal level.

2. Cost containment will dominate the health care agenda through the 1990s.

   a. The federal government will resist legislation which helps the entire system; instead it will concentrate on its own budgetary problems.

   b. DRGs will continue to be refined, but ultimately their complexity will lead to their replacement, probably by capitation-based systems.

   c. State governments will increasingly adopt prepaid systems for medicaid. Freedom of choice for the poor will be reduced.

   d. The American public will not accept health service rationing (similar to Britain) involving denial of clearly beneficial but expensive care.

3. The health system of 1995 will be both highly competitive and to some degree regulated. Centralized regulation is felt to be too expensive and inflexible. However, total deregulation would quickly lead to glaring inequities. Regulation is most likely to be adopted at the state level, but the nature and extent of state regulation is uncertain.

   This outlook on regulation and the government's role seems to mean that cost shifting from government patients to commercial patients will continue to be an important factor.

4. There will be a major improvement in the availability and quality of information on health care utilization, cost, and quality.

5. Consumers with good health habits will be less willing to subsidize the care for those whose life styles make them higher health risks. The concept that the highest users should pay the highest cost will become increasingly acceptable. Ultimately consumers will become more willing to give up some freedom of choice in support of more cost-effective care.

6. The mix of health care services and the way they are provided will change. Specifically:

   a. There will be more health care services for the aged.

   b. By the mid-1990s or earlier, there will be intense public pressure for protection against the costs of long-term care.

   c. A variety of specialty services will emerge, reflecting physician competition for market niches.

   d. The shift of care from inpatient to ambulatory settings will accelerate.

   e. Health care will be delivered increasingly within managed systems.

   f. There will continue to be walk-in, convenience-type ambulatory care services, but by the mid 1990s, the growth in this area will have tapered off.

7. Under all scenarios, a "safety net" will provide a limited guarantee of access to care. The form of this safety net and the role of insurers will probably vary from state to state.

8. A tiered system of health care with different levels of care available to the poor, the general public with group insurance, and the affluent will be specifically recognized and accepted.

9. Physicians will increasingly practice in organized salaried settings. Solo practice will virtually cease to exist.

10. By 1995, HMOs will cover 25-30 percent of the population compared to 6 percent currently. Major growth will be investor-owned HMOs, networks, or chains, and "competitive medical plans" servicing medicare beneficiaries. (This agrees with the Arthur Anderson report.)

Conclusions regarding administration are:

1. There will be an increased need for computerized data bases to:

   a. help design contracts;

   b. monitor providers;

   c. help negotiate with providers;

   d. and most importantly, to move quickly on price changes that respond to more individual characteristics.

2. Underwriters and agents will need better means to reflect the expected health and level of service the individual is likely to require when setting the type and price of coverage.

3. Rates must be allowed to change more rapidly. Actuaries, regulators, and systems must be sensitive to the need for much greater flexibility. Optionally renewable contracts with the ability to have major benefit changes and individual reunderwriting will be necessary. This will require significant and difficult changes in regulation. It is probably not possible without a state pool concept to cover uninsurables.

4. Negotiated payments will be a necessity. This will most likely lead to limited access or managed access to providers.

5. The entire process will seem too expensive or dangerous to many companies. Expense control will be very important and difficult. To reduce expense and administrative problems, one may need specializations in certain types of coverages, such as long term care, or in certain markets, such as group supplements for a more affluent population. This will allow the company to reduce the options and to design systems to minimize cost.

6. A few companies will serve as providers of such insurance, while most others will act as marketing companies, either for an override or a share of the risk.

<u>Conclusion</u>

The market for complete comprehensive care will still exist, but will be considerably changed and smaller than today. One increase in the market may be for early retirees, especially if medicare increases its age of eligibility.

The market for specialty and supplemental products may increase as cost containment measures eliminate payments for optional care by the government or employers.

The market for medicare supplements is going to change dramatically. I expect major reductions due to HMO and competitive medical plan competition, only partially offset by reduced medicare benefits. In addition, the market for ages sixty-five to seventy will shrink as medicare eliminates the younger ages from eligibility.

Expenses and rates will be under constant pressure and very fine pencils will be needed.

All in all, there is a future, and ultimately growth for the best companies, but it will come with very hard work.

MR. HAMM: A major trend is product brokerage. Is this a temporary or a permanent phenomena and, if it is permanent, what does that mean to our industry? Will it turn into two wings, one for manufacturing and the other for distribution?

MR. JANUS: We see this trend in our company. We have expanded more into brokerage and general agency marketplaces. This is likely to continue as the marketplace gets increasingly specialized.

MR. STOIBER: I think we are going to see more too. As the market shrinks, we will see more specialty products. It is going to become expensive. The number of insurance companies will diminish, but that does not mean the number of agents wanting to sell products will diminish. The brokerage approach is probably one of the best ways for companies to get products to their agents.

Mr. Janus, you talked about reentry in the individual medical business. We thought that could work with life insurance, but it did not. Why do you think it might work with medical insurance?

MR. JANUS: I am not referring to reentry as much as to re-underwriting. One of the major problems that companies have had has been the antiselection spiral. If these studies I referred to earlier are correct, people will become more attuned to the idea of paying their own costs in insurance. What I am suggesting is that both the antiselection spiral and this trend can best be met by creating contracts where we have the right to charge the price that reflects the current health situation at the time of the policy renewal as well as at the time of issue. I do not visualize reentry in the sense of re-underwriting as in a new sale and paying new business commissions. However, that does happen in today's marketplace due to a fair amount of rolling by brokers and general agents in order to get the higher first year commission and cheaper prices for their client.

MR. LEONARD KOLOMS: Mr. Stoiber seemed to indicate that there is no longer a market for any guaranteed renewable coverage. We have been selling guaranteed renewable major medical with internal limits since 1971 and it is a good market for us.

You also indicated that limited policies would have poorer persistency. We seem to have a better persistency rate. I have heard from other companies that their persistency rate is running 3 to 3.5 percent a month. The lapse rate on our limited major medical products is running only 15 percent to 20 percent a year beyond the third or fourth duration. This may be better than the experience of most. If this is true, why do you feel that the antiselection that is taking place on lapsation is caused by rolling? Maybe it is caused when a premium increase takes place. The people who really do not need the coverage lapse, leaving you with the unhealthy people who in addition may have duplicate coverage.

MR. STOIBER: I do not see anything wrong with guaranteed renewability features. In fact, I prefer them. Today's guaranteed renewable products do not have the flexibility we would like. I think we might be able to provide the consumer a better product as the environment changes.

On the question of persistency, I think we still need to look at the fact that it is the healthy lives that are rolling. If a good risk policyholder with a limited policy has that first claim, he suddenly realizes that he must pay 25 percent of the bill because the limited coverages did not move with the times. The policyholder would be a fool to lapse and start over again with pre-existing conditions and underwriting. The agent, however, gets an earfull from the policyholder and then encourages other clients to lapse. We have an obligation to provide for the better policyholders. It will result in a better atmosphere and a better client relationship with the company.

MR. JANUS: In Banker's comprehensive business, about 40 percent of the business lapses in the first year and about 25 percent in the second year. Our broker business, which comes out of different companies, has a similar first year lapse pattern but a much higher second year lapse pattern, almost equal to the first year. We attribute that to rollovers that exist when you have independent agents.

MR. JAFFE: Why don't you find out why they are terminating?

MR. JANUS: We would like to find out why they are terminating. Some of them will not tell us. We have sent out letters to the people.

The lapse rates that we get on our own business which are high, have been due to two causes. One is that the sale of much of the coverage is essentially temporary in nature. People only have a need for one or two years of coverage. Secondly, we have had some substantial rate increases due to inflation and the ART nature of the product. Obviously the rollovers might be occurring in the brokerage operation because the situation is more competitive and there actually may be better priced products available to the customer.

MR. KOLOMS: Are you suggesting that the persistency problem is due more to the distribution system than to the product design? Earlier you seemed to indicate that leveling commissions would take care of this problem. If you are not dealing with an independent agent, level commissions do not matter.

I still do not understand why you feel an internally limited product is not desirable. We feel that it is the best cost containment product that exists. Internal limits are a cost containment feature. That is why the policy we introduced in 1971 has only had three rate increases in its entire history.

MR. STOIBER: I think the average buyer only has a simple understanding of his policy. All he knows is that he has medical coverage. He does not realize that his room and board coverage has a set limit. He does not know what his hospital will charge him beforehand. He does not know that he is going to get a better buy by going to St. Mike's instead of County General. He is not going to question his doctor because his inside limits do not educate him properly. If you could educate him with seventeen inside limits, I think it would be great. It will save the company money for the short term, but I do not think this is what we should be proposing.

MR. JAFFE: Mr. Koloms, I wonder if the doctors and the hospitals are taking what they can get out of the policy. Is that possibly the secret of your success? Are they just accepting whatever payments you make, or are they billing the people for additional payments?

MR. LAWRENCE ENGEL: As a company we have been looking at some of the same questions Mr. Hamm has raised concerning corporate brokerage marketing. We cannot sell enough comprehensive major medical business with our own field force to make it work. We are counting very heavily on the availability of corporate brokerage arrangements in the future to allow us to have a viable product.

We hear a lot of talk about cost containment features, some of which are proven to be effective, others are not so effective. The one that appeals to me is precertification and concurrent review. Has anyone attempted to use that type of an arrangement with an individual contract?

MR. JANUS: We have not and I do not know of any such arrangements.

MR. STOIBER: No, I have not seen that. Some of the METs are moving in that direction, but I have not heard of an individual product. That has the potential for being one of the biggest savings in cost containment.

MR. SPENCER KOPPEL: Mr. Janus, you alluded to a future need for long-term care coverage. I know the government is putting pressure on the industry to start developing products that provide long-term care coverage, by itself or in conjunction with other coverages. It seems it is a very expensive coverage and a difficult one to market. Has anyone given thought to what kinds of products might work.

MR. JANUS: There is at least one company that has come out with a four-year skilled nursing home policy which they are marketing fairly well. It's too early to tell if their experience will be what they want. This is a challenge to the industry which will take some time to be answered.

MR. JAFFE: I think one company already went broke trying to provide long-term care coverage. The cost curve shot right off the map as the insured got older. People wind up with a 100 percent probability of dying in a nursing home. Long-term care is also a socio-economic/family phenomenon. The chances of going to a nursing home if you had a healthy spouse were significantly less than if you did not have one. The higher the socio-economic level, the less chance of going into a home unless you were seriously ill.

MR. KOPPEL: The skilled nursing home is not what the government is addressing. They are concerned with the convalescent homes or rest homes. Skilled nursing homes are sometimes long-term care but they are not typically as chronic as the rest homes.

MR. JAFFE: There is also a stigma against going into these homes. When you get put into one it's to die.

MR. JANUS: The Wisconsin situation mentioned by Mr. Jaffe was also a case of severe underreserving and underpricing. If you can define nursing care as necessary medical care and can handle claims properly, you can control the claim costs. In fact, you may have a problem paying enough claims. Some kind of a prefunding mechanism is probably going to develop.

MR. HAMM: Is there a chance of a medical IRA catching on?

MR. JAFFE: If you get into the IRA concept, you are not going to be hitting the group that needs it most. IRS statistics show very directly that the use of IRAs is predominate in those people with incomes above $40,000. Below that level it is almost a waste of time to market it.

*MR. DAVID STEPPAT: We have looked at long-term care very carefully. We have identified fifteen or so companies that have tried it in one form or another, always on a toe-in-the-water type basis; a few states, limited plans, very carefully getting into the market. We have not been able to find anyone who has been able to do it on a widespread basis with any sort of consistency. One reason is because state regulation is very unclear and people are frequently changing their views. Another reason is the lack of federal regulation. We have come to the conclusion that there is no problem marketing it. You can sell as much as you can produce. The problem is putting together a viable product. I think designing the product as we do now on an indemnity basis sold after age sixty-five is too expensive. There has to be some sort of prefunding. I hope there are some industry groups looking at it right now. But I also think it is probably one of the biggest potential markets we have in the individual market. It would be very nice to find a way to design a viable product.

MR. HAMM: This supports the concept that we need to expand our market in order to be successful. This could be through product brokerage or expanding the type of products we offer.

*Mr. Steppat, not a member of the Society, is an Assistant Vice President with Mutual of Omaha in Comparative Product Research.

MR. JOSEPH GALKO: One of the issues which almost invariably gets mentioned when we talk about individual medical expense coverage is affordability. Most of the companies that have been in the marketplace have offered high deductible plans for some time and most of the companies with which I am familiar have had relatively good experience with that type of coverage. Why has there been a reluctance on the part of consumers to buy and the agents to sell those kinds of products since they are available in the marketplace?

MR. JAFFE: I think excess major medical and higher deductibles are important coverages. I believe that the higher socio-economic level of people that are buying coverage will opt for higher deductibles if it is presented to them. They can afford the first X dollars of coverage.

The product, which is the most important for all of us and which is relatively inexpensive, is the excess major medical. Most of us, even though we have pretty good group coverage, would need it if we had a very, very large claim. It used to be that the umbrella policies that existed had some excess major medical. But I believe that has been taken out. So most of us are naked in that respect, and yet, that is a product that we can't convince the public to buy.

The excess major medical benefits us in the same way most of us would benefit from a 180-day or a 365-day deductible on our long-term disability, and yet, those are not the most popular plans that are sold. In fact, 365-day deductible options are often not even offered.

MR. HAMM: Mr. Stoiber, can you discuss your concept of a universal life major medical plan. It appears that the high deductible plans have not been accepted in the marketplace. The universal life concept seems to be an attempt to make it more desirable to the consumer.

MR. STOIBER: I think that it has something to do with socio-economic background. The buyer of the product does not want to worry about medical expenses no matter how small they are. We have to sell what people want, but we have not educated the people to realize that it is not to their advantage to pay for low deductible insurance.

I have heard of some companies piggybacking or complementing a higher deductible policy with an annuity plan. People do not care if they have insurance; they just want a way to pay those bills. I think insurance companies can take advantage of that and recognize that they don't need to pay those 30-40 percent commissions on that first-dollar care. They just need to provide a way for people to buy their higher deductible plans by some type of universal life approach. The universal life approach is not different than one of the cash management accounts currently available today. Let the people know how much money they have deposited and how much money they want to fund. When they have a bill, tell them we are paying it out of their bank account that is earning 10 percent or 12 percent. They are going to think twice about getting that prescription filled or seeing the doctor over that sore throat because it is their money. You have to let them know it is their money. People think that once they pay their

premium, it isn't their money anymore. That is the kind of attitude that must be changed and I think the universal life concept might help do just that.

MR. JAFFE: The universal life approach will call for an excessive amount of administration. From that standpoint it may not be viable for the insurer. It would be desirable if you could put it in the form of a universal health policy. You could then visably show the policyholder what goes into and out of their account. There are tax problems which may make this form unfeasible at this time. Maybe the concept is a little ahead of its time.

MR. HAMM: Most of our statements have focused upon affordability. Our products keep getting more and more expensive. This creates problems for managing the product profitably on a long-term basis. We have recently attempted to introduce a less expensive major medical plan to appeal to the segment of the marketplace which needs permanent coverage at a lower cost. The product was not successful. This plan had a second deductible for inpatient hospitalization, a low per cause deductible and higher coinsurance. We found that the cost of that plan was very similar to the one thousand dollar deductible plan and that the consumer was better off with the one thousand dollar deductible. The problem then becomes how can we get the consumer to buy the one thousand dollar deductible plan.

This also leads into the commission question which we discussed earlier today. How can this product be viable with a 30 percent commission when there are METs selling the product at a level 10 percent or 15 percent commission?

Mr. Stoiber raised the issue of portability in his remarks. An advantage of the individual product is its portability. This appears to be a high price to pay. Are there any comments on the commission level and what that means to the product's affordability? Can the product survive in the long run with that high first-year commission?

MR. JANUS: In the long run, I do not think so. I think commissions will ultimately come down. It will be a slow painful process. The first company to reduce their commissions will effectively put themselves out of the business, and, therefore, it is going to be a very gradual process built upon very bad years of experience. When experience is bad enough people will make the corrections.