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STATE-MANDATED HEALTH BENEFITS

Moderator: JOHN A. MAURER
Panelists: LARRY M. GORSKI
THOMAS D. SNOOK
WILLIAM H. WATSON III
Recorder: JANET M. SOPPE

- Who should decide and who should pay?
- Basis of making decision
- Effect on insurance rates
- Impact of self-insurance
- Legislative process
- Timing of savings, if any

MR. JOHN A. MAURER: This is a session on the topic that I know is near and dear to everyone's heart: State-Mandated Health Benefits. I'm sure we've all had a nice time dealing with our regulating friends. I think we have put together a pretty good panel to get this topic going.

Larry Gorski, who's been a life actuary with the Illinois Department of Insurance since 1976, has been active with the health standards board and has participated in such NAIC projects as long-term care on nonforfeiture and valuation issues, Medicare supplement loss ratio review, and group rate review. I am counting on Larry to make strong representation for the regulators on this open forum.

Tom Snook is a consulting actuary with Milliman and Robertson in their Houston office where he works with both group and individual health insurance. He has worked with insurers on pricing mandated benefits and has advised state governments on potential costs.

Jan Soppe, who has graciously agreed to do all the work involved with this session and be our recorder, is Vice President and Actuary at Life Investors.

Bill Watson, who's Vice President and Health Actuary at American National, is responsible for looking after all of the actuarial functions associated with the company's individual health operations.

MR. THOMAS D. SNOOK: I think it's interesting to note that two of our three panelists plus our moderator, plus our recorder, are Texans. I don't know if by birth or by choice or what. I hope, Larry, you don't feel too out of place with the Texas accents.

MR. LARRY M. GORSKI: As a regulator I usually do feel out of place!

MR. SNOOK: I think that state-mandated benefits are a topic of interest to any actuaries who have tried to price them. It's certainly an onerous subject, and I don't

know if it's humanly possible for one person to keep up with all of the mandated benefits in all the states. I think that the count is well over 600 different state-mandated benefit laws, closing in on 700. I'm going to talk about mandated benefits from the group rather than the individual side of the picture. And since this is an open forum session, I'm just going to throw out a few topics that might be worth our discussion later.

The title of the session is State-Mandated Health Benefits. I'd like to expand it a little bit to include at least a brief discussion of the possibility of future federal mandates. There's some evidence to suggest, I think, that this is the wave of the future.

My first topic: "Why are there mandated benefits?" The theoretical justification for mandated benefits is the efficient implementation of public policy. A state government perceives a need in society for some sort of health care that's not currently being delivered, or at least that's not being delivered adequately or equitably. To remedy this need, the government, that is, the state legislature, applies its authority to regulate insurance and passes a mandated benefits law.

Mandated benefit laws are in the insurance code and are not "employee benefit" laws, which is important to states when it comes to self-insurance.

The insurers are the ones who are immediately affected by the laws. They, of course, turn around and increase the premium rates to pay for the expanded coverage. The employers, in turn, pass along the added cost to the consumer in the form of either higher prices or lower wages. In the end, the way the theory works is the cost of the mandated benefit is "atomized" through the insurance process.

Well, that's the theory, and I would hold that in practice the theory fails. Self-insurance is one reason it fails, and I'll discuss that later. I think perhaps a more basic reason why it fails is that the first step in the process, the perception of a societal need, is highly politicized. Really, it's a no-lose situation for a politician. The politician looks good, at least to the relatively uninformed lay population. The voter sees himself as receiving an added benefit from government for free; that is, without a tax increase. Of course, in reality, the costs to the consumer are there, they're just hidden.

Special interest groups also play a large role in the implementation of mandated benefits. Groups are generally providers whose services have traditionally not been covered or have been covered in very limited fashion by health insurance. I think the obvious example here is chiropractors.

Before I go on to my next topic, I might mention that there's some evidence that there's a backlash against mandated benefits occurring. A number of states have passed laws that require an actuarial evaluation of a mandate proposal before the bill can be passed into law. The evaluations are, as a rule, nonbinding, meaning that even if we as actuaries say that the cost is very high, the state can still pass the law. But I think it's a good sign that legislatures are wanting, or at least going through the motions of wanting, to make informed decisions. I think maybe more importantly it's an excellent forum for us as actuaries to educate policy makers on not only the basic cost of mandated benefits,

but also on some of the more subtle issues such as anti-selection and the influence of insurance on utilization.

As further evidence of this backlash, a number of states have ceased altogether using the insurance code as a public policy tool. I think that the count is 17 states that have not passed a mandated benefit law since 1985.

The second topic we might want to discuss is the impact of self-insurance. As I mentioned, mandated benefits are passed under the state's authority to regulate insurance, and employers are not subject to these laws. Moreover, a state cannot pass a law regulating self-insured plans. The regulation of employee benefits is preempted by Employee Retirement Income Security Act (ERISA) of 1974. This preemption is something that we've all kind of believed in and worked with, and it looks like it's being challenged now.

A year or two ago, the state of Texas tried to challenge ERISA by trying to pass a premium tax on employers who self insure. "Premium," of course, isn't the right word. They were actually talking about expected health plan costs plus administrative costs -- in other words, premium. The law was struck down by the courts with a judge citing the ERISA preemption.

Interestingly, I recently read that the U.S. Supreme Court has agreed to hear a Pennsylvania case that will test the ERISA preemption. In this case, a self-funded employer sought to lay claim to a court settlement awarded in an accident case for which the employer paid the medical bills. In the insurance code, this is against the law in Pennsylvania: the employer's claiming that ERISA is the sole means of regulating self-funded plans. In the lower courts, both a federal trial judge and the Third U.S. Circuit Court of Appeals ruled in favor of the state that state regulation of self-funded plans is not preempted by ERISA. So we might want to watch out for this and see what's going to happen there.

As it currently stands, an employer who self insures does avoid state-mandated benefits. I think that nationally, maybe as many as two-thirds of all employees with group health coverage have their health care provided under self-insured plans. So the state-mandated benefits laws are helping only one third of the insured population, and, of course, mandated benefits don't help the uninsured population at all. So this theory that I just mentioned is flawed. The public policy goals are not being met. Large employers are avoiding the costs while the small employers cannot. Small employers are probably the least able to handle this extra cost, especially if they're in direct competition with the larger companies.

To this end, two states, Washington and Virginia, look like they're going to go ahead and pass some laws that will take the strain off the small employer. The legislatures of both these states have passed some fairly similar bills, and both are expected to be signed by the governors. In one of the states, I think the bill passed unanimously through the assembly. The bills call for relief from the state-mandated benefit laws for small employers who instead meet certain specified minimum standards of coverage. Generally what I would call the "periphery" benefits are not required to be covered.

The third topic is, "How do we as actuaries price these things?" I think anyone who has sat down and tried to price a brand new mandated benefit knows that it can be quite a frustrating exercise. A great deal of actuarial judgment is involved, and I think there are very few guidelines.

I would break mandated benefits down into three different categories: the first one being "covered services," for example, home health or alcohol dependency treatments; the second, and very closely related, "covered providers," the chiropractors again; and third, "covered beneficiaries," for example, employees and dependents during a labor dispute or handicapped children past the limiting age. I think this last category, covered beneficiaries, isn't usually too difficult or too costly, at least relative to the other two, since we're generally just providing the same benefits and generally collecting the same premium -- but over an extended period of time.

The other two categories are generally expansions of coverage to traditionally limited or excluded benefits. As a consequence, cost and utilization data for an insured population are either scarce or nonexistent. We can usually find some sort of general population data that offer some limited guidance. So the actuarial judgment, or if you want to be a cynic about it, guess work, comes in when you try to modify this general population data to make it appropriate for an insured population.

I wouldn't think anyone here will question the fact that insurance influences utilization, but the question becomes "How much?" To be honest, I don't think there's a good answer. The degree of increased utilization will vary depending on how "soft" the coverage is. By a "soft" coverage I mean one that is subject to a high degree of individual selection and whose insurability is consequently questionable. Many of the mandated benefits provide for coverages that were traditionally excluded because they are "soft" benefits.

I think that when we are sitting down to think about it and are drawing our conclusions and making our judgments, we can draw on the past. There's an interesting thing I know that's happening in Houston, at least, that providers of mandated care are advertising like crazy on TV, radio, and billboards. As an example, one chiropractic firm in town is advertising what it calls it's "NOOPE" benefit, that's NOOPE, for No Out Of Pocket Expense. They accept your insurance coverage as payment in full. No deductible, no coinsurance, and really no reason not to go. A vigilant insurer may catch this and reduce benefits, but you can't be everywhere at once and that's a tough thing to catch, I think.

Mandated benefit laws generally require one of two things: either the insurer is required to provide a specified coverage to all insureds or the insurer is merely required to offer the coverage for an extra premium, and the employer can choose to accept or decline the coverage. These mandated offers, I think, are even harder to price than required coverages, and I've concluded that the things really aren't priceable. An employer's only going to pay for these things if he perceives a need, and if he perceives a need, you're going to have a claim. If you do price it "correctly," meaning using the traditional actuarial techniques and then factoring in a heavy antiselection load, the price will be so high that the benefit is really of little value to the insured. That's another flaw in the public policy theory. It's not insurance, it's the prepayment of expense with an

administrative load. Even then the insurance company in some states, at least, could still take a big loss since states may not approve an unconscionably high rate.

It's been my experience that mandated offers are rarely taken; and I'd be interested to hear if anyone has any hard data on that.

The fourth topic concerns federal mandates. In 1989 our good buddy Senator Kennedy introduced Senate Bill No. 768, the "Basic Health Benefits for All Americans Act." The Bill hasn't passed, at least not yet, but given the commotion in the press and public these days about the uninsured, I wouldn't discount its probability of passage. I think that the concern about the availability of care to the uninsured is certainly justified, but I'm not sure, at least I'm not yet convinced, that Mr. Kennedy's bill is the answer. Especially if you get down and look at the nuts and bolts.

The bill, as introduced, calls for minimum standards for health insurance for all employers, regardless of size. A minimum plan of a $250 deductible, 2 X family limit, 80% coinsurance, and $3000 out of pocket maximum is mandated. Included as covered expenses are prenatal and well baby care, and both inpatient and outpatient psychiatric care. Preexisting condition exclusions are prohibited. Employees' premium contributions cannot exceed 20% of the cost, and low-wage employees must be offered a health plan with no premium payment. They're nice enough to allow us to substitute an actuarially equivalent benefit for the minimum benefit.

Employers are required to adopt the health plan of a "regional insurer" if the employer falls into one of two categories. In effect, any employer (1) without current medical coverage or (2) who is a small employer needs to insure through a regionally certified insurer. Insurers must apply to the Department of Health and Human Services (DHHS) for regional insurer certification. These insurers who are certified must agree to enroll any group in the region that is eligible to enroll with a regional insurer and to offer DHHS-approved plans.

The certification process includes among other things, a review of premium rates. Also, DHHS will review regional insurers' performance periodically, whatever that means. Particularly interesting to actuaries is that regional insurers' premiums must be community rated and cannot be adjusted for an insured's age, sex, health, or geographic region.

MR. WILLIAM H. WATSON III: My prepared speech is going to overlap a little with Tom's, but I hope you'll bear with me. State-mandated benefits are benefits that insurance companies must incorporate into their contracts, or at least must offer to incorporate into their contracts by legislative decree. Many insurance companies don't voluntarily want to provide these benefits for a variety of reasons.

I'm first going to talk about how state-mandated benefits originate, the argument of both the proponents and opponents of state-mandated benefits, and the likelihood of passage of state-mandated benefit legislation.

Then I'm going to talk about the effect of state-mandated benefits on individual insurance rates. I'll address the increase in claim administrative costs associated with

state-mandated benefits. And I'll conclude with how companies reflect these state-mandated benefit costs in their premium rates.

My presentation draws heavily from a research bulletin prepared by the Health Insurance Association of America (HIAA) and a report on mandated benefits in Maryland, also by the HIAA.

How did state-mandated benefits originate? The introduction and passage of mandated benefit legislation is primarily a product of the legislative process. Whenever a particular illness or provider is not covered to the extent desired, providers or those afflicted with that illness are likely to make this dissatisfaction known to the legislators. This may lead to a legislative proposal on mandated coverage of that illness or a provider. Enactment of mandated benefits depends largely on the organizational ability of the proponents. In large states, both providers and those seeking coverage have trade associations or consumer groups with committees to expedite passage of a mandated benefit bill. Frequently owing to large numbers of association members with access to legislators on a local basis, good organization, and effective representation in capitol cities, these organizations are successful.

These organizations frequently use emotionally charged arguments. *The Wall Street Journal* article addressing the growth of mandated infertility treatment coverage cited an instance where teary-eyed proponents paraded a two-year-old test tube baby in front of legislators at a hearing to consider in vitro fertilization legislation. As you can imagine, the measure passed.

In contrast, insurers are not as numerous, do not have the same local access to legislators, and depend on economic arguments, which frequently are not viewed as favorably, because of the perception that insurance companies can pay almost unlimited benefits without adverse effect. Cost data that can be used in the economic arguments against state-mandated benefits aren't always readily available, both because it's either a new benefit or a new experimental benefit and there are no data around, or the data can't be easily disseminated from general claims data.

It's only recently that employers are becoming more aware of the cost of mandated benefits and they're more aggressively fighting them. Of course, small employers fight them more aggressively than large employers, since self-insurance is not a viable option for them.

Advocates of state-mandated benefits included providers and those affected with a specific disease. Their arguments supporting state-mandated benefits are as follows:

1. Individuals covered by insurance are entitled to be covered for specific services. Since insurance companies have systematically undervalued the benefits of some services such as mental health, the state must intervene in the marketplace.
2. State-mandated benefits will pay for themselves by using lower cost providers and settings; chiropractors versus physicians, long-term care or nursing homes versus hospitals.

3. Absence of state-mandated benefits will expose insurers to more anti-selection, since sick individuals will try to enroll in richer plans. They're looking out for us.
4. Continuation and conversion mandates provide immediate coverage when an individual loses his job and do so inexpensively owing to the economies of scale of group insurance.

Opponents of state-mandated benefit legislation include insurance companies and employers. Their arguments used in the battle against state-mandated benefits include the following:

1. State-mandated benefits intrude on employer/employee relations, imposing a benefit package that neither side really wants.
2. State-mandated benefits expand rather than substitute services. If they saved money, insurers would have offered them already on their own.
3. State-mandated benefits cause increases in premium that may cause more employees to drop their health coverage. A recent study indicated that each new mandated benefit in a state increased by 1.5% the likelihood that a small firm could not offer coverage.
4. State-mandated benefits cause large employers to self insure.
5. State-mandated benefits disproportionately benefit specific providers.
6. State-mandated benefits increase administrative cost of both insurers and employers, especially multistate employers.
7. State-mandated benefits further escalate the cost of health insurance.

Surprisingly, organized labor and consumer groups have been relatively mute on this issue. The result of all the state-mandated benefit legislation activity is that we have approximately 750 state-mandated benefits in effect today. The last toll was 735 which was taken about eight or nine months ago and I just extrapolated up to 750.

Once again, these mandated benefits take one of three forms. The first form is where the state requires that insurance covers specific services or disease. Most require that the coverage be part of the plan, although some of these legislative decrees allow us to affirmatively offer it. Examples of this kind of coverage are alcohol treatment required by 37 states, mental health care coverage required by 28 states, coverage of acupuncture required in three states, and coverage of wigs, under certain circumstances, in Minnesota.

The second form is where the state mandates an insurer cover specific providers. Examples are coverage of chiropractors in 36 states, coverage of psychologists in 37 states, and coverage of naturopaths, which are herb specialists, in two states.

The third form is where the state mandates that coverage be made available to people who might otherwise have difficulty finding coverage on their own. Examples are coverage of newborns in 46 states, continued coverage of mentally and physically handicapped in 33 states, and continuation of coverage following termination of employment.

Now I'll talk about the effect on insurance rates of state-mandated benefits. I'll first address the increase in claims and administrative costs associated with state-mandated benefits. Then I will talk about how companies reflect these costs in the premium rates.

The studies today that measure the increase in insurance premiums attributed to state-mandated benefits use one or two methods. The first method is to examine claims data and carve out that portion of the claims attributable to the state-mandated benefit. Using this method, Blue Cross of Maryland estimated that state-mandated benefits account for 21% of the total claim costs. Similarly, Blue Cross of Massachusetts estimated that state-mandated benefits account for 18.5% of claim cost. Of course, these are two states with some of the highest incidence of state-mandated benefits in the country.

Weaknesses of this method of using claim files to estimate cost are that, first of all, it doesn't take into account that some of these mandated benefits are, in fact, substitutes, and secondly, it assumes that providers are unaffected in the coding of services by whether insurers cover this category of care.

The second method used to estimate the cost of state-mandated benefits is an actuarial approach, where a committee of actuaries will get together and try to determine the costs of state-mandated benefits. Using this method, the HIAA used a subcommittee of actuaries to estimate that Maryland state-mandated benefits increased the cost of individual coverage up to 12% and family coverage up to 17%.

A study performed by Jensen and Morrissey looked at the costs of different benefit packages to determine the marginal cost of each provision. This approach fully accounts for substitutes. Their study revealed that substance abuse can increase costs up to 8.8%. Psychiatric hospitalization coverage can increase costs up to 12.8%. Coverage of second surgical opinions can increase costs up to 6.8%, whereas home health care coverage can decrease costs up to 3.2%, and coverage of extended care facilities can decrease costs up to 3.6%.

This study may have been distorted because Bureau of Labor (BOL) statistics were used that studied the health care package of small employers. They could have been distorted if some of the small employers selected plans that were rich in these kinds of benefits owing to the fact that some of their employees had these illnesses. Additionally, it could have been distorted by what I call the woodwork effect, where people who have a condition or need chiropractic treatment, for example, don't get it until it's covered, then they rush out and get it.

These studies revealed that there is very little cost savings attributed to those state-mandated benefits. Were this the case, once again insurance companies would have had the incentive to offer these benefits on their own.

Consider the administrative costs associated with state-mandated benefits. First you've got to have a compliance unit, with all the salaries and benefits that go along with that. The second administrative cost is the cost of drafting and printing new policy and rider forms and distributing them to the policyholders. The third administrative cost is an increase in claims administration costs. Claims people have to keep track of who's got these benefits and how to pay them. Frequently they are relatively new or experimental benefits and it's hard to determine what should be paid on those benefits. And the fourth type of administrative cost is the cost to employers of the printing and distribution

of informational materials covering the new state-mandated benefits, especially for those employers who have employees in several different states.

With regard to the pricing of state-mandated benefit insurance contracts, the method of implementation of state-mandated benefits comes in two different forms: the first being where it is mandated that you provide that coverage to all insureds in that state, and the second being where you must affirmatively offer that coverage to either the policyholder or, in the case of group insurance, certificate holders. Generally, the benefit must also be made available to in-force policyholders.

The pricing of state-mandated benefits is difficult for the following reasons. Frequently the benefit is so new that very little cost data exist. The actuary must use whatever data he can obtain, mixed with ample doses of actuarial judgment, which health pricing actuaries are probably pretty familiar with anyway. Mandated coverage of services or providers will increase the number of providers anxious to provide the service in that state, thereby increasing utilization. There will be an increasing utilization, strong antiselection will exist, and there will be an initial surge in utilization due to the woodwork effect.

The approach to pricing differs depending on whether the benefit must be offered or provided. If the benefit must be provided to all, you can do one of the following: (1) Charge all insureds in the state an equal amount; (2) Charge all insureds in proportion to their expected utilization and cost; (3) Some combination of these two; or (4) Don't specifically reflect the cost of the benefit to the insured receiving it, thereby spreading it over all insureds in all other states, or passing it on to your stockholders or agents.

If the benefit must be offered, you must reflect the effect of antiselection in the premium for the benefits. Oddly, the greatest incidence of antiselection occurs with mandates for coverage of substance abuse treatment or psychiatric or psychological treatments. Of course, you could avoid antiselection by automatically providing the benefits to all insureds and using one of the previously mentioned pricing methods.

The source of pricing data for state-mandated benefits is like health pricing data in general. You use whatever you can get your hands on. Examples are as follows: general population data from National Center for Health Statistics (NCHS), Health Care Finance Administration (HCFA), the statistical abstract, and any other available government publication; data from the National Heart, Lung and Blood Institute, National Cancer Institute, and other foundations; experience on your own products if you can break it out; and claim cost guidelines from the consulting firms.

Use data from these sources along with conversation with your claims examiners and your medical director mixed in with a liberal dose of common sense to price these benefits. When pricing, I consider the increase in home office administrative costs and agent frustration associated with a separate charge for a given benefit. I mix this in with the ideal of trying to maintain equity among policyholders. The result is that I don't reflect the cost of state-mandated benefits in American National premiums if I estimate that the impact will be less then 2 or 3% of premium.

In conclusion, I believe that state-mandated benefits disproportionately increase the cost of insurance by increases in claim costs and administrative costs. I also believe that the number of new state-mandated benefits added annually is not likely to decrease dramatically anytime soon for the reasons I talked about earlier. I think that this is only going to drive up the cost of health care and increase the number of uninsureds due to small employers not being able to afford their health care programs. I think that both of these items are certain to bring about even more federal scrutiny of the health care system, which is something I know I don't want and I don't think many of you want either. It is imperative that we address this onslaught of government intervention in our marketplace more aggressively.

MR. MAURER: For those of you who may not be keeping score, it's 2-0 against right now. The next presentation might give a little different viewpoint to this problem.

MR. GORSKI: When I'm asked to speak at various conferences and seminars, I'm always kind of leery about it because they tend to degenerate to regulator bashing. I'm not really up for that. And surprisingly I think my views will probably be not too divergent from the views here. What I'd like to do is share some discussions and insights I've had over the last 12-15 months, both within our department and within the NAIC on the whole issue of mandated benefits.

I'm the actuary for the Illinois Department of Insurance. About 12-15 months ago, the Governor of Illinois established a Health Care Summit to look at the health care environment in its entirety, ranging from specific problems in the Chicago area with certain hospitals to whether the uninsured problem could be solved via the private insurance market. There was a broad range of topics that the summit was designed to analyze, including the uninsured problem. Our department, the Department of Insurance, was asked to head that particular unit. Represented on that working group was the insurance industry, the Department of Insurance, small business, and the Illinois Hospital Association. So it was a pretty broad spectrum of representation. The initial few meetings of the group were directed at mandated employer-provided benefits, so there was a lot of consideration of that view. In fact, the Hospital Association of Illinois had a bill sponsored that would have required employers of a certain size to either provide benefits or be taxed to form a pool to provide coverage to their employees. One of the precepts or conditions set on the working group by the governor was that any solution should not destroy the business climate in Illinois, so clearly with that constraint, that idea was not going to fly.

We struggled for a while as to what we should do. We did not want to simply say there's nothing that could be done. That would not be exactly the right thing to do in this situation.

We struggled, and finally we decided maybe it's time to look at mandated benefits again. Maybe the time has come. We were, and when I say "we," I'm really referring to everyone there, not just the insurance department, the general feeling was that maybe it's time to look at the idea of mandated benefits and come to the conclusion that the idea of mandates was an experiment that's gone wrong. Maybe we need to try a new

experiment, and that would be to cut back or eliminate mandated benefits. The story I'm going to tell now is some of the problems that you encounter in going that route.

The first thing that the group struggled with is, conceptually if you're going to eliminate mandated benefits, you need some kind of goal. What do we really want to accomplish? Clearly we do not want to accomplish simply a reduction in premiums that make insurance products more competitive with uninsured products. Our goal was to reduce the uninsured population. In Illinois, the uninsured population is probably 1.3-1.5 million, somewhere in that area. One-third of the uninsured are employed in a significant way, one-third are dependents of those employed, and one-third are marginally or not employed but not covered by Medicaid. When I speak of insured or uninsured, I include as within the insured population those people who are receiving Medicaid benefits.

So clearly we had to form in our minds some kind of goal as to what we wanted to accomplish. The goal was to reduce the number of uninsured. How was success measured in this case? Well, we thought about simply looking at reductions in premiums as a measure of success, and we fumbled with the studies that have been mentioned. And we sort of said, let's just throw all that out. Let's simply measure success based on the reduction in the uninsured populations. That leads us to a third question. We really don't have any data to measure the uninsured population on a state basis. There are a lot of national studies. The March current population survey gets at that kind of information. There have been other studies. But everything's on a national basis. So we struggled with trying to do something on a state basis. I'm one of the people involved in trying to coordinate the efforts among our department and the working group and the Department of Employment Security, which is the best repository of employer/employee information in the state. So we are working on that as a part of our legislative package, that not only are we going to recommend probably an elimination of mandated benefits, we want to set up a mechanism to view this as the success or failure of this venture. We're clearly viewing this as an experiment. We're not endorsing this as the end-all and be-all of the uninsured problem or cost containment or what have you. We're simply viewing it as an experiment that we need to do and see what the results are.

The next question is what happens if the experiment is a failure? Well, we haven't given that much thought yet, but what we are starting to give some thought to is, since we view this as, at best, a short-term solution, there needs to be some more constructive thought as to what can be done with the private insurance mechanism to improve the affordability and accessibility question. So while we haven't focused on the possibility of failure, we are only looking at the elimination as, at best, a short-term solution. It's essential to buy time.

Once we established our goals and means of measuring our goals, we struggled with the idea as to what's the best approach? Do we eliminate mandates, or do we set up core benefits? Eliminating the mandates would sort of be a top down approach. Take what you have and just start ripping stuff out and see what you're left with. That seemed to be the approach that was favored initially; now we tend to be moving towards establishing a core set of benefits that must be covered. It sounds like a mandate to me, but

nevertheless, it seems to be an acceptable mandate if the core is small enough. If you're going to go that route, I think you need some kind of framework to consider what that core should look like. These are simply my preliminary views as to what a core set of benefits should look like.

Criteria for a Mandated Health Benefit

1. To what extent is the current medical treatment for the risk effective?
2. To what extent is the risk applicable to all during on's lifetime?
3. To what extent is the service/procedure a less expensive but equally medically effective service/procedure?
4. Is the service/procedure readily available?
5. Is the service/procedure readily available?
6. Is the service/procedure in general demand?

As seen above, there are several criteria for a mandated health benefit. Have medical standards been established for the proper use of the service procedures? That sort of gets to the experimental type procedures. Is the service procedure readily available? I don't think we want a core set of benefits that only the people in Chicago have access to and no one else does. We're trying to develop some kind of overall philosophy as to the idea of core benefits. Is the service procedure in general demand? We talk about some of the current mandated benefits; it's a very limited segment of the population who might ever need that benefit. We're looking for a more general type of set of core benefits.

Just to digress a bit, getting back to the elimination of mandated benefits, it's really a difficult job. Besides this activity, the State of Illinois embarked on a health insurance program for the uninsurables about 15 months ago. It's actually been in the hopper for about three years, and it's been effective for about a year now. Many states have programs like this, but the unique feature of our program is that the state directly finances the deficit. There is no insurance industry assessment, maybe with a tax offset. The state picks up the deficit dollar for dollar. So clearly the state has a big interest in the impact of the cost of that health insurance program. We go through a process of trying to estimate cost based on enrollment. We look at the premiums. We look at the deficit. We go to the Bureau of the Budget and say we need $29 million. They tell us we can have $19 million. That says we have to cap enrollment, and that is not something that a politician likes to do, to say that only 4500 people can be enrolled in our program. We started a program last April, and we have 4500 people enrolled today with a waiting list of 1500, because with the dollars that were given us, we felt we could only legitimately let 4500 people in. Having a waiting list of 1500 people is not a thing a politician likes to have.

We're now looking at two avenues even with our Comprehensive Health Insurance Plan (CHIP) program, the health program for the uninsurables. One is to eliminate mandated benefits to reduce the cost somehow of the program, which is a very difficult thing to do. But at the same time, we're also thinking of a new mandate for the insurance industry and employers that has to do with the dumping problem. This is where a small group will have five or six employees. Everyone's in good health but one. It finds alternative coverage for the five or six people in good health, and that one person is left

without insurance and gravitates to the health insurance pool, sometimes with premiums paid by the employer. Somehow that aspect of the small insurance market in it's interrelationship with the health insurance program has gotten a lot of press in Illinois and there is a mandate actually in effect in Illinois already. So the whole idea of mandates and eliminating some, etc., is a very tricky business.

If anyone comes to the session on long-term care, you're going to hear me arguing for nonforfeiture benefits in long-term care insurance. You're going to wonder how in the world I can first suggest that mandates be repealed and then argue for nonforfeiture benefits -- there is an inconsistency there. The only thing is that I view a nonforfeiture benefit in long-term care insurance as being a question of equity not of mandated benefits.

We tried to set up a conceptual framework for our core set of benefits, and that's what we're working on right now.

The third issue that we're confronting is the small group market, small employers, and trying to do something to make insurance more affordable there. Someone said, "Well, let's eliminate mandates across the board. Let's eliminate mandates in the small employer area or the large employer area. No mandates at all." With that suggestion, the Hospital Association said, "We're not buying into the idea." We'll play with the idea of experimenting in the small employer market. They balked at the idea of the overall, across the board. I think the thing you have to remember is that the uninsured problem has many aspects. One is it has an impact on the access to appropriated care by individuals, but you also have the uncompensated care issue at the provider level, the hospital level. So it seems that, at least in Illinois, the Hospital Association is willing to engage in a controlled experiment, but there's some concern that if it goes too far, it's going to impinge on their uncompensated care problem.

In Illinois, uncompensated care cost for private payers is probably around $500 million. Clearly that has an impact on cost shifting problems and the viability of hospitals in certain areas. And that's outside of Medicare/Medicaid problems. That's simply private payers, whether self pay or private insurance payers. So the Hospital Association's willing to go to some degree to try an experiment, but they're not going to go the full elimination of all mandated benefits.

Those are the three issues that our group has confronted, and I felt that it was important to go through those, because one of the topics is the legislative process. I think if any of you get involved in the legislative process, you'll probably be facing issues just like that, and I think it's important to have some kind of strategy to deal with those before you even get involved.

I mentioned this earlier and I want to repeat it: We are looking at the repeal of mandate benefits as a short-term solution. We're not looking at this as any kind of long-term cure-all for health insurance in the U.S. It's simply a short-term solution to a major problem. What we still need are some major changes in health care financing and health care provision.

MR. DAVID WILLIAM DICKSON: I decided to add to the Texas contingent. As I was listening, my mind was fairly reeling with comments and questions. This takes us all over the board, from the keynote speaker's comments, to comments that John Hartnedy of Golden Rule made, to the difference between social policy and insurance. I may be a little all over the board here, but I've got some questions and I also have some things that might prompt conversation for the rest of our time.

Blue Cross/Blue Shield of Texas gets quite involved with the mandate process here in the state, primarily from the point of view that we're the insurer for the employees retirement system. So whenever the legislators are considering something, they will always ask, "How is this going to impact the employees retirement system?" They will ask because the legislators are covered by that program.

Sometimes we get directly involved; being the largest health insurer in the state, we obviously have some of the best data around, so they'll ask us what we might be able to tell. One unique feature, for those of you who are not from Texas, is that the legislators are only supposed to meet every two years here. They have bienniums. Recently they've been in special session for the past two years because of various judges telling us that what we do in the state is illegal, so they've been meeting to try to sort some of that out. They're in session right now trying to handle an issue that you wouldn't think had anything to do with health insurance -- school financing. The way it's done in the state is district by district, but one of the issues that's come before the legislators is how to handle the health insurance for the teachers, and where are they going to get some of the money. Anyway, our process here in Texas is a little bit different, and they got very active in mandates in the early 1980s. We thought they were easing off, and in the 1989 session we didn't anticipate a lot of mandates. There weren't as many mandates submitted, but more of the ones that were submitted passed.

Let me give you a little history. Back in 1987, or 1985, the Texas legislature passed a law that mandated that group insurers had to cover alcoholism the same as any other illness. No caps. Okay. They decided that alcoholism was an illness. Well, this time they decided that wasn't broad enough, so they added chemical dependency. They broadened the definition of the law and now it's chemical dependency. We found we had some groups who, of course, complied with the alcoholism benefits, but they kept the drug abuse and the psychiatric over in a separate benefit and put a real severe cap and coinsurance on it. We found a lot of cross coding. If there was any hint of alcohol use at all, it got coded up as alcoholism. Often in drug abuse and psychiatric cases, there is alcohol use as well. We're anticipating that when we had to try to price the effect of broadening that mandate from just alcoholism to chemical dependency, we had to anticipate that most of our employers have a $20,000 lifetime psychiatric benefit; how much of that is going to get cross coded? I anticipate in the 1991 session that they're going to mandate psychiatric care the same as any other illness. That'll solve our coding problem, but it'll create other problems.

I wanted to comment that in this state you can avoid state mandates if you are self-insured. Well, what is the definition of self-insurance? Basically, the way our lawyers tell us, it's if you issue the paper, then it is insurance. So our minimum premium contracts or cost-plus contracts or experience refunding contracts are considered

insurance. Only if it's ASO and the employer issues the contract, the certificate booklet, is it then considered self-insurance. The question becomes, since most of our ASOs have stop loss (specific, and some have aggregate), one way around state mandates conceivable then would be to issue a very low specific stop loss point. Say $2000 per year per person. Then you can get completely around all the state mandates. Of course, for an insurance company that raises your administrative costs and you have a bank account for every group. How low would you take that? Down to size 50? We've got insurers in this state that are issuing ASO policies as low as size 50, and even lower. That's a question I'd like to hear other people comment on.

A question was asked about mandated offerings. In 1987, I believe, the state-mandated that we had to offer an in vitro fertilization benefit. Contrary to your comment, in our fully insured pool, more than 50% of the employers that were offered that benefit took it. We did not expect that. We expected most of them to reject it, but they took it.

That leads into another question. How quickly then, when a state mandates benefits, do union groups that are self insured go ahead and adopt those? And what's the pressure for an employer if his fellow employers are adopting this, for him to say "Well I can't be competitive in my compensation system and my benefit system if I don't adopt those same mandates?" Is there a kind of herd effect that takes place even if employers are wanting to not take some of those mandated offerings? Again I would say that Blue Cross/Blue Shield of Texas is not against mandates per se. I would want to classify the difference again between what's insurance and what's social policy. What's unfair is when a segment of the population can avoid it. I don't even have the problem that the rest of you have because I only work in one state, so I only have to deal with the Texas mandates. You've got to deal with different mandates in every state. Really, from that point of view, a federal preemption is not such a bad idea. The Hatch Bill that's in Washington right now is not such a bad idea from the point of view that we could standardize and have a federal mandate that we could deal with.

The trouble is, is it easier to deal with the politicians in Washington or the ones in Austin or the ones in Topeka or wherever? That's a choice each company has to make. I guess those are some of my comments and some of my questions.

MR. MAURER: You've posed some interesting thoughts here. Maybe on your last comment about who you would rather deal with, you wind up dealing with both, so don't worry about it. I was kind of interested myself in the use of "spec and agg" stop loss insurance to get yourself into a self-funded mode. Maybe Tom can tell us how he is advising clients on that point.

MR. SNOOK: Well, I haven't addressed the issue to be honest. The insurance companies that we're seeing aren't really interested in that or at least nobody's proposed that and the employers that we consult for are generally large enough that it's not a big problem. I think that's an interesting point, but I'm wondering that it certainly would be an abuse of the intent of the self-insured preemption.

MR. MAURER: Have you faced that at all Larry?

MR. GORSKI: No we have not. At least not from that standpoint. This is really digressing but I want to say it anyway. One of my prime roles really is financial regulation and not in these quasisocial issue areas. We do a lot of monitoring of a company's health claim reserves, and one of the big problems we have is with companies who are involved in specific and aggregate stop loss reinsurance. I really wonder about the solvency of the companies who are heavy players in that market or maybe moderate players. So from that standpoint, if we saw an upswing in the utilization of specific and aggregate stop loss reinsurance, I don't think we'd be questioning it from the issue of getting around mandate benefits; we'd be more concerned probably from a financial standpoint.

MR. RONALD E. BACHMAN: Maybe I can bring a slightly different perspective. We're one of the few companies getting into the health business rather than getting out of the health business. It's important sometimes for a company like us, of course, to look at different mandates and whether it's a suitable environment to enter a state. One of the advantages of state regulation, I suppose, is that if you don't like the regulations in a state you don't do business there. A federal mandate doesn't give you that option. If you don't like what they're saying federally, you're either in or out of the whole market. Maybe state mandates at least allow us to have some competition among states to generate options for their consumers there.

I would like to commend Larry Gorski because I don't see Illinois as being one of those heavily regulated states. They have very fair laws. We happened to develop a health trust in Illinois, because those laws are fair and are accepted by 18 other states, so they seem to have a good balance; but I commend them on looking at ways to improve that.

I would offer a couple of suggestions there. That is, and maybe again it's not quite as applicable to Illinois, but for those other states considering a similar path of limiting some mandated benefits, and that is to see why companies are not offering contracts in their states. Why are companies staying out of your state? What is the inhibiting factor from a competitive standpoint? Maybe that would turn up some of those mandates that ought to be reviewed first and establish some priorities.

The second thing that might help in a state, even like Illinois, is to ask the companies what they are pricing, and what's driving up the cost of health care from the insurance company side. What do they think is creating competitive disadvantages? Maybe in a similar vein, what benefits are companies that are going to self-insurance dropping? What are they not providing to their consumers, to their employees, through a self-insurance vehicle that are being mandated through the insurance vehicle? Because that's certainly a driving force along with premium tax savings. Those may be some areas that would help you identify whether to eliminate some of the mandates. I'd also comment that you said the Hospital Association's didn't want to go across the board with eliminating all mandates because they didn't want to have the large cases avoid that. They're already avoiding that through the self-insured plans. Most large groups are self-insured, so they are not getting any benefit from those mandates now to a large degree.

I would like some comment on solving the uninsured problem. The National Center for Policy Analysis, Dallas, Texas, talks a lot about tax policies at the state and the federal

level, but they also come out very strongly and believe there ought to be heavy support and recognition for a high deductible. They say anybody that has less then a $1000 deductible is wasting their money. That may be a lot of money but it certainly could help the uninsured problem. It's more manageable. Even if they have a $5000 deductible, that's less than the cost of a used car, and a hospital would probably be glad to have a $50,000 bill covered if they're only missing out on $5000. That could be solved some other way, but they might have 1 million or $2 million protection. So there's not a lot of reason for those two-thirds that are employed in that uninsured population not to have some sort of catastrophic coverage.

The last area I'd like to ask for some comments on is: to me the state mandates are taking a new turn, and I think a rather crucial turn at this point from what I'm seeing. That is in two areas that were briefly touched on here, but maybe some additional comments could be made. That is in the area of underwriting. The states are Pennsylvania, and I guess Missouri, to some degree. You cannot underwrite a small group. In Pennsylvania the regulations now are saying that you can underwrite all you want but you can't use it. You might be able to select whether you want a case or not, but once you accept the case, any new entrants would have to have guaranteed issue. Also, the HIAA position paper is indicating that as well, I guess for the portability of coverage. That will be a dramatic change in the way this market is perceived and whether companies want to continue in the market, I think, if we cannot use some underwriting. Some small group is more like individual business these days.

The second area that seems to be taking a potentially strong turn in a lot of states is in the price review of small group business, whether it's requiring or wanting to have rate review. Florida would like to have, I think, rate review on just about anything. Whether they legislatively have it is another question, but they certainly would request review. If there's somebody from Florida here who differs on that, I'd like to talk to you, because I would like to get in the state but will not as long as I have to submit small group rerating on cases.

New legislation in Maine and Georgia, for example, says you cannot charge more than 25% above your standard rate. Whether that's enough flexibility to continue in a state or to get into a state, I don't know. But the area of underwriting and price review in small group, I think, is the next major area of mandates. I'm not sure if that's not going to drive out more people from the market and create more uninsureds because there are not the options. If you can comment on any of those, I'd appreciate it.

MR. GORSKI: I can comment on a couple of different areas I guess. I think one of your earlier comments had to do with the competitive edge between insurance and self-insurance. Our focus is to reduce the uninsured population and work through the elimination of mandated benefits. We're not interested in making insurance a more competitive vehicle relative to self-insurance through elimination of mandates. We're looking to elimination of mandates to make insurance affordable for those people who don't have insurance now. Our focus is different and that can affect our goal setting.

Secondly, I think you made some comments about a large deductible plan. Early on in the process of meeting with the Health Care Summit, I had put together a list of about

15 different ideas to just kick around. One of them was a large deductible, catastrophic type coverage. Right down the line those kinds of ideas were generally rejected by the insurance industry. Now I wasn't even saying mandate those things. I was simply saying let's find ways to encourage the sale of those kinds of products. The industry came back to us and said that those ideas would never sell in the marketplace. While I might happen to agree with some of your views in that area, it seemed like there wasn't much we could do there because we threw out the ideas of how we could encourage that, and they came back to us saying that they're just not saleable. So that seemed not to be an avenue that was worth pursuing -- when the industry's coming back and telling us forget it.

MR. MAURER: Well let's test them. How high a deductible does MILICO offer?

MR. BACHMAN: Well we're entering the market with a test phase right now in Georgia and in Texas, and our minimum deductible is $1000.

MR. MAURER: Do you have any plans on increasing that to $5000 or $10,000?

MR. BACHMAN: We have our options at $1000, $1500, $2500, and $5000, and we'll pay 100% thereafter of those deductibles. So it's a front-end deductible and then 100% coverage. Our focus will be on a catastrophic approach like that. It does dramatically cut the price of the product. You eliminate a lot of the mandate concerns as well, because a lot of the mandates for chiropractors, or psychologists, or some of the others are a lot of the smaller bills that are generated. So, I think what we've seen is that a lot of companies might offer, and we're seeing more and more companies begin to offer, the higher deductibles. But I don't think they've pushed very hard and there is an educational process there. I mean consumers have a real problem with $1000, so you've got to develop some noninsurance vehicles to help support that. Whether that's encouraged savings to accumulate funds, or doing it through credit vehicles, whatever. There's lots of other options; maybe focus on wellness. Hopefully that will help encourage that, but it does put the burden back on the consumer. One of the previous sessions talked about lifestyles. If you make the person who doesn't have healthy eating and drinking and smoking and driving habits, stress management habits, accident avoidance, those things, pay more of the bill, and maybe that's a little bit more fair.

MR. GORSKI: I guess I'd like to make one more comment. Going in the direction of shifting more of the cost back to the insured through high deductible programs makes some sense to me; it makes a lot of sense to me. But I think part and parcel of that for the individual employee, or individual insured, is to make some rational choices in terms of products that they're going to be buying. I'd like to see some more standardization in the health insurance area, the health insurance marketplace. I'm involved in some work at the NAIC level, at least with respect to Medicare supplement products. One of the goals there is to standardize policies as much as possible. To me that makes an awful lot of sense to get the cost back to the individual who's making some of the decisions in this area; but in order to make good choices, you need a standardized product.

MR. SNOOK: To add to that, I think we would need some standardization if we were going to want to implement, in a practical manner, some rate differentiation by health status and lifestyles.

I don't know that there are really good data out there. I guess there's some on smoking and the impact on health insurance, but I don't think the data are nearly of the quality as the life insurance actuaries have. I think the big problem, the traditional problem, in data for health insurance is that the plans are all over the board. I think that if the plans moved to more standardization, then we could get the data.

MR. ROBERT J. DYMOWSKI: I was just curious with regard to any of the situations where actuaries have been involved in some of the evaluation process, or in any other situations, perhaps on the NAIC work, have there been any studies done which talk about or which have attempted to evaluate the extent to which employers do directly leak out of the system by deciding to go to a self-insurance arrangement? In direct response, the thing I'm thinking of is the phenomenon that we see in health insurance where you lose volume, you lose exposure every time you increase rates, because of the people who select out because they get a better deal. We've got a similar situation here and I wonder if there have been any studies or any analysis of that kind that gets into those evaluations.

The other question that I have concerns the future implications for this whole issue. I mean, if we think about Dr. Anthoven's comments on management care competition, and how this all relates to that, when we talk about the mandated benefits, aren't we really talking about an outgrowth of what has developed in the past, the fee-for-service structure? The indemnity process that we've had. If we go into a much more comprehensive approach towards more management of care, if the emphasis really is shifted very much to the quality of the outcomes and defined contributions, shouldn't we just be saying that people can take whatever choices they want? Providers can provide whatever benefits they want, because they have to do it within the fixed budgets that are allowed, in any event. So, what do we care about how they spend it? Does this all become sort of a moot issue if that sort of thing becomes more prevalent?

MR. GORSKI: I guess some of my concluding remarks were that I felt that the elimination of mandates was simply a buying of time, and I think during a time period that we're buying through this, there needs to be a tremendous amount of work done in the managed care area to see if those concepts can really be made to work in terms of containing health care cost. I don't see eliminating mandates as the solution. It's only a buying of time. I think in the long run we need a much more consistent approach to health care provision and access.

MR. WATSON: I'll just comment on employers getting out of the insurance market and going to self-insurance. I don't have the quantitative measurement on it, but in one of these HIAA documents that I read, they said the primary reason given by large employers for self insuring is the ability to earn interest on claim reserves, followed by escaping state-mandated benefits. There's another study in one of the HIAA sources that attempts to measure the impact of state-mandated benefits on small employers just dropping the coverage all together. The results, as I recall, were something like, each

state-mandated benefit increases by 1.5% the number of small employers who decide to drop the plan.

MR. SNOOK: I think, Bob, relating to your second question, that no matter what the future holds among the supply and demand side that the employees are going to make selections and spend their money how they see fit, but it's still going to be the risk bearers, the insurers, the HMOs or whoever, that are going to have to price these things. So you've got to have a mandated benefit that is insurable. I think some mandated benefits are not insurable. If you have an uninsurable mandated benefit, then you're going to get into an antiselection cycle. I guess eventually it'll price itself out of the market.

MR. MAURER: Let me make an observation. In the area of mandated benefits, it appears, at least to me, that what we're seeing is a patch work political reaction to certain lobbying groups that tend to have some clout in the legislatures. Vis-a-vis your chiropractors, your people who run halfway houses for alcoholics or mentally disturbed people. There seems to be a real plethora of advertisements lately on television, the whole thrust of which is to convince these people who have these anxieties or whatever about their lives that really it's not their fault, it has nothing to do with their behavior.

It's a sickness. It's a sickness and here we provide a setting in which you can recover from your sickness. Now that setting can cost around $30,000 a month, but you will really feel a lot better for it after you're through. This is real grist for the politicians. When they see this type of thing, I mean, the appeals are very motivating. I mean, these guys come on, "Hi, I'm Bob and I'm cured." You know, you have the big bad insurance companies turning down your reimbursement for that type of care. I think we have a significant political problem and as someone mentioned earlier, an educational challenge, if we're going to keep insurance really a viable vehicle for public policy; and I think that there you can't separate the two. I mean, insurance, because of what it does, is part of public policy and probably always will be.

MR. BACHMAN: Larry, I know you've worked with the NAIC committee; I wonder if you can comment on the proposed filing guidelines for rates in the group area, the small group area, and the individual area. Is that going to become a standard for the states to be passing? Where is that going to lead as far as you can see at this point?

MR. GORSKI: I guess it's going to be like many other NAIC model regulations or guidelines. I see about three or four or five states adopting it, but I don't think it's going to get widespread adoption.

MR. BACHMAN: I guess it's Howard Bolnick who is chairing that committee. It comes out fairly strongly supporting and giving arguments for durational pricing and tiered rating, which seem to be hot points with a lot of regulators and consumers, as well as creating some of the problems we're seeing. Can you address those two issues?

MR. GORSKI: I've got a unique situation. As one of my other responsibilities, I am the chairman of the Actuarial Standards Board's Health Committee, and we're supposed

to be addressing the tier or durational issue also. So I have to wear a regulatory hat, a professional hat, and an in-house hat.

First, I'll give you my personal view. I don't think that tier rating based on strictly a loss ratio makes any sense at all. To me it has no statistical basis. I understand and accept all the competitive problems that exist in the small group area considering the ability of employee units to leave and deterioration of the health pools and impact of new entrants to the markets. I understand all that. And because of that, I don't feel comfortable in mandating out or making illegal tier or durational rating. To me it's part of the evolutionary process in rate making, that if other things hadn't happened we wouldn't have this. But we do have certain elements, an environment, that we have to deal with as actuaries and companies and that's where we are. I guess I'd rather try to deal with some of the other problems and maybe tier and durational rating might disappear. I guess one of the things I really believe is that if you take a look at the report from Bolnick's group, in it is a section on disclosure. During my work I happened to come across a brochure that was developed by I think it's a Wisconsin company who are somewhat active in the individual major medical area. They have the same product from benefits standpoint, but one product is on a durationally priced basis, and maybe tier and durationally priced basis, and the other one is on an aggregate priced basis. The brochure explains to prospective policyholders the pros and cons of both approaches. It suggests that if you're a short time buyer, maybe the tier rating approach, or the durational approach, makes more sense, but if you're in it for the long haul, aggregate pricing is a better way to budget your costs for insurance. That made all the sense in the world to me. I got permission to give that to Howard -- it's in the report. To me consumer education and an informed consumer in the end will make decisions that make the most sense for him or her in the health care area.

MR. GORSKI: If that's the case I don't believe there's anything we can do to really improve the situation. But given some hope that health care in and of itself is still affordable, then I think sufficient information at the policyholder level might get people to make different decisions in terms of purchasing and might straighten out some of the problems of tier and durational rating.

MR. PETER M. THEXTON: I'm finding it difficult to see how to distinguish, in principle anyway, tier rating of a multiple employer trust from regular old experience rating of a single industry trust, for instance. You experience rate that trust. If you have half a dozen industry trusts, which you might have, maybe they're geographical or something, you would experience rate each one of those trusts. If one of them started many years ago, and then the other one is just starting new, you're going to have different experience rates for those. In a particular broad-scale multiple employer trust, I don't see how tier rating is different from experience rating in principle. That isn't really what I wanted to ask about. Would you like to comment on that before we go on to something else?

MR. GORSKI: I'd like to comment on that. To me the objection comes in, or the problems come in, when you start experience rating employer units of two and three people based on loss ratios. I don't have much of a problem if you try to do some kind of reunderwriting type of approach at that level where you look at the actual claims. If

you know that a person is still an employee of that employer unit and has an ongoing claim, and you know it's going to be ongoing, then without any type of regulatory proscription, I could see where the experience rate for that unit should be, or could be, different. When you simply look at loss ratios, not taking into account the fact that the person or persons who caused that claim experience are no longer with the group -- that employer unit, it's simply a tool to me that statistically does not make any sense. That's where my objection to experience rating in the multiple employer trust area has a problem, with that employer unit.

MR. THEXTON: I could talk about that for maybe a long time, but maybe we could get back to the mandated benefits here. I wanted to get back to, I think it was Jack who was saying, the legislature considers a particular proposal to mandate (say) chiropractors, to think of one that has been done probably in more states than any other. It receives a certain number of arguments why chiropractors should be covered and why they should be mandated in insurance policies and so forth, and other arguments on the other side. What I want to get at is your views on the question of whether it is appropriate for the legislature to make that decision -- presumably on behalf of all insured persons? Is it appropriate? Are they the right vehicle to decide, on behalf of all the citizens for whom they legislate, that your medical insurance coverage should include this particular practitioner or this particular kind of coverage? Or, in fact, once the question's been presented to them, if they decide not, then they decide that each person should be able to make that choice individually if he can find a carrier that covers that. Is that the appropriate forum for making that decision? That's the question I wish you could address a little more.

MR. SNOOK: That's a really good question. I would say that I can't think of another forum; I'd have to say, yes. I think it is the appropriate forum if the theory that I talked about at too much length earlier really worked. I think that yes if there are societal needs not being filled and I mean really true needs, then I think that the government is the one. I mean not being filled by the unmanaged open market. Then yes, I can't think of another forum that would be appropriate. I think that's the theory. In reality, of course, it becomes very politicized.

MR. GORSKI: I guess the one proviso I would put on there is my response would probably be yes, but I also think that the mandates should go across the board to all providers of care, not just the insured marketplace but the uninsured. If it really is a broad-scale, social problem, then everyone should be impacted by it, not just people who choose to participate through one system and not through another system. It needs to be uniform in that respect to really be the proper solution.

MR. RICHARD W. ERDENBERGER: My concern about mandated benefits is do they really recognize the underlying principles? Is it insurable, is it an accident or is it a sickness, or is it just something somebody would like to have done, or something like that?

One of the few mandated benefits that I can think of, though, that probably was worthwhile was when the various states started mandating that we recognize licensed practical nurses (LPNs) and licensed visiting nurses (LVNs). That arose really out of the shortage

of the RNs. So they started to mandate that we recognize those as nursing practitioners. That was an area where it was okay.

One of the other things, though, is that they're mandating not only benefits, but they're also mandating how we may underwrite or may not underwrite. I think that I see that it is particularly true in the age area. The legislators can't seem to distinguish between underwriting and discrimination. They do that in all of these other things as well. They're attempting, in many instances, to take away our right to underwrite. I don't think they would ever refuse us the right, or to deny us the right, to refuse to accept somebody who had a terminal cancer. But with some of the other benefits they say, "Hey, you cannot underwrite it." When this happened in the D.C. area, the industry, I think, reacted immediately in the sense that the majority of the companies said, "Hey, wait a minute, we're just going to stop writing out here -- at least some of our benefits," or they wrote only minimum benefits.

I have a little bit of a problem again, sort of like a number of people had said, and that has to do with if it's a personal lifestyle that's involved. Is that something we should really try and correct or cover? Many of us have led very structured lives and have disciplined ourselves to get where we are, and for somebody who lacks that discipline are we going to go ahead and try to support them? I have another problem that I hear over and over again in here relating to, and Larry's attacking, the uninsured. Actually, here in Dallas I have a son and he's got tons of friends and none of them have insurance. Everyone of them is making $20,000-30,000 a year. They just have elected not to buy insurance. They don't mind spending it on cigarettes, they don't mind spending it on the bars on the weekend, but they'll be damned if they're going to buy insurance. So they're part of that uninsured group that we keep talking about, and they have elected to -- that's their lifestyle. That's true also within some of the employers, where there's an employee contribution. Those employees elect not to pay that contribution. They should be siphoned out and not considered as part of that total uninsured group that we hear Kennedy and everybody else talking about.

MR. GORSKI: I think some of your comments were the basis for some of our decision in Illinois at least not to mandate employer-based coverage. We still believe in a freedom of choice in that area, and our goal was and is to make insurance more affordable. That's why we're taking the approach that we are, because we still believe in that.

One other point I'd like to make is that, as I make these comments here, I make personal comments, not necessarily those of the Department of Insurance and not necessarily the comments of other regulators. There are a few other regulators here and if there are some divergent views, I think it would be well served if we get those divergent views on the table too. I don't want to make it sound like I'm the spokesman for everyone in regulation, because I'm not.

MR. SNOOK: I think as far as choosing not to take insurance, the question becomes, if your son gets in an automobile accident and requires $50,000 worth of surgery, who's going to pay for it? He doesn't have it. Are you going to pay for it? Or are the taxpayers going to pay for it? In that respect, you've got to think about some of these

people and figure out how you're going to deal with it. They are part of the uninsured problem that I think we do have to address. Are we going to force it down their throats or what?

As far as the underwriting and the distinction between underwriting and discrimination, I think a point that doesn't get made often enough is while, yes, underwriting, I think, is discrimination, it is not unfair discrimination. It is fair discrimination. It is equitable discrimination that is, I think, perfectly legal and perfectly right.

Your insurability question is a good one, and I'd like to ask Larry to address it. I don't believe insurability was in his list of criteria for mandated benefits. I think that if a benefit is not insurable, no matter what the societal need, then insurance is not the efficient way to provide that benefit.

MR. GORSKI: The purpose of the list was to, in effect, define insurability. While I did not identify insurability as a specific criterion, my goal was to define those risks that really are insurable as opposed to situations that are better covered through social programs. So, while I did not identify insurability as a criterion, that was what was in my mind when I was producing the list. That was the purpose of that -- trying to identify the criteria for a benefit program that insurance companies could profitably, legitimately supply.

MR. MAURER: Too bad we can't have legislation imposing mandated individual responsibility!

MR. JOSEPH J. WALLACE: Larry Gorski, the question I have has to do with standardization of benefits and specifically Medicare. I know the emphasis from the NAIC is a standardization of benefits as mandated, as in Wisconsin, and we're really getting over onto the standardization of compensation. All of this standardization that's coming about appears to be directed towards pricing a product on a standard basis. They seem to be taking away from the insurers the right to offer benefits which, whether the public wants them or not, are available. Some of the standardization is preconceived, this, this and this, and not giving options to the insureds to choose what types of coverage or duplications of coverage they even want. I know the federal government has taken away duplication, but now the states appear to be taking away any type of future enhancement that may be available out there for selling a product.

Maybe you'd like to comment on that. Isn't standardization really mandating benefits? That's another point that I'd like you to address.

MR. GORSKI: In a sense, standardization is mandating benefits and maybe my life is one of inconsistencies, I don't know. Medicare supplement is just a different kind of animal. The Medicare supplement policy is supposed to fill in the holes, the gaps, of Medicare. It's well-suited for standardization, and I think standardization is demanded there. I believe, in Wisconsin, even though there's standardization, you do have core benefits; you do have options. There is the ability to mix and match core benefits with various options, so it's not complete standardization. It's standardization only to the

degree where you have a defined core of benefits and you've got 6-7 different options that can be intertwined in any way the person chooses.

You have made some comments on duplication. I guess I was surprised by that, because, to me, why in the world would a person want to duplicate benefits, unless you're trying to make some kind of gain on the transaction? I don't see any real reason to condone duplication at any level. Standardization in the Medicare supplement area is something in which I firmly believe. I can see some problems in other lines of insurance, so I'm not willing to jump on the bandwagon completely across the board. In the Medicare supplement area it's going to put products on a comparable basis so people can make decisions based on price and maybe we can get off the loss ratio bandwagon and really have people start making decisions on price and stop worrying about loss ratio compliance so much.

MR. MAURER: I think there's another reason they might want to look for a standardization of Medicare supplement policies. Medicare supplement policies are the one area where we are able to do things because of the Federal government's involvement in setting prices, that if we tried to do on our own we'd wind up in Leavenworth. It gives us quite an opportunity to underwrite risks without worrying a lot about the inflationary aspects of the risk for underwriting.

As long as the Federal government keeps worrying about the budget deficit and keeps holding down the amounts they're going to pay for medical services, we have the ability to just get right on their coattails and use what government says is the right price for the service in determining what we will pay.

The other thing is, in my experience in Medicare supplement standardization, the standardization usually takes the form of a core benefit structure that you have to provide in order to call your policy a Medicare supplement policy. I really see nothing wrong with that, especially when you see that the Medicare program is so widespread and is really looked to as a standard. It may not be the best standard, but it is a standard. So if you're going to call your policy a "supplement," then there should be some standard by which you can measure the degree to which it does, in fact, supplement that program. Most states seem to be very willing to look at experimental additional coverage, if companies want to go in that direction. For example, if you want to pick up the difference between the set cost of a service and a usual, customary, and reasonable service, (UCR), you have the ability to do that in most states. If you wanted to pick up and expand on, say, nursing care, you can do that. If you want to provide things like prescription drug coverage, you can do that. So, I don't really see that as a basic problem. In fact, the government involvement in Medicare really came about because back in the 1960s, the insurance industry abdicated the old, the aged, population as a market. They simply would not write in that market -- any reasonable set of benefits at any type of affordable price. The political pressures were such that something had to be done. The Federal government came in, and for the most part, it has been a fairly decent program.

MR. GORSKI: I'm glad to hear those comments about standardization. The Wisconsin model, as I understand it, has a core set of benefits and also has optional benefits that

are standardized, which include some of things you were discussing such as the excess of usual and customary (UC) over defined benefit amounts. So it's standardization, but I don't think it's overstandardization in my view. You have core benefits and you have certain optional benefits. To me that seems to be the appropriate way of handling the insurance issues in the over-65 market.