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SUPPLEMENTAL AND SPECIALTY HEALTH PRODUCTS AND HEALTH CARE REFORM

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Health care reform is likely to affect all forms and methods of insurance. Are supplemental and specialty health products likely to be affected? What lessons can be learned from the international markets? How will basic medical products sold to individuals be affected?

- The international marketplace
  - What lessons can be learned from other countries with national health care?
  - What types of supplemental products are sold?
  - What is the market for supplemental products?
- Individual medical/federal health care reform
  - What is likely to be proposed?
  - How will it affect basic medical insurance sold to individuals?
  - How will state initiatives affect this?
- Long-term care (LTC)/home health care (HHC)
  - What has been proposed at the federal level?
  - What is the likely impact of the proposals
  - How will state initiatives affect this?
- Supplemental and specialty products
  - What is the likely impact of health care reform?
  - What are the challenges? Key Issues?
  - How will state regulations affect this?
- Is there a role for supplemental and specialty products after health care reform?
  - What is (are) the marketplace(s)?
  - What are the likely products?

MR. MICHAEL S. ABROE: We have a panel of four experts on specialty and supplemental products. Bill Bugg is senior vice president and corporate actuary for American Family Life Insurance Company. It is active in the supplemental health markets in the U.S. and in several international markets. He is going to be discussing Japan and the United Kingdom.

Steve Lippai is senior vice president and actuary for Combined Insurance Company of America. It also is active in the supplemental health market in the U.S. and in several international markets. He is going to be discussing Canada and Australia.

Bill Lane, until recently, was a group actuary and was responsible for managing the group actuarial area for the Mutual of Omaha Companies. He recently has been assigned the duty of developing corporate strategy for responding to health care reform. He will be discussing health care reform in the individual medical market.

Finally, Tom Skiff is senior vice president and chief financial officer for AMEX Life Assurance Company. AMEX is obviously the leader in long-term care products sold in the U.S. today. He will be discussing long-term care and health care reform.

MR. WILLIAM J. BUGG, JR.: My remarks will address the health care system in Japan and the United Kingdom. I will discuss the types of private health insurance that exist in these two countries. We will be looking at Japan first.

Every person in Japan is covered under the National Health Care System. In Japan there are three types of health insurance plans offered by the government.

The majority of the population, about 59%, is insured by the Employee Health Insurance Plan, under which salaried workers and their families are insured. Both employer and employee are responsible for half of the premium in this plan.

The second plan is the National Health Insurance Plan, which insures self-employed individuals, their families, and retirees. About one-third of the population is covered by this plan. The individual is responsible for 100% of the premium.

The third plan is the Health and Medical Services Plan, which covers those who are 70 years or older, or disabled and 65 years or older. The remaining 8% of the population is covered by this plan, with no premium being charged to the insured.

The benefits vary according to the plan. Between 70% and 90% of the medical and hospitalization expenses are covered; therefore, the insured must pay 10-30% in out-of-pocket costs.

In addition to the co-payments, there are other medical expenses not covered:

1. Hospital room rate differential (for beds not covered by the government plans). The government plans cover only ward accommodations;
2. Nursing care expenses (for care by private nurses due to the patient's condition);
3. Medicine not covered by the government plans;
4. Transportation, lodging, and living expenses for family members; and,
5. Necessities during hospitalization and gifts for the doctors and nurses

The culture in Japan involves giving gifts in a lot of situations. The patient customarily gives a gift to the doctor.

Let us take a look at the out-of-pocket expenses that a patient might incur. First, the most common out-of-pocket expense is the hospital room rate differential. In the case of a serious disease like cancer, which requires immediate treatment, the type of room that is fully covered by the government plan may not be available. In such a case, the patient has no choice but to take a noncovered bed and pay the room rate differential. Furthermore, there are many cases where a patient, due to their condition, prefers to be placed in a private room.

This differential can be as low as ¥5,000, or about $45 per day at the current exchange rate, although frequently it is much higher. Differentials tend to be higher at

the large private medical hospitals in the big cities. For example, a private hospital in Tokyo has a standard room differential of ¥30,000, or $260. The best private room charge may total up to ¥80,000, or nearly $700.

Nursing care is the next highest expense. In Japan, nurses take care of hospitalized patients, but some patients need additional or constant private care, depending on their condition. According to the Japan Clinical Nursing Care Association, the cost of private care can reach ¥10,000 per day (or nearly $90) during the daytime and 20-40% more at night.

There also are cases in which medication is not covered by the government health insurance coverage. A large number of nonmedical expenses are not covered, including travel, lodging, gifts to doctors and nurses, and the loss of income while the patient is hospitalized. These out-of-pocket expenses can range anywhere from ¥25,000 to $65,000, or $217 to $565 a day.

Supplemental health insurance is offered by life companies. The coverage is typically in the form of a rider although a few companies offer free-standing policies. The supplemental benefits are provided on one of several cases: (1) if the hospitalization is caused by an accident; (2) if it is caused by a sickness; or (3) if there is a surgical operation.

Chart 1 shows the number of benefits of each of the three types of protection as reported by the Japan Institute of Life Insurance. Sixty-four million have accident-only coverage, 55 million have coverage sickness, and 57 million are covered for surgery. The number in parentheses shows the proportion of life policies that have a supplemental AMH rider. Almost 60% of all life policies have an accident-only rider. Fifty-one percent have a sickness rider, and 53% have the surgery rider.

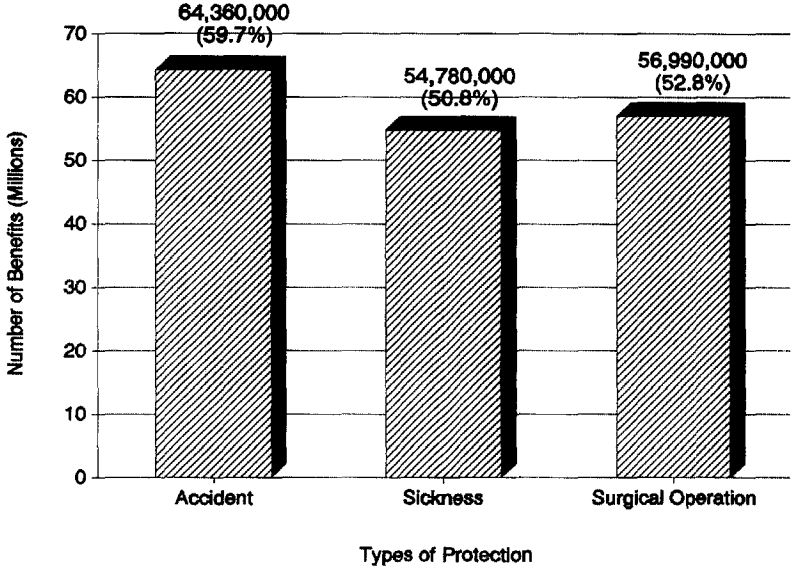
As you can see, these policies have suddenly found acceptance in the marketplace in Japan, even with the existence of a national health insurance program. There are some 12-13 million cancer policies in force in Japan which provide supplemental benefits.

The national health system in the United Kingdom is somewhat different. The National Health Service (NHS) was established on July 5, 1948. Like Japan, all citizens are covered under the NHS. Unlike Japan, the NHS provides services and benefits predominately free at the point of consumption with no copayments or deductibles. Like Japan, the NHS only covers ward accommodations. A small private sector has been permitted to exist under the NHS from the beginning. The private health system in the United Kingdom has three characteristics. The system does not provide any facilities for emergency treatment, for example, accidents or a heart attack. It is geared to providing a free plan service.

Entry to the private sector is, in all but a few specific cases, through an NHS general practitioner referral. Direct access is rare. The evaluation of medical practitioners for whom private medical expense (PME) insurers will reimburse treatment costs is on the basis of NHS accreditation and active participation. This means that the same specialists will provide the same treatment to the same patient, in the same area, regardless of whether the treatment takes place under the NHS or a private medical

expense plan. The only differences are the comfort factors of the hospital and possibly the quicker time frame, although this last reason is being eroded.

CHART 1
Hospitalization and Surgical Operation Protection
Number of Benefits In force in 1991



The existence of a private sector has led to the development of a health insurance market. You may ask why would one buy health insurance if the National Health Plan covers everything at no additional cost. There are perhaps two reasons: (1) The NHS treatment is either unavailable or is restricted; and (2) If the treatment is available, the quality is unacceptable in the eye of the beholder.

At the time of the establishment of the NHS, a number of provident associations were in existence. These associations were mutual, nonprofit health insurance companies. Having started right after World War I, they expanded rapidly between the two wars but on a localized basis. With the establishment of the NHS, it was then anticipated that these associations would collapse and disappear since the purchase of private health insurance is in effect to pay for services already being provided under the NHS. On the contrary, the majority of the associations joined together to form the British United Provident Association (BUPA). Many in the London area united to form a Private Patient Plan (PPP). Several others combined to form the Western Provident Association (WPA). These continue to operate.

The objective of the modern day provident associations is to indemnify certain medical costs incurred by individuals who wish to obtain medical services outside of the NHS. Their desire is not to promote a substitute service to the NHS, but rather to remain complementary to it.

The product sold by the provident association is designed to address these reasons.

There are over 20 provident associations, with BUPA being the largest followed by PPP and WPA.

Since the early 1980s, "commercial for-profit" insurers have entered the market. While the market share of commercial insurers is still modest, the number of companies has been increasing as more companies show interest in health insurance. There seems to be a growing market for supplemental health products. Listed below are some of the commercial insurers which are, or have been in the marketplace.

- AFLAC Limited
- Amba
- Avon
- Crusader (CIGNA)
- Eagle Star
- Economic
- Iron Trades
- Lloyds Syndicates
- London & Edinburgh
- MGI Prime Health
- National Farmers Union Mutual
- Norwich Union
- OHRA
- Orion
- Pinnacle
- Provincial
- Sovereign
- Sun Alliance

There are three main types of insurance sold by insurers: (1) individual, (2) group voluntary, and (3) company scheme.

There are several types of products being offered. The Immediate Access/Day One Plan covers from day one of the policy and allows immediate access to private treatment. All policies insist that the insured be referred by his general practitioner to a specialist, which is when the policy begins to provide coverage. The benefit takes one or two forms. It may be a full refund of cost, up to an annual maximum which is normally £50,000. There also can be inside limits that are established for various types of benefits. This can be hospital charges, specialist fees, nursing or other types of services.

The six-week waiting list plan is designed to provide full coverage only if the NHS cannot provide treatment within a reasonable period. If hospital treatment is required, the specialist will check the NHS waiting list. Benefits will be provided only if the list is more than six weeks long. If the waiting list is less than six weeks, a daily cash benefit will be provided for each night as an NHS inpatient. There is typically an annual maximum, which might run from £8,000 to £10,000 to perhaps £25,000. The six-week restriction results in a 20-40% lower premium than for the immediate access of the Day One Plan.

Another plan sold is known as the Budget Plan. This plan provides coverage for a limited number of surgical procedures. The insured may be restricted to the use of a select number of hospitals where preferential rates have been negotiated. The Budget Plans also have an annual maximum which is generally around £15,000.

In recent years, specific disease plans have been developed. There is a contract on the market designed for women which covers breast and cervical cancer. There is another contract that covers heart conditions.

My company, American Family, sells a hospital indemnity policy (HIP) plan, an accident plan, and also a specified disease plan. During the 1980s, private health insurance nearly doubled. This growth rate has tailed off a little bit in recent years because of the recession. Even so, the growth in premium has been in double digits. About 12-13% of the population is covered by private health insurance. The market penetration is largely among persons with higher incomes (Table 1).

TABLE 1
Number of Lives Insured -- 1989

	Lives Covered (000)
BUPA	3,750
PPP	1,758
WPA	500
Commercials	684

With an aging population, the demands on primary care for the elderly have been increasing. The provision of such care, along with care for accidents and emergencies, and maternity care places an increasing strain on resources. As a result, the resources available for treatment of nonurgent conditions are severely limited and demand outstrips the supply. This leads to long waits for treatment of nonurgent conditions. The government has encouraged the growth of the private sector in an effort to release the pressure on NHS.

The role available for supplemental health and the types of products will depend on the government program, its strengths and weaknesses, and on the role that is permitted and encouraged by the government. It is unlikely, due to the cost, for a government plan to be universal, to cover all expenses, and to provide whatever care might be desired by the claimant. There are likely to be deductibles and copayments like the U.S. Medicare program and the program in Japan. In the case of the United Kingdom, some constraints on the delivery of services may apply. This will lead to opportunities if the government is supportive.

MR. STEVEN E. LIPPAI: The first country I will address is Canada. There has been a great deal written about the Canadian National Health System. It was, at least for a while, being considered here in the U.S. as a possible model for our own health care delivery system. I will not be providing an extensive outline of their system. Rather, I will present a brief overview and concentrate on the role of supplemental insurance.

Like Japan and the United Kingdom, Canada has universal coverage. Each province administers its own plan so the benefits and financing differs slightly.

Their system differs from the approach used in the United Kingdom in that everyone receives the same quality of medical care delivered with the same timeliness. It is a one-class approach. The rich do not have the opportunity for better medical care in Canada.

The list below is the medically necessary services provided by the Ontario plan for inpatients. As you can see, it provides complete care while in the hospital. Even

private or semi-private rooms are available and provided when they are medically required.

Inpatient Services:

- standard ward accommodations
- nursing services
- lab and diagnostic services
- surgery
- drugs
- medical equipment
- occupational therapy and speech therapy

In addition, there is a complete set of outpatient, therapeutic, custodial, and home services available, which is listed below. You can go to any doctor who will see you. The doctor directly bills the government based on prescribed fees that are adjusted annually. They are not allowed to bill any extra fee to the patient.

Other Services:

- outpatient facilities
- occupational therapy and speech therapy
- physiotherapy
- nursing homes
- homes for the aged
- chronic care
- home care

Hospital, outpatient, and doctors' expenses are completely covered. There are no deductibles, no copayments, and no maximums. There are maximum coverage levels for treatment by chiropractors and osteopaths; the patient pays the remainder of these costs. In addition, there are daily utilization fees on nursing homes, home for the aged, and chronic-care facilities. The latter has fees only after the first 60 days of coverage.

Unlike the United Kingdom, private health care does not exist. However, an individual can purchase better accommodations while in the hospital. In other words, the patient can choose to have a semi-private or private room and pay for the difference himself. Also, there are certain items that are not covered by the provincial plans. Some of these are:

- private or semi-private room
- drugs
- dental
- eyeglasses
- psychological care
- artificial limbs, crutches, braces
- private duty nursing
- acupuncture
- nonmedical physician services

The coverage for prescribed drugs that are not part of a hospital stay varies between provinces. For example, in Ontario and Quebec, charges for drugs are 100% reimbursed for residents who are over age 65. In British Columbia, after meeting an annual family deductible, everyone receives a percentage reimbursement up to a maximum annual reimbursement level. For those under 65, the percentage is 80%, while it is 100% over age 65. The deductible is also lower for those over 65.

Only in-hospital dental care is provided by all provinces. Otherwise, there is limited dental coverage for children in certain provinces and at least one province provides limited coverage to those over 65.

Certain provinces pay for periodic eye examinations for all residents. Others limit this service to children or to those over 65. At least two provinces do not provide any eye exams. None of the provinces pay for glasses or contacts.

As you might imagine, the provincial plans do not provide coverage for nonmedical physician services such as responding to insurance company inquiries, or for physical exams required for insurance or for admission to schools or camps, or for employment opportunities. Doctors directly bill for these services.

Private insurance is allowed to supplement, but not compete with the government plan. In other words, it can provide coverage for items not covered by the government's plan. It cannot offer better or faster treatment for the items that are covered. Employers often use a group product called Extended Health Insurance. This allows people the comfort of a private or semi-private room, extends their prescription drug coverage, supplies private duty nursing, and fills in many of the gaps left by the government's plan. Some insurers have developed preferred provider networks to help keep the cost of these programs down.

In addition, private insurance often offers a wide range of dental, vision, long-term disability, and accidental death insurance. Generally those follow the same type of programs that we have here in the U.S.

This supplemental insurance is supplied by Blue Cross organizations as well as insurance companies that are active in the employee benefit pension area. There are a handful of companies that offer individual coverage. Most individual carriers offer disability insurance with a few providing fixed indemnity plans that pay per day of hospital confinement.

Like national health plans around the world, increasing costs are beginning to take their toll. The provincial plans are all looking for ways to shift costs to the supplemental plans. This is one of the facts that contributes to Extended Health Insurance premiums increasing by 15-20% per year.

At some time in the future, cost shifting may provide significant new opportunities for supplemental insurance. However, recent trends indicate that the public refuses to accept such common things as users' fees or copayments. Last year, the suggestion that Quebec residents pay a $5 fee when using medical services met with overwhelming political opposition.

On the other hand, small changes that impact only the fringe aspects of the plan appear to be politically acceptable. The Ontario plan now only reimburses residents for out-of-country treatment at the same rates that it would have paid for treatment in Ontario. This means that patients may be responsible for over half of the costs of these services. Soon after this type of change was announced, all the supplemental carriers and supplemental group plans expanded to provide this coverage.

Australia is the last country we will look at. Australia is different. In some ways, their approach to health care has it all: universal coverage, public hospitals, a choice of doctors, a second tier of medical services that provides a higher quality of care on a more timely basis, private hospitals, and a role for supplemental insurance that is limited by law.

It is even a continuing political issue, where change in the governing political party can cause a change in the approach.

National health has existed in Australia for 40 years in one form or another. Early on, it only provided subsidies to ensure that those with low incomes could afford to purchase health insurance. Twenty years ago, over 90% of the country had health insurance. Now private health insurance covers only about 40% of the population. The role of private insurance has changed significantly. During the 1970s and early 1980s, the national health program changed with each change in government. In 1984, the Labor Party installed Medicare, a significantly modified approach that has remained in force.

In the recent elections, the opposition party was proposing to again change the mix of health care by increasing the role of the private sector. However, the Labor Party remained in office -- partially due to the perception that the health system works. This may be a good indication that health care, at least in Australia, will start receiving bipartisan support in the future.

In Australia, you can go to any doctor you choose. Some doctors will bill the government for your visit using a process called bulk billing. In this case, they cannot legally charge you anything extra. Other doctors will bill you. You then need to submit a claim to Medicare for reimbursement. You will then receive a standard reimbursement payment which is probably considerably lower than what you paid.

Over 70% of the patient visits to general practitioners are bulk billed. For specialists, the proportion of visits that are bulk billed goes down considerably. For some specialties, only 30-40% of the visits are paid for this way. This means that a considerable amount of medical care is paid for by directly billing the patient.

In a direct-billing situation, the patient submits his claim to Medicare which reimburses at 85% of their standard Medicare scheduled fee. After a low out-of-pocket maximum has been reached (something in the neighborhood of $250), further doctor visits are reimbursed at 100% of the Medicare scheduled fee. However, it is important to realize that the Medicare scheduled fee is considerably lower than the fees recommended by the Australian Medical Association. That is, it may be only at a 50-60% level of what the recommended fees are. Obviously, some doctors in high demand specialties are at high levels.

Hospital expenses work in a similar way. You can always be a public patient in a public hospital and receive free medical care. While the care is supposed to be of the same quality, you do not get to choose your doctor and you may be subject to a waiting list. Public patients occupy over 70% of the hospital beds in Australia.

Should you choose to be a private patient in either a public or a private hospital, you can receive better accommodations such as a private or semi-private room and you will have your choice of physicians. A private patient would pay his hospital bill and then file a claim with Medicare. Medicare reimburses 75% of their scheduled fees. There is no out-of-pocket maximum for these expenses.

It is possible to purchase supplemental health insurance from a registered health insurance company to help meet these extra costs. This insurance will pay the other 25% of the Medicare scheduled fee. However, registered health insurers are prohibited from providing any reimbursement for charges in excess of the other Medicare fees. As you can imagine, this leaves the consumer with self-insuring these medical expenses.

Prior to 1989, it was possible for individuals to buy fixed indemnity daily hospital benefits through commercial insurance carriers other than registered health insurers. However, the registered health insurers complained that the best risks were using this type of insurance and that this was causing significant financial hardships. The government changed the regulations to prohibit commercial carriers from using the word "hospital" in any of their insurance products. Consumers then lost their ability to buy coverage for anything above the Medicare prescribed levels.

Registered health insurers are generally nonprofit organizations that cannot refuse to insure anyone. They use a simple form of community rating, where all individuals pay a certain amount and all families pay twice that amount. The opportunities for profit are extremely limited since the benefits, restrictions, and premium rates are all set by the Department of Health. Generally, this supplemental coverage is bought by individuals. While some companies pay for the premiums, it is not a common employee benefit. There is currently a complimentary plan for prescribed drugs which requires a flat fee of about $15 per prescription with an annual out-of-pocket maximum of about $500. The government is also now in the process of proposing a dental plan.

While an Australian has considerable flexibility in the level of medical care that he chooses, he cannot insure 100% of his financial exposure. In other words, if you want better medical care, you must pay for it yourself.

Commercial insurance companies do offer disability and accidental death insurance on an individual group basis. Historically, long-term care has been provided by churches, charities, and other nonprofit organizations. This has created an unrealistic impression of lower-than-actual costs for these benefits. Commercial carriers trying to develop this market are beginning to realize that a significant effort is needed to educate the public regarding the true cost and need for this product.

As you can see, the opportunities for insurance companies to provide supplemental insurance in Australia are very limited. Australians are not given the freedom to fully

insure all of their medical expenses. The lack of financial resources forces many Australians into public hospitals.

It appears that health care in the United States will be defined to permit a patient to choose his doctor and his level of treatment. We can learn from the Australian model that permitting the choice of doctors does not necessarily guarantee the freedom to buy the insurance in order to cover the financial costs of these choices.

MR. WILLIAM R. LANE: Before I talk about health care reform on a general basis covering all market segments, I would like to point out how the individual marketplace is a little bit different than what we have been looking at in total.

Within the individual marketplace, there are perceptions of abuse by the various policymakers. Some of these abusive situations are not necessarily what the industry would consider as abuse. They perceive underwriting, rating up people for health status, and riding out conditions as abusive, because you are disallowing coverage for people who need it most. In the large group market of course, you do not have these situations. The feeling is that if you can do it in one market segment, you should be able to do it in another, but not doing it is abusive.

The industry's congressional allies have been urging reform, and urging a proactive approach. Some of the reason for this is that small group market reforms have been getting a lot of pressure and moving ahead particularly at the state level, but also at the federal level. This small group reform is pushing down to numbers (in terms of group size) which would actually apply to the individual insurance, but the individual market is different than the small group market. Different factors apply. This is not always seen by people who are making the rules. They do not always understand that the marketplace is different. Therefore, those who have been educated in Congress are urging us to be proactive, to try and make the changes that will work in the marketplace, rather than subjecting them to rules that would not in fact reform the marketplace, but might in fact break it.

With the election of President Clinton, we have an administration whose major issue is economics; second on the list is health care. Health care is viewed from several perspectives. First, it is a social issue. The 37 million uninsured are a very critical issue to the administration. Health care is seen as an economic issue. You cannot solve the economy if you do not solve health care. President Clinton has been very clear that health care reform is not just a social issue; it is also the economic issue. The cost aspect of the systems are driving the real problems.

His 100-day plan, of course, is to have a proposal on the table by May 1, 1993. Hillary's father's illness and subsequent death have pushed this date back, but we are still expecting the proposal to hit the streets sometime in mid-May. By putting Hillary in charge of the task force, President Clinton very clearly indicated that health care was a top issue, and that a proposal would be forthcoming. He has a cabinet-level membership with a huge task force that has been working on this for months now. The answer he has been giving us is two-fold: managed competition plus global budgeting, an overall cap on spending. Some regulatory form that will in fact go after cost control. The reason for this is not necessarily obvious, but there is in fact a good reason for it.

Within the Congress, there has been a growing trend. In fact, with the last election, it continues. The House of Representatives has become more and more conservative while the Senate has become more and more liberal in thinking. There is a group within the House called the Conservative Democratic Forum. It is a loosely established group but nonetheless powerful. It has approximately 60 members. They are Democrats, but they are very conservative in their thinking. If these Democrats do not vote with Clinton, if they are not considered in his health care proposal, then these Democrats plus the Republicans constitute a majority in the House, and health care reform cannot be passed. The Conservative Democratic Forum has been strongly behind managed competition; in fact, they offered it as a solution in the last session of Congress, not with the intent of actually seeking its passage, but to get it on the table so that people could look at it, consider it, and hopefully move it forward in the next session. So, the House has a lot of motivation to look at managed competition.

The Senate's motivation is just the opposite. The Senate is very liberal in its thinking. It has such members as Kennedy and John F. Kerry, who proposed Canadian-style national health insurance. The Senate wants a more regulatory approach. Some form of global budgeting or rate control is very popular on the Senate side. Somehow, President Clinton has to satisfy both Houses of Congress. That is why he has come up with managed competition with the global budget.

Well, the star on the horizon for the last six months has been managed competition. I have been giving this speech for quite some time. I have been telling people that no issue can last in Congress for more than 12-18 months without getting shot down. The problem is, once it gets up there and people start looking at it, all the pressure groups come out and start hammering away at it. Very recently, it was announced that Congress is no longer going to call their proposal managed competition, although it would still have most of the elements that we are familiar with in terms of managed competition. Already they are veering away a little bit from the formal managed competition proposal that was started by the Jackson Hole Group. Nevertheless, the elements of managed competition that you have probably all seen in the press are probably still going to be there.

Some of the most critical elements in terms of the insurance industry is the concept of accountable health plans, purchasing groups, and uniform benefit packages. Accountable health plans are the proposed vehicle for providing health insurance in the future. They are supposed to be based on managed care networks. Now that could be an HMO, a PPO, an EPO, a point-of-service, or any number of network-based products. They are specifically not indemnity fee-for-service plans. The concept is that if you put the providers together in a network, you have some ability to actually control the cost of those providers. Under a fee-for-service, indemnity-type environment, you simply have no control over the cost, and therefore, you have no ability to go after the economic side of the issue. There will be strong pressure for low premiums, and a decrease in rating actions on these products. Congress recognizes that cannot be done unless there is a link between the providers and the product itself. Currently, managed care products are not often available on an individual basis. Generally speaking, when you are looking at managed care today, you are looking at the large group market, or at least the mid-sized group market. When you get down to the individual market, not much managed care is available.

Purchasing cooperatives are another key point. Generally speaking, the idea of a purchasing group is to have one entity per geographic area. It is available to all individuals in small groups. It is sort of the benefit manager for those people who buy coverage through it. It is supposed to offer all of the approved accountable health plans within the area. Each employee within the small employer, and obviously each individual, gets to choose which plan they want – much like a gigantic flexible benefits program. Within the purchasing group, you will have all of the market reform requirements that you typically see with small group reform: (1) guarantee issue, (2) rating bands, and (3) guaranteed renewability, etc. The concept is to reform the market by using these purchasing groups to control it.

Just to give you an idea of how much changed with the recent announcements, the conservative Democratic forum version of health insurance purchasing cooperatives are now called health alliances – so, if you hear the term health alliances, it is a purchasing group.

A key issue with purchasing groups is called exclusivity. If a purchasing cooperative or purchasing group is exclusive, all individuals and small groups who want to buy coverage must buy it through the purchasing group. If it is nonexclusive, they can buy it through the purchasing group, but they are not required to do so. They can still use their agent or broker, consultant, or go directly with the company. It is a very critical issue right now, and being debated very actively on Capitol Hill. If the purchasing groups are exclusive, the individual market as we know it today simply disappears, because all individuals buying coverage will be going through these purchasing group entities as opposed to being sold individually. Nonetheless, if they are nonexclusive, we can expect some major changes. We will still have the market reforms. We can still expect guaranteed issue, guaranteed renewability, rating bands and so forth. In addition, we can expect some form of risk adjuster. This is a form of reinsurance that sort of cools all of the marketplace. It takes those carriers who have a lot of unhealthy people, and provides them a subsidy from the carriers that have a lot of healthy people. This is a very critical issue right now. It is not well understood and there is a lot of debate going on. The key to making purchasing cooperatives nonexclusive is to have a risk adjuster that actually works.

Standardized benefits. These will probably be set by a national board. It has even been proposed that it would go into the legislation. In general, they are looking at comprehensive coverage. They are not looking at a bare bones, $1,000 deductible, 50% coinsurance type of product. They are looking at a product that would be beneficial for most of the country. It probably will include some deductibles and copayments, but they probably will not be very large. Some of the language that has been used to date suggests that the deductibles cannot be so large as to discourage people from seeking needed care. The group that is proposing this suggests that your deductibles cannot be very large at all, possibly copayments would be used. Additional benefits are intended to be taxable. This is another one of those open issues. The original intent was to tax the employee, by making a taxable income if an employer contributes more than a certain amount to the plan -- usually the amount in excess of what the effective benefits would have cost. The unions have lobbied very hard against that. The Clinton people have said that is probably not the approach they are going to suggest. Right now they are suggesting that the employer would

no longer get a tax deduction for contributions made towards coverage where the cost was in excess of the uniform benefits.

Right now no one really knows how they intend to do it, but they do want to try and raise some tax revenue through limiting the deductibility in one form or another. Supplemental benefits most likely will be sold, but the key issue is, how much will be there to supplement? If they have very full-blown, comprehensive coverage, there will not be a lot left for which to have a supplemental market. On the other hand, if there are holes and gaps within the coverage, a market will remain. One example of a benefit that is definitely under consideration is the prescription drug benefit. The normal commercial market under age 65, essentially expects any medical plan to have prescription drug coverage. However, if Congress says that it is mandatory for people under age 65 to have prescription drug coverage because that is necessary for a minimum benefit package, they are going to have a very difficult time with the over age 65 lobbiers; they have not given them drug coverage in Medicare for years because it's unaffordable. Even though they would like to put drug coverage in, and Clinton said that he wants drugs in this package, they may not be able to do it politically. There are a lot of open issues as to exactly what the package will contain, and that will define in large part what the supplemental market will be like.

Managed competition, even though it may not be called managed competition anymore, is likely to be a framework for the health care reform proposal. Managed competition was first defined by the Jackson Hole Group. They put together a theoretical model of how managed competition might work. Congressman Cooper, of the Conservative Democratic Forum, put it into legislative language. They made some changes from the original proposal, but nevertheless, they left the bulk of what managed competition looked like to Jackson Hole in the legislation. This was proposed to Congress last year in H.R. 5936. It was intended to provide a framework from which legislation could be built this year.

President Clinton, both during his campaign and since his election, has talked about managed competition. What he is suggesting includes a lot of elements of managed competition, but it also includes the global budgeting or regulatory approach as well. Managed competition in its purest form does not include any form of global budgeting.

It is difficult to get a total handle on what President Clinton is going to be proposing. We had sound bites during the campaign -- little one sentence statements as to what was going to be included or eliminated. Since then we have had some information but not a lot. During the campaign, he did describe purchasing groups as nonexclusive, but the information that has been coming out from the task force lately indicates they are leaning toward exclusive purchasing groups. It is still very clearly an open issue. Another key issue is whether you are going to mandate people to be within the system. If you do not insist that everyone have insurance, but you insist that insurance be a guaranteed issue, you have a major problem in the marketplace with adverse selection or antiselection.

Healthy people who do not feel they can afford coverage today, but feel they can get coverage immediately if they get sick will be very likely to drop coverage and wait until they get sick. In fact, we are hearing some small group associations actually

recommending that approach in New York state where this is actually going into effect – guaranteed issue coverage, but no mandate that you must buy.

This can lead very quickly to a disruption of the marketplace because only the unhealthy people will remain in the market. The Clinton package today includes a mandate. Albeit, it is phased in over a number of years, it nevertheless insists that everyone must purchase coverage by a certain point. It also includes system-wide price controls. Nobody really knows what this means. This is another one of those areas that is being debated very seriously right now. One of the suggestions was provider fee schedules – limiting what providers could charge across the board, not just within Medicare and Medicaid but within the commercial marketplace as well. The recent indications are that this is not going to happen. In the real world of politics, no one knows until it is finally signed. At this point in time, that does not seem to be the preferred approach.

The problem with that is the fault approach is some form of regulation of the premium rate itself. The implications of that, particularly in the individual marketplace are very significant. It is just simply not possible in an indemnity product to control your price increases if you cannot control either your risk selection or your benefit package.

Medicare under the Clinton approach would remain the same, which means the Medicare supplement market as we know it today would not change. What has the response been to this? The industry, through the Health Insurance Association of America (HIAA), has come up with several things that it is saying in terms of how it feels the market ought to change. Although I cannot give you the full scope of the vision statement, the HIAA has come up with a statement that is very significant in terms of a change from previous policy for the Health Insurance Association of America. It calls for a comprehensive reform of the system. This by itself is just simply a significant change, but it has some very key principles – principles that really do attack some of the problems in the marketplace today – calling for universal coverage, an essential package of benefits, some real cost control features, and an equitable tax policy.

What it does not call for are exclusive purchasing cooperatives that would totally disrupt the marketplace. Within the HIAA, the individual committee has been looking at the health care reform specifically with the individual market in mind – looking for what could be done to change the structure of the system, and yet still allow individual business to be sold largely as we know it today. It is addressing what is perceived to be abuses in the system. The individual committee has endorsed the concept of guaranteed issue and guaranteed renewability of coverage which is really the core issue within the system. However, they pointed out that some of this cannot be done unless there are certain things in place. It cannot be done in a vacuum. Most important, it cannot be done in a voluntary system. You cannot guarantee issue coverage at a standard rate if you do not have everyone in the system. It simply will not work.

In addition, you cannot allow the individual marketplace to become a dumping ground for the larger employers who see an opportunity to have an unhealthy employee who is going to cost them a lot of money dropped into the individual marketplace.

Therefore, you cannot allow the guaranteed issue for someone who would be otherwise eligible for group insurance. It needs to be done with some form of reinsurance or risk adjuster, so as to protect companies from getting a large or disproportionate number of unhealthy people. It should include some form of limitation on preexisting coverage if people are changing carriers. That is, if you are moving from one form of coverage to another form of coverage, you should not have preexisting limitations applied all over again.

Last but not least, carriers ought to be allowed to drop out of the marketplace. While they are suggesting guaranteed renewable coverage, they are saying that carriers ought to be allowed to get totally out of the marketplace since other carriers would be available to pick up those people on a guaranteed-issue basis.

My crystal ball broke about three or four years ago – rolled off the shelf. They are really hard to replace. It is really foolish to try to predict what is going to happen within the political process. Nevertheless, these are the trends we see. This is where we see it headed. We anticipate that the individual market will be reformed along with the rest of the marketplace. If it is done well, we think there is still a major role for health insurance carriers as there always has been. If it is done poorly, we see some major problems ahead.

MR. THOMAS A. SKIFF: As the previous speakers have already said, the administration's goal is to have a complete proposal by sometime in May 1993. Everyone is working hard to meet that deadline. They are being pushed along by the Republicans who plan to have a proposal by late April. I am not sure that is a good date.

What will the President propose with respect to long-term care? There has probably been less talk about this than almost any other aspect of the proposal. Representatives of my company and some other companies have met with the chairman of the cluster group on long-term care, Robin Stone. The following comments are based on the conversations with her and with other staff that have been working with the administration. I will try to start out with what I think are the most likely proposals to come out with respect to long-term care, and I'll work towards the more speculative.

The one thing we are fairly sure of is that long-term care will not be ignored. However, it is considered to come behind acute care reform and prescription drug funding so maybe there will not be much time left to deal with this problem. That would be my best scenario. The most likely thing to happen is there will be federal standards for long-term-care policies. Someone asked in another session why this has not happened already. We do not have specifics about the standards, but a number of standard bills have been in Congress for a year or two now. They include such things as standard definitions in terms. This might actually lead to having only one list of activities of daily living (ADL) rather than every company in every state making up its own list. There could be a minimum one-year benefit for each type of benefit, no preexisting condition exclusion over age 75, and below age 75 a limit on preexisting condition to six months. That coverage cannot be conditional on prior use of other services. Essentially this outlaws a three-day hospital stay policy. It would have a minimum policy of $30 a day, at least if that is the only policy a person has. The regulations probably will require an offer of inflation protection and have a six-month reinstatement provision if there is a cognitive impairment. The reinstatement

provision can be extended for people who just maybe, due to Alzheimer's, forget to pay their premiums, and then need coverage. It probably will include a mandatory nonforfeiture benefit. Additional items that at least staff members are talking about that would be included under standards are: (1) some type of agent marketing or sales practices standards and enforcement of those standards, and (2) a consistent and appropriate eligibility criteria, again pushing more at the ADL and cognitive test types of benefit triggers as opposed to medical necessity. Some people are still concerned about what they consider the relatively low-loss ratios of the individual market. The staff in particular feels that private insurance is inefficient, since it returns only 60-75% of premium to policyholders, compared to more than 90% for government programs. This is just a general bias of the people that are looking at this issue.

The second thing that we expect to almost certainly happen is tax clarification similar to that proposed by Senator Mitchell in the last Congress. I am told that Secretary Benson in particular supports the clarification provisions. Basically, all these provisions put into law the treatment that everyone has been using for the last several years. That is, long-term-care benefits will be treated as accident health insurance benefits, preferably for a disability model rather than having to have a reimbursement of services rendered -- although that is still somewhat open to question.

Standards and tax clarification are on everyone's agenda. The good news for the administration is that they are usually free. When you get beyond that it gets expensive. They have already got a lot of things to spend money on. I am told that the President will try to draw clear lines between acute care, transitional care, and true long-term-care services. It would seem to be relatively easy to do, but there are a number of services, especially in the home care arena, that can be provided on an acute, transitional, or long-term maintenance basis. I think that the administration is going to have a difficult time drawing these clear lines. This may lead them to push for separating home care from institutional care -- trying to deal with home care at the federal level, and leaving institutional care at the state level. This concept of splitting home care and institutional care has some interesting issues associated with it.

In 1991, through an administrative policy statement, Medicare significantly expanded their home care benefit. The policy reduced the need for periodic skilled care services in order to pay for personal care services. As a result this has led to rapidly increasing home care payout under the Medicare system. In 1992, home care costs grew by 48%. Although home care is currently a small part of the total Medicare expenditure, if it continued to grow at this rate it could bankrupt the Medicare trust fund by the turn of the century.

Clearly, any expansion of home care, and possibly just the continuation of the level of care now provided by Medicare, will need significant funding in the future. In addition, the concept of moving institutional care back to the states is not going to be welcomed with great enthusiasm. The governors know that the demographic trends are against them. The elderly population is the fastest growing segment of the population. They are the users of institutional care. The states would therefore be left with a rapidly growing cost, limited or no increase in funding from the federal government, and increased pressure to balance their own state budgets without increasing taxes.

Fortunately or unfortunately, the governors who are going to be opposing this, also have former Governor Clinton's ear. An alternative may be an expanded use of public/private partnership plans that deal with the issue of spend down to qualify for Medicaid benefits. As you know, you have to be medically indigent to qualify for Medicaid benefits. This requires either divesting assets to get under the limitation or spending all of your assets and then qualifying for Medicaid.

The Robert Wood Johnson Foundation has been working with a number of states to try and work with insurance companies to develop qualified private insurance plans. These plans allow individuals to shelter more of their assets from this spend-down provision. There are currently four states that are in the process of implementing the plans. The Connecticut plan has been working for about 18 months. New York, California, and Indiana will all implement plans by the end of the second quarter of 1993. If these plans spread, and I think their spread is highly likely, the problem from the insurance company point of view is that each one is different. We will end up with 50 different plans, 50 different reporting requirements, and a terrible administrative burden.

The good news about the approach is that it does recognize that there is a role for private insurance in the long-term-care funding market. In addition to federal activity, there also is continued modification at the NAIC level of the Model Act for long-term care. If you have attended other sessions on long-term care you have already heard these issues in much more detail than I am going to go into them.

First is mandatory nonforfeiture benefits. It was passed at the spring meeting. There will be a final vote in June. I hope that will lead to specific regulations by December. As a company, we are opposed to this mandatory benefit and are going to be continuing to work to defeat it.

The second issue at the NAIC level is rate stability. There is an on-going concern that large rate increases make the coverage unaffordable when people are most likely to need it. In order to address this problem, the industry (as represented by a higher group), currently supports a rate stabilization proposal that includes the following: (1) a minimum rate guarantee of three years from issue, (2) subsequent rate guarantees of two years after a rate increase – over age 75 the maximum rate increase in a 12-month period would be 10%, (3) a mandatory offer of reduced benefits at no more than the original premium, and (4) agreement to go out of business for at least two years if rates go up by more than 50%.

There are provisions in the industry proposal to waive these restrictions in case of extraordinary events, like the potential insolvency of the company, modifications to meet standards, and changes in the medical care delivery system. Unfortunately, there is another proposal on the table that is supported by consumer groups. It is much simpler. It would just make the product noncancelable to guarantee the premiums. I would like to believe that would not happen, but we all know how well regulators like simple solutions.

A third issue at the NAIC level is suitability of coverage. The NAIC has formed a working group that includes consumer applicants but not insurance company representatives to develop guidelines with regard to the characteristics of a suitable

long-term-care policyholder. They are looking to provide some guidelines with regard to minimum assets and minimum income. Their work is in the very initial stages at this point. At this time, it is viewed as relatively nonthreatening to the industry.

Well, that is the situation we have dealt with at this point. What do I think the likely impact of this will be on the industry? I have three possible scenarios, some of them fairly optimistic, some of them pessimistic. If the proposal is limited to some expansion of home care, maybe we will just see a reduction in the amount of home care coverage being sold, with home care being reduced to a supplemental program but continued selling of institutional care benefits at the current level. That is one of my optimistic scenarios.

A second scenario, and one that I think is much more likely, is that the government will only deal with the home care issue. It will be unclear how much funding and how rich the benefit will be. Therefore, many people will believe that the government will take care of all of their long-term-care needs even though it does nothing to deal with the institutional care issue. I believe that this will reduce the marketplace due to confusion, as opposed to a reduction in the need of the buyers. In 1992, a high-up buyer, nonbuyer survey, documented that the key difference between buyers and nonbuyers was their attitude toward the government as the payer of long-term-care services.

The most optimistic scenario would be if the government would limit the federal funding to transitional or recuperative home care. In addition, they would make it clear that this was the limit. Educate and aim an information program at consumers, highlighting the fact that there are quality long-term-care products worth considering seriously. Unfortunately, this scenario presumes a realistic view of the necessary funding, and that they realize that higher priority items, including their already astronomical tax increases, and the need to fund the acute care proposals.

In conclusion, we see the debate in Congress as other people have long-term care will take a relatively minor role. Any action before 1994 is unlikely. Our biggest challenge is going to be to continue to grow the business while the country waits for the President and Congress to act.

MR. ABROE: Can you comment on the impact of health care reform on supplemental and specialty products? What type of products are likely to remain? Are any new products likely to be developed?

MR. LANE: I guess I have a couple of responses to that. When you have a product that is standardized, like Medicare, it is relatively easy to supplement if there is something left to supplement. So to the extent they leave holes in the national package, there will definitely be a supplemental market to fill in those gaps. Certainly products like hospital income and so forth will remain in the marketplace. The products that are likely to remain are those that specifically supplement the federal program, because the other products will be superseded by the government. Are there likely to be new products? I guess yes. The product is like the Medicare supplement, only now it is the national uniform benefit supplement product.

MR. LIPPAI: At Combined Insurance, we are looking at a couple of things. First we're trying to move our portfolio to be disability based coverages, as opposed to hospital-based coverage with the anticipation that disability will be a safe harbor that the regulations will not touch.

Second, we have speculated that a two-tier type of health system could develop in the United States. Even if there is a fairly extensive national health plan, the upper income classes of America will probably always have access to better health care. To some extent, we will look at this to determine the supplemental products that will be needed.

MR. BUGG: I agree with Bill Lane. As the program develops, the gaps will lead to possibilities for supplemental products. Before Medicare we did not have Medicare supplements. Medicare led to that product.

MR. SKIFF: I think the most likely outcome is a greater emphasis in the future on private institutional care policies with the government taking a bigger and bigger role in the home care area.

MR. ABROE: How are marketing and distribution systems likely to be affected by health care reform?

MR. LANE: It depends upon these purchasing cooperatives. To the extent that we are allowed to continue our current marketing and distribution systems and simply compete with the purchasing cooperatives, I do not think it is going to have a major impact. There are those who believe they can drive a lot of cost out of the system by forcing all marketing through the purchasing cooperative. We really do not agree. We just think that instead of having agent compensation or broker commissions, you are going to be spending a lot more money on billboards, radio and television ads. The health plans are still going to compete for membership. They are still going to have marketing expenses. They are just going to have a different form. While we do not expect exclusive purchasing cooperatives, we think that is the key point as to whether the distribution systems are going to change or not.

MR. LIPPAI: In the short run, we see a couple of potential problem areas. Once the proposal comes out of Hillary's group and is discussed on a very broad basis, we expect an impact on our ability to hire new agents. Selling health insurance may not be a good career choice if a government program will take effect in the near future.

Second, we expect as the programs are discussed there is going to be a good deal of consumer uncertainty for a period of a year or so. Until everything settles down, consumers will not know what will be covered by the national health plan. This will impact their desire to purchase any supplemental health coverage.

MR. SKIFF: In the long-term-care area, I see an increased use of direct mail sales. Today, the product is too complicated to sell very successfully through the mail. If we have some simplification and some standardization, that could change.

MR. ABROE: When will reform be enacted? When will the reform be effective?

MR. LANE: Former President Ford just said that he expects it early 1994. I expect it a little bit earlier. He is probably closer to the congressional system and knows better, but we should expect reform to be enacted sometime within the next 12 months or so. After it is enacted, you still have to set up the entire structure. You have to form a Board of some sort. They have to put together the rules as to how these purchasing cooperatives will work. It will easily take a year just to define the benefit package and the cooperatives.

The cooperatives then need to be set up, which could easily take up another year in the actual implementation phase. My guess is the earliest it could be effective is January 1, 1996. Simply viewing the way the electorate works in this country, January 1, 1997 would be an ideal date for the thing to become effective and may in fact become the target date for the entire process. That would be my guess as to when it is going to happen.

MR. ABROE: Are there any state trends that will affect supplemental and specialty health products? Specifically what changes may be coming in the regulatory area? Also, what about the state health care reform efforts?

MR. BUGG: One of the concerns I have is some movement toward a 65% loss ratio. As people say, if it can be done on Medicare supplement, it can be done on all the supplemental products. I believe that would really put a pinch on the distribution side. In our case, the distribution or the commission expenses are over half – maybe 60%, 65% of your cost. You are looking at maybe having to cut that in half in order to meet a 65% loss ratio. The current distribution might collapse with such reductions in the commission levels.

MR. LANE: I will comment on the health care reform side. A number of states have in fact put together their version of health care reform. The federal government is looking at that and is somewhat interested in accommodating what the states are doing. President Clinton, being a former governor, has some real empathy for the governors who are trying to enact things at the state level. There is a lot of discussion now that states should have some real latitude in terms of the purchasing cooperative itself. Ira Magaziner has even stated that they should allow them to go so far as to let states set up single payor systems, or to have totally nonexclusive purchasing cooperatives or even competitive purchasing cooperatives. Those key decisions would be at the state level instead of at the federal level. That would obviously have a major impact on the marketplace and each state would be unique.

MR. THOMAS X. LONERGAN: How do you think the loss ratio will be defined? Do you think the law will allow active life reserves to somehow work into the definition there? Obviously it would be impossible to have a paid loss ratio of 65% of the current basis. You are just selling your business.

MR. BUGG: That is a good question. That sure is a gray area now. It is hard to anticipate where it might go.

MR. ABROE: Has that been discussed on long-term care?

MR. SKIFF: Yes, every state has a different approach to the problem. So far, it has been a state-by-state argument. A lot of people do not like putting the active life reserves into that loss ratio, but if you do not, then you have to look at it projected over a long period of time.

MR. STUART B. GRODANZ: There was some comment earlier about distribution costs and loss ratios being in conflict. Could you describe how those have played out in the international markets that were discussed earlier?

MR. LIPPAI: Generally, in the international market, we have not seen any regulation whatsoever regarding loss ratios. In most places, loss ratios are at much lower levels than they are here in the U.S., at least for basic supplemental products.

MR. BUGG: In Japan, price and parameters are set by the MOF, which is in a sense the insurance department. They are set for everyone. I am not quite sure what those loss ratios might be. It is not addressed in that fashion. Your pricing assumptions for expenses and morbidity are established and agreed to through the MOF -- I think really through the insurance industries. Everybody bites into that. In fact, everybody is charging the same premium for the same product.

MR. ROBERT H. PLUMB: There are controls on premiums in some of the European Community (EC) members. You actually have to file your premiums and they are actually very thick. In the United Kingdom and Ireland, I believe there is no control on premiums whatsoever. We have no loss-ratio controls. We can charge what we like. We have full competition in the marketplace.

I think I would like to add to Mr. Skiff's comment about long-term care. We have just changed our rules on long-term care in the United Kingdom. Previously, the state used to provide all of the money for people to go into institutional care. There was something called spend down, but in fact, that was ignored. Everybody got sick and got the home care staff for free -- while the government went from spending ten million sterling in 1979 to about 2.4 billion sterling last year. I think it is a warning for all -- do not put too much in the way of benefits. Not everybody realizes it, but the local authorities, such as the City of Coronado now have a budget. They have the access on long-term care in Tierney Home and are being given a sum of money per person. The result is that the consumers do not yet realize they have to pay for it themselves. It is chaos or will be. There is going to be a political explosion in October or November 1993 as everybody starts to run out of budget money.

If you actually get, as I expect you will, a set of proposals which turn out to be far too rich for any federal deficit, you are going to be faced with a choice of increasing your income tax from 41% up to 61% at some stage plus a value-added tax which is going to be very popular for any administration. It is a very effective method to use to collect money. If you are going to get that, what will actually happen? I predict the state is actually going to have to roll back the benefits, as is actually happening in the United Kingdom. We do not know, but the benefits are being rolled back. In which case the private sector, the insurance sector, will have an opportunity to increase their benefit levels. From what I have been hearing, that is what I expect might happen.

So even if you think you are not going to have much in the way of supplemental benefits now, hang in there, because I think in a few years you are going to get a different market.

MR. BUGG: Yes, what you are saying is that you just cannot pay for everything.