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THE ROLE OF SUPPLEMENTAL COVERAGES UNDER HEALTH CARE REFORM

Moderator: DAWN E. HELWIG
Panelists: MICHAEL S. ABROE
CECIL D. BYKERK
DAWN E. HELWIG
Recorder: DEBORAH A. GRANT

What roles do supplemental coverages play today? Will there be a role for supplemental coverages under health care reform? . . . for traditional group ancillary benefits? . . . for health care reform supplements? . . . for traditional individual/group niche products?

MS. DAWN E. HELWIG: I think that the size of the group indicates the current importance of the supplemental market for the insurance industry, and it also indicates that many of you are looking forward to the future after health care reform and thinking that supplemental products are something that you might be interested in getting into in a bigger way.

I'd like to start out by introducing the speakers and telling you a little bit about what we have planned for this session. I have foolishly volunteered myself to be the first speaker. I am with the Chicago office of Milliman & Robertson. I have the easy job; I will be setting the stage for the other two speakers. I am going to be talking about how important the current supplemental market is, or how big it currently is, and what types of needs these products meet. Will these needs still exist after health care reform?

Our second speaker will be Cecil Bykerk, who is the vice president and chief actuary at Mutual of Omaha. In his past career, Cecil was an actuarial finance professor at the University of Nebraska. He has spent quite a bit of time recently tracking and studying health care reform issues. He has testified three times before Congress, and his staff has been very actively tracking all of the different legislative bills that have been proposed. Cecil is going to spend some time talking about the major reform packages that are on the agenda, and looking at what provisions they have either explicitly or implicitly for either new or existing supplemental coverages.

Our third speaker is Mike Abroe. Mike spent 20 years at Bankers Life & Casualty, which many of you know is very big in the supplemental markets. He has spent the last eight years at Milliman & Robertson, in the Chicago office, as the chief individual actuary. Mike is going to be our man with the crystal ball. He is going to be pontificating on what the possible new products will be after health care reform, as well as looking at what types of strengths a company is going to need to have to be successful in the supplemental market.

I would like to briefly explain what types of products we are going to be considering as supplemental coverages. I have divided supplemental coverages into two major categories—what I call medical supplementals and nonmedical supplementals. Medical supplemental products are those that fill in the gaps of basic medical

protection. In these policies, because they're tied to actual medical expenses, the benefits are subject to inflation. Some examples of medical supplemental products are Medicare Supplement; CHAMPUS products, which are the products that are designed to fill in the gap of medical coverage given to military personnel and their dependents; federal employees health benefit (FEHB) coverages, which are supplemental coverages designed for the plan; special risk products; and wraparound products, which would fill in the gap of basic major medical type of coverage.

The second general category of supplemental products is what I term nonmedical supplementals. These products, as opposed to the first category, are not directly tied to actual medical expenses. They're generally indemnity type products with small premiums, and because they are indemnity, they are not subject to the forces of inflation. Examples of these products would include hospital indemnity, accident only, disability income, and possibly cancer or dread disease products. Dread disease products could fall into either category depending upon how the benefits are configured. There could be some more medical types of dread disease policies.

I have a third category, long-term care, which is kind of a hybrid of the medical and nonmedical. It could be either expense or indemnity, so it could fall into either category.

All of these types of products could be sold either on a group or an individual basis. health care reform is going to affect all three categories of coverage. The medical supplemental market is probably going to be the most greatly affected because health care reform could create some new types of supplemental products to wrap around the benefits that are provided under the health care reform package.

Nonmedical supplemental products may or may not be impacted by health care reform. The degree depends upon how broad based health care reform is, and also upon how well the regulators understand the needs that these nonmedical supplemental products are trying to fill, and whether they feel that these needs still exist after reform.

I would like to spend a couple of minutes discussing how big the current supplemental market is. I have several tables that start by showing the big picture, health care spending in general in the country. They then consecutively narrow in focus to look at individual commercial accident and health premiums, because that is where the majority of supplemental coverages are being sold.

How big is the current supplemental market? Table 1 shows health care spending in the United States in general. You can see that private insurance accounts for $216.8 billion out of the $666 billion of funding sources for health care in this country, which is 32.5% of the total. This corroborates with a recent article in the *Health Section News* which discussed the fact that, the federal and state governments combined make up the majority of health care spending in the country.

The data that is in Table 3 only include the premium dollars that are spent on the medical supplemental products. The nonmedical supplementals are not included here because they are generally not considered to be health care spending, i.e., they are not directly reimbursed to providers.

TABLE 1
FUNDING SOURCES FOR HEALTH CARE—1990
(IN BILLIONS)[a]

Source	Dollars	Percent
Private Insurance	$216.8	32.5%
Direct by Consumer	136.1	20.4
Federal Government	195.4	29.3
State Government	87.3	13.1
Other[b]	30.6	4.6
TOTAL	$666.2	100.0%

[a]Source: Date used only from *EBRI Data Book on Employee Benefits*, Second Edition.
[b]Philanthropic, industrial in-plant services, etc.

In Table 1, the private insurance total was $216.8 billion. In Table 2, that total increased to $237.7 billion, because a different data source is used. The $237.7 billion of insurance companies is broken down further by commercial insurance companies versus health maintenance organizations (HMOs) versus Blue Cross and Blue Shield organizations. From this you can see that $99.2 plus $8.9 or $108.1 billion, or 45.5% of the total health care insurance premium dollars comes from commercial insurance companies. This still excludes most of the nonmedical types of supplemental products, but includes Medicare supplement, and some of the medical ones. It does not include hospital indemnity, disability, income, accident-only and dread disease.

TABLE 2
HEALTH INSURANCE PREMIUMS (1990) BY TYPE OF INSURER [a]

Sources	Billions of Dollars	Percent
Commercial Insurance		
Companies[b]	$99.2	41.7%
— Group	8.9	3.7
— Individual	67.0	28.2
HMO & Self-Insured	62.6	26.3
Blue Cross/Blue Shield		
TOTAL	$237.7	100.0%

[a]Source: Data from *Health Insurance Association of America (HIAA) Source Book of Health Insurance Data*, 1992 edition.
[b]Includes duplication of services, i.e. HMOs offered by insurance companies are included in insurance companies.

For the HMO and self insured, or the Blue Cross/Blue Shield data, I am not going to get into any more detail here. I think there is, especially in the Blue Cross arena, some supplemental insurance, but it is not a major part by any means. In fact, it is very minor for those two types of insurers. Next, take the $108.1 billion of commercial insurance company premium and try to narrow the focus a little bit.

In Table 3, I have added one of the nonmedical supplemental types of products—loss of income. This represents $10.5, which gets us to a total now of $118.6. We're

still missing some of the nonmedical supplemental insurance products in Table 3, but we are getting a little bit closer to the total picture here. There are just a couple of points I want to make about Table 3. First of all, group insurance is predominantly medical insurance. There is some loss of income, some dental and some medicare supplement being sold on a group basis, but the vast majority of it is medical insurance. Conversely, the vast majority of medical insurance is sold on a group basis.

TABLE 3
COMMERCIAL HEALTH INSURANCE PREMIUM (1990)
(IN BILLIONS)[a]

Line	Hospital, Medical, & Other	Dental	Medicare Supplement	Loss of Income	Total
Group	$87.4	$8.3	$3.5	$6.7	$105.9
Individual	5.4	—	3.5	3.8	12.7
TOTAL	$92.8	$8.3	$7.0	$10.5	$118.6

[a]Sources: *HIAA Source Book of Health Insurance Data*, 1992 edition, *NAIC Medicare Supplement Report*

So the individual line is a very small percentage of the total health care spending in this country, but that is where the majority of the supplemental products are being sold. So from here on, I will concentrate just on that $12.7 billion of individual commercial premium.

Table 4 comes the closest that we are able to get to the total picture on the individual accident and health (A&H) side. I have added the missing lines of business to the numbers from Table 3. I've added accident only, hospital indemnity, and dread disease to try to get an idea of what the total nonmedical and medical supplemental market looks like. This is 1992 data versus 1990 data, so it's not going to match exactly to Table 3. The data in Table 4 come from a variety of sources. We've utilized a special Life Insurance Marketing Research Association (LIMRA) survey, and in addition, we have some special surveys of our own. And we've made use of company policy form experience exhibits that are filed with state insurance departments. The data in Table 4 represent over 97% of individual 1992 premiums, so it is complete. It has data from over 109 companies. From this table, we see that 46.1% of total individual accident and health premium is nonmedical supplemental types of products. If you then add Medicare supplement as being the one represen tative on the table of medical supplemental products, we get up to a total of $11 billion of supplemental premium, which is over 75% of the individual premium in 1992. If we look at this information by renewal provision (Table 5), you find that on the noncancelable side, 99.9% of the business is nonmedical supplementals, which is not surprising. It makes me wonder about the 0.001% that's medical.

On the guaranteed renewable side, 86% of the total line is supplemental products, 33% of that being nonmedical supplementals, and the remaining 53% is medical. On the conditionally renewable and other side, only 45% of it is a supplemental type of product. So in terms of the overall individual health insurance spending in this

country, the vast majority of the premiums, over 75% of them, are in the supple mental market. So we're talking about a very major market for individual insurers.

TABLE 4
ESTIMATED INDIVIDUAL A&H INSURANCE PREMIUM (1992)
(000s OMITTED)[a]

Line of Business	Total	% of Total
Accident Only	$593,620	4.2%
Hospital Expense & Indemnity	1,343,069	9.6
Disability Income	3,772,962	26.9
Dread Disease	759,051	5.4
Total Nonmedical Supplements	$6,468,702	46.1%
Basic Medicare	$2,385,607	17.0%
Medicare Supplement	4,465,095	31.8
Total Health Care Protection	$6,850,702	48.8%
Long-Term Care	$727,256	5.2%
Grand Total	$14,046,660	100.0%

[a]Sources: Data from LIMRA 1992 Surveys, Policy Form Experience Exhibits, and Special M&R Surveys

TABLE 5
PREMIUM IN FORCE 1992 INDIVIDUAL ACCIDENT
AND HEALTH LIMRA SURVEY[a b] (000)

Benefit Category	Noncancelable	Guaranteed Renewable	Optionally [c] Renewable	Total
Accident Only	$168,524	$359,585	$13,674	$541,783
Hospital Indemnity	223,706	488,464	162,044	874,214
Major Medical	—[d]	315,282	440,887	756,345
Disability Income	3,306,889	301,175	20,443	3,628,526
Dread Disease	0	729,188	0	729,188
TOTAL	$3,699,314	$2,193,694	$637,048	$6,530,056

[a]Sources: Data from LIMRA 1992 Individual Health Issues and Inforce Survey and LIMRA 1992 Individual Disability Income Issue and Inforce Survey
[b]Based on a LIMRA survey of 76 insurers, plus additional information received by four other companies
[c]Includes nonrenewable for stated reasons only
[d]Less than 1,500 policies in force

The data in Table 5 is from the LIMRA survey that I referred to earlier. It does have data from 76 different companies, and it represents virtually all of the noncancellable markets, and about 85% of the guaranteed renewal market, but only about 25% of the optionally renewable market. So it's a very good survey if you want to look at noncancelable, but it's not complete at all on the optionally renewable side.

The main reason I want to look at the LIMRA survey is for the purposes of looking at Table 6, which shows the number of policies in force. If you take the total number

of policies here and subtract out the major medical, you can see that we have over 22 million individual supplemental products in force in the country. If you tried to gross this up, so that we included 100% of the products that are in the market, we'd find that supplemental products represent over 90% of the individual number of policies in force.

TABLE 6
POLICIES IN FORCE
1992 INDIVIDUAL ACCIDENT AND HEALTH LIMRA SURVEY [a]

Category	Noncancelable	Guaranteed Renewable	Optionally Renewable	Total
Accident Only	3,250,044	2,257,939	192,015	5,699,998
Hospital Indemnity	4,705,814	2,981,983	581,534	8,269,331
Major Medical	—[b]	196,760	219,562	417,806
Disability Income	3,669,777	981,461	132,686	4,783,924
Dread Disease	0	3,285,166	0	3,285,166
TOTAL	11,627,119	9,703,309	1,125,797	22,456,225

[a]Sources: Data from LIMRA 1992 Individual Health Issues and Inforce Survey, LIMRA 1992 Individual Disability Income Issue and Inforce Survey, and Supplemental M&R Survey of Four Companies
[b]Less than 1,500 policies in force

These policies have very low premiums as Table 7 shows. Major medical has high average annual premiums, and the rest are definitely in a league of their own. They're considerably smaller annual premiums than the major medical market.

TABLE 7
AVERAGE PREMIUM
1992 INDIVIDUAL ACCIDENT AND HEALTH LIMRA SURVEY [a]

Category	Noncancelable	Guaranteed Renewable	Optionally Renewable	Total
Accident Only	$52	$159	$71	$95
Hospital Indemnity	48	164	279	106[c]
Major Medical	—[b]	1,602	2,008	1,810
Disability Income	901	307	154	758
Dread Disease	N/A	222	N/A	222
TOTAL	$318	$226	$566	$291

[a]Sources: Data from LIMRA 1992 Individual Health Issues and Inforce Survey LIMRA 1992 Individual Disability Income Issue and Inforce Survey Supplemental M&R Survey of Four Companies
[b]Less than 1,500 policies in force
[c]A few carriers market hospital indemnity policies like major medical coverages, with high daily indemnities and much higher average premiums than shown here

In summary, we are currently in a situation where supplemental products are a very major part of the market for insurers. They represent over 75% of the premium, and over 90% of the individual policies in force right now. So the next logical question is, will these products still be needed after health care reform, or are they going to

become a moot point? For the medical products, the answer obviously depends upon the type of reform package that is passed. Assuming that Medicare is not touched, which in most of the proposals it is not, Medicare supplements will probably stay around. What happens with CHAMPUS and some of the other ones depends largely on whether those programs are melded into health care reform. But I think on the medical side, the answer is more likely that there may end up being some new types of wraparound products developed. So that line may actually expand.

I think whether nonmedical products are still around after health care reform is going to depend on how the needs that these products are filling is understood, or how that need is perceived. My thesis is that the needs that these products fill are not going to go away after health care reform, and these products are still going to be needed, but we will see whether the regulators will view it that way. I think the need for disability income products is probably well understood, and it is generally agreed upon that need is still going to remain. I think everybody can agree that everyone needs to have the ability to protect oneself from income that is lost while disabled.

Long-term disability products obviously fill the need of income replacement, as does short-term disability by filling in the gap while a person is waiting to become eligible for social security, or for long-term disability benefits. However, long-term disability products are generally only available for upper income markets. Because the benefit is tied directly to income, they are not available to people that are self employed, homemakers, or seasonal employees. Also, because of the risk that's inherent, they are generally not available to blue collar workers, people in certain occupations, or people that have severe medical conditions. However, these people still need protection from the income that they lose as a result of being disabled. (See Table 8.)

TABLE 8
PERCENTAGE OF NONFARM WORKERS[a]

	Without Sick Leave		**Without Disability Insurance**	
Annual Earnings	**Private Employers**	**Public Employers**	**Private Employers**	**Public Employers**
<$10,000	83%	57%	90%	84%
$10,000–20,000	43	11	65	53
$20,000–35,000	27	5	48	38
>$35,000	20	5	35	29
Unknown	70	51	78	75
TOTAL	48%	17%	64%	51%

[a]Source: *EBRI Data Book on Employee Benefits*, Second Edition

This exhibit shows the percentage of workers that currently do not have any type of sick leave or disability insurance. It varies dramatically by income level, and the same employees that are not eligible for long-term disability insurance because they are blue collar, low income, or self-employed, are generally going to be the ones from the lower end of the income scale. They are also going to be the ones that do not have sick leave or disability coverage through their work. These people have traditionally

turned to the nonmedical supplemental products as their source of disability earnings. Many times the people that are in this market will continue working if they are ill, or if they have a minor accident. The only time that they can perceive themselves as needing to be away from work is if something major happens to them, such as a hospitalization, cancer, or a major accident. These people have traditionally bought the nonsupplemental types of products to provide disability income in the event of a major disabling incident.

The American Association of Retired Persons (AARP) commissioned a survey a couple of years ago in which they asked for the reasons hospital indemnity purchasers obtained their policies. A very major reason that was given by all of the purchasers of hospital indemnity was that they bought it to replace lost income while they were in the hospital. I think a common misconception is that the hospital indemnity products or cancer products are bought only to pay for medical expenses that a person incurs during such an event. The AARP survey, as well as some of the data I have presented, changes the perception. They are buying these coverages to replace income rather than to directly pay for medical expenses.

In addition to just replacing income that is lost, someone who is going into the hospital or is having a major disabling event, like an accident or cancer, has many extra nonmedical expenses. They may potentially need to have extra help around the house, or have extra child care expenses. If they are rural, and they need to seek hospital care or doctor care in a nearby urban area, as opposed to close to where they live, they are going to have extra transportation expenses. They may need to pay for living expenses for a family member if that family member wants to come into the city to stay where they are provided their care. The same AARP survey that I referred to earlier also mentioned that paying for these extra incidental expenses was another major reason why a person would purchase a hospital indemnity policy. (See Table 9.)

TABLE 9
MIGRATION OF RURAL MEDICARE POPULATION TO URBAN HOSPITALS[a]

Region	% of Hospital Days Spent by Rural Residents in Urban Hospitals[b]
New England	44%
Middle Atlantic	45
South Atlantic	47
East N. Central	55
East S. Central	43
West N. Central	42
West S. Central	54
Mountain	43
Pacific	65
TOTAL U.S.	48%

[a]Source: 1990 HCFA data, compiled by Milliman & Robertson
[b]Non-HCFA data available from selected state databases indicate that the non-Medicare migration is even larger than the Medicare migration shown above.

Milliman & Robertson did have some data available from the Health Care Finance Administration (HCFA) that shows the proportion of hospital days that a rural resident will spend in an urban hospital. Table 9 shows the average in the United States is about 48% of the hospital days spent by rural residents in an urban hospital. That implies some significant additional expenses for those rural residents. So again, this confirms what AARP has found out.

This leaves us with a bit of a profile of the type of person who will buy a nonmedical supplemental product, such as hospital indemnity, cancer, or accident only products. They generally tend to be self-employed, or low income, blue collar workers, and mostly rural residents. If you ask most insurers who are heavily into the supplemental market, they will agree that is a good profile of the type of person that buys their products. Because these are low-income people, they will fall into the category that they generally don't have their disability needs met through their employer.

They are also predominantly rural, and will need to travel into urban areas to get their care. As a result, they are using these supplemental products to pay for lost income and extra expenses that they incur because of disability.

In conclusion, the point that I would like to leave you with is that this currently is a large market, and it is a very major market for those companies that are in individual accident and health insurance. I think there are many companies that are looking to get into the market as health care reform knocks out a few of the other products that they may be selling.

I don't think the need that these products are meeting is going to go away as a result of health care reform, but it is very possible that the needs that these products are meeting will be misunderstood by regulators. They may feel that hospital indemnity policies are no longer needed if hospital expenses are going to be paid for everyone if we achieve universal coverage. An uphill battle that the industry is going to fight is to make sure that the regulators understand what the real needs are that these products are filling.

So having said that, I will turn it over to Cecil and he will tell us what types of provisions are included in the current legislative packages for allowing these products to continue.

MR. CECIL D. BYKERK: One thing I might comment on with respect to the federal legislative scene is that there are a few very strong opponents to supplemental products in Washington, D.C. There are some members of congress that feel like many of these products are rip offs to the consumer and they want much higher loss ratios and so on. I would say that while they're intense—and from time to time we hear a great deal about them, they are few in number. So that is a concern, because sometimes those individuals can bargain a piece into the legislation, so we have to be alert to that. By and large there aren't that many of them, and I believe they don't understand what's going on and they certainly don't understand the distribution mechanism that takes place.

Let's discuss some of the major features of the health care reform bills. Being with one of the larger individual health and major medical writers in the country, I know

that one of the things that isn't very well understood, just as individual products aren't very well understood in Washington is supplemental products. Again, the distribution approach is not understood well. It is difficult to talk about supplemental products in the bills without talking about some of the features of the bills.

What's a standard benefit package? How is it going to be defined? How often will it be changed? Will the distribution structure be an alliance structure? Will it be voluntary? Mandatory? Again, most of the bills don't get into Medicare. The sponsors originally thought about that, but then they backed off from that. One of the things that is there that might erode Medicare supplement products at some point is that most of the features allow people who are in an alliance product to stay in that product as they get to be 65 and older as an alternative to Medicare. That's a feature that we have to be alert to.

What are the insurance reform elements? Obviously, that is very critical to us. Many in Washington do not understand insurance very well. They think they can reform insurance, and then when the costs are down, they can come back and do many other things. Then how are we going to handle Medicaid? When dealing with legislators and aides in Washington, one of the things that comes up is that the solution has to have a solution for Medicaid and that has some ramifications, because they can design the whole system around fitting how to deal with Medicaid.

A few of the more prominent bills are listed below. I tried to order them from the most severe, from our perspective as an insurance industry, down to the ones that are least impactful. Representative Jim McDermott (D-MI), of course, is a single-payer advocate. He's on the House Ways & Means Committee, and he is the leader of the single-payer advocates and they're not insignificant. There are almost 100 of them in the House. That's almost a quarter of the House. Whatever happens, they have to buy those people into the solution. They have to be comfortable with the solution. That means they will move towards single payer or agree to something so terrible that it will destroy itself and then single payer will come back and hit us more rapidly.

Major Health Care Reform Bills

- McDermott (HR 1200—Single Payer)
- Stark (HR 3600—Mark of Clinton)
- Clinton (HR 3600 & S 1757)
- Cooper-Grandy/Breaux-Durenburger (HR 3222 & S 1579)
- Chafee/Thomas (S 1770 & HR 3704)
- Michel/Lott (HR 3080)
- Rowland-Bilirakis (HR 3955)
- Nickels/Sterns (S 1743 & HR 3698)
- Gramm

Representative Pete Stark's (D-CA) bill is listed as a separate bill. It was actually a mark up of Clinton, but it was so radically different than Clinton, I consider it a separate bill. Many people think Clinton's proposal is dead. I'm here to sadly tell you that it's alive and well in pieces in many of the other bills. One of the parts of it that seems to reappear happens to be supplemental. I am going to spend some time going through Clinton's proposal because of that fact. The other thing that you have to recall is that if Congress does pass something in 1994, the first thing that has to

happen is regulations have to be written, and for the next two years, the people who will be writing those regulations work for President Clinton.

Chafee/Thomas is a very prominent bill because Senator John Chafee (R-RI) is the health care leader on the Senate Finance Committee and is the one that's trying to pull a bipartisan coalition together. I'm not going to spend time on the Michel-Lott, the Rowland-Bilirakis, the Nickles-Sterns, and the Gramm proposals. They're fairly limited in scope. They're not comprehensive reform and many times they don't even mention supplemental products. They talk about medical savings account type approaches.

Let's look at the significant committees and their status. The bills are all out there, but they have to move through the committee structure. So the first and most important committee in my estimation is the House Ways & Means Committee. There are three major committees in the House that deal with health care: Energy & Commerce, Education & Labor, and Ways & Means. The important aspects of Ways & Means is they have the responsibility for taxes and whatever we end up doing; this isn't going to be tax neutral, or at least we're going to have to shift some things around. What happens in the Ways & Means Committee is extremely important. The process is an interesting one in that as a bill moves up in the committee structure each chairman can do whatever he or she wants to and then have their committee look at it.

The Energy & Commerce Committee is headed up by Representative John Dingell (D-MI), one of the strong proponents of insurance. He and his father have introduced health care reform bills in Congress for the last 50 or 60 or 70 years. So he is very concerned about health care reform, but he can't get enough votes to get his bill out of the committee, and so this one is a difficult one to pin down. Even if you get summaries of where the bill is today, it could change radically by the time he tries to get those other two votes that he needs to get it out of committee.

Education & Labor is a very liberally focused committee headed up by Bill Ford from Michigan. The subcommittee is headed up by Pat Williams from Labor Management Relations. The subcommittee has passed a bill out. The full committee is hearing it as we speak. It is clearly a version of Clinton's proposal. The aides that work with this subcommittee were significant players in the Clinton task force. They know what Clinton's all about. They also are going to have hearings on a single-payer bill. They will actually push out two bills. Senate Labor and Human Resources Committee, the Kennedy Committee, was the first to actually get a full bill out of the full committee. It is a version of Clinton's. The Finance Committee now has the Moynihan mark of the Clinton-Chafee-Cooper. That's a conglomeration of the three major bills and it's very difficult at this point to get much pinned down because there are features of all three of those in the Moynihan mark.

I'm going to turn quickly to run through the Clinton proposal and as I said, this is important because Clinton's proposal keeps reappearing in pieces. A good example is transition language, which is important to the topic of supplemental, but it's also important to the topic of insurance in general. No one likes to deal with transition. It's usually done at the last minute. I testified to the Energy & Commerce

Subcommittee on this because nobody else would testify. This will be very critical to all of us, and by the time they get done working through all the details of where they want to go they might say, "Well, we don't have time to work on transition, let's just take Clinton." That's what is happening to supplemental products as well.

Mandatory health alliances and employer and individual mandates. There will be three standard benefit packages that are fairly rich. Medicaid participants receive vouchers plus the other benefits that they're already getting out of Medicaid that's beyond that. Medicare remains. Early retirees are taken on by the government. Employers with over 5,000 employees can opt out of the alliances. Two or three forms are guarantee issue; there are no preexisting condition limitations and there is a pure community rating except by alliance region and family composition.

Supplemental insurance. A supplemental health benefit policy provides coverage for services and items not included in the comprehensive benefit package, or coverage for items and services included in such a package, but not covered because of a limitation on amount or duration. That would be like an internal maximum on mental benefits and that type of thing.

There are two kinds of policies within the Clinton sphere that are supplemental. A supplemental health benefit policy cannot duplicate coverage and generally must be guaranteed issue year around to all individuals. It may not be tied to the sale of a basic plan, and may not compensate agents for sale. I am presuming there is no preexisting condition limitations. It is very difficult to figure that out, but apparently preexisting conditions are not allowed. That is an add-on type medical feature that you would be covering here. Policies must be guarantee issued year around with no preexisting conditions and you can't pay agents to distribute it.

Exceptions to this are long-term care insurance policies, insurance limited to benefits for specific diseases, hospital or nursing home indemnity insurance, Medicare supplemental policies (but insurance reforms apply) and insurance with respect to accident. We're separating Medicare supplement from the supplemental, health benefit policies.

The second type of policy is a cost sharing policy which provides coverage for deductibles, coinsurance and copayments imposed as part of the comprehensive health package, whether imposed under a higher cost-sharing plan, or with respect to out-of-network providers, if you're dealing with a managed care point-of-service kind of thing.

Clinton did not want this policy to exist. The feeling was that people must pay their copayments, they must pay their deductibles, and they must pay the coinsurance amounts. They caught a great deal of heat from various sources about that, so finally at the last minute, actually after the first bill was released and then came out, they said it is OK for it to be sold. It said every regional alliance health plan sponsor is required to offer a cost-sharing policy. A cost-sharing policy may be offered only to individuals enrolled in that regional alliance health plan during an annual open-enrollment period. Of course, the basic plans are going to have an annual open-enrollment period, and this cost-sharing plan would tie in with those annual open-enrollment periods. If you're an insurer selling a product, you have to offer this cost-sharing plan.

You can only offer it to those people who are enrolled in your plan. It's a total linkage. You have to offer it and the people can buy it from you only.

There is the standard coverage and maximum coverage, but there is no coverage for copayments, just the straight copayments in the managed care product. Again, I presume there is no pre-existing condition limitations. It must be community rated. Now it is a voluntary supplemental market community rated. It must cover cost of benefits and increased utilization in the base plan. They're assuming if you sell a supplemental plan, you're going to have an increased utilization in the base plan and again here's this linkage; you can only sell it to people that have your plan and you can sell it to them only if they voluntarily want it. Then the real clincher, you must have a loss ratio of 90% or more.

There are actually some interesting things there. If you're paying through the supplemental benefit premium for the increased utilization of the base plan, your premium will be higher for the supplemental plan to recognize that, but the increased utilization will be in essence charged to your base plan. So getting a 90% loss ratio may not be as easy as it sounds.

Now I'll move on to Stark's plan. Stark has thrown a totally new concept in, and it was done for two reasons. Representative Stark wants Medicare for all and so he has developed a way of approaching that and dealing with the Medicaid population. This is significant because there are five members on the Ways and Means Committee that are very concerned about the Medicaid population and they are not going to vote for anything that doesn't cure or address the Medicaid population.

He came up with a concept called Medicare Part C as an alternative for individuals and employers with fewer than 100 employees. Medicaid participants would be enrolled in Medicare Part C. If you were an individual or you were in the small employer market (less than 100 employees) and you didn't buy coverage from the private market, you would automatically be enrolled in Medicare Part C and then taxed for it in a different way. The national benefit package would be based on a revised Medicare Part A and B. The revisions are stipulated but I won't go into that right now. The states may establish voluntary or mandatory health alliances or may establish a single-payer system, which has sort of become the standard feature as everybody has stripped the mandatory health alliances out of the Clinton package and put in this approach. Employers with 1,000 or fewer employees could not self-insure. So the 5,000 employee cut-off now has dropped down to 1,000.

Supplemental products are treated again quite a bit different than the Clinton approach. I see one type, as opposed to the Clinton approach of having two types. This is all Medicare supplement. There would be ten standard packages that would be defined which is also true of Medicare supplement. They would be different packages, but they would be defined. The Medicare supplement packages would have to be redefined because of the change in Part A and B.

The exception for Clinton's plan, the dread disease, is the same under Pete Stark's plan. Managed care plans could not sell supplemental plans to anyone not enrolled in a managed care plan. Offer of the basic benefit package cannot be contingent on purchasing the supplemental package. Continuous guarantee issue of this coverage

year around is on a voluntary purchase basis. Medicare supplement policies were made guarantee issue and change to reflect the changes in A and B. The change there is the guarantee issue part. Community rating, again just note that it's by geography and family composition and that would apply to supplemental as well.

Rostenkowski's gone for the moment (and he changed things), but Gibbons has changed them again. Gibbons dropped the 1,000 down to 250. Rostenkowski at one point had agreed to go to 100, but Gibbons moved it back up to 250. This tends to be the point below which you can't self-insure and above which you can't get into the alliance-type structure. Medicare Part C is limited to employers with 50 or fewer individuals, and in some cases, the people can opt to buy Medicare Part C in competition with the private industry, except we don't have the benefit of being able to tell the providers what we're going to pay them for the services. Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 is used instead of Medicare Part C for small employers. Stark was using Medicare Part C as a continuation coverage and Gibbons changed that to COBRA being used with small employers instead of switching people into Medicare Part C and then switching them back out again. There was an unlimited out of pocket in Stark's version. Gibbons came in and actually had $1,000 out of pocket and then the next day he changed it to $5,500 out-of-pocket for individuals. Obviously, from a supplemental point of view, there's a spot here to come in with some coverage. Health alliance participation is limited to individuals and employers with fewer than 250 employees.

One of the concerns that I have, from the basic design of all this, is we have one thing that's at 50 and another that's at 250. You can get some strange things going on in those break points. Community rating, Gibbons changed it from four groupings to two—individual and family. I have heard that he has gone back to three, but I haven't seen that written down anywhere. That may yet be happening, but right now, family composition is either single or family. Geography is recognized (this came from the Rostenkowski mark up). Gibbons has five market sectors. In other words, there's individual, employers with 2–250 employees, employers with 250 or more employees, association plans and health alliances. There has to be a relationship of the premiums between the alliances and your individual and small employer marketplace. You can have administrative discounts for alliances. There's no change in Stark's proposal for supplemental except that instead of year-around open enrollment, there is annual open enrollment.

Very recently the President asked the Senate Finance Committee not to take a vote because they didn't have enough votes to keep the mandate in. So it's a little uncertain exactly where Senate Finance is going. Employer size cut off is at 500 for both community rating and self-insurance. Mandatory alliances are not required. Community rating considers family size (and I think they're considering four groupings there) geography and age. The maximum high to low premium is two to one. There's a limitation here on age. Supplemental. At this point, because this is a conglomeration of three bills, it's too high a level at this point to even get a read on what's happening with supplemental.

Senate Labor and Human Resources Committee, has passed the bill in full committee largely along party lines. The major features are: mandatory alliances are not required, but are allowed; employer mandates are included, but not for employers

with fewer than 11 employees. Employers with fewer than 250 employees cannot self-insure. Those are just a few key features. Supplemental products which is what I was talking about before, is identical to Clinton except they took out that Section 1409 that I mentioned about requiring the carriers to sell the cost sharing; otherwise that's the same. The 90% loss ratio is there. This is a bill that now has emerged from committee and will be going to the floor of the Senate. It will be one of the bills most likely that will be used to begin to pull together the final bill.

Education & Labor is in full committee hearings now. Mandatory alliances are not required, but allowed again. They'll have a single-payer version as well. In the other cases, they just said states can do single payer if they want to. They actually will have a single-payer bill as well. Employer mandates are included, but there's much more subsidy for employers with fewer than 75 employees. The employers with 1,000 or fewer employees are community rated, but they can self-insure. They didn't take self-insurance away from those under the cut-off size. The other real significant thing about the Education & Labor bill is that it has a much enhanced benefit package. There's a whole list of things that they added in to the Clinton benefit package. Supplemental coverage provisions is absolutely identical to Clinton's plan. Again, while the bill is in hearings, the full committee will pass it, because they have the votes. So within a few days, Kennedy's bill, and Education & Labor's bill will be there and both of them have supplemental identical to Clinton with that one exception.

The House Energy & Commerce Committee bill. I told you that Dingell can't get it out of committee and at this point there's nothing that I can describe on supplemental.

The last two things I wanted to touch on are what I'll call the pure bill forms, not the committee versions, but the bill forms of Cooper with respect to supplemental. You cannot sell duplicate benefits, you cannot sell policies reducing cost sharing. The cost-sharing approach policy would not be allowed under Cooper the bill; again, Cooper came from the Jackson Hole approach, and beyond that, the bill is silent with respect to supplemental.

The last thing I had was on Chafee's bill. You can sell benefits not covered or the cost sharing reduction if they're offered and priced separately from the standard or catastrophic package. In the Clinton approach, you had to take them into consideration. In Chafee's bill, you have to price them separately from the standard or the catastrophic package or two packages. You can't condition the sale of them and here you can offer the coverage to people in other plans.

MR. MICHAEL S. ABROE: I want to switch gears and talk about another issue that I think is going to affect the nature of supplemental products, and that's the area of solvency requirements. I debated whether or not I should include Table 10 because the numbers that I'm showing here are from a preliminary report and based upon the industry reaction to the surplus criteria that's in there, I'm sure there's going to be much investigation and change in the numbers. The numbers that stick out are the disability income, the accident only, and long-term care numbers. They are significantly in excess of current surplus criteria. The typical comment from leading long-term care writers is this would basically put us out of business. I know that these

numbers are going to be looked at. They will probably be modified and reduced significantly. The reason I'm bringing up this issue is because, from where solvency requirements currently are, it's virtually a guarantee that there will be strengthened solvency requirements. Those solvency requirements are going to be funded by increased margins that will be needed to be built into the supplementary products, to be able to pay for the capital to support the surplus criteria.

TABLE 10
RBC REQUIREMENTS—AAA COMMITTEE

Type of Business	Surplus Criteria (%)
Accident Only	150
Long-Term Care	150
Medicare Supplement	19
DI (2 Years or Less)	16
DI (More than 2 Years)	55
Other Health	16—Inflationary 8—Noninflationary

[a]Applied to Earned Premiums; times 1.5 where rates require approval by regulatory authorities.

If you add on top of this the recent deferred acquisition cost (DAC) tax, and the federal income tax changes, a typical product sold today may need several percentage points more of margins just to retain the same bottom line impact to a company that the company would have had perhaps half a dozen years ago. Certain types of products would have to perhaps add as much as five or more profit margin points to be able to be in the same position. There are typical front-end distribution costs for supplemental type products, so when you combine the additional surplus drain that these requirements basically imply, it has a significant impact on the margins that you need to build in to pay for debt service.

Lets talk about what impact these requirements, as well as the health care reform, have, and I'll do some prognostications about what we think is likely to happen to different types of supplemental products.

If we look at the traditional, nonmedical-type supplemental products that are in the marketplace—the disability-income-type products, accident only, hospital indemnity, accident disability income (DI), sickness DI type policies—we realize the need for those products is still going to be there. That is likely to remain mostly unchanged by health care reform. I say mostly unchanged because there may be some areas where the needs would be somewhat different. Again, are they going to be allowed to be sold? Will they be subject to higher loss-ratio standards?

Are loss/ratio requirements going to be higher than the requirements that are in some of the federal proposals? It is very likely that an insurer is going to have to do one of two things in order for these products to continue to be viable. One is not change benefits, but somehow magically figure out a way of reducing expenses or premiums to be able to meet the higher loss-ratio standards. That's an easy thing to say, but it's an extremely hard thing to do. It is hard to reduce expenses on demand. There are direct response distribution costs for example. If you could become efficient you would have become more efficient already. Under an agency distribution type of

system, it costs money to maintain that agency force. It's very hard to reduce commissions. It's hard to tell somebody well, we're going to pay you 50% less salary. It's easy to say, but it's very hard to do.

What is more likely is to try to package more benefits together as a means of reducing the load that you need to build into policies to pick up fixed expenses. That means perhaps two, three or four times the combination of benefits that are currently available for sale. The problem with this approach is will those combinations of benefits actually meet a need? They may meet some of the needs of some of the people, but will they be too rich? It's going to have to be tried and tested, but it seems that's one of the primary things that the supplemental producer is going to need to do in order to meet the higher loss-ratio standards.

It also seems evident that those companies that are extremely efficient are the companies that are going to have a better chance of succeeding in this market. USAA Life is a company, for example, that's known for quality, efficient, low-cost service with the ability to handle the transactions typical in this type of a market. In this type of a market, again, there's going to have to be some belt tightening. There's going to have to be some very efficient methods of administering the business, otherwise, the margin of premium is not there.

I'd like to turn to another line of business right now—medicare supplement—and talk about some of the characteristics of this particular product line because it gives an indication of what the supplemental product may look like for the gap-filler-type products that may be available under health care reform. We can list some of these. First, there's product standardization. Only specific benefit packages would be allowed like the ten standard packages under Medicare. Under Stark's program, that would continue. Second, there's a 65% minimum loss ratio. Again those loss ratios are on a product, and by-state basis, with premium refund requirements built in if the loss-ratio standards are not met. Third, limited underwriting and guaranteed issue. Fourth, yearly rate changes with state-by-state rate-filing requirements. There are limits on commissions also.

I could go on with the list, but I think you get the point. This was the last major type of model law that the National Association of Insurance Commissioners (NAIC) put together for this type of product, and I think it's very likely that similar types of regulations may be put in place on medigap type products for those under 65. One of the things that has happened is that this market has very quickly become a price-sensitive product line. Standardization results in all the products being the same, so what are the differences in whether one company or another sells the product. There is service, quality, and reputation, but price seems to be the major determinant at this time.

One other issue that is going to have an effect on the Medicare Supplement product line is Medicare select. As I'm sure you're aware, the Omnibus Budget Reconciliation Act (OBRA) 90 legislation had a three-year test period for Medicare-select-type products, and that test period expires at the end of 1994. As of now, it will go out of existence unless there is enabling legislation passed through Congress. By talking to different people, the best I can guess is that there are some insurers and some organizations that are trying to get Medicare-select extended, but it's iffy at best. At

the last NAIC meeting in Baltimore, the Medicare task force started working on putting an industry advisory committee together to handle the issue, assuming Medicare select will not be extended beyond 1994. There's sentiment at the NAIC level, or at least on the working committee, to try to recommend to Congress that Medicare select be extended. There doesn't seem to be a great ground swell of support and effort on that however.

Let's talk about the medical-expense-type supplemental products for a moment, not the medigap products, but the current cancer, stroke, or dread-disease-type policies. Because of the loss-ratio standards, it's likely that these products are going to have to be restructured. If allowed to be sold, they're going to be subject to loss-ratio standards, and the average premium is going to have to be moved to at least the minimal size to be able to absorb the fixed expenses that these types of products will have. One thing going for this, however, is that there seems to be a general consensus among most of the people that I talk to that health care reform is very likely to heighten the awareness of the need for supplemental coverage. This happened in the Medicare supplement market back in the late 1960s I should say. Currently about 80% of eligible Medicare enrollees have some type of a supplemental product. I think the main reason why companies are interested in the medigap market is because it is a large potential market.

Let me end by talking about some of the issues that the medigap type market under-65 risks are likely to have. I mentioned a regulatory environment, the standardized packages, and the 65% loss ratio. They are likely to exist in this type of a market. If in fact, these types of requirements are in place, we are very likely to move immediately to a price-sensitive type of a market, and bypass all of the steps in between that the Medicare supplement market has gone through prior to standardization. If you look at the claims risks, you see the Medicare supplement market claims risk is rather controllable and rather definable. The supplemental carrier is working off of the claims adjudication process of the Medicare intermediary. Because of regulations in place, the inflation risk is minimal and the major risk is a utilization risk, which is controllable through annual rate increases.

When you move to the under-65 supplemental type of a market, you're not necessarily going to have that intermediary on which to base your claims. You will not necessarily have the basic medical information that the base carrier would have to be able to adjudicate the claim. It's going to be based on your own claim processing capabilities in many cases. That's going to imply certain expenses, and that's going to imply certain volatility of results between carriers. The risk itself is going to be subject to inflation if it's not subject to limits or caps, as well as to the utilization risk. It's going to be subject to more volatility as a result of the fact that the risk has a much lower claim frequency risk. If you get good market penetration you can perhaps minimize some of the antiselective risk that may result. If you don't have good market penetration, that antiselective risk is going to be very hard to predict in the earlier years of these types of products.

Expenses are likely to be higher for these types of products than for the Medicare supplemental products. Poorer persistency, for example, means any initial marketing or distribution system costs are going to have to be amortized over a lesser period of time. In terms of where the premiums are likely to lie, I think you're going to see a

premium that is perhaps one-fourth to one-third the size of a typical Medicare supplemental product. Again that will vary depending upon the gaps that are able to be filled by these products. Again, it means that expenses are going to be a very key determinant in the ability of insurers to be able to market and sell these types of products. Meeting a 65% loss ratio on a $300 average premium does not leave a large amount of room for expenses, distribution cost or profit margins. It's going to be extremely difficult for companies to compete in this type of market.

In 1966 when Medicare went in place, and for the first couple of years thereafter, the Medicare supplement market was a virgin market. Companies that entered that market initially were getting tremendous response rates through their solicitation efforts. I can remember a 6–8% response rate to Medicare supplement mailings which is unheard of today. Those companies that got into this market initially would have the ability to identify the needs, the right sales materials, and the right approach for developing those products could easily develop a dominant market share within a year. The question thereafter is how quickly will other companies be able to duplicate the same thing? So I think there is a window of opportunity, but it's a window that is going to take a great deal of hard work, and a great deal of effort. There will have to be identification of exactly what product types to offer, what the needs are, and how to go about developing the materials, the sales approach, and the distribution system that's actually going be able to take advantage of those opportunities.