TITLE: IMPACTS OF STATE REGULATION ON THE MARKETING AND PRICING OF INDIVIDUAL HEALTH INSURANCE

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I. CURRENT REGULATORY ACTIVITY

State regulation of individual health insurance has increased greatly in recent years, both in scope and intensity. The need to comply with regulations has become the dominant objective in benefit design and pricing of individual health contracts. This shift away from the dominance of market forces results from the extension of regulation to almost every aspect of the development and marketing processes.

State regulation has grown so as to influence or mandate these items, among others:

The benefits that may or must be offered

The way that contract terms must be stated

The minimum "return" to policyholders

Permissible risk classes

Sales materials, product names, etc.

Mandated benefits. This facet of regulation is comprised of required, permitted, and prohibited benefits. The stress has been on required coverage of: treatment for alcoholism and drug abuse; expanded outpatient programs; expanded skilled nursing care to cover that care in other facilities; outpatient nervous and mental conditions; home health care visits; kidney dialysis and transplant surgery expenses; certain pregnancy benefits. In addition, there has been a general expansion of the definition of "physician." Now included are chiropracter, podiatrist, chiropodist, dentist, optometrist, ostcopath, and psychologist, besides M.D., in general, any

"licensed practitioner of the healing arts."

Statement of contract terms. This aspect of regulation involves, in addition to the already standardized uniform policy provisions, requirements as to structure, placement, type style, emphasis, and reading ease of the policy contract form. At last count, about two dozen states had enacted readability requirements or had begun to develop them. A model law has been developed, calling for a Flesch readability score of at least 40. Some states have adopted this standard, but at least one requires 50 and another is considering a score of 60 for its test.

Minimum loss ratios. Model rate filing guidelines have been developed, setting up a grid of loss ratio minimums, according to plan type and renewability provision. A number of states have revised their positions on this question within the last five years; prior to that most used a 50% loss ratio test, or had no test at all. The model law represents an effort to achieve greater uniformity among jurisdictions. The popular press has tended to make loss ratio comparisons a test of the suitability of an insurance plan, without regard to individual needs, resources, or method of sale of the product. Among its shortcomings, such an approach tends to ignore the distinction between group (wholesale) and individual (retail) marketing situations.

Classification of risks. Questions have been raised as to whether age, sex, or marital status may continue to be used as the bases for premium differentiation. Also, benefits may not vary for these

classes. For instance, females must be offered the same disability benefits made available to males; pregnancy benefits must be offered to individually insured females, not just where both spouses are covered. Handicapped persons, including those with "stabilized" disabilities, must not be prevented from obtaining coverage at a reasonable cost. Maximum premiums for pooled uninsurable risks may be mandated by regulation.

Sales materials, product names, etc. The strictures applied here are, for the most part, not new. Outlines of coverage are required more often, sometimes with more demanding readability standards than those for the contract itself. Policies may be required to meet certain benefit standards in order to use particular labels. A few states, for instance, have prohibited the use of the product name "Medicare Supplement" unless certain benefit levels are provided, at least the same kinds of benefits covered by Medicare.

Regulation is steadily expanding in scope. Claim settlement practices have been the object of regulatory scrutiny in the past, but now there is increased concern for medical record privacy, at the time of issue also. Disclosure of underwriting procedures involving the Medical Information Bureau must be revealed to the applicant.

The general effects of increased state regulatory activity have been mixed. It is difficult to challenge the goals of this regulation. In practice, however, it produces considerable hardship for most insurers. "Hardship" means increased costs, extended

time frames for product development, slower action on requests for rate increases. Required policy form variations have multiplied; the use of endorsements or amendments to standard forms may be found increasingly unacceptable.

State strategies are being adopted by the companies. For one thing, mandated benefits and minimum loss ratios may differ significantly, so that the differences cannot be absorbed on an equitable basis within a single plan code or rating structure. For another, claims experience may vary substantially by geographical area; use of area rating tends to conceal some of the differences. Some states want loss experience for their residents to be reported separately. This requirement relates to minimum loss ratio tests. Expected loss ratios may be compared with actual results, as a test of the assumptions in the initial rate filing.

Depending on the scope of the company's marketing operations, a point is reached, sooner or later, where compliance activities become as complex as those of a multinational corporation. It is a credit to the commitment of the health insurance industry to its policyholders' needs that so many insurers have chosen to meet the challenge of the evolving regulatory environment and stay in the business. Of course, not all insurers have done this. Some have withdrawn from certain states, while a few have dropped their individual health insurance lines completely.

The effects of regulation on the distribution system deserve more attention. Marketing cutbacks have hurt the agents. First, certain products have been dropped. Or they have been redesigned

with more limited benefits and guarantees, and of course, with lower commissions. Agents specializing in health insurance must now sell higher cost policies with attained age premiums in return for lower compensation. Some of the pressure comes from inflation, some from competition, the rest from minimum loss ratio requirements.

Minimum loss ratio regulations indirectly control the expense factor; they also limit the margin for profit and contingencies. In fact, a product like non-can disability income cannot even be sold in a state with a minimum loss ratio of 65%, without a special dispensation.

Consumers are affected by regulations at least as much as the insurers and their agents: (1) some products will become unavailable due to regulatory strictures; (2) costs of compliance will have to be passed on to the policyholders; (3) agents can be expected to provide less service; (4) longer periods may be needed for claim settlement. The consumer will be paying for the enlarged regulatory staff as well as for the enlarged compliance staffs needed by insurers. But then, this condition pervades our society. What else is new? one well may ask.

II. A CANCER CARE POLICY

Cancer care policies have become very popular among the public. Consider these results for the leading writer of this coverage, the American Family Life Assurance Company of Columbus (Ga.). The

table below shows premiums and claims, as reported in the Argus Chart[1] for health insurance, for the guaranteed renewable category, which is mostly cancer coverage.

American Family Life Assurance Company

Guaranteed Renewable Business
(Amounts in 000's)

Calendar Year	Premiums Earned	Claims Incurred	Loss Ratio
1978	$220,439	$107,487	48.8%
1977	169,816	73,466	43.3
1976	127,550	49,706	39.0
1975	81,092	33,484	41.3
1974	55,261	22,964	41.6
1973	43,107	17,033	39.5
1972	31,874	12,026	37.7
1971	22,915	8,511	37.1
1970	15,139	5,725	37.8
1969	10,530	4,300	40.8

Much commentary has been published on the cancer care policy. Despite the evidence of its popularity, it is difficult to find a kind word about it from insurance regulators, consumer advocates, or the popular press.[2] At least one state prohibits its sale, while others require that it be sold only with a comprehensive basic coverage for all causes.[3]

The thinking which underlies the opposition to cancer-only insurance seems to include the following objections: (1) the method

[1] Argus Chart of Health Insurance, The National Underwriter Company, Cincinnati, Ohio.

[2] See [20]. [3] See [24].

of sale is unacceptable, that is, "scare tactics" are said to be used or benefit levels misrepresented; (2) the return to the policyholder, measured by the loss ratio, appears inadequate; (3) a large profit factor obtains (the success of one company and the salary of its CEO are often cited[4]).

Possible responses to these objections include: (1) all insurance is purchased out of concern for or fear of financial loss; (2) benefits under most cancer plans are designed and advertised to be supplemental coverages; (3) low premium, low frequency risks will result in relatively higher expense components and lower loss ratios; (4) many companies have suffered losses on their cancer plans. For example, in an apparent effort to meet objections like these, at least one company has attached a return of premium rider to its cancer policy, an approach unlikely to result in excessive profits.

More and more companies now offer cancer policies. If your company does not, don't be surprised if your marketing committee brings up the question: Shall we develop and market a cancer plan? If preliminary considerations --company's image, company's distribution system, regulatory impacts-- can be accommodated satisfactorily, work may begin.

The first phase of development is to set the benefit structure. Cancer benefits currently being marketed should be studied. Two main approaches can be identified. Type A is most popular and provides defined or scheduled benefits by service category. Type B

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[4]See [20], page 17.

is less used and pays lump-sum benefits by type of cancer. A sample of Type A benefits usually includes these items:

Hospital daily benefits: $50 per day, first 7 days; $30 a day after that. Includes common ancillary services. New stay begins if patient is out of hospital for at least 30 days.

Drugs and medicines: Often pays actual charges up to 10% of the hospital daily benefit payable.

Special nursing services: Up to $24 daily, $1,000 max.

Blood and blood plasma: Actual charges, $300 lifetime maximum, but no limit for leukemia.

Anesthesia: Up to $70 per operation, but $30 for skin cancers.

Ambulance: Up to $50 per confinement, $500 maximum.

Radioactive therapy: Up to $1,000; some plans pay the same for chemotherapy.

Physicians visits in hospital: Up to $10 per visit (one visit per day) and $600 maximum.

Surgical procedures: By schedule, up to $500 maximum.

Transportation: By air or rail to distant treatment centers, up to $500 maximum.

Other features sometimes found include: "bonus" payment of 10% of claim amount to cover non-medical loss; return of all premiums if death occurs before age 65; shift to 100% basis after 90 days in hospital, with monthly maximum of $5,000. A further option may allow benefits to be paid as if for loss of time, to avoid possible benefit reduction through application of COB provisions in other coverage the insured may have.

The above benefit array has been found acceptable in most states; specified minimum benefits (as in California) may be expec-

ted to increase periodically as inflation boosts costs.[5] Variations of Type A can also be found. One variation provides the same services without the internal limits, only an overall maximum of $10,000 or $20,000. Such a structure may become unworkable; it requires as much re-rating activity as a major medical product, but with a much lower premium base.

Another variation of Type A has benefit levels that vary by age. To insureds under age 45, benefits are paid at 150% of the scheduled amounts. To those age 65 and over, benefits are paid at 75%. In a couple of plans, for attained ages over 65, benefits may reduce to 20% or 25% of regular levels, to recognize the presence of Medicare; there is likely to be a corresponding drop in premiums. Note that the varied benefit attempts to achieve greater equity, since cancer plan premiums typically do not vary by age, while claim costs climb steeply as age increases.

The Type B cancer plan pays lump sum benefits at the time of diagnosis. Four categories are distinguished: (1) leukemia, for which the benefit amount is highest; (2) internal cancer, which is next highest; (3) skin cancers; and (4) lip cancers. Skin cancer benefits may be paid for up to 10 locations, while lip cancer benefits are limited to no more than two sites. The Type B approach typically includes an accident benefit so as to provide more benefits at the younger ages and thereby achieve greater equity by age.

Cancer benefits also may be used in all-cause plans; for instance, the daily hospital benefit may be doubled in a hospital in-

[5] See [23] for details.

demnity contract for confinements due to cancer. A comprehensive major medical policy provides broad coverage, but it still does not cover everything. The catch-all "bonus" payment of 10% could be used to meet some of the expense not covered by major medical.

Most companies have chosen the Type A approach. This means they sell a cancer-only specified package of benefits, with internal limits to minimize the need for rate increases. All sales materials should emphasize the need for other coverage, and, for Type A plans, avoid undue emphasis on the aggregate maximum benefit amount payable. Most companies sell one policy per family, but some allow the purchase of double benefits, or two "units" of coverage. To clarify the extent of coverage, a realistic sample claim should be shown, along with a breakdown on benefits under the plan. If such disclosure were required, it might have more impact on the marketing of cancer plans than loss ratio requirements can, since misunderstanding of the scope of benefits seems to be a major cause for complaints.

Once the benefit structure has been set, trial gross premiums may be calculated. An expected age distribution for new issues is needed because, although claim costs increase steeply by age, most cancer plans use very simple rate structures. There is one premium for individuals, one premium for families. Currently there is a move towards greater rate refinement, with some premiums coming out by sex and individual age at issue. This should help attract more of the younger lives.

The marketing method --group or individual, agent-sold or

direct marketed-- will influence the premium structure. For instance, agent-sold individual policies presumably can make use of a more complex rate classification, since the agent is present to give assistance. Any of the group approaches, or the direct-mail individual method, would probably require easy-to-understand rate structures. Where does state regulation come in?

State regulation will have an impact on premium structure in the form of minimum loss ratio requirements and policy reserve requirements. The renewability provision of the coverage will affect the minimum required loss ratio. The kind of coverage and the average premium size may also control. Since the expense factor is effectively limited by the minimum loss ratio, the marketing method may be restricted in turn. These interrelationships can become quite complex.

Probably the best place to begin is to decide on the renewability provision. Few cancer plans are non-cancellable, most are guaranteed renewable with the right reserved by the insurer to increase premiums. A number of cancer plans use a limited right to non-renew provision. Very few will be strictly optionally renewable, that is, cancellable individually for any reason.

Assuming that the pressure of competition in the cancer insurance market limits the choice here to G.R. or to non-renewable for stated reasons only: the NAIC model guidelines will call for a 55% minimum anticipated loss ratio for either case. Furthermore, the guidelines allow a 5-point reduction for average premiums under $200, and another such reduction for cases where the average pre-

mium is under $100. The basis is the average premium for a given policy form, including any riders or endorsements.

[Note: Not all states will adopt the NAIC model, and many that do will introduce variations. Therefore, each state's rules must be confirmed.]

In addition, certain coverages call for special consideration, according to the model guidelines; cancer is one of these. Combining all these points, it may begin to appear that a target loss ratio of 40% to 45% may be used for a Type A limited package of cancer care benefits. Such a level is "reasonable," but only to someone who is familiar with the nature of the risk and the problems of marketing a relatively low-premium product. A more realistic assumption is that most states will require an expected loss ratio of at least 50%.

If an insurer has opted for a policy that is non-renewable for stated reasons only, he will enjoy these advantages: this provision allows for action on a state by state basis; additional policy reserves are not required in most states. Also, for the policyholder, although the plan is not G.R., no individual cancellation can occur; premiums will be lower than if the plan were G.R.

Exception: Under one state's rules[6] the classification of the policy will change, for reserving purposes, to be equivalent to guaranteed renewable, if premiums are level and a rate increase has been effected. At that time, additional reserves must be set up, to be funded out of future premiums, treating the date of the pre-

[6] Illinois, Rule 20.04.

mium increase as the date of issue and using the attained ages of the insureds at that time as the "issue age." Premiums must be level by issue age otherwise.

With cancer plans that have a single rate base, the question may come down to whether this "structure" represents a "level" premium or an "average" premium. An "average" premium implies a group or quasi-group rating approach. The closest example we encountered of this question involved a cancer plan with two premium classes, under 65, and age 65 and over. Premiums did not change at age 65. Benefits were the same for all ages. Two marketing methods were used: franchise group and individual issues. Premiums and policy forms were virtually identical. The franchise plan required continued membership in the group, but allowed non-renewal of the whole group. The individual plan allowed non-renewal of all policies in one state. After due consideration, an additional reserve was required by the state in question for the individual coverage but not for the franchise plan. This result emphasizes the need to better define the function of additional policy reserves for plans that are not guaranteed renewable.

Underwriting of cancer policies occurs in only three of the five usual ways: in the application, in the contract, and at time of claim. There is no medical examination; there is no APS. A question in the app may ask whether any person for whom coverage is requested has ever been diagnosed to have cancer (as defined). Sometimes, instead of a question, the applicant must acknowledge his understanding of this limitation, that is, that the plan will

pay benefits only for cancer first-diagnosed at least say, 90 days after the effective date of the policy.

The policy repeats the provision on the 90-day wait. Also, the policy design, in the form of a package of benefits, is a method of underwriting, since it limits the risk on any one person. The plan promises to pay benefits without regard to any other coverage, but there may be a limit "in this insurer." In such case, a person with more than one policy in the same insurer will be paid under only one of them; any others will be void, and premiums will be refunded.

The key underwriting task occurs at claim time, since an examination of all applicants cannot be done at time of issue due to the expense. First, the presence of the malignancy must be established by review of a qualified pathologist's diagnosis. The rest is in the timing. Evidence must support the contention that the manifestation of the disease first occurred at least 90 days after the plan's effective date. Any other finding effectively voids coverage for that person; there may be a return of premium.

Regulatory requirements call for prompt and fair action by the insurer in settling claims. Privacy must be guarded. Delays may occur on an initial claim if information is lacking; but there is no defense for actions which may be prejudicial to the insured's rights. On the other hand, although the regulatory and judicial climate may currently favor the insured, there is nothing to prevent an insurer from bringing an action in response to a fraudulent claim, except, of course, the burden of proof.

In summary, the proposal for a cancer plan has resulted in a policy providing a relatively broad package of scheduled benefits, the same for all ages, designed to meet minimum benefit requirements and avoid the need for premium rate increases. Premiums have been set on an average basis to achieve a 50% anticipated loss ratio. Commissions, expense assumptions, and profit and contingency margins have been established to reflect this target loss ratio. The marketing program is expected to be mixed, in order to minimize any need for additional policy reserves. This means that the same package will be sold either individually or on a franchise group basis, as the situation may require. The franchise approach will be emphasized to realize expense savings and obtain a better spread of risks.

III. A MEDICARE SUPPLEMENT POLICY

Much attention has been paid by regulators to marketing practices used in selling health insurance to persons over age 65.[7] This age group is growing steadily, both in size and in political influence --that's part of the reason. Also, it has developed its own organizations and advocates. When the Medicare law in 1965 made basic health protection available to this segment of the population, it became apparent that this would be a good market for health insurance products that were supplemental in scope.

First of all, the Medicare program was not designed to cover

[7] See [25] through [35].

the entire health care needs of those over age 65, as these are broadly defined. Probably less than one-half of such costs were covered initially, and currently, it is estimated that only about 38% of these costs are covered by Medicare. Medicare supplement (M/s) policies are estimated to cover about 5% of costs; 19 million of these policies are now in force with annual premiums of about $4 billion (fall, 1979).[8]

A second general reason for interest in supplementing Medicare lies in the nature of the supplemental benefit package itself. Benefits supplemental to Medicare Part A (HI) will be fairly well insulated from inflation, since they are usually scheduled amounts. Although the amounts change from year to year, gross premiums also are allowed to change automatically in most jurisdictions. As to benefits which supplement Part B (SMI), they are subject to inflation, but in M/s plans their scope is much more limited than that of a typical major medical plan sold under age 65.

A third reason many insurers find this a viable market, although they may not recognize it as a factor, is the presence of utilization controls in the Medicare program itself. This is especially true for medical care benefits, where "allowable" charge levels as defined by Medicare rules are generally lower than "reasonable and customary" charge levels as recognized by most insured plans. Obviously, to take advantage of this control, the M/s medical care benefit level must be stated in terms of "Medicare allowable" charge levels.

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[8] See [27].

There are some other good reasons for entering this market. If the need is there, the sale should not be particularly difficult. The M/s plan is therefore a good source of premium income for the insurer and of commissions for the agent. Another good reason, from the agent's and insurer's viewpoint, is that the contact with persons over age 65 can provide referred leads not only to others in the same age group, but also to children and other relatives with a variety of insurance needs in all lines. The most compelling reason of all, of course, is that A&H insurers may have no choice in that state but to offer an M/s program.[9]

State regulations applicable to this specific health insurance product have grown to staggering proportions in recent years. The statutes and regulations of the following states may serve as a starting point in any attempt to understand what is happening: California, Colorado, Delaware, Florida, Illinois, Iowa, Massachusetts, Michigan, Minnesota, New Jersey, New York, Oregon, South Dakota, Vermont, and Wisconsin. In some of these states, rulemaking may still be in the initial stages.

The NAIC has developed model provisions as part of its Minimum Standards Act. The Health Insurance Association of America has formed a committee on the subject; the United States Congress has its own committees also.[10] The Federal Trade Commission is promoting legislation to require the HEW "Seal of Approval" for M/s plans issued in states which do not have regulations of their own. Additional Federal legislation is being proposed to allow insurance

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[9]Michigan, MCLA §500.2265. [10]See [29].

commissioners to take jurisdiction over direct mail sales in their states, not now regulated by them.[11]

This growth in state regulation and Federal interest can be attributed to the following: (a) unusual marketing abuses, especially in the area of disclosure of benefits; (b) inability of the public to make meaningful comparisons of dissimilar products; (c) general vulnerability of the over age 65 population, combined with lack of information; (d) relatively high sales compensation coupled with a low return to policyholders, when measured by "loss ratio" results.[12]

Because of these conditions, Medicare supplement regulations have emphasized these elements: mandated benefits; minimum loss ratios; adequate disclosure. Buyers' guides are becoming more common,[13] and these must be provided to prospects at or before the time of sale. The "ten day free look" has been enforced and extended to a longer period in some cases. A final regulatory element should be repeated here: mandated availability of M/s coverage. So far, this coercive approach to handling the problem has not become widespread.

Cancer care policies and Medicare supplement plans show many similarities in design and marketing. For instance, high cancer incidence rates make the over 65 age group a prime market for can-

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[11] H.R. 2602; H.R. 4000.

[12] See [26], pages 78-79. Also see [27].

[13] See [31] through [35].

cer coverage; for both plans sales techniques have involved arousing the fears of the prospect; both plan types are designed to provide supplemental benefits; early loss ratios may appear to be low for certain plans of each type (this relates to the scope of benefits, waiting periods, etc.).

There are important differences too: more benefit variations have been used in the design of the M/s plans; more complaints have probably been made about benefits which were thought to be covered under the M/s plans; active promotion of M/s plans by some regulators has occurred, a far different stance from that adopted towards cancer plans.

Perhaps the biggest problem --at least the most dramatic-- that has been found with Medicare supplement plans is that of multiple sales, many policies to the same insured. The solution to this problem should be one of the basic goals of the plan design. Benefit structure should be understandable; the possibility for overlapping coverage should be minimized. Currently-marketed M/s policies are designed in at least three fundamental ways: limited benefit plans, comprehensive plans, and "building block" plans.

Limited benefit plans have scheduled benefits, but usually no out-of-hospital coverage; maximums are low. Comprehensive plans may be scheduled or unscheduled; they cover expenses incurred in or out of the hospital. Plan maximums tend to be high.

"Building block" plans combine certain features of the first two types, using a limited in-hospital benefit as the starting point. Additional benefits are available by rider to complete the program;

this is convenient if at first the full premium for the more comprehensive program is not available. Still, the final package may provide less overall coverage than a comprehensive plan.

As a practical matter, the comprehensive plan approach must be adopted unless the insurer can avoid marketing in certain states; the only alternative is a more complex Medicare supplement series, where several policy forms are developed, geared to groupings of states. In any case, the significant decisions left open narrow down to about half a dozen features of the benefit structure, as follows:

1. The Part A Medicare deductible and copayments are usually covered, through the 60-day lifetime reserve. Some regulations require full coverage after this reserve has been exhausted. An alternative here would be to offer a daily benefit equal to the deductible, or perhaps up to twice the deductible for each day of hospital confinement after the reserve is used. The deductible amount is nominally supposed to represent the cost of one day in the hospital, but it is probably too low. Relating this extended daily benefit maximum to the deductible simplifies pricing and keeps pace with inflation.

2. Extended care in a skilled nursing facility is usually covered in the amount of the copayment for days 21-100. Beyond 100 days Medicare benefits cease, for that spell of illness. Some M/s plans provide benefits for stays longer than 100 days, out to two or three years. Such long stays are rare; the average stay is under 30 days. Long stays tend to involve other types of care, such as

intermediate care or custodial care. State regulation may mandate inclusion of intermediate care facilities as providers of skilled nursing services if that level of care is actually provided.

3. Medicare does not cover the first three pints of blood or blood plasma. This benefit is becoming more common in M/s plans, reversing the assumption that voluntary donors or credits are usually available and preferable.

4. .Provision for reimbursement of the Part B $60 calendar year deductible has had the most variations. First, it may be completely excluded. Second, it may be covered in-hospital only. Third, it may be covered as a disappearing deductible. Fourth, it may be covered 100% if in hospital, and ignored for expenses incurred out of hospital, that is, treated as part of the eligible expenses that are reimbursed at 20% of R&C. Fifth, it may be reimbursed fully.

5. The Part B 20% coinsurance (after the first $60 per year) has several variations, too. The minimum is to pay it only if due to hospital confinement. The maximum, one may surmise, would be to pay the whole 20%, in or out of hospital. This is wrong. The maximum benefit here is to pay the excess of reasonable and customary medical expense charges over 80% of what Medicare allows, since "allowable" charges will be less than R&C. One state may require this maximum.[14]

6. Out-of-hospital prescription drugs and private duty nursing are not covered by Medicare at all. Insurers are often criticized for not providing benefits in these areas. They are also criticized

[14]Massachusetts.

for not covering custodial care, or outpatient psychiatric care beyond what Medicare provides. To what extent can any of these benefits be covered, if at all?

The plan features outlined above are relisted below with suggested coverages to be used in a comprehensive plan. This plan will not be sold where state regulation is "coercive," because there the choices have already been made. Note that certain alternatives fit the concept of catastrophic coverage, if this is the marketing image desired.

(1) Hospital deductible and copayments are always covered. After the 60 days' lifetime reserve has been used, coverage under the M/s plan should take over, running out to a full year of hospitalization, or unlimited if catastrophe needs are stressed. A stated maximum daily benefit should be used, relating to the Part A deductible if possible.

(2) Skilled nursing care can be handled best by paying the copayment for days 21-100 and stopping there. Catastrophe emphasis calls for an extension, consistent with that for hospital.

(3) Coverage of the first 3 pints of blood involves a significant cost. It may become necessary for competitive reasons.

(4) The Part B $60 deductible should be either completely excluded or else completely ignored. If it is covered, there will be many small claims. For many insureds, the annual gross premium for it will exceed $60 (in and out of hospital both).

(5) The 20% coinsurance should be paid on a reasonable and customary basis, after the first $60 per year. If the gap between R&C

and Medicare "allowable" charge levels becomes too great, this percentage can be increased. The fixed percentage approach speeds up claim settlement, since there is no need to hear from Medicare. Also, it leaves a small gap in the charges so that the insured remains interested in expense levels. An out-of-pocket maximum can be used to keep this gap from becoming a hardship.

(6) Medicare did not find it feasible to cover these items; insurers may come to the same conclusion. Prescription drugs are high frequency, low cost items. Special systems are required for management control. Since this item is seldom covered in M/s plans, its inclusion is likely to result in selection against the insurer, at least experience shows this to happen. This is a problem that even relatively high deductibles cannot solve. Leave it out. Private duty nursing is a high cost, low frequency item, just the opposite of drugs. Aged persons who need this level of care are likely to be hospitalized. If they are ambulatory, home health visits are available. The benefit is little used, but may be included if the stress is on catastrophe care. Custodial care is uninsurable. Outpatient psychiatric care can be covered 50%-50% as done by Medicare, out to $1,000 without much problem, if this is desired. Medicare pays half of the first $500 only.

One other benefit may be considered for the over age 65 market: a daily hospital benefit for the first 60 days in a spell of illness. Since Medicare covers this period fully (except for the deductible), this benefit should be sold as an income benefit. It may be offered where the agent find a comprehensive M/s plan al-

ready in place, if the agent's own M/s plan is not superior. The use of this benefit in combination with an M/s plan may be necessary to comply with minimum standards tested by equivalency rules. This happens if the insurer prefers not to cover the Part B $60 deductible. The hospital income benefit for days 1-60 will provide the extra points.[15]

Specific plan design features are detailed in the regulations of Massachusetts, Michigan, Minnesota, and Wisconsin (and others, no doubt). Massachusetts rules mandate very comprehensive minimum benefits, including drugs, although deductibles are allowed. Michigan rules require full coverage of all gaps, no exclusions except those for Medicare, and no limits on pre-existing conditions. Minnesota defines a qualified plan and applies an equivalency test to deviations from it. The Wisconsin rule outlines four plan types; at least one other state may follow this pattern. In other states, the general rule for a plan to be sold as a Medicare supplement is that it must provide the same scope of benefits as Medicare; it need not go beyond this, it may have like exclusions.

Premium structure, renewability, and reserve requirements have not been unusually affected by state regulation. But premium levels have been hit by loss ratio tests. The NAIC filing guidelines call for 60% as the target, as do a number of states. Several states require a 65% loss ratio; Congress talks of a 70% requirement.

Premium structure may be very simple: one premium, unisex basis, same for all ages. Or it may be complex: male and female rates in five-year age groupings. Premiums are almost always level, based

[15] Minnesota test of actuarial equivalence.

on original issue age, but with automatic changes as Medicare provisions change. Policies are usually guaranteed renewable for life (sometimes mandatory). Level-premium, G.R. policies require additional reserves. Statutory minimum standards have not yet been adopted, although the 1974 Medical Expense Tables have been proposed.[16] Unfortunately, these tables do not provide factors for comprehensive Part B benefits, making their applicability limited. Also, they appear not to have been tested against actual Medicare experience. The most practical approach under the circumstances is to base additional reserves on the expected morbidity assumed in the premium calculation (ultimate basis), as would be done for a major medical plan.

But benefits change each year. One way to cope with changing Part A amounts is to adjust reserves annually, using a dual calculation. Those benefits subject to change may be valued per $4 of Part A deductible; all other benefits would be grouped and valued per policy. Both valuations would use original issue ages. This approach is convenient and not overly conservative. At least one state applies its loss ratio test ignoring the increase in additional reserves.[17] No state has yet specified a required method of reserve strengthening, either for M/s plans (subject to benefit changes) or for major medical plans (subject to inflation), beyond

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[16] Anthony J. Houghton and Ronald M. Wolf, "Development of the 1974 Medical Expense Tables." Transactions, Society of Actuaries 30: 9-69; discussion, 71-123.

[17] Colorado; see 10-8-101(1).

the general requirement of adequacy. In this connection, note that although a state may require automatic benefit increases as Medicare changes, the corresponding adjustment to premiums may require a demonstration that target loss ratios are being met. If they are not, the rule may call for a rate reduction.[18]

Loss ratio regulation limits methods of distribution. The master GA arrangement, with gross allowances of 80% first year and 25% in renewals years, may be a thing of the past in most states. To achieve a loss ratio of 65%, agent compensation must be reduced to about 40% first year, 10% thereafter. A direct marketing insurer, paying no commissions, may be able to operate within a 75% expected loss ratio level. However, the product may not be the answer to everyone's needs, or it may not be obtainable.

Initial underwriting of applicants for M/s policies has taken two common forms: (1) accept or reject, simplified app, single rate table; (2) substandard approach, standard app, up to four rating tables. Probably about the same number of rejections occur in both systems. It is likely that agents will not submit apps if they anticipate a rejection; but the general idea is to avoid the "sure claim." State regulations have allowed both approaches. An exception is Michigan which allows no restrictions unless the applicant was without group or individual medical expense insurance (reimbursement type) throughout the five-year period just prior to

[18]Colorado Rule 78-1 requires 60% loss ratio; 10-8-102.5(2) provides for rate reductions if this test is not met. Michigan has required such justifications for a number of years, not just for M/s plans, however.

the date of application. In such case, there may be a 6-month wait on pre-existing conditions.

Most contracts normally include such a waiting period; commonly it is six months. Then pre-existing conditions are defined as those for which treatment has been received in the 6-month period just prior to the policy's effective date. Waits of three, five, and 12 months have been used, with corresponding variations in the definition of pre-existing conditions.

In summary, the likely choice for the Medicare supplement plan will be one which provides relatively comprehensive benefits in a single package. The anticipated loss ratio will be 60% to 65%. Acquisition and maintenance expenses, along with profit and contingency margins will be limited by the required loss ratio. The plan will be guaranteed renewable for life and will require additional reserves. A hospital income policy and/or rider will be available as a companion product for this market. Underwriting will be on an "accept or reject" basis, the goal being to avoid the sure claim situation. A single premium scale (one class) will be used, with unisex rates and five-year age groups. Careful compliance with disclosure rules will be emphasized throughout the marketing program.

IV. THE RANGE OF REGULATORY ATTITUDES FUTURE TRENDS

Most insurers who market individual health insurance coverages are aware of the widely differing regulatory attitudes among the states. In this context "attitude" means something like what "competitive

stance" means for an insurer. It reflects the perceived commitment of the regulatory agency to the carrying out of its mission. This parallels the insurer's commitment to meet the health insurance needs of its market. Just as holds true for the company, the commitment of an insurance department to a regulatory program can be measured by the resources allocated to the job, in terms of money, time, and personnel. A certain priority among regulatory programs can probably also be observed.

One actuary has divided the states into three categories, based on policy filing results for his company (which writes in all states but New Jersey and New York). Some are found to be "reasonable," others tend always to find objections, and the rest lack a uniform response pattern.[19] This response distribution has already been illustrated in the above discussions of two common supplemental health insurance products.

For the cancer care policy: some states prohibit its sale entirely; other states require that it be sold with all-cause basic coverages or not at all; still others control its use through loss ratio requirements and minimum benefit standards. Most states do not prohibit its sale.

For the Medicare supplement policy: one state requires its sale on a guaranteed-issue basis even if the insurer has never had this kind of policy; another state requires that it be available in a "qualified" plan that meets minimum requirements; still other

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[19] See [12], page 736.

states require that any plan labeled "Medicare Supplement Policy" must provide minimum benefits and must be sold following specified procedures, primarily disclosure rules. Most states currently permit the sale of the M/s policy with relatively few restrictions.

Insurance department prohibitions of certain products exemplify the ultimate regulatory solution. For instance, is cancer-only coverage undesirable per se? The need for it continues to grow. If "only" 1 out of 4 persons is afflicted by cancer, does that make the plan a "bad buy"--just because the other three never collect?[20] Improved treatment techniques will undoubtedly lead to more survivals and the need for more hospital and medical care.

The prohibition of premium refund riders involves a similar judgment of undesirability. It has been demonstrated that profits for this benefit flow from withdrawals without value (tontine effect). Why not require a cash value consistent with reserve requirements? The real problem with the ROP rider is that premiums have proven to be inadequate and reserves have been based on favorable expectations that have not materialized, especially as to persistency and claims offsets. The regulatory alternative to prohibition of the ROP rider lies in insistence on its proper pricing and reserving. The market will do the rest.

Other examples may be found of regulations that need a "course correction." The diversity of regulatory response raises a number of questions, whose answers generate still more questions.

1. Is uniformity of state regulation necessary or desirable? If

[20] See [20].

it is, and it cannot be achieved under the status quo, what alternatives are there? Conditions vary from state to state, as do population characteristics. Some consumer groups may want or need greater protection than others. There have always been differences among the states. The same kinds of variations that we see among the states may be found among the countries who are joined in the European Economic Community.[21] Both here and there, it may be noted, some of the matters in contention appear to represent trivial differences in the way of doing things. So far, the alternatives to state regulation have not been considered practicable or desirable.

2. More specifically, shall premium rates vary by state according to differences in loss ratio requirements? Shall commissions vary? If not, such differences may lead to subsidizations that are difficult to rationalize. Many states now require that claim experience for their residents be reported by itself in addition to aggregate data. How may the insurer best cope with rules that lean towards one-way protectionism?

3. If a state fails to create a "proper" regulatory environment -- that is, one deemed sufficiently responsive to consumer interests-- shall its authority be pre-empted by Federal rules? Recent events seem to point towards such a result. However, it should be kept in mind that state regulation involves considerable extra-territoriality. The marketing program of an insurer operating in many states (rather than in just a few) will be influenced by the rules of

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[21] See [7].

those with the greatest reasonable commitment, with a "spillover" effect into the less active states. For instance, competition is now tending to increase target loss ratios above the required minimums in some states, due to this spillover effect. An M/s plan with a 75% loss ratio will appear more attractive than one with a 60% loss ratio, if both are equally accessible and provide comparable benefits. As long as enough of the states are active, Federal intervention in the regulation of insurance will be hard to justify.

4. At what point should insurers challenge state regulations? Do we need a set of guidelines within which the regulators must confine their activities, or is the U. S. Constitution enough? There are signs that regulatory activity is reaching a plateau (see list below). Insurers have been exhorted to "act and not react." Where are they to begin? Insurers and regulators cannot operate at arm's length; both need to appreciate the goals of the other. Regulators must be concerned about insurance company risks and profits; insurers must be concerned about benefit returns and policyholder rights. Beyond the current plateau lies a mutual educational effort.

* * * *

As answers are sought for these questions, the underlying one remains: What has happened to individual health insurance markets as a consequence of regulatory activity? The answer here will provide the basis for insurer planning and activity.

It appears that the market for individual health insurance has eroded over the past decade. There are at least two reasons for

this: (1) expanded government programs of health care and income protection in direct competition to private insurance programs; (2) expanded regulatory activity at both state and Federal levels, touching different aspects of the marketing process. As one Congressman has concluded:

> Our government has closed off opportunity, discouraged entrepreneurs, limited productivity and stifled freedom. Yet the government's moral attitude is that it's doing just the opposite.[22]

The level of regulation and the level of insurer response to it may have reached plateaus. Insurer responses in this recent regulatory growth period have included:

State strategies: This makes the marketing scene something like entering the presidential primaries, win some, lose some, but hope to end up with the nomination; or like playing the new Monopoly game, tailor-made to each metropolitan area.[23]

Avoidance of regulation: A different vehicle, such as a trust or quasi-group arrangement, or self-insurance, removes the product from control of the regulators; re-design of the benefit structures may accomplish the same purpose.

Cessation of marketing: The insurer ceases marketing, at least directly, opting out of the coercive environment, and contracting its premium base rather than ignore insurance principles or endure forced or inflexible marketing constraints.

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[22]Newt Gingrich, letter to Wall Street Journal, December 10, 1979.

[23]"Stock Block," ©1978 John F. Majors (J.F.M. Games Co. Seattle WA)

The tide may be turning. A number of events foreshadow changes in regulatory emphasis. Here is a sample:

--An apparently successful challenge has been made to the Minnesota Comprehensive Health Insurance Act of 1976;

--The New York Department has "exhibited concern that individual accident and health insurance availability is greatly diminished since the enactment of the maternity law" there;

--The Massachusetts Minimum Standards Regulation is to be challenged, especially as to the prohibition of cancer-only coverage; an injunction will be sought to bar enforcement;

--The trend to deregulation has taken hold in Canada[24]; perhaps the fallout will be felt in the United States;

--Mandated health insurance benefits may encounter greater resistance, and require a new rationale for justification[25];

--Congress appears more inclined to take action to reduce FTC rule-making activity.

The trend exemplified in the development of the Wisconsin rule (Ins. 3.39) on Medicare supplement marketing may be expected to influence regulatory activity in the 1980's. Other states are looking at this approach, no doubt because so far it seems to have successfully balanced the interests of the concerned parties.

The essence of this trend is education of the consumer and preservation of the market place.[26]

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[24]See [12], page 739.

[25]See [10].

[26]See [12], page 740.

The vehicle of this educational thrust will be manifold. It will involve the schools and the media. If it succeeds, we may all begin to agree on the following:

1. That the price for a retail product is greater than that for a wholesale product.
2. That the loss ratio test is not a measure of product suitability in given circumstances.
3. That agents deserve adequate and proper compensation for services performed for both the insured and the insurer.
4. That consumers deserve an insurance product that does what they think it will do, while giving them this protection at a fair price.
5. That "insurance" is not defined as protection provided to "those who need it the most."
6. That government-sponsored or self-insured health programs operate under the same basic principles as do private health insurance programs.
7. That the appointment of experienced and knowledgeable insurance persons to state insurance departments will not compromise the regulatory mission.
8. That regulation should foster competition.
9. That product availability is inversely proportional to the coercion index of the regulation that governs it.
10. That insurance companies are private business enterprises serving public needs, but are not public utilities and are not consumer co-ops.

Other learnings may result, but general acceptance of these will serve to better balance the critical interests of all parties. Such acceptance will also allow market forces to resume their proper role in benefit design and pricing of health insurance products.

V. LIST OF READINGS

A. General

[1] Anderson, William R., "Is the Supreme Court Narrowing the Scope of State Regulation?" Life Association News 74 (September, 1979): 151-154.
Discusses case of medical malpractice insurance in Rhode Island; 3 of 4 insurers dropped it, the fourth shifted to claims made basis. Result: complaint of conspiracy, boycott, etc.

[2] Doherty, Neville, and Crakes, Gary, "The Impact of a Change in Regulations on Costs in an Experimental Program." Inquiry 16 (Summer, 1979): 154-157.
Discusses "nominal" and "opportunity" cost aspects of requirement of informed consent, on a program in progress. Interesting study, although limited.

[3] Gold, Melvin, "Improving State Insurance Supervision." Best's Review (L/H) 80 (July, 1979):24-25.
Author appears to support radical changes in procedures.

[4] Habeck, Charles, "Coping with Minimum Loss Ratio Regulation." Best's Review (L/H) 79 (May, 1978): 19+.
Discusses varying state requirements and definitions of "loss ratio," including marketing & actuarial implications.

[5] Kafka, Franz, The Castle. Modern Library, New York, 1969. Also available in Schocken Books series.
Allegorical treatment of problems encountered in dealing with a bureaucracy.

[6] Kristol, Irving, "The 'New Class' Revisited." Wall Street Journal, May 31, 1979 (editorial page).
New Class has "little use for our commercial civilization or its market economy," seeks power through public and non-profit sectors, including media. Creates a convenient stereotype, but more applicable to a few consumer advocates than to most regulators.

[7] Kronholz, June, "Consumerism European-Style." Wall Street Journal, November 20, 1979 (editorial page).
"Competition" in consumer programs results in uneven

effects on members of European Economic Community.

[8] Pharr, Joe B., "The Individual Accident and Health Loss-Ratio Dilemma." Transactions, Society of Actuaries 31 (1979).
Discusses problems related to loss ratios for individual health insurance. Suggests adjustments to allow more meaningful analysis of results.

[9] Warsh, David, "The Great Hamburger Paradox." Forbes 120 (September 15, 1977): 166+.
Investigates cost elements of a finished product, including requirements of public sector and other institutions.

[10] "Mandated Extra Coverage May Violate Constitution." Article in The National Underwriter, December 9, 1978.
Reports on speech of ACLI counsel; Preston says retroactive changes in existing contracts violate 14th Amendment.

[11] "The Evolving Regulatory Environment for Health Care." Record, Society of Actuaries 3 (October, 1977, Boston): 835-854.

[12] "Effects of Consumerism & Regulation on the Health Insurance Industry in Canada and the United States." Record, Society of Actuaries 5 (June, 1979, Banff): 725-747.
Various aspects of regulation, including Federal v. state. Mr. Wood's remarks on deregulation and breadth of responsibility are pertinent.

[13] "The Extent of Federal Insurance Activities." Best's Review (P/C) 80 (August, 1979): 18+.
Some items under FTC duplicate areas of state concern.

[14] "Competition in Health Planning Enacted in Amendments to Law." Health Services Information 6 (October 9, 1979).
Sees health planning amendments as shift to planning through competition, moving away from planning by regulation.

[15] "Michigan Revamping Plans." Health Lawyers News Report 7 (November, 1979): 7+.
To slow costs, legislature will revamp Blues (they cover 58% of people); may limit plans reserves. Goal is to change Blues to consumer organization or co-op.

B. Cancer

[16] Benson, E. F., "Caterpillars," in Great Tales of Terror and the Supernatural, ed. by Herbert A. Wise and Phyllis Fraser. Modern Library, New York, 1972, 760-768.
Illustrates element of fear connected with cancer.

[17] Epstein, Samuel S., The Politics of Cancer. Sierra Club Books, San Francisco, 1978.
Reviews chemical industry resistance to regulation.

[18] McMennamin, Breeze, "A Heck of a Sales Force." Forbes 119 (March 1, 1977): 53+.
Traces progress of American Family Life Assurance under John B. Amos; marketing techniques; foreign markets.

[19] Schwartz, Harry, "A Look at the Cancer Figures." Wall Street Journal, November 15, 1979.
Rational discussion of cancer statistics, with age adjustments. No cause for alarm, unless you smoke. Dr. Epstein responds in letter to WSJ of December 10, 1979, page 23. Says "burgeoning cancer toll" now affects one out of four.

[20] "Why Cancer Insurance Is a Bad Buy." Changing Times 33 (December, 1979): 15-17.
Details good; conclusions doubtful. For instance: since only 1 in 4 Americans gets cancer, other 75% do not and won't get any benefits, making insurance a "bad buy." Compares loss ratios for dissimilar marketing situations.

[21] "NALC Urges Ingram Not to Ban Cancer Insurance." The National Underwriter, June 16, 1979, page 21.
NALC says fear of cancer exists apart from insurer activity.

[22] Three articles from Scientific American:

Old, Lloyd J., "Cancer Immunology." Scientific American 236 (May, 1977): 62-79.
How do cancer cells evade the immune systems of the body?

Croce, Carlo M. and Koprowski, Hilary, "The Genetics of Human Cancer." Scientific American 238 (February, 1978): 117-125.
Shows how to identify chromosome involved in transformation of a normal cell into a tumor cell.

Nicolson, Garth L., "Cancer Metastasis." Scientific American 240 (March, 1979): 66-76.
Investigates types of tumor cells that can travel through the body and what they have in common.

[Cancer research goes on and on and on.]

[23] California regulation: CAC 10 Chapter 5 Subchapter 2 Article 1.5 Section 2220.24.
Outlines minimum benefits of Type A plan.

[24] New York: Regulation 52.16
Bans sale of cancer-only coverage without all-cause basic coverage. Allows 6-month waiting period.

C. Medicare Supplement

[25] Gornick, Marian, "Medicare Patients: Geographic Differences in Hospital Discharge Rates and Multiple Stays." Social Security Bulletin 40 (June, 1977): 22-41.
The data on re-entries are valuable; these, together with results by region, affect cost of Part A deductible.

[26] Hoecker, James J., "Section Ins. 3.39, Wisconsin Administrative Code: The Origins and Development of a Medicare Supplement Insurance Regulation." The Insurance Law Journal 673 (February, 1979): 73-101.
Valuable account of rule-making procedures, including industry participation. Thorough documentation.

[27] Montgomery, Jim, "Predators Find Elderly Are Often Easy Prey for Array of Rip-Offs." Wall Street Journal, November 9, 1979, front page.
Lists scams perpetrated on elderly. Notes that Medicare pays 38% of total health costs, supplementary plans pay 5%. Multiple sales cited.

[28] "What Medicare Will (and Won't) Do For You." Changing Times 33 (January, 1979): 39-42.
Concentrates on explaining how Medicare works, with stress on its complexities and limitations.

[29] "Medicare Supplement Probe Hears Regulators." The National Underwriter, December 9, 1978.
House Select Committee on Aging hears views of commissioners from four states; views differ on need for Federal activity and its degree.

[30] "Pledges Solution to Medigap Abuses." The National Underwriter, March 31, 1979.
HIAA President Robert Froehlke pledges effort at state and company levels to solve problems of abuse. Cites multiple sales, undesirable sales methods, inadequate coverage, and high rates.

The following items are available to the public on request:

[31] "What You Should Know About Health Insurance When You Retire," Health Insurance Institute, 1850 K Street, N.W., Washington, D.C. 20006. 18 pages.
Describes Medicare program, ways of closing "gaps." Suggests health emergency fund for anticipated out of pocket expenses.

[32] "Advice on Health Insurance for Senior Citizens in Illinois." Illinois Department of Insurance, Springfield, Illinois, 62767. Free; send self-addressed mailing label.

[33] "When Medicare Is Not Enough." Albany, New York, 1979. Send 67¢ in stamps to Medigap, New York State Consumer Protection Board, 99 Washington Avenue, Albany, N.Y. 12210.

This source describes Medicare program, ranks supplementary programs. A discussion of this guide, including industry responses, appears in the following article:

Herman, Tom, "More on Medicare Supplementary Insurance." Wall Street Journal, August 20, 1979, page 28.

Four other reports on the subject are listed at the end of this article.

[34] "Health Insurance Advice for Senior Citizens." Prepared by State of Wisconsin, Office of the Commissioner of Insurance, 123 West Washington Avenue, Madison, WI, 53702. Revised each year.

Outlines benefits in Wisconsin-approved plan types. Discusses "limited" policies; warns about nursing home plans.

[35] "Approved Medicare Supplement Policies." Available from same address as for Item [34].

This chart, updated often, shows all approved Medicare Supplement plans in Wisconsin. Company, policy form, plan type, age 65 premium rate, underwriting, pre-existing condition limitations, commission scale, and expected loss ratios are all shown. Available on request.

Two problems: a single plan type can encompass range of benefits; marketing methods are not distinguished.