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

by CHARLES HABECK

reviewed by ROBERT SCHULER

Mr. Habeck's timely article presents a clear view of the impact of regulation on individual health insurance practices and policies which has heightened in recent years as a result of perceived and/or imagined shortcomings in the industry by consumer groups, legislators and regulators. The author's discussion of the instruments -- mandated benefits, minimum loss ratios, policy readability, reserve requirements and risk classification -- used by government regulators provides the reader, if he or she has not already experienced it, a sense of the pervasiveness of government rules and regulations. In fact, in a recent book by Murray L. Weidenbaum, The Future of Business Regulation, Mr. Weidenbaum notes "At times it seems that each and every move that business makes is studied with almost obsessive attention by one or more regulatory agencies, far out of proportion to the inherent need for government attention."[1] Yet, in spite of the regulator's growing omnipresence there is still considerable room for private initiative and action.

(1) Weidenbaum, Murray L. The Future of Business Regulation. Amacom, New York, 1979.

In the opening paragraph of the paper, Mr. Habeck raises the issue of relative effect or importance of "market forces" versus "regulation" in benefit design and pricing of individual health contracts. It is doubtful as contended by the author that regulation has become the "dominant objective" in benefit design and pricing of individual health contracts. Rather, the rules for playing real life monopoly -- old and new -- have become more cumbersome and pervasive thus requiring the players to spend more time studying the rules before playing the game. The "market forces" or the "game" remains -- to provide the challenge of obtaining a fair market share while meeting the company's objective in underwriting results. Certainly, at one time or another, we all have probably agreed with the author on the "regulation dominance." However, in our more rational moments we usually accept some government regulation as necessary and work to limit its scope and influence to only those activities that provide government "oversight" or "review" and restrict or eliminate government design or structure of policy benefits. For example, minimum loss ratio requirements appear to speak to the results of marketing products and hence provide government oversight or review opportunities. In contrast, minimum standard legislation encroaches on an insurer's benefit design practices. In this respect, Timothy B. Clark writing in a recent article in the

National Journal[2], notes that new approaches to regulation are needed. Certainly the insurance industry would welcome some innovation in this area.

Following are some observations on the various causes of the increases in regulations and mechanisms used by regulators.

Mandated Benefits

Much of the mandated benefit pressure comes, indirectly, from special interest groups which in some cases are sponsored by providers of care. EEOC and women's rights groups have also been influential. It seems that the concept of "insurable hazard" is gradually being replaced by "planned, budgetable expense" concept. This phenomena seems to be spreading from the group insurance market to the individual health insurance market.

Statement of Contract Terms

The intent of the regulators on this aspect is laudable. However, the "Flesch Test" criterion used in some states is not the answer. The October, 1979 issue of the Actuary, the monthly newsletter of the Society of Actuaries, gives a superb example which would pass though few readers would understand the mathematical proof, and a rather prurient passage which is readily comprehensive, but

(2) Clark, Timothy B., "New Approaches to Regulatory Reform -- Letting the Market Do The Job". National Journal, August 11, 1979.

would not pass. Expanded use by the Industry of communication and legal experts in the drafting of policies would seem to offer a more desirable route.

Minimum Loss Ratio

While regulators have found these useful comparative tools, the author's point that more thought should go into the drafting of the regulations is well taken, especially in such matters as statutory reserve, agency compensation, and return on stockholder equity.

Classification of Risks

Even though some classifications of risk have been under attack by regulators, insurers have been generally successful in maintaining proper classification systems. A real danger exists that regulatory actions could result in serious antiselection and could result in citizens of some states being denied access to needed insurance protection.

Sales Materials, Product Names, etc.

In many instances, the restrictions here are generally desirable and for the public good. Too often sales material - by the mere policy name - implies broader coverage than the policy actually provides.

In the author's concluding comment on these regulatory forces, he sums up one of the most serious impacts of state regulation when

he notes, "The consumer will be paying for the enlarged regulatory staff as well as for the enlarged compliance staffs needed by insurers." Certainly, with these costs increasing daily, it is in the public interest for regulators to look for "new approaches" and "innovation" in their actions as called for by Timothy B. Clark.

Mr. Habeck's discussion of the market, underwriting, and regulatory considerations needed in designing and underwriting a cancer care policy and a Medicare supplement policy clearly illustrates the importance that regulatory requirements now play in benefit design. However, it should again be pointed out that regulatory requirements remain secondary to the carrier's dual requirements of meeting the market demands of policyholders and its underwriting practices and objectives.

While I have had limited experience in the cancer care policy, I can understand its popularity and equally the controversy about such policies. Cancer spells fear and emotional reaction. Consequently, there is no doubt a certain segment of the industry is using this to their financial benefit. Unfortunately, they have given the more responsible insurers in this market a bad image and hurt the marketing of this useful product. I personally believe that responsibly set minimum loss ratio will bring a respectability to this type coverage and help its future availability.

The author provides a good overview of the Medicare program and the reasons for insurers becoming interested in the Medicare supplement. However, the author seems to imply that rate adjustments

for the supplemental policies are somewhat automatic. It should be noted that several company's success in obtaining necessary rate relief has been relatively poor, even when the Insurance Department actuaries stipulated the actuarial soundness of such requests. While these companies are still in the market, they have chosen to limit efforts for market expansion until a resolution of philosophical and political issues is reached - social goals versus sound underwriting practices.

The author's observation that Medical supplement plans supplementing Part B (SMI) are not impacted by inflation to the extent "of a typical Major Medical plan sold under age 65" does not coincide with this writer's experience. We have found the claim trend factors for Medical supplement plans and the typical Major Medical plans to be comparable.

Despite the difficulties experienced by some insurers in obtaining rate approvals, Medicare supplement is a viable market for an insurer to pursue. Level premiums for either Medicare Part A or Part B supplemental policies have built-in pricing difficulties and marketing advantages of implied - but not guaranteed - future premium outlay. An alternative utilized extensively by A & H insurers, including Blue Cross and Blue Shield Plans and the government for Medicare Part B, is one-year term pricing. This pricing strategy can be coupled with age and/or sex differentials, or a single "average rate" may be employed.

The advantages include not having to establish statutory reserves and the ability to react quickly to changes in the pattern of utilization and to cost trends. The major disadvantage - frequent rate increases - is shared by the so-called level premium plans as they respond to the constantly changing benefits supplementing Medicare.

The author's suggested design of a Medicare supplement benefit package is generally good. One conclusion I do not share, though. With proper administrative controls, prescription drugs can be a worthwhile inclusion in a Medicare supplement policy. My company's most widely held Medicare supplement offering includes a post-discharge drug benefit which pays 80 per cent of a pharmacy's usual charge after the insured has met a $20 deductible. Three factors are at play here to keep the cost of claims and administration reasonable. First, the benefit is available only for six months following a covered inpatient stay. Secondly, the deductible eliminates the "nickel and dime" claims for patients who require short-term medication immediately following discharge. Finally, since record keeping and claim submission is the insured's responsibility, substantial underreporting can be expected. With these three factors in place, prescription drugs account for less than ten per cent of total claims cost for this Medicare supplement policy.

The author concludes the paper with a discussion of the range of regulatory attitudes and future trends which sets forth a perceptive analysis of the various regulatory viewpoints and the crucial interdependency of the insurer and the regulator objectives. He also raises the question of the appropriate amount of government regulation.

It is doubtful that very few individual health insurance practitioners would quarrel with the author's observation that the individual health insurance market has eroded over the past decade due to expansion of government health care and income protection programs and expanded regulatory activity. Perhaps of equal importance if not more significant is the ever expanding role of group health insurance. In addition to increase in the number of people covered by group policies, the scope and level of benefits have exploded over the past decade. The following table summarizes recent experience for insurance companies.

Insurance Company Statistics
Group and Individual Health Insurance
Number of Persons Covered (000)

| Type of Coverage | Group | | | Individual and Family Policies | | |
|---|---|---|---|---|---|---|
| | 1977 | 1967 | % Inc. | 1977 | 1967 | % Inc. |
| Hospital | 89,219 | 71,454 | 25 | 28,687 | 24,619 | 17 |
| Surgical | 91,904 | 72,038 | 28 | 14,409 | 17,603 | (18) |
| Physician | 88,818 | 61,028 | 46 | 10,964 | 8,541 | 28 |
| Major Medical | 101,925 | 67,394 | 51 | 6,101 | 4,552 | 34 |
| Disability | | | | | | |
| Short Term | 28,176 | 24,805 | 14 | 14,302 | 13,188 | 8 |
| Long Term | 12,481 | 3,722 | 235 | 6,883 | 3,056 | 125 |
| Dental | 32,216 | 2,330 | 1383 | ---- | ---- | --- |

Source: Source Book of Health Insurance Data 1978-79
Health Insurance Institute

In conclusion, Mr. Habeck's excellent paper with a well documented List of Readings brings in focus the expanding influence of governmental regulation on designing, underwriting, and marketing individual health insurance. His concluding observation of the importance of greater policyholder awareness and education is perhaps one of the best weapons against further government encroachment into the individual health insurance market.