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MEDICAL CARE FOR THE AGED

What effect can be expected from legislation in the United States to finance the cost of medical care of the aged upon:

A. Individual health insurance policies?
B. Group health insurance policies?
C. Special health insurance plans offered by insurance companies for sale to the aged?

Toronto Regional Meeting

MR. WALTER M. FOODY:* The Kerr-Mills Bill, providing for federal participation in state-sponsored programs for medically indigent aged, is the only legislation thus far passed by Congress. If the spirit of the federal legislation is maintained in the operation of the state plans, there should be little or no effect on any health insurance program.

There are many different bills currently being considered by Congress. A number of bills use the Social Security mechanism as a tax-gathering device, and as a minimum cover all retired OASDI eligible persons over 65; most go beyond this limit. Although the benefits provided are far from uniform, all of the bills offer in-hospital care on a service type basis for 60 or 90 days. In addition some of the bills cover surgeon and physician fees.

If large numbers of retirees are covered by a federal program, over-insurance may arise on policies issued on the guaranteed-renewable-for-life basis without any qualification. As group contracts are more flexible, it might be possible to consider the over 65 employee's group benefits as excess insurance should nonretired OASDI eligibles be covered. The same approach might be considered with retiree's benefits.

If the government schedule of reimbursement does not include depreciation, research, medical training, etc., the cost of these items must be picked up in charges to other patients. Thus an additional burden will fall upon the self-insured and the commercial insurance carriers.

As all of the bills provide in-hospital coverage, the need for the private programs in providing in-hospital care is reduced to affording protection beyond the number of days covered by the government. Depending on which bill is passed, the possibility of supplementing other provisions or

* This discussion by Mr. Foody, Vice-President of the Continental Casualty Company and a member of the National Advisory Committee for the White House Conference on Aging, was presented by MR. LEROY V. BOTKIN.

providing benefits not included certainly exists. The major problems are twofold. The fewer the benefits the higher the portion of the premium dollar which must be allocated to expenses. This is true of both initial acquisition and general administration. The second problem concerns likely extensions of a federal program through subsequent legislation. Some companies might be reluctant to establish a special program for handling old age benefits if it was felt that these programs would have to be redesigned frequently. It would appear that, if such legislation is passed, the insurance companies would in the future, if not immediately, be forced out of the over-age hospital-medical field.

Other bills have been submitted which would permit insurance companies to continue to offer insurance. Senator Javits has suggested a program which would allow individuals with incomes below a stipulated amount to select between private insurance and plans offered by the state, with the state paying one-half of the private insurance program costs up to a maximum of $60.00 per year. Another bill follows very closely the theory of the legislation enacted to provide federal participation in financing coverage for federal employees. The federal government would subsidize programs contracted by the state by making a per capita payment for each person over 65 in the state with income of less than $4,000 per annum. The state would then make up the difference. Enrollment in the program by an individual would be optional. The insurers who underwrite the programs must be licensed in all states and the District of Columbia. Such programs attempt to develop competition between major types of carrier—commercial, the "Blues," group practice, etc.—but tend to rule out competition within the major types. The administrative problems reach proportions which only the very large companies can handle.

To forecast the effect on the insurance industry as a result of federal legislation for financing the cost of medical care for the aged is quite speculative because no one is sure what legislation, if any, will be enacted.

MR. CHARLES N. WALKER: The Kerr-Mills Bill, providing medical care benefits only for those unable to provide it for themselves, is in its basic concept complementary to our efforts in the insurance industry. We will undoubtedly lose some business among a borderline group, although this will be a small enough price to pay if the program successfully finances care for those who need it.

However, the broader schemes for forcing governmentally financed benefits through the Social Security system on those who neither need

nor want it appears to provide appalling consequences. The progress that the insurance industry has made in providing more and better benefit provisions to the aged through individual and group contracts will be set back in the face of Federal intervention. To continue to sell present benefits to the federally covered over age 65 group would result in overinsurance. Furthermore, our under 65 business would have to be revised to avoid duplication as existing policyholders became eligible for governmentally financed benefits.

None of the schemes under consideration offer comprehensive medical care benefits, so there would, as in Canada, be opportunity for development of new coverages to supplement, rather than duplicate, those of a Social Security scheme. Any such attempts, however, would be necessarily inhibited by the constant fear of expansion of the governmental benefit structure. This would inevitably corrode any attempts to improve our products.

The Kerr-Mills approach is, in effect, a complementary partnership of private industry and government, each covering, in essence, mutually exclusive portions of the aged population. On the other hand, Social Security financing "providing benefits as a matter of right" encroaches into areas where its assistance is neither needed nor desirable, and stifles progress through private enterprise.

MR. RALPH H. MAGLATHLIN: Under the sponsorship of various Connecticut insurance companies, Connecticut has passed a bill allowing insurance companies to join together to offer accident and sickness insurance to Connecticut residents 65 years of age or older. The principal emphasis lies in the area of major medical insurance although basic coverage is also available.

A voluntary unincorporated association is being set up to be known as "The Associated Connecticut Health Insurance Companies." The purposes of this proposed association are:

a) to provide economically-feasible health insurance coverage to Connecticut residents over age 65,
b) to conduct research, statistical studies and cost estimates,
c) to market such health coverage through member companies or other agencies,
d) to administer the coverage in such a manner that any profit will be used for the benefit of the people insured.

At the present time we plan to offer four different levels of benefits: a high and a low level major medical plan alone, or combined with basic Hospital-Surgical coverage.

Los Angeles Regional Meeting

MR. EUGENE H. NEUSCHWANDER: Fireman's Fund Insurance Company has a definite interest in future developments since we have 34,000 policies in force of the "C" type and a modest volume of types "A" and "B" business.

Federal and state legislation will end only when all aged individuals have been provided all possible benefits. Legislative expansion will follow different patterns in different geographical locations as we rush down the path to socialism.

Each of the three types of coverage presents its own problems:

A. *Individual policies.* Individuals over age 65 have never been an important market for this type of coverage. Overinsurance should be kept in mind when issuing or renewing this type of policy. A practical safeguard is to have benefits geared to the out-of-pocket expense actually incurred over and above benefits provided by any legislation.

B. *Group insurance policies.* Overinsurance may similarly be a problem for those retirees whose employers provide coverage. The solution also is to gear benefits to out-of-pocket expenses, but under a group arrangement it should be highly practical to periodically expand the scope of group coverage as legislative benefits expand. This approach could result in disparity of benefits for employees in different states working for the same employer. Of course, if the plan is contributory, the employee contributions should be appropriately adjusted.

C. *Special plans.* These plans can be classified as "Basic" and "Major" plans.

"Basic" plan benefits usually pay only a fraction of incurred expense. Because of this, many individuals purchase several policies, each in a different company. As legislative benefits expand, overinsurance will become a progressively greater problem. These individual policies should then be terminated, since it would be impractical to rewrite coverage to limit benefits to out-of-pocket expense.

"Major" plan benefits are of wider scope and are payable only after a stated deductible. The solution of possible overinsurance here would be to issue or renew only on a basis where benefits are geared to actual incurred out-of-pocket expense in excess of the larger of the deductible or the legislative benefits. As with group insurance, the scope of coverage could be increased concomitant with legislative benefit increases.

MR. RALPH J. WALKER: There are currently three types of proposals to provide federal medical care for the aged, the Forand type bill, the Javits type bill, and the Administration Bill. The Forand type bill and the

Administration Bill would provide benefits through the Social Security mechanism, while the Javits type bill would provide federal-state aid to help individuals over sixty-five in lower income brackets to pay the cost of voluntary private insurance.

Since any Javits type bill has virtually no chance of passing, I will consider first the effects of passage of a Forand type bill. This type bill leaves little to be covered under group health policies other than those groups not under the Social Security Act or the Railroad Retirement Act.

Most supplementary major medical and comprehensive medical group policies exclude benefits for services under a federal plan. Companies could either rely on this antiduplication clause or amend the policies to terminate all coverages at age sixty-five. I believe the latter alternative will be the most likely effect of the Forand type bill. If your major medical and comprehensive medical policies do not contain an antiduplication clause, you should get one very soon. Since most basic group health plans do not contain an antiduplication provision, either the latter should be added immediately or coverage should be terminated at age sixty-five.

If the Administration Bill were passed, we would have another alternative in addition to those just outlined. That is, we could supplement the Administration Bill, using the latter benefits as a deductible. Supplementing will not have much effect because the deductible is too small.

Surprisingly, if either a Forand type bill or the Administration Bill becomes law, I believe it would have only a minor effect upon premium income, because I have great faith in the ingenuity of group men to replace one coverage with another and to add on here and there so that the premium income effect would be substantially nothing.

MR. ALDEN W. BROSSEAU: The proposed legislation to finance the cost of medical care for the aged under Social Security would, according to the Administration, cost on a level premium basis about .6% of covered payroll.

Perhaps it would be useful to compare this cost to the cost of continuing a group insurance plan of modest proportions for employees after they retire.

For this purpose, let us look at a typical group of 500 employees actively at work at a nonrated industry. In Table 1 are shown the assumed characteristics of this group, as well as the assumptions used in developing the distribution of employees retired from the group. Although the group is assumed to be in a relatively stable condition, the retired population after 20 years comprises only 64 people, or 13% of the active population.

Then, let us assume a plan of basic medical care insurance, providing

for both actives and retireds hospital expense benefits of $15 a day for 70 days for room and board, $300 for hospital extra charges, and $150 for maternity; surgical expense benefits according to a $300 maximum schedule, including obstetrical procedures; and an in-hospital medical expense benefit of $5 a day, up to a maximum of $350.

The monthly premium cost for actives (using premiums that are expected to be adequate for the year beginning July 1, 1961) would be $4.27 for an employee, $11.47 for a dependent unit and $12.87 for a composite family. For retireds the corresponding costs (obtained by multiplying the male active employee costs by 325% for hospital expense, 150% for surgical expense, and 250% for in-hospital medical expense) would be $12.09 for an employee, $12.09 for his spouse and $21.16 for a composite retired family. These premiums ignore possible secular trends in medical care costs that would require premium adjustments in future years. However, it is not unreasonable to assume that such trends would also affect the group's active payroll, as well as the cost of any benefits that might be provided under Social Security.

Finally, assuming a payroll of $5,000 annually per active employee, we find that the cost of providing this modest level of base plan benefits comes to .65% of payroll, compared to the .6% of covered payroll for the benefits proposed under Social Security.

But the Health Insurance Association of America estimates the *true* level premium costs for these benefits not at .6% of covered payroll, as claimed by the Administration, but at 1.96%! Don't these figures suggest that our job of selling employers, large and small, on the wisdom of continuing group medical care benefits after retirement should not be so difficult after all?

TABLE 1

HYPOTHETICAL GROUP

(1) Less than 11% females.

(2) 375 dependent units (75% dependency ratio).

(3) *Active age distribution:*

Age	Number of Employees
0–39	267
40–49	123
50–59	83
60–64	27
	500

(4) *Assumptions:*

a) All employees retire as soon as they attain age 65.

b) The age composition of the active employee group (those less than age

65) remains relatively stable. That is, for any 5-year period the number leaving each age group by death, disability, resignation, firing, and entry into the next older age group is approximately offset by the number entering that age group by hiring and entry from the next younger age group.

c) The number of employees attaining age 65—and thus retiring—each year remains fixed at approximately the same rate so that about 22 employees (4.4% of the active group) retire in any 5-year period.

d) The population of retired employees is always composed of the survivors of those 22 employees in each 5-year period who attain age 65 and thus retire.

(5) *Retired age distribution after 20 years:*

Age	Number of Employees
65–69	22
70–74	18
75–79	14
80+	10
Total	64
Retireds as Percentage of Actives	13%

MR. NORTON W. CHELLGREN: I should like to discuss an association called "Associated Connecticut Health Insurance Companies." This organization was founded for the following purposes:

(1) To serve eligible residents of the State of Connecticut who are age 65 and over, and their spouses, by developing through the combined resources and experience of insurers economically feasible health insurance coverage of the major medical type, including any coverages of the basic type made available as a convenience to those who cannot readily obtain them.

(2) To conduct research, experimentation and statistical studies and to project cost estimates.

(3) To market such health insurance coverage in the State of Connecticut through the existing facilities of the members or through other agencies of distribution.

(4) To administer such health insurance coverage so that any excess of premiums over losses, expenses and a risk charge will be used for the benefit of the people insured.

The Association will offer major medical coverage on the basis of a high and a low option. The maximums are $5,000 for the low option and $10,000 for the high option. The deductible in both cases will be $100 plus basic benefits (based on an assumed set of hospital-surgical basic benefits).

Newspaper advertisements, including an application form, will be used. Modest commissions will be payable and any excess of commissions

saved over advertising costs because of newspaper subscribers will be paid to agents in proportion to the number of cases each has sold.

As soon as the major problems have been worked out, companies not domiciled in Connecticut (with at least $100,000 health insurance premium volume in the state) will be invited to participate.

This program is experimental and the experience derived will be available to all interested companies. Insurance companies in other states are urged to give serious consideration to similar experiments.

MR. WALTER FOODY repeated his discussion presented at the Toronto regional meeting (pp. D197–D198).

MR. ALFRED L. BUCKMAN: Our company has been writing medical, surgical and hospitalization insurance to over-age people for over a dozen years. We now have about a million and a half of premium income under type "A" policies.

Because of our concern about the effect that some type of legislation would have on this business, we have filed a rider with each of the insurance departments in states where we operate. This rider states that if any substituted policy were issued, it would be treated as though its date of issue were the same as that of the original policy. We won't know what kind of substituted policy we will issue until legislation is enacted, but we're ready to act to keep many thousands of elderly people satisfied and insured with our company.

DR. ALAN A. GROTH: As a consulting actuary, I will not be directly affected at all by the legislation. My premium income will not go down. I am not going to lose business. As a member of the public who wants to be insured, I have a few comments.

I would like to know what company would provide medical and hospital insurance coverage for me after my retirement for age (and possibly disability), the premium for which would be payable now. I am not interested in whether or not the policy would be participating or nonparticipating or whether or not a refund would apply if I die before retirement. If any dividends accrue, use the accumulated dividends to increase the daily benefit that you would pay me after retirement.

In addition, my company would be willing to apply for group insurance on a similar basis. We are not going to continue our group insurance for retired employees because we believe that the group insurance cost is part of the wage cost; thus, it should be made part of the operating expenses while the employee is performing services for the company. Any deferment of these costs is undesirable from the company's point of view since it

may result in expenses which at that time are out of line with the wage expenses for active employees. After all, we cannot guarantee that the number of employees will increase or even will remain stable. We believe it would be improper cost accounting to defer these expenses.

On the other hand, continued group insurance is undesirable from the employee's viewpoint because an employee would not be assured that in the future an unsympathetic management would not reduce or eliminate coverage because the costs were too high. I submit these requests because I believe that we actuaries have a responsibility to the public. I remember twenty-five years ago the Metropolitan was running a series of advertisements in the papers, and one advertisement was a cartoon picturing two people walking down the corridor of an insurance company. A glass door had a sign "John Smith, Actuary" and the advertisement was entitled "What is an Actuary?" This advertisement likened an actuary to the chief engineer of an industrial enterprise who is responsible for the product design, production and cost of the product.

Should not our primary concern be with what actuaries in private industry do to fill the need which is there rather than with what effect legislation may have on premium income? If the need is filled, there is no need for legislation.

MR. CLARENCE H. TOOKEY: When I was working for my previous employer, there were several companies for whom I acted as a part-time consultant. We decided to grant hospital coverage to our retired employees, and this is the approach we used. When an employee reached age fifty, we assumed he would retire in the service of the company, and over a fifteen year period we created reserves which would be sufficient, provided the employee continued his own contribution after sixty-five, to pay the benefits. This was a type of paid-up approach, and I think it is what Dr. Groth had in mind.

There is an old saying, "You can take a horse to water, but you can't make him drink." Unless you are very close to your prospect this approach has to be sold because it means higher premiums now and higher reserves. It is not an easy one to sell, particularly in these days when some rather prominent members of our profession say there shouldn't even be claim reserves on hospital and surgical insurance. I don't think actuaries necessarily lack ingenuity, but remember, the actuary can design a plan but he cannot place it. I think the consultants who have the confidence of their clients should take this matter under advisement. Possibly we are closing the stable door after the horse is gone.

Actually, there has been a great deal of progress made in extending hospital and surgical coverage to retired people. In the last five years most of the large employers have more or less accepted the idea. Even the unions are becoming interested. Unfortunately, we as actuaries were not given the time to work out the problems, and certain people have found it desirable to get the government into the business.

I agree with Mr. Neuschwander. We are running down the road to socialism now, not walking.