MEDICAL CARE BENEFITS FOR THE AGED

What are the appropriate roles, respectively, of
(i) Group insurance,
(ii) Individual insurance,
(iii) Governmental programs

in providing protection against the cost of medical care for retired persons and other aged citizens? In each case is it desirable for the higher cost of insurance encountered at older ages to be prefunded and, if so, by what means?

New York Regional Meeting

MR. RICHARD H. HOFFMAN: I believe that a discussion as to the roles of group and individual insurance and government programs in providing medical care insurance for senior citizens should begin with two fundamental principles:

(1) Health insurance protection for our senior citizens should be entrusted to the agencies which can provide the best protection at the lowest cost.
(2) Protection should be made available to all senior citizens at reasonable cost.

We in the industry are concerned about the high cost of the many programs that have been proposed recently and the dangers of improper administration. Estimates of the King Bill, H.R. 4222, have varied from an additional cost of ½% of Social Security payroll after raising the earnings base from $4,800 a year to $5,000 to a level cost of 2% of this same Social Security payroll. This variation is a dangerous difference of opinion. The public is unaware of the pitfalls of such a program being administered by the Social Security system. Many do not appreciate the difference between administering a pension or survivors' benefits program and a health insurance program.

Although our industry has the facilities, we have not insured as many of our senior citizens as is desirable. Only lately do we have experience in covering older persons. In spite of this, some companies, including the Equitable Society, have made an attempt to promote the sale of postretirement group insurance coverage. Other companies have used mass underwriting techniques under individual policies for extending coverage to large numbers of senior citizens. Nevertheless, although rapid progress is being made, there is substantial room for improvement in the case of many companies.

Conversions from group insurance at retirement are also used to provide coverage. However, most of these policies provide minimum benefits paid for entirely by the individual at a cost much higher than group

insurance. Also the latter is more flexible in fitting the needs of retiring employees to local conditions, in permitting modifications in the plans with changed medical practice, and in allowing the employer to participate in the cost.

Many employers feel they will be relieved of a heavy financial burden if the federal government provides health insurance for retirees, but a typical basic hospital and surgical expense plan which we recommend to employers will cost an estimated 20% less per covered individual over the years than the H.R. 4222 plan. To the extent that the employer has a smaller proportion of retired employees than the national average, his cost will be lower, and he will certainly have a lower proportion for many years if future retirees only are covered.

There are media in existence for financing postretirement coverage, among which are advance funding methods similar to those developed for pensions which permit the monetary outlay to be substantially reduced through interest earnings and the cost to be allocated to the working years. The absence of a ruling as to the tax status of the funds has contributed to the slow development of these prefunding methods.

The insurance industry possesses the means to provide the necessary coverage, has the administrative experience to avoid many of the hazards, and has the background to evaluate the cost of benefits. With the huge sums involved, any waste from improper management can be quite expensive.

Further progress must be made in our industry in enlarging the number of senior citizens covered, for only a sincere effort to improve our position, in my opinion, will avert the passage of more general federal legislation.

MR. MILTON A. ELLIS: In connection with this topic, I recommend for reading an article on "Medical Care for Retired Employees" by Morton D. Miller in No. 8 of the A.M.A. *Management Bulletin*, November 1960.

I believe that governmental programs have an appropriate role to play for those of our older population who are unable to finance the cost of health care because of their limited means. Last year as a part of the Social Security amendments of 1960, known as the Kerr-Mills bill (P.L. 86-778), Congress provided additional matching funds to the states in two areas:

(1) to establish or improve medical care programs for those on the old-age assistance rolls.

(2) to add a new program designed to furnish medical assistance to those elderly citizens who are not recipients of old-age assistance but whose income

and resources are insufficient to meet the expenses of hospital, nursing, physician, outpatient, dental, X-ray and other appropriate services.

It has been claimed that the states would refuse to act. However, increased federal funds under the first part of the program began to flow immediately, generally without need for new legislation. Under the second part of the program, coordinated efforts by medical associations, welfare agencies, governmental units, insurance companies, and employer and employee groups have been prompt and effective. A separate H.I.A.A. committee was established to coordinate studies being made in several states and to render assistance in adoption of the second part of the program. The following results to date are truly outstanding:

In 8 states no legislation has been deemed necessary; legislation has already been enacted in 9 states; legislation is pending in 15 states; legislation is being prepared in 6 states as well as the District of Columbia; an appropriate resolution for a constitutional amendment is pending in Texas; legislation to study the problem is pending in 3 states; no action is reported in 6 states; in 2 states, bills died with the adjourning of their legislatures.

This is a far cry from the articles indicating that the states are not interested in the Kerr-Mills bill. It is hoped that Society members will lend assistance in those states where action is required and use the H.I.A.A. Committee to help in any possible way.

MR. GEORGE E. IMMERWAHR: I don't feel optimistic that we can hold off Social Security inclusion of medical aid to the aged indefinitely. The big issue that confronts us is whether we can hold off comprehensive compulsory health insurance. The whole idea of medical aid to the aged was conceived by the health insurance proponents at Social Security only after there were too many obstacles to introduction of health insurance for all ages. They foresaw that if they were to advocate a comprehensive compulsory system immediately they would have all sorts of groups trying to elect out, which would weaken the system and probably defeat it. If they could say that the contributions were not for the contributors themselves but for those who were past the age where they could contribute, there was a better chance of establishing the program and later extending it to all ages.

While I agree with Mr. Ellis that actuaries should oppose the introduction of medical aid to the aged as part of our contributory Social Security plan, I feel real skill is needed in doing this. In a recent televised debate the opponent of aid to the aged tried to build a case on the incorrect comparison that in compulsory insurance you have a service benefit

and in voluntary insurance a cash benefit, whereas he should have stressed how compulsory insurance is bad because it is compulsory.

MR. GILBERT W. FITZHUGH: North of the border the discussion is more on the subject of a comprehensive medical care plan for the entire population with little talk of the particular portion of the aged as such. The Government has appointed a Royal Commission to find the best plan, not necessarily a compulsory one. Every province in Canada has a provincial hospital plan substantially requiring every citizen to have hospital insurance at the ward level. The Liberal Party recently came up with an idea which is the reverse of the system you have here; that is the higher the income tax, the more the individual pays for his medical care insurance.

The Canadian Health Insurance Association is greatly interested in this development and what the Royal Commission might recommend, as are various medical associations in Canada. I am the chairman of a committee of the Canadian Health Insurance Association which is studying this subject. We are in the middle of our study and haven't anything definite to report, but I thought you might at least be interested in how some of us are thinking in terms of a voluntary plan. Our thinking is similar to the way it is handled in Australia and the State of Connecticut.

The principal flaws in a voluntary plan are the classes of people that are not reached by the voluntary method. They are the indigent, medically indigent, aged, chronically ill, and the substandard.

For the indigent and medically indigent there must be government assistance. Our thought is to suggest that the government pay the premiums for these people through the income tax mechanism without the necessity of setting up another large governmental organization.

All the rest of these difficult categories can be handled without any Government assistance by distributing the risk over the entire healthy population. Some kind of government legislation could be proposed so that no insurer, self-insurer, or union welfare funds could be engaged in providing medical care insurance unless they took their share of the excess costs of these substandard risks. We have been talking to doctors in an informal way and they, I think, would undertake to underwrite part of the loss in order to keep the premiums on standard lives down to as low a level as possible.

Between the doctors and the insurance companies we are hopeful that we can work out a program which will make it possible for every citizen in Canada to have his health bills covered at an amount he can afford, except for those who can't afford anything.

MR. ALBERT PIKE, JR.: I would like to make a comment about the entering wedge theory that Mr. Immerwahr and others have spoken about. I agree with Mr. Immerwahr that the Social Security program for the aged would be an entering wedge, and with Mr. Ellis that we should support implementation of the Kerr-Mills bill to deal with the needy. However, I would like to point out that the provision for medical care for the needy is in some circumstances as much of an entering wedge as a contributory program not based on need.

In the first place, under any practical application providing for the medically indigent you have to determine whether a man is needy or not after he incurs the medical expenses and not before he incurs them. If we carry this medically needy concept to its logical conclusion, almost everyone short of a millionaire is potentially medically indigent, and this program is therefore potentially a program for the entire population just as a Social Security type program.

In the second place, the medically indigent type of program might go the way of the Veterans Administration program where the tests of indigency are perfunctory. This idea has been discussed in a recent article of the *Atlantic Monthly*.

Finally, a system based on need would be financed out of general revenue instead of an earmarked payroll tax as the Social Security program would be financed, and the Congressional committee that votes the benefits would be different from the committee that votes the finances. This does not provide the restraining influence as found in the latter program.

I make these comments because I believe the other type of program is as much of an entering wedge as Social Security. The real solution is to get a minimum implementation of the Kerr-Mills bill and occupy the field ourselves. If we rely only on the Kerr-Mills bill and extensions of the bill to take care of the needy, without doing much ourselves, we are headed down the same path as if we had a full-blown Social Security program.

Dallas Regional Meeting

MR. PHILIP F. FINNEGAN: The following is a summary of the implementation by the states of Public Law 86-778, the Kerr-Mills Bill, as of this date, April 1961. In eight states where no new legislation is necessary, two have plans approved by the Department of Health, Education, and Welfare, and six are preparing plans for presentation to HEW. Thirty-eight states required new legislation and among these ten have enacted bills, bills have been introduced in fourteen and are

being prepared in four. Bills were filed in three but no action was taken, and in seven states no bills have been filed or prepared. Three states are undertaking a legislative study and one state, Texas, requires a Constitutional Amendment and this action is pending.

In the field of individual insurance, I believe the insurance companies should do everything possible to enable those persons who do not have group insurance available to purchase individual medical expense insurance for the years after retirement. For the past four years Prudential has made two policy forms available for this purpose. The first, which is issued up to age 55, provides a lifetime benefit and is paid-up at age 65. The other, which is sold up to age 70, is guaranteed renewable for life, subject to the Company's right to change the table of premium rates.

Group insurance would seem to be the field offering the greatest possibility for providing medical care for retired persons, aside from a governmental program. This is traditionally done either through continuation, after retirement, of the plan in effect for active employees, or by providing a modified plan for retired employees. In either case, the benefits are not funded, and are subject to continuation of the group plan. It seems to me that a great deal more can be done in the field of funding group medical care benefits for employees after retirement.

Great strides have been made in the past ten years toward providing medical care insurance for the aged through private insurance. However, (if we are to confine the government's activity to providing care for the indigent) there is much yet to be done and the time is short.

MR. GENE P. ARCHER: Based on statistics available from the Health Insurance Association of America, it would appear that individual and group insurance are performing their role admirably. A December 1960 release announced that one-third of the people in the United States covered under individual and family hospital-surgical-medical expense plans today have policies which are guaranteed renewable and over 16% of them have policies which are guaranteed renewable for the lifetime of the insured. Over one-third of the people covered by individual major medical coverages have guaranteed renewable policies. According to their survey, 51 companies will now write medical expense coverages which are guaranteed renewable for life and 31 companies will issue these policies to persons 65 or older.

Their survey further shows that, in the field of group insurance, 35% of the people covered have automatic continuation of coverage after retirement and another 30% may convert to an individual coverage upon termination of their group coverage. Thus, over half of the people now covered by group hospital protection have provision for continuation

of the coverage in some form upon retirement. The proportion is even higher for group major medical coverages.

Under the circumstances, there seems to be no reason that would really justify the program advocated by the Administration bill.

It is strange and unfortunate that the practice of describing these government programs in terms of the private insurance mechanism continues unabated, in spite of the erroneous and misleading impression that this fosters.

MR. DAVID G. SCOTT: The program called "Sixty-Five Plus" introduced by the Continental Casualty Company several years ago has been quite successful—although lapses have been quite high, necessitating reopening enrollment from time to time. A new program is being currently installed in 22 metropolitan areas under which, after an initial re-enrollment period for all over age 65, it will be possible for anyone to enter the program as his 65th birthday is passed.

MR. FINNEGAN: There are just two classes of people that bother me a little bit when we are trying to take care of them through private insurance.

As I said earlier, we have been making available hospitalization that continues for life. This program has been in existence for four years now, so we have had quite a bit of experience in its underwriting. However, we still get a fairly substantial rejection rate, especially above age 60. As I recall it, the figure approximates 25 to 30 percent, even though we are underwriting pretty liberally. That is one class.

The other class is the people who may be able to pay and who are insurable but who do not purchase insurance. However, when they have a claim they then have no insurance. This, of course, immediately becomes a problem; and one way to solve it, in the minds of many people, is to have compulsory health insurance at the federal level.

MR. RICHARD W. ERDENBERGER: Mutual of Omaha's "Senior Security Program" has been offered virtually nationwide over several open enrollment periods. The experience has not differed significantly over the several enrollment periods. The average age of enrollees, for example, has been within one-tenth of one percent for each of the enrollment periods.

MR. MORTON D. MILLER: The Connecticut insurance companies have studied this subject and are attempting to develop an approach through an association of companies for the purpose of offering health insurance to older citizens of the state. They feel that a combined effort can be utilized to maximize sales effectiveness and minimize costs in

this special area. A bill to put this plan into action has been introduced in the Connecticut Legislature. In addition to a basic hospital coverage plan, it is intended to develop a major medical type coverage. It is the Connecticut companies' intention that once it is under way the non-domiciled companies may join them. This effort may prove to be a very significant guidepost for development in other areas.

MR. MORTIMER SPIEGELMAN: Although this topic raises the question of the appropriate roles of group insurance, individual insurance and government programs in the provision of medical care benefits for the aged, it should be evident that there is some overlapping among the three. It will be convenient to refer first to government programs.

Government programs—on either the federal, state, or local levels—have three aspects. First are the traditional programs for the fully indigent and for the medically indigent which have been formalized under our Social Security Act of 1935 and its amendments. The fully indigent acquire their right to public medical care, along with public support for food, clothing and shelter, by becoming recipients of Old-Age Assistance after having passed a means test. The medically indigent acquire the right to medical care only under the terms of the new Medical Assistance plan for the aged contained in the Social Security Amendments of 1960. In this case, the means test will not be as rigorous as for the fully indigent. For both categories of indigent, the details regarding eligibility and services rendered are left to the individual states, but the federal government participates in the costs. However, the individual states and their localities may render additional services for which the federal government does not share in the costs. A great many states operate mental and tuberculosis hospitals and institutions in which the aged may predominate as patients.

The second type of government program through which the aged benefit includes certain categories of the population, such as veterans and wards. With the aging of our veteran population, a rapidly growing share of the medical care of the country's aged will be borne by the Veterans Administration. Just 10 years from now, in 1971, veterans will constitute about one-fourth of the males at ages 65 and over.

The third aspect relates to government as an employer. Under the Federal Employees Health Benefits Act of 1959, active government employees are given a choice of private health insurance programs in which they might select coverage. Provision is made for continuation of coverage for the individual and family members upon retirement. In September 1960 another Act provided a comprehensive program of coverage, through voluntary insurance, for federal employees who had

already retired. Under both these plans the federal government shares in the cost. A few states have also arranged to cover their retired employees through a group insurance program in which the premiums, or the part of it not shared by the state, are deducted from the pension check.

Industry is, of course, much more familiar to us than government as a carrier of group insurance for the benefit of employees. A rapidly developing feature in group insurance is the provision whereby employees may continue protection against the costs of medical care after retirement either by being kept within the group or by conversion to an individual policy. The story has been told in the New York State Insurance Department report, *Voluntary Health Insurance and the Senior Citizen;** this report presents data only up to 1956. Since then there has been considerable progress, according to surveys by the Health Insurance Association of America describing developments during 1959 and 1960. Currently, about 75% of the active lives covered by Metropolitan group policies are eligible to continue their protection after retirement either under the group policies or by conversion to an individual policy. As far as the retiree is concerned, the group approach is the more economical, especially if the employer bears part or all of the insurance charge, since the administrative cost is low. The role of group insurance in providing the aged with protection against the costs of medical care will grow with our increasing urbanization and industrial development. There are some instances in which groups of retired persons, who have joined together for another purpose than insurance, have purchased group health insurance, a notable example being the American Association of Retired Persons.

Just as in the more active years, individual health insurance provides important services for those aged to whom group protection is not available. Another feature is that individual major medical protection can be had when the group plan provides only basic coverage. More so than in the case of group coverage, individual health insurance provides the opportunity to purchase protection to suit particular circumstances and to adapt the protection to changes in these circumstances. The cost of individual health insurance purchased in the later years is necessarily high, not only because of higher utilization but also because of the requirement of individual servicing. More recently, mass enrollment programs for the aged have been developed; some of their experience has been cited in an Actuarial Report transmitted to health insurers by Superintendent Thacher of New York dated December 9, 1960. Although a number of companies have offered a health insurance policy

* Reviewed in *TSA* X, 797.

for the later years with prefunding, no estimate has been obtained of the extent of this coverage. At the end of 1960, almost two-fifths of the Metropolitan individual policies in force with hospital-surgical protection provided for prefunding by age 65.

Both group and individual health insurance for the aged have an important role in lessening the burdens of medical indigency and public assistance. The growth of voluntary health insurance among the aged, in terms of both numbers covered and benefits provided, undoubtedly keeps many from becoming medical indigents or public assistance cases; for those whose benefits and other private resources run out, it postpones the time of claim to public resources. Without dwelling at length on the matter of a compulsory health insurance for OASI beneficiaries, it should not be overlooked that not far from half of them have already taken the voluntary approach.

MR. MILLER: The publication referred to by Mr. Spiegelman, *Voluntary Health Insurance and the Senior Citizen,* is obtainable from the New York Insurance Department for a nominal charge. The Equitable is finding it quite valuable.

MR. D. H. NOGAREDE: Although I am now at Southern States Life Insurance Company, I have lived under the social security system in Holland. In that country every employed person contributes a small amount from his salary for medical care benefits under the government program. If he becomes sick, he can choose his own doctor and hospital. However, if he wants the services of a specialist, he must pay the extra cost.

In this country, medical care benefits are provided by group insurance through the employer and such programs are more and more providing for paid-up coverage at age 65 extending to retirement years.

Medical care benefits for the aged are considered important by the common man, as evidenced by the government programs in other countries. We must meet this need in our country, too, but I favor doing so by private means working largely through the employer.

MR. MORTON J. KENT: With the State of Tennessee Indigent Care Bill paying hospital costs, doctors taking no fees on these cases, and with doctors taking set fees per insurance policy schedules for set income groups and agreeing to cut their fees 25% on nonindigent patients over age 65, we have seen the Tennessee Plan work very effectively. However, the doctors requested an extension of the coverage to include income groups over $4,200 per year with an additional schedule of fees for the higher incomes. With the exception of Blue Shield, the companies and

their associations have resisted the inconvenience of another schedule. If we are truly concerned about government intervention we must show cooperation and flexibility where a sincere effort is being put forth to make alternative solutions work.

MR. GARY K. DROWN: I want to point out that the doctor's fee is only a part of the problem. If you will consider, for example, that last year 72% of the budget of the Christ Hospital, in Cincinnati, was made up of salaries for lay people, and that the average wage was just over $1 per hour, you will realize that raising the minimum wage to $1.25 will have a very profound inflationary impact on hospital costs.