Group Major Medical

A. What important specific measures have been taken to reduce claim experience or to make it more predictable for (1) comprehensive medical insurance and (2) excess major medical coverage?
B. What is the outlook for the use of comprehensive medical plans for smaller groups?
C. What is known about the effect on claim costs of certain specific provisions such as
   (i) coverage in nursing homes,
   (ii) automatic reinstatement of maximum benefits,
   (iii) coverage for nervous and mental conditions,
   (iv) the family deductible,
   (v) nonduplication of benefits clauses?

Philadelphia Regional Meeting

MR. RICHARD J. MELLMAN: The Prudential features an active claims loss program in discussions with policyholders, brokers, and agents, stressing good plan design. In particular, we are avoiding zero deductible features and small over-all deductibles.

We are also actively engaged in questioning high fees or prolonged treatment and this program has resulted in many reductions in charges billed by doctors.

We believe that broad unscheduled coverage can be continued for both comprehensive and supplementary major medical coverage.

The contract should clearly define eligible charges when supplementary major medical is written in conjunction with a Blue Cross–Blue Shield base plan in order that the major medical plan may be integrated with the benefits that the base plan purports to pay rather than the benefits that it actually pays. This requirement insures that the premium rates for the major medical plan are adequate.

MR. PETER A. HINRICHS: At Home Life, we wrote comprehensive major medical for small groups beginning in 1956. During the period 1957 through 1959, we offered a plan that paid 80% of all covered expenses in excess of a calendar year all-cause deductible of either $25 or $50, up to a lifetime maximum of $5,000. The annual earned premium during the period 1956 to 1961 averaged less than $120,000. Our claim loss ratio for this period was 76% and for calendar year 1961 it was 70%. Considering the inadequacy of major medical premium rates in general during this period, our experience, although not satisfactory for a small group program, was better than that for regular group major medical plans.

We prefer basic health plans plus superimposed major medical to the comprehensive major medical in the small group field for the following reasons:

1. The public desire for first dollar coverage.
2. Flexibility.
3. Variation in price by plan.
4. Better cost controls.

MR. WILLIAM S. THOMAS: We, at Metropolitan, have looked at the subdivision of medical expenses of individuals who qualify for claims under the various types of major medical expense insurance plans. The following table shows the subdivision of expenses:

EXPENSES FOR SPECIFIED SERVICES AS A PERCENTAGE OF TOTAL EXPENSES

	SUPPLEMENTARY MAJOR MEDICAL*		COMPREHENSIVE*
	All Expenses	Expenses Not Covered by Basic Plan	
Hospital.....	50%	32%	48%
Surgery.....	24	21	21
Physicians.....	12	23	19
Drugs.....	1	5	8
Others.....	13	19	4

* All figures are based on medical expenses excluding maternity and obstetrical care.

It is not surprising that the percentages are different because the statistics for the supplementary plan include only the more serious cases—*i.e.*, in this case those which incurred expenses, not covered by the basic plan, in excess of $100—while the comprehensive plan includes all covered medical expenses in excess of a deductible of not more than $50 in a calendar year.

It is surprising that the distribution of expenses does not vary more widely. An analysis of these shows that:

1. Approximately one-half of the medical expenses covered under these plans are for hospital expenses. Hospital expenses are approximately one-third of the expenses after deducting the base plan benefits.
2. Under a comprehensive plan, the expenses incurred for physicians' services other than surgery are about equal to those incurred for surgery. One should not conclude that costs are rising unduly under major medical just because someone cites a few examples of high surgical charges.

An analysis of these figures shows there is some real foundation for the hopes of those who believe that a soundly designed comprehensive medical expense plan will result in a slow-down in the increase of cost of medical care. The reason for this hope is that such a plan places as much emphasis on out-of-hospital care as on in-hospital care. Accordingly, a good portion of the "wrong use" of the hospital facilities will be transferred from the sharply increasing hospital care field to the out-of-hospital care. An example of "wrong use" is hospitalization for diagnostic work or for medical treatment because such care is covered under a typical basic plan *only* if received in the hospital.

A soundly designed medical plan will not interfere with the natural pattern of medical care and will remove financial incentive to seek "wrong use." Thus, the increase in cost will be limited to that required by the change in economic conditions and not to any unnecessary charges incurred because of undue emphasis on any one or more types of medical care.

The question also naturally arises as to whether the absence of fee schedules tends to increase medical care charges faster than under plans with fee schedules. We find that the average charges under one comprehensive plan without a fee schedule compared favorably with those incurred under a conventional plan which included surgical schedules. Experience under the Medicare plan shows the average physicians' charges in those states where the schedule was not published is lower than in those where schedules were published. This tends to confirm the suspicion that a schedule soon becomes a floor rather than the maximum. Analysis of claims under comprehensive plans indicates that the charging of relatively lower fees for the noncomplicated case permits payment of higher fees for the serious, complicated cases without distorting the average charge too much.

There is intense interest by physicians and hospital administrators and their local and national societies and associations in the control of costs of medical care. There has probably never before been a time when industry, labor and insurance had so much real assistance on medical care problems from the medical and hospital professions. Our country is in an era of evolution in this regard and progressively effective controls on quality and costs in the not too distant future can reasonably be expected.

With respect to Section B, we do write a comprehensive medical plan down to twenty-five lives and a modified comprehensive plan between ten and twenty-five lives.

MR. JOSEPH W. MORAN: At New York Life, we have for about two years had a couple of standard comprehensive major medical plans with

scheduled limits. Their major value is as a talking point in discussions with employers who are concerned about the current cost, or increases in cost, and the potential future cost of the plans without scheduled limits.

In other words, sometimes it has helped to sell a rate increase on a non-scheduled type of comprehensive major medical plan, and sometimes it has been useful in resolving the question of whether the group should remain on a comprehensive major medical plan without schedule limits or go back to the more traditional approach of a base plan plus supplementary major medical.

From the sales point of view, a base plan with supplementary major medical after a modest calendar year deductible has all the advantages of both the comprehensive approach and the base plan approach. The base plan plus supplementary approach has one major advantage which the wide-open comprehensive plan doesn't have: as charges rise, the employer isn't hit with the full impact of the rise in medical charges until he decides to liberalize the scheduled benefits in the base plan portion of his package.

We feel that it is essential for the employer to have the freedom to make a good choice between the wide-open comprehensive plan which has a continuing guarantee as to the degree of adequacy of benefits on one hand and the base plan plus supplementary major medical approach which has a continuing degree of control against automatic increases in cost on the other hand.

MR. ROBERT N. STABLER: At General American, we feel that consistency of rates for the various types of comprehensive major medical plans is important if the claim experience is to be predictable. Our basic rates since February 1961 have been constructed on the premise that first dollar 100% coverage areas would have poorer experience than those without 100% coverage. The original features used to give the additional loading will be checked against actual experience.

From rate comparisons with other companies, we judge that most companies have not made a similar distinction. The ratio of our premium rates for first-dollar 100% hospital coverage to rates for a plan with coinsurance and deductible applicable to all covered charges is usually at least 5% higher than similar ratios for other companies. Such a differential affects the type of comprehensive major medical plans we sell.

Since February 1961, we have used relative value schedules on comprehensive major medical plans on an optional basis. We feel that the use of relative value schedules will tend to dampen the claim cost spiral and make claim experience more predictable, but it is not a panacea.

We have certain specific requirements in all our comprehensive major medical plans which tend to make claim experience more predictable:

1. For psychiatric cases in and out of the hospital, we limit the charge per visit and the number of visits.
2. We include an antiduplication clause in all our contracts.
3. Extended benefits limited to six months after termination of employment.
4. Benefits for intensive care accommodations are limited to two times normal room and board allowance.
5. Our definition of hospital is relatively stringent.
6. Pregnancy charges other than those for extreme complication are excluded from major medical coverage.

Experience on major medical superimposed on basic hospital-surgical plans has been good because of the use of a relatively high deductible and the liberalization of base plans.

We plan to permit certain comprehensive major medical plans on groups down to ten lives at premium rates approximately 10% higher than used for groups of 25 lives or more.

In February 1961, we introduced an automatic reinstatement provision as a standard feature on all comprehensive major medical plans. A number of years will be required to determine the additional cost, which we believe to be small.

Our comprehensive major medical provisions set a limit for nervous and mental coverage at $15 per visit, one in-hospital visit per day or one out-of-hospital visit per week. We believe the additional cost of out-of-hospital benefit will not be excessively high but will vary widely by geographical area.

In February 1961, we adopted a provision that in no event would the deductible be applied more than three times in each calendar year with respect to one family. We feel that the effect on claim cost will be small.

Experience on some of our cases indicates that the effect of duplication of benefits on claim costs is significant.

MR. ALDEN W. BROSSEAU: At New York Life, we believe that for the small employer with less than 25 employees it is more reasonable to use a base plan plus supplementary major medical to avoid automatic claim increases.

MR. HARVEY J. SAFFEIR: At the Travelers, we maintain competitive information on the rates of many insurers. Even for the standard plans without geographical differences, the variations are such that the high cost insurer charges twice the premium of the low cost insurer. Therefore, our experience studies do not emphasize minor benefit refinements. However, we do get the following impressions:

1. *Nursing Homes.*—The question here centers around the definition of a nursing home and whether or not prior hospitalization is required. Reliable cost figures are unavailable.
2. *Automatic Reinstatement of Maximum Benefits.*—We estimate that this has a minor effect on comprehensive major medical cost, raising it by 2% at the most. The effect on superimposed major medical is approximately the same in dollar amount but a higher percentage.
3. *Nervous and Mental Disorders.*—Our comprehensive major medical experience indicates that the cost of medical and nervous disorders is 10% of the total for all causes. In some groups, the ratio rises to 25% or 35%. The ratio of nervous and mental costs to total costs on major medical when superimposed on Blue Cross–Blue Shield is usually greater than 10%.
4. *Family Deductible.*—Assuming the more common three times deductible and assuming a per person deductible of $100, the increase in cost over a similar plan without a family deductible is about 1% of the family premium for comprehensive and a lesser amount in dollars but a greater percentage for superimposed major medical.
5. *Nonduplication of benefits.*—We have priced this restriction at from 2% to 3% of the standard rate, depending on the precise benefit.

Kansas City Regional Meeting

MR. HENRY K. KNOWLTON: Occidental has taken 3 major steps to improve its claim experience under comprehensive major medical policies:

1. Inclusion of a provision relating covered surgical expenses to surgical schedules based on the 1960 California Relative Value Schedule. The financial effect of this step has not been determined, but the presence of the schedules enables the company to limit its reimbursement without raising the question of whether or not a charge is "reasonable."
2. Increase in rates for $50 deductible comprehensive major medical and elimination of plans paying the first $500 of hospital coverage in full.
3. Inclusion of a requirement that a calendar year deductible be accumulated within a 3-month period.

Our underwriting loss for small comprehensive major medical plans increased from 13% in 1960 to 16% in 1961, despite rate increases in January and February of 1961; and claim experience on small variable plans covering 25 to 100 lives has even been worse, with an underwriting loss of about 25%. The outlook for small comprehensive major medical plans is not good, and Occidental is trying to get small groups to take basic medical care coverages with supplementary major medical instead of comprehensive major medical.

MR. GEORGE J. VARGA: In determining major medical rates, a good approach is to break up the rates by type of coverage and then make area and other adjustments for each coverage separately—*i.e.*, hospital room

and board, hospital extras, surgical—rather than adjusting the over-all rate. Adequate information on ages, room and board levels, and income distribution must be obtained to determine a proper rate.

MR. DAVID R. KASS: Automatic reinstatement appears to be a conservation measure designed for major medical coverages where the maximum benefit is on the "lifetime" basis. I think this speaks eloquently for the imperfection of the lifetime maximum approach (as compared with the use of a "per illness" maximum).

In any event, automatic reinstatement removes one of the few essential limitations on major medical plans, and may place the resulting coverage on an unsound basis. Unfortunately, if this proves to be the case, we will not know about it until it is too late. The eventual effect of automatic reinstatement is to preserve the lifetime maximum virtually intact for older employees.

While we may attempt to remedy the situation by withdrawing the automatic reinstatement feature from a case that has gone sour, we will be left with a group including impaired employees who can look forward to receiving future claims equal to their full lifetime maximum. Under the circumstances, the future rate levels will undoubtedly be quite high.

MR. DEAN E. WILLIAMS: I presume, since the question does not refer to supplemental major medical, that all companies are willing to write this coverage on small groups. In determining whether to write a comprehensive major medical plan or a base plan with supplementary major medical for smaller groups, the following factors should be considered:

1. The pre-existing condition clause probably exists in comprehensive major medical plans, probably not in base plans.
2. The antiduplication clause may exist in the major medical policy, probably not in the base plan.
3. Definitions of such terms as "hospital" and "doctor" may be different.
4. Subsequent revision in base plan coverages will produce increased commissions, sales costs, and issue costs.
5. The same large claims are covered under the base plan plus supplementary major medical as under the comprehensive major medical plan.

MR. RICHARD W. ERDENBERGER: Mutual of Omaha and United Benefit Life are taking an additional step to improve claims experience for major medical policies, in addition to policy limitations and premium adjustments. That step is to work with policyholders, medical associations, hospitals, and individual doctors to get them to take a stand on specific charges. Then it is possible to predict changes in medical costs

more easily. On the basis of these predictions, required adjustments can be made in premium rates for new issues and for renewals.

Area adjustments have to be constantly reviewed to keep them in line with actual plans. We make area adjustments for four levels of benefits in setting major medical rates—medical, hospital, miscellaneous, and surgical. We feel that in the last four years our basic rates have not been too far out of line, but area classifications have sometimes been inaccurate.

It is important to analyze adequately in setting major medical rates; very often poor claims experience is the result of inadequate analysis of area levels, age distributions, etc.