INDIVIDUAL HEALTH INSURANCE

A. What are the major problems facing the smaller company on entering the field of individual health insurance with respect to
   (i) policy forms,
   (ii) premium rates,
   (iii) underwriting,
   (iv) claim administration,
   (v) statistical studies?

B. To what extent have recent morbidity studies been used in the calculation of gross premiums for
   (i) medical expense policies,
   (ii) loss-of-income policies,
   (iii) major medical policies?
   What methods have been used to introduce adequate expense margins into the gross premiums for individual health insurance?

C. If a company decides to enter the individual health insurance field on a limited basis, which of the following lines could best be omitted initially and why?
   (i) hospital and surgical,
   (ii) medical expense including major medical,
   (iii) loss of income,
   (iv) accidental death and dismemberment,
   (v) the commercial or guaranteed renewable version of each of the above.

D. What policy drafting problems have been encountered in connection with
   (i) the insuring clause,
   (ii) definition of hospital,
   (iii) use of relative value schedule,
   (iv) special state requirements?

MR. JOHN C. ANGLE: I wish an Allan Nevins, a Bruce Catton or an Arnold Toynbee could record the steps that lead a typical life insurer to enter the individual health insurance field. What would a historian find? Would he discover that the impetus came from the recommendations of a careful study of the market for individual health insurance, of the sociological changes of the next ten years affecting the sale of individual health insurance, and of the training of field and home office staff needed to offer individual health insurance successfully?

Would the historian find that such a massive report had been carefully reviewed by each operating department and used to develop a plan for the first five to ten years after entry into the field—the plan to specify training for each operating department, to call for establishment of new

underwriting and claim departments, to outline the markets to be sought and the forms of individual health insurance to be offered?

Alas, the gentleman in the back row is probably nearer the truth. He has just told his neighbor that it didn't happen that way at his company. There, to begin with, one of the agency supervisors came from a company that offered individual health insurance. Next, two of the leading general agents claimed life production was off last year because they couldn't offer individual health insurance. Finally, the president of the company called a meeting to discuss entry into the health insurance field. Midway in the meeting the actuary found himself outvoted and suddenly a health insurance actuary.

If we pretend that this occurred a few months ago, we can imagine that the actuary has now accumulated "research material" in the form of rate books, policy forms, and underwriting manuals from his friends, a reinsurance outlet, and a consulting actuary. Today he sits in this meeting, hoping to learn not only the problems, of which he is already too well aware, but perhaps even an answer or two. He will probably depart comforted only by the knowledge that others long in the field have the same problems.

Let us enumerate some of the problems. A health insurance policy looks deceptively simple. Yet proposals for standardization of the sort recently advanced in Wisconsin ignore the experimentation and rapid change typical of the business today. A health insurance policy form has a short life expectancy and a high rate of amendment. Seldom do the states agree on its content, thus creating a sizable number of state changes. The HIAA is most helpful to a policy draftsman wishing assistance in this area.

A more important problem to a newcomer into health insurance is that of choosing between possible forms of insuring, benefit, and exclusion provisions and determining their effect on underwriting results. Obviously contract language affects the cost of benefits, but how much? And when?

As an example, Woodmen Accident and Life Company decided two years ago to remove all probationary periods from the loss-of-time and medical expense contracts. Probationary periods are those "except" clauses under which sickness coverage commences only on the 31st day after issue, and coverage for loss caused by hernia, tonsils, and perhaps neoplasms begins in the 7th policy month. We found that these provisions were seldom clearly explained to the insured and caused difficulty and hard feelings at time of claim. Yet we have no clear idea of the cost of this liberalization and shall have to wait several years to find the additional claim cost, if any, that this little change entailed.

As for premium rates, one will find disappointingly little intercompany

experience. The sheer velocity of change often means that by the time we have sufficient data for an analysis of experience of a kind of insurance, the kind is outdated and the results of little more than academic interest. More importantly, intercompany studies are principally supported by the very largest life insurers who so willingly contribute experience and the time of their actuaries. Many of these large companies entered the individual health insurance field after World War II and have only recently been able to contribute health insurance morbidity information for the fifth and later policy years.

In considering premium rates for hospital, medical and major medical coverages one must bear in mind the upward trend of medical care costs. Those in the group field, who offer broad coverages and operate with paper-thin margins, are hypersensitive to these trends. The best opinions seem to be that the cost of providing hospitalization insurance is increasing about 5% per year and that major medical benefit costs are increasing up to 12% per year. These trends mean that statistics of benefit costs of several years ago, or premiums based upon benefit costs of several years ago, do not adequately reflect either present or future costs. An actuary of an insurer planning to offer individual insurance of medical care cost should plan to monitor experience closely. Such an insurer should understand that periodic revision of premiums for new issues will be necessary and that occasionally renewal premiums for in-force policies must be revised.

One should understand that any real distinction between commercial and guaranteed renewable health insurance is disappearing. Changes in public opinion and insurance regulation make it increasingly difficult for a commercial insurer to exercise the contractual right to nonrenew a policy. This means that any distinction between commercial and guaranteed renewable loss experience will disappear over the years ahead.

As for underwriting, most health underwriters ply a trade based on hunch, general reasoning, and experience. Substandard underwriting is largely an intuitive work. The underwriting manuals available represent the best judgment of lay underwriters and medical officers and are a needed tool to allow us to begin substandard underwriting so that some day we will have experience statistics by which we can modify our first impressions. Most of these comments also apply to claims administration, where experience is to be sought after and highly prized.

Statistical studies are essential. In the end you will find your own statistics to be the most reliable guide to follow in establishing premium rates. A statistical system should include a means of securing the exposure, adequate instructions for coding and a detailed analysis of benefit payments. The number of days that benefits are paid will be needed, as

well as the amount paid under each kind of benefit. The objective should be to secure annual claim costs by age, policy year, occupational class, sex, and benefit. Helpful guides are the statistical plans established by the Society's Committee on Experience under Individual Health Insurance.

MR. E. PAUL BARNHART: One of the big problems facing a smaller company entering the individual health insurance field is what to do in the area of policy form structure. This is important because there are basically three different types of policy form structures on the market today. One of them, usually referred to as the package policy, has a minimum of fill-in items. The benefits provided by the policy are pretty well fixed and, therefore, it is not necessary to indicate, for example, how much deductible or how much maximum benefit is provided. A number of companies which in the last few years have gone into the individual health field have approached it along this line, using an inflexible package policy that permits very few options or choices. I think that some of these companies have found that this approach has some very severe limitations.

Suppose, for example, you come out with a loss-of-time policy and decide that you are going to have, say, a lifetime accident, two-year sickness package and this is going to serve your needs. Well, you have not had it on the market very long before some of your more influential general agents decide that they would like to have five-year accident and one-year sickness or some other variation and, as a result, you suddenly realize that your package program is not going to do the job. Therefore, you have to come up with a new form. For this reason, I think that the package approach probably should not be used unless you are sure that you can live with what you start out with and not have to do much revamping.

The second approach is one which my company (Washington National) is currently using and which we are, for the time being, satisfied with and that is to have a number of basic policy forms but to design each one of these in an extremely flexible fashion so that we can fill in the maximum period, the deductible and whatever options are involved. This flexibility may be achieved at somewhat increased policy issue expense. However, we find that it enables us to adopt very easily and rapidly any changes or additions of plan that may be demanded. We find that over the long run this seems to hold our expenses down and minimizes our filing problem with the insurance departments.

The third approach involves the scheduled policy. Some companies using this method have a single policy on the market which has a number of different coverages—hospital, major medical, loss of time, etc. The idea is that with this single flexible policy you can write almost any kind of individual health coverage you wish.

My experience has been and my opinion continues to be that this leads to some problems because when you decide to revise some of the benefits, provisions, or coverages, then you have to refile the entire policy.

Another problem facing the company entering this field is that of finding experienced personnel, caused in part by the number of new companies that have been entering this field over the last five or ten years. Our own company, which has been writing individual health insurance for many years, has recently been experiencing a rapid upsurge in production and we have found good underwriting personnel to be scarce.

A specific personnel problem that a company meets when entering the health insurance business is whether or not to try to hire an experienced A&S claims man or an experienced A&S underwriter, or to retrain existing claims and underwriting personnel. Usually a new company going into the business will try to get one experienced man in the underwriting department and one experienced man in the claims field, and then rely on these people to train the existing staff.

MR. RICHARD W. ERDENBERGER: There are three major considerations when starting out on a premium structure revision. First, there is the consideration of increasing claim costs and I think this should be reflected in the premium basis.

Second, and perhaps more important to small companies, is the consideration of cost levels varying by area. If your company operates in one area only, do not be too strongly influenced by larger companies operating over widespread areas. They may have a broad area factor and be too high in a low cost area or too low in a high cost area. Watch for selection possibilities in this sort of situation.

Third, management must make a decision as to what renewal action will be taken when the limiting age is reached under a guaranteed renewable policy. An advance decision is desirable as to when the right to terminate will be exercised or how high a loss ratio will be permitted before another premium revision is required.

MR. BARNHART: With regard to the question of entering individual health insurance on a limited basis as posed by section C, it seems to me that a company would not have to offer both hospital and surgical coverage and some form of major medical. One might think that both of these are necessary to have a complete program, but I doubt if this is really true. It seems to me that, in the individual area, major medical coverage is gradually coming to be a more and more significant field of coverage, and we have been finding with the use of inside limits and certain underwriting clauses that we can write a relatively low deductible along with

what is regarded as "major" medical coverage to the extent that we don't really need an underlying basic plan. We believe that our real future in this area consists of a rather flexible approach in major medical using inside limits and a relatively low deductible, so that the plan serves as a comprehensive as well as a supplemental major medical.

This type of insurance needs to be approached with a great deal of caution. We advise strongly the use of inside limits so there is some kind of control to keep costs in line. This can also be used to offset area variation. We don't make use of area variations in our rates. Instead, we have combined flexibility and inside limits, so that our area rating is an indirect and automatic thing.

I would also suggest that any company considering entering the individual health field consider leaving out the maternity benefits. This might sound a bit heretical, but my experience is that maternity coverage is not essential to a successful medical insurance program. On two occasions I have been involved in new policy development where the policy being replaced was a policy that had a maternity benefit and we have had great success in replacing such a policy with a new type of coverage that does not have a maternity benefit, except, perhaps, where complications are involved.

In one case we replaced a hospital policy, which happened to be optionally renewable, with a guaranteed renewable lifetime hospital policy. The old one had maternity benefits and the new did not, except for complications, and to our surprise the production doubled on the new policy.

We found there was a tremendous market among even younger families who were not interested in the dollar trade-in involved in maternity benefits. By introducing the flexibility of a major medical contract that can be used as a comprehensive medical policy, we are replacing many of our old hospital policies which had a maternity benefit. The new coverage being sold provides pregnancy coverage only with regard to complications; and despite the absence of the basic maternity benefit we find the field is switching to the new policy on a wholesale basis, and we are quite convinced the maternity benefit is not as necessary as your agency department may sometimes insist.

One of the big advantages is that you don't have the high claim cost and relatively high claim expense arising from heavy frequency of claims. We find that by eliminating the maternity benefit and using a moderate deductible we cut the claims frequency and ease the load from the claim administrator's standpoint, so that we can handle increasing business without so much expansion of claims personnel.

MR. JOSEPH W. HAHN: We are rather new in the individual health insurance field (Great-Southern Life) and we decided to get along without having both the hospital and surgical coverage and major medical. We limited our sales to a basic hospital and surgical policy. We did that because we were just getting into the business and we wanted to learn something about this major medical before we offered it on an individual basis. We do offer it on a group basis, and we are learning some of the pitfalls from our issuance of a group major medical.

I agree with Mr. Barnhart on the desirability of eliminating a maternity benefit. If you have ever made a study of your persistency rate from the point of view of those policies that have had maternity claims, you might be shocked, as we were shocked, to learn how many policies are terminated after a maternity claim. We have not eliminated the maternity benefit, but in order for the maximum maternity benefit to be obtained on our policy the policy must have been in force for 36 months.

Now for a comment on section D, the matter of policy drafting problems. The only problem we have encountered with regard to the definition of a hospital was in California. We had used the definition that the hospital must be equipped for major surgery. We were asked to eliminate the word "major" and say that the hospital would have to be equipped only for surgery. Then our medical director told me that his office was equipped for surgery, so we don't think the provision "equipped for surgery" gives us much protection, but we decided that other elements of the definition were sufficient to eliminate clinics, rest homes, and the like.

The final topic is the matter of special state requirements—and there seems to be no end to special state requirements. Each month seems to bring some additional requirements. Fortunately, we can usually take care of those special state requirements by the use of a rider, or sticker, or rubber stamp, or some red ink. Those revisions offend me, and we make them only because it is impractical to have separate policy forms for all the different states. From time to time we try to revise our policy form and put in the basic policy form some of the special state requirements. Sometimes we run into difficulty on that. We tried to do it with the 10-day free-look provision which we have handled in a number of states by a rider. I don't believe we have ever had a policy returned under the 10-day free-look provision, so we are happy to put it into the basic policy. We ran into one difficulty. The provision was worded, "if this policy is returned within 10 days the premium will be refunded and everything will be as if the policy were never issued." Some objected to that because by their law you had to say that the man had to be dissatisfied with the policy before he returned it. We haven't solved that problem yet.

MR. WILL R. MULLENS: Mr. Hahn brought up the question of definition of hospital. We have a definition of hospital in our policy which has a requirement that it have a registered nurse always on duty. One state made us take out the word "registered" several years ago and leave it "with a nurse always on duty." And the next time we filed in the same state that was not good enough—they had to have "a nurse always on duty or on call."

MR. ANGLE: The removal of the 30-day sickness probationary period from our contracts affected the matter of pre-existing conditions only by moving the effective date of the contract for sickness from 30 days after the policy date to the policy date itself. This change did not affect the terms of the insuring clause that provide coverage only for sickness originating after the policy date. If an insured suffers a new sickness within 30 days after the date of issue he is entitled to benefits. This change will increase benefit costs by an amount still unknown to us.

We believe this change to be sound. Certainly probationary periods are no substitute for careful underwriting. After acceptance of a risk an insurer should be willing to provide coverage for any illness commencing after the date of issue of the policy, subject to the usual defenses for fraud or misrepresentation in the application.

MR. KEITH SLOAN: My remarks have nothing to do with my present company (Pioneer Insurance Company) which has been in the health insurance field on a limited scale some 63 years, offering loss-of-time coverage only.

This concerns a company which went almost exactly the route that was described by John Angle. It should never have gotten into health insurance, but was taken in over the vote of the consulting actuary, who was promptly fired, and the company accumulated over a very short time about 5,000 claims.

If you are wondering how much difference the probationary period makes, out of those 5,000 there were only two in which the probationary period made any difference, as I did have occasion to analyze all of those claims. Incidentally, it took about six months to dispose of the business, but it was eventually sold to somebody else.