TRANSACTIONS OF SOCIETY OF ACTUARIES
1961 VOL. 13 PT. 2

Major Medical Expense Underwriting and Claims Practices

A. How effectively have schedule limits and other similar restrictions in amounts and types of covered charges reduced amounts of claims incurred under major medical expense policies? What problems have arisen in the sale, underwriting and administration of such plans?

B. When an employer's group major medical expense plan is transferred from one insurer to another, what special provisions, if any, are applied:
   (i) to assure continuity of benefits to the insured individual who incurs continuing charges after the date of transfer for an illness for which benefits were payable under the old plan;
   (ii) to determine benefits for an insured who had incurred charges sufficient to satisfy only part of the deductible under the old plan at the date of transfer;
   (iii) to determine the maximum amount of benefit payable under the new plan for an insured who has already received substantial benefits under the old plan for an illness which continues to require medical attention?

C. Have there been any recent changes in practice with respect to the continuation of benefits after the termination of the individual's insurance for continuing charges for an existing illness? What effect do these practices have on the amount of the insurer's liability for unpaid incurred claims?

MR. JOHN E. CHAMPE: Major medical plans as originally conceived, and in the eye of the public, provide for open-end benefits. The imposition of scheduled limits creates a problem initially because of the implication that something is being taken away, consequently making the plan less attractive. We at the Connecticut General have been improving the mechanics of claim review so that we can more readily detect and control unreasonable charges. We frequently make contact with doctors where this is appropriate in individual situations, and have been successful in explaining our position. It is our intent to insure regular and customary charges, and our contracts now more clearly define these terms.

We have attempted to correct specific situations by amending certain major medical contracts to include a schedule of surgical benefits. The level of benefits must be set with specific goals in mind: to pay 50%, 75% or 95% of expected charges. For this to be effective, local doctors must concur with the schedule adopted. In this setting, our experience in introducing schedules has been satisfactory.

MR. GEORGE N. WATSON: At the Crown Life we have been conducting a pioneering effort in types of restrictions that might be imposed on major medical policies. We include in our policies a schedule, based on the California relative value schedule, which is used, not to limit the amount of benefits, but to determine what we consider reasonable and

customary. The values in this table vary by area, income, and other factors. The clause in our contract is so worded that the claimant must prove the charge is reasonable. Most contracts put on the company the burden of proof that a charge is not reasonable. One problem we worried about most was where the claimant has already paid the doctor a fee that we consider unreasonable. I feel that in this case we would have to pay. Legally, we could say that we would pay provided some proof could be given that the charge was reasonable and customary. If the claimant is silent on the matter, then of course we have a complete legal basis for denying the claim.

MR. EDWARD A. GREEN: I recently had need of explaining to a prospective policyholder the meaning of the expression "customary and reasonable." His main question was how his employees were to know what was customary and reasonable. He much preferred a schedule of benefits with amounts so set as to match customary and reasonable charges in the area. I feel that by doing this we can give the buyer a little clearer picture of just what benefits he is purchasing.

MR. HAROLD F. HARRIGAN: At the Metropolitan we feel that by putting a schedule in a major medical policy, we are setting a benchmark for doctors' charges, and the tendency is for the average charge to rise toward the schedule limit. Most of the limits are on surgeons' fees, which make up 20% of the total nonmaternity medical expenses incurred under a comprehensive plan. Our experience indicates that the absence of a surgical schedule does not lead to increased charges. Inclusion of a surgical schedule seems to allow too much for a majority of operations with no complications, and too little for the serious complicated cases. We feel that by including a schedule you destroy the value of a comprehensive plan as being truly comprehensive in nature.

MR. STANLEY W. GINGERY: We at the Prudential are still of the opinion that the broad form of major medical coverage which covers a wide range of eligible charges with only a few inside limits can be soundly underwritten and fills a legitimate demand. There are, however, two areas in which we feel that scheduled limits are desirable. The first is out-of-hospital psychiatric treatment, where we have a 50% coinsurance factor, a $20 maximum eligible charge and a limit of 50 such treatments a year. The second is placed on hospital room and board charges, where we recommend that the maximum amount eligible be set as the charge for a semiprivate room. To hold down the claim cost of the unscheduled plan we are trying to sell our policyholders on the need for an effective claim control program. We also provide material to educate covered employees

as to the fundamental economics involved. We hope that this voluntary approach will enable us to continue offering a broad form of major medical coverage.

MR. ARTHUR G. WEAVER: I think that notice should be taken of a new dimension that has been introduced into the field by recent UAW-CIO bargaining. Coverage is to be provided in two states for medical care without deductibles and generally without coinsurance or internal limits. However, benefits are to be limited to customary and reasonable charges for necessary services. If this limitation is to be effective, it is necessary to have the cooperation of the doctors in determining what charges are customary and reasonable.

For the past few years the Health Insurance Council has been attempting to develop a close liaison with the doctors at the state level. As a result, several state medical societies have established medical review committees where, if the insurance company wishes, the doctors will look at a given charge to determine if it is reasonable and customary. The introduction of the UAW-CIO type of coverage will undoubtedly encourage the formation of additional medical review committees. This can be achieved only if each company accelerates its efforts, through the Health Insurance Council, to encourage an improved liaison with the doctors.

MR. J. BRUCE MACDONALD: I would like to introduce a survey I have made of the practices of a number of leading U.S. companies and most Canadian companies in handling cases that have been transferred from another company, as referred to in section B. All companies stressed that each case received individual consideration and was considered on its own merits. Of the twelve U.S. companies that replied, four companies will allow expenses incurred before transfer of the plan to count towards satisfaction of the deductible, subject to an extra premium being paid. Four companies may charge an extra premium or may allow such expenses without charge. One company allows a three month carry-over of expenses without charge. Another company uses pro-rata deductibles; *i.e.*, if a case transfers on July 1, 50% of the usual deductible would apply in the first year. A majority of the thirteen Canadian companies replying to the questionnaire had not established a practice. Two companies, however, charged extra premiums, and one used pro-rata deductibles. One company used policy year deductibles exclusively. One company refused to consider such a practice. The results of the survey indicate that the extra premium method is the most popular.

The problem of employees who have partially or wholly satisfied the deductible under a previous policy is a real one for the new carrier. No

employee likes to discover that he has suffered a loss because of a transfer of coverage. Solutions such as the pro-rata deductible, a carry-over provision, or the policy year deductible reduce the problem but do not solve it completely, as some employees will definitely have to satisfy a larger deductible. The only satisfactory solution to the individual is to recognize precisely his previous deductible status. One method of doing this would be for the employer to make any necessary payments to the employee himself.

We have lost at least one case because a high ranking executive has exhausted his major medical benefits. I feel that this is becoming an important problem. At this time I have not had any good ideas as to how to protect oneself against it.

MR. BURTON E. BURTON: To assure continuity of benefits to employees, we at the Aetna urge that the transfer be effective on January 1 for calendar year major medical plans. Our eligibility rules are essentially the same for transferred cases as for new cases.

We are finding that employers are requesting that a special provision be included in the plan so as to give credit against the deductible of the new plan for expenses incurred and applied against the deductible of the old plan. We are willing to include such a provision for cases of 50 or more employees for a suitable extra premium. In developing the extra premium, an analysis was made of claims under calendar year all-cause plans. The results of the study indicated that the percentage extra premiums (1) increase as the amount of the deductible increases; (2) are much larger for major medical plans than for corresponding comprehensive medical plans with the same deductible amount; (3) are relatively small for transfers near the beginning or end of the calendar year and are largest for transfers in the middle of the calendar year. The extra premiums for a standard comprehensive medical expense plan with a $50 deductible would be about 4% for a transfer in January or December but about 15% for transfers in the middle of the calendar year. For transfers of supplemental major medical plans with a $100 deductible, the extra premiums would range from 8% for beginning or end of the year transfers to 30% for middle of the year transfers.

Perhaps some thought should be given to counting benefits paid by the prior plan against the individual's maximum benefit under the new plan. This may be necessary if many transfers between carriers occur solely on account of individuals exhausting their maximum benefit.

MR. HARRIGAN: The Metropolitan treats this type of business as though the coverage had been bought from us initially. We would have

the "actively at work" provision for employees, and suitable provision for dependents. This, of course, does not provide full continuity of benefits, since a full deductible must be satisfied anew.

MR. GINGERY: We at the Prudential have not seen a lot of transfers and have not standardized a method for handling them. Our purpose in such cases is to maintain individual employee equities, within the policyholder's philosophy on how far he wants to go in providing employee benefits.

With regard to providing coverage for individuals who are disabled when their insurance terminates, our policy has been to continue benefits until the end of the calendar year following the year in which the termination occurs. We have found that shortening this period to ninety days has relatively little effect on our liability for incurred but unpaid claims; only 1% or 2% of annual premium.

We sometimes hear that other companies reflect a much greater difference than this in their dividend claim reserve factors. From what we make of the experience developing under our business, it is difficult to rationalize such large differences. Originally we had assumed that the much greater size of the incurred but unpaid claim liabilities characteristic of major medical coverage as compared with basic hospital, surgical and medical plans was largely due to this extension provision. However, it now appears that this may be mainly the result of the greater lag from the date services are rendered to the date the claim is submitted.