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DIGEST OF INFORMAL DISCUSSION

HEALTH INSURANCE

(Joint Session with Casualty Actuarial Society)

Individual Health Insurance Policies

A. How do companies allow for the increasing cost of medical expenses in setting premiums for health insurance contracts? Is it possible or appropriate to introduce automatic future increases into health insurance premiums?

B. What progress is being made in the extension of benefits under individual policies to include coverage of mental illness?

C. To what extent can the actuarial societies go further than the present Society of Actuaries' morbidity studies in developing combined company data? Would it be helpful if the actuarial societies published a compendium of the statistics at present available?

D. What plans of agents' remuneration have been found to be suitable for health insurance policies? Do plans differentiate between medical expense and loss-of-time policies?

MR. EDUARD H. MINOR: The problem of increasing costs of medical expenses is of very little importance in connection with basic family hospital and surgical coverage which includes a maternity benefit. The availability of the maternity premium after the first few policy years would be sufficient to cover a sizable increase in medical costs if there was any reasonable persistency beyond the years of heavy maternity costs. In the case of basic individual coverage at the younger ages the termination rates due to marriage and lapses make the prospect of higher medical costs a rather small problem. However, at ages 45 and over with policies guaranteed renewable for life the problem is expected to be serious.

In the case of comprehensive and major medical policies, as well as basic policies issued at the higher ages, we feel that the savings in expense loadings after the fifth policy year will be sufficient to cover increasing medical costs between the fifth and the tenth policy years. Rather than build in a provision for automatic future increases, we would much prefer to make every effort to provide a premium that would be stable for as close to ten policy years as possible. Then, for the relatively few lives persisting as long as ten years, we can avail ourselves of the provision for making rate increases by class of business on guaranteed renewable policies.

I would like to point out that the problem of increasing medical expense charges is not uniform throughout the country, and we are finding more

and more that it is necessary to consider this problem by geographical area. We are following the practice of increasing premium rates in the particular geographical area where the costs are showing the highest upward trend. Policies in high-cost areas must be considered a particular class of business, and it would be quite unfair to make over-all premium increases that would affect policyholders in those areas where physicians and hospitals are exercising great effort to keep costs from rising further.

MR. ALEXANDER MARSHALL: I assume that the question of allowing for increasing cost of medical expenses in establishing premiums for health insurance is directed primarily at the comprehensive major medical policies, since this coverage is so susceptible to inflation and technological improvements. Basic hospital policies, as indicated by Mr. Minor, are less susceptible to these rising costs.

For major medical policies I believe that a major factor in attempting to allow for, or control, increasing costs of insuring medical expenses lies in the area of benefit design, particularly through the use of inside schedules of benefits. Without these I do not think it is possible to set premiums that will be adequate to the long-range risk, particularly under guaranteed renewable policies.

Actuaries in California have been making greater use of "inside limits." This is because we have seen the devastating results of improper benefit design both in group and in individual coverage.

As long as we pretend to offer blanket benefits, even though we have a reasonable and customary charge protection built in, we invite and compound the problems of increasing cost. We are avoiding our professional responsibilities by sanctioning such coverage and luring policyowners into believing that the premiums for their policies are adequate to cover the risk. I do not think it is appropriate to introduce future automatic premium increases in a product because of lack of effective controls, unless such increases are spelled out in the form of actual expected step rates on the front page of the policy. To make the tacit assumption that it is appropriate to make "automatic" future increases in a so-called level premium is not a responsible actuarial approach. Then, after setting up a comprehensive policy with only the deductible and coinsurance controls, we move further from our actuarial responsibilities when we actually turn around and use relative value schedules to determine what are the so-called reasonable and customary charges. With "inside limits" the policyholder knows what his benefits will be. If he moves to a higher cost area or if there is an increase in medical cost, he can buy additional coverage if necessary, with a greater chance that he will more nearly understand just why his insurance cost has increased.

MR. J. HENRY SMITH: Mr. Marshall's discussion emphasized the desirability of "inside limits" in broad-coverage health insurance policies. While such limits make for a safer risk and greater premium stability, I feel that his remarks need to be balanced against other important considerations favoring no "inside limits." Also, I feel that his references to the integrity of the actuary are overdrawn.

Admittedly, if broad coverage without "inside limits" is undertaken, one must anticipate possible future premium increases. This expectation, however, seems to be a fact of life in all forms of medical expense insurance. "Inside limits" may mitigate or delay premium increases, but probably they will not avoid them completely. There are other factors coming into play which may require increases in spite of "inside limits." Among such factors are claim frequency, claim duration, administrative costs, and even the secular "creep" from the current average costs up to the "inside limits." Therefore, the question is more one of degree, and possibly of timing, than a difference in principle. Would we dare guarantee premiums perennially for policies with "inside limits"?

In any case, "inside limits" do not decrease or control the cost of medical care. Therefore, they have no magic from the point of view of the broad social purposes we are trying to serve. The vital problem to which we must address ourselves is, not how we can avoid rate increases, but how we can satisfactorily provide a broad coverage which protects individuals against the erratic incidence of the cost of medical care now and in the future.

Admittedly, we have a duty to anticipate long-term trends and to warn our clients to anticipate them; but the nature of health costs is such that it does not appear feasible to provide the kind of coverage which the public needs and wants at an unchanging cost. "Inside limits" work the wrong way from the point of view of the client and the public. Such limits produce frustration and adverse reaction against the insurance business. They produce criticism among those concerned with the adequacy of plans and among those who provide medical care. They produce resentment on the part of policyholders. The public wants broad coverage, and one thing that seems to be clear from all the experiments to date is that people are prepared to pay for adequate coverage. They realize that even the increasing costs of adequate coverage are preferable to the risk of large bills aggravated by increased cost of medical care.

If we write policies with effective "inside limits," expecting them to protect us against cost trends, we must then expect these policies to become inadequate and obsolete. Aside from the adverse reaction which will result, the only cure will be to liberalize them from time to time in the

future. Such liberalizations will mean increases in premiums. The results will be similar to those which can be obtained under policies without "inside limits"; and there is little assurance that policies with "inside limits" will be more satisfactory, all things considered, than others.

Other factors which may be briefly mentioned also bear on this matter. What further increase in cost of health care must be expected? How effective will be various devices and movements under way, or to be instituted, in controlling future costs? To the extent that control measures can be effective, and to the extent that medical cost inflation compared with other living costs has run its course, the lack of "inside limits" will not prove so troublesome as Mr. Marshall supposes.

I am not expecting here to settle the question of which system is the better, for I recognize the validity of arguments on both sides. I feel, however, that, in the face of Mr. Marshall's strong expressions, the valid arguments for no "inside limits" should be at least mentioned in these discussions. In any case, I take issue with his allegation that "actuarial integrity" dictates the use of "inside limits." The question is not one of integrity but of how to design a protective mechanism for the public which will adequately and satisfactorily meet costs. "Inside limits" may be the proper resort of the prudent actuary but not necessarily the bastion of his integrity.

MR. ALFRED V. FAIRBANKS:* The costs of benefits providing reimbursement for medical expenses on a blanket basis subject to a maximum limit are affected in somewhat less than direct proportion to the increase in cost of medical expenses. A deductible has the opposite effect, resulting in a relatively greater increase in benefit costs. Major medical policies which provide just such benefits as this are therefore extremely susceptible to the increasing cost of medical expenses.

A few years ago when major medical policies were being introduced, there was very little experience on which to base rates, and probably few if any companies provided for future cost increases. More recently some companies, finding rates inadequate, have made rate increases. With medical expenses increasing at the rate of 5 per cent per year, it would be difficult for companies to raise premiums to current levels, provide for future cost levels, and also keep premium increases within reasonable limits. Premiums for most major medical policies today probably have no provision for future cost increases or at the most provide for such increases over only a very short period of time.

A guaranteed renewable policy provides for future premium changes

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when needed. There is no certain method for predicting future medical costs. The inclusion of automatic future premium increases introduces an artificiality that could complicate the administration of necessary premium adjustments when called for.

Most major medical policies now provide "inside limits" for daily hospital and surgical benefits. There may be other areas where policy provisions may be modified to help minimize cost increases and, in addition, restrain excessive use of facilities. The inclusion of nursing-home benefits at a reduced maximum daily benefit might tend to reduce hospital costs. Coinsurance ratios based on the insured's income level to recognize tax deductions for medical expenses could be considered. Other "inside limits" might even be employed.

An insured covered under a policy providing hospital benefits subject to a fixed maximum daily amount and reimbursement for surgical procedures according to a schedule may eventually find that these benefits are inadequate. In order to maintain adequate coverage for the insured, a flexible program should be developed to increase benefits on an equitable rate basis. A program to increase benefits under guaranteed renewable policies providing level premiums to a stipulated age, on an equitable rate basis, will normally require that the premium for benefits to be continued should remain unchanged, and the premium for the increased portion of the benefits should be based on current attained age rates.

Within recent years the public has come to recognize mental illness as a sickness. This better understanding, coupled with new methods of treatment reducing and sometimes eliminating the need for institutional confinement, has provided an opportune time to review the existing coverage for mental illness under health insurance policies and consider the problems underlying the extension of such coverage.

The existence of any disability is often difficult to determine. Since mental illness has no clear definition, the problem of determining whether disability exists and the inception and termination of the period of disability is especially difficult. Visits to a psychiatrist may be for a problem rather than for an actual sickness. There appears to be no set treatment for any one type of mental illness. Little information is available regarding frequency, duration, and cost of treatment or the varying degrees to which the various segments of our society utilize the available services.

At the present time coverage of mental illness varies considerably between companies and types of policies. Most loss-of-time policies provide coverage for mental illness just as for any other disability.

Hospital-type policies providing a fixed maximum daily benefit for hospital room and board, reimbursement subject to a maximum for other

hospital charges, and reimbursement for surgical procedures according to a schedule, frequently provide the same coverage for mental illness as for other disabilities. However, a few hospital policies exclude coverage for mental illness entirely, while others provide some sort of limitation, such as excluding coverage while confined in a hospital which is primarily for nervous or mental disorders.

There is considerable variation in the coverage provided by major medical policies. Some policies exclude coverage entirely. Others usually provide limited benefits such as only for confinement in a general hospital. In addition, a limitation may be placed on the maximum amount payable for any one period of treatment.

Group Health Insurance, Incorporated, of New York, in a project designed to test the insurability of short-term psychiatric treatment provided coverage to a sample of its subscribers and dependents over a two-and-a-half year period ending December 31, 1961. This project, although limited in scope, provides valuable information regarding utilization by social, economic, and occupational groups and indicates the limitations that must be employed in order successfully to provide for extension of coverage for mental illness under health insurance policies.

Government facilities assume the responsibility for a large proportion of the long-term chronic cases. With the improved understanding of mental illness and the new methods of treatment, increased consideration should be given to health insurance coverage for short-term treatment of mental illness.

Two methods have been used to pay commissions for health and accident policies. Casualty companies have used a level method of paying commissions on commercial type policies. This method providing the same commissions for first and renewal years is used to avoid the inducement to transfer business to another company at the time of renewal.

Commission scales used by life insurance companies and sometimes by casualty companies for guaranteed renewable type policies provide a high first-year commission, as an incentive for new sales, and a comparatively lower renewal commission.

Monarch Life pays a commission to the writing agent of 40 per cent for the first year, 15 per cent for the second through seventh years, and 5 per cent thereafter. For hospital-type policies and for major medical policies the first-year commission is 35 per cent, these being considered supplemental to the basic loss-of-time coverage. Also the public has perhaps a greater realization of the need to provide coverage for medical expenses than for loss-of-time protection, and therefore medical expense coverage is more easily sold.

In order to hire qualified agents, it is essential to provide some method of financing during an initial period, since few agents can initially produce enough business to meet the financial requirements of their standard of living. This additional compensation is based on a reducing percentage of the annual premiums for new policies paid for during his first two years with the company. In addition, a bonus is paid on all business written during the first five weeks, whether or not paid for.

We require no charge-back to the agent who fails. If a man appears to have the qualifications we want, we are willing to take the chance that he will succeed. We feel this to be a proper company investment in the development of a capable sales organization.

MR. MINOR: Expenses incurred on account of mental illness can involve in-hospital and out-of-hospital expenses, or both. In all its medical expense policies Metropolitan provides fairly liberal coverage for the expenses of mental illness when a hospital confinement is involved; that is, no distinction is made in the payment of benefits for hospital confinements if the cause is mental illness or for some other sickness. Out-of-hospital expenses that are incurred for mental illness are, of course, not covered in our basic hospital and surgical policies and are excluded from our broader forms of coverage which do provide out-of-hospital benefits.

It is of interest, however, that the latest policy added to our portfolio, which was the Alberta Medical Care Plan, does provide benefits for mental illness whether or not a hospital confinement is involved. There is, however, a twelve-month waiting period for such benefits. There are, of course, many companies offering the Alberta Medical Care Plan in the Province of Alberta, and I am sure that these other companies share our interest as to the results of including such broad benefits for mental illness in a policy providing first-dollar coverage.

All our policies provide that, where any benefits are payable for mental illness, no payment will be made if the services are obtained without cost in a publicly financed institution. This restriction, however, is fairly routine in nature; we do not, as a general rule, provide benefits for services that are obtained free.

I think it is worthwhile to mention that in our currently issued noncancelable disability income policies we make no distinction between nervous and mental disorders and any other causes of disability. This represents a relatively recent change in our practice; prior to 1961, our noncancelable disability income policies contained an exclusion for disabilities caused by nervous breakdown, neurasthenia, or any other mental illness unless the insured were confined in a hospital.

In our underwriting of medical expense and disability income policies we do not accept applicants with any history of serious mental diseases. In the case of the Alberta Medical Care Plan, where it is always necessary to issue a policy regardless of underwriting considerations, we do, at least, have the option of designating the life as a pool risk. We do not, in any event, issue any of our policies with a mental illness rider.

MR. JOHN C. ANGLE: An actuary responsible for establishing health insurance premiums or for predicting health insurance morbidity rates must attempt to follow an ever changing experience that is often difficult to observe and evaluate. The variability of health insurance morbidity rates makes experience especially precious yet more difficult to obtain.

Projections of health insurance morbidity experience are more difficult than projections of mortality experience. Past experience is not always available, especially for new, experimental coverages. Since morbidity experience can exhibit cyclical characteristics, it must be followed over an extended period of time to establish a normal range of values. The claim cost of medical care coverages is constantly pulled upward by rising medical care charges and by a rising utilization of medical services. The health insurance actuary must be endowed with good judgment and needs all the studies of morbidity experience he can lay his hands on.

The morbidity studies normally desired by our members will reflect experience under the forms of individual and family health insurance issued in the United States and Canada. The edifice of intercompany experience is built with the materials supplied by contributing companies. The composition of these materials will depend upon the market and operating philosophy of each contributing company and must be handled with care. The essential point is that, unless a sizable number of companies can contribute information, no meaningful study can be undertaken. If the data come from only one segment of the business, the resulting studies will be neither representative nor appropriate for substantial portions of the industry.

How many health insurers have morbidity information tabulated in proper form for an intercompany study? The record shows that in 1954 President Walter Klem of the Society of Actuaries wrote to two hundred companies issuing individual accident and sickness insurance. Each company was asked if it was interested in contributing to a study of experience under loss of time coverage. Eighty companies expressed interest and a willingness to participate in the study. With this encouragement, a committee was formed, and instructions for submitting information were distributed. Then came disillusionment. Only eleven companies responded with data for 1955. Only fifteen were participating in 1959. Only 2 per

cent of the 653 insurers actively writing individual health insurance at the end of 1958 were able to take part in this investigation.

The Committee on Experience under Individual Health Insurance has, I feel, done a superb job with the information available. Interesting reports appear in the 1959 and 1962 Reports Numbers of the *Transactions*. Disability experience is presented for the first year of the benefit period, and variations by age, sex, occupational class and elimination period are given. The committee pointed out that sufficient experience is not yet available to allow studies of policies with elimination periods of more than fourteen days, benefit periods of more than one year, or the variation in benefit costs by policy year, renewal provision, and geographic area.

Undismayed by the response to the loss-of-time study, the committee agreed to begin investigation of hospital-surgical and major medical benefits. The studies will consist of eight major parts subdivided by age, sex, policy year, and renewal provisions. I understand information has been collected for 1960 and 1961 and that an early report is planned.

I intend no reflection on those companies that have been unable to participate. We, in fact, were one of the eighty who expected to take part in the loss-of-time study, only to find that our exposure file was not in proper shape. Just as we licked the exposure problem, we began conversion to a magnetic-tape record-keeping system and lost another two years. Our experience is a common one and may explain the time required to get this project under way.

Turning, at last, to the topic for discussion, I would comment that this Society, through its Committee on Experience under Individual Accident and Sickness Insurance, has already undertaken investigations of the most important individual health coverages. These investigations are really just getting started. Information from more insurers and more time will be needed before the present studies are complete or have become routine, continuing investigations. This scarcely seems the time to burden the committee with more studies. Rather let us give them the support they need to carry on the existing loss-of-time and hospital-surgical-medical studies.

As to the matter of a compendium of statistics, I would point out that the Health Insurance Institute publishes each year a pamphlet entitled *Source Book of Health Insurance Data*, which presents a good number of general statistics about the business. The HIAA through its actuarial and statistical committee periodically publishes a statistical information bulletin listing available studies of interest to individual insurers. Owing to the availability of these publications, there is little need for Society activity in this area.

MR. CHARLES N. WALKER: The topic of agents' remuneration was of considerable interest about eight or ten years ago in health insurance circles. It was the subject of many discussions at the Health Insurance Trade Association meetings, which, I believe, was due to the interest of a large number of life insurance companies that were entering the field which had been predominantly dominated by casualty operations.

Historically, health insurance compensation patterns had followed the typical casualty compensation plans. Casualty operational patterns involved considerable and sometimes complete field underwriting of risk, with only a home-office veto on the acceptance of cases which had been written by a field agent. Also, there was involved considerable and sometimes complete field administration, particularly premium collections and plan administration. As a result there emerged a pattern of level commissions at a fairly high level in a range of 30–35 per cent which, I think, seemed quite appropriate to the situation.

Life insurance companies entering the field brought not only a life concept of operations but a revival of interest in noncancelable and guaranteed renewable coverages with a considerable increase in emphasis on health coverages rather than accident. This made field underwriting impractical. Also, since field administration and premium collections were foreign to life company operational patterns, the concept of high first-year and low renewal commissions seemed appropriate. The result, I think, has been a rather pronounced trend to the life commission pattern, if I may describe it as that.

The result that has emerged is a fairly uniform concept of compensation. The typical pattern today involves nonlevel commissions with a first-year rate which is significantly lower than a first-year life compensation rate. This is appropriate, owing to the relative ease of selling health insurance coverages compared to the selling of life insurance. The range for first-year compensation is 40–45 per cent for loss-of-time and for major medical coverages, with a range of 30–35 per cent for hospital and surgical coverages. Renewals are significantly higher than for life insurance, which is quite appropriate, since the agency force has considerable more servicing to do. Typical renewals would range around 10 per cent and may continue for life on a nonvested basis.

Group Long-Term Disability Insurance

A. What factors account for the recent reductions in group rates which many companies have introduced?
B. Are group rates being guaranteed for more than one year, and, if so, is this sound in the light of past history and the long-term nature of this benefit?
C. In setting the levels of benefit, what problems are there with reference to the relation of benefits to income and to the extent to which account should be taken of other forms of disability benefits which might be simultaneously payable?
D. Are benefit cutoffs in the event of the cancellation of the master contract equitable, and can such cutoffs be sold?
E. What is the market for long-term disability insurance?

MR. ALLEN D. PINNEY:* As to the factors accounting for the recent reductions in group long-term disability rates, the primary answer has to be competition. The calculation of long-term disability rates is very difficult, and, as a result, it seems doubtful that any of us is confident as to what the rates should be. It is to be expected that a difference in opinion would exist as to what the rates should be, considering that most of us are working with meager data and that mature experience takes a long time to develop. We, of Travelers, do not share the optimism of the casualty companies in the area of rate-making. Judging from our own data, we have to say that we do not feel that the very low rates that are being offered presently are proper, but at the same time we really cannot say that they are wrong, because we really do not know. Competition is difficult enough to resist when you are sure of your approach. It is practically impossible when you have but a vague idea as to what the rates should be. So I say that competition is the most important reason for the reduction in rates.

As to the second question, the answer is that we sometimes guarantee a rate for more than one year when the policyholder insists upon it and where the group is unlikely to be affected by adverse economic conditions. We appreciate the policyholder's concern about the uncertainty of future experience, and we do not feel that we are giving up very much by guaranteeing a rate for up to three years. Any guarantee beyond three years we believe to be unsound.

In answer to the third question relating to design of benefits, we have run into a problem with the lower-income groups (i.e., at about $5,200 and under), where the net result of the schedule benefit less disability benefits from other sources was that no benefit was payable under the group long-term disability contract. This situation is somewhat embar-

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rassing where the contract is on a contributory basis. We have attempted to meet this problem by providing a fixed benefit at the lower salary level to be paid irregardless of any other disability benefits that may be paid. The size of this benefit, however, is based upon the assumption that Social Security benefits will be paid.

As to the fourth question, it is my opinion that it is not equitable to discontinue payment on existing claims when a master contract is discontinued, particularly where an employee may not have bought other coverage because of his employer having a long-term disability plan and especially so if the plan is contributory. It also puts the employer who has a long-term disability plan which includes the benefit cutoff feature, and who has some employees drawing benefits under the plan, under extreme pressure to accept any indicated rate increase rather than to consider a new carrier.

As to our market for long-term disability, the primary market lies with our large group policyholders who have been with us a long time and whom we expect to remain with us for a long time in the future.

MR. C. GILBERT NOREN: The present long-term disability market is a very volatile one. Rates and underwriting rules are changing daily, all in the direction of more liberal benefits for lower premiums. It is a dangerous climate sustained only by the generally favorable climate of business activity.

Those of us who watched with trepidation the inroads in major medical rates, benefits, and underwriting that took place in the early and middle 1950's were rewarded with dubious satisfaction when the pendulum swung the other way, and rate increases followed by inside limits and benefit cutbacks became common. But there the industry was fortunate in that major medical is a coverage with a high-claim frequency and a relatively low maximum liability per claim. The true nature of the coverage revealed itself gradually, which enabled company executives to keep abreast of their debits and credits and to take appropriate action. Even under these circumstances, many millions of dollars of accident and health losses were accumulated.

Long-term disability is not a coverage with an expected high claim frequency and a low maximum claim. Quite the contrary—the expected frequency is so low and the claim potential so high that a small statistical variance can mean serious losses. Furthermore, as we all know, disability is much more subjective than medical expenses—more dependent upon "the slings and arrows of outrageous fortune." A real downswing in business activity could produce enough layoffs, executive as well as rank and

file, to bring on a catastrophic rash of claims. A slight downswing in business activity could account for substantial losses.

Group writing companies are faced with a choice of following the crowd or of having inroads made on their inforce accounts by the aggressive long-term disability writing companies. Several long-term disability writing companies are using rate levels that cannot be supported by any known experience and which appear to be too low. However, it is not only the lower rate levels that are frightening; it is the erosion of the underwriting safeguards that were so carefully considered at the time we entered the business. The exceptions that are made after much soul-searching today become the point of departure in the specifications received tomorrow. There is no end in sight.

As actuaries we are professionally responsible for the soundness of the products our companies write. We must be certain that our companies' participation in the long-term disability market is consistent with sound actuarial principles.

MR. HAROLD F. HARRIGAN: As part of a very comprehensive study of all facets of our long-term disability plans, premium rates, underwriting, policy forms, etc., we made an extensive study of the available claim experience. In addition to intercompany experience, this included a large volume of experience which had been developed on Metropolitan policyholders for group long-term disability benefits, total and permanent disability benefits in connection with annuities, and total and permanent disability benefits issued in connection with group life insurance. While we wanted to have competitive rates to retain our existing policyholders and attract new ones, we also felt that reductions should be made only if the resulting rates were sound and were likely to be satisfactory for use in the immediate future.

Our analyses indicated that the previously assumed claim costs for long-term disability benefits did not closely follow the actual experience by age and that such claim costs were too conservative, particularly at the younger ages, although they were at the right level for older ages. Accordingly, substantial reductions were made in expected claim costs at the younger ages, somewhat lesser reductions at the middle ages, and none at all at the older ages. For an average age case, this resulted in a premium rate reduction of almost 25 per cent.

While we have always felt that the group life and health business should be operated essentially on a one-year term basis, we think it is particularly important, on long-term disability, that no rate guarantee be made for periods of more than one year, especially when premium rates have been reduced to their present levels. This particular benefit is one which is

subject to wide fluctuations in experience, depending upon economic conditions, the employer's retirement policies, and the local traditions as to retirement on disability. These factors, particularly the first two, can change widely from time to time, and it is important that the insurance companies be in a position to change rates rapidly as conditions change. At Metropolitan, we also feel that there should be the further safeguard of a reservation clause which will permit us to refuse to renew the policy at any renewal date with prior notice. Such discontinuance of the policy would not affect outstanding claims but, of course, lets us off the risk with respect to future claims.

In underwriting a sound program of long-term disability benefits, it is important that the aggregate amount of disability income benefits from all sources should bear a reasonable relationship to the employee's earnings. Many income benefits are available through employment, or otherwise, such as weekly temporary disability benefits, total and permanent disability benefits under group life insurance, Social Security benefits, and disability benefits under a pension program. All these types of benefits should be taken into account in determining the level of long-term disability benefits, and the aggregate of benefits from all sources should not exceed 50–60 per cent of the employee's basic earnings. This proportion becomes a much higher figure in relation to the employee's take-home pay, and we feel that the underwriter should make sure that the ratio of benefits from all sources will not exceed 80 per cent of take-home pay.

With respect to benefit cutoffs in the event of cancellation of the master policy, Metropolitan's policy is to continue benefits on existing claims after termination of the contract, since we feel that in the long run this is in the best interest of the insurance business. Employees who have come to rely on their insurance benefits would certainly be hurt in the event of discontinuance of benefits on cancellation of the master policy. Since we have not adopted the practice of cutting off benefits, we do not know whether or not they can be sold; but it would seem to us that most employers would want to have a plan whereby those who have been approved for disability benefits would continue to receive them whether or not the master policy is cancelled.

There is still a great potential market for long-term disability benefits. Most small employers do not have benefit programs of this kind, and, while some large policyholders have adopted long-term disability plans for salaried employees, many others have not. These employers now have substantial disability benefits of a long-term nature in their programs, and it is the industry's job to show them the advantages of an integrated program providing reasonable levels of benefits which would be applicable to all classes of employees.

State 65 Plans

A. What has been the experience to date as to volume, claims, duplication of coverage, persistency, and expense of the various State 65 plans?
B. Have the special administration problems that are inherent in such plans lent themselves to effective solution?
C. What are the prospects for the extension of State 65 plans to other states and regions?

MR. JOHN R. BEVAN:* The monthly premium under the Mass. 65 plan is now approximately $450,000. This consists of 29,000 insured at the $9.00 rate for major medical alone plus 11,000 insured at the $17.50 rate for both the major medical and basic plan, making a total of 40,000 insured at an average rate of $11.50. Although the plan has not yet operated one year, we predict that the claim rate for the first year will be close to the expected figure of 85 per cent. Expenses are also close to the expected.

Originally approximately 47,500 policies were issued. The 4,500 issued since that time have not been sufficient to offset terminations as about 40,000 policies remain in force. Lapses have been largely in issues of the major medical plan alone. The total in force is now remaining relatively stable. We are well satisfied with the over-all results.

The everyday problem of explaining the product and its limitations has been the most pressing and especially critical in dealing with the elderly. As aids in this direction informational centers have been opened in Worcester and Springfield. The voucher portion of the claim check has also been designed to give the claimant an understandable explanation of the derivation of the payment.

There is ample evidence that interest in State 65 plans is intensifying in other than the northeastern area of the country. The Texas 65 program opened its enrollment on October 1, and the western regional plan encompassing California and a number of other western states will start its enrollment early next year. Furthermore, about ten states, in addition to Massachusetts, New York, and Connecticut, and the other two mentioned above, will have passed legislation allowing for the formation of such programs within the next several months.

The expansion will be difficult in some states owing to lack of experienced insurance technicians, high sales and promotion costs in sparsely populated areas, and the attitude of state regulatory officials in obtaining required rate increases.

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MR. MORTON D. MILLER: New York 65 has about 115,000 persons insured, which, with the 40,000 in Mass. 65 and 25,000 in Connecticut, gives a total of 180,000 persons covered. This is a fine addition to the coverage of older persons.

The average age is about 74. Women outnumber men by almost two to one. About one-third of the applicants are persons other than the insured. Agents and brokers sent in 74 per cent of applications in first enrollment and 77 per cent in second enrollment.

Of our enrollees, 38 per cent elected the basic plan only, 24 per cent elected the base plan in combination with the major medical, while only 38 per cent bought the major medical plan alone. Originally, we expected the major medical plan as a supplement to outsell the other plans, but our experience has convinced us of the need for a separate basic health plan, which is not the case in Massachusetts or Connecticut.

Although it is too early to tell, our experience through October 15 of 29,573 payments to 17,335 individuals for a total of $7,189,329 agrees fairly well with our anticipation of one claim per annum for each three persons insured.

Careful review of claims is necessary, especially with regard to the preexisting conditions and nonduplication provisions. We find that, by using the telephone and talking directly with the doctor, the hospital, and the claimant or his representative, the processing can be greatly speeded up at no additional cost.

Persistency is of great concern. Terminations due to death run about 0.5 per cent a month, and an ultimate total termination rate of upwards of 1 per cent a month seems indicated. About 4–5 per cent return their certificates in accordance with the ten-day free-look provision. The expense picture is muddied by the costs involved in the two enrollment campaigns, but we are hopeful of leveling out at less than 10 per cent of premiums.

In addition to the normal problems of establishing a new insurance company, we had barely five months to set up the organization, and then overnight we had more than 100,000 individual policyholders. The large strain on service in the early months is therefore not surprising.

As a going concern, our problem is to secure the continued interest and active support of agents, brokers, insurance companies, doctors, hospitals, and the public. To obtain a steady flow of new applicants from the 15,000 persons who reach 65 each month in New York, the assistance of agents, brokers, insurance companies, and employers is required to help us find them and enroll them.

Prospects for the extension of State 65 plans are very good. The Texas

65 is just completing its initial enrollment. The Western 65 is expected to start in California early in 1964. Enabling laws have been passed in California, Connecticut, Massachusetts, Mississippi, Nevada, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oregon, Texas, and Washington. These thirteen states account for 40.7 per cent of the population of the nation. Nevada, New Mexico, Oregon, and Washington expect to join the Western 65 plan later in 1964. North Carolina and Virginia expect to commence a bi-state plan in the spring of 1964. There is active interest in securing legislation in eleven additional states, which include another 15.5 per cent of the population. These are Alaska, Arizona, Colorado, Hawaii, Idaho, Montana, Utah, and Wyoming, which all hope to join the Western 65 plan, and Virginia, Michigan, and Pennsylvania.