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DIGEST OF DISCUSSION OF SUBJECTS OF SPECIAL INTEREST

HEALTH INSURANCE

INDIVIDUAL AND GROUP INSURANCE

The Problem of Overinsurance Arising from Duplication of Coverage

A. How serious a problem is this now? Is it arising with increasing frequency? Unless controlled, what might be its effect upon the business?

B. How may the problem be solved? Do present statutes permit practical solutions, and, if so, what are they? What changes in statutes should be made to control this problem adequately?

C. Is it possible for companies to control this problem at the issue or renewal stage, or both? What controls are feasible for noncancellable or guaranteed renewable policies?

D. Can a practical procedure be established for yearly or frequent review of policyholders' coverage to determine whether they are paying premiums for coverage which they do not need or for which no benefits would be provided?

MR. BURTON E. BURTON: I would like to discuss Topics A, B, and C from the group insurance viewpoint. It seems clear that the overinsurance problem is a serious one and that the extent of overinsurance is increasing. Some of the more important reasons for these developments are: (*a*) the trend toward noncontributory coverage; (*b*) the substantial proportion of working wives in the labor force and widespread practice of making coverage available to dependent husbands; (*c*) expansion in the adequacy and scope of coverage provided by medical expense plans; (*d*) widespread availability of Blue Cross–Blue Shield and specially designed medical expense programs to individuals on a mass enrolment or continuous enrolment basis without evidence of insurability.

A joint ALC-HIAA-LIAA Study Group on Nonduplication of Accident and Health Insurance Benefits has prepared two reports on the overinsurance problem. The second report, published by the Associations in December, 1962, contains a sample group medical expense antiduplication provision and has been reviewed and endorsed by the standing committees of the Associations. This provision appears to be a practical solution to the overinsurance problem. The sample provision is reasonably simple to understand and explain because benefits for a covered individual are not reduced unless the total benefits from all plans would exceed the total

of those expenses which are covered by any of the benefit plans. The provision will apply to any kind of medical expense program, including basic, comprehensive, and superimposed major medical expense benefits. The new provision also provides a practical solution to the determination of benefits when more than one of the benefit plans covering an individual contains an antiduplication provision.

The Aetna has proceeded to design a standard antiduplication provision for use in connection with all of our group medical expense plans based on the recommended approach contained in the second report of the industry Study Group. The provision will be used with basic, comprehensive, and superimposed major medical expense plans. The definition of other insurance coverage to be taken into account by the provision was filed with insurance departments on a variable basis, with a sample definition which included all individual, franchise, or group insurance coverage as well as Blue Cross, Blue Shield, group practice prepayment plans, and school plans. Approval of the provision has now been obtained in all but three states, and approval is expected in these states.

We expect to make the provision available to all policyholders with medical expense benefits. Also, consideration is being given to an automatic incorporation of the provision in all plans for groups with less than 25 employees or, perhaps, groups with less than 50 employees. The definition of "other coverage" to be taken into account by the provision will be broad but will not include individual insurance policies because of the unusually difficult problem of determining the existence of such coverage.

We expect the primary control of an antiduplication provision to be psychological, and normal claim savings should amount to no more than 2 or 3 per cent. However, overinsurance is so widespread under some group plans that significant claim savings can result, at least in the immediate period following the adoption of the provision. As an extreme example, the claim savings amounted to 12½ per cent in one of our group comprehensive medical expense plans covering approximately 5,000 employees located in a single community. The average saving per claimant involved was $240, and 37 per cent of the total savings were attributable to individual Blue Cross–Blue Shield coverage.

MR. LARUE S. WAGENSELLER: The Metropolitan is convinced overinsurance in the health field is a potential problem which will become more significant as time passes. Ever increasing proportions of the population are becoming eligible for such insurance in one form or another, and the scope of coverage available is continually being enlarged. Thus,

our success in meeting the mushrooming public demand for this protection in such a short span of time has undoubtedly been a contributing factor.

Overinsurance in the health field should produce the same result as in life insurance, namely, an unduly high ratio of actual to expected claims. No one wants such a result, so it might be assumed that the underwriter of individual health insurance would, like the life underwriter, merely refrain from approving an application involving overinsurance. This is not easy to accomplish because of the innumerable permutations and combinations of coverages offered by different policies and the continuing uptrend of medical care costs, which, in some areas, have been rising by as much as 7 per cent per year. Moreover, the insured may change his occupation and become eligible for group insurance or prepayment coverage. Or the carrier may issue a conversion policy to a young man who has reached the limiting age under his parents' family policy. With the spread of noncancellable and guaranteed renewable policies, the optional standard provision permitting a carrier to retire from the risk after learning of the subsequent issuance of other valid coverage has largely lost its usefulness.

As the previous speaker indicated, the potential for overinsurance has mounted in the group fields with the growing custom for married women to work and the trend toward noncontributory coverage.

In view of these facts of life, one must conclude that there are very definite and substantial limitations to the use of issue or renewal underwriting techniques for the control of the overinsurance hazard in both individual and group medical care insurance. In our judgment, the most effective underwriting technique still available is the inclusion in all policies of nonduplication provisions.

Because of the predominance in the health care field of group coverage, for which the statutes wisely permit greater flexibility as to policy provisions, the group segment of our industry can probably move ahead on this program about as rapidly as it is willing to do so. Larger employers are becoming increasingly aware of the overinsurance problem and more responsive than ever before to recommendations for adoption or continuance of these safeguards in their plan—due in part to the trend from purely basic coverages to major medical.

The Metropolitan has used nonduplication clauses in group major medical policies from the outset, and our experience with them and with the primary-secondary carrier order of benefit determination has been generally satisfactory. But we believe the new concepts embodied in the Model Provision recommended in the Second Report of the Joint ALC-

HIAA-LIAA Study Group hold out hope of more widespread acceptance by employers and employees alike, as a long range ultimate solution. Hence, we have included those concepts in new policy forms which have been filed country-wide for use with all types of group medical care plans.

The Model Provision is complex and involves new concepts which will require careful and patient explanation. It seems desirable to start acquiring experience with this program as soon as practicable. However, we intend to proceed with due caution, recognizing that an overzealous approach which was too far in advance of public readiness might arouse strong antagonisms and possibly create demands for hastily drawn and ill-advised legislation.

MR. ROBERT P. COATES: In considering a revision of the Equitable individual major medical policy, which we wished to put on a guaranteed renewable basis for life, concern was expressed regarding the extent to which basic medical care coverage was tending to overlap the major medical deductible.

In order to avoid such overlapping coverage, our new lifetime major medical policy uses a deductible which is the greater of a "Basic Deductible" or the benefits provided by other medical expense insurance. There is a range of basic deductibles, and we encourage the applicant to choose the one that is appropriate to the extent of his other insurance coverage. Recognizing that the extent and value of his other coverage may change from time to time, the contract contains a policy provision which would permit a change of the basic deductible. In the case of a decrease in basic deductible, evidence of insurability would be required except that a decrease is permitted without evidence on the policy anniversary following age 65. This is a recognition that group insurance and perhaps other coverage often ceases at this age.

In developing the premiums for this policy, we took into account the likelihood that the deductible would be based on the coverage under other insurance for many claims, and the premiums are reduced accordingly.

We devoted considerable effort to educating our agents. We also have a program under which the new coverage has been offered to existing policyholders. This is an alternative to a rate increase, which was required because of increasing medical care costs. A substantial number of policyholders are exchanging their older forms of policy for the new coverage.

Obviously, our program adds an additional dimension to the administration of claims. Recognizing that reasonably prompt handling of claims is most important, we are asking our policyholders to give us in-

formation about their other insurance—first in the application and then in the notice of claim form. We are also asking hospitals and doctors to indicate to us whether or not they have been asked to complete claim forms with respect to other insurance. We expect in most instances to be able to make claim payments on the basis of this information without the necessity of checking in detail with the other insurance companies involved.

In connection with approving the policy, two states have asked us to send out an annual notice to policyholders pointing out the right to change the basic deductible and suggesting that they should consider this if their other coverage has changed. The first such letters will go out in the fall of 1963. We are giving some thought to adopting such a procedure nationally but probably at longer than annual intervals.

MR. ALBERT PIKE, JR.: The Pettengill Committee is certainly to be congratulated for its two fine reports on the group insurance aspects of health overinsurance. However, I think it is easy to fall into the trap of oversimplifying the problem and coming to the conclusion that the use of claim reduction clauses should be mandatory. There are contrary considerations which must also be taken into consideration. In addition to the general principle that a claimant should not make a profit from doubled-up coverage, there is also the principle to be observed that each claimant should get value received for each premium dollar he pays. These two principles must be weighed one against the other in various situations, which I would classify as follows:

1. *Group health insurance on top of group health insurance.*—Since experience rating clauses in group insurance policies have the general effect of remitting any claim salvage back to the master policyholder, there is no good reason why claim reduction clauses should not be used in all cases except where the master policyholder himself objects. For this purpose I would classify Blue Cross and Blue Shield coverage as group insurance.

2. *Individual coverage on top of individual coverage.*—As soon as statutory authorization is secured, it seems that companies should also use claim-reduction clauses in individual health policies wherever administratively feasible, but only if their company marketing procedures are such as to avoid the deliberate placing of duplicating coverage. Otherwise, the claim-reduction clauses will operate to produce a windfall profit for the company, thereby not avoiding a profit but merely transferring the profit from the claimant to the company. This cannot be successfully defended.

3. *Individual coverage on top of group, or group coverage on top of individual.*—In these situations any claim-reduction clauses should operate in the group policy only, not in the individual policy. An experience-rated group policy has built-in procedures for restoring equity after claim-reduction clauses have operated, but an individual policy does not.

All this adds up to the proposition that claim-reduction clauses should be designed to operate in group policies much more often than in individual policies.

MR. CHARLES N. WALKER: I think there is one area of overinsurance which tends to be a self-limiting affair as we progress in marketing better and better coverages.

With older applicants some overinsurance comes in a nonfraudulent manner. The older people try to buy as much as possible because they are afraid of losing what they have. They are afraid policies will not get renewed or premiums will be increased, and they worry about the problem that will be created if they lose insurance in force.

Another factor in their purchase of excessive coverages is the benefit limitations in the merchandise that is available to them. They are not able to buy comprehensive coverage so they tend to overbuy on limited coverage in the hope that the surplus they achieve here will pay the expenses which have not been covered by any single policy. Again, this tends to be self-limiting in that this would seem to disappear as the policies become more and more comprehensive.

A related item is a tendency to buy now in order to have coverage later when they need it. This is particularly prominent in the late fifties and early sixties, when people covered by group insurance attempt to purchase large amounts of individual coverage since they may lose their group when they are retired. They know they are insurable now, and they want to protect that insurability. As we provide more and more extension of both conversion and continuation on group benefits into the retired area, I think this will tend to limit itself.

In the individual field, it is possible to control to some extent the overinsurance which occurs at issue, but it is not an easy job. It is necessary to watch carefully what coverage is in force in order to determine whether the total of all coverages being sought is going to constitute what you consider to be overinsurance. It can be done, but it is a difficult underwriting job.

Limits

What changes in amounts limits have been taking place in disability income insurance? Accidental death and dismemberment insurance? Hospital insurance? Other benefits? Are these changes supported by past experience?

MR. WILLIAM L. BARBER: When we consider limits, we normally include issue limits, participation limits, and retention limits.

Without question the trend in all these has been upward. Some of this upward trend has been by choice, and some has been caused by pressures brought to bear because someone else was doing it.

I do not believe we can support these changes by past experience, since we have had no conditions in the past similar to those which now exist. On the contrary, if we go back to the depression years, we find that, as a result of overinsurance, too liberal underwriting, and a few other mistakes, the industry suffered badly.

At Union Mutual we increased our limits about one and a half years ago. At that time we set our issue limits for loss of time at $500 a month except for our professional overhead policy which we set at $1,000. We retain all this except the excess over $400 for long-term coverage.

For participation, we set $1,200 per month (of which no more than $800 may be long-term coverage) for dentists, and medical or osteopathic physicians. For other applicants in our first three classes the figure is $1,000 per month (of which no more than $800 may be long-term coverage). We consider long-term coverages as those policies providing sickness benefits for a period of five years or longer.

In considering these limits we also state disability benefits from all sources shall not exceed 60 per cent of the applicants' earned income. Disability benefits from all sources include noncancellable, commercial and franchise, disability income under life policies, group benefits payable for a period exceeding twenty-six weeks, and Social Security benefits.

I think it is worthwhile pointing out the growth of franchise or association-type coverages as well as the greater interest now developing in long-term group disability plans. I believe that underwriting must give greater attention to these forms of coverage, or we will find ourselves in overinsurance situations.

There has, it seems to me, been a tendency to ignore the benefits provided under the OASDI with the belief that, in order to qualify, an individual must be presumed near death. However, if we look at the latest report, we note that the number of disabled workers under age 65 has increased from 618,000 to 741,000 during 1962, with average benefits of

$90 per month. This would indicate that there are far more benefits being paid than most underwriters believe.

In conclusion I wish to point out that overinsurance has not been too great a problem during the past fifteen years because of a prosperous and inflationary economy. However, perhaps we are getting to the point where the benefits in force are catching up with the growth of earned incomes.

MR. HARRY A. WOODMAN, JR.: My remarks pertain to amount limits for individual disability income policies.

Issue and participation limits for disability income insurance have been steadily increasing over the last several years. These increases have been influenced by a number of factors: (1) accumulation of reliable morbidity experience; (2) favorable morbidity experience under current economic conditions; (3) increase in the cost of living and average annual personal income per individual; (4) growth of health insurance and the entry of life companies into the health insurance field; (5) greater knowledge and experience in underwriting.

As a result of these factors, the average maximum issue limit among twelve prominent companies writing noncancellable disability income insurance has increased from $375 in 1952 to $600 today; comparable maximum participation limits have increased from about $700 in 1952 to about $900 today. At New York Life, we recently increased our maximum issue limits from $500 to $750 and our maximum participation limits from $750 to $1,250.

The 1959 and 1961 reports of the Committee on Experience under Individual Health Insurance give experience under individual loss-of-time policies for the period 1955–59 based on almost 300,000 claims. This substantial volume of data is the first significant publication of experience under present economic conditions.

The fact that this experience is quite favorable has encouraged companies to liberalize their underwriting rules and, in particular, to increase their maximum issue and participation limits.

Although the Consumer Price Index has shown a relatively moderate 15 per cent increase in the past ten years, there has been a sizable 35 per cent increase in annual personal income per individual in the 1952–62 period. We have experienced a continued improvement in our mode of living, and some items which were considered luxury items ten years ago can now be considered as basic needs. It would appear that about a 25 per cent increase in maximum issue and participation limits would have been justified by the changes in our economy alone.

The growth of health insurance in force has also influenced maximum limits. Even the relatively small companies have been able to establish surplus positions so as to absorb rather large fluctuations in claim levels.

The entry of life insurance companies into the health insurance field has also had a notable effect. The large career agency force of these companies has assured them of a large volume of business, and their sound surplus position has given them the flexibility to set relatively high maximum limits. Also it was necessary for these companies to set relatively high limits in order to offer sufficient incentive to the life insurance agent to sell disability income insurance.

Perhaps the greatest single factor influencing increases in maximum issue and participation limits is the accumulation of knowledge and experience among underwriters. This knowledge and experience have made it less necessary to rely on artificially low maximum limits to prevent overinsurance. The underwriter today has a keen awareness of the importance of financial underwriting and is better equipped to limit a risk to the amount necessary to fill a basic need than he was ten years ago.

Even today, there are many cases that could qualify for amounts equal to several times the largest participation limits, and we will undoubtedly continue to see further increases in such limits in the absence of a major business recession. Actually, the limits of today are low in comparison to life insurance limits when related to comparable needs. In fact, the sizable amounts of waiver of premium benefit included in jumbo life insurance policies provide amounts of disability income, through dividends and increases in loan values, that are greatly in excess of maximum amounts available under health insurance policies.

MR. RICHARD H. MORSE: The increase in limits for disability income insurance has been dynamic in the last twelve or fourteen years. When I first went into the health insurance business with Monarch, some fifteen years ago, our limit was $50 a week, and now it is up to $1,000 a month on certain professional members for short-term coverage.

MR. WALLACE R. JOYCE: I have heard no theoretical justification for any difference between participation and issue limits. It seems to me that the hazards that we are trying to avoid by restricting our issue limits are reintroduced when we extend our participation limits beyond the issue limits.

MR. MORSE: Mr. Joyce raises a good point. At the Monarch we feel that the issue limit should be the same as the participation limit.

MR. E. PAUL BARNHART: Our present practice in the Washington National is to set an issue limit of $500 a month. In this, we do not distinguish between short- or long-term disability, but we do have some differences according to occupational classification. We will participate up to $1,000 or $1,200 a month, depending again on the occupational situation, and we question how wise this really is.

We feel that the key to this is not the issue limit but the participation limit. By way of illustration, we have had several agents point out that, when we limit issue to $500 a month, their prospect will buy $500 a month from us, and then turn around and buy another $500 or $600 a month from another carrier. Neither company's participation limit is being violated, and the man, of course, has readily obtained $1,100 a month of disability income coverage. Our agents feel that, if we would issue $800 a month, the man would buy this amount only instead of buying contracts with two carriers for $1,100.

At the present time we do not reinsure any disability income benefits, but we feel we would certainly need to do this if we got up to something like an $800 issue limit. We feel it makes more sense to bring the issue and participation limits much closer together. As a matter of practical underwriting flexibility, we feel there should be some small difference in order to exercise better control over maximum amounts of insurance carried by any individual.

We are applying this same reasoning to accidental death and dismemberment limits. Our practice in the past has been relatively restrictive. We issue only up to $25,000 for accidental death with no specific participation limit. We feel it might make a lot better sense if we issued and participated perhaps up to a limit such as $100,000.

MR. PETER M. THEXTON: At the Mutual Benefit Life our long-term disability limits for groups of over fifty lives are $1,000 a month, and our policy provides that the total amount of disability income from all sources, which includes Social Security, Workmen's Compensation, other group basis insurance and any individual policies, shall not exceed 70 per cent of monthly earnings. This is a reasonable limit considering the fact that most of this benefit is nontaxable.

Our agents report that other companies do not require integration with individual policy amounts. We feel this is a serious omission, since a man may not be aware of the exact amount of his group coverage when he goes to purchase an individual policy or he may be tempted to add on group coverage after purchasing an individual policy. Integration of group and individual policies is perfectly justified and, in fact, essential

to sound underwriting. One bad claim can distort the experience for many years, even if the volume is substantial.

MR. ROBERT E. SHALEN: I just want to give Mr. Thexton the assurance that he is not alone. At the Equitable we integrate with individual insurance by applying an over-all limit of 60 per cent of earnings.

The basic long-term disability benefit is a percentage of income, typically 50 per cent for all employees, less any Social Security benefit and further reduced if all benefits combined exceed the 60 per cent outside limit. We then apply a limit for the group which may be considerably higher than $1,000, depending on the size of the group. We will not go as far for a fifty life group as we will for a group of several thousand lives.

A recent development for us is the pooling among all groups of a large proportion of the coverage. This theoretically would permit us to give a small group the same maximum as a large group, except for the fact that a small employer might exercise antiselection if such large amounts were available.

Medical Care Coverage for Senior Citizens

A. Has enrolment under the Connecticut, Massachusetts, and New York "65" plans come up to expectations? What has been the reaction from agents? What has been the claim experience under these plans? What are the prospects for introducing such plans in other states?

B. Are changes occurring in the relative emphasis by employers on the following different ways of providing for insurance on retiring employees:
   1. Continuance under a group policy on a term basis.
   2. Continuance under a group policy by prefunding post-retirement benefits, including the use of Public Law 87-863.
   3. Purchase of individual group conversion policies.
   4. Coverage under available state "65" plans.

MR. ARTHUR G. WEAVER: A few general observations in regard to the Connecticut, Massachusetts, and New York 65 plans may be helpful for other states considering the introduction of similar plans.

1. The insurance industry has demonstrated its willingness to support state 65 plans in jurisdictions where strong local sponsorship is available. Since such plans must be self-supporting and large enough to justify the tremendous amount of work involved, a regional approach seems indicated for much of the country.

2. Agents and agent organizations have given enthusiastic support to the state plans despite only token commissions.

3. During initial enrolment periods less than 10 per cent of the eligible population signed up for state 65 coverage. Naturally, there is a certain portion of the population which already has adequate coverage, has no financial need for coverage, or is institutionalized. Nevertheless, state 65 plans must achieve higher initial enrolments. In our opinion, this can be done only by enlisting the support of employers. Several approaches are possible: (i) employer contributions towards the premium cost for retired and retiring employees; (ii) deductions from pension checks for state 65 premiums; (iii) employer sponsored franchise arrangements for state 65 coverage.

4. One interesting effect of state plans, at least in the case of Massachusetts, has been to stimulate the sale of prolonged-illness contracts by Blue Cross–Blue Shield.

5. State 65 plans have experienced abnormally high lapse rates in the early months of their operation. Intensive sales campaigns based on emotional appeal undoubtedly encouraged many to commitments beyond their financial resources. Others have dropped their coverage when they realized the implications of deductibles, coinsurance, and the pre-existing

condition limitation. In order to offset termination losses, continuous enrolment techniques have been adopted.

6. All three plans have experienced administrative difficulties in the early months of their operation. In Massachusetts these apparently stem from misunderstandings regarding the nature of the coverage involved, the cost, and an initial lack of familiarity with streamlined billing techniques. These problems are gradually being ironed out as experience is gained in handling this type of business.

7. Paid claim experience is not yet significant for Massachusetts and New York. Connecticut has reported an incurred claim loss ratio somewhat higher than expected. It is believed that premium rate structures both in Massachusetts and in New York are somewhat more conservative so that it is still expected that the programs will operate on the break-even basis over a two-year period.

8. There is considerable interest in a number of other states in offering state 65 plans. For example, Maine, Vermont, New Hampshire, and Rhode Island have been exploring the feasibility of a regional program.

The development of state 65 plans has provided a new method for insuring retiring employees. In our opinion, large group policyholders with employees in several different states will continue to favor providing health insurance on retiring employees under existing group policies. For small and medium accounts state 65 provides a convenient way to obtain an adequate level of benefits for retiring employees without jeopardizing financial experience under active employee group policies.

To the best of my knowledge there is little interest in individual group conversion policies from the viewpoint of the policyholder, the retiring employee, or the insurance carrier. A limited number of group policyholders are prefunding post-retirement benefits by the accumulation of deposit administration funds supplemental to the group life and A&H policy. Public Law 87-863 creates one more opportunity to continue health insurance benefits after retirement and will undoubtedly have some appeal. So far we at John Hancock have not been asked to write such a contract in accordance with its terms.

MR. DONALD D. CODY: The New York 65 plan has begun and will maintain until the next open period an interim enrolment campaign aimed at individuals who have become eligible since the plan was put into effect. The campaign will be publicized through employer associations. Also, the member companies of the New York 65 plan have been urged to bring this campaign to the attention of their group policyholders.

The number of people enrolling for major medical coverage during the original campaign was less than expected. Consequently, in this interim enrolment campaign and in future campaigns we expect to underline to a greater extent the importance of the major medical coverage.

MR. WILLIAM S. THOMAS: We are impressed with the continuing great interest that employers are showing with respect to continuance of medical care benefits (with or without modifications) under the group policy after retirement or by permitting conversion to an individual policy on retirement.

Over 80 per cent of the employees and adult dependents covered under Metropolitan group medical care plans are covered under plans which provide for medical care insurance after retirement. Of this 80 per cent, 70 per cent are eligible for coverage on a group basis and 10 per cent for conversion to an individual policy in place of continuation. Just two years ago, the combined proportion was approximately 75 per cent. One significant change in recent years has been an increase in the percentage eligible for coverage on a group basis and a lowering of the percentage eligible for conversion in lieu thereof. All these figures are for Metropolitan administered plans and exclude accepted reinsurance.

Continuation of benefits directly under the group plans has many advantages as compared with the conversion mechanism. It has great flexibility. Benefits may be designed to fit the particular health needs of the retiring employees. The arrangement can be changed from time to time to reflect modifications in (1) benefit levels, (2) cost of medical care, or (3) pattern of medical services and treatment. Continuation under group also costs less because of the inherent savings of the group mechanism.

Then, too, employer participation in the cost is possible. Under many group plans, either no contribution is required of the employee following retirement or the active employee contribution rate is continued, with the employer contributing enough to meet the remainder of the cost. Usually, spouses and dependent children are covered as well as retirees.

The conversion privilege is being made available under many plans. In this way, the retiring employee is afforded protection even though the employer is not yet ready to consider continuance.

The Metropolitan has offered the group conversion privilege quite freely. At the end of 1962, we had in force almost 46,000 converted policies, which is surprising, taking into account the relatively poor persistency because of the temporary nature of the coverage, especially at ages under 60. There are 13,700 converted policies in force on persons over 65,

or approximately 30 per cent of the total. Of the $4.2 million of premium on converted business, approximately $1.5 million was on account of persons over age 65.

The coverage under the available state 65 plans is another method of providing for continuation of coverage for an employer who does not want to enter into a continuance arrangement or to provide for conversion privilege. In our opinion, this method ranks third in priority. The best solution is continuance under a group policy, and the next most satisfactory arrangement is the privilege of converting to an individual policy. With respect to those major medical plans available under the state 65 plans they can, of course, be used to supplement basic group benefits being continued under a group policy or through conversion. There is less need even for this under many of our group policies, since we made available an individual converted policy providing comprehensive benefits, including coverage for room-and-board charges up to $25 per day.

There has been considerable interest with respect to prefunding postretirement health benefits, but, to date, only a relatively small number of employers have adopted any prefunding arrangement. This is due to a number of factors, including priority being placed on prefunding of pensions and of group life insurance continued after retirement. In addition, the current discussions with respect to hospital care at a federal level has resulted in increased interest in continuance but, at the same time, has diminished or depressed the employer's interest in some prefunding arrangements.

MR. MILTON A. ELLIS: I think the record should show that at least three companies, by way of mass enrolment programs of their own, have provided medical coverage for a significant portion of the high age market, which action was urged as early as 1959 by the Health Insurance Association of America.

In regard to state 65 plans, I think it is highly important that considerable care be taken to encourage state legislative action only in those states where there are companies willing to implement a law. Situations such as the unimplemented law in Mississippi should be avoided. For some states, regional plans may provide a practical alternative, and there is considerable interest in a western 65 plan for California, Nevada, New Mexico, Oregon, and Washington.

Special Group Insurance Arrangements

A. What are the latest developments in the use of special group insurance arrangements which take into consideration the benefits expected to be paid under an employer's noninsured plan? How do these arrangements differ from previous cost plus-stop loss approaches? What are the advantages and disadvantages of this type of coverage?

B. What are the prospects for imminent NAIC or state action in this area, and what course might this action be likely to take?

MR. RAYMOND G. PEARSON: The latest development seems to be essentially a method of insuring the total cost of the group plan rather than provision of all individual benefits. The policyholder is liable for any claims up to a specific level during any one policy year, while losses beyond this level become the obligation of the insurance company. The premium, which thus covers only excess claims, is only a small percentage of the conventional premium, resulting in a big premium-tax advantage. For a very large policy, the bulk of expenses may be accounted for by the premium tax, so that this new approach reduces this expense to a much smaller amount.

I think the danger here is that smaller policyholders will push for the same approach, without giving enough thought to the disadvantages. Under a smaller policy, the premium-tax saving is less important, and any noninsured approach has significant disadvantages. The consistent third-party administration provided by the insurance company is lost, as well as the specialized knowledge and services of the company.

Expansion of this new method would reduce state premium taxes. As long as the tax advantage exists, there will be a tendency toward this stop-loss approach. This would be best averted by at least reducing the difference in tax between insured, prepayment, and noninsured plans, already approved by the NAIC.

Personally, I would suggest a premium tax schedule graded by size of group policy, or a flat percentage of the first x dollars as a reasonably equitable solution.

MR. MILTON A. ELLIS: The NAIC resolution stresses not only tax discrimination but also regulatory discrimination. Bills to implement the tax discrimination have been introduced in Massachusetts, New York, and Missouri. In Massachusetts, the bill would exempt employee benefit

plans from all taxation, and in Missouri and New York the bills would reduce the tax base by permitting claims to be deducted from the premium. Proposals are also under consideration in California.

In all these efforts, the goal is to remove discrimination by reducing the tax on insured plans—a difficult thing to do in these days of need for increased state revenues. It is also complicated by the regulation angle in the first three states. The statement in favor of the bill in Massachusetts by the insurance commissioner included reference to the need of regulation to protect the public as well as the need for ending discriminatory premium taxes.

Persistency of Hospital-Medical Coverage

A. What has been the experience as to the persistence of basic hospital expense policies and major medical expense policies?

B. What has been done or what can be done to improve persistency, considering such things as (i) mode of premium payment; (ii) persistency incentives in the policies; (iii) differences between first-year and renewal commissions; (iv) use of persistency raters with applications; and (v) persistency incentives to agents?

MR. W. GLENN McCORMICK: Persistency is affected by many variables, such as type of coverage, socioeconomic class, occupation, age, policy duration, and economic conditions. When trying to determine the

TABLE 1

GRADUATED FIRST POLICY YEAR PERSISTENCY—REGULAR ORDINARY LIFE

PREMIUM MODE	AGE AT ISSUE				
	20	20-29	30-39	40-49	50 and Over
Annual	95%	94%	94%	94%	95%
Semiannual	89	88	89	90	94
Quarterly	81	78	81	82	82
Monthly	71	73	83	84	86

In health insurance, persistency seems to vary between disability income, hospital expense, and major medical expense policies. Table 2 was based on issues of the second quarter of 1961 and does not have a large exposure. As a result, there are many statistical fluctuations.

effect of any of these factors, it is difficult to eliminate the effects of the other variables. Major medical expense coverage is probably sold to a more sophisticated buyer, and perhaps all its better persistency is caused by variables other than the type of coverage. In the following tables the only variables I have attempted to isolate are age at issue, mode of premium payment, and occupation.

In life insurance, first-year persistency is relatively good. Persistency of Prudential life insurance is illustrated in Table 1.

Persistency experience by age-mode cell is not as good as that shown for life insurance. In addition, the variation by age is greater on health insurance. The data for females under disability income plans are very scant, as is evident from the number of missing cells.

In Table 3 the effect of occupational class is quite evident, the better classes having superior persistency.

TABLE 2

First Policy Year Persistency

Male					Premium Mode	Female				
Under 20	20–29	30–39	40–49	50 and Over		Under 20	20–29	30–39	40–49	50 and Over
Major Medical Expense Policies										
79%	81%	81%	84%	92%	Annual	92%	88%	84%	94%	98%
80	74	73	80	93	Semiannual	*	75	73	92	80
72	58	70	75	77	Quarterly	77	60	76	83	83
80	62	76	85	91	Monthly	74	58	70	83	93
Hospital and Surgical Expense Policies										
89%	94%	90%	84%	86%	Annual	75%	47%	75%	87%	91%
92	89	89	84	80	Semiannual	58	45	52	79	87
71	63	66	71	78	Quarterly	64	56	68	75	82
70	60	61	70	79	Monthly	65	60	71	79	84
Disability Income Policies										
*	70%	83%	85%	87%	Annual	Not issued	*	*	53%	50%
*	63	69	78	73	Semiannual	Not issued	*	*	*	*
62	55	69	75	75	Quarterly	Not issued	48	74	93	*
40	57	73	75	81	Monthly	Not issued	68	65	85	*

* Less than 10 exposed.

TABLE 3

First Policy Year Persistency
Disability Income—Male

Premium Mode	Occupational Classification			
	Hazardous	Blue Collar	White Collar	Best Class
Annual	79%	80%	82%	85%
Semiannual	50	66	72	87
Quarterly	52	65	70	74
Monthly	62	69	70	76

Studies of our in-force data at the end of five policy years show that only about one-third of our hospital and surgical expense policies remain in force. Major medical tends to be considerably better and is very close to disability income where one-half the policies are in force.

MR. THOMAS H. KIRKPATRICK: Our experience at Paul Revere Life shows that renewal lapse rates on individual hospital business are about 175 per cent of those for loss-of-time policies. First-year lapse rates are practically identical. We see a public attitude that these hospital policies can be bought and dropped, depending on the current market offerings.

With regard to Question B, we have a first-year persistency bonus for both agents and general agents, applying to both individual loss-of-time and hospital policies. This helps to improve first-year lapse rates, but its influence rapidly dissipates, and we doubt if it has any effect after about the fifth policy year.

In general, our experience indicates that high renewal lapse rates are inherent in this business, and there is not a great deal that can be done about it.

MR. STANLEY L. OLDS: As to Question A, the most recent figures we have at State Mutual indicate that first-year lapse rates for hospital were running close to 40 per cent and corresponding major medical first-year lapse rates were somewhat above 20 per cent. The second-year termination rates were approximately 22 per cent for hospital and 15 per cent for major medical.

The hospital premiums payable annually were 23 per cent of total hospital premiums, while 54 per cent of all major medical premiums were on the annual basis. Regular monthly payment basis (excluding automatic check plan) was 25 per cent for hospital and only 7 per cent for major medical. Taking all our business for each mode of premium payment, the aggregate annual lapse rate for monthly payment was 29 per cent and only 8 per cent for annual payment.

Of the hospital premium, 72 per cent was in the annual income classification for under $10,000. Only 43 per cent of the major medical business was in that classification.

These figures, along with actual observations of business as it flows through the underwriters, indicate to us that the major medical business fills a permanent need as stable superimposed, high-limit medical care coverage for an above-average income group. On the other hand, basic hospital and surgical coverage is too often sold to fill between-job gaps in group coverage. It is also a coverage sold most easily by young, new

agents, many of whom fall by the wayside, dragging their business down with them. Furthermore, hospital business seems to be most susceptible to competitive pressures, even if it was apparently bought as a noncancellable, guaranteed renewable, permanent type coverage. The frequent changes in one's basic needs as well as the ability to pay also adds to the relative instability of this type of coverage.

MR. JOSEPH M. DICKLER: With regard to Topic B, we at Metropolitan have been particularly concerned as to the effects of poor persistency on the financial experience of policies with maternity benefits. Since maternity benefit claim costs decrease with duration, good persistency is paramount in overcoming the negative reserves resulting from level maternity premiums.

As of January 1, 1961, we changed the maternity benefit in our continued protection policies, which had the poorest persistency among our policies. Previously, the maternity benefits had been the usual room-and-board and hospital special services benefit, with an amount allowed for the obstetrician. This was changed to a lump-sum maternity benefit equal to ten times the room-and-board amount during the first two policy years, and fifteen times the room-and-board amount thereafter. We also added a waiver of premium benefit if a husband becomes disabled, and we improved the benefits after age 65, which are paid-up by the terms of the policy. It is still too early to tell whether the higher maternity benefit in the third and later years and the other benefit changes will result in better persistency, but the data thus far indicate that there has been some deterrent effect on families who had been purchasing these policies for a short-term gain.

We have also made efforts to improve the persistency of our policies generally through a realignment of our commission scale. Prior to January 1, 1960, we had provided, for other than monthly premium policies, a 35 per cent first-year commission rate on hospital and surgical policies, followed by 20, 15, and 10 per cent in the second, third, and fourth policy years, respectively. In the fifth and later policy years a 5 per cent commission was paid.

As of January 1, 1960, this scale was changed to put more emphasis on renewals. We reduced the first-year commission to 25 per cent. The second-year commission was left at 20 per cent, but the third- and fourth-year commissions were increased to 20 and 15 per cent, respectively. The fifth-year commission was raised to 15 per cent, and the sixth- through tenth-year commissions were increased to 10 per cent. While we are unable to demonstrate a startling improvement in persistency, we are cer-

tain that we have reduced the deficits due to first- and second-year lapses of the younger families. Our persistency throughout has been quite satisfactory for lives aged 45 and over at issue.

As far as persistency incentives to agents are concerned, we have been offering, for some years, special yearly payments to our agency managers and assistants largely based upon the ratio of the agency's early lapse rate to the company average. Such payments are calculated as a percentage of the second, third, and fourth policy year premiums collected in the agency. They seem to have had little effect on persistency.

MR. GEORGE B. TROTTA: While the persistency of Metropolitan's personal medical expense business can generally be characterized as poor in relation to ordinary life insurance, it has been observed that certain factors such as type of policy, age at issue, and mode of premium payment exert an influence which can effect marked differences in persistency.

In illustration of the above, the following extract from our annual persistency study is shown below. In order to demonstrate the most recent three full policy years of experience, the 1959 year of issue is exhibited. For brevity, only results of the "Quarterly" mode for family policies have been used. To indicate the statistical significance of the results, the number of policies originally issued is shown in parentheses.

Where policies were issued at "ages 65 and over," the persistency at

PERSISTENCY OF FAMILY MEDICAL EXPENSE POLICIES
ISSUES OF 1959—QUARTERLY MODE
OF PREMIUM PAYMENT

At End of Policy Year	Expressed as Percentage of Policies Originally Issued				
	Standard		Continued Protection	Comprehensive	Major Medical
	Age at Issue				
	Under 65 (6,580)	65 and Over (662)	Under 55 (8,320)	Under 55 (5,856)	Under 55 (1,079)
1	80%	87%	82%	82%	81%
2	60	78	60	63	63
3	48	70	48	52	53

Note: The Standard and Continued Protection forms provide basic "in-hospital" benefits; the Comprehensive ($50 deductible) and Major Medical ($500 deductible) forms provide "in-and-out-of hospital" benefits. Only the Standard policy was issued at ages "above 65" in 1959.

the end of three years is approximately 20 per cent greater than that for "ages under 65"; this pattern holds for both individual and family policies. The above table includes terminations by death. Since such terminations would weight most heavily in the older ages, a rate of persistency based solely on controllable lapses would show the older ages in an even more favorable light than now exhibited. In mid-1961, we introduced our senior citizens' policy which was designed exclusively for "ages 65 and over." The early duration persistency results of this policy indicate that it will develop the same type of superior persistency that characterizes the "over 65" group of our previous issues.

Generally speaking, the monthly mode of premium payment exhibits a poorer persistency than the comparable figures noted in the table above, while the semiannual and annual modes exhibit more favorable percentages. The poorer monthly persistency is especially evident in those plans providing maternity benefits.

For all modes combined, the major medical policy at "ages under 55" has significantly better experience than the other policy forms.

In a recent analysis concerning the effect which the maternity benefit has upon the accumulated surplus of our family policies, it was apparent in the persistency rates that the antiselection exerted by maternity "shoppers" is rather severe. A distinct improvement in persistency is noticed with increasing age at issue; for ages 40 and above, the persistency was nearly twice that for ages less than 30. In 1962 we introduced a basic in-hospital plan with a $50 deductible which does not provide a maternity benefit. At this time we have no significant results so far as persistency is concerned, but we anticipate that it will develop a more favorable persistency than other basic plans which contain the maternity benefit.

It should be recognized that the replacement problem that seems to plague health insurance more or less reflects the active state of evolution of this facet of the insurance industry. The continual changes and improvements often cause policyholders to change carriers. Another force which would tend to cause lapses of personal health business is the extension in scope of medical expense coverage provided by group policyholders. Whereas few insured would consider lapsing their personal life insurance as a result of securing group life coverage with their new employer, the same is not true for personal health policyholders.