GROUP LIFE AND HEALTH INSURANCE

Medical Coverage

A. Does the growing use by hospitals of "progressive patient care," providing progression through three levels of care—intensive care (with high personnel-patient ratios), intermediate care (normal present hospital services), and convalescent care (ambulatory hospital wing or nursing-home care under the supervision of the hospitals)—indicate a need for changes in hospital policy design? What information is available upon which to base premium evaluation of such changes?

B. The geographical pattern of claim costs under comprehensive major medical, as indicated by group-writing company manuals as well as the 1960 Tabulars presented at the New York meeting, appears to differ materially from the pattern for basic hospital-surgical, as shown in recent reports of the Committee on Experience under Group Health Insurance. Are such differences to be expected? How can the differences be reconciled?

C. What administrative problems have developed from the use of the carry-over provision under calendar-year deductible comprehensive or supplementary major medical plans? What difference in claim levels could be anticipated between a plan which included such a provision and one which did not? What proportion of such cases does not include a carry-over provision? Has employee dissatisfaction developed on them?

MR. WALTER S. DEWAR: The Public Health Service of the United States Department of Health, Education, and Welfare has taken the lead on "progressive patient care." It has made some grants to some of the pioneering hospitals. It defines such care as "better patient care through organization of hospital services around the medical and nursing needs of the patient." Actually, five levels of care are advocated: intensive, intermediate, self, long-term, and home.

Let me comment briefly on each as defined by the Public Health Service with comments on the actual operation at the Methodist Hospital in Houston, Texas.

1. *Intensive care* concentrates critically ill patients regardless of diagnosis, sex, or economic status. Facilities are tailored to the special needs of the critically ill patient by providing constant nursing care and having life-saving drugs and equipment immediately available. The Methodist Hospital has about thirty-two beds in the intensive care unit, which accommodates both medical and surgical patients. About 60 per cent of the patients are cardiovascular. Charges are $50 per day in lieu of the normal room-and-board charge, and drugs are charged separately.

2. *Intermediate care* concentrates in a typical nursing unit those patients requiring a moderate amount of nursing care not of an emergency nature who are ambulatory for short periods and are beginning to co-ordinate their own care. Most patients are discharged from this unit. The Methodist Hospital charges from a minimum of $12 for a bed in a four-bed ward to a maximum of $28 for a private room, with the average private room costing about $22.
3. *Self-care* concentrates ambulatory patients requiring diagnostic or convalescent care in hotel-type accommodations. It provides an opportunity for patient teaching, adjustment, and transition to hospital or home environment. Methodist abandoned this unit because of the need for beds for acute cases.
4. *Long-term care* concentrates patients requiring skills and hospital services not available in the home. Rehabilitation and physical-therapy facilities are the features of this unit.
5. *Home care* extends hospital services into the home to assist the physician in the care of his patients.

On claims involving intensive care, my company's practice is to deduct the amount of the maximum room benefit from the intensive-care charge and to allow the balance as a hospital miscellaneous benefit. On claims involving charges for self-care, the experience of the Methodist Hospital was that more than one-half of the companies would not pay for these charges.

The growing use by hospitals of "progressive patient care" does indicate a need for changes in hospital policy design. As it is now necessary for a hospital to have a recovery room to be accredited, in the future it may be necessary to have an intensive-care unit.

For those wishing further information, a bibliography of all published studies on "progressive patient care" and a list of hospitals providing such care are available upon request from the Public Health Service, Division of Hospital and Medical Facilities, Washington 25, D.C. Also, a guidebook is being prepared, entitled "Elements of Progressive Patient Care."

MR. JOHN C. ARCHIBALD: "Progressive patient care," being a rather recent development, is used in its various stages only by relatively few hospitals concentrated in the metropolitan areas. Such care should also include home nursing care in which nurses from the hospital staff make calls on the patient in his home on some regular basis during the patient's convalescent period.

The "progressive patient care" approach should provide better care per dollar of expenditure, although it may not result in over-all savings in medical expense. Therefore, as this approach becomes more common, it seems to us our products should be designed to recognize its existence.

While we have experimented with nursing-home care, our main concern is to find a satisfactory method of recognizing only the intensive care units and their charges. An intensive care unit provides many and varied services. The length of time a patient stays in a unit varies widely according to the patient's condition. The patient has no choice whether he is put in the unit or when he is discharged from it.

In a study of a small sample of claims we found the average stay was four and one-half days but the length varied from one to fourteen days. Charges in the Midwest were on a flat daily rate which averages almost double that for semi-private accommodations. In some hospitals the charge may be on an hourly basis, *e.g.*, in one it was $2 per hour. In a Los Angeles hospital charges were $75 per day, which is well over twice the semi-private rate.

We are considering adding a special intensive-care benefit to our base hospital policy. This benefit would provide an additional allowance for each day the patient is in an intensive care unit, subject to some maximum number of days. The extra allowance will probably be a function of the room-and-board limit in the base policy.

MR. DEAN E. WILLIAMS: My company includes a provision covering intensive-care accommodations as a standard feature in our comprehensive major medical policies. The language used to describe it is as follows:

> Intensive care accommodation means an accommodation exclusively reserved for critically and seriously ill patients requiring constant audio-visual observation as prescribed by the attending doctor which provides room and board, specialized R.N. and other nursing care, and special equipment or supplies immediately available on a standby basis segregated from the rest of the hospital's facilities.

It has been an excellent sales feature, and no known problems have arisen.

MR. LARRY T. STEELE: I believe at least for certain areas selected at random, namely, Los Angeles, New York City, Chicago, St. Louis, and North Carolina, the results of the intercompany basic hospital-surgical plan study by area are not inconsistent with those of the major medical plan study. I reached this conclusion as follows: (1) Ratios of actual to tabular claims adjusted by national average for hospital and surgical separately for each area were obtained from the intercompany studies. (2) Corresponding ratios of average charges to national average charges were determined. (3) The 1960 Tabular major medical area factors were consistent with the product of (1) and (2) after weighting the hospital ratios by one-half and the surgical ratios by one-fifth. (Major medical charges consist of about one-half hospital charges and one-fifth surgical charges.)

MR. CHARLES E. FARR: Our standard calendar or policy year deductible comprehensive policies include the carry-over provision. We have encountered very few misunderstandings on the part of policyholders or insureds about the operation of this provision.

One administrative problem we have is the proper coding of claims affected by the provision. A new claim file is established at the start of each year. If the carry-over provision is to apply to a claim, it is necessary for the new file to include the appropriate information. A special code was assigned to such claims in an attempt to measure the financial effect of the provision and obtain a basis for claim reserves.

To date we have been unsuccessful in accurately handling this coding. As a result, we have no accurate measure of the financial effect. However, we have developed a price averaging a little over 2 per cent of premium by using some arbitrary assumptions.

We have excluded the provision on two or three cases at the request of the policyholder upon renewal rerating. Presumably, this request came as a part of a redesign of the plan in order to minimize a renewal rate increase. So far as we can determine, there was no adverse reaction on the part of those insured when the carry-over provision was eliminated from the plan. This may be due to the fact that other plan benefits were being reduced or eliminated at the same time and those insured were willing to give up the carryover rather than to have still other restrictions put into the program.

Group-Type Insurance for Groups of Less than Ten Lives

A. What sales results have been achieved in the marketing of the less than ten life employer packages? Has there been a recognizable trend in sales volume during the past year or two? To what extent has it become necessary for group field personnel to help the ordinary salesmen in their marketing of this product?

B. How do mortality, morbidity, and expense rates compare with those found on groups involving more than, say, twenty-five lives?

C. Is evidence of insurability required for all employees enrolled in such plans? If so, what type of evidence is required and approximately what proportion of employees is turned down? To what extent is evidence required for dependents?

MR. JOSEPH M. DICKLER: The Metropolitan has been issuing life insurance, weekly indemnity insurance, hospital and surgical insurance, and comprehensive in-hospital coverages specifically designed for groups of from three to twenty-four lives since 1957. Issuances of 1960 totaled 6,626 new plans, 1961, 7,389, and 1962, 9,828. Of the 1962 total, about 1,400 were on from ten to twenty-four lives. Sales are made exclusively through regular field forces, compensated by a first-year commission followed by smaller level service commissions. Marketing is co-ordinated by a "small group sales" division in the home office. We have been very encouraged by our sales and believe there is room for further growth. We are generally satisfied with our mortality and morbidity experience on life and weekly indemnity coverages, paying dividends on these after the third policy year. As expected, expense rates are higher than for larger groups. On plans involving less than ten lives we require evidence of insurability, asking questions of employees and dependents about health history and height and weight. There are no statistics on the proportion of the employees declined for coverage, but we have some indication that evidence of insurability is the major factor in the success of our program.

MR. HARRY C. EYRE: In mid-1959 Nationwide began marketing an insurance plan for employers of from three to twenty-five lives. Generally, groups of from three to nine are issued wholesale or franchise forms and groups of from ten to twenty-five lives, group forms. All plans have a common July 1 anniversary. Initially, billings were direct to policyholders, and only full-time Nationwide agents could write the plan. Three-to-nine–life plans require a pre-existing condition exclusion for health benefits.

Life insurance benefits are provided in multiples of $1,000 with a

minimum of $2,000 per life and a 50 per cent reduction at age 65 (subsequently changed to age 70). Life insurance is required on all cases of less than ten lives. Twenty-four–hour accidental death and dismemberment is written for the same amount as the life insurance. Weekly indemnities of $21, $56, $63, or $70 per week are provided for either thirteen or twenty-six weeks. Eight plans of hospital-surgical-medical benefits are provided with room benefits from $8 to $25 and benefit duration of thirty-one or seventy days. Each plan has a specific amount of hospital extras, surgical benefits, in-hospital doctor calls and pregnancy benefits. Supplemental accident and specified disease plans are optional. The major medical plan (added in 1962) can only be attached to the 70-day hospital plan. The deductible is $100 plus base plan benefits, and co-insurance is 25 per cent. Pre-existing conditions are excluded. Rates for small groups are standard group rates, plus 25 per cent for health plans. The health loading is reduced on groups of six lives or more by 1 per cent times the number of lives to a maximum of 25 per cent. Commissions are 6 per cent flat plus, after a policy is in force three months, an additional commission of 54 per cent of the first three months' premiums.

Short health statements are required for wholesale or franchise plans, and sales response to the plan is reasonably good. Initially, underwriting was liberal, and no individual underwriting was required on groups of ten or more lives if life insurance did not exceed $10,000; but after two years the claims experience forced a rate increase on health coverages and stricter underwriting of health statements, more doctor statements and more medical reports. Outside inspections were begun for groups of ten or more lives and on all individuals applying for $10,000 or more of life insurance. Special attention was focused on all individuals over age 60. As a result, we are declining from 10 per cent to 15 per cent of the cases submitted to us. On some of the smaller cases we may offer coverage with one or more lives excluded, but cases of ten or more lives require acceptance or rejection in total unless we can suggest an alternate plan to reduce the anti-selection. With this additional underwriting, our claims experience improved as much as 10 per cent of premiums on three-to-nine–life groups and about 30 per cent of premiums in groups of ten or more lives. The primary purpose in tightening underwriting rules was to remove early claims. Naturally, our recent growth has been at a slower rate, and new premium is modest. We currently have in force about 900 cases in the three-to-nine–life category with an annual premium of approximately $1,000,000, an average number of lives of five to six, and an incurred loss ratio of about 55 per cent of paid premiums. There

are about 600 groups of from ten to twenty-five lives with an annual premium of approximately $1,100,000, an average of from twelve to thirteen lives, and an incurred loss ratio of about 65 per cent. Initially, lapses were 2 to 2½ per cent of the in-force cases per month. To combat this, we now send a copy of the billing statement to the agent so that he can help conserve the business.

The small sale is not necessarily an easy one, particularly when there is no immediate claim pending. Many partners or proprietors view the cost as a deduction from their own income, since a minimum employer contribution of at least 25 per cent of the premium is required. We do not feel that the expenses incurred in training the agents have been out of line. We believe our plan is as generous as can be offered, and we are currently keeping our claim rate under control.

MR. GORDON J. MUNRO: I am a little astonished at the enthusiasm which everybody seems to have for groups of less than ten lives. Persistency is bad. Expenses are horrendous. Experience can be ghastly. I think that a company must have a small-group product, but I really do not know how it can be lived with. It is something in the nature of a difficult and expensive transition between the use of individual policies and of true group policies. Here at Mutual of New York we have found that a large part of the expense savings we anticipated by not allowing our group men to assist the agent were offset by the resultant inefficiencies. I would be glad to know if anyone here holds similarly heretical views, which, incidentally, are my own and should not be attributed to my company.

MR. HARRY L. SUTTON, JR.: One of the problems at the Prudential is the persistency of this type of business. Our North Central home office just about held its own on lives in force in 1962.

The Prudential underwriting is a combination of individual and group type. On groups of less than ten lives or for amounts of life insurance over $10,000, regardless of case size, we have a certain number of health questions, including height and weight, on both the employee and wife but not on the children. We seldom get medical examinations unless there are serious histories or unless individuals of older ages are involved. We use a fair number of inspection reports; this has been increasing, particularly in the Middle West, where our average group under twenty-five lives is about four and one-half lives. We write groups of three lives or over, and there are a lot of plans involving two partners and their wives or two partners and one wife. The inspection is made to justify the inclusion of the wives in the group as active employees. We also ask

our agents to review the employment records. In general, our case rejection rate is low, perhaps 2 per cent. We do not rate lives but we do apply waivers for individual health history. Physician statements are obtained on about 10 per cent of the lives. We use a debit system of underwriting, and an individual with a given debit might be includable at standard rates in a seven-life group but might require a waiver, reduction in amount, or rejection of coverage in a three-life group.

Long-Term Disability

A. What have been the forces creating the current rise in interest in long-term disability coverages? How successful have companies been in meeting this demand?

B. What methods are being used to meet the underwriting problems involved in integration of long-term disability plans with workmen's compensation, social security, other salary continuance plans, group term life insurance providing an instalment disability benefit, and employee pensions? What underwriting rules have been developed to deal with the differentiation between various income levels, between male and female, and between white- and blue-collar occupations?

C. What special policy provisions, underwriting criteria, or contingency reserve bases are desirable to protect the insurer from anti-selection arising from early retirement of covered employees?

D. What are the actuarial bases underlying the gross premiums now being used for long-term disability coverages?

E. What are the bases and methods in use for determining rating credits, dividends, and claim reserves under these plans?

MR. CHANDLER L. McKELVEY: In the Minnesota Mutual we believe that the forces creating a current demand for long-term disability are three in number. First, the other areas of insured employee benefits are largely used up. This is the only major fringe benefit not widely in force. Second, many firms now have the funds to buy this rather expensive benefit. Third, wide choice of carriers is now available. Most casualty and life companies offer or are thinking of offering this product, with resultant increase in discussion of the product and its availability.

There is one very important fact that distinguishes long-term disability from other group coverages. As currently issued, this is basically an entirely pooled product because of the low claim frequency and high amount of risk. Therefore, the insurance company stands virtually the entire risk in contrast to the more typical group situation where present-day retention practices have the employer assuming most of the risk. The basic protection available to insurers is care in the selection of groups, particularly when smaller groups are being considered. Also, substantial protection may be obtained by the definition of disability as inability to perform the duties of any occupation after two years of disability related to the individual's own occupation. Another source of protection is to include a nonduplication provision with regard to any retirement benefits, not just disability benefits, payable under employee or governmental retirement plans.

MR. C. GILBERT NOREN: The group insurance market seems to be able to cope with only one major new product at a time. Group life in-

surance was followed by weekly income, then hospital, surgical, and minor medical coverages, and then by major medical. Each required about a decade to establish itself. With the market ready for a new coverage, with twenty-five years of prosperity, and with the retirement of many of the people acquainted with the disability income troubles of the 1930's, the advent of long-term disability is a natural. The loss of income from prolonged disability is the last major risk uninsured by group.

One of the underwriting problems in designing a program of long-term disability benefits is to ensure a proper level of aggregate disability income; *i.e.*, to avoid overinsurance. Unless a real incentive to return to work is built into a program, it will be a failure; but the task is not an easy one. The underwriter is confronted by opposition from insurance commissioners, employers, and the insured employees. Benefit reductions are always unpopular, and the possibility of offering illusory benefits makes the problem even more serious. The potential effect of integration on any plan must be carefully analyzed in light of the contribution scheme, even to the point of insisting that long-term disability be non-contributory for the lowest salary levels.

There are two methods currently being used to integrate long-term disability benefits with income from outside sources. The first is the direct-reduction approach used by many casualty companies, where scheduled benefits are reduced by each dollar of income from specified outside sources. The second is the aggregate-limit approach used by the Prudential and many life companies, under which the scheduled benefits are not reduced until a specified level of total disability income, usually higher than the benefit level, is exceeded. Under either of these the outside sources of income involved normally include social security disability benefits, salary continuance plans, workmen's compensation awards, instalment disability benefits included under group life plans, pension disability benefits, and early retirement benefits.

There has been little trouble or opposition to integration of long-term disability benefits with social security disability benefits. Objections do arise on attempts to integrate with social security pension benefits available at age 62 to claimants not qualifying for social security disability benefits. However, integration with such benefits is a valid underwriting requirement. Also, integration should be with the full family social security benefit except for the occasional case where a low benefit formula and high salary make it appropriate to integrate with only the primary social security benefit. In fact, integration with social security can be eliminated completely for plans with modest benefit formulas on highly paid executives. At the time of claim the Prudential writes the claimant to inquire about the status of his social security claim and requires a

copy of his notice of award or rejection. If the employee has not applied or refuses to send in his notice, we state that our benefits will be reduced unless we receive such notice. Where social security claims are pending we pay the full long-term disability benefit with the understanding that we will recover any overpayment if the social security claim is approved.

No great problem arises from integration with salary continuance plans, since it is normal to establish the long-term disability elimination period equal to the duration of salary continuance. Workmen's compensation awards also present no problems and are included in the integration when twenty-four-hour long-term disability coverage is provided. Problems involved with lump-sum settlements, however, can only be handled on a case-by-case basis.

Prudential field men have been instructed to make every effort to remove existing instalment disability provisions from group life plans when long-term disability is added. To my knowledge, they have never been successful in doing this. The underwriter cannot ignore instalment disability benefits. If integration is with benefits actually claimed and received, there can be no credit in the rates, since the employees will not claim the instalment disability benefit if the long-term disability benefit is thereby reduced. If the underwriter integrates with benefits for which the employee is eligible (unless the employee can demonstrate he was rejected for the instalment disability benefit) the appropriate rate credit may be given, but the employee is forced to dissipate his group insurance at the expense of his long-term disability benefit. Neither approach is meaningful if the instalment disability benefit includes the option of lump-sum or short-duration payout. A third approach is to use a smaller long-term disability benefit and not integrate with the instalment benefit at all. None of the alternatives is appealing.

Income from employee pension disability or employee retirement benefits can be substantial and must be considered. Appropriate rate credit can be a very involved calculation, and a contribution scheme varying by duration of service is theoretically required. To add to the dilemma, certain states are considering adopting regulations restricting integration with any form of pension benefit.

The typical Prudential long-term disability plan has a 50 per cent benefit formula with benefits to age 65 for both sickness and accident. An aggregate income limit of 60 per cent allows the receipt of certain other disability income. Where lower-paid employees are eligible, we strongly recommend that all employees earning less than $5,000 per year, or at least all female employees earning less than $5,000 per year, be restricted to a five-year maximum benefit duration. This approach

not only saves the employer some premium dollars but makes disability somewhat less attractive to the lower-paid employees. Where a large case qualifies for a high maximum monthly benefit, it becomes important to scale the aggregate income limit down as salary increases. A 60 per cent plan can be very generous for the higher-paid executive, considering our steep progressive income tax. A 60 per cent plan could be so modified as to provide 60 per cent of the first $1,500 of monthly earnings, 50 per cent of the next $1,500, and 40 per cent of the excess. On the other hand, the underwriter can allow a higher percentage of net income to the executive than he can to the rank-and-file employee on the assumption that the executive has a closer tie to his position and will not be as anxious to present a claim if he can possibly get to work.

In order to reduce the temptation to claim disability for an employee who is beginning to slow down and who is ready to retire early, a number of steps can be taken. First, we integrate with early or disability pension benefits, and second, we have built loadings into our rate structure in anticipation of some selection. Net rates were loaded 25 per cent at ages 55–59 and 50 per cent at ages 60–64. Third, we pool a portion of the claim experience on most cases. If disability occurs prior to age 50, we charge the case only with the first two years of benefits. If disability occurs after age 55, we charge the case with the first five years of benefits. The duration is graded between ages 50 and 55. By this device we give the policyholder a greater interest in his experience from claims arising during the early retirement years. Fourth, rigorous claim administration is a must; approval under an employer's disability pension benefit should not sway the decision. Approval under social security disability, however, is more difficult for the claim man to ignore. Fifth, it is helpful to weed out at issue the potential early retirement claims as well as other early claims. On many of our cases we use an objective test of insurability which requires an employee to answer the following questions in the negative to become insured without a full medical examination. (1) Did you receive any hospital or other institutional care or treatment during the last three months? (2) Were you absent from active full-time work on account of disability for more than three days during the last three months? (3) Did you receive medical services to the extent of $50 or more during the last three months? (4) Have you within the last five years had an application for life or health insurance declined or postponed or had a policy rated up, waivered, or issued for a smaller amount than applied for? Sixth, for certain specified occupations such as pilots and other operators of common carriers, we can eliminate the "his occupation" test of disability which usually runs for the first year or two and require

the "any occupation for which reasonably fitted" test of disability right from the start. This avoids the claim arising from slightly impaired eyesight, for instance, that prevents the employee from flying or driving but is not disabling in the usual sense. Seventh, we will not write a long-term disability policy without the right of unilateral cancellation with sixty days' notice (there are state variations). If we find an employer is using the plan to ease out unproductive employees, we will cancel.

As a rate basis, we are using a table derived from Prudential individual income protection experience modified at the longer durations by some earlier disability income experience, adopting the fourth-year select figures for group purposes. The table is actually a continuing study that is adjusted periodically to reflect emerging individual income protection experience. The group rates derived therefrom exhibit a steep age slope due to the loadings over age 55 described above. The current low loss ratio being produced by these rates permits building up reserves for contingencies but cannot be considered a basis for further rate reductions. A small increase in the frequency of long-term disability claims could very quickly exhaust the reserves established. Dividends are a very important factor in meeting the stiff casualty company competition in this product. The nature of the coverage, however, is such that full claim credibility cannot be given to any but the very large cases. The compromise solution of partial pooling, mentioned above, is analogous to the group life practice of pooling amounts in excess of some basic table of limits. Because of the requirement that substantial reserves be accumulated from each case, the possibility of a dividend is quite remote for the first few years—especially for the smaller cases. The substantial reserve requirements are not so much a protection against anti-selection but are necessary due to the large financial moment of slight fluctuations in experience.

Long-term disability, although simple in concept, is a fascinating coverage. The underwriter must be daring and cautious at the same time. He must be an economic forecaster and a market analyst. He must have the full support of his sales department both in the turndown of the borderline risk and in the difficult decision to cancel an in-force account. And, above all, he must know more about the case he is underwriting than he need know to write any other coverage in his group insurance portfolio.

MR. SIMONE MATTEODO, JR.: At the Equitable we have seen long-term disability plans integrated with all sorts of other income benefits

for which rate credit should be given. We have experimented with a great many different ways of evaluating the credits. As a general rule, we find that working with the group as a whole produces results which are apt to vary quite considerably with the degree of judgment of the person evaluating groups. For that reason we decided to strive for a life-by-life evaluation of all the other sources of disability income benefits. Our present thinking is that for each individual entering into a rate calculation we will calculate his gross long-term disability benefit, his eligible weekly indemnity disability or salary continuance benefit, accrued pension benefit, etc. We even attempt to work out expected pension benefits when such amounts are not available to us. We have an electronic data-processing system devised, but it is a temporary one, and we are working on a set of specifications for a more refined system.

MR. WILLIAM A. HALVORSON: After listening to the pricing and experience rating problems presented here, I wonder if there is not a real need for some sort of deposit-administration–type funding for long-term disability benefits. This would shift to the employer the risk of the rate of disability and the risk of the level of benefits. The insurance company would retain only the risk of duration of disability. This would solve a great many of the pricing and experience rating problems, and the plan would be familiar with employers who have been using some kind of deposit administration funding for their pension plans.

Miscellaneous

A. What differentiation is to be found in the mortality of persons insured under the various types of creditor insurance such as small loans, consumer finance, charge accounts, sales finance, home improvements, mortgage loans, etc.?
B. 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?
C. What legal, tax, and policy-design problems are involved in the use of group term to provide a widow's pension benefit?
D. To what extent are group pension coverages being combined for dividends or experience rating with group term life or health programs insuring the same policyholder? What are the advantages and disadvantages of such a combination?

MR. COLEMAN BLOOMFIELD: We have found that the elements which seem to control the experience under creditor insurance are far more subjective than in other types of group life insurance. Specifically, it is often important to develop a financial interest by the lending institution in maintaining a favorable mortality experience. The creditor must understand the effects of anti-selection, since through its control he can be assured of a financial interest to be reflected through a modest dividend or the continuation of a favorable premium rate. In the small loan creditor field the possibility of extreme anti-selection makes it imperative to provide for effective installation and continuing service by a group representative or servicing agent or broker. Much control rests with the lending institution, and the effectiveness of the control depends in great measure on the adequacy of the servicing job performed by the field man. At the Minnesota Mutual we conducted a study separating our experience into those cases which we thought had and had not been effectively installed and serviced. The difference in the claim rates was significant—under the first class being $.44 per month, and under the second class, $.67.

Our experience in the credit union field based on approximately 400,000 life years of experience indicates mortality experience of approximately 100 per cent of the 1950–58 group mortality experience table. This experience combines the results of insurance covering deposits and loans.

MR. DANIEL W. PETTENGILL: We were all deeply concerned last year about the tremendous loss of premium which seemed to be implied in the use of special group insurance arrangements taking into consideration benefits expected to be paid under an employer's noninsured plan,

as well as the very real possibility that this increased the threat of complete self-insurance. Let us examine this situation from a particular jumbo policyholder's point of view, using as our example an Aetna policyholder. (1) This policyholder had a large, capable legal department quite familiar with insurance contracts. (2) The policyholder had an insurance department of some 250 clerks with many years' experience in processing claims on the draft-book basis. (3) The policyholder employed an actuary. (4) The policyholder had been self-insured for workmen's compensation. (5) He carried large deductibles for fire and liability coverage. (6) He was under extreme pressure from a profit standpoint. In spite of all these factors, the policyholder was reluctant to self-insure his health benefits program.

The Caterpillar Tractor type of plan has a real appeal to such an employer. In this connection, the following points should be noted:

1. The Caterpillar-type plan is insurance because the insurance company is liable for the payment of the benefits described in the policy. The insurance company holds full-claim reserves for incurred but unreported and outstanding claims, and since the contract is one of insurance, it comes under the supervision of the state insurance department, and the public interest is protected.
2. The insurance company continues to provide all the services which were provided before the change, and it charges essentially the same retention, except that the charge for premium tax is computed only on that part of the premium retained for reserve additions and expenses, since benefit payments made by the policyholder are not considered to be premiums. This means that the case makes exactly the same contribution to surplus as it did before the change.
3. The plan gives evidence that large employers do not want to rush to self-insurance, since the insurance image is important to them.

Regardless of our feelings about the Caterpillar-type plan, our present task is to determine what we can do to keep our business and to combat self-insurance without resorting to compromise solutions which must be the characterization of the Caterpillar plan. Clearly, the first thing to do is to equip ourselves to take back the functions we have forced upon our policyholders. Modern high-speed computers will allow us to do record keeping and billing at a very reasonable price. For simple plans, computers can assist in the claim settlement. For complex plans and for all questionable claims, however, we must develop an expert staff of claim adjusters. Admittedly, this is an expensive process, but once accomplished and a reasonable volume of business underwritten, we can then offer a necessary service at a lower cost, inclusive of premium taxes, than most employers would incur were they to self-insure.

MR. SIMONE MATTEODO, JR.: In the past few years, we have seen efforts to reduce the insurer's retention and make the total operation more efficient through the performance by the policyholder of premium accounting, enrolling new employees, and paying claims. In addition, a large volume of business has had the effect of minimizing unit expenses. In large cases, premium taxes, although averaging only about 2 per cent of premiums, may approximate 40 per cent of the insurance company's entire retention. All these developments have had the effect of focusing current attention on the premium tax cost of group insurance operations. In an effort to solve this problem several companies have agreed upon plans where the policyholder pays claims on an amount up to the expected claims and the insurance company pays the excess. Under this type of plan, premiums and taxes are substantially reduced but not entirely eliminated. The plan, however, has not gained wide acceptance, and some state insurance departments seem reluctant to approve any more such plans. Any widespread flight from insured plans will deny the insured public the protection of the state insurance departments. We believe that only permanent solution to the problem is to put insurance plans on an equal footing with self-insured plans, by either reducing taxes substantially on insured plans or by taxing self-insured plans the same as insured plans.

MR. CHARLES E. FARR: Group life insurance was not specifically designed to solve the need for widows' pensions and cannot provide as acceptable a solution as a directly designed widows' annuity benefit. Annual changes in amounts of life insurance coverage and contributions are troublesome. Where a definite amount of group life insurance coverage has been provided, it might prove difficult to stop paying a pension to a widow who remarries. Statutory limits on group life insurance may limit the amount of widow's pension to be provided, and the alternative choice of a lump sum benefit or the right to change the beneficiary may defeat the widows' pension idea. A conversion privilege for a very large amount of insurance is required. An insurance premium tax is payable, and the group life proceeds will be taxable through estate tax, which although not necessarily worse than the income-tax treatment of a widow's annuity, is nevertheless not subject to prediction by the employee.

At the Bankers Life, we have neither encouraged nor discouraged the combination for dividend purposes of group pension coverages with group term life and/or health programs insuring the same policyholder. From the customer's point of view, combination for dividend purposes may mean lower expense and risk-sharing charges. It may also tend to stabilize group health premium rates by permitting the use of stable or perhaps

increasing margins for the pension contract to offset the group health losses. Then, too, if group term life insurance is being used to provide a death benefit under the pension plan, the customer may consider the pension and insurance as parts of the whole. There are additional considerations from the insurer's point of view. Combination can prevent the declaration of a dividend under one policy while in a loss position on the other and may tend to bind a customer closer to the insurer.

On the other hand, combination may involve administrative problems resulting from different timing of the dividend calculations, or separate locations or control of the two groups performing the dividend calculations. The combination may result in higher cash contributions to the pension plan being required, because its dividends are absorbed by the group health contract. This could conceivably be questioned by the Internal Revenue Service.

MR. JAMES P. SMITH: In the field of life and health insurance coverages issued by the same carrier, I think most employers are rather unsophisticated and do not really realize what the combination of benefits for experience rating means. On the other hand, when you get into pension plans, I think employers are somewhat wiser and feel that when experience is kept separate they will come out better in the long run. I think that the combination of life and health coverages with pension coverages is a good idea, but I rather doubt that any real benefit is to be derived from it, since under the threat of making a change in carrier, the combination of life and health benefits with pension benefits for experience rating purposes is totally unenforceable.