Overinsurance and Duplication of Coverage—Hospital and Medical Expense Limits

What policy provisions are in current use to restrict or reduce benefits because of overinsurance? Do they determine overinsurance as measured against: (1) Each item of medical expense? (2) Total medical expense covered by the policy involved? (3) Total medical expense reduced by a deductible and coinsurance? (4) Total medical expense? What is the status of proposals discussed with the NAIC?

MR. WILLIAM J. BERRY: In the Metropolitan we are using for some of our major medical and comprehensive medical expense plans a provision which operates to reduce the amount payable under our policy in cases where total amounts payable under all policies would otherwise exceed total medical expenses incurred. The reduced amount is equal to that proportion of total medical expense incurred which the amount otherwise payable under our policy bears to total amounts otherwise payable under all medical expense policies. This provision also calls for a premium adjustment in such cases equal to the refund of "an equitable portion of the premiums (less dividends) received" from the date of the last previous claim or from the date the excess insurance was acquired, whichever is later.

Our provision does not define the term "total medical expense," but the lack of such definition has caused no great difficulty. The problem of the determination of time limits within which expenses are to be incurred has been handled in our most popular policy containing this provision by using the policy year as a benefit period.

This provision was initially used only in policies where renewal could be refused at five-year intervals, and for such policies it limited the "other valid coverage" that might produce overinsurance or duplication of benefits to insurance of which notice had not been given. In that form, the provision was approved by all states except California. However, in a guaranteed renewable policy, the limitation to coverage of which notice has not been given makes the provision useless after the first claim involving such insurance is incurred. Consequently, when policies were revised, we attempted to base reductions on all insurance, whether or not the company had been notified; but a few states would not accept the change, and in those the older form of the provision remains in use.

MR. WILLIAM A. FEENEY: In the Equitable we recently announced a new lifetime major medical expense policy which is on a 75 per cent coinsurance basis and which provides maximum amounts of $10,000, $15,000, or $20,000 per cause, depending upon income classification. We

have handled the problem of overinsurance by defining our deductible amount as the greater of a flat basic deductible amount and the amounts payable under other medical expense coverage for the type of expenses covered by our policy. We have adopted a very broad definition of "other medical expense coverage" including coverage provided for hospital, surgical, or other medical expenses by any other insurance or welfare plan or prepayment arrangement (including Blue Cross and Blue Shield plans), whether provided on an individual or family basis or on a group basis through an employer, union, or membership in an association. In the case of service-type plans, the amount of benefits under such coverage is taken as the amount which the services rendered would have cost in the absence of such coverage.

We will not issue this policy if the applicant has other major medical expense coverage. The applicant, with some limitations depending on his income classification, has a choice of basic deductible amounts, ranging from $250 to $1,000. The insured may change his basic deductible in later policy years to adjust to changes in the extent of his other coverage. At age 65 a reduction in basic deductible is permitted without evidence of insurability.

This policy is now being issued in all states except California, where it is still under discussion with the Insurance Department.

MR. ROBERT P. COATES: For a number of years several industry groups have been studying the problem of overinsurance in connection with both individual and group medical expense and disability insurance. An overinsurance committee of the Health Insurance Association of America has submitted a series of status reports to the NAIC, discussing the general nature of the problem for individual health insurance and proposing possible modifications of the Uniform Individual Accident and Sickness Policy Provisions Law. The fourth status report, submitted last June to the NAIC Accident and Health Committee and the Non-profit Hospital and Medical Service Associations Committee, included a recommended revision of the current Insurance with Other Insurers standard provision and also a revised Relation of Earnings to Insurance provision which was presented, however, subject to possible further modification in response to an industry suggestion.

An Industry Advisory Committee appointed by the NAIC has cooperated in the development of the more recent reports.

In designing the proposed revision of the Insurance with Other Insurers provision for medical expense insurance, the HIAA committee adopted the following principles:

1. The test of overinsurance should be a comparison of policy benefits with the total medical expenses which are covered in whole or in part by any one or more of the insured's policies.
2. An insurer's liability should be made definite within a reasonable time by testing for overinsurance over a specified claim determination period.
3. The provision will continue to be optional with each insurer. It will allow prorating of benefits between policies which contain the provision. However, policies which do not contain the provision will pay their benefits without regard to other insurance and policies with the provision will exclude such other benefits and pay on an excess basis.
4. The provision will not be operable until after the allowable expenses incurred during a policy year exceed the premium for that year.
5. A return of premium is not contemplated under the provision.
6. The operation of the provision should not be limited because of written notice of other coverage, as it is limited in the present law. To retain this limitation would encourage cancelation or nonrenewal of cancelable policies because of overinsurance and discourage the writing of guaranteed renewable policies.

In designing the draft of the revised Relation of Earnings to Insurance provision proposed for discussion in connection with disability income insurance, the HIAA committee adopted the following principles:

1. The provision should continue to be optional with each insurer. However, there would be an incentive to use the provision, since, if the other coverage does not contain such a provision, then the benefits payable under the policy containing the provision would become excess coverage.
2. The provision should be applicable to all types of individual loss-of-time policies, not merely noncancelable and guaranteed renewable policies as in the present law.
3. Only periods of disability in excess of 91 days would be subject to the provision. This limitation on the claims to which the provision can be applied will serve to minimize administrative problems and expense, afford the insurance company time to determine the facts concerning other insurance, and still provide protection against overinsurance in the case of lengthy disabilities where excessive benefits can be expected to encourage malingering or other claim abuse.
4. The present law uses 100 per cent of the monthly earnings of the insured as a standard for overinsurance. In view of the tax-exempt status of health insurance benefits and the substantial portion of gross earn-

ings required for taxes and other expenses incidental to employment, a more appropriate measure of income which can be replaced before overinsurance occurs would be some percentage lower than 100 per cent—perhaps 60–80 per cent.

5. Because no reduction of benefits can occur with respect to claims of less than 91 days' duration, the application of the provision will be restricted to a minimum number of claims and a return of premium as a result of operation of this provision would not be appropriate.

In connection with the proposed modification of the Insurance with Other Insurers provision, the NAIC committees asked for further statements in support of the proposed definition of overinsurance and in support of the argument that a premium refund would not be appropriate in the operation of this provision.

These matters were discussed with the NAIC Subcommittee on Overinsurance in October, 1962, in Chicago, and a further presentation will be made to the parent NAIC Committees prior to the NAIC meeting in December. At the same time it is expected that a modified Relation of Earnings to Insurance provision will be recommended for adoption.

Parallel group insurance studies have recognized the distinctive problems of the group insurance area. An overinsurance study group serving as a committee of the ALC, HIAA, and the LIAA has done a great deal of work in developing possible model provisions for use in group insurance policies.

MR. W. HAROLD BITTEL: The current study of the matter of overinsurance was originally promoted by the industry. They outlined their overinsurance problems to the commissioners, who in turn suggested that the industry appoint a committee to come up with proposals. The resulting Industry Committee submitted its proposals to the insurance commissioners in December, 1961, and in June, 1962.

Although I do not speak for the commissioners (except my own, the New Jersey commissioner), my impression of the commissioners' reaction to these proposals is that they did not show a comprehension of the problems faced by the commissioners in this area. I cannot see how any commissioner can in good conscience go along with any proposal that does not provide for any refund of premiums to a policyholder who may have purchased excess coverage, possibly not through any fault of his own, carried it for years, and then not have the coverage provided that is called for under the contract except for the prorating provision that is carried therein. The efforts made by the industry to provide additional coverage under these contracts to absorb part of the cost of premiums paid for excess

coverage do not solve this problem, since the proposed additional coverage does not seem to have much relation to the extra premium paid, and I have seen no evidence that the value of such coverage is equal to the cost of the extra premiums. As the proposal now stands, I cannot see what a commissioner could tell a policyholder who comes to him and complains about paying premiums for a long time and suddenly finds that he does not have coverage comparable to the premiums which he has paid and that the benefits he is getting are very small in relation to these premiums.

Another matter that, I think, disturbs the commissioners is that the industry has not as yet proposed any definition of overinsurance acceptable to them.

As to the industry arguments of over-all cost reductions resulting to all policyholders if the present overinsurance proposals are adopted, I do not believe that the commissioners are much impressed.

In summary, I think that the commissioners feel that this is an industry problem, caused by excess sales on the part of certain agents and certain companies within the industry. They further feel that industry should do more than it has to curb such excesses. They are not satisfied with the answer that the "good" companies cannot do anything about the "bad actors."

MR. DANIEL W. PETTENGILL: I was at the most recent meeting with the NAIC subcommittee (October, 1962). There is still, unfortunately, a wide difference between the insurance industry and the commissioners' representatives on the subject of overinsurance. For example, one commissioner has suggested that, as regards a hospital policy, no overinsurance exists until an individual has been reimbursed for not only all his hospital bills but all his doctor bills, nursing bills, baby-sitter bills, lost income, *ad nauseum*.

The commissioners' insistence on a strict return of premium perplexes me. The present law says that we have to return the excess of the premium over the benefits paid. The HIAA proposed provision states that benefits will not be reduced below an amount equal to the premium. Now, if I pay a reduced benefit that is at least equal to the premium, why have I not in reality returned the premium even though I do not express it that way?

Obviously, the industry and the commissioners are still far apart, and much more work remains to be done. On the other hand, I am sure that the commissioners are trying to understand our problem and that we are making progress.

Proposals along lines suggested by the HIAA are essential to a further development of guaranteed renewable medical expense coverage. There is

no way under antitrust laws that the industry can choke off the fly-by-night companies, and the only way to protect the public is a workable antiduplication clause for use with guaranteed renewable business. The present clause is completely unworkable in view of the fact that a company can only exercise it as to coverage of which it had no notice. This means that a claimant could notify the company of all his other coverages five minutes before he goes to a hospital, and the company would be forced to pay the full claim without any reduction.

As to the question, "How much is this going to save?" I am not looking for a reduction of normal costs. What I am looking for is an effective psychological weapon to keep people from buying double coverage and making a profit when they do get sick. This psychological value of antiduplication provisions is most important, and the claim savings are incidental.