INTRODUCTION TO SECTIONS II, III, AND IV

Several factors which influence the actual to tabular ratios for health insurance shown in this report compared to prior reports are the following: (1) the rapidly increasing use of co-ordination with other benefits provisions in basic medical plans; (2) Medicare, effective July 1, 1966, which for a large proportion of the data has resulted in a substantial reduction in claim cost for ages 65 and over with no corresponding reduction in exposure; and (3) changes in the rate of utilization of medical services for persons under age 65 following the effective date of Medicare.

In an effort to measure the first of these items, the Committee distributed a questionnaire to all companies contributing to these studies, asking for a report on the proportion of experience contributed which contains a co-ordination provision and whether or not the claims reported reflect the savings arising from this provision. The replies indicated that approximately 45 per cent of the exposure submitted to the Hospital and Surgical studies is under plans which contain the co-ordination provision, while about 90 per cent of the exposure submitted to the Supplementary Major Medical and Comprehensive Medical studies is under plans with such a provision. None of the tabulars are adjusted for co-ordination with other benefits (COB), since the amount of duplicate coverage, if any, is not known.

The companies contributing to this study do not follow a uniform practice with respect to whether or not co-ordination savings are reflected in claims reported. Approximately 15 per cent of the basic Hospital and Surgical exposure, 65 per cent of the Comprehensive Medical exposure, and 50 per cent of the Supplementary Major Medical exposure are under plans where the savings due to the application of the co-ordination provision have been reflected in the claims reported. The remaining exposure is with respect to plans without a co-ordination provision, or plans where co-ordination savings are not reflected in the claims reported.

With respect to item 2 above, company practices vary with respect to how exposure and claims are reported for periods July 1, 1966, and later. Some companies continue to report exposure and claims for employees and dependents aged 65 and over, but claims reflect the lower benefits payable as a supplement to Medicare. For such cases, all tabulars remain unchanged, and actual to tabular ratios will decrease with respect to the 65-and-over population.

Some companies have excluded both exposures and claims ages 65 and over for periods July 1, 1966, and later. The basic Hospital and Surgical tabular values per unit of exposure are not age-adjusted, and the actual to tabular ratios should decrease to reflect the lower claims cost per unit of exposure to be expected on account of the removal of the 65-and-over lives. On the other hand, the Supplementary Major Medical and Comprehensive Medical tabulars are age-adjusted, and, therefore, ratios of actual to tabular values should not be affected significantly for the experience contributed by these companies.

With respect to item 3 above, there is evidence that the hospital-utilization rates for those over age 65 have increased substantially since Medicare went into effect in July 1, 1966, while the utilization of hospital facilities for those under age 65 appears to have declined modestly.

The effect of these various influences on experience presented by the Committee in its health insurance studies should be considered in interpreting the results presented in this report. While the general direction of change for each of these items can be determined, it is not possible to measure the net impact of these influences.