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WHERE HAVE ALL THE EARNINGS GONE?

by George L. Hogeman

The effect of changing from statutory to GAAP accounting is to reallocate from one year to another the earnings which a particular block of business generates. A change in accounting cannot affect the inherent earning power of such a block, other than to the extent that a portion of the earnings is consumed by the accounting process itself. An objective of a good accounting system is to report earnings correctly in total and to allocate them correctly among the years.

The AICPA guide for stock life insurance companies specifies that a company changing from statutory to GAAP accounting must restate its earnings of many prior years. This results in the reallocation to prior years of what would have been earnings in future years. These transferred earnings were not in fact reported to stockholders in these prior years, since the insurer was then using statutory accounting; neither will they be reported in future years, since all blocks have been changed over to the GAAP basis. Thus, the stockholders and the investing public have not had and will not have these transferred earnings reported to them. Therefore, the long-term earning power of the insurer is substantially under-reported.

A hypothetical example will illustrate the principle. A block of current issues is assumed to generate earnings over ten years. The value at issue of the earnings of this current block is 46, whether the accounting method be statutory or GAAP. The table shows each set of earnings year by year, the excess of statutory over GAAP year by year, and the remaining excess at the start of each policy year.

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FAT CATS MEOW!

A survey of 15,000 *executives showed that fat executives received less pay . . . and are less likely to advance as quickly as lean persons.*

New York Times

by Milton J. Goldberg

At the invitation of the Editor of *The Actuary*, I welcome the opportunity to discuss this New York Times report. The Editor evidently envisions this response as a natural sequel to my 1940 Discussion of the Paper, "Relations Between the Average Amount of Insurance per Policy and the Height and the Weight of the Insured" (RAIA XXIX).

At the very outset, one must challenge the premise itself, because: (1) the fat executive statistics are round figures, and (2) the fat executive obviously carries more weight than the lean executive and, therefore, is entitled to the greater pay because of the added dimension he gives to his work.

It is conceivable, of course, that in the case of the fat executive—as compared with the lean executive—the fat head allows relatively little room for the brain, causing him to be narrow-minded. On the other hand, there can be little doubt that the fat executive operates on a broader base, whereas the thin executive — being more incisive — immediately comes to the point. A fat judge, for example, by sitting too long on a particular case, is well-equipped to suppress the evidence contained in the big briefs enveloping him. Irrespective of the specific case involved, the end is always in sight.

It may be that the fat executive—not unlike Uncle Sam in this respect—is in poor fiscal shape due to lack of sufficient excise.

As a result of Women's Lib, more and more females are applying for executive

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MEDICARE COST ESTIMATES AND EXPERIENCE

by Robert J. Myers

Note: Mr. Myers recently appeared before a Congressional Committee Panel on Medical Care Costs and the Impact of Health Insurance thereon and discussed the Medicare Cost Estimates and the resulting experience. As Chief Actuary of the Social Security Administration until 1970, *Mr. Myers had the responsibility for preparing the actuarial cost estimates for the various proposals for Medicare and for the Medicare program after it was established. We are glad to publish his comments to the Panel.*

Medicare Cost Estimates and the Resulting Experience

In the many years during which the proposals that are now the Medicare program were under consideration, great controversy centered around the question of what the cost of the hospital benefits would be. Such costs, for purposes of simplicity, can be said to be constituted by only two elements: (1) the average daily cost of hospitalization (including room-and-board charges and all other hospital services, such as operating room, drugs, x-rays, and laboratory tests), and (2) the hospital utilization rate (days of hospitalization during a year, averaged out over all insured persons).

First, consider the average utilization rate. This element is, to some extent, an over-simplification, since proper actuarial analysis requires consideration by age and sex. The medical economists who, in the early 1950's, had primary responsibility for the development of the cost assumptions believed that the utilization rate would be only about 2 to 2½ days per capita per year. I studied the relatively sparse data then available for persons aged 65 and over and, after making

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allowance for increased utilization when insurance benefits would be available for the entire population in this age group, arrived at a result of about 3.15 days, or some 40% higher.

My actuarial colleagues in the insurance business believed that my figure was too low and instead suggested a level of about 3½ days, or 10% higher. The actual experience when Medicare went into operation was well above even this level. After the initial period, when the rate was somewhat lower than later, the experience seemed to level off at about 4 days per year, although recently there has apparently been some small decline from this level. Thus, the actual experience was almost double the original assumptions by the government medical economists, some 25% above my 1964-65 assumptions, and almost 15% higher than the actuaries of the insurance business assumed.

Why did this occur? First, it may be noted that the resulting experience was by no means as adverse as some critics had predicted. A utilization rate as high 7 days per capita per year was mentioned, derived from the experience in Veterans Administration hospitals and in an agricultural province of Canada. Still others predicted that hospitals would be overwhelmed by the rush of aged patients on July 1, 1966 when the program began. This did not occur.

In brief, I am convinced that no amount of research can ever satisfactorily answer this question. The causes of hospitalization and the factors affecting it are so uncertain and variable as to make valid conclusions in this area impossible. The situation is entirely different from analyzing and predicting costs for life insurance and pension plans, where mortality rates are the controlling element, and these are much less subject to variation by outside factors.

Now, turning to the average daily cost of hospitalization, the cost estimating problems are even greater. The medical economists, in the more stable days of the 1950's, had made no allowance for this factor, not even recognizing the higher differential rate of increase of pital costs as compared with general ces and wages in the recent past. The actuarial cost estimates made in 1964-65 assumed that, for the next few years, hospital costs would rise at the same rate (7% per year) as they had in recent years. Needless to say, the actual rates of increase in 1966 and subsequently, which were about double the immediately preceding experience, produced disastrous results as far as the cost estimates were concerned, due to the compounding effect of the increases.

Did Medicare Cause Utilization to Increase?

There is no question that the existence of the Medicare program, with its hospital benefits on an insurance basis with only nominal cost-sharing by the beneficiary, was responsible for the increase in hospital utilization by the population aged 65 and over. Was this result desirable or undesirable?

This, too, is a question that is really impossible to answer. On the one hand, the higher utilization may have been due to previous underutilization of services, because of financial barriers, either real or set by individual preference to spend the money on more pleasurable things. On the other hand, the increase may have been due to overutilization. Or, more likely, there was some of both present, although the mix is uncertain.

And who can say what is underutilization and overutilization? Not only are these relative terms, but it is impossible to be precise about these concepts. If we say that the care furnished to the President of the United States is the highest quality of medical care, is it economically feasible to similarly treat every citizen? Should hospitalization be furnished or extended for periods when hospitalization is much more convenient for the patient and his family, although, with effort and some expense to them, care could be provided at home? The foregoing question is particularly relevant and affected by the situation when insurance with little or no cost-sharing is present.

This brings us to the matter of the effect of cost-sharing on medical care costs when insurance is involved. There are few, if any, valid and conclusive studies on this subject, and I am convinced that it is really almost impossible to make them, due to the many variable and nebulous factors involved. I am equally convinced that cost-sharing provisions, properly designed, can have a beneficial effect in preventing overutilization, without being an unjust economic barrier that will result in preventing the insureds from receiving necessary medical care.

Did Medicare Cause Hospital Costs to Rise?

Some critics of the Medicare program have asserted that it was entirely responsible for the great increases in health care costs that have occurred since 1965. This is patently *not* the case. The general price and wage inflation resulting from the Viet Nam War, plus the more rapid wage increases of hospital personnel to legal minimum wage standards, plus the historical trend of medical care costs rising more rapidly than the general price level, have been the real culprits.

Actually, there has been no health-care-costs crisis, as the proponents of national health insurance have so loudly and frequently asserted. If, in 1964, I had been omniscient about what would happen about the general price and wage level, I could have accurately predicted the trend of medical care costs after 1965.

Medicare could, to a small extent, have contributed to the rise in health care costs that has occurred since 1965. But in balance, I believe, its effects were in the opposite direction, especially as to hospital costs. For one thing, it largely eliminated the bad-debt problem for hospitals. Perhaps even more importantly, Medicare should have produced lower hospital costs by increasing the occupancy ratio (note the paralellism, from a cost standpoint, with the transportation industry).

The real factors involved in the increase in hospital costs since 1965 have been the general inflation that has occurred and the effect of federal legislation to raise the wages of the lowest-income workers (which, I believe was desirable, and even long overdue). It is true, however, that the almost full cost reimbursement under Medicare may have resulted in hospitals being somewhat indifferent to holding down costs of all kinds and even to striving for efficiency of operation.

Effect of National Health Insurance on Health Care Costs

Finally, what would the effect of a true National Health Insurance program, such as that proposed by Senator Kennedy, be on health care costs and on the quality of health care made available

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COMMITTEE CHAIRMEN: FEBRUARY 1974

We are glad to provide an up-to-date list of Chairmen of Committees in advance of publication of the Year Book.

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RECENT SOCIAL SECURITY CHANGES

by Francisco Bayo

The Social Security changes that were passed by the Congress before the Christmas recess were signed into law (P.L. 93-233) on Dec. 31, 1973. These new changes were principally intended to advance the payment of part of the automatic benefit increase that would have been payable according to the provisions enacted in 1972. The most important changes are as follows:

(1) OASDI monthly benefits are increased by 11% effective for June 1974, first to be reflected in the July 3, 1974 checks. A temporary increase in benefits of 7% will be payable for the 3-month period March to May 1974. These increases replace the 5.9% increase for June 1974 that was included in P.L. 93-66 enacted last summer.

(2) The automatic benefit adjustment provisions were modified. The first possible increase in benefits would be effective for June 1975 and would be based on the increase in the Consumer's Price Index from the second quarter in 1974 to the first quarter in 1975. Automatic increases in subsequent years would also be effective for the month of June and would be based on changes in the CPI from first quarter to first quarter.

(3) The taxable earnings base was increased to $13,200 for 1974 and will be automatically adjusted thereafter. The first automatic increase will be effective in 1975 based on the increase in wages between 1973 and 1974.

(4) The tax schedule was revised so that the total OASDHI rate would remain as in previous law through calendar year 1980. Thereafter, the scheduled total rate was increased by either 0.15% or 0.20% of taxable payroll for employer and employee, each.

(5) The level of payment under the Supplemental Security Income program was increased to $140 from $130 per month for an individual and to $210 from $195 per month for a couple, effective for January 1974. These amounts will be further increased to $146 and $219 effective for July, 1974. □

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to the citizens of this nation? When the insurer—whether it be the Federal Government or a Health Maintenance Organization (i.e. a group practice prepayment plan) — has the power and responsibility of both financing and provi[illegible] (or controlling the providing of) medical care, the situation is completely different than when these functions are separated.

The cost of health benefits under such a situation is no longer actuarially determinable, or even remotely so. Such cost can really be almost whatever the insurer or provider decides that they should be. Supply can be tailored to meet — or, more properly, reduce — the demand, so as to stay within the cost confines. Whether or not this is desirable, or whether any humans have the ability to so decide, is debatable—in my view, not likely to be the case. There are some limits to such a situation—the providers of service might rebel if the financial screws on them are tightened too rapidly or too much, or the beneficiaries might rebel if they are regimented or controlled too much as to their desires for medical services. □