SOCIETY OF ACTUARIES

Article from:

The Actuary

September 1980– Volume 14, No. 7

The Actuary

The Newsletter of the Society of Actuaries

VOLUME 14, No. 7 SEPTEMBER, 1980

TESTS OF A BUSINESS LIFE INSURANCE PROPOSAL

by Ellis D. Flinn

In this era of high interest rates, business life insurance funded by individual level-premium life policies has become popular, even to the point of undertaking to compete with group insurance plans.

It is easy and tempting to do what amounts to conjuring with facts and figures so as to show what good value these individual policy plans offer. But a proposal that fails to take all relevant points accurately into account may end up by conveying the false impression that the insurance doesn't cost anything.

We are seeing ordinary life insurance recommended for funding all sorts of benefit programs. It fills the role of chicken soup; it seems to be the answer, regardless of the question.

Uses of Business Life Insurance Frequently Encountered

Industrial firms often feel that in these days of high taxes and high cost of living, they want to do more to help their key executives meet their financial obligations. Amid substantial competition for good executives, companies are trying to find an edge over their competitors. Hence companies have turned to the use of ordinary life insurance, one of whose merits is that it can be used in selected situations, steering clear of the restrictions placed on group insurance and on tax-qualified benefits.

Companies purchase ordinary life insurance on their executives to supplement existing life, disability and retirement programs and to help solve estate tax problems. The cost of these supplemental benefits can be kept low by providing them to only a select number of, rather than to all, employees. Amounts

(*Continued on page 6*)

SPREADING WORD ON CAREER OPPORTUNITIES

by Linda M. Delgadillo, Communications Manager

Some readers may not know of the employment listing service the Society operates for its members. For a $5 fee, a member can subscribe to an Employment Career Bulletin that lists current actuarial opportunities. The subscription list is confidential; only the Society office has access to it. A subscription runs for six months and is renewable each January and July.

The service works thus: Companies that have job openings for actuaries list these positions in the Bulletin through the Society office. To do so, a company sends us a Position Listing Form for each opening. This form gives the employer's name and address; who is to receive enquiries about the position; a job description; to whom the employee would report; education and experience requirements; and salary range. A $75 fee is charged for each job description we accept.

Whenever a new job listing arrives, we send the Career Bulletin to all subscribers. It is then up to the subscriber, if interested, to write, phone or visit the employer.

Employers may like to know that for $75 they reach up to 200 actuaries who are interested enough to have paid their fee within the last six months. And subscribers are likely to receive about one listing a month for their $5. We believe that if more employers and actuaries can know about this service, such as through this article, both those circulations will grow. If you want to subscribe, send the $5 fee along with your name, your address (which may differ from that used for Society mailings), and date you wish the service to start to: Society of Actuaries, Box 91901, Chicago, IL 60693. □

HEALTH MAINTENANCE ORGANIZATIONS

by John G. Turner and Michael J. Peninger

John K. Kittredge's review of *HMO's and the Politics of Health System Reform* (May issue) comments that readers will "have to turn to other sources" to learn about Health Maintenance Organizations (HMO's). This article undertakes to describe, in a limited way, HMO's and the progress they are making.

The concept of prepaid medical care in the U.S.A. is not new. Several groups, notably the Kaiser-Permanente plans in California have been operating for many years. For the most part, though, the HMO movement is still in its first decade.

What Is An HMO?

HMO's are organized delivery systems of comprehensive health care services (hospital and outpatient) to a voluntarily enrolled population in return for a fixed prepayment from each member. Traditional health insurance by contrast reimburses for a portion of expenses of treating sickness or injury as the policy specifies.

Because HMO's are at risk for services provided, they must emphasize efficient management and tight controls on use of services. Also they encourage minor treatments, traditionally given in the hospital, to be performed on a less expensive outpatient basis.

A typical subscription rate might be $35 to $45 per month for single coverage and $95 to $125 monthly for family coverage, a substantial portion of this being paid by the employer as for conventional health insurance. Individual

(*Continued on page 4*)

Letters

(Continued from page 3)

acquisition expense faster than called for in (3). Therefore its adjusted premium for all future durations should be reduced because not all the portion for that amortization is needed. Once the cash value equals the net premium reserve, no more premium to amortize acquisition expense should be allowed.

My quarrel is with point (3). Surely the net premium reserve based on 1958 CSO mortality and 4% (or 5½%) interest less the unamortized portion of the acquisition expense allowance prescribed by a crude formula (with no allowance for maintenance expense, withdrawals or contribution to surplus) cannot closely approximate the asset share at all durations for all plans of all companies.

The actuary should have the freedom, and the responsibility, to establish cash values that resemble real asset shares. In my experience, minimum values during the first t policy years, grading to the reserve at duration n, have worked well, yet the Report dismisses this approach on the grounds (p. 36 of the Report) that it would not comply with the proposed segmentation methodology.

Let's not mess up the cash values; let's scrap the proposal.

David H. Raymond

* * * *

One (So Far) vs. Seventeen

Sir:

How many other actuaries, you ask (May issue), have broadcast on radio or television? As an actuary, I've been on TV three times, and on radio more often.

James L. Clare

RECRUITABLE STUDENTS

To help companies recruit for their actuarial student programs, the Society office prepares a booklet listing particulars of students who have just passed Part 1, 2, or 3, *and* who are using residential or academic mailing addresses. A copy is sent to all employers of actuaries in Canada and the U.S.A., usually addressed to the Chief Actuary by name. If you want a copy, ask said office.

HMO's

(Continued from page 1)

enrollment, if permitted at all, usually requires evidence of insurability.

HMO's are of three major forms:

(1) The Individual Practice Association (IPA) or "open panel" HMO which enrolls many doctors who treat subscribers in their own private offices along with their other patients.

(2) The group practice or "closed panel" HMO in which a group of physicians, generally primary care physicians and specialists, form a corporation that contracts to provide HMO services.

(3) The staff model, another form of closed panel HMO, in which the physicians are salaried employees of the HMO.

IPA's can reduce costs if their managements exert adequate controls. An IPA physician submits to the HMO his regular bill, but rather than paying him the full amount, the HMO generally reimburses a percentage, usually 80%, of the average charge by all the IPA physicians for that service. At the year-end, if the HMO has a surplus after paying overhead expenses, it is distributed to the physicians. Thus they have financial incentives to refrain from giving unnecessary services.

IPA's often institute a hospital review program as a further means of cost control. Typically, the physician notifies the HMO before he admits a non-emergency patient to the hospital; the HMO then monitors the patient's progress in an effort to keep the stay no longer than average for that illness.

Closed panel HMO's have generally controlled costs more successfully than IPA's. They have the advantage of attracting younger, healthier enrollees, because older people are often reluctant to break long established physician ties to join the closed panel HMO. Closed panel HMO's operating in well equipped clinics can perform more outpatient services than IPA physicians who must rely on hospitals for routine testing. Also, most administrative functions are handled by the HMO, freeing the physician's time for other pursuits; this alone may save 15% of normal charges. In addition, the above-described hospital review programs may be used in closed panel HMO's.

Has The Movement Been Successful

A study[2] has shown total medical-care costs lower for HMO enrollees than for people with conventional health insurance. Savings were due mainly to a lower hospital admission rate—there was no evidence that HMO enrollees had shorter stays. Federal statistics up to September 1979 showed the following comparison of hospital utilization rates per 1,000 members per year:

General Population	1,099 days
Blue Cross Subscribers	729
All HMO's	467
IPA's	531
Closed Panel HMO's	458

Physician and other outpatient visits, though, tended to be higher, at least among IPA members, than among conventional insured groups. But this was more than offset by decreased hospital use.

The most disappointing aspect of HMO's has been their relatively moderate growth in number of subscribers. Proponents had predicted a dramatic increase in the numbers and sizes of HMO's during the decade of the 1970's In 1973 before passage of the HMO Act discussed in John Kittredge's article, there were 132 HMO's in the U.S.A. with 3.6 million enrollees. Forecasts for the early 1980's ranged as high as 1,700 HMO's with 40 million subscribers; yet in April 1980 there were only 230 HMO's (110 of them qualified) with 9 million enrollees, and another 123 under development free of any government involvement.

Besides the unattractiveness of government incentives, reasons for the slow growth are: (i) lack of experienced managers, (ii) patient reluctance to switch doctors and, in the case of closed panel HMO's, to visit physicians only at a prescribed location, and (iii) the low concern for cost containment by people whose medical bills are largely paid by insurance.

Seven of 117 federally qualified HMO's have failed; four went completely out of business and three merged with other HMO's. Defaulted loans to these seven have cost the government over $12 million. Another 15 qualified HMO's are

[2] "How Do Health Maintenance Organizations Achieve Their 'Savings'?" Harold S. Luft, *New England Journal of Medicine*, June 15, 1978.

(Continued on page 5)

[redacted]O's

(Continued from page 4)

now in non-compliance with qualification regulations.

Where Do HMO's Go From Here?

It is generally agreed that HMO growth will continue, but whether the 15% annual growth rate of the last five years can continue in the 1980's will be determined by several factors.

Most important is their success in delivering high quality care at a reasonable cost. They must demonstrate effectiveness in the care rendered to their own subscribers and in their impact on health care in general. Some regard the claimed HMO economies as nothing more than a shifting of costs from them to other health care users.

HMO managers are faced with price/quality/profit decisions very similar to those of any competitive business. Margins are thin; the market is price-sensi[redacted]. Sound management practices—plan[redacted]ng, organizing, controlling—are essential. Through the painful lessons of bankruptcies, the need for strong management in an increasingly competitive marketplace has been shown; hence, growth will be constrained by the limited availability of managers with the required credentials.

The federal government role, as Mr. Kittredge has said, is likely to slow HMO growth despite exactly the opposite objective. Misapplications of capital will result in formation of HMO's that are not economically justified. An example is the power of federally qualified HMO's, not efficient enough to compete on their own, to require employers to permit employee solicitation, thus removing incentive for potentially effective organizations to be formed. Growth is likely to slow unless the federal government removes competitive limitations within the HMO industry.

A fourth factor is the developing sur[redacted]s of physicians in many areas. This is likely to accelerate expansion of prepaid health care as physicians compete for new patients.

Another factor that will spur HMO growth is the increasing sophistication among large employers in health care matters, stemming in part from dramatic increases in employee health costs. More of these employers are likely to offer their employees the HMO alternative.

The form most likely to develop rapidly is the IPA. It requires less capital and has less impact on physicians. But its success will depend on whether physicians can alter historical patterns of patient care.

New HMO's will spring from existing multi-specialty group practices, this resulting from concern by their trade associations about competition from IPA's. This type's chance for success is good because review procedures already exist and the group practice organizations already have experienced management. These will usually not choose to qualify under the federal law.

Observers of the HMO industry are closely watching developments in the Minneapolis-St. Paul Metropolitan area. There are seven HMO's here; total enrollment has increased by over 30% per year since 1975, and now exceeds 350,000, nearly 20% of this area's population. Studies, not yet conclusive, to measure the impact of this development on total health care costs have been undertaken. HMO proponents point out that we have had a smaller increase in hospital expenditures and utilization than has the country as a whole, but others contend that this is a shift in costs and that our expenditure data are not valid.

In summary, the prospects are for slowed growth in HMO's unless the federal government alters its role, either through regulatory changes or through a national health scheme that contains realistic free market incentives. In any event, competition between HMO's and the existing system seems sure to benefit all health care users, in terms of both price and quality.

Ed. Note: The attention of interested readers is directed also to the remarks about HMO's by John Haynes Miller in his article, The Continuing Escalation In Cost Of Medical Care, *in his* Disability Newsletter, *No.* 23, *March* 1980. □

Summary of Non-Routine Business By Board and Executive Committee, Four Months To June 30

by Myles M. Gray, Secretary

At meetings of the Executive Committee on March 3-4 and May 28, and the Board of Governors on April 13, the following non-routine business was transacted:

(1) *Education and Examinations.* The Executive Committee approved (a) increases in examination fees, effective May 1981, to $30 for Parts 1-3, $35 for Part 4, and $70 for Parts 5-10, and (b) publishing the newly written pension textbook.

(2) *Research.* The position of Director of Research on the Chicago staff was created. The President is to proceed to fill that post.

(3) *Future of the Society.* Reports on possible creation of Sections within the Society were received. The Executive Committee studied long-range planning objectives, issues and procedures.

(4) *Anti-Trust Guide.* (See notice elsewhere in this issue.)

(5) *Meetings.* The Board approved a special topic 1982 spring meeting on Inflation. Publication of the proceedings of the 1980 Mortality Symposium was approved. □

Study of New Mortality Basis For Individual Annuities

The Society now has a Committee to Recommend a New Mortality Basis for Individual Annuity Valuation. This Committee is to evaluate the need for new mortality tables and projection factors, and if it finds such a need, to develop such tables or factors.

Committee members are: Robert J. Johansen (Chairman), Gayle E. Emmert, Thomas R. Huber, Harry I. Klaristenfeld, John B. Kleiman, John H. Welch, Michael Winterfield and Richard K. Wong.

Interested readers are welcome to make their thoughts and views known to any member of the Committee.