TRANSACTIONS OF SOCIETY OF ACTUARIES
1950 VOL. 2 NO. 4

DISABILITY, SICKNESS AND HOSPITALIZATION PLANS

A. What have been the growth of and improvements in Voluntary Plans?
   1. Insured plans . . . group and individual policies.
   2. Blue Cross and Blue Shield.
   3. Cooperative Medical and Hospital Associations.
B. What efforts are being made to publicize the availability of voluntary plans?
C. What problems are involved in the different approaches to coverage by the various states?
D. What federal proposals have been made?

MR. J. H. SMITH briefly recalled the entry of the insurance industry into the field of hospital, surgical and general health benefits. He pointed out that while this type of insurance directly affects the economics of hospitals and physicians, and while their activity and attitudes bear quite directly on the form and success of the insurance, liaison with hospital and medical groups was not fully effected in the beginning. Instead the companies adopted protective devices of various sorts to minimize the influence of doctors and hospitals on the cost of insurance.

He remarked that although the insurance has proved sound, and has resulted in the extension of valuable coverage to millions of people, Blue Cross and Blue Shield organizations have expanded even more rapidly. They have surpassed the insurance companies in some respects, partly because of their immediate and direct connection with the hospitals and doctors involved. It appeared obvious to Mr. Smith that the insurance venture is even more effective if it has the active cooperation and support of the people performing the service which the insurance was designed to finance.

Some four or five years ago a number of farsighted insurance people began exploring what could be done to make effective contacts on a broad scale with doctors and hospital groups. They laid the foundation of the Health Insurance Council as the instrument for carrying out these purposes. Mr. Smith listed the organizations participating in the present Council, illustrating that it is a sort of federation of the major trade associations and others dealing with Group and individual Accident and Health insurance. He remarked that the liaison resulting between insurance companies and other groups was advantageous not merely in increasing the salability of the insurance but at the same time in assisting in the rapid erection of a system of voluntary insurance, the extent and character of which may well be vital in forestalling national Health insurance

and all the evils and implications which would surround and follow it. He stressed the fact that with such a large goal the efforts of the Council must be industry-wide, establishing contacts at the national, state and community levels. He felt that the Council has worth-while functions to perform and is bound to become an organization of considerable extent and importance.

MR. J. H. MILLER stressed the rapid growth of Health and Accident insurance in recent years. He remarked that while this field was a somewhat neglected part of the insurance business in the past, its rapid expansion and the increasing interest in the economics of medical care have focused a great deal of attention on it recently. In the past four years Health and Accident premium income for United States companies has nearly doubled, with approximately half of the personal and 85 percent of the Group Health and Accident coverage written by life insurance companies.

Illustrating growth and improvements in this field, Mr. Miller referred to the increase in number of persons covered by insurance companies for Hospital Expense Benefits from about 3,000,000 ten years ago to over 30,000,000 today, the correspondingly rapid growth of Blue Cross plans, and the introduction of Surgical and Medical Expense Benefits, which have shown similar tendencies toward rapid growth. He also mentioned the experiments now being made with blanket Medical Expense Benefits, and with the reimbursement of so-called catastrophic expenses for serious illnesses, such as those caused by poliomyelitis and other specified diseases, with such coverage being granted by at least one company on a comprehensive, all-risk basis.

He cautioned companies newly entering the Health and Accident field not to look upon it as a source of large earnings nor as a panacea to all the problems of agency development and management, but he did feel that this type of insurance was a natural complement to life insurance, since both are concerned primarily with the maintenance of personal income. He hoped that increasing experimentation would take place in the development of benefits and administrative procedures.

It appeared unfortunate to Mr. Miller that so little actuarial research had been done in this field. He felt that the characteristics of the health risk were such that significant results could frequently be obtained in a short time with a relatively small exposure; the high claim frequency lends a comparatively high credibility to limited exposure in many cases, and the usual absence of any pronounced or lengthy select period makes it generally unnecessary to wait a long while for a mature experience. He pointed out that these characteristics permit experimenting without

undue hazards, provided reasonable limitations are placed on the liability assumed on individual risks.

Mr. Miller also called attention to the current survey of voluntary Health insurance being conducted by the Senate Subcommittee on Health. He outlined the scope of this inquiry into the extent, nature, problems and potentialities of voluntary Health insurance, including, in addition to the policies offered by insurance companies, coverage provided by Blue Cross, Blue Shield, cooperative medical plans, union and industrial plans, and mutual benefit associations. He remarked that the success which the companies achieve in the field of voluntary Health insurance may determine to what extent the Government undertakes compulsory Health insurance and broadens its activities in other forms of insurance and security benefits.

MR. C. A. SIEGFRIED reviewed the development of special plans for simplifying the handling of hospital admissions where insurance benefits were involved. Hospitals had become concerned with the diversity and complexity of the claim forms they were called upon to complete in connection with claims for benefits under various insurance plans, and in some cases hospitals were charging a fee for completion of these forms. Two broad types of plans have evolved to meet this problem, the Chicago Plan and the Milwaukee Plan.

Under the Chicago Plan, each participating hospital has a file of cards containing the basic features of existing Group insurance plans of employers cooperating in the arrangement. When an individual insured under such a plan applies for admission to a hospital, he reports to the admissions clerk the name of his employer. The admissions clerk refers to the card file to ascertain the amount of coverage, and will generally call the designated employer representative to ascertain that the individual is actually insured. The hospital also has available a standardized uniform claim form and assignment form. The hospital is thus in a position to give appropriate credit to the individual against any cash deposit he might otherwise be asked to make on admission to the hospital. Mr. Siegfried pointed out that these arrangements were very similar to those existing with respect to Blue Cross subscribers, although no assignment of any benefits is required under Blue Cross coverage since no cash benefits are payable to the individual.

The Chicago Plan, sponsored by the Chicago Hospital Council, is a plan of the hospitals and not of the insurance industry, although the industry, of course, cooperated in its establishment. The Hospital Council acts as the clearing house in all dealings between participating insurance companies and the participating hospitals. The participating insurance

companies pay a fee for a data card prepared on each new Group policy and reproduced for each participating hospital, this fee reimbursing the Hospital Council for the expenses it incurs. So far, these arrangements are available only to Group insurance plans and participation by an individual employer or an individual hospital is optional with each. In the Chicago area, the great majority of hospitals are participating.

Mr. Siegfried expressed the general feeling that the plan is functioning to the satisfaction of all parties concerned. He mentioned the establishment of similar plans in the Cleveland area, in New York City, and in the San Francisco-Oakland area.

He also outlined the principal features of the Milwaukee Plan. Under this plan, employers are provided with a combination information and hospital claim form, with provision for assignment. An employee may obtain a copy of this form from his employer prior to admission to a hospital. The form acts as a certification to the hospital that the individual is insured, and gives the hospital pertinent facts as to coverage. The handling thereafter is substantially identical with the Chicago Plan. The participating hospitals under this program do not maintain a file containing data on the plans of individual employers, nor do they, as a matter of routine, contact employers directly to confirm the existence of insurance, this being the function of the certificate obtained by the employee prior to admission. No centralized hospital agency is needed for the successful functioning of this plan, but it does call for some additional effort on the part of the employer and the employee. Milwaukee type plans are now functioning not only in Milwaukee but also in St. Louis, in New Jersey, in Ontario, and a plan of this type will be established in other areas in the near future.

Mr. Siegfried mentioned as an important development resulting from the introduction of these plans the use of a uniform and simplified hospital claim report form. The sponsorship of this report form by the American Hospital Association and its wide adoption by insurers has accomplished a great deal in satisfying the criticism voiced by many hospital managers concerning the cumbersomeness and diversity of forms with which they were required to deal. The use of a standard form may obviate the necessity of establishing further admission plans in some areas.

Mr. Siegfried pointed to a very desirable and helpful by-product of these developments, the bringing together of insurance and hospital representatives of different parts of the country, and the exchange of thinking on problems of current interest which has been helpful to both sides and has served to strengthen the position of voluntary prepayment plans generally.

MR. M. D. MILLER stressed the perplexing and challenging activities

of the Health Insurance Council in connection with state medical society sponsored plans designed to be underwritten by insurance companies. Such plans have been developed in Wisconsin, Rhode Island, Maine and Tennessee, and one is soon to be announced in Georgia. He remarked that doctors are becoming increasingly aware of the need for supporting voluntary insurance efforts; and that while in many localities Blue Shield type organizations, which are in effect insurance companies sponsored by doctors and often controlled by them, have been developed, there has been the feeling on the part of physicians in some areas that they should lend their support to existing insurance agencies directly. This view has been largely responsible for the development of state-wide medical society plans which may be underwritten by any admitted insurance company through Group or individual policies. Mr. Miller described the function of the Health Insurance Council, acting on behalf of the insurance industry, in working with the medical society concerned in the development of such a plan, making available to the doctors the experience and technical knowledge of the industry, and acting as a liaison with the individual companies. He pointed out that the Health Insurance Council cannot, of course, commit any company in any respect. He described the basis of such plans, the stipulated schedule of surgical and obstetrical fees in return for which the doctors are prepared to guarantee service without additional charges to insured persons whose incomes fall below the plan's income limits.

He stressed the guarantee of service benefits by the doctors as the most important aspect of state medical society sponsored plans from the standpoint of the insurance industry, meeting the criticism of insured plans voiced by some that the existence of insurance merely serves to increase the doctors' charges. He pointed out, however, that the income limits specified should be high enough to include substantially all of the wage earning population.

The participation of the Blue Cross on the same basis as insurance companies in such programs seemed essential to Mr. Miller for the success of these plans, principally because of the usual strong community interest in the Blue Cross programs, which must be turned to the support of the medical society plan if the plan is to succeed.

Mr. Miller remarked that in connection with these plans insurance companies have had to prepare special policy forms, modify existing sales and administration practices, and adapt to the attitudes of the physicians, and have incurred some increase in expenses. The difficulty of writing blanket Medical Expense insurance because of a lack of control over the amount of doctors' charges, combined with the desirability of finding a

way ultimately to write such coverage, seemed to Mr. Miller sufficient reason for continued experimentation by the companies with the state medical society plans.

MR. ALBERT PIKE, JR., confined his remarks to a review of federal proposals which have been made in connection with disability, sickness and hospitalization plans. He mentioned the principal federal health proposal, the so-called "National Health Insurance Plan" publicized by Federal Security Administrator Oscar Ewing, involving a multi-billion dollar tax-supported government system tying in with Old-Age and Survivors Insurance and other programs under the existing Social Security Act; and he referred to a proposal that a Federal cash sickness benefit plan also be made part of the Social Security program superseding existing State programs in this field. He said, however, that neither of these Federal Security Agency proposals was likely of adoption, at least in the near future, for reasons parallel to those behind the effective opposition to the Brannan agricultural subsidy plan. In spite of the sidetracking of the Ewing plan, it appeared to Mr. Pike that many members of Congress believe the compulsory Health insurance controversy has attracted public attention and that some sort of compromise Health legislation would be popular. As examples of the wide variety of compromise proposals, one of which may sooner or later become law, he described the Ives-Flanders-Javits Bill, calling for federal subsidies to cooperative health service plans, the Stassen "reinsurance" proposal, which would provide so-called reinsurance for nonprofit plan benefits exceeding $1,000 per subscriber; Senator Taft's proposal for eliminating medical indigency; and a plan by Senator Lodge to make certain medicines available free of charge to the public. All the proposals involve the spending of federal money, directly or indirectly.

He stressed the significance in this situation of the activities of the Health Insurance Council in improving the effectiveness of voluntary Health insurance and promoting its acceptance by the public. He felt that these activities should not be regarded as sales promotional, but as an institutional effort intended to make secure the right of voluntary Health insurance organizations, particularly insurance companies, to continue as a primary means of insuring against, and budgeting for, the costs of medical care. He emphasized that unless the insurance companies can convince the public that they are doing all that should be done in such matters as insuring against catastrophic risks, providing comprehensive Health benefits, and making sure that the insurance claim dollar will not be dissipated in paying excessive medical charges, the voluntary Health insurance movement is in much more danger from compromise alternatives to the Ewing plan than from the Ewing plan itself. The Health Insurance Coun-

cil is providing a basis for cooperative efforts by commercial insurance companies along these lines.

MR. E. B. WHITTAKER reviewed the existing state cash sickness laws, comparing their relative merits and defects in a general way. The original Rhode Island law was illustrative of many of the undesirable features which can appear in these plans, he said, with its state monopoly, its poor financing arrangements, its excessive maternity benefits, and the possibility of duplication of benefits. He pointed out that although some of these drawbacks have been removed, the state monopoly of the program means that no one can obtain more than the maximum benefits, since no private insurer is interested in providing additional amounts on top of the state plan. Not only does the lower average amount, with attendant higher expense rates, act as a deterrent, but the possibility of very poor public reaction, if the company's claim action did not parallel the state's in all cases, makes the insuring of these excess amounts very unattractive. He remarked on the California plan, with its contracting out privilege, and decried the use of the percentage of female coverage assumed by a private insurer as a measure of adverse selection against the state plan. He mentioned the influence of politics on the liberalization of benefits, and alluded to the difficulty of integrating private plans with the recent extension of coverage to include a twelve-day hospital benefit of $8.00 per day. In New Jersey he found political pressure to be the most serious problem, and he pointed out that the New York plan was on an entirely different basis from the others. The position of the state fund as really just another competing insurer appeared to him very desirable. He felt that the practically unlimited freedom of action granted to the administrator might create difficulties in the future, although it was not an immediate problem because of the cooperative attitude of the present administrator.

Mr. Whittaker mentioned the probability of legislative action on similar plans next year in Pennsylvania, Wisconsin and Massachusetts.

MR. MORRIS PIKE commented briefly on the importance of hospitals in our current society and in relation to voluntary Health insurance plans. He reviewed the results of the Hill-Burton hospital construction law, enacted in 1947, which has led to a program involving some 1,000 hospitals and facilities at a total cost of about $700,000,000, one-third of which is borne by the federal government. This new construction is located chiefly in the smaller towns, and most of the hospitals have less than 100 beds. Prior to this program, there were some 6,000 hospitals in the country, one-third of them operated by government organizations, state, city or Federal. He remarked that the government hospitals had two-thirds of

the total bed capacity, but that they were treating only one-third of the patients, this being due to the specialization by government hospitals in the long-term type of patient, such as the tuberculosis or mental case. The average stay for disability in a Federal hospital has been thirty days, while in nongovernment hospitals it has been ten days. Mr. Pike then illustrated the increasing importance of hospitals in the community. Three-fourths of all births now occur in hospitals and one-third of all deaths. He noted that hospitals rank among our large industries, with plants worth more than $3\frac{1}{2}$ billion and annual expenditures of $1\frac{1}{2}$ billion. Rising hospital costs have been due to increases in the cost of food and of labor. There is a trend toward the use of more and more full-time trained specialists rather than a reliance on voluntary labor performed gratis or at nominal cost. The method of financing hospitals is also changing, Mr. Pike said, with decreasing emphasis on income from endowment, bequests and gifts. Taxes, community chest collections, and payments by patients, including benefits under insurance plans, are of increasing importance.

Because of the importance of the hospital to our community life and to voluntary insurance plans, he felt that the insurance business should be especially interested in helping to maintain them in good physical and financial condition. He remarked that it has been reported that the deplorable state of the British hospital system, partly resulting from German bombing, facilitated the British Government's decision to nationalize its health services and its voluntary Health insurance plans.

MR. W. J. D. LEWIS stated that in Canada premium income under voluntary Health insurance plans has increased at least tenfold in the last decade. Insured plans have been improved by such means as adoption of simplified uniform claim forms in a scheme similar to the Milwaukee plan previously described. The introduction of government plans in the provinces of Saskatchewan in 1947 and British Columbia in 1949 has eliminated private insurers, he said, and he called attention to the unusual action by the City of Calgary in Alberta on November 1, 1950 in adopting a compulsory plan of limited extent there. He stated that federal proposals were expected eventually.

There is no industry-wide survey of insurance coverage under voluntary plans in Canada as yet, Mr. Lewis said, but one is planned, and he thought that it might well be integrated with the survey already being conducted in the United States.

MR. A. G. WEAVER referred to figures showing that today 66 million Americans are covered by Hospital Expense insurance, 41 million have Surgical Expense insurance, and 16 million have some form of Medical Expense insurance. The emergence of our present voluntary Health insur-

ance program may be measured from about 1940, with most of the growth in the last five years. He attributed this growth to recognition by the public of the major effect of serious illness upon the family budget, general acceptance of the prepayment principle, even for minor illnesses, and appreciation by employers of the advantages of Health insurance in cementing employer-employee relations.

He reviewed the part played by Group-writing life insurance companies in this development, beginning with contracts providing cash benefits in event of disablement from sickness or accident as early as 1914. Regarding the development of new coverages, he pointed out that since 1940 most Group insurance companies have extended Health insurance to include dependents, with a wide variety of Medical Expense coverages introduced in recent years, including laboratory and X-ray examination expense, supplemental accident expense, and polio expense insurance. Nursing and dental care coverages are now being experimented with by certain companies. He remarked on the liberalization of scales of benefits, with higher daily benefit for hospital room and board charges, with very high or unlimited maximums on payments for other hospital services being not uncommon, and with surgical schedules running to maximums as high as $400. He stressed the importance of some element of co-insurance in controlling unnecessary or extravagant accommodations and services. Although certain restrictions may appear desirable when a new coverage is first introduced, Mr. Weaver pointed out that Group-writing life companies have consistently endeavored to provide as broad a coverage as possible, and any restrictions imposed are eliminated at the earliest possible moment.

He referred to the reductions in gross premium rates that have accompanied the development of Health insurance. These reductions have been possible because the expanding coverage has given a more reliable statistical base for ratemaking and permitted the use of narrower margins for contingencies, and also because expenses have been reduced by streamlining administrative routines and distribution methods. Certain savings also result from the increased volume of business. He illustrated the reduction in premium rates which has taken place with figures for one large company, showing over a ten-year period a reduction in rates of from 29 percent to 45 percent for Employee Hospital Expense insurance, from 5 percent to 31 percent for Dependents Hospital Expense insurance, from 10 percent to 24 percent for Employee Surgical Expense, and from 25 percent to 36 percent for Dependents Surgical Expense. The operation of experience rating and dividend formulas also affects the cost, of course, he said.

Mr. Weaver gave estimates of the coverage of Group Health insurance in the past decade, stating that about 5 million people were covered by Group Hospital Expense insurance and about 2 million people by Group Surgical Expense insurance in United States and Canada in 1941, and that in 1949 these figures for the U.S.A. were 17 million people under Group Hospital Expense insurance, and 15 million under Group Surgical Expense insurance. He stated that in one company Group Accident and Health insurance premiums increased from $4 million in 1941 to $24 million in 1949. Although sizable segments of our population are still not covered by voluntary Health insurance, the Group-writing life companies are actively exploring ways and means to insure these groups wherever the Group principle seems feasible, and searching for improvements and extensions in coverage.

MISS E. W. WILSON remarked on the British Government's interest in mutualizing industrial insurance. She referred to the comment in a Labour Party Brochure: "There is too much competition, too many offices, too much overlapping; it is far better for the staff and the policyholders that reorganisation should be undertaken in proper fashion by a Labour Government." She stated that insurance officials fear this is merely the forerunner of the nationalization of all insurance, and that the financial difficulties of the National Health Service may be a determining factor. The National Health Service is costing three times the anticipated amount, she said, but not a hospital or hospital wing or nurses' home has been built since the socialized medicine program began in July 1948. Hospitals will cost, at present prices, £3,000 per room, and nurses' homes £1,000 per room. Insurance companies have offered to build these facilities and lease them to the government, but Miss Wilson felt that the program will nevertheless cost the National Health Service many million pounds a year, and result in additional taxes. Moreover, such payments by the government to the insurance industry appear to her as a possible additional incentive for the nationalization of insurance.