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DIGEST OF INFORMAL DISCUSSION

SICKNESS AND ACCIDENT

A. In considering the function insurance should fulfill in meeting the economic consequences of sickness and accident—
   1. What portions of the loss of income and of the expenses incurred are properly insurable?
   2. What special problems are encountered in providing suitable coverage for the following?
      a) Employees and dependents eligible under Group plans;
      b) Individuals (employed or not employed) and their dependents ineligible under Group plans;
      c) Aged persons.

B. How can companies meet the problems of overinsurance arising from duplication of coverage or from other causes?

MR. K. B. PIPER discussed the factor of coinsurance when applied to insurance against loss of income. Sound underwriting requires that the claimants bear part of the loss. Inflation has, except in the case of the service type of plan, kept benefits lagging behind costs thus maintaining an element of coinsurance. The Provident Life & Accident has experimented with hospital benefits eliminating the board and room charge for the first one, two or three days and with a deduction of $10, $15 or $25 from hospital extras. Employer reaction was favorable. It is hoped that coinsurance may reduce overutilization of hospital facilities.

MR. MORRIS PIKE referred to the statement of Mrs. Oveta Culp Hobby, Secretary of the Department of Health, Education, and Welfare, citing the need for adequate nongovernmental methods of meeting the cost of chronic illnesses and of illnesses of old age. He stated that recent insurance developments are aimed at providing a solution to these problems. New policy forms provide insurance against major medical expense and limits of reimbursement have been raised. Group coverages are being extended to cover retired employees and dependents. The sale of additional life insurance policies and annuity contracts is also needed to provide funds to meet the growing cost of chronic illnesses, among other reasons.

In some states, public aid is available to persons whose resources are adequate for normal living expenses but cannot cover their medical care. Perhaps an extension of this type of provision at the local or state level would reduce the interest of the Federal Government in this area. Govern-

ment hospitals have specialized in chronic diseases and care of the aged more than nongovernmental institutions.

He said that, in order to have a successful voluntary health care plan, (1) the hospital, medical, and surgical services must be available, (2) they must be efficient, economical, and humane, (3) the public must have a high priority for these services, and (4) there must be an effective insurance mechanism. Insurance and other prepayment plans have in the recent past brought the attention of the public to the importance of voluntary insurance of medical costs, resulting in a tremendous growth in the number of those insured. The present concentration of attention by the government on the area of chronic diseases may result in further significant developments in the field of insurance.

MR. E. A. GREEN stated that a plan of insurance has been defined to be a method of spreading over a large number of persons a possible financial loss too large to be borne conveniently by an individual. If risks were rated in order of inconvenience to the individual, the order in the field of loss of income would be, first, loss of income from total and permanent disability, followed by loss of income from long term temporary disability, and finally loss of income from short term temporary disability. In the field of medical expense the order would be, first, the so-called major medical expense, followed by hospital and surgical expense, and finally the run-of-the-mine medical expense. It appears that we have been most successful in covering the areas of the least serious losses. Many more individual persons are insured against loss of income for periods of 26 weeks or less than are insured against total and permanent disability. While major medical coverage is spreading very rapidly there are still not less than 52 persons with hospital expense insurance, 49 with surgical expense insurance and 15 with medical expense insurance for each person with major medical expense insurance.

The reason for this distribution of coverages appeared to him to be due to the nature of man himself—his economic desires and self-interest and his relations with the community. If insurance is to work soundly, there must be a community of interest between insurer and insured, in recognizing, defining and evaluating the hazard as well as in the operation of the coverage. The less serious financial losses occur most frequently and are most readily understood by a larger segment of the people. Lately the economic impact of total and permanent disability and of major medical expense has increased because of increased urbanization, smaller family units, more expensive medical techniques and greater difficulty in accumulating savings. The tendency to take care of the greatest needs through public and private charities has delayed recogni-

tion of the hazards of long term disability and major medical expense, and accounts for the lag in the development of satisfactory insurance coverages.

Benefits fully replacing loss of income and meeting expenses of care are most satisfactory to the insured but increase the claim rate and the premiums. The benefit must be less than the insured's income so as to provide an economic incentive to recovery. Determination of a proper benefit level is especially difficult in the field of total and permanent disability where changes in wage levels may make previously determined benefits too high or too low. Coinsurance of the cost of hospital and surgical insurance by the insured is desirable to discourage overutilization of services and give the patient the incentive to use the same care in spending the money of his neighbors with whom he has banded for sharing the risk as he would use in spending his own money. Current opinion among underwriters indicates that a benefit schedule covering 70% to 80% of the loss with the remainder borne by the insured gives proper balance. There is evidence that plans covering more than this portion of the loss have more than proportionately greater costs.

Small, more or less regular, losses can be budgeted against and borne by the individual. The cost of claim handling of small losses is wasteful and makes it reasonable to apply deductibles of some sort to all insurance against loss of income or expenses incurred as a result of illness. The present trend is toward the more general use of such deductibles and toward higher limits than in the past. He expressed the hope that this sound progress would not be nullified by precipitate legislative action.

MR. J. C. MAYNARD defined the ideal hazard for insurance as one in which the loss is clearly defined and entirely beyond the control of the contracting parties. A hazard which can be completely controlled by one of the parties is not suitable for insurance. Between these two extremes lie most of the hazards of accident and sickness insurance where varying degrees of control over the loss may be exercised by the insured. In order to have such risks successfully insured, the portion of the loss to be indemnified should decrease as the degree of control increases. The insured has some control over the hazard of temporary loss of income but none over the amount of the loss. Insurance should be satisfactory if limited to 75% of income after taxes. The same principles apply to insurance against the expense of accident and sickness.

MR. H. S. BEERS recalled that in the early days of accident and sickness insurance from 50% to 60% of regular wage was considered to be an adequate loss of income benefit. Now 70% is insured quite freely and this may mean 90% of take home pay after income tax. Prior to some 20

years ago, insurance of hospital and surgical expense was thought impossible, but now it is working, not perfectly, but pretty well on the average. Speaking as an actuary, it was difficult for him to account for the present satisfactory experience. The answer probably lies in the fact that hospital-surgical insurance has become one of the most common things in the world. Everyone has it, and everyone wants it, so there is little self-selection.

MR. MANUEL GELLES stated that a method of coinsurance fully as important as limitation of income is use of waiting periods whereby the first week or two weeks, or more, of disability is not covered. He questioned whether any first day sickness income coverage could be properly written. He referred to coinsurance as part of underwriting of all insurance lines including life insurance, often resulting in lower premium rates because of reduction in antiselection.

MR. G. N. WATSON was of the opinion that in the case of persons with low incomes the ratio of benefit to income should be about 80%, decreasing to 50% or less as incomes increase. In the case of insurance against the expenses of accident and sickness, the proportion properly insurable is higher, from 75% to 80%, since there is no income tax factor involved. It should be noted that there is a difference between a prepaid medical and a medical insurance plan. Under the first, it is assumed that all medical expenses should be paid, whereas under the second there is no such intention. The prepaid medical plan will tend to increase the cost of medical care as there is no incentive for the insured to check his expense.

Since most of the business is sold through group sales representatives, small groups in out-of-the-way places do not find it easy to obtain coverage. The recent development of small group insurance package plans will answer this problem since the rural insurance agent can sell them with relative ease.

He felt that it was necessary for insurance companies to obtain the cooperation of hospitals and doctors so that the cost of medical care will not increase because of the existence of insurance.

He suggested that attention be directed toward the problem of those federal, state and municipal employees who are prevented by regulation or law from having group insurance or salary deduction plans. There is no valid reason why government employees should suffer this disadvantage.

Group insurance against the costs of medical care does not at present reach a large part of the rural population, professional people, the self-employed, the indigent or the aged. The difficulty in reaching the rural

population is to find a central office of administration and collection. This may be done through a farm bureau or public utility. In the case of professional people, there is the difficulty of keeping up the enrollment and of providing a substitute for payroll deduction. For the self-employed the only coverage available is individual insurance and that is limited to those eligible under underwriting rules. There is no reason to try to cover the indigent by the insurance method. Some of the aged may continue to be covered after retirement by group insurance. Some few companies permit the conversion of group insurance and this offers a partial solution.

MR. R. H. MAGLATHLIN pointed out that it is an accepted principle in our economy today to provide pensions for retired employees. Providing group life insurance for them is becoming more prevalent, but provision for group hospital and surgical benefits for retired employees is still in the experimental stage and involves many problems. The claim cost is high, although perhaps no higher in relation to the claim cost on active lives than under group life insurance. Claim statistics are meager. Claim administration is difficult since they are no longer employees. There is also the question as to whether benefits should be reduced or limited after retirement. In addition to these problems, which have generally been recognized and discussed, there is the problem of prefunding the cost of these benefits. From both an economic and a cost accounting standpoint, all benefits for a retired employee should be funded or paid for during his active working career—and sound methods of prefunding should be worked out.

MR. H. C. DUNKLEY pointed out that duplication of coverage is no problem in individual accident and health insurance if Optional Provisions 4 and 5 of the new Uniform Standard Provisions or the old Standard Provision No. 17 is used. These provisions give the insurance company adequate protection against deliberate overinsurance due to duplication of coverage or accidental overinsurance due to a change in economic conditions. Life companies have not had such provisions in their total and permanent disability benefits and have depended on adequate underwriting to prevent overinsurance. If every insurance carrier made adequate inquiry at the time of application the problem would disappear.

He pointed out that although many companies believe that duplication of coverage is not a real problem in hospital insurance, the subject is becoming acute. One possible reason for overinsurance lies in unrealistically low limits offered by most companies. A hospital policy with a daily benefit limit of $10 is unreasonable when the individual may have to pay $20 to $25 a day. The insured is obliged to buy policies in several companies to get a reasonable amount of insurance instead of having his entire

coverage in one company. Another factor leading to overinsurance is the failure to service old policyholders adequately and to change their coverages with changing needs. This results in the purchase of additional coverage in a new company. One result of this failure is that claim expenses are duplicated.

MR. H. J. STARK stated that the problem of overinsurance is common to all insurance and usually a satisfactory solution is found through underwriting restrictions, prorating, coinsurance and deductible provisions. Overinsurance of medical care has become acute, resulting in increased claim costs especially where medical facilities are adequate. Overinsurance arises out of the issuance of a single policy with more than adequate benefits or the duplication of coverages. The former type can be prevented in both individual and group policies by amount restrictions. Recently some group plans have been designed to cover the full cost of hospitalization in a semiprivate room for an extended period and this experimental "service" type of plan seems to involve the danger of overinsurance. However, they usually omit areas of the cost of medical care so that there is some coinsurance.

Duplication of coverage arises where the husband has personal and dependent group insurance and his wife is employed and covered by other group insurance. While this type of overinsurance can be eliminated by proper policy language it is not generally done, although worthy of consideration where benefits are close to the "service" level. Another form of duplication arises where individual policies cover employees who have group insurance. Companies writing individual policies will find it to their advantage to give careful consideration to the existence of group insurance in their underwriting. In the past there was a proper field for a supplementation of group insurance by individual plans but now group medical care insurance has become more adequate.

The most important duplication occurs between Blue Cross and Blue Shield and group insurance. Group underwriting should require consideration of the proportion of employees previously covered by Blue Cross and Blue Shield. Where the employer has previously contributed to the cost or provided payroll deduction for these plans, it should be required that payroll deductions be discontinued after the group insurance is effective, especially if the plan is noncontributory. Insurance companies alone cannot solve this problem. The continuation of membership in Blue Cross while group insurance is in effect, or the superimposition of Blue Cross on group insurance, creates a class of overinsured individuals who will be at least a drain on membership fees of all Blue Cross members. To what extent this is already true is not known, but it appears as though

these organizations owe it to their members to alter rules so as to discourage such duplication. A recent court decision in Ohio makes it appear as though this action is legally possible.

MR. J. F. COLEMAN stated that while it was possibly true in the beginning that Blue Cross and Blue Shield had put more emphasis on promotion than on actuarial science and underwriting rules, that is no longer true.

There are national actuarial and underwriting committees preparing manuals and conducting workshops to guide the smaller plans which do not have experienced personnel of their own.

There still remains some of the Blue Cross and Blue Shield philosophy of "once a subscriber, always a subscriber," but many plans now take advantage of the cancelable nature of the contract when an employer elects to install group insurance on top of Blue Shield or Blue Cross.