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GROUP INSURANCE

A. What approaches have companies adopted for selling, underwriting and administering group coverages for small employer groups?
B. What considerations and techniques are involved in establishing the larger maximum amounts of group life insurance currently being offered by many companies?
C. What plans of major medical benefits are gaining public acceptance? How well are these plans filling the needs for which they were designed?
D. To what extent can electronic data processing machines be applied effectively to group insurance problems?

MR. A. G. WEAVER stated that the John Hancock had recently entered the small employer field of 10 to 24 employees. Reasons for doing so included the desire to encourage agents to write group, the feeling of social responsibility to provide group benefits for small employers, the establishment of early relations with small expanding organizations, and the desire to provide a medium for experimenting with new ideas in group operations.

Some of the principal features of his company's plans are as follows:

(i) Six predetermined packages are offered and no modification is permitted. All packages contain group life insurance of $5,000 for executives, $2,000 for general employees, and $1,000 for anyone over age 70. All packages contain accidental death and dismemberment. Some packages contain weekly indemnity benefits (flat $28.00 on the 1-8-13 plan). Some packages contain health benefits for employees or employees and dependents, such benefits paying (to a maximum of $2,000) 80% of most hospital, surgical, and in-hospital medical charges beyond a deductible of $25 per disability. All accident and health benefits are nonoccupational.

(ii) Administrative routines are simplified. Sales literature as well as standardized policies and certificates are preprinted. Group specialists give only general assistance to agents and brokers. Monthly billing forms automatically handle movement, and all renewal dates are April 1st. There will be no individual experience rating, but rather the experience under each package will be pooled. Accident and health claims are paid locally.

(iii) Underwriting rules are also simple. Certain industries are not accepted, but otherwise virtually any employer can qualify subject to 85% participation. There is no evidence of insurability required. Agents prepare the cost quotations and the risks are accepted by the local group manager.

Mr. Weaver noted that approval has been obtained from those states in which the law does not prohibit such a plan, and that the number of applications received to date is encouraging.

MR. P. A. ALEXANDER explained the program of the London Life for groups of 10 to 24 employees. While certain simplifications have been effected, the same general approach throughout has been used for these groups as for larger ones.

The small group must contain group life, but may contain any combination of accident and health benefits except major medical. Evidence of insurability is seldom required, but there is a requirement of continuous service which is designed to control antiselection. Premium rates are determined in the same manner as in the case of larger groups except that an extra is added for size.

The dividend formula is greatly simplified for small groups. If either the life or accident and health dividend is negative, it is offset against the other and only the net is actually paid.

MR. J. W. MORAN discussed the development of the techniques and system used by New York Life in underwriting life insurance for groups of 10 to 24 employees.

The objective was a system under which the average level of mortality experience on such groups would be approximately the same as average group life experience, but the prospects of antiselection did not permit the use of full group underwriting.

It was decided that all groups and lives should be accepted except those which were so seriously substandard as to raise the average mortality costs for all groups combined above the group level. Instead of requiring that all highly impaired lives be declined, the system provided for acceptance of all lives in any group for which the properly weighted average mortality rating by ordinary insurance standards was less than 200%.

A survey of several hundred randomly selected hypothetical groups demonstrated that such a system would produce an average aggregate experience of 130% of standard ordinary mortality, which is approximately the same as average group mortality. The survey also showed that the system would accept well over 90% of all groups as submitted.

The underwriters estimate the probable extra mortality cost for each life from nonmedical evidence, and obtain additional information for applicants only where the acceptability of the group is in doubt. By expressing all extra mortality costs in terms of "debits" (equal to the extra mortality cost which can be absorbed by $1 of monthly premium), the underwriter can test the acceptability of the group simply by comparing the number of debits with the monthly premium for the group.

The system has required the medical underwriters to estimate mor-

tality ratings for many obviously uninsurable lives in order to estimate whether their probable extra mortality costs would be within the limits provided for the particular groups in which they are members. The medical underwriting guide used includes ratings of 1,000% and over for some very serious impairments and also includes assumptions to be used in estimating probable ratings in the absence of full information.

MR. N. H. FISCHER discussed the basis that has recently been adopted by the Aetna Life for groups of 10 to 35 employees. Life and accidental death and dismemberment are available in several schedules, although there is an automatic reduction to 50% at age 65 which was felt necessary in order that increasing term premiums would not cause lapses. Weekly indemnity is available on 1-8-13 and 1-8-26 plans for flat amounts of $20, $25, $30 or $35. All plans involve hospital benefits on a 70 day, 20 times basis for daily benefits from $8.00 to $16.00. All plans also involve surgical and in-hospital medical benefits. Supplementary accident and poliomyelitis benefits are available.

Mr. Fischer considers his company's volume of sales to be quite encouraging. In anticipation of a higher than normal lapse rate on small cases, and because of the drain on surplus of a higher first year rate, commission rates in first and renewal years are equal.

In general, evidence of insurability is not required. However, employees aged 65 or more are medically examined, as are supervisory personnel who are to be insured for a greater amount than general employees. In the latter case, unsatisfactory evidence does not mean that the supervisor is excluded, but rather that he is insured as a general employee.

The need for economies of administration was stressed, and it was pointed out that the Aetna Life makes extensive use of its electronic equipment in administering small groups.

MR. R. J. MELLMAN pointed out, with respect to section B, that there has been considerable competitive pressure in recent years towards liberalization of maximums. This pressure has arisen largely from smaller employers who are forced, in a competitive labor market, to seek the same coverage for executives as they would receive if employed at the same salary by a larger employer.

The Prudential is currently experimenting with two special techniques which will permit acceptance of higher amounts than the maximum specified in its table of limits. One technique involves the establishment of a special reserve. In Mr. Mellman's opinion this technique is not suitable for the small group. He suggested that the second technique, pooling, is suitable for all sizes of groups. In the pooling method, premiums for the excess for all groups are credited and the excess portion of claims from all

groups is charged to one pool; normal dividend treatment would apply to that portion not in excess of the normal maximum.

Under either method, he felt it highly desirable to obtain satisfactory evidence of insurability for the excess.

With respect to section C, Mr. Mellman noted that major medical is still in the development stages and he expects that it will require several years before the many variations in approach form a standard pattern.

The deductible amount is sometimes applied to each illness, sometimes to all the illnesses of one person, and sometimes to all the illnesses in a family unit. Feeling that the "family" deductible was theoretically best, the Prudential featured it originally but this proved difficult to explain to the public. Consequently the "per illness" deductible has been featured recently with much greater success in public acceptance.

Of several methods of defining a benefit period, Mr. Mellman favored a calendar year definition on the grounds that it best gains public acceptance.

There has been a trend toward lower amounts of deductible with typical amounts being $50 or $100. The deduction seldom exceeds $100 except at the top end of the scale graded by salary.

Mr. Mellman strongly recommended the basic major medical approach (which replaces all other accident and health coverage except weekly indemnity) as opposed to the earlier forms of major medical coverage which were added on top of existing hospital, surgical and medical benefits. To facilitate adoption by an employer of this approach, he suggested a lower deductible, or an area of 100% benefits immediately after the deductible, or both. He reported that one-third of the major medical plans sold recently by his company were basic plans.

He expressed the opinion that major medical was providing valuable insurance protection and was steadily gaining in public acceptance. However, he cautioned that certain medical expenses have to be excluded because of the possibility of abuse or overutilization, and that it is important to explain this to the prospective purchaser.

MR. G. W. FITZHUGH, speaking on section B, discussed the factors which govern the normal maximum permitted by the Metropolitan. These include the total volume of insurance, the number of employees, the schedule of insurance, and the distribution of employees within the schedule—particularly for higher amounts. If the question arises on a group already in force, the financial experience is considered.

He pointed out that it was particularly important in groups containing large individual amounts of insurance to have a substantial reduction in coverage at an age approximating retirement age. Because of the possibility of unsatisfactory experience with respect to disability benefits, his

company has a maximum beyond which additional coverage has no disability benefits.

When an amount in excess of the normal maximum is required, his company uses either the special reserve or the excess pool methods.

With reference to section C, Mr. Fitzhugh agreed with Mr. Mellman's favorable comments about catastrophe coverage for medical expenses, but felt that it was yet too early to abandon experimentation with different plans in favor of one "ideal" plan. He stated that the insurance industry has been on the wrong track in the past with a multitude of segregated benefits that are apt to provide adequate benefits for small illnesses but do not provide adequate benefits for the serious illness. Everyone can expect and should be able to afford medical expenses of a few dollars; this problem is more one of budgeting than of insurance, and he suggested that it was wasteful to pay the overhead involved in having some organization perform the budgeting function. However, he felt that major illness involves expenses that create serious financial problems for most people and that this is the area in which insurance should operate.

Mr. Fitzhugh mentioned that catastrophe coverage requires good faith on the part of employees and the medical profession, and that it is in the true interests of both to cooperate toward the successful operation of catastrophe plans. He felt that it is essential that the medical profession agree to establish charges without reference to the existence or extent of insurance coverage.

MR. J. B. WALKER of the Canada Life noted, with respect to section B, that his company's policy form, which requires evidence of insurability for excess insurance, has been refused by the one state to which the policy has been referred. The reason for refusal was that the amount of protection would not be determined solely by conditions of employment.

MR. J. H. SMITH pointed out that the Equitable's recent new business record in group major medical plans indicates that major medical is catching on generally. Further, there is a trend toward coverage of all classes of employees, not merely the high paid ones, as indicated by a comparison of recent figures with earlier ones.

Mr. Smith commented, as did previous speakers, on the large number of different approaches and definitions currently found within the industry, and expressed a preference for the "per cause" method of defining the deductible and limit of benefits.

In a study of some 318 group major medical expense claims, Mr. Smith found that while the "base plan" benefits reimbursed the claimant for 48% of his medical charges, the major medical plan added another 34% reimbursement, bringing the total to 82%. He concluded that this goes far to establish the validity of major medical benefits.

MR. G. L. HOGEMAN, in discussing section C, suggested that the success of major medical may be measured in three ways: the number of employees insured, the degree to which more adequate benefits are payable for expenses that previously were insured, and the degree to which benefits are payable for expenses previously not covered.

He quoted figures of the Life Insurance Association of America showing that the number of employees insured for major medical benefits increased by 78% during 1953 and again by 55% during 1954. He estimated that 2,500,000 employees would be insured by the end of 1955.

Mr. Hogeman analyzed the major medical claims experience of the Aetna Life as is shown in Tables 1 and 2. In these tables, "covered"

TABLE 1

DISTRIBUTION OF TOTAL "COVERED" EXPENSE BY TYPE

(Major Medical Claimants)

Type of "Covered" Expense	All Claimants	Large Claimants*
Hospital Room and Board	26%	32%
Other Hospital Charges	24	14
Surgeons	23	6
Other Physicians	15	9
Registered Graduate Nurses	7	35
X-ray and Laboratory	2	1
Other	3	3
Total	100%	100%

* Average of 10 claims for which largest major medical payments have been made.

expenses involve all eligible expenses, including those covered by the base plan and those deducted by the corridor. "Claims," on the other hand, represent only payments under the major medical benefit.

From Table 1, the speaker concluded that approximately 12% of the "covered" expenses of major medical illnesses would be virtually excluded under older plans. For the very large claimant the difference is more extreme, due largely to the high cost of nursing in such illnesses.

In Table 2, he said that the difference between the percentages in the two columns is a measure of the extent to which major medical coverage provided more adequate benefits related to the benefits of the base plan. He noted that the important areas of circulatory and mental diseases are more adequately covered in his company's experience under major medical plans.

DR. J. P. STANLEY expressed the opinion of the United Automobile Workers, with which organization he is associated, that too much atten-

tion is currently being given to the whole subject of major medical expense. He felt that some physicians would react to major medical coverage with higher charges, which would tend to raise the fees for other medical protection. He felt that great caution in this field is indicated, until proper safeguards have been worked out to avoid this problem.

MR. E. B. WHITTAKER disagreed strongly with the previous speaker. While admitting that the charges of an occasional physician seemed unreasonable he felt that the American Medical Association was interested in avoiding this situation. He also felt that the degree of this problem does not warrant general condemnation of major medical plans, which he considered, along with group pensions and group life, to be the best

TABLE 2

DISTRIBUTION BY CAUSE OF CLAIM

(Major Medical Claimants)

Principal Cause	Total "Covered" Expense	Major Medical Claim Payments
Diseases of Digestive System	25.5%	23.4%
Diseases of Circulatory System	13.9	15.5
Diseases of Female Reproductive System	13.8	10.7
Mental Diseases, Nervous Diseases, etc.	11.6	14.7
Diseases of Musculo-skeletal System	7.8	7.8
Diseases of Respiratory System	7.5	8.5
Accidents	7.0	6.9
Other	12.9	12.5
Total	100.0%	100.0%

products of the insurance industry. While certain union leaders may disapprove of the principle of major medical, union members, according to the Prudential experience, sign up for this coverage enthusiastically.

MR. W. A. HALVORSON expressed his observation that the major medical idea of broad unscheduled benefits through the application of the coinsurance principle has gained considerably in public acceptance within the last two or three years. New York Life's experience is that currently the public is less enthusiastic about comprehensive major medical plans which are designed to replace existing plans of first-dollar benefits. With time and education, he believes these plans will become economically popular.

He stated that his company had received requests from major medical policyholders that the coverage be extended to pensioners. This aspect of major medical is currently under investigation.

MR. S. W. GINGERY, in discussing section D, stated that the Prudential currently makes very extensive use of punch card equipment in group operations. This involves premium calculation and billing, premium accounting, the preparation of statistics for valuation and dividend calculations, and the preparation of various detailed analyses for year-end statements. Furthermore, the system provides controls for billing and accounting as well as the means of obtaining various actuarial analyses.

However, certain group operations have not been handled by punch card equipment because their complexity of calculation was considered to be beyond the capacity of the equipment. These include the calculation of commissions and dividends and the processing of data for renewal premium calculations.

He reported that his company has made a preliminary but encouraging survey of the possibility of using electronic data processing equipment in order to transfer the above-mentioned manual calculations to machines. (This would necessitate the transfer of existing records from cards to tape.) In spite of the lack of uniformity in group operations, it appeared to him that the electronic equipment now available has the capacity and the flexibility to accommodate these operations. In fact, he suggested that group is an ideal field for the application of electronic data processing machines because the input files are relatively small compared with the number of processing steps to which they will be subjected.

In conclusion, Mr. Gingery cautioned that more extensive study would be required in order to confirm the opinions derived from the preliminary investigation.

MR. G. C. STREETER stated that the Aetna Life has a Type 650 (I.B.M. Drum Calculator) assigned solely to a variety of group jobs including analysis of business, reserves calculations, and certain agency statistics. The cost of this machine is approximately 50% offset by the saving on equipment released by its acquisition. Furthermore it has resulted in a reduction in peak loads, in personnel and in the complexity of operation, as well as in the ability to handle jobs previously beyond the capacity of punch card equipment. An example of the latter is the calculation of group commissions.

Mr. Streeter pointed out that his company currently has four persons engaged on a full-time basis in studying further group applications of this and other electronic machines.

It has been their experience that at least a quarter of the time spent in the final installation phase of a new problem is required to correct minor flaws.