INSURANCE AGAINST THE COST OF MEDICAL CARE

A. What proportion of new issues are represented by (*a*) basic, or comprehensive, major medical expense insurance, (*b*) integrated or corridor-type major medical expense insurance, and (*c*) traditional hospital, surgical, and medical expense insurance? Can comprehensive major medical expense insurance effectively take the place of the traditional hospital, surgical and medical expense insurance?

B. Under comprehensive type plans, to what extent is it advisable to offer hospital and surgical benefits without coinsurance or without a deductible amount?

C. What controls are advisable in limiting the amount of benefits under major medical expense plans (*a*) in the aggregate, (*b*) for mental and nervous disorders, and (*c*) to avoid duplication of coverage?

D. Is there a trend toward the use of a deductible amount in traditional hospital, surgical and medical expense policies? What new actuarial techniques have been developed for the calculations of premiums? How are benefits adjusted for misstatement of age where deductible amounts are involved?

E. How can the increase in health insurance coverage on older people be accelerated? What practical methods may be employed for funding, during the working life of the family head, the cost of insurance against the expense of medical care during his retirement years?

MR. C. A. SIEGFRIED defined the "corridor" type of major medical plan as one associated with a plan providing basic hospital, surgical or medical expense followed by a corridor of expense, say $50 to $100 or 1% of earnings which the insured individual must pay. The major medical plan pays all expenses over these amounts.

The "comprehensive" type deals with all areas of medical expense as part of a unified plan possibly with a deductible amount. The deductible could be such that the first $25 or $50 of expense of whatever character would not be covered or one deductible could apply to hospital-surgical expense with a separate, different deductible applicable to other medical expense.

Of the total persons insured by the Metropolitan under some form of medical-hospital expense insurance 35% now have major medical, 40% of which is on a comprehensive type plan. Last year under newly issued plans more persons were insured under the corridor type but this is partly due to the ease with which it may be added to an existing basic plan. The comprehensive plan has functioned favorably where introduced and has attracted widespread, growing interest. It is expected that a growing number of persons will be insured thereunder in the future.

MR. E. B. WHITTAKER stated that of 386 major medical cases written last year by the Prudential 130 were superimposed on an existing plan, 245 were basic with a full area of hospitalization, while only 11 were basic without full hospitalization. Eventually, after the public has been educated, there is little doubt that basic major medical will replace basic hospital and surgical. It is the only way to avoid national health insurance.

When major medical was first introduced the presidents of the medical societies as well as the Steel Workers and the Automobile Workers Unions feared that it might serve to increase the cost of medical care. This, however, has not happened. If exorbitant fees are charged, the insurance company's Medical Department can generally adjust it with the doctor or, failing that, through the Appeals Board of the State Medical Society. The CHAIRMAN suggested that there is an obligation to the public and to the policyholders to do so when fees are excessive.

In the area of psychiatry Mr. Whittaker feels we are, however, being "taken to the cleaners." Psychiatry has now become respectable and even fashionable in industries such as advertising or areas such as Southern California. One company paid out more in psychiatric care than the total in medical care. Suggested solutions vary. The Prudential has a maximum on the amount paid for treatment out of hospital if the ailment is organic but not functional. However, $5,000 was paid for a case of bed-wetting. Is that organic or functional? Excluding payments for out-of-hospital cases would arouse the ire of psychiatrists who, today, get people out of hospitals to promote recovery. Reduced maximums for out-of-hospital cases would probably work in 90% of the cases. A coinsurance factor of 80–20 for in-hospital cases but 50–50 for out-of-hospital cases would encourage fee padding. A logical solution supported by a leading psychiatrist who is chairman of the New York Grievance Committee is to have a flat $10 or lower reimbursement for out-of-hospital psychiatric treatment which is about 50% of the average fee for such treatment.

It may be necessary to urge employers to exclude psychiatric cases and to charge extra if they do not. A change of this type in an existing contributory case might require a re-enrollment of the employees. A statement by the employer that the plan is to be changed might be sufficient; in that case, employees who did not agree to the change could then drop out.

MR. R. N. STABLER gave figures based on the New York Life's 1956 group insurance issues to policyholders who had no kind of group insurance in that company before January 1, 1956. Approximately two-thirds of these new groups involved some form of medical care insurance. Of these new issues involving medical care, 19% provided comprehensive

major medical, 27% supplemental major medical and 54% some form of traditional medical care insurance only. This trend to major medical has increased in 1957. However, based on lives or premiums traditional issues would have increased weight, as the 1956 comprehensive issues were predominantly on small groups. The trend to comprehensive is due to its broad coverage, liberal maximums, relatively simple benefit basis and more effective utilization of the premium dollar.

Introducing section B, Mr. Stabler stated that the New York Life has had satisfactory experience, except in some geographic areas, with a comprehensive plan which has no deductible on the first x dollars of hospital expenses with a 75% or 80% coverage of remaining hospital charges. This plan is popular and hospital administration procedures are simpler than under a deductible type.

The elimination of the deductible on surgical charges is far more difficult. The addition of a surgical schedule complicates the design and leaves the insured in doubt as to the proportion of expense he must bear. Salability is thus reduced. If no deductible and no schedule is included it is necessary to define surgery precisely and rely on the cooperation of the medical profession in setting fees independently of the insurance benefits available.

The New York Life limits the individual's coverage for pre-existing conditions for which treatment has been rendered within the three months prior to the time he becomes insured. Coverage is limited to $500 until the earliest of (*a*) one year, (*b*) end of a three months' period during which no charges are incurred for such conditions or (*c*) for employees, the end of a six months' period of uninterrupted active full-time work. Possibly a longer full-time work condition should apply to mental conditions. Such a limit is advisable, especially for small groups where there is a possibility of antiselection.

The antiduplication provision included in their major medical policies integrates their comprehensive plan with other group plans. Such a provision is more important for comprehensive than for supplemental plans, as the comprehensive plan covers less severe illness with smaller loss of income or indirect losses and hence offers greater opportunities for financial gain.

MR. W. S. THOMAS stated that the Metropolitan has one maximum applicable to all medical benefits paid within a benefit year and another maximum, usually twice the first, applicable on a lifetime basis to all sickness in industry. The full lifetime maximum may be reinstated on submission of evidence of insurability; this could include a medical examination, but to date none has been required. Favorable action on reinstate-

ments has been high and generally action can be deferred until more complete recovery rather than denying outright.

The majority of their policies do not contain any limitations for expense of mental or nervous disorders but the few plans that do have such limitations cover a substantial number of persons. Policies with limitations may provide that 75% of such expense is covered for totally disabled or institutionalized persons, only 50% is covered for other persons, or alternately may provide reduced maximums. This has worked satisfactorily.

Duplication is avoided by not covering expenses covered under any other plan or recoverable by legal action or settlement. Antiduplication is necessary not only to avoid overinsurance but also to keep the good will of doctors. A doctor becomes annoyed if, after he accepts the fee set by the plan as full payment, the insured brings in several claim papers on which the insured will personally profit.

MR. C. D. WILLIAMS, through Health Insurance Council studies, found almost 20% duplication on basic hospital-surgical insurance. Major medical duplication, potentially a much more serious problem, had not reached significant proportions. He also stated that preliminary industry figures for new group policies show basic type policies down to 80% with supplementary major medical accounting for 13% and comprehensive, the remaining 7%.

MR. C. N. WALKER indicated that the trend toward use of a deductible amount in traditional hospital-surgical and medical expense insurance is shown by the fact that where only two companies did so in 1954, now at least fifteen do, with more to be expected. The deductibles range as flat amounts from $25 to $100 or as a multiple of daily room and board benefit from four to ten times. Fourteen of the companies also issue nondeductible plans. Five add the deductible by rider to a regular policy, the others write it into the policy itself. Seven offer a guaranteed renewable adjustable premium form while eight do not guarantee renewability.

Deductible hospital and surgical plans are being offered to offset the race between premiums and loss ratios which is possibly pricing the usual forms out of the market. Criticism is rising that current plans do not cover an adequate portion of the medical bill, while the public is demanding inclusion of costly out-patient and diagnostic treatment. The deductible will permit more adequate protection without increasing premium costs. The Lincoln National's experience with deductible hospital and surgical insurance indicates that, depending on age and sex, premiums can be reduced 15% to 20% with a $50 deductible and 30% to 35% with a $100 deductible. Agents have been enthusiastic and production good, with no reduction in premium income or in the average premium per

policy. Loss ratios have been well within anticipated levels. Half as many claims as expected under a nondeductible form have been received but the average claim has been twice as high, permitting economies in administrative expense. Public understanding and acceptance of the deductible has been good.

MR. J. F. RYAN discussed the New York Life's new hospital policy issued only with a $25 deductible. Study showed this would eliminate about a third of the claims without seriously reducing the proportion of the bills payable on serious claims. This permitted a substantial increase in benefits with a larger proportion of the premium dollar returned as benefits. Public and field reaction has been very favorable. The policy is guaranteed renewable to age 65 with the right reserved to change the premium rates on a class basis. The maximum hospitalization period is 365 days with a miscellaneous hospital expense limit of 15 times the daily hospital benefit.

In March the New York Life took an important step to increase hospital expense coverage on older people through the introduction of two new policies. Both are guaranteed renewable but reserve the right to change rates on a class basis and have a $25 deductible with level premiums and level benefits for life. The Lifetime policy issued up to age 60 provides the same benefits as their coverage to age 65 policy, but at a premium rate about 5% higher at age 20 to 12% higher at age 60. The Senior policy issued at ages 61 to 75 has lower benefits to keep the cost within salable limits. The maximum period of hospitalization is 60 days and the maximum miscellaneous hospital expense is ten times the daily benefit.

MR. W. V. HAUKE felt that the rising incidence and severity of illness after age 65 coupled with the lower financial resources of the aged strongly indicated that health insurance for the aged should be wholly or partially funded prior to retirement. This could be accomplished through a level premium payable to retirement or through the accumulation of funds to purchase paid-up benefits at retirement as in Ordinary and Group life insurance.

Some companies are now issuing paid-up health coverage on an individual noncancelable basis. However, probably 75% of the premiums now in force for health insurance are on the group plan. Most of the population will look to group insurance to provide their retirement coverage as it does their active life coverage. Present methods of continuing protection after retirement have various weaknesses. The use of individual policies is inadequate, the market at 65 or 70 is almost nonexistent, coverage is not guaranteed renewable, rates are high, and coverage is restricted and subject to severe underwriting. Conversion policies are essentially individual

policies issued on a guaranteed basis and subject to the same failings. Not only are individual policies subject to discontinuance but they require the retired individual to budget for the premiums. A change in his health status or finances might terminate his protection.

A simple and common approach is to continue to protect the pensioner and his family right in the group. The employer's contribution on this basis could increase as much as 50% over his contribution for active lives. Some employers seek to defer or eliminate this future increase in cost by reducing benefits after retirement or by placing an over-all lifetime limit on benefits. The retired person, however, can least afford an increased coinsurance factor and the lifetime limit would generally be effective at the extreme older ages leaving the individual dependent on charity, the community or his former employer.

The glaring defect of the group approach is that employee's or dependent's coverage is not guaranteed for life. Termination of the plan, switch of carriers, change of management, death of the employer, or, if contributory, an increase in the required contribution might terminate the coverage. A fully paid-up policy after retirement is in Mr. Hauke's opinion the only effective answer.

The lack of current statistics on health costs at the older ages and uncertainty as to their future trends places some financial risk on the insurer. The Continental decided that it was their function to bear this risk, not the function of the pensioner, the employer, the community or the government. In December they installed a program of paid-up hospital-surgical insurance for the retirees of one of their group policyholders paid for by a single premium at retirement. The benefits are a continuation of the basic type coverage on active employees. Separate nonparticipating policies are issued to the retiree and his wife. At the outset 12 policies were issued, with 150 expected over the next ten years. Tremendous interest has been shown not only by the employees but by other employers, agents, consultants and the public in general.

MR. H. J. STARK also discussed the uncertainties involved in fixing the cost of medical care for the retired. Not only does the cost of acute illness and injury increase at the higher ages but the cost of the chronically ill rises even faster. In addition, the care of the senile can be very costly especially if hospitalization becomes available through insurance. Plans must be designed to avoid bearing these latter costs, which as a last resort must be the responsibility of government.

Available statistics—of which there are still too few—must be applied cautiously to groups with different income levels or to geographic areas with different levels of medical costs and must be modified for the tenden-

cy to greater utilization of health care if larger funds or insurance benefits are available. Changing patterns of medical care, possible new treatments, and lengthening life add to the uncertainty.

The need for adequate margins in our rates for after-retirement coverage is indicated. In individual insurance this may be difficult to secure in a competitive market. In group insurance it may be possible initially for current coverage when the number of retired employees is small, but securing ample margins under advance funding arrangements will be more difficult.

A ray of light is the fact that, while the cost of funding various plans of after-retirement medical benefits may run from $1,000 to $3,000 per family, these amounts are not large compared to the amounts required to fund retirement or life insurance benefits for which we are already arranging. On a fully funded basis a generous plan might cost two or three cents per hour worked.

For funding these benefits all the devices for funding pension plans and group life insurance are available. There are probably fewer requirements for favorable income tax treatment.

We should now stress the offer of appropriate plans. There is widespread public demand for lifetime protection, reflected in employer and employee interest and some perhaps ill-advised legislation. Various individual insurance plans are now available. In group insurance there has been some continuance of medical care benefits on retired employees but the pattern of benefits remains to be improved. Many employers are continuing benefits to the retired on a restricted basis with arbitrary dollar limits and on a current cost basis. When the potential costs become clear, more attention will be given to advance funding, probably through a fund built up periodically to meet the actuarially forecast cost. Flexibility of approach should be preserved as numberless variations of benefit and funding patterns are tried.

MR. M. D. MILLER presented some estimates he had made of the cost of a representative plan involving retirement income, life insurance and health insurance in an attempt to appraise realistically the cost of health insurance for older people and the relationship of such costs to the value of other types of insurance for them. A stationary population and pay-as-you-go basis was used to eliminate variations arising from different proportions of retired persons and to show ultimate costs. The population is that in Cammack's paper *TASA* XLI, increased above age 65 to allow for improved mortality since 1941 so that those over 65 and presumed retired are 18% of the number of active persons. A fairly steep salary scale was used, but use of a flatter scale does not materially change the

pattern of costs. Full health benefits are provided after retirement. No provision is made for administrative or overhead costs (Table 1).

The cost of health insurance for retired employees and their dependents is of the same magnitude as the cost of the death benefit after retirement. The retirement benefits are more than 13 times as costly. The total cost of all benefits to both the active and retired comes to 14% to 15% of payroll. The cost of health insurance for the retired is only about one-twentieth of this, surely a modest salable amount for an urgent need.

TABLE 1

Benefits	Plan	Cost of Benefits as Percentage of Total Salary of Active Employees		
		For Active Employees	For Retired Employees	Total
Retirement Income..	50% of final salary	.....	10.5%	10.5%
Life Insurance.....	For active employees—one year's salary. For retired employees—half final salary	.6%	.7	1.3
Health Insurance....	(*a*) Hospital and surgical expense, with maternity benefits†	1.6*	.5*	2.1*
	(*b*) Health care plan, with maternity benefits‡	2.0*	.8*	2.8*
Total*.....	With 3(*a*)	2.2%*	11.7%*	13.9%*
	With 3(*b*)	2.6*	12.0*	14.6*

* Including benefits for dependent wives and children.

† Benefits appropriate for level of salaries assumed.

‡ Pays three-fourths of substantially all medical expense over a $50 deductible up to a $5,000 lifetime limit.

Mr. Miller added to the discussion of funding methods the possibility of developing more package type policies to include pension, life insurance, and health insurance as a step to more effective merchandising to individuals or small groups. This would reduce marketing costs and also strengthen the premium structure through the offsetting of required margins for one benefit with the margins available on another benefit. Present day mechanical equipment can probably cope with the administration of this kind of policy. Some statutory changes may be required.

The problems are not insuperable and public and legislative interest and some impatience should give us a sense of urgency.

MR. B. N. PIKE in a discussion limited to providing medical care coverage for retired lives through the use of group insurance agreed on

many points with previous speakers. He noted that retired lives are becoming an increasing proportion of the population and constitute a group whose welfare is of vital concern to government authorities.

A recently used method of issuing individual paid-up A&H policies as conversions to retired people apparently shifts to the insurance company the risk of the unknown level of claim costs for the retired. It would appear advisable to purchase the paid-up benefits under the group policy and keep them tied to the experience of the group policy by revaluating the reserve for retired lives each year that the group policy remains in force. A conservative rate and reserve basis should be used since the insurance company will assume the risk in event of termination of the group policy.

In view of the single premium of over $1,000 which would be required, advance funding is desirable. The purchase of a paid-up unit each year requires guaranteeing the rate for long durations in the future and could lead to problems if the plan is changed. An unallocated fund approach seems more flexible and desirable. Income tax deductibility of these costs prior to retirement may be a problem.

It seems advisable to proceed slowly and gather data as we go. We should then be able to give the employer a clearer cost picture to consider. As a starter, benefits should be limited to:

(1) 31-day hospital plans with room and board limits consistent with the going semiprivate rate and special services limited to 10 or 15 times the daily room limit.
(2) surgical schedules of $200 or $250, and
(3) medical benefits limited to periods of hospital confinement.

With an adequate volume of experience it may not be too much to hope that even major medical coverage on a paid-up basis for retired people may someday become a reality.