ACCIDENT AND SICKNESS INSURANCE

A. What have been the recent developments in expanding major medical expense coverage under (*a*) individual policies and (*b*) group policies?
B. What progress has been made in providing hospital, surgical and medical expense coverage beyond age 65 under (*a*) individual policies and (*b*) group policies?
C. What are the important long-range questions involved with the type of individual accident and sickness insurance that guarantees renewability with the right reserved to increase premiums on the class? What are the Federal Income Tax implications? What reserve problems are involved?
D. What steps are being taken to extend individual accident and sickness insurance to persons who are substandard for medical reasons?

MR. B. E. BURTON, speaking on group policies, cited the growth of major medical by comparing the 5,000,000 persons covered at the end of 1955 with about 2,200,000 at the end of 1954.

Interest has increased in the comprehensive type of major medical, a plan which has no underlying hospital, surgical, or medical benefits, and is characterized by a low deductible of $25 or $50. With uniform coinsurance and a deductible applicable to all expenses this coverage is a true insurance program. However, to make the plan more attractive, provision has been made for the deductible and coinsurance features not to apply to some expenses. Hence, the comprehensive plan represents a compromise with first dollar coverage.

Mr. Burton felt that a definite need now exists for adequate industry statistics on major medical costs.

MR. C. M. STERNHELL limited his remarks to individual policies. A revision of the entire A & S portfolio of the New York Life in 1956 replaced the original major medical expense policy of June 1953 with a new form. The change has given rise to a greater sales expansion than had been expected.

Three of the main changes in the major medical program are:

1. The modified commercial type of renewal provision has been replaced by a guarantee of renewability to age 65 with the Company reserving the right to change the applicable table of premium rates on classes of policyholders.
2. The requirement that a person must be confined in a hospital in order to qualify for benefits has been eliminated. The qualification requirement for receipt of benefits is now satisfied if medical expenses in excess of the $500 deductible limit are incurred within 90 consecutive days. The benefit period starts on the first day expense is incurred and runs for one year or until discharge from the hospital, if later. The Company pays 75% of the amount by

which eligible medical expenses incurred during any benefit period exceed the $500 deductible amount. While several benefit periods may be established for the same accident or sickness, the maximum benefit payable for an accident or sickness is $7,500.

3. A simplification in premium structure. Under the new policy, the premium rate for a family depends only on the age of the husband. There is theoretical justification for this type of premium structure on major medical expense policies, but the practical advantages are even more important. The Company saves the expense of changing premium on change of coverage. The agent can obtain a family policy premium directly from the rate book without calculation. A review of the first 1,000 new major medical expense policies indicates that the average number of children is about 2.2 per family with children, and about 1.7 per family policy.

In 1954, major medical expense policies accounted for only about 6% of all A & S policies sold by the New York Life. Sales reports for 1955 indicate that the new major medical expense policy applications constitute over 15% of the increased number of A & S applications that they are currently receiving.

MR. I. S. WOLFSON mentioned two sources of the expansion of group major medical coverage: (*a*) to groups not covered before or groups which had restricted coverage, (*b*) changes in the product which have made it more attractive to potential buyers.

The change of company rules to permit writing groups down to 25 lives with no minimum premium or other coverage requirements has resulted in many new groups being considered for major medical coverage. In many cases, an awareness of a *general* need for major medical insurance has made it the rule to have all employees covered rather than only the executive class.

Practical considerations have led to changes in the product, such as the developing of a major medical plan which in itself is complete in the coverage of medical expenses and which waives the deductible on hospital charges, or waives coinsurance on the first $300 or $500 of hospital charges, or builds a surgical schedule into the provisions of the major medical policy with additional surgical benefits available after a deductible, or does all three.

Even though many complicated claims problems may arise, the Massachusetts Mutual has decided to put the major medical maximum benefit on the per-cause-of-illness basis. It was felt that this broader scope of coverage should lead to great acceptance of the major medical coverage by the buying public even though it would increase the net cost of insurance as compared with the lifetime maximum basis. Mr. Wolfson felt that recent rate reductions by some companies would also lead to expanded major medical coverage.

A consideration which may be important in making the coverage more attractive is the family budget approach to the deductible under major medical coverage. Since in most cases medical expenses of a family must be met from the earnings of one person, it would seem that the statement that once a family has had x dollars of expenses, benefits will become payable, would have great appeal to any person with a family.

Mr. Wolfson stressed the need for greater standardization in such features as the method of applying the deductible, the basis for paying maximum benefits and the way pre-existing conditions are handled before realization of the potential demand for major medical coverage would be possible.

MR. C. A. SIEGFRIED said that the rapid growth of major medical coverage must be attributed in part to the increasing number of cases where coverage is extended to all employees instead of being limited to the executive class.

Some clarification and improvement of the semantics of major medical insurance, particularly within the field between plans that supplement basic benefits and plans that are comprehensive, would be helpful to the industry and to the public.

There is an expanding amount of activity in the direction of getting doctors and hospital people, as well as employees, to understand the principles behind these plans.

The claim experience of the Metropolitan Life has been, on the whole, encouraging.

The successful administration of these plans depends on adequate information for all concerned and particularly on an understanding of the reasons for the various features of a plan.

Some questions which warrant especial attention in the development of these plans are:

1. How and to what extent should the dividing line be fixed between expenses to be borne by the plan and those to be borne by the insured?
2. To what extent are "inside" limits needed or desirable, *e.g.*, on surgical fees? On room and board daily benefits?
3. To what extent can benefits be made available to retired employees, and what modification of benefits for such employees is desirable?
4. To what extent should special procedures be developed for dealing with such expenses as drugs, psychiatric treatments, nursing care?
5. What treatment should be made in cases where other plans are also in effect?

MR. A. M. THALER emphasized that standardization is important in aiding sales. His own company has secured standardization by developing one or two types of plans and specifically training the salesman

along that line. As a result of such training, sales in major medical and particularly comprehensive plans have increased tremendously.

They have made their comprehensive plans more attractive to the public by featuring no coinsurance on the first $500 of hospital room and board and special charges, and plans with a zero deductible on both hospital and surgical benefits. In this way, the public has been met halfway when selling major medical in competition with the Blue Cross approach.

MR. H. A. LACHNER spoke on old-age coverage under individual policies. One of the new policies introduced by the Metropolitan at the beginning of this year gives lifetime coverage with premium payments limited to age 65. The policy is issued to age 55.

The coverage provided after age 65 is somewhat less liberal than during the premium-paying period. The maximum amount for hospital services is 10 times the daily benefit before age 65 and 5 times thereafter; the maximum period of hospitalization covered is 120 days before age 65 and 31 days thereafter; and there is a benefit for physicians' attendance in hospital before but not after 65. These maximums after age 65 are the maximums for any policy year, rather than any one confinement. There is also an aggregate limit of 180 times the daily benefit for all hospitalizations from any one cause after age 65. The policy is guaranteed renewable with reservation of the right to adjust the premiums.

In addition to the paid-up policy, they issue a whole life policy. As this policy is offered to applicants up to age 75, it supplements their other policy by making old-age coverage available to those over age 55. This policy provides the same scales of benefits as are provided after age 65 by the limited-payment policy. It is also guaranteed renewable, with adjustable premiums.

MR. R. H. MORSE stated that his company has for a number of years offered coverage in this field. Since 1949 it has been made available to holders of noncancelable policies who were insurable when their policies terminated. As a result of the experience they are now considering offering this coverage to all holders of noncancelable policies when their policies terminate, regardless of insurability. In addition to this program individual hospital policies have been available at all ages for a number of years.

Some of the obstacles to more extensive coverage of older people were mentioned: (*a*) lack of buying power, (*b*) more are uninsurable, (*c*) habit and tradition of insurers that the insurable interest ends at retirement.

The obvious solution to (*a*) and (*b*) is lifetime coverage which is guaranteed renewable at level premiums preferably to age 65. One difficulty here is that no one would care to design a whole-life contract to fit the

costs and the pattern of medical practice or the needs of the patient 60, 40 or even 20 years from now.

The development of health insurance along the lines of the major medical approach may offer the solution to the problem of future changes in the pattern and methods of medical practice. Blanket coverage subject to deductibles and coinsurance is more flexible. The adjustable premium guaranteed renewable type of policy seems the best answer to the problem of changes in the medical price level.

A partial solution of the problems of financing would be to separate the funding aspect which is no different from the funding of income to buy food, clothing and shelter from the health insurance function of spreading insurable medical expense. The health insurance policy might be sold on a basis of a level premium to 65 followed by an increased premium to the end of life. Both premiums would be subject to adjustment in event of substantial deviation from the original cost assumption. To provide for the premiums beyond age 65, a companion contract in the form of a retirement annuity at 65 could be sold. Thus provision would be made for the advance funding of a substantial part of the cost of insurance in the later years of life but it would avoid introducing nonforfeiture values into the health insurance contract.

MR. VALENTINE HOWELL, in discussing section C, quoted the rate change provision from the first page of the Prudential hospital expense policy currently being issued to illustrate that the insured could hardly remain ignorant of the right of the company to change premium rates.

The interpretation of the rate change provision may alter the character of the policy. At one extreme a company may issue a policy at rates not much higher than those for cancelable (commercial) policies. On the other hand, the premium rate and benefit structure of a policy with such a rate change provision may be comparable with that of a noncancelable policy with fixed premium.

Whatever may be the merits of the rate change provision as applied to the commercial type of policy, it seems evident that the noncancelable form will be of more value to the insurance industry. For accident and sickness hazards the most practical way to accumulate experience is through the issue of a policy that provides for an increase in the premium rate if the actual experience under the policy makes it necessary. Furthermore, increasing medical expenses, changing rate of utilization of medical or hospital services, logically call, on a noncancelable coverage, for a provision to increase the premium to the extent that cost increases make it necessary.

To obtain these advantages we must identify the rate increase provision

with the noncancelable policy and not with the commercial type of policy. Unless the new plan remains a noncancelable policy of the traditional variety and not a sales feature we will have lost a very valuable tool in our business.

Companies can, by exercising restraint and controlling their competitive urge, prevent the down-grading of noncancelable coverage. The insurance departments are in a position to exercise a more effective control and Mr. Howell outlined what the policy of the departments could be in approving policies with premium increase clauses:

1. Full compliance with the requirements of Section 4 of the Advertising Rules for accident and sickness insurance. Any statement as to guaranteed renewability or noncancelability should be followed by a statement that rates may be changed by the company.
2. Provision for no change in the rating classification of the individual.
3. Possible rate increase according to the original age of the insured.
4. Agreement not to place restrictive riders on the policy or otherwise change the benefits while the policy is continued in force.
5. Careful scrutiny of the wording of the rate change provision.
6. Consistency of rates and benefits with generally similar noncancelable coverage at fixed premiums.

Fair administrative practices by issuing companies are essential to the continued success of noncancelable accident and sickness insurance.

MR. R. R. ANDERSON called attention to three long-range questions concerning guaranteed renewable A & S insurance:

1. What type of coverage will be offered under this type of insurance?
2. What type of company is most likely to adopt it?
3. What purpose will it serve?

Because of the pronounced trend of increases in the costs of medical care, guaranteed renewable A & S insurance is particularly appropriate for coverages which provide reimbursement for such costs. It is very difficult to forecast accurately future medical costs; however, by retaining the right to change premiums, a company will be able to reflect the actual future costs equitably by classes of policies. Of the 14 life insurance companies shown in Table 1 on page 374 of Mr. Phillips' paper in the 1954 *Transactions*, each of the companies that has adopted this new type of renewal provision has done so for hospital or major medical insurance. None has adopted it for loss-of-time insurance, where there is no evidence of a long-range trend of increasing costs and where future morbidity rates can be estimated with some degree of confidence.

With respect to the type of company adopting guaranteed renewable A & S insurance, all except one of the 14 life insurance companies shown

in Mr. Phillips' table issue medical expense policies. Seven out of 9 mutual companies, and none of 4 stock companies, have adopted the guaranteed renewable provision. It is only natural that companies which are accustomed to providing insurance to policyholders at cost and to allocating costs equitably among classes of policyholders would find the provision most appropriate.

Mr. Anderson believes that the most important feature of an individual A & S policy is whether the policyholder is guaranteed the right to continue his policy in force in spite of any change in his insurability. Guaranteed renewable A & S permits a company to offer medical expense insurance—including even the most experimental types of coverage—on a sound noncancelable basis. Time will show the introduction of this type of coverage to have been one of the major steps in the development of individual A & S insurance.

MR. C. N. WALKER stated that in February 1956 the Lincoln National announced and commenced writing individual A & S to physically impaired risks. Thus, with the exception of their major medical policies, they are now writing all commercial A & S plans on both the standard and substandard bases. The program is quite comprehensive. They are writing all types of impairments, with impairment ratings ranging from 25% to 300% above the standard level. Accident and sickness benefits are rated separately.

Policies can usually be written to provide full coverage, including the impairment for which the rating is required. In most cases, the impairment risk is covered by the use of extra premiums. This method has two advantages:

1. The impaired risk receives coverage as comprehensive as that for the standard risk.
2. The extra premium method is applicable to a great many impairments which cannot be handled with elimination riders. Elimination riders to be effective must be quite specific and, preferably, be quite narrowly worded. This means that many impairments such as blood pressure and overweight cannot be handled by this method.

Elimination riders cannot be completely discontinued. Some impairments require them, particularly those which present the possibility of an elective or semielective surgical procedure, such as an existing inguinal or femoral hernia.

For physically impaired risks, policies are modified only to obtain an application amendment form to show that a rated premium has been used. Issue limits are reduced, with the maximum issue limit depending on the rating classification.