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INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE

A. What progress has been made in offering accident and sickness and hospitalization insurance benefits (*a*) to those over age 65, (*b*) to the physically impaired, (*c*) in rural areas, and (*d*) to the lower income groups?
B. Can mass distribution methods be found to provide sickness benefits to the rural areas or the low income groups?
C. Will the formation of a risk-sharing pool encourage the extension of benefits to these groups?
D. What has been the recent experience with individual major medical policies?
E. What can the insurance associations do to collect morbidity data or other information which will be needed by companies desiring to offer new forms of accident and sickness insurance or coverage to risks not previously considered insurable because of age or health?

At the request of the Chairman, MR. G. H. DAVIS reviewed the political implications behind the development of broader coverage for more segments of the American public. He pointed out that this topic has political overtones because the subject of health insurance has been a political issue in the United States for a number of years. He reviewed briefly what had happened in connection with attempts by the Federal Government to promote the payment of the costs of accident and sickness by different kinds of insurance mechanism. He reviewed the events leading up to the formation of the ideas of the government reinsurance facility and a private reinsurance pool, in both of which interest seems currently to have waned.

With respect to the latter, he pointed out that it was never considered that the proposed private reinsurance pool would be used to try to provide coverage for the indigent.

It had been considered that one of the more important functions of the pool organization would have been to carry on research into the needs for and possibilities of accident and sickness insurance. It was hoped that this research would assist in developing new forms and areas of coverage. When the opinion had developed that the pool idea was not workable, it was suggested that it might be desirable to set up some mechanism to carry out this research function independent of any pooling arrangement. There is a joint committee that has been exploring the possibilities of a research facility in this area. Three committees representing the Life Insurance Association of America, the American Life Convention, and the Health Insurance Association of America are now working jointly to explore the possibilities of a research facility in this area.

Also, at the request of the Chairman, MR. J. J. OLSEN reported on the work of Task Force IV, which was established to study the problem of reserves for accident and sickness insurance. He stated that the NAIC Subcommittee plans to have a further meeting with Task Force IV prior to the November 1956 NAIC meeting in Miami, looking toward final recommendation at that time.

The Task Force recommends that, where all of the following conditions prevail, reserves in addition to the pro-rata unearned premium reserves be maintained, unless it can be demonstrated that the pro-rata unearned premium reserve on a gross basis is an adequate measure of the liabilities:

1. The company's right to refuse renewal is substantially limited.
2. The premium is either presumed or guaranteed to be level for a period of five or more years during the continuance of the policy.
3. The basic annual benefit costs increase with advancing age.

He described the valuation standards being recommended for disability due to accident or sickness, for hospital expense benefits and for surgical expense benefits. For accident only, major medical expense and other benefits not specified above, each company would be required to establish reserves that place a sound value on the liabilities under such benefits.

With respect to insurance for those over age 65, MR. C. N. WALKER stated that when his company introduced their deductible hospital policy in January of 1955, they then entered the overage field for the first time by issuing through age 75. The policy was not designed solely for the higher ages, with the result that its benefit features are somewhat more liberal than in other policies usually made available to older age people. They felt that the deductible would enable them to do this. Benefit limits are 120 days for hospital room and board, 15 or 25 times for miscellaneous expenses and $200 or $300 for surgical benefits. They also have the usual rider benefits for nursing fees, physician and supplementary accident. The premiums for such broad benefits at these higher ages are correspondingly high. So far their experience is statistically too immature to be significant. Their chief problem has been one of establishing proper underwriting standards for applicants at these ages. Medical histories are long and varied and much of the history is old and difficult to obtain precise information on. So many of these people have impairments which, by the usual underwriting standards, prevent acceptance, that they have had quite a high declination rate, with the expected reaction from their field forces. They are now restudying the question of standards with the thought that a somewhat different standard should be used at the advanced ages in order to accept a reasonably high percentage of applicants.

With respect to insurance for the physically impaired, Mr. Walker stated that in February of this year his company commenced writing a comprehensive program of substandard accident and sickness. With the exception of their major medical policies, they are now writing all of their commercial accident and sickness plans on both the standard and substandard bases. This includes two accident and sickness loss-of-time policies—one with lifetime accident and two-year nonconfining sickness benefits and one with two-year accident and one-year nonconfining sickness benefits—two accident only loss-of-time policies and both their deductible and nondeductible hospital and surgical policies.

The substandard business is classified in eight rating groups ranging from 25 percent to 300 percent above standard morbidity levels. This wide range of extra morbidity permits consideration of a large number of impairments. In fact, only a very few impairments are considered to be categorically outside these limits. Accident and sickness benefits are rated separately, even on policies containing both coverages, so that on cases where it is appropriate, accident benefits at standard premiums can be combined with sickness benefits at rated premiums and vice versa.

They also feel that they can largely avoid the use of elimination riders. The program they are using for substandard risks—using extra premiums to cover the additional risk instead of using elimination riders to avoid the additional risk—has several distinct advantages. For one thing, elimination riders are severely limited in their proper applicability. They may be used only for a rather limited number of impairments, since in order to be effective they must be quite narrow and specific. It is not practical, for example, to attempt to avoid the additional risk associated with elevated blood pressure by the use of an elimination rider, since the additional cost of disability associated with this impairment bears no close relationship with the existing impairment. This same sort of situation occurs frequently. Either the rider method is hopeless to begin with, or else the rider required is so broad in scope that it not only makes it difficult or impossible to place the case, but it also removes so much coverage from the policy as to make one wonder whether what is left is worth the premium to be paid. In addition, we have all seen cases where a not too honest claimant can make an elimination rider a mere academic exercise in semantics.

The extra premium method of substandardization, on the other hand, gives the company or the policyholder or both the positive advantages of:

(1) a much more universal applicability, which substantially increases the number of cases which the company can accept, or, to put it another way, substantially decreases the declination rate

(2) avoiding the all too familiar difficulties both at time of issue and at time of claim as to what is actually intended to be excluded by the rider
(3) giving the policyholder complete rather than partial protection and in particular giving him protection against what in many cases will be the most likely cause of future disability
(4) simplifying to a great extent the problem of delivering substandard policies. The Lincoln National feels that the agent will find it much easier to deliver a policy on which the only difference from the policy applied for is the price, as contrasted with a policy which differs in coverage from what the applicant wanted.

They have not completely discontinued the use of elimination riders. Some impairments still require them—particularly those which present elective or semielective surgical hazards, such as hernias.

It is much too early for them to draw any conclusions about production or experience. However, their agency forces are enthusiastic about the program and their production, while not large, has shown a rapid growth.

MR. G. J. VARGA reported on the experience of his company in covering on a group basis persons living in rural areas. Their approach has been to work through the various county farm bureau associations.

Under their plan they bill the local county farm bureau and in turn the local bureau bills the individual member. Originally a person was eligible to sign up for his insurance when he paid his first bureau membership fee. They soon found that too many persons were signing up as bureau members just to receive the insurance benefits. They now permit new entrants into the insurance program without evidence of good health only during periodic drives, subject to a minimum number being received from the county. Applications made at any other time require satisfactory evidence of insurability.

Maintaining an adequate level of participation has always been a problem. Their insistence upon a minimum number of applications before waiving any health statement has helped. Recently they revised their rate structure so that it would more appropriately reflect the influence of age upon hospital and surgical utilization. Among their various county groups a median age of 55 or higher is not uncommon. Recognizing this, they have attempted to price their product so as to make it attractive to the younger married couple while at the same time requiring the older age person to pay a rate more in line with his anticipated utilization of benefits. They have accomplished this by limiting the total number of days of benefit available through a person's lifetime for any one disease, condition or allied ailment. Although they have had

no particular problem with this limitation, they are studying the possibility of waiving it where at least one year has elapsed during which no hospitalization for that disease or ailment has occurred.

Under their method of handling this type of insurance they have experienced drops in new applications mainly because the local county farm bureau agent felt it was taking up too much of his time. To overcome this, they are attempting to get the bureau to make a service charge.

With respect to insurance for persons over age 65, MR. MORTIMER SPIEGELMAN stated that his company has been offering family and individual hospital and surgical expense policies to lives aged 65 and over since December 1955. Although very little experience has become available so far, the following observations may be of some interest:

1. Family coverage policies have been issued to twice as many males as females.
2. About four times as many policies are written on an individual life basis as on the family plan. On the individual policies, the ratio of females to males is three to one.
3. On the basis of present production, it appears that the company will issue coverage during the year to about 3,500 persons at ages 65 and over. These will constitute about four percent of the total number of adult lives to whom such coverage is issued.

With respect to insurance for the lower income groups, Mr. Spiegelman said that the problems involved in the development of accident and sickness insurance for them become evident in a review of their population characteristics. Whatever the criteria may be to set the lower income groups apart from the rest of the population, the level of demarcation will vary widely within the country. To provide a picture in this situation, he had made a study of money income received by families and individuals in 1954 before deductions for personal taxes and social security payments.

Three annual income categories were used: under $1,000; $1,000 to $2,499; and $2,500 and over. The value of farm products used for family living was excluded; this may be a significant element for lower income families in farm areas. Also important is the fact that many farm workers and domestics occupy rent-free living quarters. Such payments in kind may be large in proportion to money income.

Among the 42,000,000 families in the United States in 1954, three-quarters had a family income of $2,500 or more, one-sixth fell between $1,000 and $2,499, and somewhat over one-twelfth had a money income of less than $1,000. For present purposes, there may be a special interest in the 7,000,000 families with a money income between $1,000 and $2,499.

Among these lower income families, 24 percent were living on the

farm; almost 40 percent were located in the South; 18 percent had a female as the family head; 25 percent of the family heads were over 65 years of age; over 10 percent had four or more children under 18; almost 20 percent of these families had no earners; almost one-third of the family heads were either in the Armed Forces or outside the labor force; and almost one-fifth received their incomes from sources other than current earnings.

In almost all instances, the corresponding proportions are much larger for families with an annual income of less than $1,000. For example, almost 40 percent of these families were living on the farm; over 25 percent were headed by a woman; 30 percent of the family heads were over 65 years of age; 35 percent had no earners in the family; almost half had family heads who were unemployed, outside the labor force, or in the Armed Forces; and about one-third had income from sources other than earnings or no income at all. These characteristics of low income families, as portrayed in census data, reflect in large measure the underlying factors cited by Secretary Folsom as the causes of low income.[1] These factors are:

"1. Unemployment; lack of full-time employment; or employment at less than highest skills.
2. Old age.
3. Death of the family breadwinner.
4. Sickness and disability.
5. Broken homes.
6. Inadequate education and training."

MR. H. R. ROBERTS reported on the experience with individual major medical policies. He pointed out that the word "experience" in the topic could be interpreted in the actuarial sense as a comparison of claims with exposure or in the everyday sense of the word.

In the former sense they had nothing to report at the present time because of still inadequate statistics. He pointed out that an overelaborate statistical analysis of a small volume of material may tempt a company into making decisions which it may later have to reverse. In the meantime, however, they have maintained the figures that enter into Schedule H so as to get a rough idea whether the premium seems sufficient to take care of expenses, claims and increase in reserves. Although there is a flaw in this method because the claim reserves in the early stages have to depend so much on the same judgment that was incorporated in the

1. Statement of Marion B. Folsom, Secretary of Health, Education, and Welfare, Hearings before the Subcommittee on Low-Income Families of the Joint Committee on the Economic Report, 84th Congress, First Session, November 18–23, 1955, p. 8.

premium calculations, the indications are that the rate structure of their individual major medical, judged by this method, would seem to be satisfactory on the average.

Their experience in the broader sense of the word seems to have been quite satisfactory. Although the idea of this type of coverage was apparently new to many of their field force and sales activity at the beginning was much slower than hoped for, there had been since that time a steady and substantial growth in the use of the form. In the first five months of this year, they have issued as many of these policies as they did in the first 15 months after it was introduced.

When they introduced this coverage, they decided to look on it fundamentally as a family coverage and not to expose themselves to the selection that might be inherent in allowing a family to select its members that should be covered. They required that insurance on all eligible family members be applied for. In some cases it was necessary to eliminate one or more of them as being uninsurable. An individual form was available for men or women who were not members of a family group.

In the actual underwriting of applications they encountered a number of problems peculiar to this coverage which required special care in handling. In general this stemmed from an apparent capacity for antiselection among applicants for major medical. They found that it was necessary to be more than usually thorough in getting additional information, such as reports from attending physicians. The necessity for this was added to because of his company's commitment to its field force with regard to renewal underwriting. They had stated that it was not their present intention to take any renewal underwriting action in individual cases simply because of change of health after the policy was issued.

They also found that the deductible factor does not necessarily protect the company against claims arising out of so-called minor conditions. For example, in the first 100 claims paid, four of these were for hemorrhoids. On one of these the expenses incurred amounted to nearly $2,000. They found it necessary to require impairment riders for such apparently innocuous things as pre-existing tonsilcitis, hernia or hemorrhoids.

At the present time their policy does not contain an exclusion of pre-existing conditions. They therefore have a defense against conscious antiselection only to the extent that they are willing and able to contest the policy for misrepresentation. Such cases could probably be handled more smoothly through the medium of a "pre-existing" exclusion. Also, the use of such a provision would enable them to continue insurance

on those cases where an operation had actually removed the substandard element. It could also be helpful in connection with occasional problems which arise because of the ignorance claimed by some husbands about certain of their wives' difficulties.

Their experience indicates that even with the 25 percent coinsurance protection, this coverage cannot be successfully sold to the very rich. Such people receive bills, especially from surgeons, which may be reasonable for them but which are exorbitant and unreasonable in relation to the amount charged to most insureds. They are considering the adoption of a flat maximum family income.

Although there have been such problems to cope with, and although the successful administration of this business requires a high degree of skill and coordination between the field underwriter and the home office underwriter, they feel that their experiment has progressed very satisfactorily and has been well worth while. They are enthusiastic about major medical as a real insurance protection to men and their families against serious losses.

With respect to the collection of morbidity data and other information, MR. T. H. KIRKPATRICK stated that the Health Insurance Association of America has established an Actuarial and Statistical Committee with two subcommittees primarily interested in obtaining statistical information on which new forms of coverage can be based or coverage extended to risks not previously considered insurable because of age or health. These subcommittees are the Subcommittee on Surveys and the Subcommittee on Developmental Research.

In the past, the insurance companies have not taken too active a part in collaborating with outside organizations which have undertaken surveys covering disability and resulting medical costs. It is hoped that, through the work of the Subcommittee on Surveys, surveys completed by outside organizations can be made more accurate and be in a form useful to the companies in risk appraisal. In particular this subcommittee is interested in the survey being planned by the Department of Health, Education, and Welfare and hopes to have an opportunity to actively cooperate with HEW in this regard. It would be possible through this source to obtain information most helpful to the companies in extending coverage to the older ages, to substandard risks and to those not now insured due to a variety of reasons. Furthermore, it is hoped that more accurate information can be obtained regarding the extent to which medical costs are being covered by insurance.

The Subcommittee on Developmental Research has the immediate and practical duty of seeking statistics which should shed light on the

problem of extending our insurance both to those uninsured and to those who have incomplete coverage.

The Society's own Committee on Experience under Individual Accident and Sickness Insurance is making slow progress. The two principal difficulties are (*a*) only a limited amount of work can be performed on a voluntary basis by those with other full-time jobs, and (*b*) only 20 companies (of which only three are companies without members of the Society) accepted its invitation to contribute.

Notwithstanding those problems, the Committee is proceeding to construct tables covering loss of time benefits from the limited number of companies who will contribute. Although the data will be very limited in some areas, they are hopeful of having one or two tables by fall.