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PANEL DISCUSSION—ATLANTA REGIONAL MEETING

HOSPITAL AND MEDICAL CARE NEEDS

1. How the problem is being met and can be met by Health Insurance plans.
2. The role of local, state and Federal Government agencies.
3. Relations of hospitals and the medical profession.

Panel Members:

JOHN M. BRAGG, Moderator
MORTON D. MILLER
W. SHEFFIELD OWEN, Vice President for Business Development, Life Insurance Company of Georgia

JOHN M. BRAGG:

Our main purpose on this panel will be to deal with certain actions which private health insurance must take if the threat of socialized medicine and state health insurance is to be overcome.

The health insurance business has come a long way in the relatively short time that soundly financed protection against the cost of hospital and medical care and treatment has been offered to the public. Less than 20 years ago in 1939, only twelve million persons, representing 9% of the U.S. population, had some form of health insurance coverage. Today, 121 million, or 70% of all the people in the nation, have some type of health insurance.

Almost no health insurance coverage existed 20 years ago for Americans of advanced years. As late as 1952 only 26% of this segment of the public, 65 years of age and older, were covered by health insurance. Today more than 40% of this segment of the U.S. citizens have some form of health protection. The number insured is rising more rapidly than the number of persons entering this age bracket. By 1960 the insurance business estimates that 60% of the aged needing and wanting health insurance will have it; 75% will have it by 1965; and by 1970 it is estimated that this figure will increase to 90%.

Despite these spectacular advances there is much activity largely aimed in the direction of compulsory Government coverage. At the present time, there are hundreds of bills before Congress, similar to the Forand Bill and the Murray-Dingell Bill, that would provide health care for aged persons. Pressure for the passage of such legislation may be particularly great before the 1960 Presidential elections.

Among other developments at the federal level, we could mention the

U.S. Senate Subcommittee on the Aged and the Aging—the McNamara Subcommittee. This body is to begin panel type hearings in Washington on June 16 and is expected later to hold hearings in various cities throughout the U.S. Then there is the White House Conference on the Aging, which is to meet in January 1961 and is to be preceded by state conferences on the problems of the aged. And there is the recent 117 page report entitled "Hospitalization Insurance for OASDI Beneficiaries," prepared by the Secretary of Health, Education, and Welfare. This report gives six reasons why the Federal Government should not act to provide such insurance and five reasons why it should do so.

Without going into great detail it is only necessary to mention the Metcalfe legislation in New York and similar legislation elsewhere to indicate that there is much activity at the state level as well, on various problems affecting the health insurance business.

Apart altogether from legislative activity, there is a myriad of activity throughout the Country on the part of study groups, old age organizations, studying such questions.

So much for background information. We now come to the question: What must the health insurance industry do to grow and prosper, and to preserve our voluntary health insurance system?

The Health Insurance Association of America, which represents companies writing about 80% of the A&H business written by insurance companies, is naturally very much concerned about all these developments. After extensive study, a special meeting of the HIAA was called on December 8, 1958. That meeting, by overwhelming vote, adopted a "Statement and Resolution" which has been described as "probably the greatest forward step in the history of insurance in our time." This resolution urges each company to consider independently and carefully the implementation of seven specific recommendations. The resolution has been duplicated and may be picked up by members at the rear of the room following this panel discussion.

Four of these recommendations relate to individual policies and deal with minimizing of cancellation practices; adoption of policies that are guaranteed renewable for life; offering of coverage to persons now over 65; and insurance of substandard business. Mr. Miller will now deal with the individual policy situation.

MORTON D. MILLER:

Individual health insurance to defray the costs of hospital and medical care covers about 29,000,000 persons and is the principal means of insuring people to whom group insurance is not available. In a short quarter

century, individual and family health policies have assumed their place as essential forms of personal security alongside individual life insurance and retirement provisions; note the substantial number of life insurance companies that entered this field during that period. Unlike life insurance, however, we do not expect people to have individual as well as group protection, since the presence of both usually results in overinsurance.

Until recently, health insurance has developed more along casualty than life insurance lines. Most of the existing policies are on a one year term basis with the renewal of the policy subject to the consent of the insurer. Many but not all companies by administrative practice permit the insured to renew his policy indefinitely, except only in cases of fraud or abuse. A minority of the policies guarantee by contract the insured's right of continuance for life or to a specified expiry date as is the universal practice in life insurance. Viewed in the broad, the Health Insurance Association of America resolution would have individual and family health insurance accelerate at a jet propelled rate its development already begun toward permanent policy plans and the same types of guarantees in the public interest as have been the hallmarks of life insurance for so many years.

The HIAA resolution deals separately with the present aged who until now have not had equal opportunity to provide themselves with health insurance for their retirement years. The imperative need here is to make policies available which they may buy for themselves or which may be bought for them by their children or other family members who may be assisting in their support where their own resources are limited. This challenge is rapidly being met as more and more companies are developing special policies for senior citizens, some without any limitation on the issue age. The use of such policies when issued on a blanket basis without evidence of insurability to groups of retired persons who are members of a Golden Age Club or an association of older persons or to older persons resident in a state or region is a particularly noteworthy development. The spirit of the HIAA resolution which was voted unanimously will not have been met until every company has a "65 plus" or senior citizen policy on the market.

For the future aged, the HIAA resolution emphasizes the need for permanent policy forms which guarantee renewability after issue and through the retirement years. These should be available on a whole life basis and alternatively on a paid-up at 65 or similar plan so that post-retirement protection can be paid for during the working years. A recent survey showed that 85 companies are now issuing whole life guaranteed renewable policies.

The HIAA resolution would also have us find more ways of extending health insurance to persons who now may be ineligible for coverage because of a physical impairment. Most companies will issue policies to an impaired life subject to the waiving by rider of benefits that might result from the particular condition. More recently, about 40 companies have been experimenting with health insurance for physically impaired persons on an extra premium basis analogous to substandard life insurance. There is a need for more companies to be doing so in order to minimize the number of persons deprived of the opportunity to secure adequate health insurance.

What are the problems in setting up a premium structure for lifetime health benefits? Fundamentally the computations are no different from those we make for life insurance gross premiums and should present little difficulty for the life actuary.

One must have:

1. Expense rates for commissions and other sales overhead, and for policy issue, premium collection, claim settlement, and other administrative functions.
2. An interest basis.
3. Rates for policy termination because of lapse and death.
4. Expected claim costs or morbidity rates by age for the plan of benefits.

Some of the hesitation to undertake lifetime benefits in the past has probably stemmed from the limited statistics available concerning claim costs. While there are still nowhere nearly as much data as in the case of life insurance, information has been accumulating very rapidly so that this should no longer be a serious obstacle. I call your particular attention to a number of studies giving the pattern of present day costs:

1. The report of the New York Insurance Department, "Voluntary Health Insurance and the Senior Citizen." It contains a chapter of actuarial analysis and extensive tables on the frequency and duration of hospital and surgical benefits by sex and for all ages. This section of the report was prepared by a committee of members of this Society appointed by the Department.
2. The Bartleson-Olsen paper, "Reserves for Individual Hospital and Surgical Expense," *TSA* IX, 334, which contains tables of basic functions as well as reserves.
3. The annual reports of the Society's Group Morbidity Committee and the several special studies published in the form of papers such as Stanley Gingery's "Special Investigation of Group Hospital Expense Insurance Experience," *TSA* IV, and the more recent surgical claims study.

4. On individual major medical, there is the material in Charles Walker's current actuarial note and the preceding one in *TSA* VII, "Gross Premiums for Individual and Family Major Medical Insurance."

Given the pattern of current health insurance costs, the premium calculation should also involve consideration of changes to be expected in the assumed claim cost levels due to such factors as the continued improvement in medical science, the trend toward greater use of medical care, and the effects of economic inflation on medical and hospital charges for which the policy will be promising benefits. Under a lifetime policy, guesses concerning the effect of such factors on the policy experience extend far into the future and are surrounded by such uncertainty as to make the likelihood of the development of long-term benefits slim if it were not for an important safeguard available to the insurer. The insurance company may reserve the right to change the premium rates for a class or classes of policies as the future experience may require. This important protection to the underwriter removes the need to project the change in the level of medical care costs too far into the future.

It would appear sensible in the initial premium calculations to anticipate the effect of increases in the cost of medical care for a reasonable period such as five or ten years, and so have in mind making it unnecessary to consider changing the premium rates on outstanding policies for a like five or ten year period at least.

There is ample reason to think that the next five or ten years will see a rise in over-all medical care costs of the order of 5% per annum. The effect of this tendency will depend on the nature of the benefits and the types of limits a particular policy contains. For example, a major medical policy without internal limits will experience the full effect of such changes in cost levels. On the other hand, the effect should be considerably less on a surgical expense policy with a specified schedule of benefits.

When a company embarks upon a lifetime policy program, it must be ready to set up the appropriate reserves for future benefits from the premiums of the early years. These should be on a basis consistent with the premium assumptions and in accordance with the Task Force 4 report adopted by the NAIC in 1956. Bartleson's paper should be a great help in this connection.

One of the plaguey problems we should be increasingly conscious of especially with the expansion in lifetime guaranteed renewable policies is the matter of overinsurance. This can be controlled at issue by proper underwriting. But after issue the applicant may become eligible for other benefits by reason of marriage or by participation in a group program or a Blue Cross–Blue Shield plan. The proration provisions permitted by

statute do not enable us to deal with such situations effectively. I commend wholeheartedly the suggestion advanced by Milton Ellis at the Philadelphia meeting of the HIAA that industry should begin studying the uniform provisions laws to see whether in this and other respects they adequately meet the current needs of the health insurance business, if we are to serve the public best.

JOHN M. BRAGG:

In addition to having the products to do the job, we must also see to it that these products are put into use effectively. This essentially involves the sale of these products to the public, and also the sale of our services to hospitals, doctors, and other providers of medical care. Mr. Owen will first of all speak to you about this latter aspect. These activities are carried on through the Health Insurance Council.

W. SHEFFIELD OWEN:

We are concerned with the preservation of voluntary health insurance not only as persons engaged in the business of insurance, but also as citizens and consumers. Health insurance is an important part of our business. Without voluntary health insurance, many of us, and the vast majority of the American people, would be unable to afford, as private patients, the kind of medical care which modern science makes available. Only as private patients, with freedom to choose or dismiss our doctor, can we be sure of the personal relationship without which we are merely case numbers on a medical assembly line.

The preservation of voluntary health insurance depends upon efficient operation by us, cooperation from doctors and hospitals, proper use by the insured public, extension of insurance to all segments of the population, and effective education of the public and legislators with respect to the achievements and prospects of the voluntary method. The Health Insurance Council has responsibility for only one of these factors, obtaining the cooperation of doctors and hospitals, but the attitudes and activities of doctors and hospitals affect all the remaining factors.

Many insurance company operations depend upon doctor and hospital activities. The aggregate benefits provided by insurance depend upon the level of fees and the amount of utilization. Proper determination of premiums to provide these benefits depends upon there being some degree of predictability in fees and utilization. Information from doctors and hospitals is needed in order to pay benefits when due. Policy design must keep pace with developments in medical practice.

Doctors can help to educate the public in the proper use of insurance

and in a large measure can prevent improper use. Doctors' attitudes and practices affect the public's demand for health insurance and the ability of companies to provide protection for all segments of the population against all types of health expense. Doctors and hospitals have a large stake in the preservation of the voluntary nature of health insurance and can be effective partners in the education of the public and legislators as to the advantages of the voluntary way.

The Health Insurance Council performs its functions through national and state committees assisted by staff of the member trade associations.

The Council is directed by a Central Committee, consisting of the Chairman of the Council, several Vice-Chairmen, the Secretary, the Chairman-Elect and the Retiring Chairman, the Chairmen of the Standing Committees, representatives of the member associations, and members at large. A number of outstanding Fellows of the Society of Actuaries have served as chairmen of the Council and in various other capacities on the Central and other Committees. The Central Committee has subcommittees on Coordination of State Committees, Communications, and Budget.

The Council has four standing committees and a fifth has been authorized.

The Medical Relations Committee is in charge of relations with doctors. It has subcommittees on Nervous and Mental Illness and on Medical Education.

The Hospital Relations Committee is in charge of relations with hospitals. It has subcommittees on Group Accident and Health and Individual Accident and Health.

The Technical Advisory Committee studies technical questions relating to health insurance coverages. It has subcommittees on Overinsurance, Relative Value Unit Fee Schedules, Uniform Format and Nomenclature of Surgical Schedules, and Medical Services.

The Uniform Forms Committee has developed standardized claim forms and questions and is charged with obtaining company participation in the Uniform Forms Program.

A new committee is being organized to have charge of relations with paramedical groups.

State Committees have been organized in almost all states and the District of Columbia. Over 500 insurance executives take part in the work of these committees. Organization is both geographical, with subcommittees in various parts of the state, and functional, with hospital and medical subcommittees. Committees meet wide variations in hospi-

tal and medical problems and cooperation. Accomplishments are published in HIC report.

The state and local program is the Council's most effective way of communicating with the individual doctors and hospitals whose fees and practices determine the aggregate cost of medical care.

JOHN M. BRAGG:

Mr. Miller dealt earlier with those aspects of the HIAA December resolution which had to do with individual insurance. That resolution contained two points relating to group insurance. One concerns group coverage for retired persons and the other deals with group accident and health conversions. Mr. Miller will now deal with these two points.

MORTON D. MILLER:

Group health insurance against the costs of hospital and medical care for employees and their families covers almost 50,000,000 persons. Here, too, the Health Insurance Association of America resolution would have us hasten our progress toward the long established pattern of group life insurance, in this case by continuing health insurance benefits after retirement and including a conversion privilege for terminating employees. From the earliest days, group term life insurance has been continuable into retirement after the employee leaves the active working group. A study several years ago showed that the policies accounting for 75% of the total volume of insurance in force included provision for the continuation of at least some portion of the insurance into retirement. A significant percentage of the postretirement insurance was continued on a paid-up basis.

In addition, group term life insurance has from the beginning included a conversion privilege preserving the employee's insurability whether he left the group at retirement or during his working years. No one would deny the importance of the conversion privilege in furthering the growth of group term life insurance and in enabling it to achieve the position of high regard that it holds in the eyes of the public. The privilege has also worked out well in practice from a cost point of view. The transfer of funds to the ordinary branch required to pay for the extra mortality losses under converted policies is of the order of half of 1% of premiums.

Continuation under the group plan where that can be arranged is clearly the best way to provide health insurance for retired employees and their dependents. It affords desirable flexibility to adjust the benefits from time to time to follow the changing patterns of medical care and the costs of such care. It permits of economical administration of the benefits. And the cost of the benefits continued can be subsidized by the policyholder.

Retirement continuance of health insurance has been growing very rapidly. Already about 35% of the group coverage with the companies makes some provision for health insurance after retirement, most of the arrangements having been established within the last five years or so. Some plans have even been extended to existing pensioners and their dependents. In most instances the policyholder pays all or a substantial part of the cost so that the continuance is at little or no cost to the retired person. It should be pointed out that persons who continue at work beyond age 65 remain in the active employee group with automatic continuation of the same benefits. A substantial number of older persons are covered in that way.

What benefits should be continued for retired employees and who should be covered? We should strive to have approximately the same benefits provided for retired employees as for active employees, since the need for health insurance does not diminish after retirement as in the case of life insurance. This may not be practical in some cases such as where the plan for active employees is very comprehensive. In such instances we should try to be sure that there is a realistic pensioner plan of hospital and surgical benefits at least. We should seek to have the spouse and any dependent children of the retired employee eligible for coverage and also provide for the continuance of coverage by a widow who may survive the retired employee. Incidentally, the New York Insurance Law was amended last year specifically to permit the continuance of widows' benefits.

Uncertainty as to costs has tended to retard the progress of retirement continuance of health benefits, but that should no longer be an important consideration with the increasing amount of data at our disposal. Premium rates for group health insurance for active employees generally do not take age variations directly into account, but are charged per employee covered. Costs per retired employee are then expressed as a percentage of the cost per active employee. On this basis, the average cost per retired employee for a typical plan of benefits, including protection for dependents, is about one and one-half times the average cost per active employee for the same plan with dependents also included. The tendency for the cost to increase with advancing age is substantially offset by the dropping out of the cost of maternity benefits and the coverage of children which add to the premiums for active employees. With coverage for dependents in both instances, the cost per retired employee turns out to be not much different from the cost per active employee.

There is another approach to these costs that it is helpful to bring out.

Health insurance is only one of the pensioner's insurance needs along with the need for cash retirement income and survivorship benefits. Sensible retirement planning should look at these requirements and their cost from an over-all point of view. We sometimes tend to obscure the picture by reason of the way we market the benefit plans for retirement income, life insurance, and health insurance separately.

Total expenditures for retirement provision should be reasonably apportioned to meet each requirement. I made some estimates some time ago intended to suggest the relationship of the separate costs of retirement income, death benefits, and health insurance to the whole. These were presented in a discussion, *TSA* IX, 87.

We determined the cost on a pay-as-you-go basis of the total retirement provision for income benefits, death benefits, and health insurance for an average group, when the group's active and retired staff had fully matured, and related the aggregate pay-out to the total payroll on the active employees. The components were assumed to be a 50% of final salary pension benefit, which accounted for 10.5% of payroll; a 50% of final salary life insurance benefit, which represented about .75% of payroll; and finally a typical plan of health insurance benefits for retired employees and their spouses, which accounted for another .75% of payroll. The total cost is 12% of the active employees' payroll. This figure omits the benefit cost of life insurance and health insurance for active employees and their dependents, which came to a further 2.5% of payroll.

I think these figures demonstrate that the cost of the vital health insurance need for pensioners is small. Only .75% of payroll out of the total of 12% of payroll for pensioner benefits is required by the health benefits. Thus we should be able to say to our policyholders: first, take an over-all view of your retirement costs; second, allocate a portion of your retirement provision to health benefits; and third, the amount required to be pledged for health benefits will be relatively small. Maybe such an approach will be helpful in selling group health insurance for the aged as aggressively as we have sold pensions and life insurance.

Prefunding of health insurance costs for retired lives is possible through a deposit fund in much the same way as the group annuity deposit administration plan. There has already been a little experimentation along these lines. Of course, continuance must come first before the consideration of prefunding.

The wide variation in the benefit provisions of group health plans makes it much more difficult to provide a conversion privilege than in the case of life insurance. Nonetheless, it is possible to have a standard conversion policy to which conversion on termination of the group insur-

ance is permitted. Many companies have such a conversion option available for inclusion in group health plans. The sense of the HIAA resolution was to the effect that all companies should have such a provision and more importantly we should see to it that the conversion right is incorporated in the group plans we sell. There is real need for us to change our approach here and to promote the conversion privilege vigorously. One way is to include it automatically in all new policies written and to bring it to the attention of outstanding policyholders at renewal or at the time of a change in plan.

JOHN M. BRAGG:

We must have these products available, and we must have suitable machinery for dealing with hospitals and doctors so as to insure a smoothly operating system. Even this is not enough, however. Our products must be aggressively merchandised so as to bring about the greatest possible increase in the number of Americans covered by voluntary health insurance, especially among the aged groups. Mr. Owen will now deal with the question of merchandising these products.

W. SHEFFIELD OWEN:

We can take great pride in the spectacular growth of the health insurance business in the past decade. If we exclude those in the armed forces and those on relief, about 75% of the population of the United States is covered by some form of health insurance. Actually, we have more people insured under health insurance policies than we have under life policies —almost ten million more, in fact.

But, before we become, or remain, complacent about these figures, let us take a quick look at the other side of the coin. There are still some 50 million Americans with no health insurance at all. There are almost 75 million who have no surgical insurance, and 110 million without insurance for medical expenses incurred outside of a hospital. More than half of the rural population has no health insurance, and 60% of our senior citizens are currently uninsured. Many of the 123 million of our population who are insured have coverage for only basic medical expenses. These are some of our weaknesses. I make no apology for directing your attention to them, for they are already well known to the staunchest advocates of such proposed legislation as the Forand Bill and the Murray-Dingell Bill.

The number of people we have insured is impressive, but the extent to which we meet the total bill for health care expenditures is far less impressive. Our policyholders will prepay through health insurance this year only approximately one-third of their total medical expenses.

A great deal of our concern as thoughtful citizens, and as responsible

insurance executives, is for that uninsured or underinsured segment of the population whom we refer to as our senior citizens. This is as it should be. We may not have in private enterprise the answer to the problem of the indigent. The problem of the uninsurables, and the impaired risks, while serious, is not insoluble. But in the area of the retired, whose coverage is so obviously deficient, we can, and we must find a prompt solution.

Several companies have pioneered in the field of writing individual hospital and surgical insurance policies specifically designed for the 65-and-over age group. I wish I could say that my own company is one of them, but we only entered the individual hospital and surgical field some 14 months ago, and, proceeding with due caution, we have not yet ventured into the upper age bracket. Our actuary tells me that we have the rates ready, however, so we probably shall shortly join the fine group of companies which are doing something about the situation. They are the trail blazers, and we owe them a debt for blazing the trail for us.

If we succeed in our objective of retaining the right to offer to finance the medical care needs of the American public, we must extend the coverage to the full range of medical services that people want and are willing to prepay—and we must extend it to those segments of the population that are difficult to insure. There are certain things to which, if any are entitled, all are entitled. Among these is the right to adequate medical care, which we firmly believe can best be provided on a prepaid basis in a free society when every man has the right to select the doctor of his own choice. It does not necessarily follow that all, or that even a majority of the people believe that. Until we demonstrate our capacity to furnish the services that are needed and desired by the people—on an efficient and effective basis—we deserve to fail.

If we fail, it will be less because of ignorance than because of inertia. We have the "know-how." If we did not, we would not have progressed as we have. The question now is whether we are sufficiently concerned about it to have recourse to the measures whereby we can complete the job we have so valiantly begun.

Our success is not necessarily measured by economics, but by politics. We are presently in the position of an officeholder who must demonstrate effectiveness or be voted out of office. We could conceivably be a financial success and still "go down the drain." And this we may very well do unless we satisfy a majority of the voters, whether they are insured or not.

I would not have you think I am pessimistic about the situation. No agency man can long remain one unless he is basically optimistic. It does not hurt to temper that optimism with a touch of realism now and then, however.

There are a few specific suggestions which I want to make to this group, because I believe sincerely that no other group in our business has as much internal influence as you have.

The first one is that you take a copy of that HIAA resolution, study it carefully and consider the nature and extent of your responsibility for implementing its seven points in your own company.

Another suggestion is that you persuade your sales people routinely to include a provision in every group insurance proposal for continued coverage on retired employees and their eligible dependents, without reduction in benefits upon retirement except possibly in the cases with very "fat" major medical coverage. If cutbacks are necessary, we will be less than political realists if we allow the proposed resulting benefits for retirees to be less than those proposed in the current Forand Bill!

In our own company we have been writing our proposals to include such continued coverage on persons who are retired. In the past we did this only if the employer requested it. We now believe we have an obligation to suggest to the employer the kind of coverage that will meet his social obligations and the approval of the community. What is your company's policy on this? Are you waiting for someone to prod you into progress?

Then I hope you will include a conversion clause in every group hospital and surgical policy you issue. In the case of my company, we have never issued a group policy without such a clause, and we do not intend to do so.

Morton Miller has already proposed that the widows of retired employees under group policies should be provided for through provision in the policy. I should like to urge your favorable consideration of this suggestion.

We cannot afford to leave loopholes in the protective armor. To do so is to make ourselves vulnerable to the potshots that self-seeking politicians and rabble-rousers are sure to take at us—especially in the forthcoming election year.

It has been said that insurance is more than a business—it is an instrument of social and economic welfare. As such it must be administered and interpreted by men with a high sense of trusteeship. To management falls the duty to administer—and to the segment of management represented by the members of the two groups here today falls much of the duty also to interpret and to design and to price—the product or service which our field forces purvey to the public. It is in your private laboratory that the sale really begins.

The public needs our services. May that knowledge motivate us to

continue to work together in supporting such devices as the Health Insurance Council in its program, and in implementing the resolution of the HIAA. There is a broad market for our product. The best way to protect this market is to occupy it.

JOHN M. BRAGG:

The things that need to be done have been most ably outlined by our two speakers. More than any other group, we as actuaries are in a position to bring into existence the products and developments which are necessary to do the job.

MR. MORTON D. MILLER, in response to a question as to what is being done to develop adequate morbidity statistics for people over age 65, stated that he understood the HIAA is going to ask the member companies to submit any unpublished material they may have, to be put together and made available to the companies working in this area.