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Group Accident and Sickness Insurance

A. What loss ratios are expected during 1960 and 1961 under newly determined premium rates for basic medical care, supplementary major medical and comprehensive major medical insurance coverages?

B. What are the design trends under comprehensive major medical insurance coverages? What influence have Health Insurance Council and related activities had on these trends?

MR. STANLEY W. GINGERY noted that keen competition in the hospital insurance field has made it difficult to keep premiums charged, for both new business and renewals, in line with rising costs of hospital and medical care. Under the reasonable assumption that the trend of increasing claim costs for medical care insurance will continue, more frequent (possibly annual) increases in premium rate scales may be needed in the future to keep them up to date.

He reported that the Prudential revised premium rates for hospital and major medical coverage and for the obstetrical portion of surgical coverage early in 1960. The objective was to make rates adequate to cover expenses and claims anticipated for policy years ending in 1961. The increases in rates ranged up to 20% for hospital coverage, up to 27% for comprehensive major medical, and up to 33% for supplementary major medical. The average increase was 10% for hospital coverage and 21% for major medical.

MR. ROBERT N. STABLER reported that loss ratios to manual premiums developed from analysis of renewal activity were used by the General American to check on the adequacy of their manual rates. Premium rates were increased in May 1960 to the amount needed to support claims at the level projected from this information.

Using a sample of groups of less than 300 lives, and allowing for a 5% annual trend in claims, the loss ratios projected for the policy years ending in 1960 and 1961 for basic hospital-surgical-medical coverage are 75% to 80% and 80% to 85%, respectively. The General American's experience indicates comparable ranges for these years for comprehensive major medical coverage, except that there is a somewhat greater upward trend.

MR. NORTON W. CHELLGREN reported that the Aetna's loss ratios for policy years ending in 1959 were 80% for hospital coverage, 78% for surgical coverage, 77% for comprehensive major medical, and 71% for supplementary major medical, for employee and dependent experience combined in all except jumbo groups. These loss ratios were computed at former manual rates which have since been increased, on

July 1, 1960, by 10% for hospital coverage, 12% for comprehensive major medical and 15% for supplementary major medical.

Annual rates of upward trend in claim costs were estimated at 5% for hospital coverage, 2% for surgical, 10% for comprehensive major medical, and 12% for supplementary major medical. The trend rates for hospital and surgical coverage were estimated from a study of loss ratios experienced at manual rates for policy years ending in the years 1954 to 1959, which indicated average annual increases of 5.7% for hospital and 2.2% for surgical. More rapid increases for the major medical coverages are forecast from the fact that claim costs will increase more rapidly than medical care costs themselves, particularly as the general public becomes aware of these coverages.

Using these estimates of trends, projected loss ratios at present manual rates for policy years ending in 1961 are 80% for hospital coverage, 81% for surgical, 83% for comprehensive major medical, and 81% for supplementary major medical.

MR. BERTRAM N. PIKE reported that analysis of the John Hancock's claims experience data for 1959 indicated an over-all loss ratio of 75% at January 1, 1960, on the new premium rates adopted early in 1960. He anticipated an increase in loss ratios of 5% per year for hospital coverage and 5% to 10% per year for major medical, with some indications that hospital charges may rise even more rapidly in the future. If these expectations are realized, another increase in premium rates will be needed in the near future.

MR. WILLIAM W. KEFFER predicted that loss ratios experienced in 1961 will climb beyond the levels provided for in 1960 premium rate scales. The continuing upward trend in costs of medical care benefits should be taken into account in predicting claim costs by looking more than a year ahead, since the first year of experience on next year's new business will not be concluded until two years from now. With rising costs, rates adequate for a year will be inadequate for issues in the latter part of that year.

The Connecticut General's regular studies show that claim costs for 1960 exceed those for the same months of 1959 by 4.5% for hospital nonmaternity coverage, 3.1% for surgical, 4.8% for doctors' (nonsurgical) attendance benefits, and 3% for X-ray and pathology benefits. Any talk of a possible leveling off in the rise in medical costs is not supported by either available facts or general reasoning.

Mr. Keffer cited several factors contrary to such possibilities. The American Hospital Association has reported annual increases in the average expense per patient-day in short-term general hospitals of some 7%.

Hospital employees' pressure for higher wages increases. Hospitals seek billing procedures such that patients will support costs. The medical care portion of the Consumer Price Index continues to rise, and some medical associations have indicated their members' charges can be expected to rise with the rise in prices generally.

Recent stress on new hospital construction and improved facilities can lead to increases in utilization beyond population growth. Connecticut General experience shows a 5% to 10% increase per year in nonmaternity hospital admission rates. However, a recent decline in birth rate and costs of maternity benefits may be a temporary offsetting factor.

Schedule limits hold down the effects of higher charges on the basic coverages. Higher charges have a more direct effect on claim costs for major medical. To the rates of increase in cost and increase in utilization of facilities must be added the tendency for the more liberal benefits under major medical to result in still higher charges and utilization, so that the rate of increase in claims costs for major medical can exceed that for basic benefits. In one case an increase in charges exceeding 15% in less than a year was observed.

MR. GINGERY stated that the Prudential's new rate structure provides for separate calculation of room and board, miscellaneous charges and maternity portions of the total hospital premium rate. Geographical variations in the miscellaneous charges portion recognize the substantial differences in costs by area. General American and John Hancock also introduced the use of area classes for hospital rates, according to statements by MR. STABLER and MR. PIKE. John Hancock had previously used an age gradation in hospital rates.

MR. STABLER noted that variations among companies in rates for hospital coverage are now much greater than before in most situations, because of the lack of uniformity among companies in their evaluations of area cost differences. For example, there are some differences among competitors for the same plan as high as 20% and 15% for employee and dependent hospital coverage, respectively. The over-all average variation, measured by the General American's in-force, is about 8% for hospital coverage and 10% for dependent coverage. Variations on other basic coverages are less, so premiums for a typical basic plan vary by about 6% over-all among the new rate scales studied.

MR. PIKE noted that these variations indicate different estimates of the effects of these factors on expected claims, which are not surprising in view of the relative newness of rate variations and the absence of data for checking them. Widespread use of area and age factors could lead to a change in distribution of new business, and could present acute problems

for companies which have not yet adopted any area gradations in their rates and find they obtain more business in areas where rate margins are smallest.

Prudential's major medical rate change, as stated by MR. GINGERY, included upward reclassification of many important areas for rate purposes. Suburban areas are now included in the same classification as the city they surround. MR. STABLER said that General American also revised its area classifications, generally upward.

MR. GINGERY noted the continuing importance of variations in costs and utilization of facilities by area, age, and income. He hoped that more meaningful data on such variations will be furnished by a subcommittee of the Society's Committee on Group Accident and Sickness Experience and reported also that Prudential is looking into mechanical methods of getting more data faster from its own experience.

MR. FRANK J. ALPERT stated that a company's loss ratios on manual rates depend both on the level of the rates and on the quality of business to which the rates are applied initially and at renewal. If higher rates are charged for groups likely to be poorer than average, the average loss ratio at manual rates will be lower than if all groups are charged the same rates, in which case loss ratios may be affected adversely by inclusion of a disproportionate number of worse than average groups.

For cases which transfer from other carriers, there are two available quantitative measures of whether experience will be worse than average: the past experience of the group itself and evidence that indicates transfer business as a class generally to be substandard as to both loss ratios and lapse rates. New York Life's practice is to consider that transfer cases are worse than average, in the absence of evidence to the contrary, and to charge higher than manual rates unless past experience or qualitative factors justify exception.

New York Life's renewal practice is to set renewal rates on the basis of all past experience of the group. For small groups the objective is to achieve premium adequacy for the class as a whole; the allocation of the necessary total premium among groups considers all past experience as some indication of things to come.

Experience rating has improved the over-all loss ratio in two ways. Persistency of groups with better than average experience is improved by charging lower than average renewal rates. The use of higher rates for groups with poorer experience assures a more adequate premium for those groups which persist, even though rates above the market level make them subject to cancellation. As the poorer cases cancel more frequently than the better, the culling effect improves the average of those remaining.

A sample of cases lapsed after the 1959 anniversary has had experience 30% worse than the average of the cases remaining in force. On cases which transferred in 1959 to three companies, claims have been 20% worse than average; excluding transfers to consolidate coverages, the experience on these cases was even worse.

On section B, MR. JOHN R. WILLIAMS reported a sharp change in attitude toward major medical by the Lincoln National. Issue of comprehensive major medical is considered against the best interests of employers, union members and the public, because of the constant and rapid increase in costs. Such coverage violates the fundamental insurance concept of insuring a known risk for a known amount, and the attempt has failed.

Actions taken by Lincoln National since 1957 have included elimination in October 1957 of plans with 100% coverage of all expenses, introduction of a "Controlled Major Medical" plan with inside limits in May 1958, and discontinuation in September 1958 of plans covering the first $300 or $500 of hospital expenses in full. Since April 1960, the only plans issued are superimposed plans and the Controlled Major Medical plan. This plan limits hospital room and board benefits to a specified dollar amount chosen according to area costs and pays 80% of hospital special charges. Benefits for surgical charges are limited by a schedule chosen according to cost area. Benefits for all doctor calls (including psychiatric) are limited to 80% of a daily maximum defined by cost area. Out-patient drug charges are excluded. Benefits for other expenses are 80% of charges after a $35 deductible.

MR. CLARENCE H. TOOKEY commented on practices on the West Coast, where the Occidental is considering elimination of comprehensive plans for small groups and another company has withdrawn from the comprehensive field. Most large groups adding major medical benefits recently have used superimposed coverage with a corridor deductible rather than comprehensive. There appears to be a trend toward revising the very liberal comprehensive plans.

California doctors as a group are highly critical of the comprehensive approach. When the insurer's claim department determines a customary fee for a procedure lower than the doctor's charge, the patient may assume that the fee was too high. Doctors prefer to use surgical schedules in policies as a guide so that there can be no such implication.

Investigation of a large number of doctor charges on Occidental claims showed that bills were about 18% higher for insureds with comprehensive coverage than for those with basic coverage, with or without superimposed major medical. The average conversion factor to the relative value

study was $7.16 for comprehensive, compared with $6.03 and $6.08 for basic plans with and without superimposed major medical. This study, for the period from October 1959 to July 1960, showed the same pattern as a study two years earlier. An analysis of experience in the Los Angeles area for several companies, now in preparation for the Health Insurance Association of America, shows corresponding factors to date of $7.08, $6.38, and $6.32.

Although Health Insurance Council activities have not reduced this gap, other H.I.C. activities have been effective, notably the accomplishments in overcoming the very bad public relations with doctors and hospitals caused by comprehensive coverage. The California Medical Association's relative value study and the doctors' desire for schedules indicate a desire to work with insurers. Much work has been done in standardizing claim procedures and by hospitals in adopting methods for determination of charges.

Mr. Tookey felt that the comprehensive approach inflates medical costs because of its lack of guides for patient, hospital and doctor. The apparent simplicity which appeals to salesman and customer does not work out in practice and leads to misunderstandings.

Mr. Tookey also challenged the theoretical attitude that the $50 deductible saves claim handling expense. Occidental claims men report that the necessity to include and keep track of many small items such as prescriptions may make comprehensive plan claim adjustments cost two or three times the cost for basic plans.

MR. WILLIAM A. HALVORSON questioned whether comprehensive major medical will be either comprehensive or major medical if the adoption of inner limits continues. He noted that major medical used to be defined as broad medical care insurance providing high dollar benefits, with only coinsurance and deductibles as controls, and that comprehensive was defined as a low deductible major medical plan designed to replace basic coverage.

The popularity of comprehensive major medical over the past four years has convinced him that insureds want better and more comprehensive coverage of all types, regardless of the policy form in which these coverages are embodied. This should lead to design of broader basic coverages as well as comprehensive major medical.

Hospital coverage should provide benefits for long confinement, recognize existing room and board charges in an area, and attempt to control unnecessary confinement through deductibles and coinsurance, as has been done in comprehensive major medical. It should be expanded to recognize the advantages of qualified convalescent care hospitals (for short dura-

tions) and well-organized home-care programs in lieu of hospital confinement, and should also recognize that insureds seek treatment in many types of hospital.

Surgical coverage should be modified often in order to meet changing practices and relative value studies in an area. Coverage for major surgery by top-rated specialists is a major feature of major medical and should be retained wherever possible in some form.

Expenses for intensive hospital and medical care and medication for nervous and mental conditions should be covered under new plans to help meet a serious medical and financial problem. Coverage of illnesses from birth and coverage of complications of pregnancy should also be included in basic coverages. Major medical benefits should be designed to lighten the burden of oppressive amounts of coinsurance on the more serious illnesses.

Even though the public will not always buy comprehensive coverage, insurers must offer it and lead buyers to it, or else buyers and legislation will push insurers into it.

In addition to helping doctors and hospitals to gain a better understanding of each other's problems, Health Insurance Council activities have led to better design of comprehensive hospital coverage to help the hospital solve its problems, encouragement of more realistic schedules of benefits designed to meet local conditions, and discouragement of insurance coverage under which the insurer is the sole judge of the reasonableness of charges. H.I.C. has also helped in many areas to impart a sense of urgency to doctors who are making strides in developing their own internal controls over the economics of medicine.

MR. REINHARD A. HOHAUS quoted the saying, "Let's light a candle and not curse the darkness," to point out that the picture is better than it may look. He warned against making the mistake of carrying over into health insurance principles and concepts which are sound for life insurance but not properly applicable to health insurance. Techniques from casualty insurance, such as antiduplication provisions, should also be brought into health insurance. Health insurance is more a managerial problem than actuarial.

The Metropolitan is convinced that the people want comprehensive medical expense coverage and that it can be written satisfactorily, but that it requires a lot of managerial work. A proper medical relations program headed by an able doctor is important. The Metropolitan has always felt that comprehensive plans must have a deductible.

MR. DONALD D. CODY thought that there is a great difference between larger employers, who are willing and able to exercise some control

of a comprehensive plan, and the small employer who has no means of controlling it. This is especially so in an area where the medical societies and hospital associations have not brought order to the medical charges matter.

Mr. Cody introduced an additional topic not on the program by citing the attention given to medical care for the aged in the press and in Congress during 1960. Congress will undoubtedly explore the need for federal government provision for medical care for the aged beyond the recently adopted program for federal assistance for those who lack means to provide such care for themselves. Meanwhile, the insurance industry has a further opportunity to demonstrate what it can do to fill this need.

MR. EDWARD M. NEUMANN described the Prudential's new approach to the problems that must be solved in order to extend group hospital-surgical coverage into retirement. Because the cost of coverage for older persons is several times the cost for active employees, the employer is concerned with the effect on the cost of his group program of continuation of coverage for retired employees. The administrative cost of providing a special plan for the few retirees in a small group is unduly high.

The Prudential's plan is to extend to all in-force and new groups with hospital or comprehensive major medical coverage a plan of health benefits available for their retiring employees. The same premium rates are used for retirees in all groups, and all claims experience is pooled. While coverage can be provided on an employee-pay-all basis, the employer is encouraged to pay all or a large part of the cost. The standardization built into the plans keeps costs of operation to a minimum.

The employer chooses which of three plans of benefits will apply to all retirees. Under the three alternatives, hospital room and board benefits are $12 for 70 days, $15 for 100 days, and $20 for 100 days. Corresponding hospital extras are $100, $150, and $200. The surgical schedules provide maximum benefits of $200, $300 and $400.

The program was announced to all policyholders in the spring of 1960, and all policyholders will be contacted by field representatives within the next year. There has been slow but steady acceptance by employers, with surprising interest among larger groups. Of those employers electing a plan, 44% have elected the middle-cost plan, with the remainder split about equally between the other two plans.

MR. CHALMERS L. WEAVER stated that the New England Life had offered a similar arrangement but without a direct approach to policyholders. The program had failed up to that time. MR. TOOKEY noted that the Occidental has offered conversions since 1934. In larger

groups most conversions are at retirement, so separate rates are charged at ages 65 and over. Loss ratios on conversion policies have consistently run between 80% and 90% and expenses 20%.

MR. CODY noted that unilateral extension of a conversion privilege is difficult if a conversion charge is needed, so it is hoped that antiselection will be slight enough to be covered by conversion policy premiums.