Group insurance in 1960

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Boston University
THESIS

Group Insurance In 1960

by

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Submitted in partial fulfillment of the requirements for the degree of

MASTER OF BUSINESS ADMINISTRATION

1960
This thesis was prepared under my supervision and approval is hereby indicated.

Warner C. Danforth
Professor of Insurance
First Reader

This thesis was read by me and is approved.

Louis Q. Giovanni
Professor of Law
Second Reader
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INTRODUCTION

For the past half century, we have witnessed the growth of the Group Insurance Industry from its infancy to an industry now approaching its maturity. During that time, the industry has expanded from a neglected step child of the Life Insurance business, to an operation which constitutes a significant portion of the insurance industry's premium income. Much of the growth is directly attributed to the increased social consciousness on the part of industry and government, and the interest evidenced by labor in the many forms of fringe benefits.

To a considerable extent, the business has grown like the proverbial "topsy." As a result of the extremely competitive nature, it has not developed with the actuarial preciseness of the rest of the industry. The group insurance industry, at least over the period of its greatest growth since World War II, has been characterized by excessive competition, unlike the experience in some other industries which are basically dominated by a few large firms. This competition has manifested itself basically in two general forms:

1. Marginal and sometimes inadequate rate structures.
2. Coverages which, in many cases, are hard to justify from the aspect of sound underwriting practice.

While there has been a considerable amount of material published on the general field of group insurance, most of it has been primarily technical or historical in nature. It is the intent of this paper to concentrate on the current status and problems of the industry.
For the casual reader, I have included as Part I a brief history of the industry and a description of the various coverages provided. There has been no attempt to cover the technical details, since they have been very completely covered in the basic texts such as those done under the auspices of the Huebner Foundation. In particular, I would recommend highly Group Life Insurance, by Davis W. Gregg, and Group Disability, by Jesse Fredrick Pickrell, to those readers who desire a more technical description.

Part II presents some of the more vexing problems within the industry. It is, I hope, an objective appraisal of these problems. For the most part, reference to these problems in published material has been very casual, to avoid antagonizing any of the respective parties involved. Within the industry itself, however, there is considerable discussion; both formal and informal. It is the outcome of such discussions, as translated into management activity, which will ultimately have considerable bearing on the future of the industry. It would be extremely naive to think that the solutions could be reached immediately, if they are reached at all. The managements of all group insurers are well aware of the issues involved, and in some areas have made policy decisions regarding the issues. It is equally obvious that, in some areas, a management decision has not been made, and perhaps will not be made due to differences in opinion between management officials. Also, there have been many decisions which have been made in the past which have already been changed, or will be changed in the future. In fact, the propensity for change in the sales and underwriting of group insurance
has been characteristic of this portion of an industry generally noted for its conservative nature.

Part III is a very frank discussion for the potential purchaser of group insurance, or for a presently insured firm desiring to review their group insurance program. It is not an attempt to find any one right answer for all buyers, since the business itself precludes developing of pat solutions. Instead, it attempts to set forth the pertinent considerations involved plus enough background to permit proper evaluation by the purchaser who is normally entering into an area in which he has little direct knowledge and little unprejudiced information to which he can refer.

Part IV is basically a summary of the previous material with an attempt made to formulate, in so far as possible, the future direction of the industry. Actually, any attempts at prognostication are extremely subjective since the basic determinates of the industry's future are dependent upon the economic and social developments within our government and society.

I would like to reiterate that where I have touched on controversial subjects, I have tried to be completely objective in my approach. My intent is to promote understanding and awareness of the industry's problems. By focusing attention on some of these problems at this time, a better perspective of the general outlook will be attained possibly. If these problems are not resolved, then the proponents of Federal Government control of the industry, and even Federal Government intervention to the extent of providing the Accident and Health benefits as part of
the "social welfare" programs, will probably be successful in their
efforts to have this sector of the economy taken over by the government.
Part I
Chapter I
A Brief History of the Development of Group Life Insurance

While the subject of this paper is basically a review of current developments and problems within the group insurance industry, a brief history of the growth of the industry since the early 1900's is helpful since it serves to give some insight into the present day situations. A fascinating and detailed description has been presented by Louise W. Ilse,¹ Ph.D., in her book Group Insurance and Employee Retirement Plans. Most of the material in this chapter has been derived from that text.

The concept of group insurance, in a sense, is as old as the insurance concept itself since all insurance is basically group insurance - a spreading of the risks of a few over a large group in order to protect the individuals to some extent from the whims of chance and substitute instead a degree of certainty. However, group insurance, as we know it, developed out of discussions held between the Montgomery Ward Company and the insurers to provide a death benefit for their employees which was to be paid for by insurance purchased by the employer. Mass purchasing arrangements had been executed prior to this time, but they involved the purchase of insurance on an individual basis by the employees and were subject to regular medical underwriting rules. This insurance was similar to what is now known as wholesale insurance, or Employee Life Insurance, and still is sold occasionally to employees of firms too small to qualify for the group insurance. It was the Montgom-
ery Ward concept of non-medical term insurance paid for by the employer which was the true group insurance coverage as it is known today. In fact, many of the original concepts and policy provisions are still part of the standard coverage being offered at present. Prior to the conclusion of the negotiations on the Ward case, which became effective on July 1, 1912, prior policies were issued to a few smaller firms which recognized the desirability of the group concept. The first policy was issued to the Pantasote Leather Company of Passaic, New Jersey, effective June 1, 1911, which company was owned by a Director of the Equitable Life Assurance Society of the United States, the Company which was chosen as the insurer for the Ward case.

The new type insurance was vigorously opposed by some sectors within the industry, in particular, the fraternal associations. However, the attractiveness of the coverage was not to be denied, and various state legislatures soon began to make specific provision to enable the companies to proceed with this type of business.

Growth since the beginning has been remarkable, and since the end of World War II, it has been phenomenal. Table I shown on the next page indicates the growth involved over the years.
<table>
<thead>
<tr>
<th>YEAR</th>
<th>NO. OF MASTER POLICIES</th>
<th>NO. OF CERTIFICATES</th>
<th>VOLUME OF INSURANCE</th>
</tr>
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<tbody>
<tr>
<td>1911</td>
<td>3</td>
<td>427</td>
<td>403,000</td>
</tr>
<tr>
<td>1916</td>
<td>650</td>
<td>200,000</td>
<td>1,550,000,000</td>
</tr>
<tr>
<td>1921</td>
<td>6,000</td>
<td>1,400,000</td>
<td>1,527,000,000</td>
</tr>
<tr>
<td>1926</td>
<td>14,000</td>
<td>3,800,000</td>
<td>5,362,000,000</td>
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<tr>
<td>1931</td>
<td>20,000</td>
<td>5,700,000</td>
<td>9,783,000,000</td>
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<tr>
<td>1936</td>
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<td>7,400,000</td>
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<tr>
<td>1941</td>
<td>29,000</td>
<td>13,000,000</td>
<td>17,754,000,000</td>
</tr>
<tr>
<td>1946</td>
<td>40,000</td>
<td>16,000,000</td>
<td>27,755,000,000</td>
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<tr>
<td>1951</td>
<td>73,000</td>
<td>31,000,000</td>
<td>58,106,000,000</td>
</tr>
<tr>
<td>1956</td>
<td>136,760</td>
<td>59,241,000</td>
<td>130,419,000,000</td>
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<tr>
<td>1957</td>
<td>156,160</td>
<td>62,442,000</td>
<td>148,671,000,000</td>
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<td>1958</td>
<td>176,850</td>
<td>64,397,000</td>
<td>160,290,000,000</td>
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Sources: Years 1911 - 1955, Davis W. Gregg, Group Life Insurance, Richard D. Irwin, Inc., 1957 Tables 1 and 2.

Years 1956 - 1958, Figures were received directly from the Institute of Life Insurance. This is the same source used by Dr. Gregg, for the years 1912 - 1955. Figures include credit life insurance, but not dependent life coverage.
In 1917, the National Convention of Insurance Commissioners adopted a standard group life insurance definition and recommended consideration of a uniform statute to the states. The Uniform Act was passed by several state legislatures in most particulars. In any event, the definition and principles set forth by the convention were adopted by most of the group writing companies.²

In 1926, the companies writing group insurance formed the Group Association, an organization which had the following stated aims:

1. Promote the welfare of group policyholders.
2. Advance the interests of group insurance.
3. Promote economy and reduce general administration expense by an interchange of views between the groupwriting companies.
4. Represent the members before governmental and public bodies.
5. Collect and analyze group experience, but making, or promulgating of premium rates, was specifically prohibited.³

While it was strongly denied by the insurance companies, it is quite likely that at least a measure of cooperation between companies resulted from the Association activities. The Temporary National Economic Committee, which conducted hearings on the insurance industry in general during the late 1930's, concluded that the activities of the Group Association had tended to eliminate competition within the industry by agreeing on premium rates and underwriting practices.⁴ Whether the charges were actually true or not, several of the larger companies withdrew from the Association after the hearings, and the Association itself was disbanded shortly thereafter.⁵
In addition to the dissolution of the Group Association, the industry found itself subject to possible Federal Anti-Trust Legislation as a result of the Supreme Court decision in the Southeastern Underwriters Association case. This decision reversed the previous attitude that insurance was not interstate commerce; and hence, subject only to regulation by the various states. While Congress granted a moratorium on the enforcement of this decision subject to action being taken to provide the required regulatory legislation by the states, the industry still exists under the threat of removal of the moratorium.

It appears that since that time, the industry has been quite circumspect in avoiding activities which might possibly be construed as being monopolistic or even cooperative in its intent. While about 80% of the Group Life volume and about 50% of the Master Policies are still being written by the largest companies in the group field, they are gradually losing their relative share of the market. If fostering of competition has been the aim of the Federal and State Governments, their activities have been phenomenally successful since the industry is extremely competitive in both the benefits being offered and the rates being charged.

At the 1946 N.A.I.C. Convention, the Commissioners adopted a new model bill which, while it adhered to the basic principles set forth in the 1917 bill, extended the group definition and imposed corresponding limitations with respect to coverages which had developed during the
years for groups not involving the strict employer-employee relationship envisioned by the 1917 Bill.*

The growth of group insurance was aided significantly in 1948 by the N.L.R.B. decision to the effect that group insurance and pension benefits were proper subjects for union bargaining. This decision was later upheld by Federal Courts, and opened the door for extensive bargaining by the unions on the subject of group insurance.

Further impetus to the industry growth developed as a result of the Wage Stabilization Board's actions during the Korean conflict, and the National War Labor Board during World War II particularly. Under the Wage Stabilization Board orders which were placed in force, wage increases were severely limited; but the more liberal attitude of the Board towards provision of employee welfare plans led many employers to purchase the welfare plans as a means of providing additional inducements to attract new employees and to retain their existing work force.

* See Part II, Chapter I, p. 39, for additional background on the 1946 Model Bill.
Part I
Chapter II
A Brief History of Group Accident and Health Insurance

Group Accident and Health coverage, or Group Disability Insurance, as it is designated by Professor Pickrell, encompasses several types of coverages and subcoverages. As in the case of the life insurance coverage, a detailed history of the development of the various types of coverages is presented in Dr. Ilse's book; and an analysis of the contractual aspects is given in Professor Pickrell's book, Group Disability Coverage. The description which follows is primarily intended only to give the reader who may not be familiar with the group insurance terminology, a little background on the types of coverage involved so that the subsequent material will be more intelligible.

The coverage which was developed in the insurance portfolio of the groupwriting companies subsequent to the writing of the first group case was Accident and Sickness coverage. This coverage was first written in about 1915, on an experimental basis. By 1919, it was a fairly standard offering. Actually, this coverage was an outgrowth of the Workmen's Collective Insurance, which was first written around 1896, to supplement the benefits provided by the Employer Liability insurance. The Employer Liability Insurance was developed to protect the Employers from liability incurred under the Employer Liability Acts, which had been passed in an attempt to correct some of the abuses of the system of common law defenses under which it was almost impossible for an employee to collect damages due to an injury on the job.
While the Employer Liability Insurance was developed to protect the employer in the event of an adverse court decision, the Workmen's Collective Insurance was for the benefit of the employee. It provided an immediate benefit in the event of an occupational disability. Often, there was a lengthy period after the accident before the employee could collect as a result of the court decision.

The Workmen's Collective Insurance, however, covered only accidents on the job. In order to fill the major need left in the event of accidents or sickness incurred off the job, Montgomery Ward investigated an expanded coverage at the time of its purchase of Group Life Insurance in 1912. The coverage was eventually awarded to the London Guarantee and Accident Company, which issued the contract as a Workmen's Collective Policy with expanded coverage. While it was developed to fill a specific need, the days of the Workmen's Collective insurance were numbered, and by 1930 there was very little of the coverage remaining in force. The decline of this form of insurance was due to the rapid development of the Workmen's Compensation Legislation in the early 1900's. Of even greater importance was the development of separate Accident and Sickness coverage along the lines of the Montgomery Ward plan which was much more comprehensive.

Presently, the Accident and Sickness coverage, or weekly income coverage as it is occasionally called, provides coverage for a certain specified period of time such as thirteen, twenty-six, or fifty-two weeks maximum duration. Benefits are commonly provided from the first day of disability due to accidents, and from the eighth day of disability due
to illness. Many other waiting periods can also be used although the companies have consistently refused to write a plan which will pay for disability due to illness from the first day. Plans are sometimes written which will provide benefits from the first day of hospitalization, if the employee is confined prior to the fourth or eighth day.

A fairly recent development, which has been requested by some buyers, is a long term duration accident and sickness plan to provide coverage for very serious disabilities. These plans may run for two years, five years, or occasionally until attainment of age 65, or for life. These plans usually use a very substantial waiting period of perhaps three months to a year, and generally require a much more stringent definition of disability than is used in the normal short-term duration plans.

Unlike the old Workmen's Collective insurance, benefits for Accident and Sickness coverage are usually restricted to non-occupational disabilities since the occupational disabilities are taken care of by Workman's Compensation. Some plans will also provide a supplementary benefit to Workmen's Compensation to bring the level of weekly benefits up to that provided under the non-occupational coverage.

The benefits paid are usually related, at least indirectly, to the level of earnings in such a way as to prevent any person from being eligible for more than approximately two-thirds of earnings. The insurers feel that to go higher than this would be unsound underwriting, since it would mean that the income replacement would then be very close to an employee's take home pay and that this in turn would encourage mal-
Whereas benefits were previously limited to $60 per week maximum, most companies are now considering much higher maximums in recognition of the rising level of earnings. The requirement that benefits be substantially less than take home pay is still followed, however.

Accidental Death and Dismemberment coverage is basically an outgrowth of the dismemberment and accidental death provisions of individual health policies and the double indemnity feature of life insurance policies which were first developed about 1910. With the advent of group insurance, the accidental death and dismemberment coverage was a natural rider coverage to either the life insurance or the accident and sickness insurance. The benefit payable in the event of accidental death is called the face amount, or primary amount, and is usually equal to the amount of group life insurance in force up to a $20,000 maximum. The face amount is also payable in the event of a double dismemberment or the loss of both eyes or a single dismemberment plus the loss of an eye. A single dismemberment or the loss of one eye is reimbursed by payment of one-half the primary amount.

The coverage can be written on either an occupational and non-occupational basis, or on only a non-occupational basis. If occupational coverage is involved, the rates are higher for hazardous industries.

There are three major subdivisions of the section of group disability insurance known generally as hospitalization and medical coverage. These subdivisions are: Hospital Expense coverage, Surgical Ex-
pense coverage, and Medical Expense coverage. Furthermore, this coverage is pretty evenly divided between the Blue-Cross and Blue-Shield using the service type plans, and the commercial insurance companies using the indemnity type plans.* Coverage is nearly always on a non-occupational basis.

Hospital Expense coverage, as its name implies, provides reimbursement for hospital expenses incurred. The Blue Cross plans and the commercial plans both typically provide reimbursement for room and board expenses up to a specified maximum daily benefit and for a limited number of days. Other hospital expenses for items such as operating room fees, drugs and medicines, laboratory fees, etc., are usually paid for in full by Blue Cross and up to specified maximums by the insured plans. In terms of comparisons, while most insured plans have a maximum limit, they include reimbursement for items such as ambulance fees and blood which are not covered by the Blue Cross.

Surgical Expense coverage provides reimbursement for surgical fees charged by the general practitioner or by a surgeon up to the maximum benefits specified in the surgical schedule for the procedure involved.

Medical Expense coverage refers to reimbursement for doctor’s visits. Such coverage is restricted to doctor’s visits made during a period of hospital confinement. However, the insurance companies also offer a coverage which provides for the reimbursement of calls made in

*See Part III, Chapter I, p. 94 for brief description of the basic difference between "service" and "indemnity" plans.
the doctor's office or in the home at an additional premium.

One of the details often overlooked in the purchase of in-hospital medical plans is the exclusion applicable to days of confinement subsequent to the performance of surgical procedure. Some Blue Shield plans exclude any reimbursement if the hospital confinement involves surgery, and about 60% of the hospital admissions involve some form of surgical treatment.12

The insurance companies offer several other types of minor coverages to provide coverage for needs not covered by the Hospital, Surgical, or Medical expense coverages. These coverages, such as: Laboratory and X-Ray, X-Ray, Supplemental Accident Expense, Polio, etc., are generally categorized as forms of Medical Expense. Space does not permit a description of the details of the minor medical coverages, and Major Medical coverages are covered separately in Part II, Chapter II.

Historically, the hospitalization and its rider coverages were developed in about 1932, in the form of the Blue Gross organization under which the hospitals formed an association whereby members agreed to pay a specified monthly fee and in turn, the hospitals would provide hospital services up to specified maximum limits. It is interesting to note that the arrangements were set up not to benefit the individual, but basically to provide a means of prepaid medical expense wherein the hospitals would be certain of receiving at least some payment for services rendered during the depths of the depression. Prior to this time, similar arrangements had been instituted by individual hospitals.13

Initially, the coverage was offered only on a group basis and
the insurance companies followed suit shortly thereafter, as it pro-
vided a natural supplement to the other coverages which were being sold.
Unfortunately, instead of insisting on the proven insurance principles,
of deductibles and co-insurance, the insurance companies elected to
follow the Blue Cross lead of first dollar coverage subject to top
limits. Of course, from a competitive point of view, they had to pro-
vide benefits comparable to those offered by Blue Cross, and thus they
actually had little choice. In retrospect, however, they probably wish
quite fervently that they had not gone along on the first dollar approach
so easily. The problem is basically one of the insurance coverages,
being at the same time a cause of increasing hospital and medical ex-
pense; and yet, it is these rising costs which pose a most pressing
problem to the industry. As long as reimbursement from the first dollar
is involved, there is a vicious circle wherein the presence of insurance
encourages higher charges, and the higher charges encourage higher
amounts of insurance. The Blue Cross and Blue Shield problems are
somewhat mitigated in this area because the Blue Cross has contracts with
the hospitals and doctors which apparently result in lowering the charges
made by the hospitals and doctors to Blue Cross and Blue Shield to a
lesser amount than is being charged to other patients not so insured.14
Similarly, the doctors agree to accept the Blue Shield schedule as full
reimbursement if the patient's income is under an agreed upon maximum.
Of course, this is all to the advantage of Blue Cross-Blue Shield, but
cannot help raising the average charges made, as the hospitals and
doctors have to recoup the costs not reimbursed to the hospital due to
the Blue Cross contract from their uninsured and commercially insured patients.

In effect, the insurance industry and Blue Cross did such a good job of selling the idea of first dollar coverage, that when the catastrophic coverages were developed, the industry was unable to sell the deductible and coinsurance features which are necessary to provide the real insurance for catastrophes at a reasonable cost. This is partially the reason for the hodge-podge of Major Medical coverage reviewed in Part II, Chapter II. The industry, finding itself unable to re-educate the public immediately to the desirability of deductibles and coinsurance, have tried to let them have their cake (major medical) and eat it too (base plans with supplementary major medical, or comprehensive major medical with waivers of deductible and coinsurance).

If anything, the group hospital expense coverages and its riders have shown an even more phenomenal growth than the group life insurance. Table II indicates the growth of such coverages.

Percentage-wise, Table III demonstrates clearly the growth in popularity of the insured Group Hospital plans relative to the other types of Blue Cross in recent years.
Table II
Hospital Expense Protection in the United States

<table>
<thead>
<tr>
<th>END OF YEAR</th>
<th>TOTAL * (000 Omitted)</th>
<th>INSURANCE COMPANIES</th>
<th>BLUE CROSS/BLUE SHIELD (Individual and Group)</th>
<th>INDEPENDENT PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1940</td>
<td>12,312</td>
<td>2,500</td>
<td>1,200</td>
<td>6,012</td>
</tr>
<tr>
<td>1942</td>
<td>19,695</td>
<td>5,080</td>
<td>1,800</td>
<td>10,215</td>
</tr>
<tr>
<td>1944</td>
<td>29,232</td>
<td>8,400</td>
<td>2,400</td>
<td>15,772</td>
</tr>
<tr>
<td>1946</td>
<td>42,112</td>
<td>11,315</td>
<td>3,000</td>
<td>24,707</td>
</tr>
<tr>
<td>1948</td>
<td>60,995</td>
<td>16,741</td>
<td>11,286</td>
<td>31,246</td>
</tr>
<tr>
<td>1950</td>
<td>76,639</td>
<td>22,305</td>
<td>17,296</td>
<td>38,822</td>
</tr>
<tr>
<td>1952</td>
<td>90,965</td>
<td>29,455</td>
<td>21,412</td>
<td>43,475</td>
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<tr>
<td>1954</td>
<td>101,493</td>
<td>35,090</td>
<td>25,338</td>
<td>47,484</td>
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<tr>
<td>1956</td>
<td>115,949</td>
<td>45,211</td>
<td>27,629</td>
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<td>1958</td>
<td>123,038</td>
<td>49,508</td>
<td>29,372</td>
<td>55,205</td>
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</table>

*Duplication among persons protected by more than one kind of coverage eliminated.

Table III

Individuals Covered by Insured Group Hospital Plans Relative to Blue Cross (Group & Individual)*

<table>
<thead>
<tr>
<th>YEAR</th>
<th>INSURED GROUP</th>
<th>BLUE CROSS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(000 Omitted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1940</td>
<td>2,500 29</td>
<td>6,012 71</td>
<td>8,512 100</td>
</tr>
<tr>
<td>1945</td>
<td>7,804 29</td>
<td>18,899 71</td>
<td>26,703 100</td>
</tr>
<tr>
<td>1950</td>
<td>22,305 37</td>
<td>38,822 63</td>
<td>61,127 100</td>
</tr>
<tr>
<td>1955</td>
<td>39,029 44</td>
<td>50,726 56</td>
<td>89,755 100</td>
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<tr>
<td>1958</td>
<td>49,508 48</td>
<td>55,205 52</td>
<td>104,713 100</td>
</tr>
</tbody>
</table>

*While the Blue Cross figures include both Group and Individual coverage, the bulk of the Blue Cross is in the form of Group Coverage.

Part II
Chapter I
Excessively High Amounts of Life Insurance

One of the most controversial aspects of the group insurance has been the fairly recent development wherein amounts of life insurance far in excess of the maximum previously contemplated for even the larger cases are sold on an almost routine basis for cases of any size. Initially, group life insurance was sold in very modest amounts with the idea that the insurance would provide a burial fund and perhaps a small clean-up fund. The typical amounts ran from $500 to $2,000, based on length of service or position. Gradually, the weakness of the length of service schedules, whereby the higher amounts of insurance tended to be in force on the older lives, was recognized and schedules using annual earnings became more popular.

At present, an amount of insurance equal to approximately one year's earnings is common, and the industry is endeavoring to promote general acceptance of group insurance equal to twice annual earnings with maximum amount limited to perhaps two or three times the average amounts on the group as a whole. Some companies relate the maximums to both average amounts and total volume. Table IV shows the increase in the average amount of group life insurance. The underwriting philosophy of the major companies until a few years ago, was to avoid writing amounts of insurance so high that the death of one individual would seriously impair the claims experience of the group for several years. On the smaller cases, this meant that maximums were generally limited to $10,000.
### Table IV

**Average Amounts of Group Life Insurance**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>AVERAGE AMOUNT</th>
<th>YEAR</th>
<th>AVERAGE AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1915</td>
<td>830</td>
<td>1945</td>
<td>1,930</td>
</tr>
<tr>
<td>1920</td>
<td>960</td>
<td>1950</td>
<td>2,480</td>
</tr>
<tr>
<td>1925</td>
<td>1,330</td>
<td>1955</td>
<td>3,200</td>
</tr>
<tr>
<td>1930</td>
<td>1,700</td>
<td>1956</td>
<td>3,500</td>
</tr>
<tr>
<td>1935</td>
<td>1,590</td>
<td>1957</td>
<td>3,750</td>
</tr>
<tr>
<td>1940</td>
<td>1,700</td>
<td>1958</td>
<td>3,900</td>
</tr>
</tbody>
</table>

Sources: Institute of Life Insurance and Spectator Yearbook. Figures for the years 1915-1955 were taken from Table III, Gregg, D.W., Op.cit., P. 12, and for the years 1956-1958 were derived from data supplied directly by the Institute of Life Insurance.
or $20,000, with the limits on the larger cases in the area of $40,000 to $50,000 on the top executives. A few of the "jumbo" cases even had maximums of $100,000. Now, smaller case maximums of $50,000 to $100,000 are being written by some insurers and maximum amounts on some of the large cases may run as high as $300,000 and over.

One of the major factors encouraging the growth of group insurance has been section 162(a), Reg. 118.15 of the Internal Revenue Code of 1954. The Code provides that group insurance premiums paid by an employer for the benefit of his employees is tax deductible as a business expense. At the same time, the premium is not to be considered as taxable income to the employee. This is one of the few instances under the Federal Income Tax Law where one can have his cake and eat it too. It is this beneficial tax provision which has been a bulwark in the advance of the industry. Yet, this provision is now creating the problem of excessive amounts of insurance being demanded by some buyers.

While the dual tax advantage of group insurance has been recognized at all times, it has only been within the past three years or so, that brokers and buyers alike have become aware of the tremendous savings possible through this tax loop hole as it applies to the highly paid executives of corporations, both large and small. Here is an opportunity for an executive fringe benefit which permits the corporation to buy a large amount of life insurance for the benefit of its executives with the government paying for half of it due to the tax deductible feature of the premium payments. At the same time, it adds
nothing to the income of the executive whose earnings place him in an upper income tax bracket. Combined with a permanent assignment of the benefits to the beneficiary and an irrevocable beneficiary designation, it may even be possible to remove the policy proceeds from consideration as part of the taxable estate.

Moreover, since the executives are usually older than the other employees in the group, the average rate per $1,000 of coverage is significantly less than the rate would be if he had to purchase it as an individual. Also, since the underwriting requirements of group insurance are a little more liberal than the underwriting on personal insurance, he stands a better chance of being accepted by the insurer for the amounts requested. In practice, the underwriting practices of the various insurers vary considerably on excess amounts of insurance from requiring full medicals to requiring little or no evidence of insurability. The strictness of the underwriting, as might be expected, varies with the maximum amount requested as related to the desirability of the group case as a whole, with particular reference to the size of the case in terms of the total volume of insurance and the premium involved. One final advantage to the group life vehicle for providing the high amounts of insurance is the lower rate structure developed on group life insurance as compared with the ordinary life insurance.

Considering the apparent advantages of the arrangement, it is surprising that the industry has not had greater problems resisting the scheme than it has experienced to date. Basically, the larger, well-established groupwriting companies have resisted the trend and still try
to retain sound underwriting for the higher maximums. The most aggressive approach has generally been from a relatively small number of companies who are willing to use the arrangement as a means of building up the volume of group life insurance they have in force, even if it involves somewhat questionable group underwriting procedures.

Without going into the technical arrangements whereby at least a portion of the higher amounts of insurance is "pooled" with the insurance of other groups, the insuring of one or two individuals for amounts equivalent to fifteen or twenty years' annual premium on the entire group is an unrealistic approach, even if one assumes that no other claims are incurred during that period. The problem is compounded when it is recognized that the individuals who control the group programs are the same executives who will be insured for the high amounts of life insurance. Under these circumstances, there is a serious possibility of selection against the insurer by individuals who may be otherwise uninsurable. Such selection can well lead to adverse claims experience in the future. In this respect, it should be pointed out that selection against the insurer does not necessarily manifest itself immediately, but instead may not be evident until some years hence, when the lives involving less than the expected longevity start to drop out.

To some extent, there has been a feeling among many life insurance salesmen over the years, particularly among those not actively engaged in writing of group insurance, that the writing of life insurance on a group basis was depriving them of prospects for individual life insurance. On the other hand the proponents of group insurance
contended that the group life coverage was hardly more than a start in the life insurance programing of any individual; and, in fact, it provided a "door-opener" since it helped make employees more insurance conscious, and pointed up the deficiency in one's insurance because the amounts of group life available to the individual were generally very limited. However, as the maximum amounts of life insurance increased, it was obvious that the group business was departing from its initial concept of providing a burial fund, and perhaps a clean-up fund, and invading the area of family protection and estate planning. The local and state agents' associations were generally united in opposition to the trend. In many states they were instrumental in having laws passed which provided a maximum amount of group life insurance which could be written on any one individual regardless of the size of the group involved. By 1956, there were eleven states which had statutory limits of $20,000 or less, and 19 states, plus Hawaii, now a state, which had maximums limited to $20,000 or to an amount not to exceed one and one half times annual earnings up to $40,000. The remaining eighteen states had still established no maximum.17 The National Association of Insurance Commissioners Model Bill which was adopted in 1946 formally recognized the $40,000/20,000 maximum as desirable and provided a maximum of "$20,000 unless 150% of the annual compensation of such person from his employer or employers exceeds $20,000, in which event all such term insurance shall not exceed $40,000 or 150% of such annual compensation, whichever is less."18 Of course, adoption of the Model Bill is basically only a recommendation to the various states and the final determination
rests with the legislatures of the various states.

The A.L.C. and the L.I.A.A., in a re-examination of group policy, set up a committee of prominent life insurance men to make a specific recommendation as to the industry's attitude on high maximum amounts of group life insurance. The initial report of this committee was submitted in December, 1959, and no conclusive agreement was reached. 19 A further subcommittee has likewise been unable to make any progress in this area to date, and it is unlikely that any general agreement can be reached. 20 The basic problem is that the industry itself is so divided on the issue that it probably cannot resolve it without legislative assistance, or perhaps as mentioned by Dr. Gregg, the loss of the favorable tax status under the Federal Income Tax Law.

The Internal Revenue Department is, of course, well aware of the tax advantage permitted under the present law. It would come as no surprise to see this tax loop hole removed in the not too distant future. 21 It is only to be hoped that if such action is taken, it be in the form of a removal of the tax advantage only on amounts over a given maximum, 22 perhaps the 20,000/40,000 arrangement in the N.A.I.C. Model Bill referred to above. A revision in the Tax Code beyond that could have a disastrous effect on the entire industry, and it does not seem reasonable to hurt everyone in order to avoid the abuses by only a few.

To date, the inroads made on existing policyholders and in competition for new cases has been almost insignificant. This has been so partly because those insurers who are willing to write schedules which have been developed obviously for the purpose of taking advantage of the
tax law, write only an infinitesimal amount of the total group insurance written each year. Furthermore, the other insurers have been willing to write higher maximum amounts themselves, provided it can be done on a sound underwriting basis in terms of the total volume on the case, the average amounts, annual premiums, evidence of insurability, etc., as governed by each company's own policy in this area. Unfortunately, this problem, while relatively unimportant in terms of the total business being written at present, shows signs of building up, and could be very serious unless a solution is found shortly. Recently, the New York Insurance Commissioner indicated that a case which provided a $100,000 maximum on one individual and only $1,000 amount to the other employees, while appearing to be basically in conformity with the group insurance law, would not be considered as a legitimate group because the law prohibits selection of the amounts of insurance either by the insured persons or by the policyholder, and that the selection in such a plan was self-evident.23

While there is undoubtedly at least a temporary saving possible through taxes, in purchasing or switching to such a plan, the use of the group vehicle as a means of cutting costs of one's personal life insurance program is basically unsound, and potential buyers should be extremely cautious in moving into such a plan. Careful consideration should be given the following points:

1. Even if the tax advantage is retained indefinitely, the coverage is still one year renewable term and is re-rated annually by the insurer. On this basis, with
the bulk of the insurance on the one or two top executives, there will be an ever increasing premium rate as the executives grow older even if the turnover among the remaining employees is such as to keep the average age of the lower classes of insured employees at a constant level. Ultimately, the rate may become prohibitive for even the corporation, and the insurance will have to be dropped or cut back at a time when the executives can least afford to lose their insurance.

2. The approach is usually recommended as a replacement for existing personal insurance, or in place of the purchase of additional personal insurance. This means that the buyer is giving up his present permanent coverage, or foregoing what may be his last chance to acquire permanent coverage, since a year or two in the future might find him uninsurable. In the close corporation or small corporation where the lop-sided proposals are typically found, the argument is made that since the executive controlling the purchase and benefiting from it is also the boss, he will be there until he dies. In many situations, this is what actually happens, but it is taking a long gamble with one's estate plan, that such will be the case. An objective appraisal of any business, large or small,
will indicate the possibility for failure during the next twenty or thirty years, particularly if it is at all marginal in nature at present. If the firm is doing very well, there is still a good chance that the next decade or two will see the merger of the firm, or outright sale, materialize in which the group insurance can of necessity be of little or no consideration. Under either of these circumstances, failure or success, there is the distinct possibility, and even probability, that the change will bring an end to the group insurance coverage. Instead of the $50,000 or $200,000 of coverage which looked like such a great bargain when purchased, the executive ends up with only a conversion privilege of $2,000, or less, upon the lapsing of the group policy and may find himself uninsurable. If the conversion privilege permits conversion of the full amount of his coverage, he still faces the problem of taking the ordinary insurance at standard rates and at his then attained age. The cost may well be prohibitive.

3. There is the likely change in the Internal Revenue Code which could take place at any time and which, if it occurred after the executive had become uninsurable would wipe out much of the net cost advantage of the group insurance over an ordinary policy, and still
leave the insured executive exposed to problems (1) and (2) above.

4. If an existing group plan is lapsed to take advantage of a maximum amount of insurance with a new insurance company after the existing insurer has refused to go to as high a maximum, it may well be that some valuable provisions in the older policy may be relinquished which could off-set at least somewhat, the advantages of the high amounts. In particular, the old policy may well have more liberal disability benefits, better settlement option provisions, and a higher rate of guaranteed interest on the settlement options. While the actual effect of these provisions is unlikely to offset this apparent advantage of the new policy's maximum, they should be considered in conjunction with the primary shortcomings.

While the above may seem to be a harsh evaluation of the situation, I don't believe it is overly so. It cannot be stressed too often that the primary reason for purchasing insurance is to substitute an element of certainty into the protection of life value for the family of the insured, to replace the uncertainty which otherwise exists. To base one's personal insurance program on an unsound group insurance program, which is also subject to the possibilities presented in (1), (2), and (3) above, defeats the basic concept by re-introducing the element of uncertainty. Since the insurance industry itself is not in
a position to enforce a policy of limitation, even if it could agree on the policy to be followed, it seems obvious that in order to protect the public from falling into one of the pitfalls suggested above and to limit the abuses of the present tax advantage rightfully enjoyed by true group insurance, the following action should be taken by the authorities:

1. Legislative limits on group life insurance maximums, perhaps along the lines of the N.A.I.C. Model Bill.
2. Revision of the Internal Revenue Code to remove the present tax advantage on excessively high amounts of insurance. Perhaps the maximum here might also be the $20,000/$40,000 limits included in the N.A.I.C. Model Bill.
Part II

Chapter II

Major Medical Expense Coverage

In an industry marked by spectacular growth, the rise and acceptance of Major Medical Expense Coverage has still been remarkable in the degree of public acceptance. The first Group Major Medical coverages were written in 1950. Their initiation was surrounded by underwriting safeguards, and the coverages were provided only on extremely select cases. At the end of 1951, there were only 96,000 persons covered by group Major Medical plans as compared with 16,229,000 covered by the end of 1958. Table V on the next page shows the phenomenal growth of this coverage.

It will be noted that the statistics shown represent only those persons covered under group plans insured with the insurance companies and do not include those covered by Blue Cross organizations. At the end of 1958, there were very few of the Blue Cross organizations which offered this coverage, although they were experimenting with plans which provided basically the equivalent coverage for certain specified diseases. These plans were known by such names as "Dread Disease," "Prolonged Illness," etc. In order to meet the competition from the commercial companies, some of the Blue Cross-Blue Shield plans have now developed their own Major Medical plans.
<table>
<thead>
<tr>
<th>END OF YEAR</th>
<th>SUPPLEMENTARY</th>
<th>COMPREHENSIVE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1951</td>
<td>96</td>
<td>-</td>
<td>96</td>
</tr>
<tr>
<td>1952</td>
<td>533</td>
<td>-</td>
<td>533</td>
</tr>
<tr>
<td>1953</td>
<td>1,044</td>
<td>-</td>
<td>1,044</td>
</tr>
<tr>
<td>1954</td>
<td>1,841</td>
<td>51</td>
<td>1,892</td>
</tr>
<tr>
<td>1955</td>
<td>3,928</td>
<td>831</td>
<td>4,759</td>
</tr>
<tr>
<td>1956</td>
<td>6,881</td>
<td>1,413</td>
<td>8,294</td>
</tr>
<tr>
<td>1957</td>
<td>9,290</td>
<td>3,138</td>
<td>12,428</td>
</tr>
<tr>
<td>1958</td>
<td>11,072</td>
<td>5,157</td>
<td>16,229</td>
</tr>
</tbody>
</table>

*Represents people covered by insurance companies only.

Source: Source Book of Health Insurance Data, 1959, Health Insurance Institute, Pg. 18.
Table V also indicated a breakdown in the Major Medical coverage between "Comprehensive" and "Supplementary" plans. This terminology is generally accepted throughout the industry. However, some insurers have their own variations in terminology, and it behooves the buyer to be sure he understands exactly what types of medical expenses are covered, and to what extent.

As used above, a "Supplementary" plan is one in which the Major Medical coverage supplements the basic hospital and surgical coverages which may have been in force for a number of years. In effect, the Major Medical coverage takes over where the underlying coverage limits are imposed; either by the type of coverage such as out-of-hospital expenses, or by a maximum such as that imposed on the room and board charge or on the allowance for a surgical procedure. Some insurers refer to supplementary plans as those plans which do not provide any coverage for hospital and/or surgical expenses. These companies then refer to the plans which have underlying hospital and surgical coverages, and include charges in excess of the limits on the underlying coverage in the Major Medical covered expenses, as an "integrated" plan if there is no deductible imposed on hospital and surgical expenses over and above the amounts reimbursed under the base hospital and surgical plans. If, as is more common, there is a deductible which must be satisfied before benefits are payable, then the plan is called a "corridor deductible" plan.

"Comprehensive" Major Medical refers to those plans which cover all hospital, surgical and medical expenses, in or out of the
hospital, as a package. This approach was first used in 1954. Instead of having several underlying base coverages plus a supplementary major medical, it was found that it was much easier to administer all coverage as a single coverage, and this approach was much easier to explain to the public. Since its development, the relative growth of the coverage has been much greater than that of the supplementary plans. For reasons discussed below, this may have been an unfortunate trend.

In the interest of clarity, the graphic illustrations shown below may be of some assistance in firmly establishing the difference between the various types of plans. The following items are all covered by Comprehensive Major Medical:

1. Hospital Expenses
2. Surgical Expenses
3. Doctor's Visits
4. Drugs and Medicine
5. Anesthesia and Oxygen
6. Diagnostic Procedures
7. Ambulance Service
8. Services of Registered Nurse
9. Rental of Medical Equipment, Prosthetics, etc.
10. Blood and Blood Plasma
11. X-Ray and Radium Therapy, Physiotherapy, and Similar Therapeutic Treatment.

The hospital expenses usually include the full charge for semi-private accommodations, but impose a maximum for room and board.
in private accommodations. Thus, in a Comprehensive Major Medical plan all of the items shown in 1 - 11 above are included under a single coverage.

<table>
<thead>
<tr>
<th>TOTAL EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
</tr>
<tr>
<td>Insured's Co-Insurance Portion</td>
</tr>
</tbody>
</table>

**COMPREHENSIVE MAJOR MEDICAL PLAN**

**Deductible:** This portion of the expenses incurred must be paid by the employee before he is eligible for reimbursement. The deductible is a variable amount from a minimum of $25 to a maximum of $500. A uniform deductible may be applicable to all employees, or a graded deductible which increases as earnings increase may be employed. In practice, the deductible is often waived for hospital expenses and/or surgical expenses to overcome employee objections which are naturally evoked when they previously had a basic hospital plan, which provided coverage from the first dollar of hospital expenses or surgical expenses subject to a stated maximum benefit.

**Co-Insurance:** After having incurred expenses equal to the deductible, the insured is eligible to receive reimbursement on subsequent expenses with a portion of such expenses paid by
himself, usually 20% or 25%, and the remainder paid for by the insurer. As in the treatment of the deductibles, the co-insurance feature is often waived for hospital expenses up to a specified amount such as $300 or $500. The co-insurance, however, is not waived for surgical expenses, although some insurers will include a standard surgical schedule not subject to the deductible or co-insurance, which somewhat achieves the same basic effect as a waiver of the co-insurance.

The older type hospital and surgical coverages generally provided maximum limits for room and board charges and surgeons' fees which were lower than prevailing charges. Therefore, they contained a built-in co-insurance factor. This is often overlooked when consideration is given to a comprehensive major medical. The cost of waiving the co-insurance feature to avoid cost to the employee on relatively minor hospital and surgical expenses is generally more costly than an increase in the maximum benefit payable from $5,000, to perhaps $10,000 or $15,000. While the administrative simplicity and easier understanding of the Comprehensive plans partially explain their greater popularity relative to the supplementary type plans, a more important factor was the general underpricing of the Comprehensive plans initially. The inadequate rates were partially due to the underestimation of the claims potential, particularly for those plans involving a waiver of deductible
and co-insurance on hospital expenses; but the primary reason appears to have been basically one of competitive pricing. There were instances where the cost of a complete comprehensive Major Medical plan was less on a manual rate basis than the insurer was charging for a limited hospital, surgical, and medical expense plan. The supplementary Major Medical plans, on the other hand, retained most of the basic coverages in force and added the Major Medical as another coverage to supplement the base plans. This meant that the total premium for all coverages was higher than the premium for the base coverages alone.

<table>
<thead>
<tr>
<th>TOTAL EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Plan</td>
</tr>
<tr>
<td>(Typically covered items)</td>
</tr>
<tr>
<td>Deductible</td>
</tr>
<tr>
<td>(1, 2, 3, 5 &amp; 7 on page 41)</td>
</tr>
<tr>
<td>Insured's Co-Insurance Portion</td>
</tr>
<tr>
<td>Insurer's Co-Insurance Portion</td>
</tr>
</tbody>
</table>

In view of the inadequate rates applicable to Comprehensive Major Medical, it is easy to see why the Comprehensive Plan was popular relative to the supplementary plans. The buyer thought he was getting something for nothing, and as is so often the case, many of the buyers who purchased the plans at inadequate rates without sufficient investigation of the ultimate costs, plus the insurers who sold the plans, have become gradually disillusioned as the resulting rate increases have been encountered, and in turn lead to continual conservation problems for the insurers.

One of the important advantages of the Supplementary approach over the Comprehensive approach, and one which is not generally recog-
nized, is the fact that each disability under a Comprehensive plan reduces the remaining benefit under the maximum lifetime benefit. Exhaustion of the benefit could leave the individual without coverage. The Supplementary plan, however, even if the maximum Major Medical benefit should be exhausted, still provides the full benefits of the underlying hospital, surgical and medical expense coverages for any future unrelated disabilities, regardless of the number of such disabilities.

In addition to the two fundamental types of Major Medical coverage discussed above, Comprehensive and Supplementary, there are three basic approaches to the benefit period which can be utilized with either a Comprehensive or a Supplementary plan. Originally, there were two or three other approaches which have since been discontinued by the industry as being either impractical when the insurers had gained experience with them, or which had not been saleable. This is not surprising, however, when it is recalled that each company had to start almost from "scratch" in developing its own coverage with an almost infinite variety of combinations, limitations, benefits, and safeguards possible. About the only universally accepted principles, were that of the need for deductible and co-insurance features. The end result of the considerable amount of experimentation was to narrow the industry offering down to the three basic approaches previously mentioned which are known as the Calendar Year, the Period of Disability, and Per Cause.

Of course, even within these general categories there are variations of a more or less minor nature, either to satisfy the under-
writing requirements of a particular company, or to provide a competitive "gimmick" as a sales tool. This in itself is indicative of the intense competition which has developed in the group insurance industry as compared with the basic hospital and surgical coverages which were almost identical for every commercial insurer.

The basic differences of the three approaches are as follows:

**Calendar Year**

1. Benefit period runs from Jan. 1 to Dec. 31, of each year and is not directly related to the timing of disabilities or the number of disabilities incurred during that period.

2. The deductible is reapplied at the beginning of each year. Allowance is made for expenses incurred in connection with disabilities commencing during the last three months of previous year, whereby such expenses may be carried over into the current year for purposes of satisfying the deductible. This avoids the necessity for paying two deductibles within a short period of time, but still does not avoid an apparent inequity in treatment for disabilities commencing on Sept. 30, as opposed to those commencing on Oct. 1. Usually, these plans require too that the deductible be satisfied within a specified period of time such as three months or six months from the time the first medical expense charge is incurred. This is the so-called "sniffle
clause." Some plans don't include the "sniffle clause," and this permits payment of these minor claims. This can appear as an advantage from the employee's viewpoint, but also has the effect of increasing the claim costs to the insurer and ultimately increasing the net cost to the policyholder. Also, it encourages, and even necessitates, a bookkeeping system on the part of the employee to keep track of all medical expenses incurred during the year in the expectation that at some point during the year, the deductible will be satisfied, even though no major illness is involved. Administratively, this can be a problem since it results in the submission of a large number of minor claims concentrated at the year's end.

The deductible is applicable to each employee and each dependent separately, except that in the event of a common accident to a family, the deductible is applied only once.

3. The maximum benefit is generally a lifetime benefit applicable to each employee and each one of his dependents separately. There is also a provision for reinstatement of the maximum benefit when at least $1,000 of expenses have been incurred, subject to the individual submitting satisfactory evidence of insurability to the insurer. The probability of reinstatement, of course, depends upon the nature of the disability involved. The lifetime
maximum represents a disadvantage as compared with the "Per Cause" approach which limits the maximum only to a particular disability. If a large enough maximum is utilized, this is not too important, however, because of the infrequent exposure of an individual to two or more unrelated disabilities serious enough to deplete a large maximum. As a practical matter, such a disability will often prove fatal in itself.

**PERIOD OF DISABILITY**

1. This approach initially was used by some insurers with a one-year benefit period running from the date the first Medical expense was incurred, while others used a two-year benefit period. At present, some carriers have even extended this to a three-year benefit period.

2. As in the Calendar Year approach, once the deductible is satisfied, all subsequent expenses, whether related to the same disability or not, are immediately eligible for reimbursement without a reapplication of the deductible. However, unlike the Calendar Year approach, complete recovery from all disabilities, or failure to incur an amount equal to the deductible within a specified period, usually six months, will result in a termination of the period of disability and reapplication of the deductible in the event of a subsequent disability, even though it is within the two-year benefit period from the time the
original Medical expenses were incurred. This plan has the advantage over the Calendar Year plan of reimposing the deductible only every two or three years with respect to a long or chronic disability, or in the event of several concurrent or consecutive disabilities. Since complete recovery makes possible the imposition of more than one deductible during a calendar year, the plan does not lend itself quite so readily to the concept of budgeting one's Medical expenses. The record keeping problem for the employee is similar to that of the Calendar Year approach, since the employee must be able to prove the necessary continuous expenditures required to avoid reapplication of the deductible through failure to satisfy the six-month provision.

3. The Period of Disability approach to the maximum reimbursement permitted is the same as that for the Calendar Year plan. It is a lifetime maximum subject to reinstatement conditioned upon evidence of insurability satisfactory to the insurer.

PER CAUSE

1. The benefit period is directly related to the disability involved. Some plans provide no time limit for incurred expenses with respect to a particular disability, while others do impose a time limit such as two years. The plans providing no time limit, of course, are advan-
tageous to the employee who is assured of relatively complete coverage; but expose the plan to the heavy claims involved in chronic illness.

2. The deductible is applied separately to each unrelated disability and to each employee or dependent, subject to the common accident provision used in the other two approaches. This involves serious difficulties for the insurer due to the problem of separating charges for the various disabilities which may be running concurrently. How does one divide the doctor's charge when a visit is made to check a chronic heart condition, and also to treat a current minor ailment? Also, from the employee's point of view, there is no assurance that he won't have to satisfy several deductibles during any one year, making budgeting difficult. Conversely, he is reasonably assured that there will be only one deductible with respect to a long term or chronic illness.

3. The maximum is applied separately to each unrelated disability, and this is a distinct advantage over the lifetime maximum since it assures the employee of continuous coverage even though he may exhaust his benefits with respect to a particular disability. This is an advantage which is more apparent than real, however, if the Lifetime maximum is established at a high maximum,
or if the Supplementary approach is being utilized whereby a substantial benefit under the base plans were still available for unrelated disabilities even though the Major Medical maximum may have been exhausted.

Professor Pickrell describes an interesting alternative form of deductible which could be used presumably in place of the Calendar Year or Period of Disability approach, but which, in so far as I have been able to determine, is not a standard offering of any major commercial insurer. Under this plan, which he calls "Family Budget," all Medical expenses of the entire family combined, in excess of an established monthly budgetable figure, would be paid presumably without co-insurance. The deductible would vary from $25 to $250 depending on earnings, and is waived if the total expenditures exceeded a given amount. While this plan is very practical and understandable from the employee view point, it is difficult to understand how it would succeed without a form of co-insurance to keep the bills within reason once the deductible had been satisfied. If it were utilized by a Blue Cross-Blue Shield organization which was in a position to control most of the expenses, or if some other form of control over the charges made were developed, this plan would be quite attractive. Under our present system for hospital and medical care, the problem is acute enough even with the co-insurance aspect. To remove the co-insurance without some form of control, and control is not recommended, would appear to be courting disaster for the plan.

* At least one company, Equitable, has considered this type of plan, but retains the co-insurance feature.
There are indications that the Major Medical situation may be improving, although it is still much too early to be definite. The insurance companies are gradually raising the rates to more adequate levels, as a result of continually climbing loss ratios and in spite of the competitive pressures which are becoming even greater. Also, there appears to be a trend towards imposing limits on the various aspects of the coverage, such as psychiatric treatment, which have been particularly subject to abuse, and to eliminating double coverage to some extent where a husband and wife are employed by different firms and have group coverage through each firm as employee and dependent in each of the respective plans. Both of these limitations have now been instituted by many of the major carriers as part of their standard offering. In addition, there appears to be a trend towards specified limits in the Comprehensive plans to make them more nearly equivalent to the supplementary plans, and to avoid some of the overusage and abuses which have been fostered by the liberal hospital and surgical benefits available on even routine disabilities. To some extent, the advantages of Supplementary Plan are even being recognized once again. While the ultimate solutions have not been found, current discussions among the insurance industries' leaders indicate that the problems, which have been recognized right along, may finally be receiving the necessary action. The basic difficulty lies in re-educating the public away from first dollar coverage. Only the utilization of the deductible and co-insurance will permit catastrophic coverage at a price which the public can afford.
Part II
Chapter III

Rising Claims on Hospital and Medical Coverages

One of the most formidable problems facing the industry at present has been the steady increase in hospitalization and medical expenses during the past decade. Not only are costs increasing, but they are increasing at a faster rate than the other costs of living; and to date, there is no apparent end to the increases. Chart I on the following page demonstrates this relative rise in the costs of Medical Expense over the other consumer expenditures.

A breakdown of the claims experience by the nature of the coverage also demonstrates the rise very effectively. Chart 2 shows the increase in cost of the average daily room and board charges made by the hospitals, increased cost of surgical procedures, and the cost of various other medical expenses.

These graphs show that over the past 12 years, there has been an increase in Medical Expense costs averaging about 13/4% a year. For Hospital Room and Board charges, the average increase is about 9% a year.
Consumer's Price Index

United States 1947 - 1958
(1947 - '49 = 100)

MEDICAL EXPENSE

ALL ITEMS

Source: Bureau of Labor Statistics, Adapted from figures shown in Source Book of Health Insurance Data, P.46.
Consumer Price Indices for Medical Care Items

United States 1947 - 1958
(1947 - '49 = 100)

Source: Bureau of Labor Statistics, Adapted from figures showing Source of Health Insurance Data, P. 50.
Prior to the advent of Major Medical coverage, the claims experience of the group insurance plans were not too drastically affected by increasing costs due to the specific limits imposed by these plans. Thus, a plan which paid up to $12 a day for hospital expenses would continue to pay only $12 a day even though the hospital room and board charge was raised from perhaps $114 to $16. Similarly, the surgical schedule with a $200 maximum and which provided up to $100 for an appendectomy would not be affected when the surgeon increased his charge from $100 to $120 for example. The brunt of the increased costs fell directly on the individual who had to pick up the difference between the charges made and benefits received.

While the limits of the insured plans helped keep down the claim costs for the group plans, there was still a rise in the overall costs of even the limited plans. One of the reasons for this increased cost was the rising frequency of hospital admissions. In 1946, the average number of admissions annually per 1000 of the population was 98.7; the corresponding average number of admissions was 113.5 in 1952 and 125 in 1958. The increased frequency of hospital confinements is both a cause and an effect of the rising costs. As an ever increasing proportion of the population is covered by health insurance, the doctors tend to prescribe hospital confinements to take advantage of the more adequate facilities for treatment and diagnosis. It is sometimes claimed that one of the reasons is the doctors' desire to make it more convenient to visit their patients, but this cannot be substantiated.

Another factor which contributes to the rising costs of
medical care is the development of the innumerable new medical drugs, X-Ray, and Radium treatments. As wonderful as these new drugs and treatments are, they are much more expensive to administer. Furthermore, they come under the "special services" provision of the commercial insurers' contracts, and under the "ancillary charges" of the Blue Cross plans.* Under these conditions, the average expense for a hospital confinement is bound to rise. Chart #3 presents this feature graphically, and indicates an increase in over-all average cost to the hospitals per patient day of about 15% annually relative to 1946 costs, and between 5% to 7% increase each year relative to the previous year for each of the past five years.

Of course, as medical costs went up, the inadequacy of the existing plans was recognized, and steps were taken voluntarily by the employers and as a result of union bargaining to increase the benefits. The increased benefits, in turn, only encouraged a further rise in the charges being made. This entire movement has now been accelerated by the introduction of the Major Medical coverage, particularly of the

* Special Services or ancillary charges are those charges made by the hospital for other than room and board charges which are reimbursable under the hospitalization coverage or Blue Cross. See page 19 for a more complete description. This may also be the reason why the high-priced wonder drugs thus do not appear to have unduly inflated the over-all cost of drugs as shown in Chart 2.
Chart 3

Average Cost Per Patient Day in Non Federal Short-Term General and Special Hospitals*
(In the United States 1946 - 1958)

Average Cost Per Patient Day

Source: American Hospital Assoc., adapted from figures shown in Source Book of Health Insurance Data, 1959, P. 52.
* Excludes psychiatric and tuberculosis hospitals.
Comprehensive type wherein the deductible and/or co-insurance is being waived.* This coverage practically gives the hospitals and doctors a "carte blanche" with respect to charges. It has been indicated that, "while some instances of excessively high charges have been encountered, we have found the medical profession cooperative in dealing with those individual problems equitably. The problem which concerns us both more seriously, however, is the gradual unwarranted increasing of charges and services due to this type of coverage."28

The seriousness of this problem is obvious when one considers the number of commercial insurers who developed combined underwriting losses on their over-all group Accident and Health coverages during 1958. Of the 35 companies which had in force more than $5,000,000 of group accident and health coverages, and which account for the great bulk of the business written, only 13 did not develop an actual underwriting loss on these coverages. Of the 13 companies which didn't sustain a loss, only 5 companies had underwriting losses of less than 98%, relative to premium. Of the 10 companies which had in force more than 50,000,000 of Group Accident and Health coverages, only 5 did not develop actual underwriting losses, and none of these 5 had more than the 2% margin of premiums in excess of the claims and expenses.29 Of course, the statistics shown above demonstrate not only the problem of rising costs, but also the results of the intense competition. Similar figures for Blue Cross organizations were not available, but they have also had difficulty in keeping up with the increasing costs as evidenced

* See the preceding Chapter.
by the many rates increases necessary during the past few years.

Unless some means of controlling Hospital and Medical Expense is found through cooperation of the industry with hospitals and the medical associations, or through the imposition of contractual limits, deductibles and co-insurance in the coverages being offered, there is a very real danger that the industry may price itself out of the market. Moreover, as costs continue to climb, there has been an increasing rise in the sentiment for government control, and this would ultimately result in "socialized medicine." Without getting into a discussion of the merits of socialized medicine, which is beyond the scope of this paper, it can be stated unequivocally that such a development is a distinct possibility, in spite of the fact that it is violently opposed by both the industry and the medical associations. Furthermore, if the experience in Great Britain is any criteria, this would not result in any lower cost of services, but exactly opposite.* It would only mean a redistribution of the costs of medical care through increased taxes.

*The original cost of the National Health Service in England was 130,000,000 pounds a year, whereas the cost is presently running at 690,000,000 a year.30
Part II
Chapter IV
Providing Benefits for Retired Employees

Closely related to the problem of rising costs is the difficulty which the industry has had in providing hospital and medical coverage for retired employees. In terms of actual expenses incurred, individuals over age 65, who comprise 9% of the population, account for 13% of the medical charges. However, this doesn't take into consideration the fact that many of such individuals are not in a position to pay for benefits received. Therefore, they must either go without necessary treatment, or receive it at a reduced cost. For male retirees age 65 or over, who have insurance to pay for the charges incurred, it is estimated that costs run about three times as high on the average, as costs on the average active employees, when the same coverage is available to each. Another indication of the higher cost of insuring the aged is demonstrated by the fact that whereas the average length of stay in short-stay hospitals during 1957-1958 was 8.6 days, the average for individuals age 65 to 74 was 14.3 days, and was 15.6 days for individuals age 75 and over.

It has only been during the past few years or so that coverage for retirees has been of real concern to the industry. Previously, group coverages other than life insurance were terminated upon retirement, and the retiree was left without coverage when it was most needed. Most of the Blue Cross-Blue Shield plans, on the other hand, permitted
an automatic conversion privilege to such employees whereby they could take the coverage on an individual basis if they so desired. Of course, the benefits on an individual basis were often lower than on the group plan, and the rates were higher. However, there was still coverage and this was very important to the employee.

The conversion privilege for both terminating and retiring employees has long been a strong point of Blue Cross in competition with the commercial insurance carriers. To meet this competition, many of the insurers will now provide a conversion privilege to individual accident and health policies for terminating employees, although they generally try to avoid the conversion privilege for retirees. Even where the conversion privilege is extended to retired employees, the cost of such policies at the retiree's attained age is usually prohibitive. As an alternative approach, the insurance companies will now generally permit coverage of the retired employees under the group plan. Usually, in order to safeguard the experience of the plan from the higher claim costs attributed to the retired employees, some combination of increased rates and reduced benefits relative to the plan for the active employees is developed. The ultimate effect is to increase the costs of the group insurance plan to the employer through both an increase in the gross premium and a reduction in dividend as a result of the increased claim losses. Fortunately, there is an increased awareness of the employer's responsibility toward his retired employees, and a consequent willingness to assume the increased costs involved. The coverage for retired employees under the group plan is still the excep-
tion, rather than the rule, but there is a definite trend in this direction. The two primary reasons for this trend, aside from genuine benevolence on the part of the employer, is the increased threat of government action in this area,* and the pressure of union bargaining.

In a study of 300 selected health and insurance programs, which each covered 1,000 or more workers and which were the results of union bargaining, it was found that 67 of the plans continued at least the hospital coverage. 35

Another approach which may find increasing favor is the purchase of a paid up individual health policy by the employer for his retired employees. Payments could be made on either a pre-funded approach during the employees working years such as used in retirement plans, or could be on a "pay-as-you-go" basis, with the single premium paid at the time the employee retires. Such an approach is still experimental, and only a limited number of plans have been written. One plan provides benefits graded by length of service with employees having over 20 years of service being covered for basically the same plan as active employees. If he desires, the employee with less than 20 years of service can pay for the difference between percentage of coverage provided by the employer, and the full plan. As a safeguard, there is a provision limiting liability for longterm (final) illness. 36

It will be most interesting to observe the Congressional action on the Forand Bill (H.R. 4700), currently under consideration

* See discussion of the Forand Bill below.
along with other similar proposals. Under the Forand Bill, beneficiaries of the Social Security program would be entitled to Hospital, Surgical, and Nursing Home care at government expense. Specifically, the Bill would provide such benefits to:

1. Male retirees age 65 and over and female retirees are 62 and over, and their dependents.
2. Dependents of workers who die either before or after retirement.
3. Workers who work beyond the Social Security Benefit age, and
4. Individuals who are receiving disability benefits under the present law and their dependents.

The proponents of this Bill maintain that private industry has not, and cannot, provide these benefits because of the high cost of the coverage and the inability of the retired to pay the very high premiums involved for the coverage. The opposition, which is led by the insurance industry and the medical associations, is completely opposed to the Bill, contending that private industry has recognized the necessity of providing such coverage for the aged, and points to the recent developments under group coverage, the new programs of individual coverage offered to individuals over age 65 by some of the insurance companies and Blue Cross-Blue Shield organizations. It is the opponents' contention that private industry is doing the job now and will do an even better job in the future.

The Department of Health, Education and Welfare indicates
that forty per cent of the individuals over age 65 were covered for Hospital and Medical Expenses in 1959, as compared with twenty-five per cent in 1952. It estimates that seventy per cent of these people will have coverage by 1965. Industry spokesmen tend to place the percentage of coverage a little higher, contending that by 1965 seventy five per cent of the individuals over age 65 who need and want the coverage will have it, and that by 1970, ninety per cent of such individuals will be covered. A study made in Michigan recently indicates that the population over age 65, apparently sixty-one per cent felt that either they didn't need the coverage or didn't want to purchase it. In examining these statistics, however, it should be noted that the industry figures are related to those who need the coverage and want it. The "wants" of any individual are basically a relative matter, and it is quite likely that the medical care may well be desired, but only after more basic needs such as food and shelter are provided. If one's income is depleted before the purchase of basic needs is accomplished, one can scarcely be expected to want medical care insurance realizing they could not possibly pay for such coverage out of their already inadequate income. On the other hand, the mere fact that the income of many aged is inadequate to meet the even more basic needs, provides an excellent argument to the opponents of the Forand Bill in the sense that perhaps the more basic needs should be taken care of first.

Of more basic concern to the opponents of the Forand Bill than the coverage it would provide for the aged as such, is the feeling that
the Bill is merely the opening wedge on the part of the proponents to eventually extend the hospital and surgical coverage to the entire population. This, of course, is nothing less than socialized medicine and explains the violent opposition on the part of the insurance industry and the medical associations, as well as most other supporters of a free economy. Socialized medicine would mean the loss of practically all accident and health business to the insurance industry and a control over the doctors which they feel would be unbearable.

To have the Bill come before the Congress in a general election Year will present a difficult choice for many legislators torn between voting for an extension of government to another sector of the economy, and voting against a Bill which, basically, has considerable public appeal.

There is another aspect of the Bill which is emphasized by the insurance industry, and the medical associations plus those legislators favoring greater economy in government. Estimates of the cost of the Forand Bill, which is to be paid for through increased O.A.S.I. contributions on the part of the employers and employees, vary from one billion to two billion dollars during the first year, to between six or seven and a half billion by 1980. As indicated previously, experience with the English program, while more extensive than that proposed by the Forand Bill, would seem to indicate that the estimate is not unreasonable.
Part II
Chapter V

Industry Handling of Transferred Business

One of the most demoralizing situations in the industry today is the increasing tendency for groups to transfer from one insurance carrier to another. While there are many reasons why firms transfer insurers, the most important reasons are either to receive greater benefits or as the result of a promise of lower costs. Of course, as discussed in Part III, Chapter II, the present carrier will usually provide the benefits desired, and can do so more economically than a new carrier can. With respect to lower costs, the change in insurers often follows a request by the present carrier for a rate increase at renewal time, or occurs at the time plan revisions are being made. As a general rule, while there may be a savings during the first year, there is little reason to hope that claims and, indirectly, costs will be any lower with a new carrier than with the previous insurer. This is particularly so when a smaller case is involved and net cost is not so important a consideration.\(^*\)

"Transferred business" is the industry term applied to those cases which switch their group insurance from one insurance company to another, regardless of the underlying reasons for the transfer of coverage. Generally, a transfer of coverage from a Blue Cross-Blue

\(^*\) See Part III, Chapter II, p.110, for a more complete discussion of this point.
Shield program is not treated as transferred business for two reasons. First there is the basic difference in approach between the Blue Cross-Blue Shield coverages, service type plans, and the commercial insurance plans, indemnity type plans. This difference in approach prevents any comparison between the benefits and the costs involved for each except in very general terms. Also, up until recently, and even now only on selected groups, the Blue Cross-Blue Shield plans did not maintain separate experience figures on individual cases. Hence, there was no way in which the prior claims experience for a particular case could be determined.

The underwriting philosophy of every group insurance writing company, other than those carriers which are openly buying business to build up their group department, is basically the same. As might be expected, they want to write business on which they will not lose money. This is the principal aim of any industrial organization; and yet, for some reason, many buyers feel that because they are buying insurance, their past claims and rates with another insurance company should not be considered by the new carrier. This overlooks the basic fact that groups are made up of individuals, and while the industry can talk about the average expected mortality (death rate) or average expected morbidity (accident and sickness rate) for individuals of a given age, sex, and income located in a particular area and industry, the individuals in a particular group are not necessarily "average" and, in fact, it is probable that they are not "average."

With respect to a case which has never had insurance, the
insurer must rely on averages as applied to the particular group and therefore, uses its standard rates. A case which has had group insurance previously, however, will have established a claims record of its own, and this is certainly a more satisfactory guide to the nature of the group than the application of an "average." Of course, on the larger groups, past claims experience is a much more reliable measure than on smaller groups since statistically there is less opportunity for one or two individuals to significantly affect the over-all claims experience. Even on smaller cases, however, past claims are at least an indication as to whether the group is better than average or poorer than average, and in the absence of any additional background, the rates will be determined by the past claims experience. Thus, investigation of prior claims experience is not so different than the development of cost estimates in any other industry.

Any producer must estimate the cost of the raw materials (claims to be paid) and add in the cost of production and overhead (retention) in order to determine a price for a particular job (insurance contract). If the raw materials used are more expensive, or if the costs of production and overhead are higher, the price quoted to the buyer for the business is going to be higher. Is it unreasonable to expect the insurance companies to proceed differently?

As in the case of other industries, there is room for judgment as to the cost factors which go into the particular job and it is the underwriting function to provide the judgment factor. While the underwriting of most companies appears to be very similar, there are areas
in which the particulars involved on a case will be weighted differently by the underwriter. Hence, if there is a reason for the poor experience on a case which has been corrected or eliminated, or could be corrected or eliminated, it is possible that the underwriters, for the various companies, will assess the value of the reason for poor prior claims experience differently. Accordingly, they will rate the case more or less liberally than the competition. Instead of withholding the full story from the underwriters and compelling them to suspect the worst, it behooves the buyer to give as complete a background as possible and let the underwriters make their own evaluation. In fact, a full story in itself is a creator of the desired psychological reaction by giving the underwriter a feeling of confidence in evaluating the situation.

It should be kept in mind that the mere fact that the buyer may be contemplating a change in insurers to avoid a rate increase is enough to make the underwriter skeptical of the situation and anxious to avoid being faced with an unrecoverable loss himself, in the next year, should claims experience be poor. It is for this reason that the underwriters are going to look very carefully at a prospect before agreeing to quote lower rates on a case than the present carrier, whose underwriter has more information about the case than the buyer is willing to provide. Such practice, if followed vigorously, would lead to a more stable industry which would benefit buyers and sellers alike, except for those groups which are not willing to pay for the benefits received.

Thus far, the presentation has been concerned with the industry's handling of transferred business as it should be done, on cases
where the insurance companies are aware of the fact that the prospective purchaser is insured with another carrier. Occasionally, either the prospect or an overzealous agent will try to conceal the existence of the other carrier in the hope that the poor experience of the past will not affect the rates quoted by the other insurers. Too often, this maneuver is successful, and the case is sold on the basis of an inadequate rate structure. As pointed out previously, this may result in a temporary cost advantage to the buyer, but it is only temporary, and the new carrier will soon be asking for a rate increase. Then the whole process of changing carriers must be repeated all over again, unless the buyer, at this time, is convinced of the futility of transferring coverage, and decides to pay the more realistic premium for his insurance.

It is sometimes overlooked by the buyer that the application of the insurer contains an inquiry as to whether the insurance being applied for is "in addition to or to replace any other group insurance." A false reply to this question could be a material misrepresentation to which the purchaser must affix his signature.

It is this latter possibility which leads to the more common situation whereby the various companies being asked to quote on the business will have the background story on the group, and in order to write the business, will find enough justification to rationalize a quotation at rates slightly below the rates being asked by the existing insurer. They are willing to take the business knowing that the rate is slightly inadequate in the hope that, if the need for a rate increase does materialize, they will be able to conserve the business even though
the prior carrier was unable to do so. Of course, in many cases, this is wishful thinking and would be denied by most underwriters. On the other hand, it is definitely easier to conserve a piece of business than it is to sell it, so there will probably always be this inconsistency in underwriting philosophy as long as the current competitive atmosphere prevails. Naturally, this practice is more prevalent on the larger cases where there is more at stake and a very small percentage in the rating margin between the offerings of the various carriers can still mean a very substantial difference in the actual amount of money involved.

It might be asked what difference it makes if some carriers are willing to use an inadequate rate in quoting on the transferred business since they are the ones who stand to lose by following such a practice? If it were only the insurer which stood to lose, the rate cutting could be ignored, perhaps. However, every time a group policy cancels with a deficit outstanding, the loss must be absorbed by the insurer. To the extent that this is done, it affects the remaining policyholders through an increased rate of retention by the insurer and thus an increase in net cost. Also, as claim losses rise, the insurers must raise their standard rates and also institute more stringent renewal underwriting consideration for the cases that remain with them. Therefore, while the insurer absorbs the immediate loss, this loss is ultimately passed on to the other policyholders. Moreover, from an industry standpoint, the existence of a hard core of cases which are frequently transferring to avoid paying their actual share of the claims, means that the inadequacy of rates on this class of cases must
be borne by the other group cases. In a period of continually rising claim costs, this is hardly a fair imposition.

In view of the delicate position of the industry under the anti-trust laws, the insurance companies have avoided any cooperative effort in group insurance to set up any form of a control group to identify policyholders or to permit development of a claims record on cases which are continually switching their coverage from one insurer to another. Therefore, there is no way in which the firms falling into this category can be identified; or, for that matter, the number of cases involved cannot even be determined. Of course, over the years, each insurer develops records of continual requests for quotations of particular cases and may even have taken its turn at losing money on a few of them. Hence, the insurer approaches such cases with extreme caution. In argument against the continual transferring of group insurance, it is sometimes voiced that, at some point, the buyer will find himself unable to purchase the insurance since no carrier will be willing to assume the risk. However, to date this has not been the situation and there has always been a company new to the industry, or new to the area, or which has not been previously requested to quote, and which will willingly assume the risk.

There is no way of determining the actual magnitude of the transferred business problem with any degree of certainty from a central source; and the individual insurance companies are understandably reticent about releasing the statistics on cases which they have lost to other insurance carriers, or which they have written as take-overs
from other carriers, even to the extent that they are aware of such takeovers. However, Table VI below has been developed from the production reports of the individual companies, and to my knowledge, this aspect of the resulting statistics has not been presented before. The exhibit is presented only to indicate the relative magnitude of the number of cases transferring. It is not possible to estimate accurately how many of the cases making up the "gap" demonstrated are actually transferred business, as opposed to how many represent business failures where there was no successor firm to which the policy could be assigned; how many policyholders were merged with other policyholders, either completely or insofar as their insurer is concerned and lost their identity; or how many policyholders merely decided to drop their insurance. However, group insurance is generally not written until a firm is fairly well established, and while the number of mergers between business enterprises is increasing, it is unlikely that it is a significant factor in this regard. As for firms dropping their group insurance entirely, this is extremely unlikely in this day of ever increasing fringe benefits.

A report from one insurer indicated that ninety three per cent of their business written during the first eight months of 1958 was on single employer-employee groups. Of this ninety three per cent, sixty two per cent represented business transferred from other carriers. These particular figures are the results of a small company which had only eleven per cent of its new business resulting from increases in plans already in force. However, it seems to point up the problem, since only twenty six per cent of its business was on cases with no previous insurance.
### Table VI

**TRANSFERRED BUSINESS**

**Number of Master Policies of Group Life Insurance on Employees**

<table>
<thead>
<tr>
<th>Year</th>
<th>A IN FORCE JAN. 1</th>
<th>B IN FORCE DEC. 31</th>
<th>C ACTUAL INCREASE</th>
<th>D ACTUAL INCREASE</th>
<th>E UNACCOUNTED FOR DIFFERENCE IN NUMBER</th>
<th>F UNACCOUNTED FOR DIFFERENCE AS A &quot;OF REPORTED SALES&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1956</td>
<td>90,706</td>
<td>106,220</td>
<td>15,514</td>
<td>23,140</td>
<td>7,626</td>
<td>33.1%</td>
</tr>
<tr>
<td>1957</td>
<td>106,220</td>
<td>120,390</td>
<td>14,170</td>
<td>25,530</td>
<td>11,360</td>
<td>44.5%</td>
</tr>
<tr>
<td>1958</td>
<td>120,390</td>
<td>133,880</td>
<td>13,490</td>
<td>25,740</td>
<td>12,250</td>
<td>47.5%</td>
</tr>
</tbody>
</table>

The Survey was conducted and complied by the Institute of Life Insurance. The In-Force figures and the column headed "Reported Increase", were taken from their report supplies for the years 1956 through 1958. The percentage figures and other columns are the writer's own calculations based on the data shown. The Survey represents data of the approximately 650 United States and Canadian insurance companies which write group insurance.
If the effect of policies lapsing for reasons of business failure, merger, and permanent discontinuance is assumed to be negligible, the exhibit shows that at least one third of the reported growth in the number of group life insurance policies during the period January 1, 1956, through December 31, 1958, did not mean an increase in the number of firms having group life insurance for their employees, but instead, was merely a switching from one insurance carrier to another. While the actual magnitude is not determinable, the relative magnitude of the problem for the industry, which should be characterized by stability, is disconcerting, to say the least.

Furthermore, it is perhaps even more important to notice the apparent upward trend which is developing, in that Column G indicates 33.1 per cent in 1956, 44.5 per cent in 1957, and an increase to 47.5 per cent in 1958. This is not an auspicious record for an industry previously marked by phenomenal actual growth and which is still providing coverage for only a little over one half of the nation's non-agricultural work force.\(^42\) It appears that an increasing proportion of the cases written is in the transferred business category. Unfortunately, while the companies deplore the transferred business situation, there is nothing which any one company can do to alleviate the situation, and there is little evidence that the industry as a whole can correct the abuses on its own under the existing philosophy of the anti-trust laws.
Part II
Chapter VI
Combining of Claims Experience Between Policyholders for Dividend Purposes

A recent movement in the group insurance industry is the practice of combining the claims experience between policyholders for dividend purposes. Within the industry this is known as "pooling," and to some extent is similar to the Blue Cross approach on cases not experience rated.*

Up until a few years ago, every group insurance plan was basically entirely separate from each other plan, regardless of the size of the case. Under that arrangement, the size of the dividend returned to the policyholder at the end of the policy year was inversely related to the claims incurred by the employees and dependents insured under that particular policy.

Dividends are equal to premiums less claims and retentions; and since the retentions are basically divorced from the claims incurred,**

* See Part III, Chapter I, p. 101.

** While retentions are generally considered as being independent of the level of claim losses, there is a slight correction in that retentions, which are the insurers' expenses, include the taxes paid by the insurer. Some insurers use an average tax figure in computing retentions and thus the claims figures would not affect the taxes. However, many insurers use the actual taxes paid on each case, feeling that cases in which corporate taxes are low should not have to pay a portion of the tax for those cases in which the taxes are higher. Moreover, many states tax on a net premium basis. Since the dividend reduces as the claims increase, the net premium and, hence, the taxes also increase as the claims increase. On a small case, the taxes are a small percentage of the total retention, but on a large case, they often constitute a large percentage of the total retention, and a variance in the level of claims can significantly affect the retentions involved.
A relatively low level of claims would mean a larger percentage of the premium would be returnable to the policyholder as a dividend. Conversely, a high level of claims would mean little if any dividend would be earned.* In fact, if the claims plus retention exceeded the premium, there was, in effect, an underwriting loss to the insurer on that case. In order to recoup the losses under these circumstances, the insurer would carry forward the loss to the next year. If a dividend were earned then, at least a portion of the dividend would be withheld to pay off some of the prior year's loss. This process was repeated each year until the case deficit was extinguished.

On the large cases, where the number of lives involved give a measure of statistical reliability** to the experience figures, and large fluctuations in the claims are unlikely, rising claims usually indicate a trend which can be corrected by rating action prior to the development of a large deficit. On the small cases, however, it is common for a case to have very low claims for one or two years, and then be faced with a very high level of claims. In fact, the relatively limited amount of premium on these cases meant that it was practically an all or nothing proposition. Either there were few or no claims in which case a large dividend, relatively speaking, was earned; or there would be perhaps only one or two serious claims, but that would be enough to develop a case deficit. The deficit could affect the dividend potential in both the current year and for the

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* See Appendix, p. 139, for complete discussion of dividends.

** Within the industry, this is referred to as the "Creditability Factor."
next two or three years as well.

This was an unsatisfactory situation to both the policyholders and the insurers. It meant that the policyholders could never predict their group insurance costs with any degree of certainty when establishing their annual budgets; and insurers always took the risk that the policyholder would take the dividends as long as the experience was good, and would then jump to another carrier as soon as a poor claims year resulted in a substantial case deficit.

It was due to these problems that the concept of "pooling" was developed to even out the wide fluctuations in claims experience on the smaller cases by combining them with other cases of the same general nature. In a sense, this had the effect of making one huge case out of the many smaller cases insofar as consideration for dividends was concerned. This was effected by substituting the experience of the "pool" for that of the individual case in the dividend calculation.

In practice, there are many details of determining which cases are to be pooled, and to what extent. Generally, the extent of "pooling" is determined by the number of lives insured under a policy, or by the amount of premium collected under a policy. The small cases are completely "pooled" and as the size of the case increases, the portion of the case being "pooled" reduces until on the larger cases, there is no pooling involved.43

It is important to distinguish the action of "pooling" from the renewal underwriting practices and rating practices of the commercial carriers. "Pooling" affects only the dividends, and each case
is still rated initially, and at renewal time, on the basis of its own experience. It is not unusual to find cases with poor experience earning a dividend as a result of the "pooling" operation, while at the same time, the rates are being raised to absorb the rising claim costs. This may seem contradictory, but actually the insurer is merely insisting that the rates on each case be sufficient for each case to support itself over the long run in terms of its losses being no higher, on the average, than the losses of the entire pool. It is only in this way that all members of the pool will receive equitable treatment. Certainly, it would not be fair to have a few cases consistently incur higher losses than are being charged to it as part of the pool. This would merely mean that the cases with good claims experience were supporting those cases with consistently poor experience.

The short-run effect on "pooling" is to help those cases which have actual claims which are higher than the pool charges made. Conversely, those cases which have good experience during any particular year are hurt, since they are charged for more claims than they actually had. However, on the smaller cases, this year's loss in dividend due to "pooling" might be more than made up during the next year when, through no fault of the policyholder, the situation is reversed. Furthermore, since the pool charges are relatively stable, a more realistic budget for group insurance costs can be established.

Unfortunately, the insurance companies must, of necessity, always deal in overall averages in determining the basic formulas to be used. If it is established that the losses over a period of years on a
given size case will be perhaps 70 per cent based on the rates being employed, then a "pool charge" of 70 per cent will be employed with respect to cases in that category. If a policyholder has a better than average group such that the claim losses average perhaps 50 per cent instead of 70 per cent, then, in effect, that case would be overhanged by 20 per cent. On the other hand, it would be just as possible for the average to exceed 70 per cent in which case there would be an unquestionable advantage to the policyholder.

In the long run, the "pooling" should average out to about the same amount as the actual claims incurred, and there will be relatively little effect on the overall net cost, provided that the insurer has set the pool charges at a realistic level. In addition, there will have been the advantage of leveling off the claim charges, and net costs. If there is substantial reason to believe that the claims will be lower than average, then the firm would be well advised to place the insurance with an insurer not using the "pooling" concept. There is no reliable guide for predicting the actual claims experience on a case not previously insured. Death and disabilities are no respector of individual differences, and even past experience on a small group is not sufficient, although it may give a hint of the future experience.

Apart from making a choice between the insurers "pooling" or not "pooling," the buyer must assure himself that the charges made by the pool for any particular carrier is about the same as that being charged by a competing insurer. This is very important for the small cases which are completely "pooled," and becomes progressively less
important as the size of the case increases, and stands increasingly on its own experience. Basically, the concept of "pooling" is sound and will probably be adopted ultimately by nearly all companies to at least some extent. In spite of the fact that in the short run, it seems to be grossly unfair to policyholders having good experience, but receiving a much smaller dividend as a result of the "pooling charge" or "claims charge" made, it is only through "pooling" that the smaller cases can gain a measure of true insurance.
A fairly recent development within the industry is the instituting or the switching of group insurance from an insured basis to a self-insured arrangement. To date, this has been a limited movement, and is confined primarily to the Union Welfare Plans. To a considerable extent, the plans which are self-insured are very large. A primary consideration was usually a desire for closer control over the program by the principals than is possible under an insured plan based on a written contract between the Welfare Fund and the insurer. As might be expected, the other major reason for self-insuring is the anticipation of lower net costs.

The self-insuring of the Accident and Health portion of a welfare plan involving a really large group is theoretically quite feasible, provided the limits of the plan to be provided are moderate and protected by specific safeguards. Also, there should be a reasonable geographical distribution to alleviate the possibility that a local epidemic or catastrophe might exhaust the fund. Under such conditions, the claim frequency or morbidity on a large group can be reasonably predicted over a sufficient length of time. Moreover, the Accident and Health coverages, unlike the life insurance coverage, involves a large number of claims and establishes a high enough frequency of claims so as to remove much of the element of insurance for the group, as opposed to the individuals composing the group. In effect, the large group acts
much like a small insurance company in spreading the risk among the individuals constituting the group.

Like an insurance company, the self-insured plan must also incur costs for performing the myriad tasks accepted as routine operation by the insurer. Often, particularly if there was previously an insurer in the picture, the policyholder fails to recognize the extent of such services. Generally, he has performed the administration of the case himself and, for example, may not appreciate the amount of clerical work entailed in the rather simple appearing claims analyses which had been prepared periodically by the insurer.

The success of a self-insured plan depends to a considerable extent on the ability of the plan administrator. He must be extensively versed in the fields of administration and claims handling since in these areas he must make the ultimate decisions which are normally made by the insurance company. Also, he should possess some underwriting background, in order to evaluate the recommendations of the consulting actuary who should be engaged to insure that the fund remains on a sound basis. As medical costs continue to increase and the pressure for increased benefits is encountered, this phase could be extremely important.

Naturally, the potential savings of a self-insured plan will vary with the specific factors surrounding the case. However, the savings may often be more apparent than real after the additional specialized personnel required for administration of the plan have been hired. The insurance company is able to utilize the special talents involved on many cases; thus, it is able to more completely use the specialists' skill. While collateral duties may be assigned to keep the specialist
busy, the fact remains that the special ability of the individual for which the self-insurer is paying, is only being partially utilized. If a consultant is engaged, the firm is paying only for the services rendered; but even then, it is probably more than the insurance company charged for the equivalent service. Of course, his advice is probably more impartial as well.

One of the areas commonly looked at with suspicion by the insured is the reserve requirements of the insurance company. However, if the fund is to be maintained on a sound basis there must be reserves established within the fund. Furthermore, since the spread of risk is smaller, there should actually be a larger reserve, proportionately, than is necessary under an insured plan which has not only the reserve established out of the particular case's premium for unforeseen contingencies, but also the reserves established out of the premium of all other cases in force, and thus may be proportionately much smaller. Of course, with a self-insured program, such a reserve is still policyholder money as opposed to an insurer's contingency reserve, but it is still money which must be earmarked and is not usable as operating cash.

There is a possibility for real savings in the area of taxes. As explained in the footnote on page 76 in Chapter VI, the taxes, either actual or averaged, which are paid by the insurer for Federal and State Income Taxes are charged directly as part of the retention. On the large cases, the taxes paid represent a substantial portion of the total retention and the savings in terms of actual dollars saved may also be substantial. These taxes possibly can be avoided or reduced through
inclusion in the overall tax picture of the self-insurer, particularly in the case of state taxes and in the case of labor unions qualifying as tax exempt institutions. It should be noted, while speaking of taxes, that in the case of a tax paying entity, at least, the Federal Income Tax acts as a leveling agent in the matter of savings in net cost. Even if savings in net cost are possible through self-insurance, about one-half of the savings is ultimately lost through the operation of the Federal Income Tax.

There is another aspect of self-insurance which is sometimes not fully considered insofar as control over the plan is concerned, namely that the plan is freed from the contractual limitations imposed by the insurance policy. The self-insurer must now assume the responsibility for refusing claims as well as for paying them. In terms of personnel relations, this can be most important and could offset any cost advantage which might be possible. Of course, additional employee good will might be endangered by paying claims which could not have been paid under the insured plan. Such payments imply a considerable amount of discretion will be available to the administration and such discretion is a double edged sword. Whereas the refusal of a claim under an insured plan can always be blamed on the insurer, this is not so in the self-insured plan. The buffer previously provided by the insurer, between the policyholder and an employee's dissatisfaction with claims reimbursement, is lost. Most personnel managers will agree that the dissatisfaction of an employee who feels mistreated is more intense and pervasive than the attitude of the satisfied employee.
In the typical industrial set-up, particularly if there is a union involved, frequent claims disputes could become disastrous and may even disrupt the normal grievance procedures between union and management. The union welfare plans do not have to be overly concerned about the members' attitudes on claim payments and hence, there is less need for consideration of this problem. For either the industrial enterprise or the labor union, the basic problem, however, is the need to say "no" to some claims or face the prospect of much higher claim costs than would have been the case under the insured plan. Unless costs are to be prohibitive, a line must be drawn at some point. It is usually easier to have it drawn by the insurance company.

Another complication which must be investigated before any decision on whether a plan should be self-insured or not, is the attitudes which will be taken by the insurance commissioner in the respective states. Obviously, if the self-insurance operation is going to be interpreted by the state to be engaging in the insurance business, which in turn subjects the firm to the insurance regulations and to treatment as an insurance company under the statutes, there is little to be gained by a switch to self-insurance except many headaches in a field in which the company management is not acquainted. To date, there has been no court ruling directly on this point, and this merely adds to the uncertainty involved in the problem.

Up until recently, the self-insured plans had to bear all the risks of epidemic or catastrophe on their own since the insurance companies were unwilling to take on the risk bearing function without also
assuming the administrative portion as on the typical cases. It is now possible for self-insured plans to purchase "stop-loss" insurance, whereby losses over a specified amount are assumed, either wholly or partially, by the insurer. This is an extremely desirable feature and, indeed, is almost indispensable to a sound plan since it makes the much larger reserves of the insurance company available to the fund. This fills the need for a reserve fund sufficiently large to meet the unforeseen catastrophes which, while rarely occurring, would be beyond the capacity of any practical reserve to be established by a single plan.

Most insurance companies still refuse to underwrite this form of coverage on the very practical grounds that to do so would eliminate one of the most powerful arguments in favor of the insured plans. However, some insurers have been forced by competitive pressures to accede to the requests for the coverage and will provide it under certain circumstances although they do not publicize its availability and each contract is specially negotiated.

Instead of full self-insurance or self-insurance plus a "stop-loss agreement," a more common arrangement is the cost plus coverage offered by many insurers. Under this set-up, the insurer agrees to charge a specified amount over and above the claims incurred. The amount may be related to the level of claims paid also, with a minimum amount usually indicated. Under such an agreement, the risk of adverse claims experience and the gains of good claims experience rest basically with the buyer. At the same time, the services of the insurer in administration, claims payment, actuarial work, and position as a buffer between
the policyholder and the employee in the event of claim disputes is retained.* On the other hand, this is actually a reversal of the logical position of the insured and the insurer, in that the insured is bearing the risk rather than the insurer. As previously indicated, however, the relative predictability of the accident and health claims does not make this approach too unreasonable. Occasionally, an arrangement close to the cost plus is achieved through the use of a retroactive rate adjustment. The insurer agrees to charge a rate which is perhaps less than what it feels is completely adequate, in return for an agreement on the part of the insured to accept a retroactive rate agreement sufficient to cover the claims incurred plus a specified allowance for retention.

In the final analysis, the cost-plus arrangement or the retroactive rate provision are actually more a difference in approach than an actual departure from the normal insurance arrangement involving specified premium charges slightly above expected claim and retention costs with the excess repayable as a dividend or retrospective rate adjustment. The only real differences are that in the cost plus and retroactive rate adjustment set-ups, the risk of excess losses rests with the insured instead of the insurer. In the standard approach, the insurer assumes the risk of excess loss, and then must rely on the resulting rate increase being acceptable to the insured, and future sur-

* While the insurer is spoken of as being a buffer, it is not meant to imply that the insurer actually interposes itself between the employer and employee, but rather that the onus of non-payment can be placed, perhaps fictionally, on the insurance company.
pluses being available to off-set the loss incurred. As might be expected, the net costs to the insured under the arrangements whereby the risk is assumed by the insured are slightly less in the long run, assuming no catastrophe is involved. For most plans, however, the difference in cost in any particular year is not worth the risk involved.

All of the discussion presented above is directed to the handling of accident and health coverages as opposed to group life insurance. The spread of risk on even the larger plans would appear to be insufficient to warrant the exposure involved in self-insurance of the life insurance. Even if a reserve could be established over a period of years sufficiently large to cover the possibilities of extreme losses during a one or two year period or in the event of catastrophe, such a reserve would in itself have to be so large as to make the plan impractical. Life Insurance is properly the business and function of the Life Insurance companies and should be left to them.

Other reasons indicating the impracticality of self-insuring the life insurance benefits are: the inability of a self insurser to provide any form of a realistic guarantee with respect to providing a conversion right to an ordinary form of insurance to individuals who leave the group plan through a termination of employment in an eligible group; an inability to guarantee payment of proceeds in the future on individuals who would qualify for waiver of premiums under the provisions of a standard group life insurance contract; an inability to provide guaranteed settlement option provisions to permit the beneficiary to receive the proceeds over a period of years; and finally, difficulty
in locating beneficiaries living in an area far removed from the location of the self-insurer.
Part III
Chapter I
Selecting An Insurance Carrier

There are few major purchases made by a company during its existence which are surrounded by so many intangibles, and about which the firm's management will have so little background, as the purchase of group insurance for its employees and their dependents. Furthermore, there are few fields in which the business is so competitive and in which representatives of the various sellers often manage to offer conflicting advice which, generally, only has the effect of confusing the prospective buyer. Of course, to be fair, each insurer, while selling basically the same product, usually feels that its own approach is the most satisfactory. To some extent, the larger cases can spare themselves this problem by engaging a professional insurance consultant to handle the purchase and this is probably a wise decision. Even this may not be perfect, however, since even the consultants have natural biases towards the relative importance of such items as gross cost, net cost, pooling, retentions, projections for one or two years opposed to retention projections over ten or eleven years, self-insurance, service, indemnity type plans as contrasted with service type programs, etc.

Obviously, the consultant through years of experience develops a scale of relative values for such items, and those insurers which tend to be strongest in the areas in which he places the most emphasis will be the ones considered for the business.

Since the large cases are generally in a position to make a
more objective approach to the purchase through a consultant or on their own, much of this chapter will be directed primarily toward the purchase of a group program by the smaller buyer, who does not have an adequate staff of its own conversant with group insurance, and for whom the hiring of a consultant would generally not be worthwhile.

The considerations involved fall into four major categories, although the categories are my own and somewhat arbitrary. These major considerations are:

(1) The benefits desired
(2) The costs involved
(3) The attitudes of the firm's employees
(4) The service rendered.

An attempt will be made to give an objective appraisal of the various factors, but in the final analysis, each firm's management must make its own decision on the relative merits of the considerations involved. Only the primary facets of each consideration will be reviewed, since an investigation of the niceties of retention figures would only serve to confuse, and most buyers would be much better advised to concentrate on the fundamentals.

The benefits desired will have an effect on the general type of organization which will act as the insurer. If only group life insurance is desired, then the choice is relatively simple since the business will have to be placed with a company which writes group life insurance, as opposed to some casualty insurers which do not write group life insurance. If only weekly indemnity coverage is desired, the choice is
somewhat wider since nearly all the group life writing companies, plus the group casualty writing companies are willing to write the weekly indemnity coverage. It is most advantageous, if life insurance and weekly indemnity coverages are desired, to place both coverages with the same carrier, since the combined premium should result in larger premium discounts and lower net costs, as well as a more simple administration.

When only hospitalization and related coverages are desired, and there is little likelihood of including life insurance in the program in the near future, then the wisest approach is probably to investigate the coverage offered by the group casualty writing companies and the local Blue Cross and Blue Shield organization. In fact, group life insurers are often reluctant to cover a group on a "casualty only" basis. Therefore, their rating and underwriting requirements, both initially and subsequently, are likely to be more stringent than is their practice when life insurance is included as part of the group insurance package.

Another benefit factor in determining the insurers to be considered is the geographical scope of the plan. If the same level of group insurance benefits is to be provided to employees in several different states, then it will probably be advisable to place the coverage with a large commercial insurance company since the smaller insurance companies may not have adequate facilities to service the various locations adequately and the Blue Cross-Blue Shield plans vary significantly between states. There has recently been discussion among the various Blue Cross-Blue Shield organizations about the possibility of establishing a national Blue Cross-Blue Shield to meet this problem.
To some extent the actual nature of the hospital, surgical and medical expense benefits may determine whether a commercial insurance company or the Blue Cross-Blue Shield plan—should be utilized. Traditionally, the Blue Cross-Blue Shield has been categorized as a "service" type arrangement meaning that they tend to provide practically unlimited or full reimbursement for certain specified services, with little or no benefits available for some other services. On the other hand, the commercial insurers' plans are usually called "indemnity" plans since they provide coverage for nearly all types of services, but impose a dollar limit on the amount of reimbursement for the services. While a direct comparison between the two approaches may be attempted, it is extremely difficult to come to any specific conclusion that one approach is better than the other since it is like trying to compare apples and oranges to determine which is the better fruit. The question resolves itself into a matter of individual choice, with proponents of each being able to point to specific claim situations, in which their own coverage appears in a far more favorable light than the other. Furthermore, over the past few years there has been a definite trend, whereby the two approaches are coming closer together. The Blue Cross plans in many areas imposing dollar maximums, etc., and the commercial carriers providing for the full cost of semi-private rooms, etc. As a practical matter, there is little difference in the overall benefit picture. In terms of growth, the commercial carriers have grown relative to Blue Cross organizations over the past ten years,* but this probably should

* See Part I, Chapter II, Table III, p. 24.
be attributed, at least in part, to the greater sales effort of the commercial companies during those years.

While the cost element is naturally a big factor in the selection of the insurance carrier, it should not be considered as the only factor. It should be recognized that, except for the Blue Cross-Blue Shield arrangements which in some areas may give these organizations an actual advantage cost-wise, * in the short run at least, the prospective insurers will all be faced with the same claims, assuming they are actually providing the same coverage. Therefore, ultimately the differences in costs between insurers must resolve themselves into either a difference in their costs of doing business, or a difference in the actual coverage being provided.

The costs of doing business are a closely guarded secret of each company, and the method of allocating costs between cases of different sizes and coverages can vary significantly. However, since all of the commercial companies operate on approximately the same basis, it is unreasonable to suppose that the actual costs of operating are radically different. This leads then to the conclusion that basically the buyer will get what he pays for; and a substantially lower cost will probably reflect a variation in the coverage being offered by the insurer. While minor variations in cost may reflect the minor differences in coverage being offered, it behooves the purchaser to be very careful in consideration of any plan which, while pretending to be basically the same as other

* See Part I, Chapter II, p. 19.
plans being compared, is much lower in cost than the other plans. Group insurance is written on a one year renewable term basis and the insurer has the right to adjust rates at least once a year.

There are many insurance companies who have only recently actively entered the group field and which often need to build up a decent volume of business to support their expanded organizations, even if it means an excessive claims experience. The easiest method of developing the necessary volume is to cut rates and charge what amounts to inadequate premium. Such an operation means that as soon as the poor experience develops, they will be asking for a rate increase to bring the rates up to an adequate level. They hope at that time they will have sufficiently solidified their position to retain the business in spite of the rate increase. It is not intended to imply that this is a condemnation of all the companies which have recently entered the group field, however. There are well established companies which follow the practice also, and by and large, the great majority of insurers are struggling, with considerable futility it appears at times,* to remain competitive and on a paying basis.

While it is obviously a savings in cash outlay during the first year to purchase at the cut rates, this would be basically an unwise practice to follow with respect to the purchase of a long range proposition such as a group insurance program. In the first place, the annual reconsideration of a new group insurance carrier is an expensive imposition on precious executive time. This will be indelibly impressed

* See Part II, Chapter III.
upon the buyer after sitting through the sales presentation by the representatives of several different insurers. Also, a continual changing of insurance carriers has a tendency to demoralize and confuse the employees since they can never be sure of where they stand. Therefore, the savings made may well be more apparent than real in even the first year, if the selection made is likely to lead to a reconsideration in the near future.

Since each new carrier has to re-incur the same acquisition costs already incurred by the prior carrier, a continual switching of carriers results in the acquisition charges never being amortized. Consequently, the average retention and, hence, net costs, are going to be higher in the long run than if only one carrier is involved.

Although the buyer is ultimately likely to get just about the coverage for which he pays, there are some general rules which deserve consideration. The cardinal approach which should be followed by all buyers, large and small, if costs are to be the primary consideration, is to ask three or four companies, either directly or through an agent or broker, to submit types of plans for consideration. As much description as possible should be supplied with respect to the general types of benefits desired. After selecting the one plan which seems to most adequately fit the buyer's needs, the plan selected should be given to each of the companies with identical, current data regarding employees and dependents, and quotations requested on the basis of that plan. This is as close as one can come to "comparing apples with apples," and should give the buyer a firm basis on which to select a carrier insofar
as gross costs are concerned.

For the case with less than 25 employees, and increasingly so those cases with less than 50 lives, there is little chance of receiving a dividend regularly, if at all. Therefore, such buyers in considering costs would be well advised to consider the gross cost\(^*\) as the final or net cost as well. The larger cases will usually qualify for a dividend if the claims experience is satisfactory, and the larger number of lives and amounts of premium involved, the more emphasis should be given to the net cost.\(^*\) As discussed in the Appendix, net cost is the gross cost less any dividends paid.\(^*\) For the smaller cases considering net costs, it would be advisable if they look at the dividends proposed more as an indication of approximate costs, and as merely a tentative guide as to the relative net cost with the various insurers. Furthermore, there is considerable merit in the recent tendency in evaluation of retention exhibits on even large cases towards giving the most weight to the first five years of the projection, rather than ten years' projection. After five years, there is the probability that the underlying assumptions of the insurance carrier with respect to taxes and expenses, as well as the paid premium and claim losses actually developed, will have changed to the extent that the original projection beyond the first five years will not be reliable. In practice, most insurers usually supply retention exhibits on a large case over both 5 and/or 10-year period. The 5 and 10-year averages should be compared for consistency, even though it is unlikely that they will prove to be reliable guides for actual develop-

\(^*\) Refer to Appendix, pp. 130 - 140.
ments beyond the first few years. Of course, it must be kept in mind that the dividend or retention projections are never guarantees, but merely projections of the existing dividend formula.

With respect to retention exhibits, attention should be called also to the occasional use of company-wide averages, as compared with the average retentions or the specific retentions of the competition on a particular case. The proposition is that, because of a lower average retention company-wide than is developed by the competition, the insurer is a lower cost company. Actually, the company averages are only that. They bear no relation necessarily to the retention which the company will charge on a particular case. The average retention figure can be extremely misleading because an insurer which has on its books a heavy proportion of large cases and/or cases which have been in force for a number of years, so that the acquisition costs have been amortized, will naturally reflect a low average retention, even though it may be charging a higher retention on its new business. It is most important to consider only what treatment is to be accorded the buyer, himself, since the average is going to have no effect on any new case.

A few paragraphs above, the assumption was made that with the same plan of insurance on a group, the claims paid out would be approximately the same regardless of which insurer was actually on the risk. While this is true in itself, it is necessary to go one step further with respect to those smaller cases which, for claims experience and dividend purposes, are either completely or partly combined with other cases of the same general description. Dividends are related to the claim charges
made rather than directly to the claims incurred for such cases. Over a long period of time, the "average" case will probably have average claims, and there will be little difference between the claim charges made and the actual incurred claims. For the cases which, for one reason or another, are better than average, however, the claim charges would exceed incurred claims and the result would be a smaller average dividend and higher net costs as a result of the "pooling." Of course, the converse would also hold for a case with higher than average claims experience.

Unfortunately, there is no method of determining in advance whether a particular case is going to have higher or lower than average claims. In fact, as the size of the case decreases, even less reliance can be placed on general underwriting considerations such as the class of industry, type of employee, living conditions of employees, sexes, ages of employees, etc. It was precisely this difficulty which brought about the "pooling" concept in the first place. In practice, the pooling is an attempt to remove to some extent the gambling aspect involved in having a case stand strictly on its own for dividend purposes. The "pool" is designed to substitute a measure of true insurance which would permit a more constant level of claims charges through the combining of cases, and thus mitigating the tremendous fluctuations in year to year claims experience.*

The final cost consideration is the practice of individual case experience rating on the part of insurer. On cases of 25 lives or

* This subject is covered more extensively in Part II, Chapter VI.
over, the commercial insurance companies are very uniform in the rating of cases based on actual experience for each group. Every company's underwriting department has its own basic philosophy on the magnitude and timing of rate adjustments; but generally speaking, it appears the similarities are much greater than the differences in practice. On the other hand, Blue Cross-Blue Shield organizations still tend to look at their experience trends as a whole, without reference to experience on a particular firm. When the experience on all cases climbs too high, then a general increase is imposed on all subscribers. This means that cases which have reason to expect higher than average claim losses might avoid the effect of the individual rating systems imposed by the commercial carriers, by insuring with the Blue Cross-Blue Shield. Conversely, the case expecting a better than average claims loss ratio would probably be better off with the commercial carriers, where their low level of claims will be recognized. As pointed out before, the Blue Cross-Blue Shield organizations in some areas will now rate cases on an individual basis in some instances, and thus are using the commercial carriers' approach of recognizing poor experience by increased charges, and good experience with reduced overall costs. Of course, such action was necessary in order to avoid losing their good cases to the commercial insurers, while at the same time, picking up the poor risks on which the commercial insurers were requesting rate increases.*

* This paragraph applies basically to smaller cases where the insurance aspect is still the primary consideration. For large cases where better than average experience is expected, the possibility of self-insurance or cost plus plans might be investigated. Usually this is done only after a few years' experience with an insured plan has been successful, however. See Part II, Chapter VII.
Closely related to the renewal underwriting procedure which an insurer will follow is the initial rate development on the part of the commercial insurers as compared with Blue Cross-Blue Shield. Of course, it is necessary for each buyer to investigate the rates proposed by the various insurers for his own case. However, it should be noted that the commercial insurance companies set their rates depending on the percentage of females involved, ages of employees, and other considerations relating to a specific case. The Blue Cross-Blue Shield organizations, in contrast, generally use the same rates for all groups regardless of age or sex. In practice, this means that a case with a large percentage of females will nearly always find that the initial rates of the Blue Cross-Blue Shield are lower than those of the commercial insurance carriers for plans involving the same approximate level of benefits. For groups involving substantially all males, the converse may be true, since the Blue Cross rate is based on an average female indemnity and in a sense would be a slight over-charge to the males. Generalities in this area are not of much assistance, however, and each potential buyer should investigate his own cost situation.

It should be obvious, at this point, that selection of an insurer is, at best, a difficult decision, even if all facts could be known. However, all of one's efforts can be for naught, if adequate attention is not given to the human aspects of the problem as reflected basically in the employer's attitude towards the employees, and the employees' attitude toward the type of coverage chosen and the carrier selected.
To dispose of the simplest problem first, the employees will generally not have any particular preference between the various commercial insurers, although the well known insurers generally have greater acceptability since the employees will often have had some exposure to them with respect to their personal insurance, or that of their friends. Quite often, however, due to past experience, both the employer and the employees, either collectively or individually will have had a happy or unhappy experience usually related to claims with either a commercial insurer or Blue Cross-Blue Shield. In such instances, the feelings can be quite intense. If they are general among a significant portion of the employees, then these feelings should be considered if the greatest satisfaction is to be obtained from the program.

The last area to be considered is that of the service supplied by the insurer or the agent. Service by the insurer to the insured is an item which should be evaluated thoughtfully, insofar as it is possible to do so. Unfortunately, an objective decision in this respect is impossible for the new buyer, and reliance must be placed on the general reputation of the insurer within the area, and the buyer's personal estimate of the insurer's representatives. It can sometimes be helpful in relatively highly industrialized areas for the buyer to inquire about the service and attitude of the neighboring firms. Remember, however, that such an inquiry should be directed basically towards the service rendered, rather than the costs of benefits, since the level of benefits is decided upon by the policyholder. The rates or costs are related to the level of benefits purchased, the past claims experience, and the characteristics of the group insured. Of course, the inquiries should
be made to firms of the same basic size and general geographical area, if possible, since the actual service by a particular company can vary significantly between large and small cases, and various areas, as a result of the different representatives which service the respective areas and cases.

The selection of the writing agent or broker, assuming a commercial carrier is to be the insurer, can be most important. In some cases, the selection of the agent or broker is made first, and this is perhaps the most common arrangement on small cases. Once the agent or broker is selected, the choice of the insurer almost automatically is made, in that the insurance is usually placed with the company represented by the agent, or the company with which the broker customarily does business. Of course, this does not mean that the best choice of insurers has been made from a management point of view; but it has its compensations in that the agent or broker, in a sense, acts as a middleman between the insurer and the insured, and while he is not likely to be an expert in the field of group insurance, he will have enough background insurance-wise, to give effective advice to his client on the important aspects.

Of course, the ultimate in this arrangement is the consultant wherein the consultant acts strictly to protect the policyholder's interest in its dealing with the insurer. In between the two extremes, there are many agents and brokers who do a considerable amount of group business and are well qualified in the field, even though they do not classify themselves as consultants.

In the many instances wherein the choice of the insurer is not affected by the choice of the agent, i.e., when the buyer chooses the
insurer without outside advice, the typical arrangement is to have the agent selected basically on the merits of the buyer's internal politics. Any agent or broker licenced by the state involved, for the type of coverage purchased, can be designated by the buyer to receive the commissions payable. The agent or broker does not necessarily have to be a representative of the company selected. To some extent, this is most unfortunate, since it results in a great many cases being written through agents and brokers who have never written a group case before, and may never write another. This discourages qualified agents and brokers from more actively soliciting business. It is this fact, plus the technical nature of the business, that led Dr. Gregg to comment that, "After the sale is completed, the agent or broker on the case usually leaves all further details to the group representative."51

Administration services by the Home Office of the insurance company can range from simple processing of applications from new employees to involved legal problems. As pointed out above, there is no way of determining in advance what satisfaction will be received, but the companies do vary in the quality of their representatives and willingness to provide special treatment and considerations, particularly on smaller cases. On larger cases, all insurers, of necessity, are very responsive to requests involving non-standard contractual provisions and handling.

The personal service rendered by the insurer's group representative can be one of the most important features of the group program. A good representative can do much to insure that the case runs along
without frustration due to misunderstandings between the policyholder and the insurance company. Furthermore, since the case is installed by the representative, a good job can double the effectiveness of the program, whereas an incompetent job can get the case off to a bad start through creating confusion instead of satisfaction in the minds of the employees. In choosing a particular insurer, the buyer is generally choosing the group representative who has represented the insurer in discussions as well. While it is not a primary consideration, certainly it would be most unwise to select an insurer, regardless of other factors, whose representative did not impress you as being likable, trustworthy, and competent.

The last consideration of service rendered is in the area of claims settlement. It is obviously most important to have satisfactory claim service, since the payment of claims directly involves the individual employee and insofar as he is concerned it is the group plan. Generally there are three types of claim settlements possible for the typical group case.

First of all, there is the Blue Cross-Blue Shield approach wherein the bill is sent by the hospital or the doctor directly to the Blue Cross-Blue Shield for that portion of the amount due which is due to be paid by the Blue Cross-Blue Shield. The employee is billed directly for the remainder. This means that the employer does not have to be concerned with the claim settlement administratively, at least, at all. On the other hand, it also means that by having the employee deal directly with Blue Cross-Blue Shield, the employee tends to lose sight of
the fact that the employer is paying for at least part of the insurance, assuming that is the case; and thus, the employer is not getting full value from his contribution to the insurance.

The second possibility is to have the commercial insurer issue the checks for claim payments either to the employee, or to the doctor or hospital directly if the employee desires to assign the benefits. This system has the disadvantage of requiring a claims form to be completed and submitted to the insurer. The administrative inconvenience, however, may well be offset by having the employee appreciate more fully that it is through the efforts and contributions of his employer that the group insurance plan is possible. Most insurers, in fact, when there is no assignment involved, will send the claim check to the policyholder for transfer to the employee. This reinforces the personal touch which many employers desire.

It should be noted that if this method of claims settlement is elected, there will be a few days delay in the claim payment. For this reason it may be well to choose a company which has a local claims office, thus cutting down on the delay in claim payments. To the employee, prompt settlement of claims is an absolute must. The time lost between a one or two day settlement, and that involving a week or so, can spell the difference between success and failure to the group plan's objective.

The third method of claim settlement is commonly referred to as the "draft" system, whereby the insurer supplies the policyholder with a set of drafts on the insurer. This permits the policyholder to draw the drafts in favor of its employees in direct settlement of the claims,
with subsequent review by the insurer of the amounts paid. This system involves more administrative handling than the two previous types, but also permits the employer to really have "his own" group plan for his employees. Handled correctly, this can be a significant part of the employer's personnel program, and is certainly one of the services most appreciated by the employees.

From a cost standpoint, the dividend formula of many companies permits a small allowance to compensate the employer for the extra work required the employer in settling his own claims. In these days of machine accounting, etc., it is somewhat questionable, however, as to which is the most efficient way of handling the claim payments from the insurer's viewpoint. It may well be that it would be less expensive overall if the insurer wrote all checks as a matter of routine.

If hospitalization and other medical expense coverages are involved, it is important to have a claims representative of the insurer available for consultation and explanation of particular claims. Some insurers provide this service as a routine matter, while others may not have sufficient local claim representatives in all areas to provide this service, and must rely on their group representatives.

Generally speaking, there is no hard and fast rule for choosing the group insurance carrier. At best, the presentation of above is merely an indication of the factors which must be considered in any careful analysis. The ultimate choice rests with management, and will depend on the relative weight which each management gives to the various considerations involved.
Part III
Chapter II

Considerations Involved in a Change of Insurance Carriers

The considerations presented in the previous chapter regarding the selection of an insurance carrier pertain basically to the selection of a new carrier. There are additional refinements which apply once a case has been insured for a few years which are not present in the initial selection of an insurer. These refinements will be the subject of this chapter.

Changes in insurance carriers can result from any number of causes. The reasons fall into the same four categories applicable to the initial selection of an insurer. They are: dissatisfaction with benefits; gross costs and net costs; employee attitudes; and dissatisfaction with services rendered.

A change in carrier should rarely be made in order to obtain a more satisfactory level of benefits unless an entirely different approach is desired, such as a change from an indemnity type (commercial insurers) to a service type (Blue Cross-Blue Shield), or vice versa. While the commercial companies all offer the same general plans, occasionally a policyholder is offered a plan variation which is particularly attractive, but not offered as a standard plan by the existing carrier. The present carrier will often vary its standard procedure to accommodate the policyholder in order to avoid losing the case. Of course, the extent of the deviations which will be agreed to depend on how much the insurer values the particular case. The larger cases are in a better
bargaining position than the smaller cases, obviously. If the insurer should refuse a request for special plan features, the reason for such a refusal should be carefully evaluated. The insurers are not arbitrary, and the reasons for such refusal may be much sounder than the competing insurer's offering. The buyer should beware of "gimmicks" used as a sales approach. If the coverage requested is sound, the present carrier can usually provide it at a lesser cost than the competition, since many of its acquisition costs will already have been amortized under the old plan.

The primary reason for a change in carriers is cost, either gross or net. For the most part, manual rates among the larger insurers are quite similar. Differences of 10 per cent or more usually indicate that one insurer has recently increased rates and the other insurer probably has a similar increase under consideration. In these times of rising medical costs,* a case which has had good claims experience and thus has not had its rates increased for a few years will find that its rates are lower than the rates currently being charged on new cases. Unfortunately, even good cases are ultimately affected by the rising costs and will be faced with a rate increase. At such times, the policyholder may well find that another insurer will offer to take over the coverage at a lower rate level than that proposed by the existing insurer. The magnitude of the savings offered varies with the amount of increase being proposed and the previous level of rates, which are directly related to past experience. Conceivably, the new insurer is

* See Part II, Chapter III.
offering to take the business on a narrower margin than the existing insurer. If the premium requested appears to be adequate to cover the claim losses plus expenses, the change should be considered. It will be found, frequently, that the premium rates offered by the new insurer will not cover the losses incurred. Obviously, the insurer is "buying" the business, and is in no better position to sustain losses on the case than the previous carrier was. Unless the management is willing to accept the arduous task of reviewing the group plan every other year or so as succeeding carriers find their initial rates too low and ask for rate increases, the change should not be made.

While a change in insurers to avoid a rate increase is probably the most common reason for changing carriers, we are moving into an era wherein much of the emphasis is being laid on the net cost aspects of the Group Insurance. Competition on this phase of costs makes considerably more sense than on the cases involving rate increases. In talking net costs there is the assumption made that the claims experience in the past has been good enough to warrant a dividend or retroactive rate adjustment, and will continue to be so in the future. While savings are apparent occasionally in examining the retention exhibits of competing carriers, it is important to remember that the retentions shown are merely estimates based on the current dividend formula of each company and are not guaranteed. Furthermore, they are usually based on the most favorable possible combination of circumstances, and it is extremely unlikely that all the conditions would apply in practice. In fact, if the retentions of the existing carrier are higher, they probably reflect
the fact that all circumstances are not the most favorable possible. Finally, the acquisition costs will have to be paid all over again if the change in carriers is made; whereas at least part of these costs will have been paid for already with the present carrier.

Even though there is unlikely to be an advantage net-cost-wise in changing carriers in most cases, there is one set of circumstances in which a change in carriers would be advantageous from a cost point of view. On large cases and on smaller cases not involving a "pooling," deficits are developed due to adverse claims experience in a given year and are carried forward to succeeding years. It is customary to write off these losses over a period of years, through reductions of succeeding years' dividends. Therefore, if a case experienced an extremely poor year and built up a deficit which would act as a drag on its dividend potential for several years in the future, it would probably be wise to consider a change in insurers. Of course, a move which is advantageous from a cost viewpoint certainly may be unwise for various and sundry other business reasons. There is also a definite ethical consideration of leaving an insurer, which has been fair in its past treatment of the case, with an outstanding loss. Such decisions are, of course, strictly a function of management and each management must make its own decisions. A case which is wholly or almost wholly "pooled" does not have to be concerned about carry over deficits because the pool will usually be set up to absorb such deficits.

If the decision is made to cancel the insurance, it is impor-

that no dividend is payable unless the case completes the policy year in question. Therefore, a case lapsing just prior to its policy anniversary would forfeit any dividend. This means that if a case has been earning dividends in past years and expects a substantial dividend in the current year, the coverage should not be cancelled until the anniversary or shortly thereafter.

Just as the employees' reaction to the coverage selected initially is an important factor, their reaction to a change is even more important, since it will often be more intense. The group insurance program is merely one phase of any personnel program and should always be considered within that framework. For this reason, generalities are difficult. However, it does seem reasonable to expect that while one change in insurers would be accepted by the employees, particularly if they have confidence in the management, a continual changing could not help but undermine that confidence. The changes also would result in some confusion due to the different contractual and administrative procedures followed by the different carriers.

While lack of service or dissatisfaction with service is quite often given as the reason for a change in insurers, this is seldom more than a convenient rationalization given to hide or divert attention from the primary reason. For the most part, service will be rendered in the amount requested or as needed, and the field representatives and claim representatives do their best to insure that it is satisfactory. If poor service does become a serious enough matter to warrant consideration of a change, preference should obviously be given to those insurers with
the larger local facilities since this will generally mean better service all around.

Whereas there are a great number of valid reasons for making an initial choice of insurers, there are only a limited number of reasons which should lead to a subsequent change in insurers, assuming, of course, the expectations leading to the initial selection were fulfilled by the insurer selected. In other words, if the initial selection was based on net cost, and the projections made by the insurers were reasonably accurately followed in the succeeding years, then it is unlikely that there would be any great advantage in switching to another insurer. On the other hand, a gross failure to meet the original promises of either benefits or costs would seem to indicate that the policyholder had been "sold a bill of goods," and might do well to look for a change in insurers. In making the change, this time more attention should be paid to the consistency and veracity of the proposals being made, and less attention to the "gimmicks" and high-sounding promises.
Part IV
Chapter I

Future Industry Potential

The future of the group insurance industry is somewhat of an enigma. On one hand, there is considerable potential for growth even beyond the amazing rate already experienced. Yet, there is the darker side of the picture which envisions, not growth, but absorption into the government services, and a collapse of the industry, except for Group Life Insurance, if the proponents of socialized medicine prevail. Unfortunately, insofar as the industry is concerned, the latter possibility looms as a distinct threat, and there is really very little that the industry itself can do to preserve its independence. The final outcome is inextricably bound to the social, political and economic developments within our society. If there should be even a slight drift towards greater Federal government control or socialism, the chances are good that the accident and health portion of this industry will likely be among the very first to be taken over.

In addition to the threat of Federal Government taking over the services now provided by the industry, there is also the distinct possibility of additional state encroachment into the same area through an extension of the compulsory non-occupational accident and sickness laws currently in force in Rhode Island, California, New York, and New Jersey, to other states. These laws make it mandatory for employers to furnish coverage similar to the accident and sickness offering of commercial insurers. If other states follow the New York law known as the Disability...
Benefits Law (DBL), and require that an employer elect to have his coverage with the state or with an insurance company, it is possible that the arrangement will permit a measure of co-existence, particularly if the New York law is not modified to provide hospitalization coverage. The Rhode Island plan, called the Disability Benefits Act, was the first state plan. Written in 1943, the Act is completely monopolistic in the sense that all of the insurance must be placed with the state plan. As a result, little or no Group Accident and Sickness coverage is written in Rhode Island by the insurance companies. In California, the law is known as the California Unemployment Disability Benefits Law (UCD), and in New Jersey is entitled The Temporary Disability Benefits Law (TDB). These two laws provide for automatic inclusion of an employer in the state plan unless he specifically elects coverage with an insurance company. As a practical matter, in both California and New Jersey, the effect has been to result in ever decreasing numbers of employers insured with the insurance companies.

From the industry standpoint, the California Law, UCD, is particularly dangerous, since it provides a limited amount of Hospital expense coverage in addition to the Accident and Sickness. The New York Law, passed in 1949, was the last bill passed. It is the industry's hope that, if the passage of such laws cannot be prevented, at least they should take the New York approach. Each year, similar bills are initiated in other states, but thus far none have been passed. In 1951, thirty-six bills were introduced into the legislatures of fourteen states.

Examining the more positive aspects of the industry's future,
and assuming that the Government intervention, if it comes at all, is
still at least a decade away, it would appear that there is still con-
siderable potential. However, the remaining business is going to be a
lot more difficult to get from the individual companies' point of view.
The larger groups have nearly all been insured. Therefore, the oppor-
tunity of picking up large amounts of volume and insurance on one case,
except in the event of transferred business, is almost gone. The few
remaining sources of previously uninsured large groups are the newly
formed Taft-Hartley Trust cases or Trade Association plans, both of
which involve insuring multiple employer groups. Also, some of the large
union welfare funds which were previously self-insured may decide to go
to an insured basis as a result of the current Congressional inquiries
into their operations, and the Federal Disclosure Act.

With respect to the large groups which are already insured,
and which may for various reasons be seeking a new carrier, the competi-
tion between insurers is intense, and the margin of profit non-existent.
In spite of the definite possibility, or even probability, of sustaining
losses on such business if terms good enough to attract the business
away from the present carrier are used, the pressure for increased volume
and premiums will be enough to entice insurers into the bidding for the
business. Of course, this transferred business merely represents growth
to the particular company involved rather than to the industry.

It has previously been indicated that the industry presently
insures about one-half of the economy's non-agricultural employees. Of
the remaining one-half, a substantial number will fall into the small
group areas where coverage will not be possible due to the state laws setting a minimum number of insured for eligibility for group insurance, or because of the difficulty in developing administration and underwriting procedures to make insuring of such small groups on a non-medical basis feasible at anything resembling a group insurance rate. The remaining groups represent the new case potential and will provide a real test of each company's sales aggressiveness and ability. First of all, as the market narrows, the competition for what remains will become more intense. Furthermore, there is an increasing number of insurance companies entering the field and seeking their share, and a little more, of the remaining market. In 1953, there were 239 companies writing group casualty coverages compared with a total of 389 companies at the end of 1958. Not only will the competition be keener than in the past, but the prospects will be much harder to sell. It is unusual to find a firm which has not been previously approached in the matter of group insurance. This means that such firms will already have made a decision in the past not to buy. The prospect will not only have to be sold on the desirability of the insurance, but will also have to be sold out of the reasons for the previous rejection. There is also that small portion of the unsold market which consists of firms in a marginal financial position, which precludes the purchase of the insurance even if it is desired.

Of course, as in the instance of the larger cases, there will always be the smaller cases transferring from one carrier to another. It is unfortunate that this will probably be an increasing problem for
the industry, although a source of new business for the individual insurers. In effect, it basically will mean eventually an approximate trading-away of the insurer's poorer cases to other carriers, and picking up their poorer cases in return. This can hardly be considered either a profitable or beneficial operation, in any sense, for either the industry, the policyholder, or the individual insurance company. It can only be hoped that the underwriting and sales policies of all companies will eventually be tightened up to eliminate the abuses in this area.

One of the greatest sources of new business for the industry and the respective companies is the sale of increased benefits on their present policyholders. In this area, there is still room for improvement in almost every group plan, and it is up to each insurer to make the most of the natural opportunity presented. The average amounts of life insurance are still woefully small on the vast majority of cases, and the rising medical expenses offer built in needs for increasing the level of benefits. As the market for new cases becomes tighter, the natural outlet for sales effort is in this area, and should be exploited to the utmost. Furthermore, if the existing insurer does not make every effort to keep its in-force plans up to date, it will undoubtedly find many other companies only too eager to oblige the policyholder.

The final area for expansion is the development of new coverages such as coverages for dental treatment, and group mortgage insurance; or the use of existing coverages for groups which heretofore had not been considered as desirable prospects such as tuition plans to
guarantee payment of indebtedness incurred in sending a child to college, and professional associations, students of a particular college, etc. Some of these coverages have already been written on an experimental basis, but it will be at least another year or two before the adequacy of underwriting practice for such groups can be assessed.
Part IV
Chapter II
Conclusion

To those readers actively engaged in the industry, the preceding material undoubtedly is to a considerable extent a repetition of their day to day problems. However, individuals working within any operation often do not, or cannot, take enough time to examine the overall situation to determine if perhaps its obviously disturbing features are really as inevitable as they appear.

With respect to the group insurance industry in particular, most of the aspects covered in this paper fall into the general categories as follows:

1. The problem of excessive competition between the various insurance companies, and between the insurance companies as a group and the various Blue Cross-Blue Shield organizations. Such competition of course, as pointed out in Parts II and III can take the form of competition in benefits, gross cost, net cost, and service; and

2. The possibility of ultimate government intervention within the industry, or an outright takeover of at least the Accident and Health coverage portion of the industry by the government.

While all facets of the competitive problem have not been explored due to the limitations of space, of those which are covered, there are some signs of improving conditions. Yet, there are those areas in which the industry cannot do anything collectively, and there will have to be
either individual company recognition of the problems and long range desirability of the solution to the problems. The alternative is that the government will be forced to take a more active role to correct the situation.

The first problem presented was the practice on the part of some insurers to write excessively high amounts of insurance relative to the size of the case and the schedule of insurance for the regular employees. Basically, this approach divides into two areas: The first is a competition in benefits with a semblance of reasonableness being retained; and the second is the use of group insurance as a tax dodge.

The first area is a sign of healthy competition within the industry. As long as the various companies continue their present general underwriting practices of relating the maximum amounts on a particular case to the average amounts of insurance in force, the total premium income, the graded schedules, etc.; the higher maximums, even though they go beyond the original concept of a death benefit only and arouse the antagonism of the agents and brokers not writing group insurance, are generally beneficial to the public as a whole.* This development in itself, means greater amounts of protection being made available with somewhat relaxed underwriting rules, at a lower cost, and more efficiently distributed than can be the case when the insurance is sold on an individual basis.

* Some of the most vehement opposition to the higher life maximums is raised by the insurance agents and brokers themselves, who feel the higher amounts are cutting into their markets, which may well be the case, and that this poses a threat to the agency system.
The second area, and the one which represents the real abuse, is the utilization of group insurance to provide a high amount of insurance on the owner(s) or executives only with practically no insurance, relatively speaking, being provided for the other employees. This is meeting the letter of the tax law, perhaps, but certainly not the spirit of the law. Since this problem has arisen primarily as a result of the tax laws, the most obvious and the best way of eliminating the abuse is to remove the tax loophole which permits the premiums paid on the high amounts to be taken as a tax deduction. As pointed out in the original discussion, it is hoped that if such action is taken, the Congress does not go too far and remove the entire tax advantage on all of the group life insurance. Such action would be extremely detrimental to the entire industry, and the employees who are the real beneficiaries of this coverage when it is written properly.

Other possible solutions to the problem which might be employed are the passage of the recommended life insurance maximums included in the N.A.I.C. Model Bill by the states, or the passage of Federal Legislation in the insurance area similar to the state legislation. The passage of the N.A.I.C. Provision would be a most desirable development, and I suspect would be welcomed with relief by most insurers. However, such action is unlikely in the immediate future, if for no other reason than the general state of inertia among so many state legislatures. The passage of a Federal Bill, at least in the near future, would, of course, be a radical departure from the past, when Congress has consistently left the regulation of the industry in the hands of the states. Ultimately,
there seems to be a trend towards more control in all industries by the Federal Government, and it is quite likely that the insurance industry will not escape this trend permanently. Actually, without even attempting to explore this area, which could be a thesis in itself, it would appear that a Federal insurance law would have many advantages, particularly in eliminating the great hodge-podge of non-uniform and occasionally conflicting legislation now existing among the various states on nearly every phase of insurance. However, the ramifications of such Federal legislation go far beyond the question of group life insurance maximums, and this problem would be only an incidental even if such legislation were proposed.

Major Medical coverage, in spite of the fact that it has been written for nearly ten years, is still in the development stages. It has passed through its infancy, but the insurers are still not in accord as to the best approaches to be utilized, beyond a general agreement that the poorest claims experience is being encountered on comprehensive plans, particularly those involving a waiver of the deductible and/or co-insurance for some covered medical expenses. Of course, the poor claims experience is caused primarily by the inadequate rate structure fostered by the competitive situation. To an increasing extent, the insurers are deciding that, competitive considerations notwithstanding, higher rates for the coverages are necessary, and are adjusting their rates upwards accordingly. In addition, the insurance carriers are gaining enough experience with the coverage to determine which areas have been subject to abuse. They are now taking steps, individually, to impose varying
types of limitations and additional underwriting safeguards in these areas. Care for psychiatric treatment is a good example of this. The supplementary plans are also returning to favor due to their built-in limits for the more common types of disabilities.

Major Medical care has now become an established part of health insurance. It is time there was more concerted effort on the part of industry to educate the public away from the first dollar coverage. Coverages such as the underlying plans of the supplementary approach or the comprehensive plan with waivers of co-insurance and deductible amount to little more than a dollar-swapping proposition for minor disabilities. They barely qualify as a form of insurance. The introduction of "front end" deductibles and co-insurance on all payments is a necessity if the Health coverages are to be placed on a sound insurance basis.

The general inadequacy of hospital and major medical expense rates has been a continuing problem during the past ten years. As indicated before, most insurers are demonstrating greater willingness to charge the more adequate premium, in spite of the competition. However, there are still many of the insurers who are using the inadequate rates to buy business in hope of retaining the business in the future.

Unfortunately, the rate cutters are going to be around as long as the industry is operating without government control. Those insurers doing a sound job will have to live with them as they have in the past. As the competition gets keener, the problem will become worse rather than better. Furthermore, even government rate regulations would not solve the problem unless the regulation also covered the benefits being pro-
vided and the dividends to be paid. Of course, this latter arrangement could not be agreed to by any insurance company and could only lead to a socialized industry. Rate controls, whether state or federal, are not a solution in themselves, as is occasionally envisioned, because rate control would immediately result in more emphasis being placed on the net cost aspects, rather than the gross costs. Also, unless uniform coverage in every respect was mandatory, there would be a tendency for even more "gimmicks" than there are at present as another means of price cutting to supplant the present rate competition.

From the industry's point of view, particular insofar as the conservative companies are concerned, the rate cutting presents quite a dilemma. To meet the competition in terms of rates, means the utilization of inadequate rate structures. Yet, not to meet the rate competition means fewer sales and loss of some cases to the companies with lower rates. Rate setting, by either an industry board, even if it were permitted under some future legislation, or by a governmental board which might be established, merely makes the problem that much more critical. It means that the only real alternatives to a continuation of the existing situation are:

1. Complete control of all phases by the government or even provision of all accident and health care by the government, thus eliminating the private insurance in this area to all practical extent.

2. Recognition by all of the individual insurers of the futility of continually swapping the poorer cases
back and forth, and a genuine refusal to quote on transferred business at other than reasonable rates. In most cases, this would mean rates at least as high as those being requested by the existing carrier. To date, there appears to have been considerable lip service to this concept, but no uniform adherence to the principle.

3. A general recognition by the buyers of the true costs involved in a continual changing of insurers in terms of the additional acquisition costs such as commissions, underwriting, etc. There is an increasing amount of sophistication on the part of the buyers towards their group insurance plans and costs. It is unlikely that the buyers as a class will ever fully realize the implications involved in a change of carriers. Except on the larger cases, the buyer is just not overly inclined to be concerned about the details of the plan being purchased beyond the cost, either gross or net, and the benefits. Certainly, it cannot be expected that the salesman is going to get into an elaborate explanation of costs if it can be avoided since to do so would merely raise doubts in the prospect's mind and result in the loss of the sale.

Therefore, the only time in which a policyholder is likely to receive an education in underwriting and retention practices is at the time he has indicated he is considering a change to another insurer. However, at this point,
the decision to change has usually been half made, and anything said by the existing insurer is received with some reservations by the policyholder. An explanation under such circumstances is working at a handicap, particularly if there are several other companies willing to take over at lower rates than charged by the existing carrier. None of these carriers is going to concede that the buyer might be well advised to stay with their present insurer.

Of the three alternatives, the first is obviously unpalatable to the industry and large segment of the population. However, the direction of government control is unlikely to be influenced by any action or lack of action taken by the insurers. Instead, it will be dictated by economic and political considerations and developments.

The third alternative is unlikely to materialize, leaving only the second alternative, i.e., industry and individual insurer recognition of their responsibilities. As long as there is the prospect of considerable overall growth in the industry, it is likely that the present situation of excessive competition, aggravated by continually rising claim costs, will prevail. This period should last for several more years. The best that can be hoped for is better cooperation between the hospitals and doctors providing the service, and the insurers providing the means of payment to keep overall health care at as low a level as possible during this time.

If and when a saturation point is reached, there will be more
attention paid to the retention of existing business, as opposed to the sale of new business. It is likely that the desired stability within the industry will then be attained.

While stability within the industry is indicated as desirable, this is not synonymous with maintaining the "status quo." On the contrary, competition within the industry to date has undoubtedly resulted in a much wider variety of coverages and benefits, as well as lower rates, than would otherwise have been the case. In the future, there will probably be coverage for medical expenses not presently considered insurable like dental care and preventative medical care such as periodic check-ups. There will probably also be an increasing trend toward coverage of the smaller cases, on which retentions are now very high, as part of large trade associations and union-management welfare trusts, which can procure the same or better coverage at much lower costs.

Each insurer is presently concentrating on obtaining as much of the market as possible now, as a hedge against the time when most of the potential market will be exhausted. Fortunately for the industry, this saturation point to date has proven very elusive. It has been considered often over the years as being just a few years away but has not yet been reached. In this quest for sales, however, each insurer should keep in mind that the industry has a position of responsibility to the buyer which is not present in many industries. It is incumbent upon the insurer not to act as though the product being sold was "patent medicine," but rather to give the buyer an honest appraisal of the insurance service which he is purchasing.
Appendix

A Guide To The Group Insurance Jargon Relating To Costs

In many specialized lines of business, the individuals actively engaged within the industry tend to develop a highly technical vocabulary for use among themselves whereby the meaning of a short phrase such as "switch maternity" conveys the thought which when translated into contractual wording will take a full page of small print to present. Unfortunately, it becomes second nature for the group insurance representatives to use these terms in discussions with parties not fully initiated. This is unfortunate because often the use of such terms leads to misunderstanding of the terms of coverage. The group insurance technician uses such terms in the interest of being specific; but the prospective buyer or policyholder is often unable to distinguish between the general terms and those of a more specific nature.

In order to provide a handy guide to those interested in the cost terms from either an academic or practical usage viewpoint, a description of the most basic terms is given below. The order in which the descriptions are presented is not random, but leads logically to the definition of net cost which is a figure close to the heart of every buyer.

A. Policyholder - The policyholder, sometimes called the policyowner, is that person/persons, or legal entity to which the policy is issued by the insurance company. In most cases, this is the employer, but the policy could
also be issued to the Trustees of a Union-Management Health and Welfare Trust, a creditor organization, a union, an association or the trustees thereof, etc.

B. **Insured** - This term is used to describe both the policyholder itself or the individual employees or creditors who are insured under the group policy issued to the policyholder. It is important to keep in mind that the group policy is a contract between the insurance company and the policyholder. There is no contract between the insurance company and the individuals composing the group. The individual insured is sometimes referred to as a certificate holder.

C. **Manual Rates** - This term is occasionally used interchangeably with Gross rates, see below, but generally it refers to those rates shown in the insurance company's manuals prior to adjustment for industry loadings, size discounts, and possible experience loadings in the case of a case being transferred from one insurance company to another.

D. **Gross Rates** - On coverages other than Life Insurance, nearly every insurer follows the practice of permitting additional discounts to their manual rates as the size of the premium increases. They also add a special loading if the nature of the industry or occasionally the married female indemnity or age composition of the group is such as to make a loaded rate advisable.
E. Gross Cost - The result of multiplying the gross rate quoted, times the volume of insurance, or the number of employees, as appropriate, determines the gross cost for any particular type of coverage.

Example:

<table>
<thead>
<tr>
<th>COVERAGE</th>
<th>MONTHLY GROSS RATE</th>
<th>UNIT OF</th>
<th>MONTHLY GROSS COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIFE</td>
<td>1.00 per $1,000</td>
<td>$100,000</td>
<td>$100.00</td>
</tr>
<tr>
<td>ACCIDENT &amp; SICKNESS</td>
<td>.70 per $10</td>
<td>2,000</td>
<td>140.00</td>
</tr>
<tr>
<td>HOSPITAL</td>
<td>3.50 per Emp.</td>
<td>50</td>
<td>175.00</td>
</tr>
</tbody>
</table>

There is no particular significance to the rates shown except to demonstrate how the rates for the various coverages are usually expressed.

F. Paid Claims - This is the actual dollar amount of the claims paid out to the individuals insured during any specific period of time. It is generally of only indirect significance to the average group policyholder.

G. Incurred Claims - Depending on the size of the case, or coverage premium developed on a case, this is an extremely pertinent figure. On a case which stands completely on its own with respect to dividends or retrospective reductions, it is the primary variable in determination of the refund of premium to be made. Basically, it is determined by the amount of paid claims over various periods during the policy year. These paid claims
are then adjusted by the insurer's formula to provide a reserve sufficient to cover claims which were incurred during the policy year, but not reported, or claims which had their beginning during the policy year, but on which further claims payments are still pending.

This reserve is established as a "washable" reserve in the sense that the reserve developed in one year is carried forward into the succeeding year's dividend calculation as a credit item and, in effect, tends to offset the reserve established in that year. If, as a result of an unusually favorable claims loss ratio in one year, a low reserve is set up and the following year an unfavorable loss ratio results in a relatively large reserve being established; the effect is to increase the loss ratio on an incurred basis, since the prior year's reserve is not enough to completely offset the subsequent year's reserve. Similarly, if the claims pattern in two successive years was identical, the second year's reserve would just be offset by the first year's reserve. Also, a year in which a large reserve is established followed by a year in which a smaller reserve is required could have the effect of reducing the incurred claim figure below the amount of claims actually paid out during the year.

In one sense, the application of the incurred
claim reserve formula makes the bad year's experience look worse than is actually the case, or, on the other hand, it can make a good year's experience look better than it actually is.

As a practical matter, on a large case with relatively stable claims experience, the incurred claim reserve established in one year tends to balance off the reserve for the succeeding year, and the concept of the "washable" reserve is fairly well justified. Moreover, in the event the policy is lapsed, most insurance companies follow the practice of actually charging off claim payments made subsequent to the lapse under the extended liability involved in several types of coverages, such as maternity claims, payments on disabilities commencing prior to the lapse and continuing after the lapse, etc., and returning the balance, if any, to the former policyholder in the form of a terminal dividend after all such claims have been paid. It might be well to mention again the important technicality followed by most companies of paying a terminal dividend only to those cases which cancel on an anniversary. (See Part III, Chapter II, page 113).

Some insurers are now eliminating the "washable" reserve and, instead, are delaying their renewal action until three or four months subsequent to renewal date.
In this way, they are able to determine the actual claims paid during the year. This avoids the controversy which arises occasionally, particularly on a small case, when the reserve established by formula did not represent the true paid claims.

H. Claim Charges - The actual dividend or retrospective rate reduction will vary basically as a function of the claim charge assessed against the case premium, assuming that the retention (discussed below) is a fixed item. On the large case, the claim charge is generally the incurred claims on the particular case. For the smaller case, the claim charge will generally be determined in whole or in part by the effect of the "pooling" arrangement or creditability factors of the insurance company.*

In this respect, it is important to remember the basic formula, the Dividend = Premium - Claim Charges - Retention.

I. Retention - Retention is that portion of the premium which is retained by the insurance company to cover its costs of doing business. This is the cost of the insurance plan beyond the actual claims paid out by the insurer. Since the level of claim payments made under a particular plan of group insurance will be the same re-

* For a more complete discussion, see Part II, Chapter VI, pp. 77-80.
gardless of which insurer is involved, the retentions are the focal point for competition on cases where the claim charge is related only to the actual claims incurred.

The major cost factors composing retentions are as follows:

1. Sales and service charges which include the commissions paid to the agent or broker, the salaries of the group sales personnel, both field and office, the maintenance expense for the field offices, etc.

2. The contingency reserve: This is the basic charge for the insurance in the sense that the contingency reserve is the fund established by the insurer to protect against truly catastrophic losses on any of its policies.

3. Claims administration charges: This is the expense of handling claim payments and involves the salary and maintenance costs applicable to supporting the field claim force and home office claim department.

4. The underwriting cost: This charge includes the cost of evaluating the particular risk, as well as the cost of research on the rate structure, and coverage requirements for the writing of group
insurance. In some companies, this would also include the cost of writing the contract and issuing the individual certificates; whereas some insurers count this as part of the administration expenses.

5. The administration charge: The costs of maintaining records, preparing or checking accounting statements, etc., are lumped together in this charge.

6. Federal and State Income Taxes: This charge in effect passes along the cost of the tax involved directly to the policyholder.

Except for a few very large group cases, which are cost accounted individually to determine the insurer's actual expenses of operation, the insurance companies follow a formulaized approach toward allocating expenses to the various cases.

In a mutual company, all cases within a class as determined by the formula must receive the same treatment. It should be kept in mind that the dividend formula is voted on by the Board of Directors in a mutual company, and is subject to change at any time. Therefore, a mutual company cannot guarantee the future payment of dividends. The elaborate projections of future costs and dividends are strictly estimates showing only the treatment which
would have been accorded a given case under the dividend formula in effect at the time the proposal is made. As a practical matter, the companies try to avoid radical changes in the formula from year to year. However, radical changes do occur occasionally and even relatively minor changes over a period of several years can seriously distort the original estimates.

In general, the dividend formulas for the various insurers, except in the area of "pooling," are quite similar although the actual details of the formula are closely guarded trade secrets. The various cost factors indicated above are merely indicative of the areas covered, and treatment can vary considerably between insurers and between the policyholders of any one insurer. For instance, some companies charge the actual amount of state taxes paid on a particular case directly to that case; whereas, other insurers will develop an average tax rate for all states to be applied against the particular case. This naturally has the effect of lowering the retentions of the first carrier relative to the second carrier in those states in which the taxes are low. Of course, the converse is true in states where the tax is higher than the average assumed by the second insurer. Between the policyholders of the same insurer, we find a wide range in the level of the percentage of retention because some of the charges, such
as taxes, vary directly with the amount of premiums paid. Charges such as commissions decrease percentage-wise relative to the total premium. Administration and underwriting charges vary with the number of lives and the records or accounts to be maintained, but nearly always decrease proportionately as the size of the group increases. It is this variability of the factors which lead to retentions as low as 4 per cent on the large case to 30 per cent or more for the small case.

J. Dividends and Retroactive Rate Adjustments. - In practice, there is little to distinguish the mutual companies from the stock companies in the group insurance field. In either type of company, the premium received, less the claim charges and retentions, is returnable to the policyholder as a dividend by the mutuals, or as a retroactive rate adjustment by the stock companies. Also, Blue Cross-Blue Shield will pay a refund on cases which are experience rated if the level of claims justifies the refund.

K. Net Cost - The net cost of the group plan is a basic consideration in the purchase of group insurance, although by no means should it be the only consideration (see Part II). Restating the basic net cost formula illustrates the relationship of the various factors determining net cost. Net Cost = Premium - Dividends = Claims + Retention.
For the smaller case, the pool charges and creditability reserves hopelessly becloud the net cost issue; but the potential dividend is usually not large enough to warrant much emphasis on net cost anyway. The larger cases must consider the net cost issue. The best approach is to specify a reasonable amount of paid claims and then determine the net cost from the premium less the dividend or refund projected by each insurer. This assures that each insurer is using the same basic factor, paid claims, and permits as objective an analysis as possible.
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