

Old age- Medical Care

FINANCING MEDICAL CARE IN THE LONG PULL

Jerome Pollack
Program Consultant
UAW Social Security Department

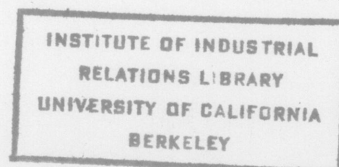
Address before
9th Annual Conference on Aging,
University of Michigan,
Ann Arbor,
July 10, 1956

2 Detroit, 1956

For almost a decade, the problems of aging have come under unprecedented attention in our country. Tangible progress has been made in advancing the economic condition of the aged through improvements in the Social Security Program and in private retirement plans. There have been marked advances in medicine and in rehabilitation for older people. But the crucial need for sound arrangements to assure the availability and insure the cost of adequate modern health services for the aged has been scarcely heeded. Financing medical care in the long pull, ranks first among the unsolved problems facing the aged today.

It is not merely a matter of financing approximately \$102 of care each year for every person 65 and over -- the average present private expenditure for personal health services -- although this in itself is a formidable economic problem. We are attempting to find ways to finance for a segment of the population with severely curtailed income and whose day-to-day general needs are presumed to be diminishing, a necessity of life that does not diminish but rather increases with age. It is, moreover, a necessity that unlike food, clothing and shelter, varies drastically in cost from the minimum spent to maintain health -- often nothing -- to magnitudes in excess of \$100,000. To make it possible for the older people of this country to have modern health services it will be necessary to raise the prevailing standard of care. Although important economies remain to be used, the expenditure for needed health services will inescapably have to be increased.

No single solution thus far advanced -- and certainly none of the more publicized tricks such as reinsurance -- is going to dispell these difficulties with electronic speed. It is clear, however, that progress must be made toward three primary goals: (1) to broaden greatly the base of health insurance for the aged. Older people have not shared equitably in the rapid rise of health insurance in recent years. Among the general population two out of three now have some form of health insurance; among those 65 and over the most optimistic assumption is that one in three is insured. (2) To provide insurance that is suitable for the aged. Thus far, much more attention has been directed toward protecting



SEP 13 1956

the insurers against anticipated losses than to meet the needs of aged people.
(3) To encourage arrangements for better care for the aged, placing far greater emphasis than at present on health maintenance and prevention.

Why is insurance of such importance among these goals?

The insurance principle provides a means whereby health care can be paid for in advance thus making it possible for an accumulation to take place during the productive periods of life to help meet the needs of later years. It permits the costs of health services to be shared and not visited solely on the sick. It provides a system whereby the needed services can be budgeted more orderly by the individual, by the purveyors of health care and by society. It provides benefits as a matter of right to which people feel they are entitled and can freely accept. It reduces dependency on relatives and relieves undue drain on the resources of people who cannot spread the cost and may not be able to provide for it. Insurance is the most effective alternative to increased dependency on public funds for needed care. More than one-eighth of the private medical care received by people 65 years and older is now provided through public assistance. This is socialized medicine and its certain spread if insurance does not expand sufficiently should be of real concern to those opposed to having government engage and pay physicians. And, most encouragingly, from every evidence, people want health insurance and are quite willing to pay for it. The idea of installment buying is well accepted in our country. The people want more health insurance and much more comprehensive coverage than they are now able to buy from insurance companies and from most of the community pre-payment plans.

Let us examine what actually happens when people of advanced years try to buy insurance.

INDIVIDUAL COVERAGE

The individual who sets out to buy health coverage from an insurance company faces extremely severe obstacles if he is old. Most companies do not sell individual health insurance to persons past a prescribed age. According to the Table of Age Limits in Time Saver, a digest of the policies of principal companies writing accident and health insurance in the United States, 96 per cent of the companies ordinarily do not sell hospital insurance to persons past a stated age. Although a few write insurance up to age 70 and some even up to 80, the most common age limits are 59 and 60 years. Moreover, even if an aged person is able to buy insurance, he often cannot maintain it. Two-fifths of the companies have a stated policy of not permitting renewal after age 65 and this includes 10 per cent in which renewal is barred as early as 59 or 60.

Even where there is no stated age barrier to becoming and remaining insured, policies may be cancelled or not renewed when large claims are filed. The extent to which cancellation and non-renewal clauses are abused is a disputed matter. However, where older people have such difficulty in getting insurance they may be classified as unacceptable risks in good faith and according to standard usage and still have been arbitrarily denied a needed coverage in a manner contrary to sound public policy. A Subcommittee of the National Association of Insurance Commissioners has commented: "when members of the public buy sickness insurance, they do so because they expect their health to deteriorate and expect to make use of the sickness insurance. . . . Yet, the very reason for the purchasing of such insurance may then be used by the company as the cause for its cancellation of a policy." The Subcommittee recommended that the right of an insurer to cancel accident and health insurance be entirely eliminated and that the right to deny renewal be restricted.

Individual health insurance is extremely important to the aged, many of whom cannot qualify for coverage in any other way. It is a profitable business. Benefits paid to the insured under individual accident and health insurance generally average somewhat less than one-half of the premiums; the rest goes for overhead, profit or surplus. The average ratio of benefits to premiums, the "loss ratio," was 48.6 per cent last year. There are companies who reveal in their annual reports to the state insurance commissioners that their loss ratios on their entire individual accident and health business or on their individual hospital-medical insurance are less than one-third, one-fourth and sometimes even less than one-fifth of premiums. In many more companies reports on specific policies chronically show negligible returns to the policyholders. Some state insurance commissioners have been campaigning to require at least the prevailing loss ratios, although much greater reforms are obviously needed.

The time has come to pose the question: why should the aged be denied individual health insurance as poor risks? In automobile liability insurance a way has been found to make coverage available to all eligible drivers even though they may be bad underwriting risks. This has been accomplished through assigned risk plans under which applicants rejected for insurance through normal channels are able to obtain it from a separate agency. The insurance industry itself originated these arrangements later made mandatory by statute in order to make it possible for bad or questionable drivers to buy insurance. Why have the insurance companies or the legislatures not made similar provisions to extend health insurance for older people?

The constitutionality of the assigned risk plan in California was challenged in an appeal to the U.S. Supreme Court. The Court's review of the issues would apply with even greater force if health insurance rather than the hardship

to drivers who might lose their licenses had been involved. The appellant claimed that the plan was unconstitutional because it commands insurers to enter into contracts and to incur liabilities against their will; because it forces on insurers contracts that have abnormal risks from which financial loss may be expected; and because it requires the appellant to alter its type of business from a cooperative with select membership to a venture insuring members of the general public.

The Supreme Court observed that the statute provides for an equitable apportionment of the assigned risk to all insurers. It stated: "The case in its broadest reach is one in which the state requires in the public interest each member of a business to assume a pro rata share of a burden which modern conditions have made incident to the business."

Similar reasoning applies to an assigned risk plan for health insurance. Enrollment should be opened to individuals without age barriers. They should be offered policies which do not permit cancellation or failure to renew. Standards should be developed which require insurers to continue accepting assigned risks so long as the insurance at advanced ages does not exceed the proportion of the population at those ages in the states where the carrier is licensed to do business. Safeguards should be developed to see that the benefits are not unduly diluted and that the rates are not excessive. Considering the inadequate return of benefits on this type of business there is room for a tremendous expansion of insurance among the aged with no increase in premiums. Nor would it be inappropriate to consider reducing the high underwriting costs in order to provide suitable coverage for people of advanced years.

GROUP COVERAGE

Let us next consider how the commercial insurance companies deal with older people in quest of group health insurance.

Group insurance is characteristically more liberal and more economical than individual. Usually there are no age barriers to enrollment, nor is the insurance cancelled or subject to non-renewal. However, coverage usually depends on an employment relationship. To be insured the person must be an employee or a member of a rather restricted class of an employee's immediate dependents -- wife, husband or child. No provision is made for aged parents or others who may in fact be dependent on the employee. And coverage generally terminates on retirement.

Efforts to get insurance companies to continue protection after retirement have succeeded primarily with large groups and under favorable circumstances. The following is a fair statement of the issues quoted from the rate

manual of one of the most prominent insurance companies:

"In general, hospital, surgical, medical, diagnostic and other special features may not be continued for retired or pensioned employees or their dependents." The Company goes on to discourage the employer from covering the retired people. "The claim rate for this class of employees is several times higher than that for active employees and their dependents and the continuation of coverage for this class of employees may have an adverse effect upon the experience under the policy.

"Under certain circumstances and subject to certain conditions, where the employer, after being fully acquainted with the probable cost, feels that for employee relations it is necessary, coverage may be continued. . . . subject to prior home office approval." Approval, however, is considered only if the case numbers at least 1,000 active employees in size and is subject to other qualifying conditions. Even so the coverage is limited to hospital and surgical and there are benefit limitations. And the premium rate is three times that for the corresponding active employees or dependents.

Many insurance companies have built their sales campaigns around the idea of experience rating. They have stressed to the employers that substantial dividends can be paid to the extent that experience proves to be favorable. But favorable experience is often achieved by excluding the retired members of the group. Thus employers have been discouraged from covering the retired workers; in large numbers of small enterprises coverage of the retired is unobtainable from the commercial insurance companies.

The final irony is that actually the companies have had little experience in insuring health benefits at higher ages. The triple premiums which they have arbitrarily charged are grossly excessive. D. W. Pettingill, Associate Actuary for Aetna Life Insurance Company has admitted:

"Even after six years of experimentation we have only a hundred cases in force which provide pensioner coverage and over half of these are less than two years old. Up until recently, we discouraged our policyholders from continuing hospitalization coverage for pensioners for the reason that the cost was presumably large and still pretty much unknown."

The community prepayment plans of the Blue Cross type have shown far greater hospitality to people of advanced age, especially in groups. Many such plans have agreed to continue retired workers and their eligible dependents in groups with the same benefits as before retirement and at the same premiums. This has meant that the burden of extra cost has been borne by the subscribers to the plan as a whole.

These plans have been gathering actual experience rather than assuming prohibitive cost. One of the leading Blue Cross Plans, on recently examining its experience concluded:

" There is no evidence [] that [] experience is, or will be, as severe as many authorities have predicted, i. e. , 200 to 300 per cent. This study would indicate experience to be generally in the vicinity of 150 to 175 per cent. "

Yesterday, Mr. William S. McNary, Executive Vice President of the Michigan Blue Cross Plan reported to this Conference: "So far, our expense for the hospital care of retiree groups has been about 161% of our expense for their parent groups. "

The ultimate costs may be higher. But here we enter the field of speculation. Even if the cost would double in the long run there is nothing in sight to support the triple premium rule under group insurance.

It is by no means an extreme or unusual situation in group coverage to have some segments of the group whose claim cost is twice that of the rest of the group. Women in the child-bearing ages often require double premiums, but I don't recall many serious efforts to exclude them from coverage.

Although some progress has been made in covering retired persons under group insurance and especially under the community plans much more remains to be done. Those now covered are by and large the people most easily reached by insurance. To cover the remainder will require bold, major steps. These should include reforms in the individual and group coverages. However, the most important step that will assure broad coverage is to cover at least hospitalization under the national social security program.

OASI COVERAGE

Support for OASI action comes from a variety of important sources. A few years ago, the Commission on Financing of Hospital Care after studying the problem for two years and spending more than a half million dollars on research came to the conclusion that hospitalization benefits should be provided under OASI but only for needy beneficiaries. This was a compromise in which sight was apparently lost of the inappropriateness of applying a means test in a social insurance program. However, a tremendous step was taken by this conservative body in recommending OASI action. It requires only one additional step to realize that a social insurance program must operate on the basis of presumptive need. And in this instance, presumptive need conforms closely to verified need.

The Rhode Island Governor's Commission to Study Problems of the Aged recommended in 1953 that the State's General Assembly memorialize Congress

for an amendment to the Social Security Law which would provide automatic hospital insurance for persons receiving OASI benefits.

From an unexpected, but exceedingly significant source, the Commission on Geriatrics of the Medical Society of Pennsylvania, comes support for a program to be administered by OASI for an additional Social Security deduction to be used to finance health benefits in the later years.

All of these recommendations have in common a recognition of the necessity of turning to the national social security program to get a broad enough base for action. The OASI is the primary source of economic security in old age for a large segment of the population. It is probably the best vehicle for accumulating funds over the working lifetime with reasonable assurance of continuity of coverage. The individual employer unit is not satisfactory for this purpose. Likewise, plans tied to a particular community or even a state may prove too limited geographically. OASI coverage would mean joint financing by the employer and the individual: at present many retired people who are permitted to retain group coverage have to pay the entire cost of coverage, except for such implicit savings as result from group membership. For these and other reasons, OASI coverage of hospitalization benefits would mean the most important advance in extension of coverage.

SUITABLE COVERAGE AND CARE

So far we have been considering only the problems of securing coverage for older people. We now have to examine how adequate the existing coverages are in meeting the needs of those who are insured.

Typical health insurance plans deal primarily with hospitalized illness and surgical care. These are not necessarily the most important risks to insure; they are the most easily verified medical contingencies. Preventive care is not covered and diagnostic services are usually avoided.

Many of the available benefits do not attempt to pay the entire cost of the service. This leaves the patient to pay the rest of the bill which unfortunately has no convenient ceiling like that assumed for itself by the insurer.

There are many complaints that cash indemnity benefits in the health field give the insured less protection than out-of-pocket payments. In a field where pricing of services is traditionally set according to ability to pay, the status of insurance benefits is indeed ambiguous. Who would buy life or fire insurance if the cost of living or to rebuild a house was increased because there was insurance?

The weakness of ^{limited}~~minuted~~ cash benefits are far more serious when applied to retired than to active workers. The active group has more resources

for making up the deficiencies, while the retired may be unable to supplement the insurance. Therefore, higher standards of service should be applied to the retired group.

Instead there is a general lowering of standards. Some of the common ways of reducing benefits for the retired or for persons 65 and over include:

(1) A lifetime limit is imposed on hospital, surgical and even under the much publicized major medical insurance that is supposed to protect against catastrophic contingencies, which places a dollar maximum on all claims.

(2) A dollar limit on claims honored in a year.

(3) Coinsurance provisions requiring the insured to pay a specified share of each item of cost. In some cases the coinsurance percentage is increased for the retired, rather than decreased.

(4) Deductible provisions requiring the insured to pay the first part of bills incurred.

The primary emphasis of insurers has been to cut protection, not to seek out the positive ways in which protection for the aged can be tailored to meet their needs more effectively. There are ways of maximizing the use of nursing and custodial care under proper medical supervision which suggest that even the residents of a home for the aged could be an insurable risk. Where genuine efforts have been made to insure older people on a sound basis the results have generally proved far more successful than would be expected. Dr. George Baehr and Neva R. Dierdorff have published an article entitled, "Experience of a Group Insurance Plan with Older Enrollees" (Journal of Gerontology, Vol. 7, No. 2, April 1952) whose conclusions based on experience with the Health Insurance Plan of Greater New York enunciate a sound principle and approach:

"Enrolled in the proportions in which they occur in the general population, older people do not present problems of any magnitude or seriousness to a properly conducted plan of prepaid comprehensive medical care. Those supported by public agencies constitute a peculiar medical care problem, and their inclusion would require a modification of this statement. . . . A plan of prepaid medical care which covers a true cross-section of the general population, outside of custodial institutions cannot evade responsibility for the prolonged terminal care of such older persons. . . . From the experience reported. . . . there is no reason to believe that under group enrollment, the inclusion of the aged in a prepaid comprehensive medical care plan should materially affect the premium rates necessary for good medical care of families at other stages in their life cycles. . . . "

Insurance is often thought of as independent of medical practice when actually it has an inescapable bearing on medical care. That is why a plan of insurance directed primarily at the needs of the younger ages will not be entirely suitable in later life. And a plan that is not even suitable for the younger ages may prove to be absurdly inadequate. The profile of ailments changes. Although the incidence of certain diseases increases with ages, others, that may be an important preoccupation in earlier life, virtually disappear. Thus there remains the major project of designing sound insurance and medical care plans for old age, not primarily in an attempt to cut cost but to meet the changing needs. The elements of a proper constellation of services would include greater emphasis on the promotion of health and prevention of disability; comprehensive medical services and adequate modern rehabilitation care; and, in the zone of life that we have under consideration optimum use of home care, nursing and convalescent care.

In the meantime, medical needs are often not being met and vital resources of our society are being wasted. A recent survey in California reveals the tremendous volume of chronic disease among the needy aged that is getting little or no attention. Many were found to be handicapped by the need for eye glasses, hearing aids and dental care - things "pooh-poohed as frills." Others were sent to mental hospitals as "seniles," when what they actually needed was medical care. "Most of the disability suffered by old people lying around the hospitals," this survey found, "is due to neglect." The present status of geriatrics, compared with pediatrics recalls Shakespeare's sigh, "welcome ever smiles, and farewell goes out sighing."