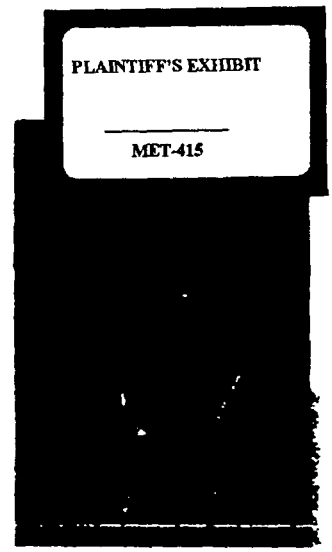

Aspects of Overinsurance

Against Hospital, Surgical and Medical Expenses

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HEARING an insurance man complain about overinsurance is somewhat akin to news of the *Man Bites Dog* variety, but one can have too much of even such a valuable commodity as medical care insurance. Too much, that is, for the good of the individual, the community in which he lives and works, his employer who pays part or all of the cost of his insurance program—and even the insurance carrier. Let's review some of the reasons why this is so.

What Is Overinsurance?

Perhaps we had first better define what we mean by overinsurance. As far as Medical Expense insurance is concerned, this seems to be confined almost entirely to situations involving duplicate coverage; that is, to persons who are covered under two or more insurance plans and may thereby profit financially as a result of increasing expenses for medical treatment. Surely, we can agree that sound insurance principles won't permit anyone to profit from his own illness—that would be like making it possible for someone to reap a financial gain when a fire destroys his home or when he smashes up his automobile. To do so would only invite extra and more costly claims. The same result would certainly follow if your disabled employees could, through overinsurance, be better off financially than when actually on the job.

Now, how does overinsurance invite more and costlier medical expense claims? Let us take, for example, the patient who insists on going to the hospital for a minor medical problem that could very well be treated at home or in the doctor's office. Consider also the patient who may have required hospitalization but who is in no hurry to leave the hospital after recovery. He may actually be making a profit of $20 to $30 a day, or even more, for as long as he stays. Then, too, there is the person who makes frequent, but medically unnecessary, trips to the doctor's office and who perhaps demands the use of unnecessary, but expensive, diagnostic work-ups.

These practices obviously increase insurance costs and if continued may eventually hurt both employers and insured employees who must pay more for medical expense protection. Let me assure you that they also hurt the insurance company who must account to its Group policyholders if a premium increase becomes necessary. This is one phase of the overinsurance problem. But there are other aspects which seem to be equally important.

A Community Problem

If overinsurance should exist on a large scale within a community, and we know of some instances where this has happened, there may be other far-reaching effects. As a community problem it can be dealt with most effectively by a proper design of Employee Benefit Plans. If overinsurance resulting from duplicate coverage is to be eliminated, it seems to require the combined efforts of all interested parties.

Many communities have devoted a great deal of attention to hospital planning and the more efficient use of medical services and medical facilities. Certainly we know that hospitals are overcrowded in many parts of the country and physicians are very often overworked. Overinsurance merely places an additional strain on these already overburdened medical facilities. When this occurs it can mean that a really sick person may have difficulty in obtaining a hospital bed or securing prompt medical care. Conceivably it can also influence a decision

to expand existing hospital facilities unnecessarily which could result in an extremely heavy expense to the entire community.

While there are no exact figures concerning the full extent of overinsurance, there have been a few studies in this area, two of which we would like to mention. The Health Insurance Council once estimated that 12.9% of insured people had multiple coverage and a small sample study made by the Council revealed that approximately one out of every ten insured hospital patients had multiple hospital expense coverage which paid aggregate benefits of $1.11 for every $1.00 of hospital expense incurred. A more recent study of some 5,000 hospital cases in California showed that nearly 7% of the patients made a profit and that the average profit was a little over $200.

Another good question that might now be asked is how this situation came into being.

Growth of Group Insurance

In the early years of Group insurance, policies were generally limited to what is termed Basic coverages such as Hospital Expense and Surgical Operation insurance and usually the level of benefits was quite low. In some cases there was an actual need for two policies in order to provide reasonable protection for the individual's over-all medical expenses. Over the years, however, Employee Benefit Plans have been constantly improved as you well know. They now cover more types of medical services and the benefit payments are much higher than they used to be. At the same time, the number of families with two or more employed members has increased and there has also been an increase in the number of persons holding two jobs. As a result of post-war industrial relations trends, Medical Expense Plans of one type or another now cover the great majority of our working population.

As benefits were raised and as the opportunities for duplicate coverage increased, more concern was expressed about overinsurance. However, it was not until the advent of the Major Medical type of policy that overinsurance really developed into a serious problem. Although there are many variations among Major Medical policies, they all provide a very broad range of benefits, as you know, and maximum payments can be as high as $20,000 per year and $40,000 for the covered person's lifetime. Because of the liberal benefits provided by these Plans and in order to keep their cost at a reasonable level, almost all Major Medical policies include a non-duplication of benefit provision.

Much further educational work had to be done the insurance industry and by employers to explain the necessity for non-duplication to employee unions, physicians and hospitals. At the same time it must be recognized that some of the confusion concerning non-duplication arose because there was no standard provision within the insurance industry. Many companies were experimenting in this field and, therefore, there were many different and sometimes conflicting provisions in use and also conflicting concepts as to how the provisions should operate in actual practice.

Study of Non-duplication

It was evident that the entire subject of overinsurance and duplicate coverage required thorough review by the Industry. A study was completed in 1962 by a Committee operating under the direction of the Insurance Industry Associations. In its report, the Committee noted that the many varieties of non-duplication provisions in use were actually hindering the Industry in its primary objective of safeguarding Medical Expense insurance from the dangers of overinsurance. Also and this is important, *the Committee advanced the opinion that employee dissatisfaction with existing provisions might cause some employers to give them up.*

One cause of employee dissatisfaction arose from the fact that although a person might be insured under two policies at least one of which had a non-duplication provision, he was usually left with some out-of-pocket expenses. A second complaint was the delay that frequently occurred in the settlement of claims, especially those where both plans involved had non-duplication clauses.

The study of non-duplication by the Industry Committee resulted in the formulation of the so-called "Model Group Coordination of Benefit Provision" which has received wide acceptance within the Insurance Industry. The "Model" provision is based on two guiding principles. First, that employees and employers will accept such a provision provided it permits recovery of all medical expenses insured against. Secondly, that in order to be effective, claim settlement has to be simple, prompt and easily understandable to employers and claimants.

It is also important to note that the "Model" provision was drafted in a form which makes it adaptable to Basic Hospital and Surgical plans as well as Major Medical. This is of particular significance because, up to the present time, non-duplica

tion in a basic type of Medical Expense policy has been practically non-existent.

Outline of the Model Industry Provision

Let's briefly outline how the "Model" Industry provision works.

1. When duplicate coverage exists the claimant should be permitted to receive reimbursement (up to normal contract limits) for all reasonable, and customary charges for necessary medical expenses that are covered at least in part under either plan. These are referred to as *Allowable Medical Expenses.*
2. When two plans with the "Model" clause are liable on the same claim, the one which is required to determine its benefits first will always pay full regular benefits, as if no duplication existed. The other will pay the *lesser* of:
   (a) the remaining Allowable Medical Expenses, and
   (b) its full regular benefits.
3. The order in which the two plans are required to determine their benefits is as follows:
   (a) The plan covering the patient as an employee pays before the plan covering the patient as a dependent.
   (b) The plan covering the patient as a dependent of a male person pays before the plan covering the patient as a dependent of a female person.
   (c) Where the order of payment cannot be determined by these rules, the first plan to make payment will be the one that has covered the patient for the longer period of time.
4. When one of the two plans has no non-duplication clause, it will pay its regular benefits and the other plan, under the "Model" clause, will pay the *lesser* of:
   (a) the remaining Allowable Medical Expenses, and
   (b) its full regular benefits.
5. On successive claims the benefits of the second plan and the patient's Allowable Medical Expenses will be calculated cumulatively over a specified period of time, usually a calendar year. Any benefit reduction due to duplicate coverage will be set aside as a credit for the balance of the calendar year. It may be used if the patient has additional Allowable Medical Expenses in that period.

Occasionally, one of our policyholders has expressed the opinion that it is not fair that his own Basic type plan, which does not have non-duplication, should bear the brunt of certain medical expenses while another employer with Major Medical gets off more lightly because he excludes duplicate coverage. In the past we could only point to the industry custom of confining non-duplication to Major Medical. In the future, however, if, as we expect, non-duplication will be used extensively in Basic type plans, then some of these *seeming* inequities may cease to exist. I say *seeming* inequities at this point because we honestly do not believe that there is any real injustice in this situation.

Even in its present form we can't say that non-duplication in a Major Medical plan has increased in any way the benefits paid by other plans which provide only Basic benefits such as Hospital Expense or Surgical Operation insurance. The benefit costs to these Basic plans are, of course, exactly the same regardless of the fact that the claimant may be insured by another employer for Major Medical. As a matter of fact, non-duplication in the Major Medical plan cannot help but benefit the Basic plan to some extent since it always tends to eliminate any possibility for profit on the part of the claimant and removes the incentive to increase medical expenses in order to enlarge profits from insurance. This makes it difficult to understand why any employer would ever hesitate to authorize his carrier to report data on a claim paid to another carrier seeking to apply its non-duplication clause. It is really in his own self-interest to cooperate to this extent.

I would be much more concerned when a claimant is insured under two plans neither of which has non-duplication. Here we would definitely have a situation in which both plans could be hurt by unreasonable or unnecessary medical expenses. It would appear to us that once again what is needed here is more non-duplication in Group contracts and not less.

What is more, the contention that a Major Medical plan does not bear a just share of claim costs in a community because of its non-duplication clause overlooks completely two important facts: (1) The Major Medical Plan has the sole liability for numerous claims involving types of expenses which do not qualify for any benefits whatsoever under Basic plans inforce in the area; and (2) Under the "Model" provision, credits arising under non-duplication can now be set aside and actually used in some cases where the patient incurs ad-