INDIVIDUAL ACCIDENT AND SICKNESS

A. If a life insurance company enters the accident and sickness field is it advisable for it to issue noncancelable, commercial or combination policies?
B. Should commissions on accident and sickness policies be on a level basis each year or should they decrease with duration?
C. What are the best sources for morbidity experience in a form suitable for rate making?
D. What reserves, if any, should be set up in addition to the unearned premium reserves to cover cyclical changes in the level of morbidity rates resulting from epidemics or economic upheavals?
E. What methods have been found satisfactory for determining the total claim reserve and the division of it for annual statement purposes?
F. What items of medical expense are insurable and to what extent?

MR. IRVING ROSENTHAL, commenting on sections A and B, stated that the Guardian Life had recently entered the individual accident and sickness field and had decided to issue all three types of policies. He felt that the most important decision related to the matter of issuing noncancelable insurance due to the stronger guarantees involved.

His company decided to enter the noncancelable field on the strength of three basic considerations. The first was the territory of company operation. Most of the company's business originates in the northeastern quarter of the United States and it is in the cities of this area where most noncancelable business is written. The second consideration was level versus graded commissions. His company had already decided to use a graded commission scale for commercial policies. Considering the fact that 50 percent of the company's life business came from brokers who were generally used to getting level commissions on commercial accident and sickness business, his company felt that very little business would be written unless a noncancelable line of policies were offered. Actually, as things turned out, the graded scale for commercial policies got a much better reception than was anticipated. Brokers write approximately 50 percent of all new accident and sickness business of the company. The split of this business by premiums is roughly 60 percent noncancelable, 40 percent commercial. This percentage split is reversed for business written by full-time agents of the company. The third consideration, which he felt was the most important, was the estimate of the field force with regard to the quality of underwriting. With the volume of brokerage business anticipated it was necessary for the company to satisfy itself concerning

the control of its managers over brokerage business. In this connection, the company relied largely on its field and home office underwriting experience relative to income disability benefits on life insurance policies which the company continued to issue all through the depression years. Were it not for the training received in the underwriting of these benefits the company might well have decided to stay out of the noncancelable accident and sickness field.

Mr. Rosenthal mentioned that his company considered an exclusively noncancelable operation, on the theory that it would be difficult to operate two different classes of business side by side. In the case of his company it has not been true, probably because of the field force. Over-all, by premium volume, 50 percent of the business being received is on noncancelable forms, although by number of applications the commercial business outnumbers the noncancelable roughly in the proportion of 3 to 1. The average annual premium on their commercial forms is $70 as against $200 for noncancelable forms.

MR. E. D. ARMANTROUT said that the type of policies issued by a company will probably be decided by a number of factors peculiar to the individual company, such as the company's objective, agency force, types of client and general merchandising plan. A company whose agency force sells largely to business and professional men will probably lean toward noncancelable insurance. The guaranteed renewability feature fits in well with life insurance and program selling.

Commercial policies are more satisfactory on certain types of risk and there are some coverages which cannot be handled safely on a guaranteed renewable basis. Also, a company may want to supplement its noncancelable coverages to reach a substantially broader market.

The decision as to what types of policies are to be issued is closely tied up with the decision which leads the company to enter the individual accident and sickness field. Mr. Armantrout felt that several key questions relative to a company's internal and field organizations must be answered before a philosophy of operation is finally formed as the basis for the structure of the entire new program.

MR. R. R. ANDERSON felt that any company intending to concentrate on hospital and medical expense coverages should not issue policies where both renewal of coverage and premium rates were guaranteed. For loss-of-time coverages with sickness benefit periods of one or two years and with relatively short waiting periods, the New York Life decided on the commercial type of policy. It was thought that larger indemnities could be offered to a broader market at lower cost. The company's right to refuse renewal or offer renewal on a modified basis

permits coverage on certain borderline physical risks and applicants whose incomes fluctuate to some degree.

He pointed out the problem in commercial A & S of finding the proper balance between too strict and too liberal initial underwriting. A measure of the company's initial underwriting can be obtained by examining the company's action on renewal. With respect to the policies which came up for renewal from February 1952 to April 1953, the New York Life took renewal underwriting action, either by imposing a physical impairment rider or by refusing renewal, on approximately 1 in every 300 policies. Refusals or modifications were due to the following reasons: (1) physical impairment (mostly pre-existing conditions previously undisclosed)—71%, (2) change to an uninsurable occupation—14%, (3) habits—9%, (4) other—6%. All these policies were in their first or second policy years, his company having entered the field in June 1951. He felt that as the field force gets more experience, the rate of renewal refusal because of pre-existing conditions will decrease.

He referred to the difficulty of refusing renewal on cases where there was physical deterioration due to a condition which arose clearly after the policy had been issued. His company is introducing a major medical expense policy where the company reserves the right to change rates and refuse renewal, except that the company will not base their refusal solely on a change in the physical condition of a covered member. Naturally, the policy will provide for a maximum benefit payable for illnesses arising from the same or related conditions. He suggested that a similar provision might be feasible in a loss-of-time contract if an aggregate benefit or a six months recurrent disability clause could be used.

He questioned whether a life insurance company could safely assume that severe losses would not again be incurred in the noncancelable and income disability fields. Granted that we understand the factors which led to the losses of the 1930's (uneducated underwriting, lifetime sickness benefits, and inadequate premiums), the prosperous years of the past decade have not provided any real test of the measures taken to offset those factors. Moreover, new factors may be present during the next recession—such as the pyramiding of income benefits which has resulted from the tremendous growth of group insurance, franchise insurance, etc.

Mr. Anderson stated that the question of level versus unlevel commissions is almost academic today. The unlevel scale clearly better reflects the actual services performed by the agents as most companies are administering the business today and all of the life companies recently entering the field have adopted this type of scale. He mentioned that the unlevel commission scale has become more practical with the trend of

companies and policyholders to regard individual A & S as a more permanent part of the policyholder's program of insurance rather than as short-term insurance. Evidences of this trend are the adoption of more liberal renewal underwriting and claim standards for policyholders of longer durations, the adoption of level premiums increasing by age at issue, and the writing of participating contracts.

The grading of the commission scale should depend on the coverage. Coverages with high claim frequencies and modest average payments generally require less initial selling and more conservation effort. A flatter scale is therefore suggested for this type. For instance, commissions on the New York Life's hospital expense policy are 20 percent for the first two years and 10 percent thereafter. On the major medical expense policy, which involves smaller claim frequencies for higher average claims, the scale is 40 percent for the first year, 20 percent for the second year, 10 percent for the third through the tenth years, none thereafter.

MR. A. M. THALER referred to the apparently prevalent feeling that the market for noncancelable insurance is rather restricted. He said that in the Prudential they feel that they are reaching the market generally reached through the commercial line of policies. They are writing the noncancelable line on practically all occupational classes. They consider that their noncancelable business is reasonably competitive with commercial business as regards amounts, plans and premiums (after dividends). Very little difference exists between their underwriting practices for noncancelable business and those for commercial business.

The Prudential is selling noncancelable business in some areas on a monthly debit basis, thereby reaching the industrial market. Eighty percent of such business is being written on other than "white collar" workers.

Referring to section C, Mr. Thaler said that a company which has been in the accident and sickness business for some time will undoubtedly rely on its own experience for its rates. A company newly entering the business should consider what kind and sources of data are desirable for rate making purposes before any available materials are used.

The traditional casualty company "loss ratio" approach is not suitable for sickness insurance where differences in risks by age and waiting periods present a much more complex problem. Intercompany comparisons of rates are of limited value due to differences in benefits and company practices. Ideally, claim costs on a select basis by age at issue for each basic benefit would be desirable. Very little information is available in this form and the actuary will find it necessary to go to many disconnected sources in order to form a basic rate structure.

Mr. Thaler listed the following references, pointing out that none of the material is likely to be directly applicable to a particular situation.

1. "The Basis and Technique of Personal Accident and Sickness Insurance," by Horace R. Bassford, *TICA* XII, 1940, Vol. II.
2. Conference Modification of Class III Disability Table for Calculation of Reserves on Non-Cancellable Accident and Health Insurance—Prepared by Non-Cancellable Reserves Committee, Health and Accident Underwriters Conference.
3. Public Health Reports, Federal Security Agency, U.S. Public Health Service —particularly certain reports dealing with the duration of disabling sickness and with the incidence of poliomyelitis.
4. Reports of the National Foundation for Infantile Paralysis.
5. Annual Reports by the Society of Actuaries Committee on Group Mortality and Morbidity of the morbidity experience of group accident and sickness insurance and group employee and dependent hospital and surgical expense insurance.
6. "Special Investigation of Group Hospital Expense Insurance Experience," by Stanley W. Gingery, *TSA* IV.
7. "Hospital Service Insurance," by Arthur Hunter and Allen B. Thompson, *TASA* XLIV.
8. "Blue Cross Hospital Service as a Source of Morbidity Statistics," by Allen B. Thompson, presented at Biometrics Section, American Statistical Association, December 27, 1950.
9. Annual Reports of the Saskatchewan Hospital Service Plan, Department of Public Health, Province of Saskatchewan.

MR. R. P. WALKER felt that the answer to question B lies in commissions reducing with duration. He pointed out the trend among companies from a level basis to a nonlevel basis. He offered the following reasons for adopting a nonlevel commission scale: (1) there is a larger return to policyholders per premium dollar, putting the company in a better competitive position; (2) the financing of agents is easier; (3) the agent is compensated more directly in proportion to the work performed unless the agent is burdened with service functions which could be handled more efficiently in other ways; (4) lapse rates on nonlevel commission business are no worse than on level commission business.

Mr. Walker indicated that perhaps the most practical way for a company to switch from a level to a nonlevel basis is to introduce attractive policy forms and coverages on the nonlevel commission basis. The emphasis on the new forms will probably detract from the existing forms so that in time it will be possible to withdraw the old line of policies entirely without major objections from the field force.

MR. C. N. WALKER, in discussing section C, stated that, other than

a company's own experience, very little material was available for rate making purposes. He pointed out that the actuary is concerned primarily with two aspects of rate making, namely, the level of rates and the pattern of rates. The former will depend generally on such things as company practices and the economic cycle, whereas the latter depends largely on factors such as age, sex, occupation, etc. He felt that a published morbidity table would be very helpful in establishing the "pattern" and for making adjustments for modifications in benefits. Modifications of the table might make it suitable for determining level of rates just as modifications of the Class 3 disability table are suitable for calculating noncancelable insurance gross premiums.

With regard to hospital and related benefits he felt that the group hospitalization data published by the Society form valuable points of departure for the various benefits. Adjustments would naturally have to be made for the characteristics of individual selection.

Mr. Walker pointed out that an increasingly greater proportion of the commercial accident and sickness market is being serviced by life insurance companies which will undoubtedly pattern their operations as closely as possible after their life operations. Such companies will probably want better indications of the morbidity experience under such policies than are now available. He felt that an intercompany experience, particularly on commercial loss-of-time coverages, would be of real value.

MR. R. C. BARNSLEY stated that the objective of the insurance industry should be a contract which leaves no doubt as to the amount and type of coverage and which may not be terminated at the option of the insurer. It would appear that this objective can best be reached by issuing the noncancelable type of policy. He considers a provision giving the company the right of nonrenewal as being somewhat inappropriate for contracts issued by life insurance companies. However, companies should be expected to see that statutory prescribed policy provisions do not preclude the issue of types of contracts best suited to meet particular needs.

Mr. Barnsley thinks that nonlevel commissions are more in keeping with the remuneration on life policies. Existence of two types of remuneration may be a source of irritation and internal problems.

In discussing section D, he recommended building up a special fund for adverse experience in an amount equal to 50 percent of a year's premiums, borrowing from life insurance funds if necessary and permissible.

Commenting on section F, he stated that experience indicates that in the case of accidental bodily injuries, it is possible to insure all necessary medical attendance, surgical, hospital and nurse expenses, subject to the

expense being incurred within a prescribed period. In the case of sickness, it would seem possible to insure all necessary medical attendance, surgical, hospital and nurse expenses, if coupled with reasonable self-insurance and other presently common limiting factors.

MR. M. I. DOXSEE stated that the Aetna Life had been writing commercial accident and sickness business for well over fifty years with reasonable success, except during the depression years. Their experience with noncancelable insurance was not so fortunate and even in this day of reduced benefits, enlightened underwriting and higher premium rates he would not recommend re-entering the field.

He felt that the matter of commission scales would probably depend on the background of the agency force. In his opinion a decreasing scale would in the long run be desirable from the standpoint of reducing the over-all expense rate.

He suggested the intercompany policy year experience tabulated by the Bureau of Accident and Health Underwriters as being the best source for rates on commercial policies. Adjustments would have to be made for the characteristics of individual company practices as well as the lag in the tabulation of the experience.

With reference to section D, it was suggested that reserves for excess losses due to epidemics are becoming less important due to the progress of medical science. Reserves for experience fluctuations due to economic conditions are advisable, and preferably should be a part of the general contingency reserve, since specifically earmarked reserves have a habit of not being reduced.

Commenting on section E, he described the Aetna's practice in setting up claim reserves. Based on the company's experience, $145 per commercial accident claim and $400 per commercial sickness claim is set up. For death and dismemberment claims the reserve is the amount payable. After three months on life income claims, a tabular reserve based on Cammack's Table of Claim Reserves (*PCAS*, 1921) is used. This table is still quite satisfactory for this purpose.

For incurred and unreported claim reserves as of December 31 a percentage of earned premiums for the preceding twelve months is set up. This percentage has increased gradually in the last twenty years so that it is now $3\frac{1}{2}$ percent for commercial accident and $4\frac{1}{2}$ percent for commercial sickness. The corresponding reserve for deaths and dismemberments is the total of such claims reported during the first ten days of January. The split between accrued and unaccrued benefits is made on a more or less arbitrary basis.

For life indemnity claims on noncancelable business a select modification of the Class 3 disabled life table is used, starting out with a reserve of $120 per $10 monthly benefit increasing to ultimate Class 3 reserves at the end of two years duration.

MR. E. W. MARSHALL restricted his discussion of sections C and D to noncancelable accident and sickness insurance and treated long term benefit contracts (more than two and less than ten years' benefits) and short term benefit contracts (benefits for two years or less) separately.

In estimating morbidity on long term benefit contracts there are two available landmarks, namely, life insurance disability income experience

TABLE 1

90 DAY LIFE INSURANCE DISABILITY
LIFE INCOME CLAUSE
ESTIMATED RATIO OF ACTUAL CLAIM COSTS TO
EXPECTED BY CLASS 3

ATTAINED AGE	PERIOD OF OBSERVATION		
	1930–1935	1935–1939	1946–1950
20–24	114%	70%	.....
25–29	124	93	.....
30–34	137	103	38%
35–39	154	119	51
40–44	169	145	72
45–49	205	178	91
50–54	247	226	142
55–59	297	272	210

and published noncancelable disability loss ratios. He illustrated the impact of the depression on life insurance disability income experience by Table 1, derived from the 1952 report of the Society's Committee on Disability.

He doubted whether one should be influenced by the 1946–50 experience because of the prosperous years represented by them, and suggested that the 1935–39 experience would be more representative of future morbidity for life income benefits. The incentive to antiselection and malingering would be much less on contracts whose benefits do not extend past ten years or to retirement age, whichever comes first. He felt, therefore, that the morbidity experience under such contracts should be better than life income experience. Furthermore, the effects of a depression should not be nearly as great when benefits are limited in this way.

The effect of a depression is highlighted in a comparison of loss ratios by calendar years published in *PCAS* XXI, 246. The same table shows that loss ratios for aggregate indemnity contracts were far less than those on the life indemnity contracts. He also pointed out that recent company loss ratios under noncancelable life indemnity contracts are misleading due to (*a*) the old premiums being low compared to modern premiums, (*b*) the adverse effect on loss ratios of current reserve strengthening programs, and (*c*) considerable antiselection on old policies still persisting.

For short term benefits the loss ratios referred to above can be supplemented by loss ratios in insurance handbooks, Schedule H, and the Supplement to Schedule H showing ratios for major plans.

Premium waiver disability experience on life insurance policies indicates that when benefits are small the morbidity cost per unit of benefit is relatively low. The experience on short term noncancelable benefit contracts appears to confirm this.

He stated that when the Provident Mutual recently entered the participating noncancelable accident and sickness field, asset shares were worked out using tentative premiums and combining in various ways favorable and unfavorable assumptions as to morbidity, expenses and persistency. Final premiums were fixed on the basis of intermediate assumptions and included a provision for "model" dividends, policy and contingency reserves.

A study of the asset shares indicated a parallelism with those of life policies. The results for long term benefits corresponded to those for life policies for large amounts and the short term plans to life policies of smaller amounts.

Mr. Marshall stated that he was convinced that participating noncancelable disability insurance with benefits running for 10 years or less can be safely issued provided underwriting is sound, overinsurance is avoided, claim handling is alert and fair, and the business is sold to a substantial and stable clientele on the basis of programmed needs just as in the case of life insurance.

MR. C. M. BEARDSLEY, discussing section D, stated that for all companies issuing noncancelable accident and sickness insurance, the ratio of claims to net premiums written increased from 52.0 percent in 1929 to 89.1 percent in 1935. His company, the Massachusetts Protective Association, was writing approximately 40 percent of the noncancelable premiums in the country during this period, and its loss ratios rose from 60.0 percent in 1929 to a maximum of 73.8 percent in 1933 and returned to approximately 60.0 percent in 1935. The premium income of his company

dropped by 26 percent during the period 1930–35, and during this period the combined loss and expense ratios were near or above the 100 percent level. The failure of expenses to decline in proportion to premium income was partly responsible.

He questioned whether it was logical to expect this experience to be repeated in a future depression, because of the influence of essential changes in benefits on the one hand and government controls over the economy on the other. The same trends will probably appear though perhaps not the extreme swings, but management still has a responsibility to make provisions for such fluctuations.

He favored handling such a reserve as an integral part of the free surplus of the company, on the assumption that management recognizes that one of the functions of free surplus is to provide for sudden or violent fluctuations in experience. He questioned the value of earmarking the reserve as a special contingency reserve, except perhaps during a depression when the company may want to satisfy the public that adequate provision has been made. The size of such a reserve is a matter of conjecture and it should be realized that claim rates may increase from 15 to 20 percent within a relatively short period, such as three years, and any margins in claim reserves may be reduced or removed altogether by such experience. When this is taken into account together with possible shrinkage in premium income it does not seem unreasonable to set aside 25 to 50 percent of a normal year's premiums as the portion of surplus which may be called upon to meet major emergencies.

MR. A. W. LARSEN, dealing with section E, divided the claims into four major categories and described the practice of the United Benefit Life with respect to each.

1. *Claims on which notices are received in the last 90 days of the accounting year and for which a specific reserve is not otherwise provided.* An average anticipated claim per notice is obtained by analyzing previous experience. This average is multiplied by the number of notices received, excluding those on which claims have been paid in full and those for which specific reserves are being set up.
2. *Unreported Claims.* A study of unreported claims on the previous December 31st is made. It is assumed that the current year's reserve will bear the same ratio to that of the previous year as the claims incurred during the current year bear to those of the previous year.
3. *Claims for unaccrued hospital, medical and surgical expense and for time loss payments of expected short duration.* Claims for polio and other so-called dread diseases are included in this category. Comparatively few payments are required for claims in this group and they are usually evaluated according to the individual judgment of the claim auditor.

4. *Claims for continuing monthly income disability benefits.* Tabular reserves based on Class 3 disabled life tables are used if disability has extended 27 months or more. For claims of less than 27 months duration, the reserve is taken as $3\frac{1}{2}$ times the aggregate amount incurred since the beginning of the claim.

Categories 1, 3 and 4 are handled in line 23 of Schedule H whereas the unreported claims are handled as unpaid losses in line 19.

All claim reserves except those in categories 1 and 2 are calculated separately by types of policies as required by Schedule H. For the first two claim categories, a percentage distribution is made based on the number of notices received in the last 90 days for each policy classification. Tests have indicated that the implied assumption is reasonable when applied to the business of his company. For another company, however, this procedure may result in distortion.

MR. S. F. CONROD discussed section E from the point of view of a company whose principal line of business is noncancelable accident and sickness insurance. He pointed out that for the same benefits there should not be any material difference between claim reserves on commercial and noncancelable business.

The practice and treatment of the Loyal Protective Life is as follows for five divisions of its reported noncancelable disability claims.

1. *Specific estimates.* These consist principally of accidental death and dismemberment claims in process of settlement. The maximum liability is set up in each case.
2. *Accident life indemnity claims.* The minimum valuation basis is the Conference Modification of the Class 3 disability experience and 3 percent interest, except as modified by the $3\frac{1}{2}$ times rule described by Mr. Larsen. It is felt that this basis overstates the true liability since only 32 percent of the reserves set up in 1949–51 was needed to pay claims. This is because the termination rate on accident claims is higher than on sickness claims during the earlier durations of disability.
3. *Claims more than a year old, other than accident life indemnity.* The basis described in (2) with $2\frac{1}{2}\%$ valuation interest rate is used for these claims. The reserves appear to be adequate in that 88 percent of the 1949–51 reserves represented the true liability.
4. *Approved claims less than a year old, other than accident life indemnity claims* and
5. *Reported claims in process of approval.*

   Approximately 95 percent of the claims fall in groups (4) and (5) where average claim factors are used, based on the company's experience. A factor per claim generally independent of the type of claim, length of benefit, amount of indemnity, etc., is used. The factor varies only by the month in

which disability is incurred. The company's Family Hospital Policy is separately handled, due to a different claim factor.

After the close of each year the adequacy of the claim factors is checked. For example, in January 1953, 1952 claim payments and reserves on 1951 claims are compared with claims outstanding at the end of 1951. As a result of these tests his company is using the following claim factors currently:

GROUP (4) NONCANCELABLE DISABILITY CLAIMS

Month Incurred	Reserve Factor	Month Incurred	Reserve Factor
December.....	$300	July	$500
November.....	500	June	500
October.....	425	May	475
September.....	450	April	450
August.....	475	Jan.–Mar.	400

The current factor for group (5) claims is $220, except that $100 is used for Family Hospital claims. Although these factors are of little use to any other company they may be of interest to a company newly entering the noncancelable field.

In addition to the above groups additional reserves must be provided for reopened claims and for incurred but unreported claims. Approximately 1.8% of the claims paid during the year is required as a reserve for reopened claims. The liability for incurred but unreported claims is obtained by multiplying the number of notices received in the first three weeks of January, giving half weight to the third week, by an average factor per notice. This average factor has been increasing in recent years and in 1953 the company contemplates using a factor of $240 per notice.

MR. E. H. MINOR suggested that a company may find it worth while to go to some refinements in determining claim reserves, since it is very helpful to know the true claim costs of various types of coverages. He pointed out that the claim costs of a coverage issued separately may be quite different from those of the same coverage issued as a part of a package, and such differences should be recognized, particularly if dividends are contemplated.

By following up each separate liability for a moving period of five years, the Metropolitan Life is able to observe the trend in average amount incurred from year to year (especially for pending and unreported claims). Mr. Minor referred to his paper dealing comprehensively with the subject of claim reserves on individual accident and sickness business presented to the Insurance Accounting and Statistical Association (1952).

He commented on the importance of determining adequate reserves for

claims providing long term benefits. He feels that the reserves based on a "mixed" table such as the Conference Modification of Class 3 experience are not satisfactory for benefits providing for lifetime accident benefits combined with shorter sickness benefits. Such a table tends to understate reserves for accident claims at longer durations and overstate them on sickness claims.

The Metropolitan Life has constructed a table of annuity values for lifetime accident claims, based on its experience over 10 or more years prior to 1942 (see Table 2).

TABLE 2

INDIVIDUAL ACCIDENT AND HEALTH DISABLED LIFE RESERVES FOR $1 OF WEEKLY INDEMNITY PAYABLE AS LONG AS DISABILITY EXISTS*

DURATION OF DISABILITY IN YEARS	AGE AT DISABILITY							
	25		35		45		55	
	Met. Acc. (2½%)	Class III (3%)	Met. Acc.	Class III	Met. Acc.	Class III	Met. Acc.	Class III
3	$ 552	$361	$552	$458	$552	$499	$552	$426
4	585	403	585	513	585	531	585	433
5	862	455	742	558	608	543	468	430
6	903	520	771	595	626	542	476	422
7	937	598	795	627	639	534	479	411
8	965	687	813	652	646	523	480	401
9	987	756	825	664	650	510	477	390
10	1,003	778	833	659	651	496	472	380
15	1,021	725	819	579	612	436	420	336
20	969	659	750	496	537	380	350	283

* For claims with durations of less than 3 years, reserves based on company's own experience should be used; the reserves have been graded into the Combined Annuity Table at the 20th year of duration and that table is used thereafter.

It will be noted that the Class 3 annuities (applicable mainly to "lifetime" sickness claims) are significantly lower than those intended only for lifetime accident claims.

MR. D. W. PETTENGILL commented on section F from the point of view of group insurance. If benefits are carefully defined and reasonably limited, hospital room and board and hospital miscellaneous services can be written. Limits can be increased if there is a coinsurance feature. Surgical fees can be written if the surgical schedule has an over-all maximum with regard to one period of disability and if the level of individual fees insured is slightly below the prevailing level.

Doctor's services for hospital and medical care can also be covered as part of a package plan. The small amounts involved make it impractical to offer this benefit by itself.

It is doubtful whether doctor bills for medical care outside of the hospital should be covered. The Aetna's experience indicates that at present the average number of visits per claim (under a plan covering the first fifty visits) is eight and at, say, $3.00 per call, the average claim is $24.00. The cost of settling such claims is a relatively large proportion of the premiums charged and it is questionable whether it is economic for the public to buy such coverage.

His company is now experimenting with major medical expense insurance or catastrophe insurance and wants to make sure that such plans will operate successfully on a group basis before they are offered on an individual basis.