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ACCIDENT AND SICKNESS

A. What has been the experience under the individual major medical type of coverage with regard to (1) level of benefit payments, (2) volume of sales, and (3) type of market? What effect, if any, does the medical deduction under the personal Federal income tax have on the salability of this coverage?
B. Would an individual hospital expense policy with a deductible clause meet a current demand?
C. What problems have developed with the underwriting of group hospital expense insurance on full service type plans or on the basis of covering full semiprivate accommodations and unlimited hospital ancillary charges?
D. What has been the claim experience under the group major medical or catastrophe type of coverage?
E. To what extent does improvement in the effectiveness of accident and sickness insurance, including major medical insurance, depend on a joint effort of organized medicine, hospitals and the insurance business? How can such joint effort best be stimulated?
F. What steps are being taken to meet the adverse criticisms that have been directed at the accident and sickness insurance business?
G. What steps are being taken to extend accident and sickness insurance to those segments of the population which are insurable but not now adequately protected?

MR. M. D. MILLER reported the Equitable Society's experience with individual and family major medical expense policies, the only form of individual accident or health coverage his company writes. This insurance was first offered in August 1951 and covered only expenses incurred in the hospital. The present policies, adopted January 1, 1954, cover expenses both in and out of the hospital. The current rate of production is about 200 applications a week which approximates 5% of their Ordinary life insurance applications. The Equitable has a total of 15,500 policies in force covering about 45,000 persons with an annual premium income of $1,250,000.

In discussing the level of benefit payments, Mr. Miller stated that the average claim payment under policies with a $500 deductible is about $500, and that approximately one-sixth of the claims involved amounts in excess of $1,000. The claim frequency for these policies may be of the order of ten to fifteen per one thousand persons insured.

A sample of their applications showed a fairly diversified market with about one-half of the policies being issued to persons with monthly earnings of less than $800, and about 15% to persons earning less than $400

monthly. This same sample showed a variety of occupations represented including not only salaried employees and professional people, but also tradespeople, housewives and farmers. The medical deduction under the personal federal income tax has apparently not had much influence on sales.

With reference to section D, Mr. Miller stated that interest in major medical coverage on a group basis continues at a very high pitch, the Equitable Society having over one hundred group plans covering more than 100,000 persons. Particularly significant is the recognition being given to major medical expense by labor unions as evidenced by two substantial cases recently closed where major medical benefits were part of union demands and by the fact that such benefits will be included in the health and welfare plan currently under negotiation for the million non-operating employees of the railroads. Mr. Miller also stated that although his Company's claim experience under group major medical is running satisfactorily in relation to premiums, he is convinced that as the coverage spreads there will inevitably be a substantial increase in the claims load.

Mr. Miller felt, as regards section E, that the success of our efforts in connection with any and all of the various medical expense insurances depends in the long run on our ability to work with, and to secure the co-operation and understanding of, the medical profession and the hospitals. He emphasized the tremendous amount of progress which has been made in that direction in the last few years largely through the establishment and work of the Health Insurance Council. Among the major concrete accomplishments of the Health Insurance Council are (1) the publication of a book entitled "The Health Insurance Story," (2) the development and annual distribution of an authoritative statement of the extent of voluntary health insurance in the United States, (3) the establishment of plans for facilitating the admission of insured persons to hospitals, (4) the development of uniform claim blanks and their acceptance by the companies, the doctors and the hospitals, and (5) the inauguration of state medical society sponsored surgical plans in the underwriting of which insurance companies participate. Mr. Miller indicated, however, that these efforts were still too little for the magnitude of the job to be performed and supported his statement by comparing the insurance industry's efforts with what Blue Cross and Blue Shield do and spend to secure the co-operation of doctors and hospitals. He advocated that the insurance industry undertake to devote even more money and time to such work, to an extent more commensurate with what is required.

In discussing section F, Mr. Miller stated that the criticisms recently

directed at the accident and sickness insurance business as well as the attention being given to federal enactment in the health insurance field have had the beneficial result of having the industry begin to devote top level consideration to its problems. He stressed the importance of the work of the Joint Committee on Health Insurance established early this spring on such problems as public relations, regulation of accident and sickness insurance both through law and the Insurance Departments and through self-regulation, and the improvement of the accident and health coverages available to the public. Mr. Miller felt that a good beginning has been made in the huge task of overcoming any loss of confidence in the industry by the public and of earning the public's positive appreciation of the value of our accident and sickness insurance.

MR. R. R. ANDERSON stated, in reference to section A, that the New York Life had sold 1,486 individual and family major medical expense policies in the first nine months of 1954. Some characteristics of the applicants were that about two out of three were age 40 or above, approximately one-half earned at least $10,000 a year, and they were more likely to live in the higher medical expense areas.

Mr. Anderson expressed the opinion that the insurance industry faces a long uphill struggle in the education of the public to the need for the deductible form of medical expense insurance. He felt that sales efforts should be directed primarily at the untapped part of the market, those at the younger ages and those with more modest incomes.

Mr. Anderson stated that the New York Life has thus far had very little claim experience under major medical policies. Of only thirty-five claims on which payments have been made, he expected the average payment to be about $1,000.

Mr. Anderson did not believe that the 1954 federal income tax law would have much effect on the salability of major medical insurance. He expressed the belief that few applicants for major medical expense insurance really understand, or are even aware of, the interrelationships between the mechanics of the major medical benefit formula and the federal income tax provisions. Any additional relief under the new law due to the reduction in the medical deduction factor from 5% to 3% would be relatively small for a person confronted with medical expenses of major proportions. For instance, for a person earning $20,000 annually, the additional tax relief would be about $120 (30% of 2% of $20,000). He stated that the additional relief due to the increase in the total allowable medical expense deduction from $1,250 to $2,500 could be of greater importance, being as much as $375 (30% of $1,250) for the person earning $20,000 annually.

MR. J. F. MACLEAN, in discussing section B, stated that an individual hospital expense policy with a deductible clause is a logical development in hospitalization coverage, which in many cases is merely a "trading of dollars" with little or no insurance in the classical sense. He reported that the Bankers Life of Nebraska offers individual and family hospital policies providing both first dollar coverage, and coverage with a deductible equal to five times the daily benefit and applicable to all benefits under the policy. He indicated that the differential in the premium rate for a man, wife and two children is approximately equal to the deductible amount. Mr. MacLean stated that all states in which his company is licensed have approved the deductible plan except California and that their California policies eliminate coverage for the first five days.

MR. W. G. SCHNEIDER described the recently introduced individual hospital expense policy of the Bankers Life of Iowa which combines both the deductible and coinsurance principles. This policy provides for selected daily benefits payable for a maximum period of 120 days for any one confinement, reimbursement for 75% of the hospital charges for ancillary services with a maximum allowance of 75 times daily benefit, a surgical benefit with a maximum of $250, a $5,000 polio benefit and, on the family policy, a maternity benefit of the regular daily benefit and extras allowances for hospital charges incurred on and after the 8th day of hospital confinement. The deductible is $50 and is subtracted from the combined allowance for hospital and surgical benefits for any one injury or sickness; it does not apply to the polio or the maternity benefit. Earlier in the year an individual hospital policy providing first dollar coverage with modest limits and no coinsurance on hospital extras had been introduced in recognition of the popularity of this type of coverage. He was pleased to report that about one deductible application is being received for every two conventional type applications.

Mr. Schneider indicated that the percentage reductions made from the conventional policy premium rates to obtain premiums for the deductible policy ranged from 13% to 33%, even though the maximums under the deductible policy are higher than under the conventional policy.

Mr. Schneider stated that their goal in developing the deductible policy was to give more economical protection to the insured by avoiding the uneconomical use of insurance to cover small claims and that they hope the deductible hospital policy combined with major medical type coverage can eventually turn the trend away from first dollar coverage in the hospital field.

MR. C. N. WALKER expressed the belief that there is a pressing demand for deductible medical expense coverages, coming not from the buy-

ing public but from the pressures and crossfires in which the insurance industry finds itself today. Mr. Walker attributed the present pattern of first dollar coverage to the original development of the business and referred particularly to the following factors. The service organizations that originated hospital insurance were primarily interested in protecting the accounts receivable of the hospitals and hence they provided first day coverage for the frequent, short confinements. Both employers and labor leaders are more interested in employee good will than in real insurance and hence desire benefits payable to the greatest number of people without regard for their woeful inadequacy in a few instances. Finally, the violation of insurance principles inherent in so much of today's first dollar coverage was not apparent at the beginning because of the low frequency and cost of hospitalization and surgery at that time.

Mr. Walker pointed out that claim costs, and premiums, for today's first dollar pattern of hospital and medical care coverages have reached a point where they are beginning to price themselves out of the market. They are losing their economic value to the policyholder by inability to make the amount of risk transferred worth the price of administration and distribution which must be paid. He noted that Mr. J. T. Phillips' current paper on accident and sickness insurance showed that 51% of the claims paid under the New York Life individual hospital expense policies were for amounts of $50 and less and that a $50 deductible would reduce the aggregate amount of claims by approximately 52%. He concluded from these figures that a deductible of $50 on present day policies would result in claim cost savings in the range of 25% to 50% and that if such reductions were applied to the average family premium of from $100 to $120, premium savings of $25 to $60 per family would be obtained.

Mr. Walker felt that the industry has an obligation to insure as high a proportion of the American people as can be insured and to make coverages as effective as possible against the expenses of serious accidents and sicknesses. To fulfill this obligation, he urged the industry to redirect its efforts, even in the face of consumer demand, and to educate the buyer to provide his lesser items of medical expenses directly from his own pocket. Only by so doing can the rapid and effective growth of the industry be continued and universal coverage be accomplished by voluntary rather than by compulsory methods.

MR. T. L. ANDERSON described the conditions which gave rise to the formation of Blue Cross organizations. He stated that in the middle thirties the hospitals were faced with many problems such as low bed utilization and inability to collect accounts and that Mr. C. Rufus Rorem, then head of the Chicago Hospital Association, asked a group of insurance

men, of whom Mr. Anderson was one, to help solve the hospitals' problems. Although Mr. Anderson felt that they could help the hospitals, the group finally told Mr. Rorem that the problem could not be solved by insurance. This decision forced the hospitals to solve their own problems, which they did by the formation of Blue Cross plans providing first-dollar, first-day coverage.

MR. M. J. WOOD, in discussing section C, stated that the difficulties experienced in underwriting full service hospital coverage develop because such plans violate two of the basic principles of insurance; namely, the risk must be measurable and the existence of insurance must not tend to increase the risk materially. The violation of the first principle occurs because there has been a steady rise in hospital costs due to general inflation and also due to improvements in hospital care. A recent study made by his company, The Travelers, disclosed that there is a close relationship between the frequency of hospitalization and the percentage of the hospital bill covered by insurance—hence, the violation of the second principle. Mr. Wood pointed out that medical authorities have stated that full service benefits bring about unnecessary hospital admissions for diagnostic purposes, X-ray therapy and physiotherapy, plus inexcusable charges for overmedication and unnecessary laboratory procedures. These problems have caused many insurance carriers, employers and even some Blue Cross organizations to revise plans by placing limitations on the benefits originally written on a full service basis. On some 40 group cases of this type written by The Travelers, the over-all loss ratios have averaged about 10 percentage points higher than on their total hospital business.

MISS JOSEPHINE W. BEERS stressed the importance of an adequate premium rate for Group hospital plans providing full reimbursement for semiprivate accommodations both because of the difficulty of determining average hospital semiprivate charges and because of the virtual certainty that such charges will increase as time goes by. She warned that the annual booklet on hospital rates published by the American Hospital Association must be used with care, since it gives averages based on uninsured patients as well as insured ones and since it shows state-wide averages which frequently differ from the average applicable to a specific community within the state. The Occidental's experience under two Canadian cases covering over 5,000 lives each and providing full semiprivate room and board benefits showed that the average room and board charge had increased $1.50 between 1951 and 1954, an increase of about 25%.

With respect to plans providing unlimited benefits for hospital services other than board and room, Miss Beers stated that early fears of hospitals

unduly boosting their charges for ancillary services were unwarranted. Where poor loss ratios have been experienced by the Occidental, the claims of less than $300 ancillary charges have caused the loss rather than those in excess of $300. One study of 439 employee claims showed that only 10% of the claim cost for ancillary services arose from payments beyond the first $300 and less than 5% from payments beyond the first $500. Another study of 631 claims showed corresponding figures of 3.3% and .4%. With dependent benefits limited to $500, this latter study showed that payment for services in excess of $300 was 2.9% for wives and .1% for children.

MR. N. J. PRENDERGAST agreed with Miss Beers regarding the difficulty of setting premium rates for hospital plans providing full payment of hospital room and board charges for semiprivate accommodations. He stated that at the Metropolitan the initial premium rate is set by multiplying the monthly premium rate per dollar of daily benefit by the best available estimate of the charges for semiprivate accommodations. The Company then reserves the right to increase the rate on any monthly premium due date if the room and board charges actually being incurred are different from the dollar amount used in determining the initial premiums.

MR. N. F. JONES AND MR. A. M. THALER commented that since insurance companies were relatively inexperienced in writing full service type hospital plans and since the pressure to write such plans came from Blue Cross competition, the companies would do well to look to Blue Cross for the problems involved. In this regard, they called attention to Dr. Harry Becker's report at the recent American Hospital Association meeting which showed that one out of every five days spent in hospitals by Blue Cross patients was unnecessary, while uninsured patients seldom misused hospital stays. They also pointed out that the hospitals in a locality might raise their rates as a result of issue of a full service coverage plan to a very large local employer. They reported that the experience under a Prudential group plan providing semiprivate accommodations and unlimited special charges for about 25,000 lives indicated claim frequencies on employee hospital coverage of more than twice those indicated by intercompany studies, and dependent hospital claim frequencies about one-third higher than expected. It was pointed out, however, that the intercompany studies are nearly four years old and there is some evidence that claim frequencies generally have increased, perhaps as much as 50%, in the interval.

Mr. Jones and Mr. Thaler stated that the real problem in the underwriting of hospital coverage is to encourage plans which will keep the cost of the coverage within the pocketbook of the lower income groups who need

the coverage most. They were of the opinion that the element of coinsurance was an essential ingredient to any service type coverage and that encouraging coinsurance in the sale of service type hospital coverage will be beneficial to the public and to the insurance industry.

MR. W. S. THOMAS, in discussing section D, stated that the claim experience under group major medical expense plans depends on the

TABLE 1

DISTRIBUTION OF TOTAL CHARGES INCURRED BY TYPE OF EXPENSE ON CLAIMS QUALIFYING FOR MAJOR MEDICAL EXPENSE BENEFITS
(Average Charge)

	Employee		Dependent Wife or Husband		Dependent Children	
	Group I	Group II	Group I	Group II	Group I	Group II
	Claims Where Individual Was Confined to a Hospital (Includes Expenses In and Out of Hospital)					
Total Expenses	$1,022	$732	$831	$832	$943	$604
Type of Expense						
Hospital Services						
Room and Board	315	256	234	230	364	169
Special Services	225	146	171	189	178	101
Surgery	221	195	227	195	232	169
Physicians—In Hospital	73	44	58	71	38	20
—Out of Hospital	71	18	30	31	25	10
Registered Nurses	82	53	89	79	93	19
Drugs—Out of Hospital	18	3	11	7	9	4
All Other Expenses—Out of Hospital	17	17	11	30	4	112
Number of days of Hospital Confinement	22 days	18 days	16 days	19 days	27 days	15 days
Number of Claims	187	73	179	38	40	14
	Claims Where Individual Was Not Confined to a Hospital					
Total Expenses	$253	$208	$367	$204	$244	$187
Type of Expense						
Surgery	11	12	15	.....	29	.....
Physicians	155	123	194	107	120	171
Registered Nurses	.....	.....	82	88	.....	.....
Drugs	59	14	45	.....	44	.....
All Other Expenses	28	59	31	9	51	16
Number of Claims	53	16	44	6	18	1

benefits provided by the basic plan which the major medical plan supplements as well as on the characteristics of the insured group, such as age, earnings, geographical location, and local tradition as to medical care. He then presented a series of tables giving a detailed analysis of 667 claims under two of the group major medical plans underwritten by the Metropolitan. The two plans were quite similar as to the range of covered expenses and amount of deductible (corridor type, graded by earnings, with a minimum of $100) but the basic plan of Group I was more liberal than that of Group II. In order to eliminate some of the nonhomogeneity

TABLE 2

GROUP MAJOR MEDICAL EXPENSE

DISTRIBUTION BY SIZE OF AMOUNTS PAID BY BASIC HOSPITAL-SURGICAL PLANS ON CLAIMS QUALIFYING FOR MAJOR MEDICAL EXPENSE BENEFITS (ALL CLAIMS)

SIZE OF BASE PLAN BENEFITS	PERCENTAGE OF TOTAL NUMBER OF CLAIMS					
	Employee		Dependent Wife or Husband		Dependent Children	
	Group I	Group II	Group I	Group II	Group I	Group II
Under $200	34.1%	24.3%	28.4%	28.5%	42.2%	64.7%
$ 200 to $299	8.7	14.0	12.6	14.3	12.5	17.6
300 to 499	22.2	47.7	28.8	40.5	23.4	5.9
500 to 999	29.4	12.8	27.5	16.7	14.1	11.8
1,000 and over	5.6	1.2	2.7	0.0	7.8	0.0

due to the differences in the basic plans, any miscellaneous fee benefit of more than $200 under the more liberal Group I basic plan was taken as $200 and the balance was considered a major medical expense. Group I consists of the salaried employees only of a nation-wide employer while Group II consists of all employees of a firm with one primary location. Group I has a smaller proportion of female employees than Group II, and an average age somewhat higher.

Table 1 shows the average charge per claim for each type of expense incurred, subdivided by type of claimant. When hospital care is required 70% to 85% of the individual's expenses are hospital and surgical. Mr. Thomas added that if the expenses paid by the basic benefits had been removed from this Table 1, hospital and surgical expenses would still have amounted to 45% to 65% of the total major medical expenses.

Table 2 shows the distribution by size of amounts of benefits paid under

TABLE 3

GROUP MAJOR MEDICAL EXPENSE
DISTRIBUTION BY SIZE OF TOTAL CHARGES INCURRED

SIZE OF TOTAL CHARGES	EMPLOYEE				DEPENDENT WIFE OR HUSBAND				DEPENDENT CHILDREN			
	No. of Claims As % of Total No. of Claims		Charges Incurred As % of Total Charges		No. of Claims As % of Total No. of Claims		Charges Incurred As % of Total Charges		No. of Claims As % of Total No. of Claims		Charges Incurred As % of Total Charges	
	Group I	Group II	Group I	Group II	Group I	Group II	Group I	Group II	Group I	Group II	Group I	Group II
Under $500	40.8%	41.9%	15.0%	19.1%	37.3%	45.3%	15.9%	22.8%	62.4%	76.4%	27.6%	43.2%
$ 500 to $ 699	17.9	20.9	12.7	17.5	25.6	26.2	20.1	22.8	9.3	0.0	7.6	0.0
700 to 899	11.9	15.1	11.6	16.7	10.8	7.1	11.3	8.2	6.3	5.9	6.5	9.0
900 to 1,499	19.8	17.4	28.4	28.0	18.5	11.9	27.4	21.6	14.1	11.8	23.0	28.6
1,500 to 2,499	4.4	2.3	9.7	6.6	4.5	9.5	10.5	24.6	3.1	5.9	8.3	19.2
2,500 to 3,499	2.8	1.2	10.0	4.8	1.4	.....	5.1	.....	1.6	.....	6.2	.....
3,500 to 4,499	1.6	1.2	7.5	7.3	1.4	.....	6.8	.....	1.6	.....	9.4	.....
4,500 to 5,499	0.4	0.0	2.3	0.0	0.5	.....	2.9	.....	1.6	.....	11.4	.....
5,500 and over	.4	.0	2.8	.0	.0	.....	.....	.....	.....	.....	.....	.....

TABLE 4

GROUP MAJOR MEDICAL EXPENSE
DISTRIBUTION BY SIZE OF MAJOR MEDICAL EXPENSES INCURRED
(Total Charges Less Amounts Paid by Basic Plans)

SIZE OF MAJOR MEDICAL EXPENSES	EMPLOYEE				DEPENDENT WIFE OR HUSBAND				DEPENDENT CHILDREN			
	No. of Claims As % of Total No. of Claims		Expenses Incurred As % of Total Expenses		No. of Claims As % of Total No. of Claims		Expenses Incurred As % of Total Expenses		No. of Claims As % of Total No. of Claims		Expenses Incurred As % of Total Expenses	
	Group I	Group II	Group I	Group II	Group I	Group II	Group I	Group II	Group I	Group II	Group I	Group II
Under $300	59.9%	62.7%	27.4%	29.2%	58.5%	57.1%	28.3%	25.7%	68.7%	88.2%	30.9%	47.8%
$ 300 to $ 499	19.4	18.6	17.6	20.0	26.1	21.4	25.1	22.0	18.8	0.0	19.8	0 0
500 to 999	14.7	12.8	24.0	22.8	9.5	16.7	17.1	35.2	7.8	5.9	16.1	20.0
1,000 to 2,499	4.0	4.7	16.4	17.1	3.6	4.8	12.4	17.1	3.1	5.9	17.1	32.2
2,500 and over	2.0	1.2	14.6	10.9	2.3	0.0	17.1	0.0	1.6	0.0	16.1	0.0
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

the basic plans and indicates that a typical base plan pays substantial amounts of benefits for the more serious cases. (The room and board benefits under the two plans analyzed did not exceed $12 per day.) Mr. Thomas recommended consideration of the distribution of the basic plan benefits as detailed in Table 2 in determining the type and amount of deductible to be applicable. Table 3 gives the distribution by size of the total charges incurred, while Table 4 gives the distribution by size of major medical expenses incurred. Although the number of claims with major medical expenses in excess of $500 is not too substantial, the expenses incurred by these claims as a percentage of the total major medical expenses is substantial. Table 5 shows the number of claims per thousand per year

TABLE 5

NUMBER OF CLAIMS PER THOUSAND PER YEAR

	Employee		Dependent Wife or Husband (Per Family Unit)		Dependent Children (Per Family Unit)	
	Group I	Group II	Group I	Group II	Group I	Group II
Claims where the individual is confined to a hospital	23	18	26	18	6	5
Claims where the individual is not confined to a hospital	8	4	8	2	3	1

arising during the first policy year under the two plans. Mr. Thomas commented that the claim trend under group major medical expense plans insured by the Metropolitan has not as yet shown the anticipated sharp upward secular trend.

MR. C. A. NAYLOR presented the major medical claim experience under the plan in force since January 1952 on the staff of the London Life. This major medical plan is superimposed on a basic hospital plan providing $9 daily benefit for 70 days with an allowance of ten times the daily benefit for miscellaneous hospital charges and on a surgical plan with a maximum of $275. The major medical plan is the corridor deductible benefit year type. The deductible was originally 5% of the annual earnings with a minimum of $100 but was changed in August 1954 to 3% with a minimum of $60 and a maximum of $750. The plan provides for 25% coinsurance and a maximum benefit of $5,000. Mr. Naylor stated that 2,500 employees and about 1,500 families are covered and that during the first thirty-three months of the plan 48 claims have been paid for a total

of about $23,500. On the basis of the incurred claims for the year 1952, the unit annual claim cost for the employee benefit was $4.09 and for the dependent benefit $4.93 per employee with dependents. The corresponding estimated claim costs for the year 1953 were $2.68 and $4.03 respectively. Mr. Naylor expressed the belief that these surprisingly low unit claim costs were due in part to the fact that their staff is carefully selected, has periodical medical examinations, and has a large proportion of female employees with relatively low incomes.

He stressed the need for holding a reserve for accrued claims under major medical plans substantially higher than the reserves commonly held for other casualty benefits. The accrued liability at the end of the first year of the London Life plan amounted to 51% of the total incurred claims for the year for the employee benefit and 75.6% of the incurred claims for the year for the dependent benefit.

MR. N. F. JONES and MR. R. J. MELLMAN stated that the major medical claim experience of the Prudential could best be described as inconclusive, although their earliest plans appear to be developing a 50% loss ratio. The existence of the coverage doesn't seem to have caused any significant spiral in the medical care costs for those insured.

Since most major medical plans are written on groups which have basic benefits, determining how much premium credit to give for integration of major medical with basic benefits has been the principal rate question. Prudential has recently made further refinements in its rate structure for this purpose. They also have changed from a benefit year basis to a calendar year basis inasmuch as the calendar year approach appears to be more readily understandable to the public.

Mr. Jones and Mr. Mellman also pointed out that they had intended to pool a large portion of the major medical claims under individual groups for experience purposes but that the pressure from large policyholders, who apparently felt that their claim experience would be favorable, has resulted in much more charging of claims against individual cases.

MR. D. W. PETTENGILL concurred with the other speakers on the importance of the effect of basic benefits on integrated major medical plans. He cited the experience of the Aetna Life shown in Table 1 as an indication that the size of the reserve for outstanding claims, expressed as a percentage of the major medical premium, will probably vary directly with the richness of the basic benefits.

Mr. Pettengill stated that the multiplicity of plans being sold coupled with the numerous factors affecting claim cost will hinder the accumulation of reliable major medical statistics. He suggested that the interested companies separate out for special study those major medical claims where

the total expenses incurred by the claimant amounted to $1,000 or more. While the actual major medical payments could not be combined, the total expenses could. An analysis of such cases by type of expense coupled with their incidence should give the industry important clues as to the cost of the truly catastrophic portion of any major medical plan.

TABLE 1

RATIO OF PAID CLAIMS TO PREMIUMS

	GROUP MAJOR MEDICAL PLANS WRITTEN IN CONJUNCTION WITH:	
	An Average Basic Plan	No Basic Plan
1st quarter	Under 1%	20%
2d quarter	6%	30%
3d quarter	12%	40%
4th quarter	23%	67%

TABLE 2

Type of Expense	No. of Claims	Average Charge
Hospital Room and Board	217	$ 551
Hospital extras	217	380
Surgeon's fees	166	485
Physician's fees	195	245
Registered Nurses' fees	127	454
X-ray and Laboratory exams.	93	52
Other Expenses	122	66
Total	220	$1,822

Mr. Pettengill then presented such an analysis (Table 2) based on the 220 claims the Aetna has had to date which involve total expenses of $1,000 or more.

A further analysis of these claims in relation to nurses' fees showed that the percentage of total expenditures spent on private duty nursing increased as the total expenses increased, with this percentage exceeding 25% when total expenses exceeded $5,000. The percentage of claims involving nurses' fees also increased with the age of the claimant, ranging from 44% for children to 70% for adults over age 55. For the 127 cases

with nurses' fees, the average number of eight hour units of nursing service rendered was 36.

MR. H. F. ROOD opened the discussion of the sections E, F, and G by reporting that earlier in the week the Federal Trade Commission had issued a release charging some seventeen companies in the A & H field with misleading advertising practices. A counter release by the insurance companies had been made and the press had reported the story fairly and without banner headlines.

Mr. Rood also called attention to the fact that both President Eisenhower and Mrs. Hobby were again pushing the President's reinsurance plan.

MR. MORRIS PIKE pointed out that actuaries, as the technical research men of the insurance industry, are concerned with their company's entry into new fields and with ways of modifying existing coverages and effecting economies in operation. The actuary measures his company's position by the percentage of the industry's volume which it writes and the industry's position is measured by the percentage of the consumer's dollar that goes for insurance premiums. In the A & H field, the actuary must take cognizance of three additional ratios: the ratio of claims to premiums for each of his company's lines of business; the ratio of medical claims received by a policyholder to the medical bills he incurred; and the ratio of total medical claims incurred by all insurance carriers to the total medical bill incurred by the entire population. These ratios present a continued urge to the actuary to seek ways and means of insuring more lives for more lines of insurance and for increased limits of dollars and duration.

Major medical and comprehensive plans are efforts in the right direction. However, the deductible and coinsurance principles of these plans may be interpreted improperly as increasing the portion of the medical bill to be borne by the public, unless the limits of coverage are properly extended to offset it. Also, on these and other new plans, the actuary must join forces with the agency director and the advertising manager to attractively present the new plans to both the company's field force and the public.

MR. G. H. DAVIS, in discussing section E, stated that insurance against hospital and medical costs is different from other casualty coverages in the way the actual amounts of benefits paid are determined, in that the amount of loss cannot be determined by the use of objective judgment or of actual or estimated costs determined by the normal play of competitive forces. The amount of benefit to be paid depends upon the amount and kind of treatment received as well as the actual charges made for this treatment. The amount of treatment necessary may vary

greatly depending upon the judgment of the doctor and, to some extent, of the insured himself. In addition, the cost of the treatment, although affected by competitive forces, is not determined in the same way as prices generally, but rather is determined partly by the patient's ability to pay. If this principle is made to apply to cases where the patient has insurance, the purpose of the insurance will be defeated since its existence will increase the costs it is intended to reimburse. Mr. Davis then pointed out that all of this means that some coordination is necessary between the insurers and those who provide the services if hospital and medical insurance is to perform its function effectively at reasonable cost.

Mr. Davis reviewed the areas mentioned by Mr. M. D. Miller in which the Health Insurance Council has made substantial progress in developing cooperation between insurance companies and doctors and hospitals. He pointed out that while hospital admission plans for persons with individual accident and sickness policies have not developed as rapidly as those for group coverage because of the greater problems involved, nevertheless such plans have been developed in three cities and seem to be working satisfactorily with the prospect good for their extension to other areas. Mr. Davis reported that although a state medical society sponsored surgical plan has worked very well in Tennessee, it has had rather limited acceptance in other areas of the country. Therefore, the Health Insurance Council is now suggesting in its discussions with doctors that the state or local medical society set up merely the schedule of surgical fees which would set the maximums its members would be expected to charge for patients within specified income limits. This schedule would apply whether the patient were covered by insurance or not, and an individual within the specified income limit, or his employer, could procure insurance knowing that it would provide full payment or some definite fraction thereof. Mr. Davis felt that, even if no such schedules developed from these efforts, there would at least be a realization that voluntary insurance will not do a satisfactory job if the existence of insurance increases the cost of medical care.

Mr. Davis pointed out that insurance men can make a real contribution to this effort, not by dictating changes but by showing the doctors and hospitals how insurance works most effectively and letting them develop what changes are desirable in their own professions.

MR. J. H. MILLER, in discussing section F, agreed with Mr. M. D. Miller on the importance of the work of The Joint Committee on Accident and Health Insurance, the Health Insurance Council, and other organizations in improving public relations. However, he felt the most important contributions to the improvement of the business stem from the

individual efforts of companies to expand the volume of their business, while at the same time improving its quality and adequacy.

Mr. Miller commended Mr. Valentine Howell's invention of guaranteed renewable individual accident and health policies which reserve to the company the right to raise premium rates for classes of policyholders. He stated, however, that this approach was not a panacea and warned of the possibility of its use by companies motivated by expediency and opportunism. He pointed out that the right to increase the premium does not obviate the need for maintaining adequate reserves and for establishing sound and adequate premiums.

He felt that Mr. Howell's approach was particularly appropriate for medical care benefits where the incidence, character and price level of medical care are so difficult to predict. His company, the Monarch Life, uses it for its individual major medical policies. Mr. Miller expressed the hope that a distinctive name for policies using Mr. Howell's approach would be developed, since the public has associated the terms "noncancelable" and "guaranteed renewable" with policies having guaranteed premium rates.

MR. J. M. BRAGG, in discussing section G, described the progress which the Great-West Life has made in extending accident and sickness insurance to segments of the population which are not now adequately protected. His Company will write reasonable amounts of hospital, surgical and in-hospital medical coverage for pensioned employees and their dependents provided coverage for active employees is in force. The hospital and medical coverages are limited to 31-day plans and all three coverages are limited to one maximum per policy year as well as per disability. Mr. Bragg did not feel that a lifetime limit was satisfactory since it leaves the individual with no coverage once the limit has been exceeded. The Great-West Life uses premium rates reflecting the higher incidence of illness for older persons and requires that at least half of the cost be paid either by the employer or out of a special deposit fund which has been built up during the active working life of the employee.

Mr. Bragg stated that they are also willing to write similar coverage at similar rates for certain older age dependents of an employee where a standard group plan is in force. The dependents eligible are those parents and grandparents who are financially dependent upon the employee as evidenced by appropriate income tax forms filed with the employer.

Mr. Bragg presented the results of the experiment that the Great-West Life has made in recent years in Canada with the provision of Group life and accident and health benefits through master policies issued to Chambers of Commerce. Coverage is available for all persons who are employees of a firm of any size which is a member of the Chamber of Commerce.

100% participation is required for firms with less than four lives and 75% for larger firms, the average size being five or six lives. At least half of the cost must be paid by the employer. The Great-West Life now has 74 Chamber of Commerce cases in force with an annual premium in excess of $1,250,000 and has found the financial experience very satisfactory.

Mr. Bragg also reported that they had issued one Group life and accident and health policy covering farmers, with satisfactory results so far. The policy is issued to a rural cooperative electrical association. Enrollment was performed one township at a time with the coverage being effective for a particular township as soon as 60% participation had been obtained in that township. Premiums are billed in conjunction with the electric light accounts.

MR. T. H. KIRKPATRICK felt that there is no new and spectacular device that will extend accident and sickness coverage to those segments of the population which are not now adequately protected, but that progress in this direction is being made in a succession of short steps. Among the factors contributing to this progress he listed the following:

The very energy and thought being given to the problem; the introduction of major medical with its attendant education of the public to accept it and not abuse it; the insuring of Federal employees for group life insurance with the possibility of accident and sickness coverage to follow; the expansion of creditor accident and sickness insurance; the experimentation with coverage of retired employees and their dependents; increased economy of operation which may make possible the extension of coverage to untouched groups such as farmers.

Mr. Kirkpatrick pointed out that the most difficult of the unsolved problems was how to pay for medical care for the group of people who cannot afford insurance.