Individual and Family Major Medical Insurance

With respect to individual and family major medical insurance,

A. What have been the limiting factors in its sale in comparison with the rapid expansion of group major medical?
B. To what extent have companies offered such plans with deductibles of $100 or less, and how has the sale thereof compared in volume with plans providing a large deductible?
C. What has been the claim experience to date, and what trends are indicated?
D. Can coverage be extended to over-age and substandard risks?
E. Can the coverage safely be made guaranteed renewable for life?
F. What limitations appear desirable in coverage for mental illness?
G. What problems are companies encountering in underwriting and claims administration?
H. Is coinsurance effective in restraining abuse?
I. What are the advantages and disadvantages of grading the deductible by income at the time of claim?

MR. ALLAN K. ARCHER, a member of the Policy Benefits Subcommittee of the HIAA, presented the following summary of surveys of member companies issuing individual and family major medical coverage. These surveys were made by the subcommittee in 1957 and 1958.

As of January 1959, some 77 companies out of a membership of 270 were writing major medical, and an additional 16 planned to enter the field during 1959 or 1960. However, there was no uniformity in any of the 26 aspects of the coverage that were surveyed. The closest approach to uniformity was found in the manner of providing coverage, which 74 companies accomplish by issuing a separate policy rather than by adding a rider to a loss-of-income contract.

The deductible ranges from $50 to $2,000, with the more common amounts being $500, $750, $1,000, and $250, in that order. Five companies offer $50 and four $100. At least three deductible amounts are offered by 45 companies, of which 22 offer four, while in 20 companies only one such amount is available. The income of the insured usually determines which amount may be elected.

The maximum benefits also vary widely, from a low of $500 to a high of $10,000, with individual companies offering more than one maximum; for example, 26 offer two maximum benefit amounts and 12 offer three. The most frequent combination is a deductible amount of $500 with a maximum benefit of $7,500 and the next most common is $500 with $5,000.

The most common coinsurance factor is 75%-25%, the next 80%-20%, and four companies have no coinsurance. It is of interest that, during the

interval between the two surveys, four companies switched from a no-coinsurance basis to 75%-25%. A few companies change the coinsurance as the expenses accumulate; at least one has no coinsurance for expenses due to accidents; another applies the factor only to expenses other than hospital room and board, surgeons' fees, ambulance and anesthesia; yet another uses coinsurance only with nurses' fees.

A majority of the companies (54%) use no internal limits, while 41% apply limits of $15 or $25 per day on hospital room and board. Surgical charges are limited by 14% of the companies and nurses' fees by 13%. Some companies also use limits for physicians' charges, both in and out of hospital.

Reductions in coverage because of age (other than terminations of coverage) are made by only 14 companies, of which one reduces at 60 and 13 at 65.

Maternity benefits are limited to complications of pregnancy by 66 companies; the remainder cover normal pregnancy and delivery, and only two of these set an internal limit on such benefits.

Only 5% of the companies cover pre-existing conditions, except as required by uniform policy provisions.

The policies of 38 companies are in force for sickness as of the policy date; 25 exclude sickness commencing within 30 days, 10 within 15 days.

Only 10% of the companies require hospital confinement to establish a claim.

The time limits within which expenses must exceed the deductible amount range from a minimum of two months to a maximum of two years, with the most common period being three months; the next most common is one year.

The maximum benefit is applied to each unrelated cause by 74 (98%) of the companies, and by three companies to the expenses of each person for all causes. The common accident provision is used by 91%. It is not customary to provide for reinstatement of the maximum, although 10 companies do so in a variety of ways.

Two years is the most usual maximum period for which expenses are reimbursable, 35 companies using two years, 20 using three years, and 15 one year. Five companies impose no limit.

The majority of companies set 18 as the minimum adult age at issue, the range being 15 to 20; the most common maximum age at issue is 60, with other companies using from 49 to 70. For children, the usual minimums are zero (coverage from birth), two weeks, or three months, which are used by 22, 18 and 21 companies, respectively. Age 18 is the most com-

mon maximum age at issue for children. As to termination, 40 companies employ age 65, while 29 specify no age for termination. Since completion of the surveys, at least one company has guaranteed continuation for life.

For substandard risks, the practice of 66 companies is to issue with a waiver or rider, although 13 of these also issue full coverage at higher premium. Eleven companies decline to issue.

As to premiums, 48 companies charge a level amount, depending upon the age at issue, for the duration of the policy, while the remaining 29 use step rate premiums by attained age. In 16 companies premiums vary geographically, but no companies vary the premium according to income of the insured.

MR. HERBERT J. STARK was of the opinion that one limiting factor in the sale of individual major medical expense insurance is the unfamiliarity of agents and the public generally with that type of insurance. It was also his thought and hope that another such factor is the caution that has gone into the development of policies and premiums. At least in the case of Metropolitan, unsatisfactory experience on hospital and surgical expense policies led to the use of conservative assumptions for individual and family major medical.

Mr. Stark explained that Metropolitan issues two kinds of such policies: one, called major medical, has a $500 deductible and is designed for those who have some other coverage, but this policy has had rather limited sale; the other is a similar policy, with a $50 deductible amount, covering a broad range of medical expenses. This comprehensive form follows many group policies in general design, in that it divides expenses into Types A and B, of which Type A are hospital and surgical expenses and Type B the others. It has an area of full coverage after the $50 deductible on Type A expenses, with 80 percent coinsurance on remaining Type A expenses and on all Type B expenses. Sales of this comprehensive policy have been large. Applications for it have run about one for each three for basic hospital and surgical and exceed by three to one those for all forms of loss-of-time policies combined.

With regard to claim experience, Mr. Stark remarked that since his company had started issuing this business only in 1958, it was too early to have any significant claim experience, but such evidences of trend as have been observed appear favorable. He pointed out that group experience on that type of coverage showed an increasing claim rate over a long period of years as people became better acquainted with the benefits, thus suggesting a conservative view of the experience until well into the future.

The major medical type of coverage is not extended to over-age risks, and substandard risks are covered by Metropolitan only through the use

of exclusion riders—a method which Mr. Stark considered unsatisfactory and which he hoped might eventually be replaced, at least in part, by an extra premium approach.

Mr. Stark expressed the opinion that it would be a long time before one could say whether coverage of the major medical type could safely be made renewable for life. His company had taken an intermediate position and issued policies for a five-year term within which renewability was guaranteed but at the end of which the company had the option of refusing renewal for a subsequent five-year term. He felt that this was in the nature of a temporary compromise and hoped that liberalizations might be possible, first in practice and later by contract.

As to coverage for mental illness, Mr. Stark felt that some limitation is necessary. His company requires hospitalization to establish a claim but he noted that in the group insurance field good results have been obtained with a lower coinsurance payment. He thought that an answer to the problem could be found among these and other approaches.

Section H, Mr. Stark believed, covers the most important question on this subject. It seemed to him, from studies made in both the group and personal field, that coinsurance was moderately, but not completely, effective in restraining abuse. There is some abuse despite the coinsurance and deductible provisions, but whether it is enough to endanger the future of the business cannot yet be said. It is clear that this must be watched and that companies should do what they can to restrain abuse.

MR. ROBERT P. COATES stated, with reference to section A, that one area in which there might be greater difficulty in expanding individual and family, rather than group, medical expense insurance was that of education of individuals in the need for and desirability of the coverage. In the group field, the insurer frequently deals with brokers, consultants, and other experts who are in a position to study the coverage and recognize its merits. Moreover, the group companies' salaried field staffs have been trained to explain the concepts involved, whereas many individual agents have first to acquire an understanding of the advantages of the coverage and then educate their clients.

From August 1, 1951, to January 1, 1954, Equitable Life Assurance Society offered a form of major medical insurance to individuals and families, with a choice of $100, $300 or $500 deductible amounts. Of the policies now in force from this block of business, approximately 45% have the $100 deductible, with the remainder divided about equally between $300 and $500. The Society's major medical program was revised and generally liberalized January 1, 1954. At that time policies with the two lower deductible amounts were withdrawn because substantial increases

in premiums were indicated for them and this made it doubtful whether the policies could be effectively marketed.

Mr. Coates gave the following summary of claim experience on major medical:

1. Claims have been somewhat heavier than originally anticipated, although not so much so as to force an increase in premiums on outstanding policies as yet. However, a future increase seems indicated.
2. On the form which offered a choice of $100, $300 and $500 deductible, experience was progressively less favorable as the deductible decreased, with claims on the smallest being considerably over what was anticipated.
3. An increase in claim cost of about 5% per year is estimated as the effect of the increasing trend in medical costs shown by recent statistics.

In discussing section E, Mr. Coates expressed the opinion that the safeguard provided by the right to increase premium rates warrants an attempt at making major medical insurance guaranteed renewable for life, but that the problems should not be overlooked. In the first place, at the oldest ages data are almost nonexistent, so that the appropriate premium level is uncertain. Second, the steady increase in medical costs suggests that periodic increases in premium will be a feature of the business for some time to come. Mr. Coates also thought that a third deterrent was the New York Insurance Department's letter of September 30, 1958, asserting its right to require approval of any rate increases on outstanding policies of this class; and that even a casual reading of the trade press makes one conscious of the difficulties that insurers have so often had in securing approval by the various state insurance departments of what appear to be well justified rate increases. He felt that the New York Department's position is a disturbing development that could slow the trend toward granting more liberal renewal rights.

Among the considerations referred to in section I concerning grading of the deductible amount by income at the time of claim, Mr. Coates listed the following as advantages of the practice.

1. The gearing of benefits to the insured's ability to pay and the automatic reflection of increases and decreases. Decreases might be helpful to applicants for lifetime coverage who anticipate a substantial reduction in income at retirement.
2. Since changes in costs of medical care because of inflation or deflation will probably be correlated with changes in income, a deductible varying with income affords some adjustment for inflation.
3. In the case of a contract guaranteed renewable for life, a varying deductible appears particularly suitable in view of the likelihood of changes in income over a long period.

4. Such variation tends to minimize some very difficult problems concerning premiums. Since claim costs can be expected to vary substantially with income, it is necessary to recognize this factor in some way in premium calculations. If the deductible varies with income level at time of claim, there is a substantial offsetting factor for the higher costs associated with higher incomes, which should give greater assurance of reasonableness and adequacy of premiums.
5. The necessity for underwriting rules and restrictions based on income at issue is minimized.

As difficulties associated with variation of the deductible according to income, Mr. Coates gave:

1. Possible uncertainty as to the benefit to be expected, particularly when income is near the point of transition from one level of deductible to another;
2. Greater complexity of its explanation to the agent and applicant, and the possibility that some of the reasons behind it may be difficult to make clear to a layman;
3. The additional complication in claim administration, which may on occasion prove difficult, of determining the income at time of claim.

MR. JOHN C. ANGLE, in commenting on section A, observed that the number of persons now insured under individual and family forms of major medical expense insurance is disappointingly small as compared with the number covered by hospital and surgical expense insurance or by group major medical expense insurance. He ascribed this to the average individual's lack of understanding of the need for major medical coverage and his unwillingness to accept relatively large deductibles with their associated sharing of losses. Although it may be possible to change this attitude, at present the average consumer does not understand the advantage of budgeting for small recurring medical expenses while insuring against the more serious expenses that may be catastrophic.

The continuing demand for insurance covering the normal hospital and surgical expenses of maternity, which insures expenses that can be readily anticipated and budgeted for by the insured, was cited as an example of an attitude deemed unsound and indicative of one of the difficulties in convincing the public of the advantages of major medical insurance.

It was suggested that group major medical expense insurance has been more successfully placed, possibly because of greater familiarity with the subject on the part of the employer or his representative. Moreover, the placing of such insurance is easier when the employer pays a portion of the cost.

In connection with section C, Mr. Angle felt that while Woodmen Accident and Life Company's total in-force, resulting from four years'

issue of individual and family major medical policies, was still too small to provide a reliable index of experience, it would be of interest to present the trend of average claims paid, as shown in the accompanying table, under an additional hospital expense benefit covering the first $100 of miscellaneous hospital charges and 75% of the next $1,200. The claim payments studied cover expenses such as operating room, anesthetics and their administration, drugs, medicines, dressings, diagnostic X-ray examinations, and so on, paid during the first 100 days of hospital confinement. While there was no deductible, the relatively high limit ($1,200) has exposed the insurer to much of the increase in hospital charges that has taken place. It may be noted that the index of such changes has increased more rapidly than that of any other included in the price index of medical care costs of the Bureau of Labor Statistics.

This analysis of trend in claim payments was made by first calculating the average claim paid for various age, sex, and kind of policy classifications according to the Company's experience for 1953 and 1954. Multiplying these 1953–54 claims by the number paid in an age-sex-kind cell for any year gave the expected total claim payment, comparison of which with the actual payment produced a ratio that could easily be translated into an index number.

	Index of Average Claim by Year Incurred (1956 = 100)			Rate of Annual Increase in Average Claim Incurred
	1956	1957	1958	
Individual Policies				
Men	100	114.8	122.2	10.6%
Women	100	102.5	114.7	7.2
Family Policies				
Men	100	101.7	112.4	6.1
Women	100	104.9	111.0	5.4
Children	100	113.8	117.7	8.6

Much of the exposure under individual policies was at ages above 45, while under the family policies it was mostly at the younger, child-bearing ages.

These evidences of continued inflation in hospital claims were offered as an indication of one of the underwriting problems in offering catastrophic expense insurance. Annual increases of the magnitude of 5½% to 10% can create serious problems and indicate a strong probability that major medical premium rates will have to be periodically adjusted. An insurer wishing to change premium rates may have some interesting problems when the

amended rates are to be applied on the basis of the original insuring age and the intervening experience since the issue date has been considerably different from that assumed in calculating policy reserves and initial premiums. We may need a reserve basis that will project future increases in average claim payments in a manner similar to that in which projection factors are employed in establishing annuity values and reserves, as originally suggested by Messrs. Jenkins and Lew.

MR. E. PAUL BARNHART, in discussing section B, stated that, in his opinion, major medical insurance with a low deductible, which he thought of as "comprehensive," offered the most promising means of attacking the problem of insured medical care and deserved more experimentation. He was concerned over possible inroads of socialized schemes and believed that unless private insurers were successful with reasonably comprehensive plans, government would intervene.

He thought that some recent experiments in coverage with low deductibles may have failed because of insufficient consideration of how the first dollars payable to the insured (in excess of the deductible) were applied.

Mr. Barnhart gave as an important question entering into the design of major medical coverage that of whether reliance should be placed solely on the deductible amount and coinsurance factor or whether one should use inside limits, such as those provided by a surgical schedule or by a daily limit for room and board. He believed such limits provided useful controls and helped to eliminate problems concerning income groups and geographical variations, since to a considerable extent, when several plans were available, that one which best fits the circumstances of income and area would be purchased. He also thought that inside limits would be important in reducing the need for coinsurance, which was not fully effective in controlling claims and which often left large amounts to be paid by the insured on those large losses that it was the purpose of major medical to mitigate. He gave as an example expenses of $2,500 on a plan with a deductible of $500 and 25% coinsurance, which would leave $1,000 to be paid by the insured—in itself a catastrophic loss for the average person.

Mr. Barnhart gave as an additional advantage of inside limits the fact that they would reduce the need to rely on determination of what was a reasonable and customary charge for services. A definition using the "reasonable and customary" language is effective, he felt, only in the case of a gross overcharge.

MR. JOHN A. FIBIGER shared Mr. Barnhart's concern over the loss remaining to be borne by the insured in the case of large claims. He stated that his company's present policy provided 75%-25% coinsurance but

that a new policy would be brought out, in which this factor would vary, as the amount of loss increased, from 75%-25% through 80%-20%, and 90%-10%, until, for the portion of medical expenses over $5,000, there would be no coinsurance. This developed out of the Company's limiting its A&S activities to two major areas, rural Middle West and California–West Coast, in which there were rather low costs on the one hand and very high costs on the other, and the Company's desire to liberalize the coinsurance factor without giving up the protection provided in high cost areas. In the new policy, the Company expected to use $500 as the lowest deductible at first, with the hope of lowering it somewhat if experience proved satisfactory. A deductible dependent upon income was rejected because it was thought that agents would be confused and would feel themselves incompetent to explain it.

With regard to the efficacy of coinsurance in restraining abuse, Mr. Fibiger thought that when expenses of more than $5,000 were incurred, there was either a genuine need for full coverage or else an indication of overuse of facilities that would not be curbed by further application of coinsurance.

The new policy referred to above contains inside limits of $1,500 for nursing, and, for surgery, a flat amount that may be replaced by a schedule, depending upon how experience develops. The policy is to be issued through age 60 with renewability guaranteed until age 65, subject to the Company's right to change premiums. However, renewal at the option of the Company after age 65 is contemplated if justified by experience. A desire to integrate life and A&S operations was given by Mr. Fibiger as a reason for not varying premiums by area. He added that the policy would be underwritten cautiously and not issued, at least initially, to applicants with incomes over $25,000.

MR. JOHN W. HUNTLEY, in discussing section I, stated that of the many factors which influence the cost of major medical expense insurance, none is more difficult to reflect in a rate schedule than the relationship between the income of the insured and the amount of medical charges. The higher charges incurred by those in the higher earnings brackets result not only from the practice of many doctors of varying their fees by the patients' ability to pay but also from the higher priced accommodations and services frequently sought by those at the higher income levels.

Many companies now use a flat deductible independent of earnings and provide for this variable by setting rates at a level adequate for an assumed distribution of incomes—an "averaging" concept that penalizes the lower income group. Studies of major medical expense claims indicate that, for the insured in the $10,000 to $15,000 earnings bracket, the total

charge, including that for accommodations and services, is over twice that for an insured in the less than $5,000 bracket.

Mr. Huntley expressed the opinion that the soundest and most equitable method for handling this problem involves the use of a deductible which varies according to the insured's income at time of claim. Such an approach attempts to provide the same amount in claim dollars for a given disability in each of the varying earnings brackets. He also believed it to be a much safer method, since using a flat deductible can result in adverse claim experience if the actual earnings distribution is appreciably higher than the assumed distribution. Such variations are difficult to avoid and even companies which set an earnings limit, above which they will not issue, may soon find that salary increases have disturbed their original assumptions. In major medical expense policies currently issued by The Travelers, the deductible is based on the combined incomes of the insured and spouse for the last completed income tax year preceding the date of the first charge used to satisfy the deductible amount. In one policy it varies from $500 for incomes under $7,500 to $1,400 for incomes of $25,000 or more.

Although believing this to be the soundest method of recognizing this factor, Mr. Huntley noted certain objections that have been raised and suggested answers. Some agents have complained that because of the larger deductibles at the higher income levels, the policies were not competitive with those having a flat deductible. However, in such cases, the insured receives approximately the same amount of claim dollars as the insured in a lower bracket and, in addition, will usually have a substantial basic policy, so that he may have little, if anything, to pay out of his own pocket. It has also been objected that the insured would be reluctant to reveal his income tax return, but Mr. Huntley knew of no case in which his company had required it, although the right to request proof of income had been reserved. Opponents of the plan have also complained that with a variable deductible, the insured cannot know at issue what he will receive on a claim. However, the policy clearly states the amount applicable to each income bracket and the insured should be able to make a reasonable estimate of his future annual income.

Mr. Huntley stated that since use of the variable deductible permits one to charge the same premium for all economic classes, the company avoids the risk of an unfortunate guess as to distribution of claimants by salary brackets and is able not only to preserve individual equities but also to avoid adverse experience arising from incorrect assumptions. He thought that if the public and one's agency force could be brought to an understanding of the underlying principles, major medical expense

insurance could become desirable from the company's standpoint and a good investment from that of insureds in all economic classes. Although the concept of a variable deductible was not original with The Travelers, Mr. Huntley said they were much impressed by it. They were pleased to note its recent adoption by other companies and had received several inquiries concerning details of their program, which were welcomed as they were glad to share their thoughts with interested companies.

MR. IRVING ROSENTHAL remarked that since his company, the Guardian, was the first to guarantee renewability of major medical insurance for life, he felt obliged to answer the question of section E; that is, whether it can be done safely. He thought that it could be if there were a willingness to face a long period of trial, error, and correction, and that the risks were no greater than would be involved, for example, in setting up a pension plan for a firm in the field of atomic energy, where many factors such as mortality, disability, turnover, or the future of the industry were unknown in advance. Reliance would be placed on conservative assumptions and the opportunity to follow the experience and make whatever changes were indicated.

He agreed with Mr. Coates that the heart of the matter was the right to change premiums, particularly in view of the problem of long range price inflation. He was concerned over the effect on lifetime coverage of large increases in the price level, such as a doubling or trebling, and regarded the right to change premiums as the most important safeguard in such an eventuality. However, it is necessary to contemplate the unpleasant possibility of having to increase premiums charged persons who are over age 65 or are retired and whose incomes are limited, and, while some shifting of the burden to the younger ages might be possible, the problem, he thought, was the most difficult that must be faced.

Mr. Rosenthal believed that, in addition to the right to increase premiums, other safeguards against inflation were needed and gave that as the main reason for favoring a deductible varying with income, although the latter would not generally be effective after age 65, since the income of retired persons would be unlikely to increase. He considered the provision for inside limits an additional safeguard against inflation and next in importance to the right to increase premiums, and he endorsed Mr. Barnhart's remarks in this connection. Mr. Rosenthal doubted the effectiveness of coinsurance, particularly in case of an inflationary rise in prices and, while recognizing that the existence of inside limits might seriously impair the pattern of benefits in the event of inflation, felt that they were an essential and powerful safeguard.

MR. MORTON D. MILLER called attention to the question of dupli-

cate coverage and overinsurance, which, he recognized, had broader application than solely its relation to major medical expense insurance. He and others working with doctors and hospitals realized that there was an increasing difficulty in relations with them, since they could not understand why the insurance industry does not take steps to prevent persons from having one or more policies under which they can collect more than the medical expenses charged to them. While something can be done in connection with initial issue, Mr. Miller feared that even there insufficient effort was being made to ascertain the type and extent of existing coverage at the time of application. He pointed out that even if as much as possible is done initially, there remains the important question of what is to be done later when dealing with insurance that covers the whole range of medical care cost and is guaranteed renewable for life. The answer to this serious question can no longer be sought in refusal to renew, as was formerly possible under so-called commercial policies when overinsurance was discovered at time of a claim. The insurance laws are of little help and may require some modification.

Mr. Miller referred to the possibility of a Commissioners' committee to study overinsurance. In his company, the Equitable, which plans to issue policies guaranteed renewable for life, the thought has been to explore with the insurance departments the possibility of their approval of a clause that would base prorates on the total medical expense. Such a clause would contemplate full coverage of such expense among all companies, with the particular company prorating its benefits on the total and returning some appropriate portion of a year's premium. They expected to try such a clause in a future filing and, while he could not predict reactions in the various states, he urged that more thought be given to the problem and emphasized its importance in the establishment of satisfactory relations with hospitals, doctors, and others in the medical profession whose cooperation is necessary if health insurance is to be successful over a period of time.

MR. JACK A. SINGER stated that during the $2\frac{1}{2}$ years that the Prudential had been in the individual major medical field, their over-all morbidity experience had been within the limits anticipated and that, in analyzing the experience by area, they had not found any trouble spots. However, they were checking it at the end of each quarter for any unsatisfactory trend.

With regard to limitations in coverage for mental illness, Mr. Singer mentioned that when his company was drafting their major medical policy, which was first issued in March 1957, many companies had a complete exclusion of mental illness. They felt that this was contrary to the basic

idea but, knowing of unfavorable experience under group major medical coverage, felt that some limitation was needed. They considered limiting coverage to those cases in which total disability had existed for a specific period, but this was objected to because of the obvious difficulty of establishing the existence and duration of such disability. It was finally decided to pay benefits for mental illness or functional nervous disorders only during hospital confinement as a resident in-patient. During the 2½ years of sale of the coverage, this limitation had proved quite satisfactory.

In discussing section G, Mr. Singer classified the underwriting problems of major medical coverage into three main types.

1. *Existing coverage.* Some difficulty was found not only in obtaining the facts from the applicant about existing coverage but in their evaluation when received. Failure to admit coverage may sometimes be intentional but may also be due to the applicant's lack of knowledge as to the nature of benefits under his existing policies. To evaluate the facts, rules had been set up to cover cases in which other major medical or a specific daily hospital benefit was in force but a problem arose with respect to various miscellaneous benefits for which rules could not easily be derived.
2. *Income bracket.* Since people with higher incomes can provide for in their budget, and generally incur, higher medical expenses, Prudential issued major medical expense insurance with three different deductible amounts, $200, $500 and $1,000, depending on the applicant's income. Unfortunately, accurate information about the applicant's income cannot always be obtained and there was a suspicion that, in some cases, policies with the lower deductible amounts were being issued to families whose incomes would call for the higher amounts.
3. *Failure to admit health histories.* The tendency of doctors to minimize the importance of certain illnesses for the patient's peace of mind often caused the applicant to omit mention of an illness in the application, whereas some of these illnesses, such as skin disorders and nervous conditions, could be very significant in underwriting major medical insurance.

Mr. Singer said that his company was aware of four types of claim problems in connection with major medical expense insurance, as follows:

1. *Unreasonably high medical fees.* As expected, claims had revealed quite a few examples of medical fees considerably higher than the company would consider reasonable. This applied mainly to fees for surgical procedures but in some instances to calls at the home, hospital, or office. When the claim department thought that a fee was out of line, the matter was referred to the medical department, and if the doctors felt that the fee should be questioned, a representative of the home office called on the doctor submitting the bill and discussed the nature of the services performed and the special problems involved. Occasionally one of the company's doctors entered into the discussion. An effort was made to explain the nature of the policy in the hope of convinc-

ing the insured's doctor that this type of insurance is valuable if charges are approximately the same as they would be if the patient had no insurance. In a fair percentage of cases the doctor agreed to reduce his fee but in others insisted that it was what he would charge a patient of the same income bracket, often referring to services rendered without charge in clinics. In view of the obvious expense of this procedure, it was resorted to only when there appeared to be a good chance of effecting a substantial reduction in the bill.

2. *Calculation of benefits.* Because of the necessity for such safeguards as deductibles, time limits, etc., in the issue of major medical expense insurance on a sound basis, the calculation of benefits is considerably more complicated than in the case of a regular hospital expense policy. Mr. Singer said that efforts had been made to keep this problem to a minimum by using special forms designed to guide the user as much as possible, but that nevertheless the cost of administering claims under major medical policies remained high when compared with that for other plans of insurance.
3. *Higher claim rejection rate.* Mainly because of the deductible and the manner in which it has to be satisfied, a higher rate of claim rejection was being experienced under major medical than under hospital policies. This could probably have been anticipated, since the insured might find it difficult to know if the deductible amount had been satisfied—if he did, in fact, try to find out.
4. *Overusage of certain benefits.* There was a suspicion of overusage with respect to some benefits. For example, the company pays for 75% of the expense of private duty nursing care in the hospital, once the deductible amount has been satisfied, and it appeared that the insured had taken advantage of this service (at relatively low cost to himself) in cases where the illness was such that the company would not expect private nursing to be required. The cost of drugs is another benefit which might be abused, although the company required that they be "deemed necessary by a licensed physician." Benefits under their policy were paid for "Benefit Periods with respect to *one sickness or injury* . . ." and they suspected that payment for drugs for one sickness might occasionally cover those for another. Overpayments in each case might not be large but could be significant if the volume were great enough.