

Group Accident and Health

A. Premiums

1. To what extent have companies found it advisable to vary premiums for basic hospital, surgical, and medical coverages by area, sex, age, and income? Are frequencies as well as charges and durations assumed to vary? Do maternity premiums vary by age?
 2. What are the considerations in the development of accident and health volume discount tables? Is the volume of life premiums to be considered in determining discounts? To what extent does prior experience affect the applied discount on transferred business?
- B. What factors are appropriate for the projection of accident and health experience on a given case for succeeding periods? Do these factors vary by coverage and type of benefit? Do the factors include the effect of increasing frequencies, changing durations, as well as inflationary changes? What adjustments might be made to known claim experience to reduce the effect of extremely large claims, especially those due to accident?
- C. What has been the effect on claim experience of basic hospital, surgical, and medical coverage of the introduction of deductibles, limiting clauses on mental and psychiatric claims, and nonduplication clauses? Has the addition of out-of-hospital benefits materially affected in-hospital utilization?
- D. What has been the experience with regard to insurance for persons over age 65?

Jacksonville Regional Meeting

MR. THEODORE J. KOWALCHUK: With regard to section A, at the United States Life for groups of over 25 lives we vary our premiums for all basic medical care coverages by age and by sex. First we calculate a composite employee age factor based on the age distribution of the employees. This is determined from the following factors:

Age of Employee	Age Factor
Under 45	0.70
45-59	1.40
60 and over	2.40

An employee factor based on this composite age factor and on the female percent is then applied to the basic employee rates. Similarly a dependent factor based on the composite employee age factor is applied to the basic dependent rates. The tabulation on page D287 is an excerpt from the table we are using.

The employee and dependent factors reflect the lesser variation by age of female claim costs than male claim costs. The dependent factors also take into account the fact that younger couples tend to have a greater number of dependent children than older couples. However, because our

loading for female exposure is insufficient for a group written with surgical but not hospital coverage, we would apply an additional loading in such circumstances if the group is very large and the female percent very high.

For maternity coverage for both basic and comprehensive major medical, we compute the percentage of employees who are under age 45 and then apply this percentage to our basic maternity rates.

Five months ago we began using hospital area factors which take into account variation by frequency, duration, and amount of miscellaneous charges, by area. We apply these factors to our total basic hospital premium. The differential between areas where hospital utilization rates are highest and areas where they are lowest is 30 percent.

Our volume discount table is based on only the total health premium, but we are considering changing the table to base it on the total life and

COMPOSITE AGE FACTOR	EMPLOYEE FACTOR			DEPENDENT FACTOR
	Female Percent			
	0-14	15-24	85-100	
0.70-0.89	90%	95%	130%	95%
0.90-0.94	95	100	135	98
0.95-1.04	100	105	140	100
1.05-1.09	105	110	145	103
1.10-1.14	110	115	150	104

health premium. For transfer cases we determine our rates in the light of both the past experience of the group under consideration and our probable retention and margin requirements. One of the steps in the determination involves the application of a trend factor to the claims to attempt to forecast the claims for the next policy year.

Turning to section B, in projecting health experience on a given case for the next policy year we apply a credibility factor, and, in the case of medical care, a trend factor to the actual experience in the current year. Our credibility factor is based on the number of lives in the group and varies by coverage. Credibility is greatest for weekly indemnity and basic medical care coverages. Our trend factors, which we hope are adequate to take into account both increasing utilization and inflationary changes are 5% for basic medical care and 10% for either comprehensive or supplementary major medical.

If we learn that a particular group had adverse claims experience due to an accident or a large claim paid to an individual no longer in the group,

our renewal action is more favorable than if the poor experience was due to a number of smaller claims. Although our formula does not take into account experience in years prior to the current year, we take such experience into account on a judgment basis.

MR. JOSEPH W. MORAN: For each group of 100 lives or more, we predict the most likely ratio of incurred claims to manual premium at our current manual rates for new business. The first part of this prediction is an estimate of the "standard" claim ratio at manual rates, for a hypothetical average group, for each of the coverages included in the plan, for the particular calendar period involved. The second part of the prediction is an estimate, for this particular group, of how far above or below "standard" its own claims are likely to be.

1. To estimate the standard claim ratio for a particular coverage for the coming year, we compile bulk claims data for that coverage for several hundred cases for each of the last several years, and convert the premiums actually charged to corresponding standard premium amounts at present manual rates. By observing the patterns of increasing claim ratios over the past several years, we estimate the average annual effect on claims of upward trends in costs and utilization of medical facilities. The standard claim ratio for next year is our current estimate of the standard claim ratio for this year, plus a year's trend differential.

Currently, these trend differentials in claim ratios at manual rates are estimated at 3% to 5% for the various basic hospital-surgical-medical coverages, about 10% to 12% for supplementary major medical coverage, and about 7% to 9% for comprehensive major medical plans. These differentials presume an annual recomputation of the manual rate for each group; on the average, changes in census data during the year result in a 3% increase in the manual rate for major medical coverage from one year to the next. Thus the estimated trend differentials in major medical claims levels themselves for the average group would be about 3% higher than the differential in claim ratio to manual rates.

2. For each group we maintain a continuing record of its actual claims history and a parallel hypothetical history of standard claims. From the experience ratios of actual to standard claims computed for each of the last several years, we note the level of these ratios, their stability, and whether there is any trend upward or downward.

Ideally, each of these factors should be reflected directly in the prediction of the experience ratio for the coming year. In practice, we rely heavily on formulas, based on volume of exposure, to determine the weighting of each year's data in computing the cumulative experience ratio for the

group and the credibility factor to be applied to it in predicting next year's experience ratio.

The following table illustrates one scale of credibility factors¹ which might be applied to a group's observed actual experience ratio in predicting the most likely experience ratio for the coming year, and relative weights which might be applied to current and prior year experience in determining a cumulative experience ratio:

	NUMBER OF EMPLOYEES INSURED		
	100	300	500
A. Projection based on 1 year's experience			
Credibility factor for actual experience.....	31%	57%	69%
B. Projection based on 3 years' experience			
1. Credibility factor for actual experience....	59%	77%	81%
2. Weights assigned to experience for			
a. Latest year.....	25%	42%	56%
b. Prior years.....	34	35	25
C. Projection based on 5 years' experience			
1. Credibility factor for actual experience....	66%	79%	82%
2. Weights assigned to experience for			
a. Latest year.....	20%	38%	55%
b. Prior years.....	46	41	27

We do not attempt to predict claims experience for a single policy year for a specific group of under 100 lives. The reason is that claims experience fluctuates so violently from year to year on these groups that previous experience is not a direct indicator of next year's claims experience.

This is demonstrated by a recent study comparing experience ratios of actual claims to standard claims for the current policy year on about 900 cases of less than 100 lives with cumulative experience ratios for all prior years combined for the same cases:

Type of Coverage	Number of Groups	(A)	(B)
Basic Hospital-Surgical-Medical only..	304	.633	.27
Basic HSM and Supplementary Maj. Med.....	123	.629	.26
Supplementary Maj. Med. only.....	148	1.201	.06
Comprehensive Maj. Med. only.....	320	.555	.20

Column (A) is the standard deviation of experience ratios (about a mean of 1.000) of actual claims to standard claims for the current policy year.

Column (B) is the coefficient of linear correlation between cumulative experience ratios for all prior years combined and experience ratios for current policy years.

¹The statistical reliability of these factors has not yet been tested adequately.

We use a group's past claims experience ratio only as a basis for evaluating it as average, $x\%$ below average or $x\%$ above average. A fairly reliable prediction may be made of the *aggregate* experience for the coming year on all small groups with similar evaluations, even though no attempt is made to predict experience for any of them individually.

MR. TED L. DUNN: At the Provident Life we recently adopted new manual rates for hospital expense benefits in which the premiums for basic miscellaneous fees vary by cost area. Our manual premiums for hospital daily room and board charges, surgical, medical, and maternity benefits do not vary by area.

In our new hospital manual rates the spread in the rate for female content was increased a little and is now 3.5% for each female content bracket rather than 3%.

We have, for a number of years, used an age loading which depends on the percentage of insurance on employees age 65 and over. No loading is applied if the percentage of insurance on employees age 65 or over is less than 5%. The amount of the age loading is determined by applying a percentage loading to the less than 11% female excluding maternity employee rate. The dollar amount of the loading also applies to dependent benefits, except that no age load is applied on dependent hospital and surgical benefits when the plan provides for hospital and surgical care in maternity cases.

I believe that in developing volume discount tables one should take into account the number of employees, the average premium per employee and the margins desired for expenses, risk charges and claims fluctuation. Further, the premiums to which the volume discounts are to apply should be combined for both experience rating and commission purposes.

A formula which expresses these considerations is as follows:

$$\text{Percent Volume Reduction} = 100\% - \frac{R + E}{.9},$$

where:

R is the expected loss ratio percent of incurred claims to manual premiums,

E is the expense and risk charge requirement as a percent of manual premiums,

.9 is a factor so that the margin for chance fluctuation of claims will be 10% of required net premiums.

This same type of approach may be used to develop the loading to apply to groups having a very low average monthly manual premium per employee.

At the Provident we have three volume discount tables with the first table being constructed along the lines of the formula given. The second and third volume discount tables apply where the employer contributes a substantial proportion or all of the premium. Slightly greater volume reductions are granted on the assumption that the expected ratio of incurred claims to manual premiums will be a little lower on such cases. However, the second and third volume discount tables do not apply to multiple employer groups, voluntary employer association groups, or union-negotiated trustee welfare plans.

The life premium volume is considered along with that of group accident and health coverages in determining volume discounts. In states having minimum first year premium requirements the volume discount applicable to the employee group life insurance is determined separately from the Commissioners' Method volume reduction formula. The discount applicable to the employee life insurance premium under group policies issued in other states may be determined from the Commissioners' Method volume reduction formula where it develops a more favorable discount than our usual volume reduction tables.

On transferred business we almost universally quote rates based on the prior experience, together with a margin for claim fluctuation. Thus, the possibility of granting a volume reduction rarely comes up on transferred business.

As for section C, we use basic plan hospital deductibles of the order of \$15 to \$35 generally applied to both employee and dependent benefits. We have some 215 cases in force with deductibles covering around 120,000 employees and we have seen some tremendous reductions in claim costs and some astounding reversals of experience on large cases. Apart from the saving just from the application of the deductibles themselves there appears to be a definite deterrent effect arising from the introduction of some element of coinsurance. Further, we feel that a deductible slows up the rising trend in claim costs from year to year.

MR. WILLIAM V. HAUKE: Because there is so little demand for them, we at the Continental Assurance Company do not offer in our rate manuals base plans with deductibles. We have, however, upon request used deductibles in lieu of rate increases on existing groups. They have not been nearly as effective in reducing claims costs as had been hoped, probably because of the low level of deductible which is acceptable to policyholders and because most base plans already included a substantial element of coinsurance because the level of benefits was below the cost of care.

Deductibles are more easily applied to blanket benefits than to scheduled ones. They are most commonly applied to hospital extras, with the excess, if any, applied to room and board. Although we feel they should be applied to out-patient as well as in-patient benefits we find quite a bit of resistance to this approach. The same can be said for surgical, medical, X-ray, and laboratory benefits. The deductible is applied per confinement, using the same definitions as in respect to room and board. The deductible might or might not be applied to maternity confinements, depending on the reduction in cost desired.

We find that the application of a deductible to a base hospital plan on which is superimposed a major medical plan with a corridor deductible increases the complexity of the plan from a claim point of view and is likely to lead to misunderstanding and dissatisfaction on the part of the insureds and claimants.

Limitations on "mental and psychiatric" claims in major medical coverages have arisen from our experience that this type of claim sometimes results in excessive usage and in unreasonable charges. Most of these limitations are geared to physician or psychiatrist services, and generally for out-of-hospital care. In base plans, out-of-hospital benefits are generally set very low in relation to the going charges for psychiatric care and hence abuse is minimized and restricted. The major areas of concern in respect to "mental and psychiatric" claims in base plans are the rest homes and sanitariums that questionably meet the definition of hospitals and secondly the "tax supported" public institutions. Although our contracts do not provide coverage in these instances we are finding it increasingly difficult to maintain our position.

If a nonduplication provision makes sense in major medical coverages it makes equal sense in base plans, since both types of coverages provide benefits to the claimants and these benefits could conceivably exceed their expenses. The major differences between base plans and major medical plans lie in the methods, formulas, limitations, etc., applied to determine the number of dollars the claimant receives. An overinsurance problem may arise under either plan. Therefore, as a matter of consistency with major medical and as a matter of self-protection, it seems to me that nonduplication clauses should be included in base plan contracts even though they would present almost impossible problems in administration.

We hear from many sides that the way to reduce the number of in-patient hospital cases is to provide more extensive out-of-hospital care so that it will no longer be less expensive for a claimant to receive care as an in-patient. While it is certain that a reduction in the number of confinements would result in some savings, let us not be deluded as to their

extent. A decrease in the rate of occupancy of a hospital would not produce a proportionate decrease in hospital personnel costs and would result in little or no decrease in overhead and administrative costs. It appears to me, therefore, that a substantial part of the hospital claims savings which we would enjoy immediately would come back to us later in the form of higher charges for those claimants who do require confinements.

As an industry, therefore, I think we should consider seriously the effects of such a radical change in benefit structure on the over-all cost of health care before we blithely accept it as the long awaited panacea of our business.

MR. PAUL E. SINGER: With regard to section D, the "65 Plus" basic hospital program of the Continental Casualty Company is beginning to provide a substantial amount of statistical information on the costs of insurance for persons over age 65.

For purposes of our preliminary analysis, exposure during the 7th through 18th policy months was used to eliminate the effect of the 6 month probation period and to eliminate seasonal variation; only policyholders with effective dates more than 18 months prior to the cutoff date of the study were considered. The exposure base was found to be approximately 150,000 life years; the sex distribution was 39% male and 61% female.

The over-all annual frequency of hospital confinement was .29 for males and .25 for females; average hospital stay was 11.2 days for males and 11.7 for females (subject to the policy limit of 31 days). This pattern of higher claim frequency for males but approximately the same cost or severity per claim was typical of all benefits in the program (room and board, miscellaneous expenses, surgical schedule). As a result, the over-all cost for male lives was approximately 16% higher than for females. This represented a consistently higher cost for males in every age bracket, offset slightly by a higher average age for female lives (75 against 74 for males). The greatest disparity between male and female lives was in the cost of the surgical schedule, where the claim frequency for males was 1.26 times that for females; the average surgical benefit was 7% higher for males with a resultant surgical claim cost 1.35 times that for females.

Some data on more costly claims are beginning to be available from the experience under the "\$5,000 Reserve" catastrophe hospital plan, a companion policy to the 65 Plus basic program. This policy covers hospital expenses in excess of \$500. The imposition of the \$500 deductible reduces claim frequency under this program to .10 or about 40% of the frequency for first day confinement under 65 Plus. The average duration of hospital

confinement satisfying the \$500 deductible is nearly 40 days and the average number of days required to satisfy the deductible is approximately 8. Unfortunately this catastrophe hospital program is a poor source of statistical data because the \$500 deductible produces a severe distortion in the distribution of most parameters. However, for claims which satisfy this deductible—generally the claims of longer duration, although some qualify by virtue of high per diem cost—the split of benefits between room and board and miscellaneous is almost exactly two to one.

Chicago Regional Meeting

MR. IRVING S. WOLFSON: Ever since major medical was first introduced we at the Massachusetts Mutual have been very much concerned over the difference in manual premium costs between very similar plans such as comprehensive major medical and a combination of base plan and superimposed major medical. Even after achieving consistency among the various component rates we would find that for a particular type of age distribution the cost of one plan would differ markedly from the cost of a different program of benefits even though the actual benefit payments were very, very similar.

For this reason, about two and a half years ago we introduced the concept of complete age rating in all of our basic plans with the age recognition being essentially the same as that we utilize in our comprehensive major medical rating.

It is surprising that not more companies have followed this approach, as I think it is clear from almost every study that has come out in the last two years that the effect of age is very substantial on hospital costs, for example, and yet most companies seem to have ignored this in their basic rates. Perhaps this is due to the feeling that the effect of age on maternity costs might offset the age effect on nonmaternity coverage. This is actually very close to being true so far as dependent coverage is concerned but is very far from being true for employee coverage. Incidentally, we apply age rating regardless of the size of the case, although I understand that one of the large companies is proposing to do it only for cases of less than 50 lives.

We also recognize sex in the computation of our premium rate since it costs more to insure females for most types of coverage. At the same time, because the effect of age is different depending on whether males or females are being considered, the amount of loading which we apply to our base rate is determined by the combination of the female percentage and the age distribution rather than by treating these two cost factors independently.

We have given only modest recognition to area insofar as base plans are concerned, although we feel that perhaps more should be done in this respect. The only way in which we have so far recognized area is to apply an additional loading in the event that the room and board benefit for the particular area is too low. We were one of the first companies to use this approach to offset the otherwise distorted cost of other ancillary charges if a small daily room and board benefit was written in a high cost area.

Income we have ignored completely as far as base plans are concerned, although we treat it heavily in major medical plans. It is our belief that income affects primarily the level and type of charges and consequently is not an important variable for the type of scheduled benefits such as are contained in typical base plans.

MR. WILLIAM CUNNINGHAM: In Pacific Mutual we have recognized age, sex and area since 1957. We took advantage of this because about 50% of our business comes from the State of California, and as you know, this is not one of the low cost areas in the United States.

Age and sex information on every employee is obtained and factors by sex in 5 year age groups are applied to our basic rates. Ten different areas are recognized. The area and age-sex groups are the same for basic, super-imposed major medical and comprehensive major medical, but different factors are used for these types of medical plans.

For basic medical, the age-sex variations are not the same for the various subcoverages—for example, the age factors for hospital benefits increase more rapidly than for surgical—but for practical purposes we derive a set of composite factors for basic medical by assuming a percentage premium distribution for the different benefits, hospital, surgical, medical, etc.

We have found it essential to vary maternity premiums by age and we feel that only by bringing the age-sex factors into consideration is it possible to obtain a proper relationship between actual and expected claims for underwriting purposes.

MR. LINCOLN C. COCHEU: One of the large fire and casualty companies with whom I was talking recently informed me that they were basing their rates solely on the proportion over-age and that male and female content was taken into account only in that 35 or more is considered over-age for women and 45 or more for men. In this way they have leveled out their losses from group to group very markedly. Competitively they have found themselves at a disadvantage on older groups but are showing excellent loss ratios on younger groups.

An interesting by-product of their investigation is that it appears un-

necessary to apply an industry rating. Practically all the standard industry ratings which were looked upon as poor risks for accident and health are in reality the result of over-age groupings.

MR. E. PAUL BARNHART: In the Washington National we have been feeling for some time that more detailed consideration ought to be given to factor adjustments on our basic hospital-surgical-medical coverages. In fact, we are going to be forced to do something about this because of the rating formula we follow in providing supplementary major medical coverage.

In arriving at our supplementary major medical premiums we have been introducing income factors, age distribution factors and area factors on a fairly detailed basis and then giving credit for the particular basic coverage that existed on the group. As this basic coverage was not being adjusted for some of these variables, we found rather frequently that the resulting premium for the supplementary coverage was growing pretty inconsistent. Because of this inconsistency we have, on occasion, had to abandon our normal formula entirely. This is forcing us to give renewed consideration to age, possibly income and other factors, on basic hospital-surgical-medical.

With regard to jumbo claims, for short-term projections on the smaller cases we have been using a cutoff technique by which the excess loss over, say, \$400, \$600, etc., depending on the size of the group, is not charged against the policy. This is done on an individual claim basis so that there is the advantage of charging the group with the frequency of claim but not the excessive amounts. For long-term experience or projecting experience in larger volume or over several years we have either to charge these jumbo claims directly or make some excess loss charge in place of them.

MR. RICHARD H. LOEBER: Referring to subsection 2, at the Aetna our manual or standard premium rates for Accident and Health coverages are computed so as to cover expected claims and expenses for the minimum sized policies written, assuming that a "normal" amount of premium per life will be developed. Since expenses, expressed as a percentage of the premium, reduce as the size of the premium increases, it is appropriate to offer lower initial premium rates for larger sized groups in order to reflect the lower proportion of the premium which will be required to provide for the expenses of operation. Each year we analyze our expenses of operation and make any adjustments which are indicated in our experience rating expense formulas. Our scale of volume discounts reflects the relative differences in our experience rating expense ratios for various sized

cases. These volume discounts vary from 2% to 17% and depend not only upon the total premium volume for the case but also upon the average premium per life. This system recognizes that the expense percentage of premium varies according to both the total amount of premium for the case and the average amount of premium per life.

In order to further take into account the effect that the average premium per life has on the expense percentage of premium we have also constructed a table of percentages by which the manual premiums will be increased if the average premium per life is very low. These loadings apply only to smaller sized groups covering between 25 and 300 employees. Again, this is a two-way table and the loading increases both as the size of the group decreases and as the average premium per life decreases.

Because our volume discounts apply generally only to groups with fairly high average premium rates per life or to groups containing a substantial number of employees, we consider that the volume of life premiums contained in a package plan would have little effect in determining the volume discounts for the accident and health coverages. However, in the area where premium loadings are required because of the low average premium rate per life the reduction in expense percentage of premium because of combining with life insurance becomes significant enough to be taken into consideration. Accordingly, we take account of the life insurance premium only where a premium loading is required. While it can be argued that the existence of life insurance in the package plan provides a greater spread of risk, thus justifying lower billing rates, our volume discount table is based only upon considerations involving the relative expense levels of various sized groups.

For transferred business involving 25 or more employees in the group, the Aetna requires a complete description of the plan of benefits previously in effect together with the premium rates in force, the premiums collected, and the paid and incurred claims for the two most recently completed policy years. This information allows us to determine what the experience has been in relation to our manual premium rate structure, and our premium rate quotation will then be made on the basis of expected claims for the group, including a deterioration factor for health insurance coverages together with our expense requirement and a margin for fluctuation in claims. In no event will the quoted rate be less than our appropriate manual premium rate with advance expense adjustment. For life insurance we will also investigate the past experience, but for smaller groups the rate quotation will be on the basis of the minimum rate according to our New York filing. For larger groups we may quote a somewhat higher rate if the past experience indicates the need for it.

MR. SIMONE MATTEODO, JR.: At the Equitable we revised our volume discount tables for accident and health in June of 1961. The major considerations involved are the expense requirements by size, claim fluctuation margin by size, and competition.

As compared with our old premium volume reduction scale, there are the following differences. The new scale ranges from 0% to a maximum of 25% compared with the old scale range of 0% to 18%. For all but the smallest cases the new scale recognizes directly the expense savings inherent in simplified premium and claim administration. Thus, the new scale allows an additional 2% if simplified premium administration is used and an additional 2% if the employer is responsible for most of the claim administration. Finally, because of the lower expenses and the different expense gradients by size, we use a modification of the basic scale for the loss-of-time coverage.

We make allowance for group life insurance in determining volume reduction. For the larger premium volume, expenses amount to a lesser percentage of total premium and, in addition, a lower margin for fluctuations is required.

On transferred business, our premium rate basis is geared to recognize prior experience. Thus, we do not adjust our volume reduction scale.

Regarding section B, at the Equitable we use projection factors for two purposes. The first purpose is to project past experience used in determining a rate level for new business premiums to be used in the future. The second purpose is to project an individual case's past experience into the future. This latter occurs for both existing cases and transferred cases when setting prospective premium rates. We are using the following factors:

Coverage	Inflationary Factor, per Year
Basic insurance, including hospital, surgical, and medical coverage..	4%
Comprehensive Major Medical.....	8%
Base plan and Major Medical, combined.....	8%
Supplementary Major Medical.....	12%

The factor for basic insurance agrees approximately with trend tables published by the Society of Actuaries in the Reports under the section for group morbidity experience. The factors include the effect of increasing frequencies, changing durations, and inflation.

These factors vary by coverage as indicated above; however, we have not recognized the type of benefit.

MR. DON F. FACKLER: With regard to section B, following is a partial list of factors which should be analyzed in an attempt to project experience for the succeeding period:

1. The historical loss ratio experience pattern for at least the past three years.
2. Analysis of any changes in the plan during this period or contemplated change on the present anniversary.
3. The development of an average cost per claim incurred.
4. An analysis of claims either by percentage, by number of claims, or amount paid, between accident and sickness.
5. A thorough review of all large claims. The claims selected for review should be chosen by a predetermined method either as a percentage of total premiums or by size of claim.

In addition to the above factors, weight should be given to the exact geographical location of the group and whether there have been increases in medical costs exceeding the average inflationary factor. This inflationary factor, which varies by coverage, should similarly be taken into account in setting future rates.

However, as an additive to developing loss ratios by coverage, it is important to discern whether unscheduled benefits are being held in check. Particularly susceptible to inflationary increases are special charges under the hospital coverage and various areas under major medical, depending upon limitations which are presently in effect. Obviously, some of the above factors play a greater influence on a particular coverage than on other coverages. In any event, the expense involved in gathering the data must be weighed against their use.

In reply to the last part of section B, individual judgment must be used as to exactly to what extent this type of claim should be included in the experience for determining underwriting action for succeeding years. If it can be determined that the claim is unlikely to recur, then obviously it could be completely ignored. However, this appears to be rather foolhardy since a repetition is always possible. It would undoubtedly be better to assume some type of credibility for this claim and weigh it less in determining the loss experience than the actual amount involved. Determination should also be made as to whether the claim is completed or merely in its embryo stage.

Turning now to section C, it has been our general policy in the Lincoln National not to impose limitations on basic coverages for mental and psychiatric claims and not to include a nonduplication clause. However, at times, we have introduced deductibles on specific coverages in order to alleviate the rate increase and stem the increasing loss ratio. This ap-

proach must be used carefully and generally has its place in those instances where the unfavorable loss ratio results from over-all poor experience, rather than from a limited number of large claims. We normally calculate the savings by the introduction of a deductible in specific areas by determining from past experience the actual amount of savings. We are hopeful that this is conservative since the larger financial participation by the claimant should discourage overutilization of the facilities.

Although we have no statistical information to back this up, it is my personal feeling that the addition of out-of-hospital benefits materially affects in-hospital utilization. This is most noticeable with the introduction of diagnostic X-ray and laboratory benefits which alleviates the necessity of being hospital-confined to secure payment. In contrast, I do not believe that the payment of doctors' services out of the hospital materially influences hospital utilization.

Normally, we have had favorable claim experience on cases where deductibles have been introduced. The major problem seems to be in selling the deductible, since it is too easy to effect a transfer to another carrier who is willing to disregard the previous experience and write the same plan at essentially the same rates which proved inadequate to us.

MR. WILLIAM V. HAUKE reviewed a discussion on section D presented by Mr. Paul E. Singer at the Jacksonville regional meeting.

MR. RAY M. PETERSON: I would like to pass on to this group a question which was directed to me by a professor of insurance who is not sympathetic with the King-Anderson Bill. He asked why the insurance companies are not extolling the value of group life insurance to cover the health care costs of final illness. How much of group life insurance goes to pay the cost of health care in the final days? I didn't know the answer.

DR. ALAN A. GROTH: If I remember correctly there were figures published a few years ago that were around \$600 to \$700 for final illness.