RECENT TRENDS AND INNOVATIONS IN INDIVIDUAL HOSPITAL INSURANCE

BY

M. EUGENE BLUMENFELD

One of the nation's leading multiple line insurance companies underwrites almost every conceivable type of personal insurance. The major exception is Accident and Health insurance. The agents of this company pride themselves on their complete coverage for any hazard except accident and sickness. Most of these men will not even advise their clients where to obtain such protection. This attitude stems from the belief that an accident and sickness policyholder will eventually become dissatisfied with his company. If he has no claim, he feels his money has been taken for nothing; and if he has a claim, he feels he has not been fully compensated for his loss. Why risk losing a man's auto, fire, and personal liability premiums by trying to provide a type of coverage which is not profitable anyhow?

Recent occurrences, such as governmental restrictions and programs providing medical care for large groups of our population, plus a trend toward excessive use of medical facilities when the cost is to be borne by an insurance company, have not weakened the position of the carrier mentioned above. Why then, are so many insurance companies making optimistic plans for the future in the field of Accident and Sickness insurance?

To attempt to answer this question in detail would be quite a task. There are so many phases of the Accident and Sickness field that it would require a whole book to study each one. There is Group insurance, Credit insurance, Special Risks including Travel Accident, Student, and Sports insurance, and Individual insurance. Each of these can be further subdivided into finer divisions. Probably the most widely publicized recently has been the area of Individual Hospital insurance. Government regulations on the State level, particularly in New York, and Federal proposals for "Socialized medicine" make daily reading material in our newspapers and magazines. Increased attention has also been focused on this field by recent developments among the various Blue Cross and Blue Shield types of organizations. Here, then, is an area where we can direct our attention and find clues to the whole problem of Accident and Sickness insurance.

THE PROBLEM

Insurance has been defined as the pooling of risk by a group of individuals, each exposed to a common hazard. Through the operation of the law of large numbers, the chance of a large loss is replaced with a small known charge. These charges, or premiums, are pooled in order to reimburse those members of the group who actually suffer the loss insured against. This conception of insurance is easily discernible in such coverages as ocean marine, fire, and personal liability.

The earliest form of insurance covering medical expenses was that offered to train passengers in the 1840's. A lump sum was paid in event of death or

serious injury due to an accident occurring while the insured was a passenger on a railroad. Here, also, the elements of insurance, as defined above, were present. Soon the idea of insurance against loss due to accidents spread, so that protection was provided against almost any type of accident.

Aside from the assistance rendered by the ancient trade guilds to their members in event of sickness, insurance providing for the reimbursement of losses incurred due to illness was not actually available until the late 1840's. However, all attempts to establish a sound health insurance program failed until late in the 1890's, when the established accident carriers expanded into this field. The early policies were strictly loss of time forms, providing weekly indemnities for disability. Soon, however, provisions were added granting additional benefits, as reimbursement for certain surgical procedures. Later, policies were sold which also provided for special benefits to be paid while the insured was hospitalized.

Gradually accident and sickness contracts merged into single policies. Until the 1930's, however, coverage for medical, surgical, or hospital benefits was provided to an individual as a supplement to loss of time benefits. During this decade, the seeds were sown which were to become the present hospital insurance field. Protection was made available to family members, as well as to individual insureds. Special policies offering rather comprehensive hospital, surgical and medical provisions were developed. In 1939, the first state-wide voluntary prepayment medical care plan was instituted in California.

In 1940, less than 10% of our population had any form of health insurance protection. By 1950, this figure had risen to 50%. In 1959, nearly 128 million people, or 72% of the U. S. population had some form of health insurance. While in 1950 the premium dollars paid for this protection were split almost equally between individual policies and group contracts, in 1959 individual coverages accounted for less than 40% of the total premiums.

Today's typical health insurance plan bears only slight resemblance to an insurance which comes under the definition presented earlier. Even the most minor occurrence is covered, and then the choice of whether there is to be a financial loss is left up to the insured. He can choose to seek medical attention or not. He can enlarge his family at the expense of his insurance carrier —an event which by no stretch of the imagination could be classified as a financial hazard. The very serious disability, which is truly an insurable hazard, is usually not covered because "Such things always happen to somebody else".

Some of the specific problems which have arisen, as our insurance "Topsy" has grown up over the past twenty years, are quite serious. There is a public demand for policies which provide for a continuation of coverage for the lifetime of the insured. Why terminate the protection when a person reaches a given age or when his health fails? When the need for protection against a real financial loss arises, the availability of that protection is withdrawn. Why not make adequate protection available to those already suffering from some substandard health condition and those already in the twilight of their lives?

Another serious problem is the abuse of insurance. Included here is over-

utilization of medical facilities, inflated charges, false or exaggerated claims, and over-insurance. These abuses are spawned by misunderstanding of the basic intent of the insurance contract, by the hypochondriac tendencies in many of us, and by the desire to make an "easy dollar" at the expense of an insurance company, that "is in business to give away money". The sales pressures and techniques of many insurance agents have been known to encourage these abuses by failing to create the proper attitude on the part of the public toward the health insurance program. A very pressing problem facing hospital insurance carriers is the threat of socialized medicine. This interesting paragraph dated 1916 is quite revealing:

> "A number of persons with socialistic tendencies are at this time engaged in a propaganda for sickness insurance in the interest of the working class, with premium contributions divided between the employer, employee, and State, and it is not unlikely that this propaganda will get headway in the near future. It will, at least, have the effect of hastening the introduction of ideal sickness insurance with premiums graduated to the attained age of the insured, as in life insurance and with policies carrying no cancellation clause." (Note: This paragraph has appeared annually in the *Cyclopedia of Insurance in the United States,* published by The Index Publishing Company of New York.)

THE ANSWER

To anyone not acquainted with the intricacies of the health insurance field the answer to these problems is obvious. It is to offer the best possible coverage at the lowest possible price and to educate everyone how to use this ideal contract; to find out how much money people are going to pay for all medical expenses for a year and divide the cost among all of the people: to add a small amount of administrative expenses, and collect the same amount for each person; and to remember to caution people that they must only obtain the same treatment and care that they would have obtained if they had had to pay the expenses out of their own pockets.

The two basic fallacies in this utopian scheme are the grouping of all people together as one class and the expectation that total costs will not increase if the bills are to be paid by someone else. Even the minimum classification for rating hospital forms provides for distinctions by age, sex, and health condition. Other classes are based on occupation, earnings, residence and marital status. A study made a few years ago by the Health Information Foundation indicates that the average expenses incurred by those families without insurance coverage were less than half of those incurred by families with insurance. When one considers that many of those who had no insurance were elderly persons or those whose health was too poor for them to qualify for coverage, and that these people are most susceptible to disability, these figures are very revealing. Apparently the need for medical care is not as important in determining the treatment to be obtained as is the source of income to pay for the treatment.

Is socialized medicine the answer then? If private insurance is going to fuss about spreading the cost by class, and complain about abuses or non-

critical use of their plans, why not have Uncle "Robin Hood" Sam come in and provide adequate care for all according to need, paid for by taxes on those who can afford to pay? (Great Britain has had such a scheme for some years now. It leaves much to be desired.) The result would be a plan similar to the utopian one presented above except that the charges would not be equally distributed. Also, the red tape involved would run the small administrative costs up to major proportions. The problem of abuses would be multiplied. Medical professional standards would be lowered. A little more of the individualism, which helped make our nation so great, would be traded for a false security.

Getting back to basic fundamentals, isn't a return to sounder insurance principles, plus an extension of coverage to every person in our society what we need? By dividing the situation into three parts, we can answer each one on the basis of its own problems. First, we must offer true insurance protection against the hazard of financial catastrophe caused by severe disability. Second, we should offer a satisfactory program for prepaid medical care for those who must exist on a restricted budget. Third, we must provide adequate protection for those persons who, because of age or health conditions, are, or will become, substandard health risks.

THE METHODS

Just as there is no one medicine to cure all ailments, there is no one plan of insurance to meet the needs of all people. Since some people are confronted with more than one of the three insurance needs just mentioned, there are more than three distinct methods or plans of insurance. Seven plans appear worthy of consideration. Each one is currently being sold by leading companies. Because they are all relatively new, none is presumed to be perfect, not even as an answer to the specific need for which it was developed. However, each shows promise and can be bettered through trial and error. In order to learn how to improve a product, research is necessary. Statistics are the tools of the health insurance researcher, the Actuary. Therefore, a sound statistical program is essential to the future of any insurance program.

The plans which will be taken up here include (1) Major Medical coverage, (2) Hospital coverage with a deductible, (3) Comprehensive scheduled plans, (4) Guaranteed Renewable hospital coverage, (5) paid-up Hospital plans, (6) Substandard coverage, and (7) Over-age plans. After a discussion of each and notation of certain statistical problems or comments, a discussion of general statistical considerations will be taken up.

MAJOR MEDICAL COVERAGE

Every year the cost of sickness and accidents goes up. (See Appendix 1) Rising medical costs, new methods of treatment, and our aging population all contribute to this trend. Each year more than half a million American families have medical bills which are larger than their total yearly income. Even the more robust are not immune to a severely fractured leg which requires a lengthy hospital stay or to a respiratory infection due to the capricious

habits of a flu bug. The medical expenses for either of these incidents could well run over $500. A heart attack, cancer, or any severe injury could easily cost thousands of dollars. This would be a financial catastrophe. Thus a need for catastrophe medical expense insurance is evident. It seems surprising that such coverage has only recently become widely available. Probably the answer lies in the problems confronting those carriers already in this business.

Necessity alone is not the only mother of invention of an insurance form. Adequate and fair rates have to be determined. The policy has to be written and administered so as to provide proper coverage with a minimum of red tape and controversy. The plan must be rated so that it will be acceptable to the potential insured. The agent must be sold on the merits of the plan.

Major Medical insurance has presented certain unique problems. It was known that many doctors set fees based on a patient's ability to pay. Where an insurance company was to foot the bill, what standards should be used? People have varying medical requirements based on their socio-economic status, on their past medical experiences, on their psychological attitude toward infirmities, and on their geographic location. Just because a person preferred to spend three weeks at a special clinic when ten days in his local hospital would have been sufficient, can he be denied full insurance coverage on the grounds that the additional expense was unnecessary?

In order to meet the different requirements of individuals, and to guard against over-utilization, Major Medical plans are usually sold with a choice of deductibles, an element of co-insurance, an inner limit on certain charges, and restrictive language defining reimbursement expenses. Rates are based on age, sex, earnings, and residence.

In spite of these refinements, insurers complain that there are still many unsolved problems of Major Medical insurance. Abuses due to excessive charges are being handled through meetings with medical groups or by scheduled fees. Over-insurance, where overlapping coverage is provided by some other type of policy, is being controlled through better underwriting. Over-utilization is being controlled by larger co-insurance factors and better insurer education.

Problem areas which still remain include bills for drugs or medical fees which are too small to investigate, but could invite fraud or padded expenses. There is the question of whether or not to re-rate a policyholder whose salary or residence has changed since his policy was issued. There is also a problem concerning cancellation of a policy, when the holder has presented a rather large claim. Most carriers do not cancel, unless there is evidence of abuse on the part of the insured.

If the Major Medical plans are to be considered as quasi-guaranteed renewable, however, shouldn't reserves be established? What about rates based on projected costs? Of interest here is the fact that medical costs have shown a tendency to rise faster than the increase in costs due to the increased age of the insured. Thus the rates for a policy which is guaranteed renewable should be higher for a younger person than for an older one.

Probably the best solution here is to set rates based on a leveling off in

the trend of medical costs and for insurance companies to join with others in the fight to control the super-inflationary trend in this area.

Besides keeping statistics on all Major Medical forms, in detail, regarding the rating classes and underwriting categories previously mentioned, data should be recorded by type of charge paid (i.e. hospital room and board, hospital extras, physician's fees, surgeon's charges, nurse's fees, special medicines, etc.). Also, a breakdown of claims into cause of loss categories would be very useful. The effect of medical advances in certain fields, such as cancer or heart conditions, could then be taken into consideration in re-rating or revising a form. Such data would also be helpful in providing special catastrophe type policies which would cover specific conditions.

HOSPITAL COVERAGE WITH A DEDUCTIBLE

The principal reason for the existence of the Major Medical plan is that it provides true insurance. Medical charges, which do not impose a severe financial burden on the insured, are borne by him. The portion of the expense of more serious conditions, which would create a financial strain, is shifted to the insurance company. Most Americans, however, have been educated to think of hospital insurance as a prepayment plan. They prefer to set aside a few dollars a month for a health insurance plan that would be adequate for most disabilities. There is really nothing wrong with this budget plan, except that medical expenses have risen faster than the average American's personal income. An adequate insurance plan now costs more than the average budget allows for this item.

There is a simple solution to this dilemma. By using a small deductible on health insurance forms, premiums can be reduced considerably. The deductible on automobile collision insurance has long been accepted. Everyone knows that the claims cost for every little claim under $50 would increase the rates for first dollar coverage on collision insurance to a fantastic figure. It is not hard to transfer the same logic to Health insurance.

The following quotation from Charles N. Walker of the Lincoln National Life Insurance Company appears in a release by the Health Insurance Association of America.

> "Would you be interested in a hospital policy which cost a third less than the one your company now offers, yet paid the policyholder more money when he had a claim? Would you be interested in a hospital policy which cut claim administration costs in half? Would you be interested in a hospital policy which costs a third less than the one your company now offers, yet paid your agents just as much commission as they now receive? Deductible hospital insurance will do all these things."

There are two separate types of deductible plans. The first is a deductible applicable only to hospital room and board charges. Usually, surgical, medical, or miscellaneous expenses under this plan are provided by riders, so it is easier to rate and administer the plan when the deductible is applied to the basic coverage only. The second plan is one where all benefits are provided

in the basic policy and the deductible applied to all expenses. Here a certain amount of sales flexibility is lost, but the complete comprehensive program is usually easier to administer.

One advantage of the hospital deductible plan is that it is a step toward the Major Medical catastrophe plan. Once the idea of a deductible is accepted, it should not be too difficult to increase the amount that the insured is to bear, as his ability to absorb larger losses increases with economic advancement. Thus, this plan seems to be the answer for the young family of today. A $25 deductible plan can later be increased to a $100 deductible with higher or more comprehensive benefits, and then replaced with a $300 deductible Major Medical plan. Of interest is the fact that the cost of a $25 deductible plan sold to a family with three children would cost about $25 a year less than the same plan providing first dollar coverage. Thus, even if the family had a claim during the year, the deductible plan would not cost them any more than their old plan. If there were no claims, the $25 would be saved, or perhaps used to purchase additional coverage for the next year.

The following chart was used to help rate one deductible plan. It is based on experience under a first dollar hospital plan sold only to risks under age 65. The policy provided 18 weeks' coverage. These figures exclude hospitalization due to maternity.

Given Day of Hospitalization	*% of Total Hospitalization Contributed to By Given Day*	*Accumulation of Preceding Column*
1	10.0	10.0
2	8.8	18.8
3	7.7	26.5
4	6.7	33.2
5	5.8	39.0
6	5.0	44.0
7	4.3	48.5
8	3.7	52.0

COMPREHENSIVE SCHEDULED PLANS

In order to provide supplementary coverage to an existing policy with another carrier, many companies have marketed special Surgical or Surgical and Medical plans. This type of policy has been used lately as a supplement to a limited group plan, which covered hospitalization and provided a small surgical indemnity, but contained no medical coverage. With the advent of free hospital insurance in Canada, the use of a scheduled plan built around the basic Provincial plan became the only way to sell medical expense insurance there. Now that hospital insurance dollars are collected as taxes, the insurance agent has had to find a means of replacing his lost income.

Since only about one-fourth of all expenses for medical care each year go to hospitals, it is not difficult for an energetic agent to show the need for

insurance to cover medical expenses other than those billed by the hospital. The ideal place to start is with Surgical insurance. Add on medical coverage to provide for doctor's calls, reimbursement for ambulance charges, anesthetists' fees, X-ray or laboratory expenses incurred when not hospitalized, and special nurse's care, and you have quite a comprehensive package. Throw in a special benefit to provide payment for obstetrical fees to appeal to the young married prospects and you have an ideal replacement for hospital insurance. Now the government pays the hospital bills and the insurance company pays the rest.

If such a program could be developed to meet the needs of the Canadian population who were convinced to purchase the plan by ambitious salesmen, why couldn't a similar comprehensive plan be developed to fit the insurance needs of any other large group of people? Why couldn't a catastrophe type comprehensive plan be developed? Such a plan would provide for all of the favorable features of the present Major Medical plan, the scheduled policy and the straight hospital form without many of their shortcomings.

An over-all deductible should be applied to eliminate small, non-serious claims. There could be a choice of two or three surgical schedules, with liberal benefits to meet the needs of various insureds. Inner limits on hospital indemnities and nurse care would provide the co-insurance feature deemed essential. An allowance for special drugs could be provided if there was an itemized list from the pharmacy giving the prescription number, the doctor's name and the type of drug. A maximum benefit limitation should be imposed so that there will be a maximum stated liability and a point at which a company could close out an extremely serious case.

GUARANTEED RENEWABLE HOSPITAL COVERAGE

In 1959, the State of New York enacted legislation which made every individual hospital policy sold there a Guaranteed Renewable form. A two year period for each policy is allowed during which time a policy may be cancelled and a few exceptions are allowed; but for all practical purposes, the forms are not cancellable at the option of the company until a stated age is attained. The effect of these "Metcalf Provisions" is still to be ascertained. The initial response by the various companies doing business in New York has been varied. Some increased rates only slightly and took a "wait and see" attitude. Some companies came out with forms rated somewhere between their old cancellable policies and their true Guaranteed Renewable policies. Others decided to sell only the true Guaranteed Renewable forms, with full reserves.

One problem in developing and rating a Guaranteed Renewable policy is the reserve. Fortunately, there are tables and methods for establishing such a reserve which have been approved by the NAIC. A problem, which is tied to the reserves, however, is that of persistency. Studies show that the lapse rate on Guaranteed Renewable forms is not too much lower than that on a good commercial form. Since the policyholder has no claim to any reserve, the company need not refund any cash value to him. Because the reserve, as in Life insurance, builds up slowly, the small amount relinquished in the early

years can be taken over by the company to offset the expense of cancelling the policy and to pay for any deficiency due to high acquisition expenses.

What should a company do when a policyholder lets his policy lapse after the reserve has been built up to an amount more than adequate for these contingencies? Some carriers take this lapse rate into account in rating their forms and need not worry about individual cancellations. Other companies do not make rate adjustments for anticipated lapses because they feel that there is no savings to the company when a policy is lapsed. They point out that the policyholders who retain their coverage are probably poorer risks in general than those who drop their coverage each year. Therefore, the reserve released on those policies which are dropped should be used to cover the anticipated increased liability on those who have retained their policies.

The Metcalf legislation in New York was not the work of radical politicians. For years, people had complained that insurance companies were being unfair in cancelling their protection when they became ill, or when they reached an age where they could not buy replacement protection. The companies have always maintained that they rated their forms on the basis of insureds in good health. Since the contract was a short term one, they had every right to protect themselves and their other policyholders by eliminating potential bad risks. Guaranteed Renewable forms seemed to be the answer. But most people didn't understand all of the technicalities of the various plans, and many agents did not fully understand the situation either. The new plans cost more and offered only a few sentences of complex terms in return for the additional premium.

The New York decision to eliminate the cancellable form may prove to be a boon to both the insureds and the insurers. The public has what it always wanted, guaranteed protection.

The carriers can establish reserves to provide for "aging" of policies so that they are not faced with the unpleasant task of asking for rate increases every few years on forms which are not being subsidized by new insureds each year. Agents trying to sell the Guaranteed Renewable forms need not worry about competition from "cheap" cancellable policies.

While it is true that Guaranteed Renewable forms have not shown as good a persistency record as most carriers have anticipated, there are some good reasons for this situation. The earlier policies were probably "over-priced". As the force of competition and more adequate statistics led to lower rates, many persons probably switched their coverage to take advantage of better rates. Also, many earlier forms called for fairly broad age categories. The trend has been toward fewer age brackets, with a resulting lower premium for younger persons. Thus a man would save money by transferring his coverage to another plan, if he could profit by the more refined premium tables. It is assumed that this picture will change in New York State where there is no competition from cancellable forms, where carriers are fairly well controlled, and where competition has forced rates to be fairly consistent between companies. When a person finds that his current coverage can not be duplicated by another carrier for a lower premium, chances are that he will hold on to his policy.

PAID-UP HOSPITAL PLANS

The Life insurance field for many years has featured plans which call for premiums to be paid-up before the policy matures as an endowment or before the insured retires and no longer can afford to continue to build up a death benefit fund. The Twenty Pay Endowment at age 65 provided a good means of building up a retirement fund for a young man who planned ahead and thought of diverting his income after the twenty years to education for his children or special investments, once his life insurance program was complete. The Life Paid-Up at 65 policy offered a good value in insurance without the burden of continuing payments after retirement. The problem of transferring this innovation to the Hospital insurance field has been a challenge. Mortality statistics have been available for many more years than morbidity data. When many companies were uncertain as to the premiums for Hospital insurance for the present, how could they compute premiums for the future? A paid-up hospital policy could not be cancellable and the rates could not be increased on existing policyholders who were no longer paying premiums. The experience of non-cancellable policies during the Depression was a deterrent to any type of guaranteed premium plan.

With more statistics concerning morbidity in general and hospitalization in particular, a few companies have broken through the barrier of uncertainty and have come out with paid-up hospital plans. Some of the fears regarding this type of policy can be dispelled by providing a definite scheduled benefit to be paid. Then the major unknown factor in rating becomes the expected frequency. Recent statistics provide a very good picture of this experience. Actuarial functions for expected losses, lapses, mortality, interest on reserves, expenses, and so forth can be developed just as they are for Life insurance.

Thus we have a hospital policy which can be paid for while the insured is capable of paying the relatively high premiums, but which will provide hospital benefits after he has retired. This type of policy is ideal for the man who takes pride in his careful considerations for the future. He need not fear that disability will disrupt his retirement plans, at least not financially. Also, he has removed any uncertainty concerning the availability of insurance in his later years. There have been too many men who find that they can not obtain adequate hospital insurance at a reasonable rate after they retire.

A consideration of no little importance in the selection of such a plan, however, is the benefit level to be used. The buyer wants to have adequate protection and the insurance company wants to have a satisfied client. So both should be concerned with the recent trend in increased medical expenses. The increasing costs of medical care, especially hospital charges (see Appendix I), are frightening. Here again is a good reason why the public and the insurance companies should work together with members of the medical profession to halt this situation. There will be no value in having a paid-up hospital policy, if the coverage afforded will only pay for one pill and perhaps the use of the glass to hold water with which to wash it down.

Statistics which provide data by the attained age of the insured are es-

sential in rating and continuing to analyze this type of policy. Since policy reserves must be kept, it is extremely important to have accurate and detailed studies of expected future payments. These can only be obtained by a careful study of past experience. Benefit studies by age of claimant are most helpful. Statistical trends, sex differences, and lapse studies would be vitally important in analyzing these policies.

SUBSTANDARD COVERAGE

One of the reasons why many persons have been dissatisfied with commercial insurance companies has been the denial of coverage to those not in perfect health. Even the use of waivers, allowing a person with some substandard condition to obtain insurance for all other conditions, has not been graciously accepted. For years, persons with medical histories which make them substandard risks have complained that their insurance should cost them less than average because they are aware of their health and take better care of themselves. While this has proved true for many individuals, there is still the medical fact that most of the chronic conditions which cause a person to be classed as substandard are degenerative in nature. The original condition may recur or the total physical system may be weakened so that susceptibility to other ailments is increased.

Of interest, statistically, is the fact that the actual experience of carriers offering Substandard Hospital coverage has fallen between the optimistic hopes of those persons who have argued that they should be above average risks and the early underwriters who foresaw only the worst experience for substandard hospital insurance. Probably the same advances in medical techniques which have caused hospital costs to rise so rapidly of late have helped curb the serious effects of previously crippling conditions.

Now, there are very few persons who cannot obtain some sort of hospital coverage, regardless of past medical history. Of course, the rates for certain conditions are still quite high. The trend in this field however, has been toward lower rates and more liberal coverage. It is even possible for a person with a substandard condition to qualify for standard rates and forms after favorable experience under a substandard policy. If the insured can prove that his health condition and his health attitude make him a good risk through favorable claim experience, he can have his coverage transferred to a standard policy form. This idea works well in the automobile field, where insureds are rewarded for good claim experience by lower rates or lower deductibles.

In evaluating the results of a Substandard Hospital insurance program, quite detailed statistics are necessary. Appendix V is a suggested list of conditions on which individual experience should be kept. Appendix VI is a list of rate-up factors, ranging from the less severe (1) to the more serious conditions (7). By coding each policy according to the rate-up factor used, a statistical analysis of the substandard underwriting selection can be obtained. This is especially valuable when the rate-up factor used may be varied at the discretion of the underwriter. Also, the combination of this code with the substandard condition code provides all of the detail necessary for making

a good analysis of substandard insurance by condition and severity, which should be the ultimate basis for underwriting and rating.

OVER-AGE PLANS

Just as the sale of Substandard plans to those who formerly were uninsurable because of health has helped fill half the hole created by former standard commercial insurance practices, the creation of special Over-Age plans promises to complete the process. Now no person need be denied hospital insurance because of health or age. There have always been plans available for those persons over age 65 who were in good health who could pay the high premiums asked. Under the pressures of government regulation or competition, some of the leading carriers have developed low cost plans for the elderly segment of our population. By offering coverage similar to group insurance, with no initial underwriting, and expenses pared down by volume sales, companies can provide millions of people over age 65 with adequate hospital insurance at a reasonable price. Continued protection is offered, even if a serious condition develops. The basis for the rates for this type of insurance is not dependent on the good health of the insureds but rather on the total health picture of all older people. Statistics have indicated that as a person grows older the tendency toward over-utilization of medical care because of insurance benefits become less. By providing a co-insurance factor, this tendency is further discouraged.

Thus, for an annual charge of about $75 per person, payable monthly if desired, a generous hospital plan can be purchased. Even providing guaranteed renewable coverage, this allows about 10 or 15 per cent to the insurance company for expenses. By keeping commissions down to a minimum and through volume accounting procedures, the program has proven financially self-sufficient.

While certain people within the insurance industry have objected to these plans on the grounds that they break from the traditional agent-client relationship of the American Agency System, the program seems to be moving ahead. There still is a demand for government subsidized insurance for the aged, but some of the former critics of private insurance have softened their views, due to this new concept. As long as the private carriers keep up with the needs and demands of the people, the fear of socialized health insurance need not be any greater than it was in 1916.

STATISTICS

The problem of insurance statistics is two-fold. First, statistics have to be gathered to rate a new form. Then, statistics on the form must be kept to support the rate structure and to provide for internal company requirements and external industry studies. Some people wonder how a new form can be rated if no similar form has ever been sold by a given company. Sometimes rates for such policies are based on the rates charged by competitors, tempered with experience on related forms offered by the company. However, there

are quite a few sources of statistical data available which can be used in arriving at rates for a new policy form.

Of special interest in this regard is an annual publication of the Department of Health, Education and Welfare entitled *"Sources of Morbidity Data"*. This booklet lists various studies made or being made by governmental agencies, schools, private research organizations and others. A brief description of each survey is presented along with any publication plans and the person who could provide further information on the project.

The following is a list of source documents which have proven quite useful as reference material for statistical studies of morbidity. It is by no means a complete list of available sources, but rather is representative of the material published in the past few years.

Compendium on Risk Selection for Individual and Family Accident and Health Insurance—published by the Health Insurance Association of America.

Health Statistics from the U. S. National Health Survey—a series of reports prepared by the U. S. Department of Health, Education and Welfare.

Voluntary Health Insurance and the Senior Citizen—a report prepared by the State of New York Insurance Department.

Journal of the American Hospital Association—Guide Issue—an annual report published on August 1 each year by the American Hospital Association.

Health Costs of the Aged—Report No. 20—Published by the Social Security Administration of the U. S. Department of Health, Education and Welfare.

Accident Facts—An annual publication of the National Safety Council.

Source Book of Health Insurance Data—Published by the Health Insurance Institute.

HIC Action Kit—monthly series of bulletins and reports prepared by the Health Insurance Council.

Family Medical Costs and Voluntary Health Insurance by Anderson and Feldman published by McGraw Hill, 1956.

Comprehensive Medical Services Under Voluntary Health Insurance by Darksy, Sinai, and Axelrod; published by the Harvard University Press, 1958.

With the advent of new electronic data processing equipment, the accumulation of adequate morbidity statistics within a company has been transformed from a tedious task to an interesting experience. The errors of manual records and the lack of time and space inherent in older statistical systems are no longer a hindrance to a sound statistical program. The following is an outline of the premium accounting and statistical card and the claim accounting and statistical card which are to be used in gathering information for future analysis in one company. As inferred in the title of the cards, they are to serve as both Accounting Department sources and Actuarial Department statistical records.

Premium and Accounting Statistical Card

Size of Field	*Card Columns*	*Title of Field*	*Explanation*
1	1	Accounting Month	
3	2-4	Accounting Book	Collection Department Record
7	5-11	Policy Number	
5	12-16	Due Date	Month, Day, Year
2	17-18	Term or Mode	Premium Period in Months
3	19-21	Paid to Date	Month, Year
7	22-28	Agent Code	General and Sub-Agent
2	29-30	State Code	
3	31-33	Coverage	See Note I
4	34-37	Policy Form Number	
3	38-40	Issue Date	Original month and year of issue
2	41-42	Year of Birth	Of principal insured
1	43	Sex	See Note 2
1	44	Dependents	Number of Persons covered other than principal insured
7	45-51	Policy Size, etc.	See Note 3
4	52-55	Special data	See Note 4
1	56	Initial or renewal	
1	57	Adjustment	Special Accounting Field
1	58	Transaction	Special Accounting Field
7	59-65	Premium Paid	
5	66-70	Commission	Rate and Plan
8	71-78	Name	Last name of insured
1	79	Billing Method	
1	80	Card Code	Tabulating Dept. use

Note 1: The coverage code is set up so that the first digit indicates the type of business (i.e., Individual Hospital, Individual A & S, Group A & H, Credit A & H, etc.) The second digit subdivides the type into such categories as Regular Hospital, Guaranteed Renewable Hospital, Substandard Hospital, etc. The third digit is used to indicate the extent of coverage within these classes. For example, a Regular Hospital form could provide very limited room and board benefits, or it could offer long term benefits plus surgical, medical and miscellaneous coverage. (See Appendix II).

Note 2: The sex code is based on the following categories:

1 Male only
2 Female only

3 Male, principal insured, and female
4 Female, principal insured, and male
5 Male, principal insured, female and children
6 Female, principal insured, male and children
7 Male and children
8 Female and children

Note 3: The coding of information in this field will be such that pertinent data may be recorded on various types of policies. Different information will be necessary on different types of policies. On Major Medical forms, the codes will indicate (1) the deductible amount called for, (2) the geographic area used in rating the policy, (3) the maximum limits of the policy, and (4) the salary classification of the principal insured. On other policies any or all of the following may be coded: (1) principal sum, (2) maximum miscellaneous coverage available, (3) amount of deductible, (4) maximum duration of benefits, (5) daily room and board benefit allowance, and (6) maximum amount of surgical schedule applicable.

Note 4: The special data field will be used for special policies, such as Substandard, Franchise, or Associations. There will be codes to provide for future analysis of experience by occupational groups or by substandard conditions. Appendix V contains an illustrative system for coding various substandard conditions by bodily system and major impairment within the system. This is based on the *"Standard Nomenclature List of Physical Impairments*—1956" published by the Health Insurance Association of America. Appendix VI provides a guide for rate-up codes which can be used for rating and for statistical purposes, as well. The information obtained in studies based on such a coding plan can be used for internal rating or for inter-company studies.

Claim Accounting and Statistical Card

Size of Field	*Card Columns*	*Title of Field*	*Explanation*
4	1-4	Accounting Date	Month, Day, Year
7	5-11	Policy Number	
6	12-17	Claim Number	
2	18-19	Reported Date	Month, Year
2	20-21	Loss Date	Month, Year
7	22-28	Agent Code	General and Sub-Agent
2	29-30	State Code	
3	31-33	Coverage	See Premium Card
4	34-37	Policy Form Number	
3	38-40	Issue Date	See Premium Card
2	41-42	Year of Birth	See Premium Card
1	43	Sex	See Premium Card

Claim Accounting and Statistical Card (cont.)

Size of Field	*Card Columns*	*Title of Field*	*Explanation*
1	44	Member	See Note 5
1	45	Reinsurance	Type of reinsurance, if any
1	46	Claim History	See Note 6
5	47-51	Policy Size, etc.	Same as Premium card col. 47-51
4	52-55	Special Data	Same as Premium card col. 52-55
2	56-57	Cause of Loss	See Note 7
1	58	Reserve Status	See Note 8
1	59	Type of payment	Initial, partial, final, additional
2	60-61	Period of Indemnity	In days
4	62-65	Form of specific	Policy or rider form under which payment is made
2	66-67	Benefit Code	See Note 9
6	68-73	Payment Amount	
6	74-79	Check number	
1	80	Examiner	Claim Examiner's Code number

Note 5: The code for member will be used to distinguish between a claim on the insured and one on his dependents. The following system is to be used on the Individual Hospital business:

1 Male, principal insured
2 Female, principal insured
3 Male, spouse
4 Female, spouse
5 Male, child
6 Female, child

Note 6: The use of a special code for claim history will serve a dual purpose. It provides a general cause of loss code which can be combined with the specific cause of loss to give a detailed breakdown of claims. Also, it is the key for special studies of Substandard Hospital Policy experience, and for policies providing maternity or accidental death and dismemberment benefits. The codes to be used are:

1 Specific Loss (A.D. and D.)
2 Maternity
3 Accident Claim—related to substandard condition
4 Accident claim—all other
5 Sickness Claim—related to substandard condition
6 Sickness Claim—all other

Note 7: The cause of loss code for Sickness will be the first two digits of that suggested by the HIAA as an illustrative set of codes for cause of disability under their 1958 statistical plan. The two digit code plan is shown in Appendix III. The code, as it is to be used for accidents, will vary from the HIAA code. Since it is not to be used in detail with Hospital policies, the code is not presented here.

Note 8: The code for Reserve Status is to be used in determining the type of reserve to be applied to a pending claim. The following are the codes to be used:

0 Regular pending reserve (factor)
1 Accidental death reserve
2 Lifetime contingency reserve
3 Legal reserve
4 Special reserve

Note 9: The Benefit Code has been developed to provide a basis for cost analysis of each provision in a policy. The coverages provided by each form have been outlined, and a code assigned to each one. Appendix IV illustrates how such a code can be developed.

APPENDIX I

CONSUMER PRICE INDEXES FOR MEDICAL CARE ITEMS

(1947-49 = 100)

Year	*All Medical Care Items*	*General Practitioners' Fees*	*Surgeons' Fees*	*Dentists' Fees*	*Optometric Examination and Eyeglasses*	*Hospital Room Rates*	*Prescriptions and Drugs*
1935	71.4	73.9	73.8	68.2	80.5	47.1	83.0
1936	71.6	74.3	74.1	68.3	80.7	47.5	82.8
1937	72.3	74.6	74.3	69.9	81.2	48.8	83.3
1938	72.5	74.6	74.6	70.0	81.3	49.9	83.8
1939	72.6	74.6	74.8	70.1	81.9	50.1	83.5
1940	72.7	74.7	74.0	70.1	82.6	50.4	83.2
1941	73.1	74.9	74.7	70.3	82.8	51.4	83.9
1942	75.1	76.6	76.8	72.1	83.9	55.4	85.8
1943	78.7	81.3	81.3	75.4	87.5	59.8	86.4
1944	81.2	84.8	84.5	79.6	89.6	62.5	87.2
1945	83.1	86.8	86.9	83.0	90.8	64.4	87.9
1946	87.7	91.1	90.9	87.9	92.5	73.3	89.5
1947	94.9	96.9	96.2	95.2	96.2	87.4	96.1
1948	100.9	100.6	101.0	100.3	100.2	102.1	101.2
1949	104.1	102.5	102.9	104.4	103.5	110.4	102.7
1950	106.0	104.0	104.5	106.9	104.5	114.6	103.9
1951	111.1	108.0	107.3	110.9	109.2	126.9	106.9
1952	117.2	113.0	111.5	113.3	110.5	139.5	107.9
1953	121.3	116.1	113.9	117.0	109.4	148.2	108.9
1954	125.2	119.9	115.2	120.9	108.0	156.8	110.1
1955	128.0	124.3	116.4	122.0	109.5	164.4	111.2
1956	132.6	128.4	118.2	124.4	111.2	173.3	113.7
1957	138.0	134.5	120.9	127.4	115.5	187.3	116.7
1958	144.4	139.3	122.7	131.4	116.7	198.0	120.7

Source: United States Department of Labor Bureau of Labor Statistics.

APPENDIX II

COVERAGE CODE

First Digit

1 Accident only
2 A & H
3 Hospital
4 Group A & H
5 Students
6 Credit A & H
7 Credit Life
8 Ind. Life
9 Group Life

Second Digit

10 Accident only—obsolete forms
11 " " —Loss of time
12 " " —Principal sum only
13 " " —B A M R & P. S.

20 Accident & Sickness—obsolete forms
21 " " —Regular L/T
24 " " —Substandard
25 " " —Guaranteed Renewable
22 " " —Franchise type

30 Hospital—obsolete forms
31 " —Regular
32 " —Franchise Type
33 " —Special*
34 " —Substandard
35 " —Guaranteed Renewable

Third Digit

10-20-30 = All require "0"
11 - 1 = All risk-short term—no hospital coverage
- 2 = " " " " —with " "
- 3 = " " " " —with surgical or surgical & hospital coverage
- 4 = " " long " —no hospital coverage
- 5 = " " " " —with " "
- 6 = " " " " — " surgical or surgical & hospital coverage

12 - 0 = All risk—renewable
or - 1 = " " —single term
13 - 2 = Specified risk—renewable
- 3 = " " —single term
- 4 = Single flight air travel

21 - 1 = Short term—no hospital coverage
- 2 = " " —with " "
- 3 = " " — " surgical or surgical & hospital coverage
- 4 = Long " — " no hospital coverage
- 5 = " " — " hospital coverage
- 6 = " " — " surgical or surgical & hospital coverage
- 7 = Over-age —no hospital coverage
- 8 = " —with " "
- 9 = " — " surgical or surgical & hospital coverage

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* Includes Major Medical, Medical-Surgical, Specified Diseases, and Accident only.

22 - 1 = Regular Franchise—no hospital coverage
- 2 = " " —with " "
- 3 = " " — " surgical or surgical & hospital coverage
- 4 = Special " —no hospital coverage
- 5 = " " —with " "
- 6 = " " — " surgical or surgical & hospital coverage
- 7 = True Ass'n Group —no hospital coverage
- 8 = " " " —with " "
- 9 = " " " — " surgical or surgical & hospital coverage

24 - 0 = All policies

25 - 0 = Short term
- 1 = Long term

31 - 0 = Short term—with room & board only*
34 - 1 = " " —plus surgical only
or - 2 = " " — " miscellaneous only
35 - 3 = " " — " surgical & miscellaneous
- 4 = Long " —with room & board only
- 5 = " " —plus surgical only
- 6 = " " — " miscellaneous only
- 7 = " " — " surgical & miscellaneous
- 8 = Any Hospital form with A & H riders
- 9 = Over-age Hospital forms

32 - 0 = Regular Franchise—with room and board only*
- 1 = " " —plus surgical only
- 2 = " " — " miscellaneous only
- 3 = " " — " surgical & miscellaneous
- 4 = True Ass'n Group —with room and board only
- 5 = " " " —plus surgical only
- 6 = " " " — " miscellaneous only
- 7 = " " " — " surgical & miscellaneous
- 8 = Special Group forms

33 - 0 = Major Medical
- 1 = Surgical only
- 2 = Surgical and medical
- 3 = Polio only
- 4 = Specified disease (no cancer)
- 5 = " " (including cancer)
- 6 = Accident only
- 7 = Surgical-Medical with Hospital coverage by rider

Notes: Short term Accident forms are those providing coverage for one year or less. Short term Accident and Sickness forms are those providing one year coverage or less for each benefit. (A five year Accident and one year Sickness plan would be long term.)
Short term Hospital coverage includes all forms where the duration is less than 90 days. (90 day coverage is long term.)

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* Medical riders do not affect the coverage code.

APPENDIX III

CAUSE OF LOSS CODES

Sickness Code	*Cause of Loss*
01	Tuberculosis of the respiratory system
02	Tuberculosis other specified form
03	Syphilis and its sequelae
04	Gonococcal infection
05	Dysentery, all forms
06	Infectious diseases commonly arising in the intestinal tract, including food poisoning
07	Certain diseases common among children Scarlet fever Diphtheria Whooping Cough Meningococcal infections Acute Poliomyelitis Smallpox Measles Chickenpox Mumps
08	Other diseases attributable to viruses *Note:* When virus is not otherwise specified and is reported with a respiratory condition, *always* code the case according to the respiratory condition. For example "virus infection, acute sinusitis" would be coded as sinusitis, i.e. 34
09	Malaria
11	All other diseases classified as infective and/or parasitic
12	Malignant neoplasms (tumors) including neoplasms of lymphatic and haematopoietic tissues including Hodgkins disease Leukemia and aleukemia
13	Neoplasms (tumors), benign and of unspecified nature
14	Allergic disorders (includes hay fever, asthma, eczema, etc.)
15	Diseases of the thyroid gland
16	Diabetes mellitus
18	Anaemias
19	Psychoneuroses and psychoses (includes nervous exhaustion)
20	Diseases of the nervous system Vascular lesions affecting central nervous system (includes cerebral hemorrhage, cerebral embolism and thrombosis, etc.) and Other diseases of the central nervous system, nerves and peripheral ganglia
21	Inflammatory and other diseases of the eye
22	Diseases of the ear and mastoid process
23	Rheumatic fever
24	Chronic Rheumatic heart disease
25	Non-rheumatic heart disease Heart disease specified as involving the coronary arteries Angina pectoris Arteriosclerotic heart disease, chronic endocarditis and other myocardial degeneration Acute and subacute endocarditis, acute myocarditis, acute pericarditis, and functional heart disorders Other and unspecified non-rheumatic heart disease
26	Hypertensive disease
27	Diseases of arteries and veins

29	Acute Tonsillitis, Hypertrophy of tonsils and/or adenoids
30	Influenza, Grippe
31	Pneumonia (including alcoholic pneumonitis)
34	All other respiratory diseases (including croup, chronic pneumonitis)
35	Ulcers and other non-cancerous diseases of the stomach and duodenum (includes acute gastritis)
36	Appendicitis
37	Hernia of the abdominal cavity
38	Diarrhea and enteritis
39	Diseases of gallbladder and bile ducts
40	Other diseases of digestive system (including diseases of rectum, intestinal obstruction, spastic colon)
41	Diseases of the urinary system
	Nephritis and nephrosis
	Infections of the kidney (includes acute pyelitis)
	Calculi of kidney, ureter and other parts of the urinary system
	Other diseases of the urinary system
42	Diseases of genital organs
43	Deliveries, complications of pregnancy childbirth and the puerperium
44	Boil, carbuncle, abscess, cellulitis and other skin infections
45	Other diseases of skin and subcutaneous tissue
46	Arthritis and rheumatism, except rheumatic fever
47	Diseases of bones and other organs of movement
48	Congenital malformations and diseases peculiar to early infancy
49	Other specified and ill-defined diseases

APPENDIX IV

BENEFIT CODE

A.	*Illness Indemnity*	
I	Confining Illness	11
II	Non-confining Illness	12
III	Hospital Confinement	13
IV	Indemnity for graduate nurse service	14
B.	*Accident Indemnity*	
I	Total Disability	21
II	Partial Disability	22
III	Surgeon's fees for non-disabling injury	23
IV	Hospital Confinement	24
V	Blanket Expense	25
VI	Fracture settlement	26
C.	*Hospital Benefits*	
I	Room and Board	31
II	Special Services & Supplies	32
III	Graduate Nurse Service	33
IV	Maternity Benefit	34
V	Emergency doctor's fees	35
VI	Female disorders	36
VII	Drugs and Dressings	37
VIII	Recuperative Indemnity	38
IX	Supplementary Accident expense	39
D.	*Surgical Benefit*	
I	Scheduled Benefit	41
II	Non-scheduled Benefit	42
III	Obstetrical Benefit	43
E.	*Medical Benefit*	
I	Scheduled Benefit	51
II	Non-scheduled Benefit	52
III	Miscellaneous Expense	53
F.	*Specific Losses*	
I	Loss of Life	61
II	Loss of Limb	62
III	Loss of Sight	63
G.	*Miscellaneous*	
I	Natural Death Benefit	71
II	Pilot Refunds	72
III	Polio Policy Coverage	73
IV	Conversion costs	74
V	Waiver of Premium—Strike	75
VI	Waiver of Premium—Total Disability	76
VII	Premium Refund—Accidental Death	77
H.	*Compromise Settlement*	80
I.	*Dread Diseases*	
I	Tularemia	78
II	Psittacosis	79
III	Scarlet Fever	81
IV	Tetanus	82
V	Lukemia	83
VI	Encephalitis	84
VII	Cancer	85
VIII	Spinal Meningitis	86
IX	Diptheria	87
X	Small Pox	88
XI	Rabies	89
K.	*Claim Expenses*	
I	Hospital Records	90
II	Investigation Expense	91
III	Medical Examinations	92
IV	Legal Services	93
V	Court Costs	94
VI	Miscellaneous Expense	95

APPENDIX V

SPECIFIC IMPAIRMENT CODES

Brain

Important Subdivision	
00	N.O.C.
01	Infectious
02	Epilepsy, catalepsy, narcolepsy, etc.
03	Fractures
04	Headaches
05	Psychoses
06	Neuroses
07	Moral Hazards
08	Concussion
09	Vertigo

Nervous System

Important Subdivision	
10	N.O.C.
11	Neuralgia, neuritis
12	Paralysis
13	Reflexes
14	Sclerosis
15	Spinal Cord
16	Tremors

Cardio-vascular System

Important Subdivision	
20	N.O.C.
21	Anemia
22	Aorta
23	Arteries, veins, except Aorta
24	Heart Disease except coronary artery disease
25	Blood Pressure
26	Coronary artery disease
27	Murmurs
28	Pulse
29	Spleen

Ear

Important Subdivision	
30	Deafness, total
31	Meniere's disease, labyrinthitis otosclerosis, mutism

Eye

Important Subdivision	
32	Major eye troubles, N.O.C.
33	Partial loss of sight
34	Total loss of sight
35	Cataract
36	Eye diseases, general
37	Glaucoma
38	Myopia, detached retina, etc.

Gastro-intestinal Tract

Important Subdivision	
40	N.O.C.
41	Mouth
42	Esophagus
43	Upper G.I., except peptic ulcers
44	Peptic ulcers
45	Gall Bladder
46	Liver
47	Hernias, internal
48	Large intestine
49	Rectum

Genito-Urinary System, Breast Disorders and Female Disorders

Important Subdivision	
50	V.D. and Genito-urinary, N.O.C.
51	Bladder, ureters, urethra
52	Breasts
53	Kidneys
55	Pregnancy
56	Prostate
57	Testes and scrotum
58	Urine
59	Uterus and adnexae

Glands of Internal Secretion and Metabolism

Important Subdivision	
63	Adrenal
64	Diabetes Mellitus
65	Pancreas, other
66	Parathyroid
67	Pituitary
68	Thyroid
69	N.O.C.

Miscellaneous

Important Subdivision

70 N.O.C.
73 tbc, non-pulmonary
74 Overweight
75 Other build abnormalities
76 Fevers
77 Skin affections
78 Benign tumors
79 Malignant tumors

Respiratory System

Important Subdivision

80 Abscess
81 Allergies
82 Respiratory disease, major, except tbc
83 Respiratory disease, minor
85 Pneumonia
86 Pleurisy
87 Pneumothorax, non-therapeutic
88 tbc, minimal
89 tbc, more than minimal

Skeletal and Muscular System

Important Subdivision

90 N.O.C.
91 Arthritis, rheumatism
92 Ankylosis, bursitis, other joint disorders except dislocations
93 Back, except lumbosacral
94 Lumbosacral
95 Deformities
96 Dislocations and fractures
97 Hernias
98 Amputations

APPENDIX VI

TABLE OF SUBSTANDARD IMPAIRED CONDITION RATE-UP CODES

1. GENERAL CONDITIONS

Allergies	1
Arthritis	1
Bone or joint disorder	2
Breast, disorders, malignant	3
Brucellosis	5
Cataracts	1
Diabetes	3
Ear disorder	1
Glaucoma	1
Gout	2
Hearing, impaired	1
Infectious Mononucleosis	1
Lumbago	1
Malaria	1
Malignancy, internal	3
Malignancy, skin	1
Metabolic disorders, not listed elsewhere	3
Osteomyelitis	2
Overweight	2
Rheumatism	1
Sarcoidosis	6
Syphilis	3
T. B. other than pulmonary	4
Thyroid disorders	2
Tumors, cysts, non-malignant	1
Underweight	2
Vision, impaired	1

2. BRAIN AND NERVOUS

Abscess or Tumor, non-malignant	2
Bell's Palsy	1
Central Nervous System Syphilis	7
Encephalitis	2
Epilepsy, Grand Mal	4
Epilepsy, Petit Mal	3
Fractured Skull	1
Headaches, Migraine	2
Headaches, not Migraine	1
Meningetities	2
Multiple Sclerosis	7
Neurasthenia, Psychoneurosis	2
Neuritis and Neuralgia	1
Paralysis, Agitans	3
Sciatica	1
Vertigo or Syncope	3

3. HEART AND CIRCULATORY

Angina Pectoris	3
Aneurysm	4
Arteriosclerosis	2
Cerebral Vascular Accident	3
Coronary Artery Disease	3
Coronary Occlusions	5
Endocarditis	2
Hemophilia	4
High Blood Pressure	2
Hodgkin's Disease and other Lymphomas	7
Leukemia, chronic	7
Low Blood Pressure	1
Murmur, functional	1
Murmur, organic	2
Myocardial Infarction	5
Peripheral Vascular Disease	4
Pernicious Anemia	3
Purpura	5
Rheumatic Fever	2
Varicose Veins	1

4. RESPIRATORY

Asthma	2
Bronchitis	1
Emphysema	2
Pleurisy	1
Pneumoconiosis	3
Pneumonia	1
Pneumothorax	3
Pulmonary Tuberculosis	3
Sinusitis	1
Tumor or Cyst, non-malignant	1

5. DIGESTIVE

Achylia gastrica	1
Cirrhosis of Liver	3
Colectomy, non-malignant	2
Colitis, ulcerative	3
Colitis, not ulcerative	1
Duodenal Ulcer, no complications	2
Gall Bladder, disorder of	2
Hernia, Diaphragmatic	3
Hernia, inguinal, femoral or internal	1
Liver, disorder of	2
Intestinal Obstructions	1
Malignancy, lower gastro-intestinal tract	3
Malignancy, upper gastro-intestinal tract	4
Pancreas, disorder of	3
Pilonidal cyst	1
Rectum, disorders of	2
Tumors or cysts, non-malignant	1

6. KIDNEY AND GENITO-URINARY

Bladder, disorder of not listed elsewhere	2
Cystitis	1
Floating Kidney	2
Genito-urinary Stone or Colic	1
Gonorrhoea	1
Kidney, disorder of not listed elsewhere	2
Nephrectomy	2
Nephritis	2
Nephrotomy	2
Prostatitis	2
Pyelitis	1
Testicle, disorder of	2
Transurethral Resection	3
Tumors or Cysts, non-malignant	2
Varicocele, Hydrocele	1