# OVERINSURANCE

A. Is there more evidence of speculative buying in connection with:
   (i) Ordinary and group life insurance,
   (ii) Accidental death benefits,
   (iii) Disability income benefits?
   Are large amounts of accidental death benefits on business insurance justifiable?

B. To what extent are the expanded disability provisions of the Social Security Act affecting the underwriting of disability income benefits under life or health insurance policies?

C. In connection with individual and group hospital and medical expense benefits what steps are being taken to avoid overinsurance through
   (i) Initial underwriting,
   (ii) Renewal underwriting,
   (iii) Policy provisions?
   What may be expected from the Insurance Commissioners' interest in the problem of duplicate coverage and possible statutory remedies for the situation? Is it desirable that policy provisions aimed at preventing overinsurance be permissive or mandatory?

*New York Regional Meeting*

MR. EARL M. MACRAE: The underwriters in the New York Life have not noticed any recent trend towards more speculative buying of individual life insurance. Our first year mortality on issues of 1959 is the same as for issues of 1958, but somewhat higher than on issues of 1957. However, the fluctuation is no greater than normal, considering the volume of business involved and the number of large amount cases in the exposure. Our second year mortality for these three years of issue has shown steady improvement. Therefore, we feel that the observations of our underwriters are confirmed by our mortality studies.

If we were experiencing speculative buying in connection with accidental death benefits, it would seem that a considerable portion of our issues would be with the triple indemnity rather than the double indemnity benefit. Our triple indemnity program was introduced in October 1960, and although we are issuing double indemnity on approximately 50 percent of our issues, by amount, the current issues with triple indemnity amount to only 3.5 percent. Furthermore, the average amount issued with triple indemnity is only slightly greater than the average amount with double indemnity and each is lower than the average amount without either double or triple indemnity. While this information is

not conclusive, it does suggest that there has been no recent increase in speculative buying of accidental death benefits.

With regard to large amounts of accidental death benefits on business insurance, our rule is to limit the amount payable by all companies in the event of accidental death to whatever amount we would regard as proper were there no accidental death benefits involved. We feel that accidental death will usually cause a greater loss to the corporation or partnership than death from natural causes and therefore we do not consider the purchase of *double* indemnity on business insurance as evidence, per se, of speculation. We do regard as questionable an application for triple indemnity on business insurance. Actually, we see very few business insurance cases involving relatively large amounts of accident indemnity and, so far, they have not caused us any problems.

In regard to section B, my company does not issue income disability as part of a life insurance contract, but we do issue a noncancelable policy providing for sickness income benefit for periods of one, two and five years, and to age 65. Our maximum issue limit for males is $500 per month or 60% of earned income, whichever is smaller. For business and professional women earning $650 per month or more, our limit of issue is $300 per month. For other females it is $200 per month. We recently discussed an increase in our limits for business and professional women, but decided against it, one of the reasons being the availability of Social Security disability benefits. It is true that because of the strict definition of "disability" under the Social Security system, not all persons eligible for benefits under our policies would also be eligible for Social Security benefits. However, we felt that we should take into account the possibility of a liberalization of Social Security benefits or of their administration, or both. Should any such liberalization be made in the future, we will consider the adoption of more conservative limits for both males and females in the light of then current conditions.

As to section C, individual medical care insurance, my company has a limit for hospital coverage of $25 per day in all companies. We do not issue major medical if the applicant already carries such coverage (either group or individual). Our policies are guaranteed renewable and they do not contain any provision for limitation of benefit because of other insurance in force on the life.

MR. BARTON S. PAULEY: The speculator is always with us, but probably no more so today than at any other time. I have not heard of any fraud ring operations for some time. However, airline trip insurance by machine appears subject to some abuse and I recently saw a suspicious claim where automobile accident trip insurance was part of the picture.

Speculation presumably succeeds only if the reasons behind it are concealed or glossed over in some way. Sometimes the speculator is helped because an agent is not alert to warning signs or because a physician is not completely frank with us about his true suspicions. The public is growing increasingly aware that misrepresentations carry no penalty after the contestable period has expired. The courts tend to favor the policyholder on the slightest pretext. We must protect ourselves by good initial underwriting in both the field and the home office.

There are indications that some underwriters may be forgetting the depression evidence of the hazards of innocent looking overinsurance, particularly when they offer limited amounts of insurance. The mortality losses of 5 companies are going to be the same whether they each overinsure one of 5 lives by taking $500,000 or share all 5 lives by each taking $100,000 on each life.

There is definite evidence of antiselection at some of the young ages, particularly in the teens. Parents buy $10,000 instead of $5,000 on the careless driver and they ask for $20,000 additional accidental death benefit. The inspection companies catch the applicants with a really bad driving reputation, but it is impossible to sort out degrees of moderate recklessness. Fortunately, even a 200% mortality at these young ages is of relatively small financial significance. If we contrast the occupations of those adults who buy our double accidental death benefit with those who do not, we see that the public is alert to even a slight bargain.

We at Prudential are not adverse to large amounts of accidental death benefit on business insurance. Much of this insurance (partnerships, close corporations) serves the same purpose as personal insurance in the end. We also recognize that untimely accidental death can cause additional loss, especially if it occurs in the midst of an important deal or negotiation. We look primarily at the total life insurance in relation to the financial picture and rarely question the accidental death benefit unless there is some question about the total life insurance. Our limit of issue for accidental death benefit is $150,000. A borderline overinsurance case is much more borderline if a substantial amount of accidental death benefit is asked for.

MR. GEORGE L. HOGEMAN: This discussion will be confined to individual life and accidental death benefits insurance.

In the Aetna Life there has been no statistical evidence of speculative buying in connection with Ordinary life insurance. Our average policy size has increased from $8,700 in 1957 to $10,800 in 1960. This is not a dramatic increase by any measure. The proportion of our Ordinary life volume represented by applications of $25,000 or more has stayed

remarkably constant at just under fifty percent for the past two or three years. Our individual accidental death benefits are limited to an over-all issue limit in all companies of $150,000, so we do not see applications where a suspiciously large amount is involved.

While the recent intercompany large amounts study shows that large amounts as such can produce favorable mortality, there are very scanty data available on the experience on policies which are large in relation to the insured's financial status. Eventually this material will be available, since the companies contributing to the intercompany large amounts study are being asked to code for each such risk the amount of current income. It will take some years before this experience is available and

TABLE 1

INSURANCE AS A MULTIPLE OF EARNED INCOME

| Age | 75% of Temporary Annuity* to Age 65 | 37½% of Annuity* Deferred to Age 65 | What 20% Buys on Ordinary Life |
|---|---|---|---|
| 20 | 19.5 | 1.0 | 17.3 |
| 25 | 18.2 | 1.1 | 14.9 |
| 30 | 16.7 | 1.3 | 12.5 |
| 35 | 15.0 | 1.4 | 10.4 |
| 40 | 13.1 | 1.7 | 8.7 |
| 45 | 11.1 | 1.9 | 7.1 |
| 50 | 8.8 | 2.2 | 5.8 |
| 55 | 6.3 | 2.6 | 4.7 |
| 60 | 3.4 | 3.2 | 3.7 |
| 61 | 2.8 | 3.4 | 3.5 |
| 62 | 2.1 | 3.5 | 3.4 |
| 63 | 1.5 | 3.7 | 3.2 |
| 64 | 0.75 | 3.9 | 3.0 |
| 65 | 0.00 | 4.1 | 2.9 |

* Table $X_{17}$, 2½% interest.

published. In the meantime, each company has to make up its own mind as to what represents an overinsured risk.

Two or three years ago, we calculated the present value of a temporary annuity to age 65 on Table $X_{17}$ at 2½% interest. If it is assumed that one-quarter of the applicant's earned income is needed for self-support, then the remaining three-quarters of this temporary annuity is a measure of the insurable value of his future earned income. In the same way, we made a similar calculation of the present value of postretirement income assuming income would be reduced to 50% of the preretirement level. Next, we calculated what 20% of earned income would buy on the ordinary life plan, expressing the result as a multiple of earned income. Table 1 shows the results.

From this table, we then established the range within which a case would not be considered as representing overinsurance (Table 2).

The junior underwriters may approve cases within their factor limit, but any application which exceeds it is referred to an executive underwriter, who may approve up to the limit in the right hand column if unusual circumstances warrant. In applying such discretion, we try to take account of any prospect of an increase in earned income, and we also try to remember that deflation could make a borderline financial case become overinsured, thereby aggravating antiselection by nontermination.

TABLE 2

FINANCIAL UNDERWRITING RULES
MAXIMUM MULTIPLES OF EARNED INCOME

| Age | Junior Underwriter's Factor | Executive Underwriter's Discretionary Factor |
|---|---|---|
| 20..... | 15 | 20 |
| 25..... | 14 | 18 |
| 30..... | 13 | 17 |
| 35..... | 12 | 15 |
| 40..... | 10 | 13 |
| 45..... | 9 | 11 |
| 50..... | 8 | 9 |
| 55..... | 7 | 8 |
| 60..... | 6 | 7 |
| 61..... | 5 | 6 |
| 62..... | 4 | 5 |
| 63..... | 3 | 4 |
| 64..... | 2 | 3 |
| 65..... | 2 | 3 |

If an application represents overinsurance, it is a substandard risk because there is a greater than normal chance of claim in such a group. The greater the degree of overinsurance, the higher the substandard rating ought to be. Therefore, neither reinsurance nor limitation of issue is an adequate solution. The proper solution is to rate such a case substandard, but in the present state of the underwriting art this is tantamount to declination. In our company, we normally limit an overinsured application to that amount which we believe is the maximum proper insurable interest. This is contrary to the theory just outlined and is an example of the fact that an underwriter must take some inadequately priced risks in those areas where his competitors do likewise. He must do so if he is to attract the adequately priced risks as well. The objective

is to be just a little more accurate than the competition both in assessing the degree of the price inadequacy and in the actual price charged.

In connection with accidental death benefits on business insurance cases, we do not believe large amounts are justifiable and consequently we try to discourage the feature in these circumstances. However, if the applicant is insistent, our usual practice is to count the amount of accidental death benefits as one-half in applying the financial underwriting tests.

MR. FRANK G. WHITBREAD: Some twenty-five to thirty years ago concern about death rates on large amounts of life insurance and accidental death benefits led to a ready acceptance by many underwriters of somewhat rigid amount limits and principles. While it was recognized that death might result in financial loss by different interests—a man's employer or his creditors, for example—in addition to the ever present economic loss to dependents, there was some feeling that the total amount of insurance carried should not exceed the multiple of income usually set as the maximum for personal needs only. So far as accidental death benefits were concerned, many companies adopted the practice of limiting participation in all companies to $50,000 and many underwriters were critical of allowing the benefit in any amount in business insurance cases.

In recent years—and favorable mortality experience undoubtedly played a big role here—underwriters have been more willing to recognize that the loss a family may suffer in event of the death of the breadwinner may be separate and distinct from the loss which an employer may suffer, and that these, together with the various other forms of loss which may be precipitated by death, may quite properly permit increased amounts of insurance to be issued. But it must be kept in mind that each of these separate limits tends to be quite liberal, so the question of speculation or overinsurance arises whenever the total insurance desired seems to be approaching the sum of the different limits permitted for each type of insurance involved.

Perhaps the most difficult type of case to handle—and which, unfortunately seems to have become more common in the past few years—has been the promotional type, where an individual has pyramided real estate and construction projects, or where he has created numerous interlocking, but apparently separate, business interests, some of which appear to be very profitable and some of which appear to cause loss. The ease in obtaining loans of substantial size, leading, as it does, to requests for insurance to cover the full amount of the loan, also contributes to difficulty on these cases.

The problem has been made even more acute by the decreasing term plans many companies have recently introduced, since such plans make available large amounts of insurance at quite nominal cost. For these plans, the general practice of my own company, the Lincoln National, has been to limit the amount to what we would issue on the ordinary life plan, with increased amounts allowed only when the future prospects of the insured appear to justify more favorable treatment.

In a rare case the guaranteed insurability rider has suggested that future amounts may be excessive, but generally speaking agents seem to sell this coverage only where there is reasonable prospect that additional insurance in future years will be justified.

It is easy to think of speculative buying only in connection with large amounts. Underwriters, however, should be continually aware of the possibility of selection against the company or speculation, whenever insurance is applied for at older ages—over age 55, say—and there is difficulty in determining what financial loss needs to be covered.

In my own company, we are seldom concerned about large amounts of accidental death benefit since we adhere to a maximum participation limit of $150,000. However, occasionally the large amounts made available by other companies are disturbing to both home office and field underwriters.

In past years, double benefits for certain common carrier accidents have been a popular full coverage in personal accident coverages. Some life companies have recently picked up this common carrier coverage and added it to their double indemnity rider to make what is loosely called triple indemnity coverage. As this practice becomes more common, it seems certain that more difficulty with speculative amounts of insurance will be encountered.

The question regarding large amounts of accidental death benefits in business insurance cases is also an intriguing one. For a long time most underwriters felt that accidental death benefits should never be allowed in business insurance cases. Today it seems the only question is, "How much is too much?" There is little doubt that in a growing business, where most of the available money is being used for development, the buyer may think it necessary to round out insurance needs with the accidental death benefit. This is not dissimilar to the situation with individual insurance where many people—especially younger people—cannot buy the full amount of insurance needed and consequently must place some reliance on the accidental death benefit to build up an insurance program of more adequate size.

Our general approach here is that unless we would approve additional

insurance on a permanent plan, the additional accidental death benefit should not be accepted. With both individual and business insurance, when the applicant is a young man with promising prospects, there is probably little risk in allowing such future prospects to influence the determination of satisfactory limits. In no event, however, do we exceed our maximum participation limit of $150,000 for the accidental death benefit. We feel that there is considerable hazard in large amounts of accidental death benefits and the very small premium involved should discourage, rather than encourage, the issue of excessive amounts.

MR. WALTER A. MERRIAM: I feel there is some increasing anti-selection against companies, although I have no way to measure it. Also, I believe that there is greater knowledge on the part of applicants on how to groom for an examination. For example, we occasionally see blood sugar tolerance tests in which our laboratory people think there is pretty clear indication that the applicant was taking a certain drug.

Also, it seems to me that applicants are much more aware of how to put pressure on a company and how to play one company against another. Where is the agent who doesn't think his company is the toughest? And where is the agent who isn't quick to tell you that the so-and-so company has issued standard and you haven't?

In addition, it seems to me there is a greater unconcern as to such niceties of civilization as honesty and fair dealing.

In the matter of the accidental death benefits in business insurance cases, our attitude is that of other companies. The question as worded uses the word "large," which is a relative term. An amount can be large only in relation to the case at hand and we look, as others do, at the total amount that would be payable in the event of accidental death in relation to the insurable worth of the applicant.

MR. ANDREW C. WEBSTER: With respect to section A, I should like to mention that before the roof fell in on large risks in the thirties the mortality was rather good for a period up to about five years. It is true today that our large risks have shown excellent mortality, but this is largely due to the superior underwriting precautions that were taken after the bad experience of the thirties. It is my opinion that these same precautions are not being continued at the present time.

For example, the promotional type of insurance mentioned by Mr. Whitbread has increased greatly in the last few years. It is not unusual for a business which was started by subscribing or borrowing a half million dollars to apply for a million dollars of insurance on the life of their key employee on the grounds that, if he lives, the business will make a million dollars over the next ten years. This would seem to be

a violation of the insurance principle that if there is no measurable established loss, there is no measurable insurable interest.

I agree with Mr. Whitbread that overinsurance is not confined to large risks, for there is, I think, slight evidence in the annual mortality reports that the mortality experience for the first, second, and third policy years is not as good as in the past.

On the question of accidental death benefits, either on business insurance or on regular insurance, my view that speculation is increasing has not been justified by mortality results. However, if you look at accidental death benefits experience, there is a wide variation by contributing company which would indicate that the experience may be a matter of luck.

MR. ROBERT B. GOODE: In general, the answer to the first part of this question regarding more evidence of speculative life insurance purchases seems to be "yes," and the answer to the second part regarding the justifiability of large amounts of accidental death benefits on business insurance is "usually not."

While speculation is entirely possible by the individual to whom $10,000 is a lot of money, I think we are more concerned with the larger operators. Let's bear in mind that in many cases corporate dollars are being used to pay premiums and corporate dollars are usually smart dollars. We are finding in recent years that the sophisticated life insurance purchasers have been turning to term insurance.

If we accept the basic premise that term insurance is more speculative than permanent insurance, then we need turn only to the 1959 intercompany large amounts study to find evidence of increased speculative buying. We have traditionally accepted higher mortality on term plans than on permanent plans, but we are finding the spread between permanent and term mortality getting larger, and even more alarming is the worsening of experience on term plans at the young ages and early durations, as shown in the 1959 large amounts study. The combination of a large amount of term insurance and a low issue age has led to surprisingly high mortality ratios for the early durations. Accidents and homicides account for a large proportion of this excess mortality and they are more frequent in this group than among other young persons. The reasons for this may be quite significant when considering speculative buying, but I will not go into these reasons here.

I would like to make a few further comments on evidence of speculative buying of ordinary life insurance and point out areas where speculation can most easily be studied.

First, speculative buying can most easily be identified when consider-

ing applications from older, retired persons. The total future financial requirements of these people can usually be readily determined and applications for amounts in excess of these financial needs often indicate speculation. Here is an area that can easily be watched and can often provide interesting results.

Substandard business in the very high mortality classifications presents another opportunity for us to study possible speculation. A willingness to pay $200 per thousand, in the absence of a compelling reason, certainly points up the presence of speculative motives.

Guaranteed insurability riders currently being offered may offer some opportunity for long-range speculation, and in recent months we have seen evidence of applications for guaranteed insurability being submitted to several companies for their maximum issue limit. This would seem to be a rather expensive way to speculate, but some companies have seen fit to include a question in Part I of their applications regarding existing or applied for guaranteed insurability coverage.

Moving now to evidence of speculation in disability income benefits, I would only like to mention an intriguing new approach to an old game which may become popular again. This involves using financed life insurance to convert disability waiver of premium benefits to disability income benefits. While premiums are being waived, the insured can still borrow the increase in cash value and thus provide himself with a form of disability income. I understand there have been a few recent examples of this approach, and it is one which will certainly bear watching in the future.

Also in considering speculative buying in conjunction with large amounts, we should bear in mind that it is easy to confuse speculative buying with overselling, particularly in years when production is down.

In connection with the last part of the question concerning large amounts of accidental death benefits on business insurance, the answer will usually be that such benefits are not justifiable. Some small justification may be made in that occasionally corporations add accidental death coverage to key man insurance and noncontractually pay the accidental death benefits to the widow, whereas the corporation retains the proceeds from the basic policy. Whether or not this is ample justification is open to conjecture, but at least it provides some motive for including such benefits in business insurance.

MR. DOUGLAS T. WEIR: The view of several Canadian underwriters and actuaries is that there is less evidence of apparent speculative buying of ordinary and group life insurance in Canada than, say, in the two preceding years. The reverse is true of the situation in our United States

market where there is a sharp increase in cases presenting an overinsurance aspect.

It is my feeling that there is plenty of evidence of overinsurance in connection with disability income benefits. Although initial underwriting generally prevents speculation at the time of issue by limiting participation to 50% of earned income up to a maximum of $500 to $1,000, some companies continue to ignore or give less than 100% weight to casualty benefits. Furthermore, the availability of noncancelable and commercial insurance, which generally has much higher limits, makes it possible to achieve coverage approaching full net income after issue.

It seems obvious that all benefits should be given full weight and serious overinsurance even for temporary periods should not be consciously approved at issue. A realistic prorate clause seems an essential safeguard but is rarely used, if at all, in life income disability benefits and is only at the level of full income before taxes in the Sickness and Accident field in Canada.

Large amounts of accidental death benefits on business insurance are justifiable if the business is shy of working capital and can afford cover for only part of its valid insurance needs. Even then a smaller amount of full cover seems more sensible and hence less speculative. In practice ADB business purchases are quite freely granted. These tend to be of high average amounts where antiselection by amount is indicated both in the Society reports and in the Bureau of Accident and Health Underwriters' studies.

In my experience in underwriting, corporations, especially smaller ones with a handful of insured executives, can select judiciously on an individual's accident potential. It can be based on a precise information regarding driving habits, for example, which will not be available to the insuring company. Such purchases if granted should be selected with caution.

MR. ARTHUR PEDOE: In the last twenty years there has been an enormous improvement in the United States population mortality in the age range 20 to 70. It seems to me that all the underwriters have to do is to eliminate speculation and then go along for the ride.

MR. J. HENRY SMITH: Speaking on section A, we have not found in our underwriting any evidence of an increase in the speculative buying of individual insurance.

As to large amounts of accidental death benefits in business insurance cases, it is now widely held that this form of coverage has a legitimate purpose in that the early death of a key man by accident may be especially difficult for the business. It appears that many firms want accident

insurance and are going to buy it one way or another. Therefore, it may as well be provided through the inexpensive double indemnity form, thus making the salesman's package more attractive and the sale of life insurance somewhat easier. It appears that so long as the amount of benefit is reasonable in relation to the individual's worth to the corporation, so long as the firm is financially solid and there is no cause to suspect speculation, and so long as the benefit is consistent with the company's underwriting rules generally, there is not much more reluctance in providing large amounts of this form of benefit for business purposes than for other purposes.

As to section B, the Equitable re-entered the field of individual disability insurance on January first of this year, after a lapse of forty years. Our underwriting rules were developed after the last changes were made in the Social Security Act and they reflect our attempt to encourage policies with long durations. Our present rule is that where the sickness benefit period is over 30 months, Social Security benefits will be taken into account. Our participation limits are 60% of earned income with an outside maximum of $750 per month. This rule occasionally forces us to limit the amount of disability income benefit to some figure below that applied for.

Although we receive vigorous complaints from affected agents who have suffered competitively from this rule, and although it may be argued that the administration of Social Security benefits has been vigorous so that only those who are certainly disabled are admitted to benefits, we feel that in the light of history—and here we speak from rather bitter experience—and underwriting theory, there is no excuse for disregarding important elements of overinsurance whether they be another company's disability coverage or Social Security benefits.

It must also be realized that many types of disability may disappear or become significantly alleviated. If the individual's total disability income is high, what motivation will there be for him to return to work? Furthermore, I am convinced that we cannot depend upon the administration of the law to continue to be tough and that we must anticipate the well-established pattern of continual liberalization in governmental benefits in all directions.

MR. WILMER A. JENKINS: For four years Teachers Insurance has been writing a group long-term income disability benefit. This has also been coupled with a waiver of premium benefit, the premiums waived being those payable under the college's retirement plan. Our underwriting of this disability benefit has been affected in certain ways by the new

Social Security disability provisions, but the over-all effect has not been important.

The group disability benefit we have been writing is gauged to needs of college people and usually involves moderate amounts of income benefit, our maximum being 50% of salary. However, for the higher salary in unusual cases there is need for rather substantial amounts, running up to as much as $800 per month of income benefits. The waiver of premium benefit is, of course, in addition to these amounts. As is true of group coverages generally, our policy is cancelable and the rates are adjustable. Both the waiver of premium and income benefits begin after six months of disability and cease at age 65, the retirement plan taking over and supplying income after age 65.

All along we have been convinced that, wherever possible, under a coverage of this type our benefits should be reduced by other disability benefits, and we have done this to the extent possible. Accordingly, when the first Social Security disability benefits law came along, our policies already provided that any governmental benefits received by the individual were deducted from our benefits. We haven't deducted these governmental benefits automatically if the individual is eligible for Social Security benefits; we deduct only if he gets the Social Security benefits, or is disqualified because of the work clause or rehabilitation clause or because he hasn't done everything he could to get the OASI benefits. By this, we may in a way be underwriting the Social Security benefits, but we didn't think the risk was great and were convinced that our coverage would not be really satisfactory if we were to deduct Social Security benefits that the individual couldn't possibly get.

Now, there were several effects of the recent Social Security disability benefits expansion. In the first place, of course, the reduction provision in our policy applies to many more people; that is, all people under age 50 are now involved. Thus, the over-all average amounts of our income benefits are reduced somewhat and expense rate correspondingly increased.

A second effect is that, in the case of certain low-paid employees, we would pay no benefit whatsoever if we simply deducted the Social Security benefits. This wouldn't happen very often for college people over age 50, so the extension below age 50 really made this a new problem. Paying no benefit whatsoever to an individual didn't seem satisfactory when we apparently had been collecting premiums for the same person under the group policy. Technically, this is perfectly fair because the premium is an average one and takes into account the actual coverage, but it is very hard for employers and employees to understand why there should

be a premium where there is no benefit. As a result, we made a change in our policy provision so as to provide a $50 minimum monthly income benefit in all cases. Of course, this minimum, as well as all of the reductions in amount on account of Social Security, has been reflected in premium rates.

A third effect of expanded Social Security disability benefits was a little troublesome. This had to do with dependent government benefits in event of disability. All along, our policy has provided that our benefits will be reduced, not only by employee benefits, but also by dependent benefits if based on the employee's wage record. This works out satisfactorily unless the family income is so reduced by the husband's disability that the wife must work to keep the family together. But when this happens, it didn't seem fair to us to deduct the dependent's benefit when the wife couldn't get the benefit because she violated the work provision. Accordingly, we don't deduct the wife's dependent benefit in these circumstances.

On the whole, the effects of the expanded OASDI disability benefits have not been important. They have reduced somewhat the over-all scale of benefits granted by our policies and thus make them somewhat less beneficial and desirable, but a real and substantial need for these benefits still exists.

MR. FRANK H. DAVID: To qualify for disability benefits under the Social Security Act, the applicant must be totally and permanently disabled, and there is a waiting period of six months. We understand that the provisions of the Act are being administered strictly. The Prudential's income protection policies have a more liberal definition of disability, and most of them are written with elimination periods of less than six months. As a result, most policyholders who would qualify for benefits under our policies would not be immediately eligible for Social Security disability benefits. Moreover, the Social Security Act calls for a rehabilitation program; refusal to participate in it may result in loss of benefits. We feel that this feature will be helpful in controlling abuse and in shortening the period for which benefits may become payable under our policies. For these reasons, we disregard Social Security benefits in determining the amount of disability income for which an applicant is eligible. It is possible, of course, that future changes in the provisions or the administration of the Social Security Act may cause us to reconsider this practice.

MR. JOHN H. MILLER: I think that if we take into account not only the Social Security Act but the impact of federal income taxes in underwriting disability income benefits, we may find that the percentage of

income that is insurable has been leveled out by the introduction of Social Security disability income benefits. Perhaps the answer is to start in with a lower maximum percentage of gross income rather than specifically consider the Social Security benefits.

MR. ROBERT P. COATES: This discussion is confined to the use of policy provisions to avoid overinsurance in connection with individual hospital and medical expense benefits.

The Uniform Individual Accident and Sickness Policy Provisions Law contains optional clauses which provide for pro-rata reduction in benefits if coverage with other insurers is held and written notice of such coverage is not given to the insurer.

This limitation in regard to notice was basically sound when the standard provisions were developed some years ago. In effect, if an insurer chose not to be concerned about coverage of which it had notice on the application, the insurer should not later reduce its benefits because of such insurance. Furthermore, if the insured took out additional insurance and told the first insurance company about it, that company had the option, in the cancelable policies typical of that time, of judging whether or not the additional coverage constituted objectionable overinsurance and of canceling its policy.

Now that insurance companies are offering guaranteed renewable coverages and the companies with cancelable forms are under great pressure to use cancellation rights only in extreme cases, the notice requirement in this clause has ceased to be appropriate. Some states, however, have not been willing to permit the standard provision to be altered to be consistent with guaranteed renewable coverage and in such states inclusion of the present provision can lead to absurd results. If a policyholder who is attempting to create deliberate overinsurance purchases excessive insurance, all he has to do is to notify the company with the prorating provision of this coverage and it has lost its statutory defense.

In the major medical field a more logical approach might be a policy which would supplement basic coverages on an "excess coverage" basis. For example, the deductible might be expressed as the greater of a flat amount or the basic benefits, with appropriate adjustments made to the premium rates for the level of basic coverage. Furthermore, with the trend toward expansion of basic coverage, such a policy would automatically adjust for this trend, thereby significantly easing the problem of premium increases resulting from higher medical care costs. While there are many practical problems facing such a policy, it would be particularly unfortunate if the present prorating standard provision proved to be

an obstacle to state approval of policy forms embodying a principle that appears theoretically sound and in the long-range public interest.

As to whether policy provisions aimed at preventing overinsurance should be permissive or mandatory, there are many sound arguments for a mandatory approach to this problem. If it is agreed that overinsurance is unsound, a mandatory provision would seem to be the appropriate remedy. Moreover, if all policies must contain such a provision the questions of competitive sales advantages or disadvantages cease to exist.

On the other hand, I believe there needs to be much more unity of viewpoint before we are ready to think concretely in terms of a uniform mandatory provision for individual policies. For example, what should be the relationship between individual policies and the coverage offered by the Blue Cross–Blue Shield organizations? How should group insurance and the health insurance benefits included in many automobile insurance policies be recognized?

With the variety of coverages that exist it will be a most difficult matter to draft any reasonably understandable clause which can be expected to have universal application. I am persuaded that the course, at least for the present, should lie in the direction of granting the companies more freedom to experiment with clauses appropriate for the benefits offered. It may well be that some supplement or amendment to the Uniform Standard provisions will be called for to facilitate this endeavor and it is to be hoped that the necessary area of agreement to encourage a uniform enactment can be created in the reasonably near future.

Overinsurance is a problem that may become of greater importance in the future and will require much constructive effort before its complexities can be overcome.

MR. BURTON E. BURTON: In recent years the Aetna Life has become increasingly concerned with the problem of overinsurance under group medical expense plans. In the future, as medical insurance plans become even more widespread and as benefit levels continue to increase, it seems reasonable to expect duplicate coverage to become more prevalent and the degree of overinsurance in relation to medical charges to increase.

For our comprehensive and major medical plans we have adopted a broad nonduplication provision which includes any other employer-sponsored plan, whether provided by an employer of the employee or by an employer of any of his dependents. These provisions are admittedly difficult to administer, but with employer cooperation we believe they can provide a reasonably effective control of overinsurance.

As employers have become more familiar with our comprehensive

and major medical coverage, we have experienced increasing interest in similar nonduplication provisions for basic medical expense plans. Unfortunately it is doubtful that such provisions would be approved for these basic plans in several important states.

To a lesser degree, we at the Aetna were concerned with overinsurance under group medical expense plans before the advent of comprehensive and major medical coverage. At that time, however, benefits provided by the typical basic hospital or surgical plan represented a relatively small proportion of the total medical expenses incurred by an individual with respect to an illness, and therefore it was unlikely that an individual would show a financial profit from his illness. Today many of these basic medical expense plans cover expenses incurred out of the hospital as well as in the hospital, and the benefits are often at a level equal to 80% or more of the actual medical charges. Up to now the only steps we have taken to avoid overinsurance under these basic plans have been, first, a strong resistance to the coverage of dependent husbands and, second, the verification in both initial and renewal underwriting of the absence of other employer-sponsored medical plans.

MR. JOSEPH W. MORAN: My remarks are directed to section C.

At New York Life most of our control efforts have been through major medical policy provisions, but policy provisions are not enough.

Our group major medical plans, including comprehensive plans, have included a general antiduplication provision which excludes coverage of "any charges paid for or furnished under any other group, franchise, Blue Cross, Blue Shield, or other service or prepayment plan arranged through any employer, association, trustee, union, or employee benefit association as reported to New York Life by the employer or otherwise, to the extent so paid for or furnished."

The fact that we have to include "as reported to New York Life by the employer or otherwise" introduces what I think is the most important problem: enforcement of whatever you include in the policy. We have found that it takes a great deal of effort and initiative on the part of the group claims organization, including some real detective work, in order to get any effective results. You cannot detect duplicate coverage by just having claims clerks process papers. You have to have claims men who can take the initiative to set up a system for finding out where the employee's spouse is employed. In one test, a claims man found unreported duplicate coverage amounting to 10 times his salary over a period of several months.

We have brought antiduplication limitations into basic medical care coverage through the back door. When we started writing major medical,

we found we needed and could sell policies with antiduplication provisions. When major medical extended down into the minor medical area with the introduction of comprehensive plans, we continued the use of the same antiduplication provisions for comprehensive plans which had generally been used for true major medical. Admittedly, the enforcement problem became greater and our enforcement is undoubtedly less effective.

After having made this entry into the area of protection against duplicate coverage on minor illnesses, virtually no company has since made any effective effort to extend it into the important area of basic hospital and surgical coverage.

In the few situations where we have suggested basic plans with antiduplication provisions, we have found essentially no employer sales resistance. As a matter of fact, we have been asked why we haven't done this all the time.

MR. JOHN H. MILLER: Whatever kind of antiduplication or prorating clause you have, the question remains, should proration prevent collecting more than the largest amount of insurance or should it permit you to collect the entire medical bill but nothing over and above that? I think that is a technical point of some interest.

Another phase of this problem of overinsurance is the question of medical relations and public relations. Many of us have talked with doctors on this subject and found that nothing annoys them more than to accept a payment under a Blue Shield plan or group policy, for a medical bill, having scaled their fee down to the amount of benefit provided, and then have the patient show up a week or two later with more papers for a second policy. That has a very serious medical relations aspect and I think also a public relations aspect. What impression does the public get when this is permitted?

Of course, the problem has been compounded by the great growth in medical payment benefits in other forms of insurance. This is pretty much limited to accident, but it is still a big problem. You have medical payments in automobile policies, home owners' policies, personal liability policies, travel policies, school policies—you can pile these one on top of the other almost without limit.

MR. CHARLES N. WALKER: In this area of overinsurance resulting from other types of coverages, we ran into the problem of selling both a blanket medical expense policy for accident and a hospital policy on the same life, even though they duplicated each other on accident claims. To avoid the obvious area of overinsurance, we designed a supplementary accident rider for our hospital policy which provides only an excess coverage.

MR. MILTON A. ELLIS: There is one point that might be stressed with respect to whether policy provisions should be permissive or mandatory. I don't think mandatory provisions would be politically possible. We must remember that the old Standard Provisions Law for individual health insurance was in the form of mandatory verbatim provisions, and the present law, adopted in 1950, went completely in the other direction by having both required and optional provisions, but in all cases you could use provisions more favorable to the policyholder.

In getting that law enacted in all states, which was done as a tremendous legislative effort, the supervisory people, the legislators and the insurance people all joined in stressing the importance of the "more favorable than" concept. To reverse our position now and say that the overinsurance provision should be mandatory would be, in my estimation, political suicide. We haven't sold many supervisory officials on the problem of overinsurance and many of them think in terms of life insurance—if a person pays a premium he should get the benefits, for if the companies don't take care of it by underwriting, it is their own headache. For that reason I don't think we should strive for a mandatory provision.

The present thinking of the industry, as expressed to the Insurance Commissioners at the last meeting, is that an overinsurance provision could provide that policies that did not contain such a provision would be considered primary insurance. Primary insurance would be paid first and then those policies that have the provision would be prorated to cover any excess claim. Thus, without being mandatory, we would give a great deal of weight to encouraging companies to put such provisions in their policies. Although this was stressed for loss of time coverage, the same principle might be carried over with appropriate modifications to medical care coverages.

With respect to the problem of medical relations, mentioned by Mr. Miller, I have heard our medical director tell me many times that the doctors don't understand how we can ask them to keep their fees low for low-income people and to work out state medical plans where the fees are accepted, when the people turn up with duplicate coverage thereby making a profit on their illness. When we are urging the doctors to do all that can be done to keep medical costs within bounds, they in turn will not stomach profit through overinsurance by their patients.

MR. ALTON P. MORTON: In the underwriting of health insurance benefits we will run into many special coverages, such as medical coverage in automobile insurance policies, hospital benefits in state compulsory insurance, etc. It is my feeling that we must give what we think is practical underwriting weight to any in-force coverages. We should depend

primarily on our initial underwriting rather than on special prorating clauses or other clauses to rescue us from trouble after the coverage is on our books.

Mr. David of my company mentioned previously that we are at the moment ignoring the disability provisions of the Social Security laws in our initial underwriting. This is only seemingly a violation of the principle I advocate above. This is so because our limit of issue is conservative in relation to the insured's gross income. Also, considering the longer waiting period and the special provisions of the Social Security law, we feel we will have enough margin so that these risks will in fact be coinsuring some portion of their gross income in the event of disability.

*Dallas Regional Meeting*

MR. JOSEPH W. HAHN: Our company, the Great Southern Life, had very poor mortality on its life insurance last year: it was about 10% higher than the average for the preceding five years. Four large claims, all due to accident, accounted for the excess mortality. On the other hand, our accidental death benefit losses were substantially under the five year average. Hence, we see no sign of antiselection with respect to this benefit.[1]

MR. LLOYD K. FRIEDMAN: I question whether any accidental death benefit on business insurance is justifiable. I remember that one of my clients told me several years ago about a rather large case of business insurance on which ADB was requested. The client's experienced underwriter was unwilling to issue the ADB. As a result, we sought reinsurance. Eventually it was placed without ADB. Two years later the individual was killed in a hunting accident. Both my client and the reinsurance connections were very happy that no ADB had been granted![2] Is it now considered good underwriting to grant accidental death benefits on business insurance, and if so, to what extent?

MR. ROBERT P. BRADY: I, too, would like to know the justification for double indemnity on business insurance. We at Republic National had a business case a few months ago on which I was surprised that our reinsurer accepted double indemnity and additional automobile accident indemnity. I presume we do it because everybody else does. I would like to know who the first one was!

MR. PHILIP F. FINNEGAN: I would like to ask, "What is the justification for double indemnity on personal insurance?" Those who justify

[1] MR. RALPH H. GOEBEL (Northwestern National Life) cited similar experience.

[2] MR. ANDREW DELANEY (American General Life) cited another example of ADB overinsurance.

it do so by saying it is cheap. You can use the same argument on business insurance.

MR. QUINTIN J. MALTBY: I suggest that double indemnity, whether business or personal, is not really a life insurance function. It is more of a casualty function.

MR. MORTON D. MILLER: In New York the argument was stated somewhat in this way—the young man has a greater insurance need than he is able to pay for. He has maximum family and home responsibilities, which are arguments for substantial term insurance. The worst hazard is accidental death, so completely unexpected. Maybe his limited funds should go to cover that hazard.

Otherwise, they are mostly sales arguments. I guess to many of us who have a gambling instinct, double indemnity looks like a small amount of money for a potentially large gain.

Since the Equitable is in group insurance, we do see the casualty side of the picture. A number of casualty companies will offer from ten thousand to five hundred thousand dollars of double indemnity on an individual choice basis to members of a group at seventy-five cents or one dollar per year per thousand.

We are concerned about the broad public relations aspects of large amounts of accidental death and dismemberment benefits. If a plane crash results from the manipulations of an individual trying to take advantage of large accidental death benefits made available to him, the possible public relations backwash comes into very sharp focus. It will be recalled, the Civil Aeronautics Board has reduced the maximum amount of travel accident insurance that is available through the Washington airport because of such considerations.

MR. RICHARD W. ERDENBERGER: In group insurance, I see increasing demands for larger amounts of term insurance. Invariably it appears on groups involving a partnership or sole employer. The employer is trying to get a lot of term insurance on himself at a minimum cost and a watered-down program for the employees. On numerous occasions we have declined them.

I am sure that anybody buying air trip insurance feels that this is purely speculative.

With regard to disability income benefits, I am not so sure whether speculation occurs before or after the claim. Even though expenses per unit are less on larger amounts, there is hardly a policy form in the Mutual of Omaha books on which the loss ratio does not go up with increasing amounts of benefits. This is especially true after $500 per month.

I think it is when they start receiving the benefits that they decide they have a good buy and stay out of work.

With the extension of the federal program to ages below fifty, we must take a forward look at business already on the books. Some programs which have had reduced benefits commencing at age fifty are obsolete.

MR. MENO T. LAKE: The risk committee at my company, the Occidental Life, invited a representative of the Los Angeles social security office to tell us about the substantial disability income benefits available.

We had convinced ourselves in the past that the definition of disability was so severe it would not create too much of a problem. Also, the act provides for rehabilitation services which you might expect would put the disabled back at work in the shortest possible time.

They will try to rehabilitate a disabled person if they are asked. Their staff isn't equipped to handle even five percent of the cases they are presented.

We feel we must modify our underwriting rules to consider this social security benefit in our issue and participation limits. Integrating benefits with social security benefits seems like a real possibility. There is a problem in determining a charge when the exact benefits are unknown. The insurance departments might not approve quickly either. In California we beautifully fill in the six-month waiting period with UCD benefits up to $65 a week currently.

We are reluctant to be squeezed out of this field on young men earning less than $600 a month. We hope the picture isn't that dark.

MR. RALPH P. WALKER: There are a number of considerations in setting limits. One is to adequately insure a single man without having him become overinsured when he marries and later has children. As soon as the children are grown he becomes underinsured.

Heretofore, our Wisconsin National Life underwriters have taken eighty percent of income after taxes as a limit, including all types of benefits. As a practical matter, they disregarded social security disability benefits. Therefore, some risks are overinsured right now. Other companies' underwriters indicate they have disregarded them too.

We have been considering a limit in the neighborhood of fifty percent of income for long-term benefit periods. We do not issue in states with UCD benefits so we anticipate a supplementary benefit for the first six months.

MR. MILLER: Do you think that ultimately this will be a problem of integrating benefits with social security similar to pensions?

Of course, in the pension area there is less concern with the underwriting hazards of too much insurance.

My company, Equitable of New York, has taken these social security benefits seriously right along. Our new guaranteed renewable income disability program takes into account that over a period of time the careful administration and high disability restrictions will not stand up. This is another instance where almost without our realization the government has taken over an entire area of our activity to a very substantial extent.

MR. ERDENBERGER: In connection with section C, I read about situations of overinsurance in the *Wall Street Journal*. A survey in Alabama found a fantastic number of individuals with more than one health insurance policy. Some had as many as seven policies, on up to fifteen or twenty, and one individual even had thirty-five. Another example cited several students at the University of Texas who were going into the hospital on weekends and holidays and collecting duplicate benefits on seven or eight policies, thereby putting themselves through school.

You can establish some control through initial underwriting. On a commercial policy you can cancel after the first claim when you discover overinsurance. Group major medical contracts generally have an antiduplication clause. Not many individual policyholders want to include such a clause deducting anything that may be payable under workmen's compensation, automobile liability, etc. Employers, however, can be convinced that it is actually their money buying these duplicate benefits, and they are happy to include these restrictions.

MR. FINNEGAN: We do not have too many cases of overinsurance, and I wonder if we aren't a little tougher than most companies with our initial underwriting. Only in rare instances will we rewrite an individual hospitalization policy on top of group coverage where the employer pays any part of the premium, even if the individual does not elect to have the group insurance. Of course, our field forces argue that there are many reasons for purchasing individual insurance, such as it being guaranteed renewable even though they change their place of employment. With the amount of insurance in force shown in the application, the underwriter can do a proper job of underwriting unless there is misrepresentation. Even if the policy is incontestable after two years, the probability is good that a claim will occur within the two years and you are in a position to do something about it.

MR. GENE P. ARCHER: Our underwriting department at American Hospital and Life Insurance Company will refuse to issue individual

hospital benefits where they feel there can be a loss. However, some of our policyholders do not tell us how much insurance they have in force. Our field force and inspection reports do not always find out how many policies a man has, either.

I believe the fire insurance principle should apply in connection with hospitalization. The claim payments should not exceed the cost. In fact, I advocate coinsurance because it has some beneficial effect on how quickly he gets out of the hospital and on how much the doctor charges.

Our claims attorney has been very active in making use of the prorate clause in the Uniform Act. We have been successful on one or two occasions in the courts in connection with fraudulent obtaining of insurance. He has also told the commissioners about the problem. He said the industry has failed miserably in taking strong legal action, and he urged the NAIC to clean our house for us. The prorate clause should be made a mandatory part of the individual policy.

MR. MORTON J. KENT: At Interstate Life & Accident, our new series of guaranteed renewable hospital policies has various categories of daily benefits and surgical schedules, and ties the underwriting of a particular category to the income of the individual. In most areas there is a correlation in the cost with the income. We also put in the prorating clause. We have not had a prorating clause before, and so I am wondering whether anyone else has been successful in using it to a large extent.

We have a fire insurance company. We have experienced where people in the government actually enforce the avoidance of overinsurance and do the investigation without a feeling of bureaucratic direction. I think the same thing could happen in hospitalization.

MR. WALKER: We at Wisconsin National Life have used a prorating clause in our commercial policies for some time and we hesitate to use it any more than absolutely necessary. If you follow the clause strictly and you have not had notice, you should prorate whether there is overinsurance or not. We do not use the prorating provision in our guaranteed renewable policies. A better provision is needed.

There is also the problem of getting overinsurance by government action. We have attempted to meet that problem by excluding payment where the person is entitled to government care of service, without legal obligation to pay if the policy were not in force. Ten states have approved and only Illinois will not.

Initial underwriting can't anticipate the problem of the subsequent introduction of group insurance or lax underwriting of another company after the individual policy has been issued.

MR. ALFRED N. GUERTIN: At a recent industry meeting, the representative of a company writing a large amount of individual health insurance coverage made the point that his company had a specific program for the writing of hospital coverage on persons already holding Blue Cross, a deliberate duplication of coverage, on the basis that there are many costs in connection with hospitalization over and above those covered by Blue Cross, and that a supplementary hospital insurance policy will meet such a need. I thought this was a very interesting statement, and would be interested in any discussion of this practice.

MR. GEORGE M. SHERRITT: I am of the firm opinion that duplication of benefits to the extent of profit to a policyholder has been forced upon him by the insurance companies. Policyholders themselves do not expect this and often are not even aware of it. I favor the excess coverage approach over the present prorating provisions because the benefits of two policies are often needed for treatment of certain conditions.

I would like legislation to this effect: "If, as a result of any one injury or sickness, the amount payable under this and all other policies providing benefits for the medical care as defined for this purpose by the laws of the state where this policy was delivered exceeds the total expense of medical treatment as defined in the same manner, any such excess will be deducted from the amount payable under such policies in sequence according to the dates of issue and to the extent of the amount payable under each policy." Under this arrangement, the bills would be paid, but nobody would profit from a claim.

MR. GEORGE H. DAVIS: From the standpoint of the policyholder, it is reasonable to say that the first policy issued should pay first. If he purchases additional coverage, it should be with the knowledge that it will only apply to excess expenses. Looking at it from the standpoint of the issuers of the insurance, you can argue that it ought to be the other way around because, if not, you remove the incentive to prevent overinsurance from the later issuing company.

I do not think we can expect rapid progress from studies of the NAIC committee and the industry committee because of the enormous complexity of the problem. There is too much difference between group and individual insurance and between different types of coverage.

I feel the real solution lies in underwriting at time of purchase and not at the time of claim settlement, but I admit I do not have the answers for some of the questions raised in connection with initial underwriting.

MR. MILLER: The Life Insurance Association appointed a committee only a little while ago. The Health Association has had one for a number of years. The problem is a difficult one, further complicated by the

fact that if the Blue Cross–Blue Shield organizations do nothing, it gets to be a little one-sided. Duplicate coverage is important to doctors and hospitals too. They see that a profit can be made on more than one policy and wonder how we expect them to be temperate or reasonable with charges.

Statutes stand in the way, to which Mr. Walker referred in some detail. It isn't easy to figure out what the statutory relief should be. There has been some cooperation with Blue Cross and Blue Shield who have become conscious of this problem. Coming together at the commissioner level has also been helpful. If the Uniform Provisions Act is to be changed, it will have to be supported by the commissioners. The Blue Cross brought the problem to the attention of the commissioners. The industry committee will report their progress at the commissioners' meeting in June.

MR. ROBERT L. ROEBUCK: How much overinsurance can be eliminated through proper underwriting? This question ought to be answered before going too far with the mandatory provision. In addition, I am not convinced all such business is unprofitable. As a previous speaker has indicated, some individuals are making a mint of money because of this problem. At the same time, there are many good risks who have a number of policies because of a morbid fear of illness. No question is raised in these cases, I presume, unless there is a claim.

MR. GARY K. DROWN: As I recall, the fire insurance proration clause says, "a valid identical coverage." You do not have to have a standard policy although there is a tendency toward that. There is still room for ideas and new garnishments on your policies.

MR. SHERRITT: I am the last one to believe in the government, state or federal, having to solve our problems. However, this problem has been imposed on us by the Uniform Code because we are prohibited from using certain policy provisions which would prevent duplication of benefits. What good is a proration clause on a guaranteed renewable policy? I think some of us are reluctant to move into a senior citizens program right now because of the possibility of duplication of coverage if a government program takes effect after our guaranteed renewable policies have been issued. It is reprehensible to me for a single dollar of profit to be made through duplication of coverage after all medical expenses have been paid.

MR. WILLIAM E. BUTLER: You have to bear in mind that very, very few applicants for hospitalization insurance do not already have some coverage. Secondly, unless the original policy is kept through the waiting

period of the new policy, he does not have coverage. Further, the agent will indicate the old policy will be dropped as soon as the new policy is in effect. Waiting periods almost compel duplicate coverage for a period, and then he may just keep on carrying it.

MR. HAHN: I want to speak against mandatory policy provisions aimed at preventing overinsurance. I do not want rigidly controlled policy forms and rates such as fire insurance companies have (at least in Texas). Traditional mandatory provisions in life and disability policies are for the protection of the public and not for the companies. Certainly, some permissive legislation is needed.