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GROUP INSURANCE AND EMPLOYEE PENSIONS

Group Health Insurance

A. What changes have been or are being made in considering the following categories of medical services as eligible for insurance?
   1. Type of practitioner, such as podiatrists, oral surgeons, optometrists, clinical psychologists, other therapists, chiropractors, Christian Science practitioners, and naturopaths.
   2. Nursing homes and home care.
   3. Rehabilitation and custodial institutions.

B. What help have been the Society of Actuaries' annual studies of group weekly indemnity, hospital, and surgical morbidity experience? Do the results of these studies bear directly on current actuarial and underwriting problems? How can the periodic special studies of hospital and surgical claims be updated for office use by succeeding annual studies?

C. There continues to be considerable interest in group, franchise, or blanket plans offering large amounts of accidental death coverage on a twenty-four-hour basis, a nonoccupational basis, or a travel-accident basis.
   1. Is the coverage being offered on a basis where the individual has an option as to the amount of insurance?
   2. What has the experience been? To what extent is pooling of claims utilized?
   3. Is the underwriting of this benefit creating pressures to relax the underwriting of traditional group accidental death and dismemberment written with group life insurance?
   4. Is a lump-sum payment for total and permanent disability commonly desired as a part of such coverage? If so, what problems have developed in determining whether total and permanent disability exists?

D. Can dental care insurance be successfully underwritten? What demand is developing for this coverage? What types of benefits have been developed? What has been the financial experience to date?

MR. RICHARD H. HOFFMAN: Group health insurance can be characterized as a field that is constantly undergoing changes. Besides the rising cost of health benefits, another area of change is the expansion of health insurance plans to encompass the additional forms of medical care and treatment indicated by this topic.

In regard to types of practitioners other than M.D.'s, there has always been some question as to what types of practitioners are covered under various health insurance contracts. The answer usually has depended upon the definition of the physician used by the insurer. In recent years, how-

ever, another factor has entered the picture: state laws and insurance department rulings have required insurance companies to pay benefits for the services of certain types of practitioners if the services which they perform are otherwise covered by the plan. Thus coverage has been expanded in a manner not initially contemplated by the designers of the insurance contracts and in spite of the definition of physician used. Policyholders should probably be made aware of this.

These developments have made it necessary for companies to consider altering their contracts and administrative practices accordingly. Most companies have been using two types of definitions of physician. The broader one is "legally qualified physician," while the more restrictive is "physician legally licensed to practice medicine and surgery." According to a recent survey, many companies have covered the services of podiatrists, oral surgeons, and osteopaths under both definitions, while chiropractors, Christian Science practitioners, and naturopaths have been recognized only under the broader definition. Optometrists and psychologists have generally not been recognized except by a few companies, and then only under the broader definition.

The recent legislation and rulings have occurred in more than ten states, among them California, Michigan, and New York. In all these states the services of a podiatrist must now be recognized for health conditions otherwise covered under the policy. A few of these states include the optometrists, and California includes dentists on the same basis. Legislation of this type is expected to spread to other states and to include other types of practitioners.

Several alternatives are open to insurers in dealing with this situation.

1. To go all the way and recognize all legally licensed practitioners, a position which has recently been adopted by at least one company. The effect of this varies somewhat from state to state because of differences in licensing laws.
2. Same as (1) except that some conditions not originally intended to be covered could be excluded. For instance, some companies have excluded certain foot conditions from their policies.
3. Expand the definition of physician to include certain of the practitioners, that is, those affected by state laws or rulings, but not others.
4. Make no change in policies or practices but expand coverage only when forced to do so by legislation and rulings. Under this alternative, also, policy limitations could be used to exclude certain conditions.

The choice is an extremely difficult one, and there would appear to be no easy solution in this very complicated area. In any event, this expansion is bound to increase costs.

In the past few years increasing interest also has been shown in insur-

ance for nursing-home care. This prompted the Health Insurance Council to appoint a subcommittee to make a study, and the subcommittee subsequently developed some illustrative provisions which are available to members of the Council. Almost concurrently such coverage was introduced in the Retired Federal Employees Benefit plan and in other senior citizen programs, such as the State 65 plans.

The major purpose of this coverage is to permit a patient to convalesce in a nursing home, rather than in a hospital, after he has reached the point in his recovery where the more extensive hospital facilities are no longer required. The purpose is not to provide custodial care. Thus nursing-home coverage may be considered as an extension of protection afforded by a basic hospitalization or comprehensive major medical expense plan.

The type of plan developed by the Health Insurance Council, which would be appropriate as an extension of a typical group insurance plan, provides benefits on a two-for-one basis (i.e., two nursing-home days are equivalent to one day of hospitalization). Daily benefits for nursing-home charges would be payable up to an amount equal to one-half of the base plan daily room-and-board maximum for a period not exceeding two times the unused balance of the remaining hospital room-and-board days. A further limitation on the duration of coverage of, say, sixty days is also placed on such benefits.

In the typical senior citizen plan, the number of days available is not tied in with the hospital plan. These plans generally provide benefits in the form of, say, $7.50 a day for sixty days in addition to hospitalization benefits.

One of the most troublesome problems is defining an eligible convalescent nursing home. Although a nursing-home accreditation program is in the process of development, it is of little assistance at this time. Thus, rather strict definitions of convalescent nursing homes had to be created. Typically, benefits are only available while the patient remains under the continuous care of his physician, and confinement to the nursing home must be preceded by at least five days of hospitalization for the same cause of disability, with no more than seven days elapsing between the two confinements.

It is expected that some portion of the cost of this benefit will be offset by reduced hospital stays. At this time the cost is lower than it might be later because of the shortage of convalescent nursing-home facilities, although, as insurance for this coverage becomes more prevalent, facilities can be expected to expand and costs to rise.

Coverage for home care is in its infancy, at the moment lagging some-

what behind nursing-home care in its development. To my knowledge only one or two companies offer it. However, the Health Insurance Council subcommittee mentioned earlier has turned to studying the problems presented by this form of coverage.

Home-care coverage can also be viewed as an extension of a hospitalization plan. The possible kinds of services that might be covered are: visiting nurse service, physician's visits, drugs and tests provided by a hospital, physical and speech therapy provided by a hospital, and, perhaps, homemaker services. There is a serious question as to whether the latter can be properly insured.

As in the case of nursing-home coverage, about five days of prior hospitalization should probably be required to qualify for benefits and home care required to be authorized immediately upon discharge from the hospital. Benefits should continue only while total disability persists and a physician certifies to the continuing need for services. Other problems to be considered are the maximum benefits that should be available and the internal limits that should be placed on the various services.

In contrast to nursing-home coverage, early experiments in this field have indicated that the majority of persons who would use these benefits would be under age 65 rather than over age 65. Although more study is necessary in this area, in the not-too-distant future we can probably expect home-care coverage to be offered generally together with nursing-home coverage.

MR. JOHN H. MILLER: Rehabilitation service broadly includes therapy, training, and maintenance (i.e., living expenses of the individual who is undergoing rehabilitation). We have the federal-state program of occupational rehabilitation which is aimed at the people for whom there is a reasonable chance that rehabilitation services would make them employable.

This federal-state program, as I understand it, provides for the full cost of therapy and training without a needs test, which would seem as a practical matter to take these services out of the area of an insurable expense. In regard to maintenance, I believe, that there is a needs test; so perhaps the greatest opportunity for health insurance in rehabilitation is to provide adequate income replacement during the period of rehabilitation.

Here we come to possible conflicts. Any of you who have had experience with long-term disability benefits, particularly back in the depression, would recognize that the best way to keep somebody from becoming

rehabilitated is to give him a very large income that will be maintained so long as he is disabled.

On the other hand, a liberal disability income benefit running for a maximum of, say, one or two years, can be extremely helpful because it relieves the individual of the problem and the worry of balancing the domestic budget and gives him a definite target date which can be quite an inducement to rehabilitation.

Of course, there are disabilities for which there is no hope of either recovery or rehabilitation. A good program in these cases may be a very liberal benefit for one or two years and then a minimum long-term disability benefit at a subsistence level thereafter. This would fit very well into the rehabilitation picture and provide assistance without negative motivation.

A number of the companies in the workmen's compensation field have made great contributions to rehabilitation by providing facilities or encouraging the use of existing facilities and helping the industrially injured to get back into employment. Many of the insurance companies issuing health insurance or disability insurance have also had very effective programs of this type, although I do not know of any group insurance benefits specifically directed toward rehabilitation.

Sometimes without going into specific policy provisions relating to rehabilitation a great deal can be done through claims administration. In other words, if you have a claimant with a long-term disability benefit and the claim adjuster finds that there is a good chance of rehabilitation, sometimes an informal arrangement can be made so that the insurance company will give the individual assurance of continuation of income while he becomes occupationally rehabilitated. This income would continue while the individual tests his ability to carry on an occupation.

The rehabilitation field, I think, offers great promise. There are great humanitarian aspects here as well as the economic benefits of getting people back on their feet again.

MR. ARTHUR G. WEAVER: About a year ago the general chairman for Committees on Mortality and Morbidity invited comments regarding the value of intercompany studies from each company contributing to their preparation. In general, the replies indicated satisfaction with the studies and the feeling that the costs were well in line with the value of the results. The next logical step in the evaluation process is to inquire how the factual information developed by the Society of Actuaries is actually being used in practice and how its value can be enhanced by appropriate modifications and extensions.

In order to make this discussion of group morbidity studies as significant as possible, I have corresponded with some fifteen or twenty group actuaries regarding their use of these statistics. Represented in this survey were several medium and small companies as well as most of the larger group-writing life companies. I believe the many thoughtful letters received constitute a fairly complete catalogue of applications.

1. Most companies use the annual studies of group weekly indemnity, hospital, and surgical morbidity as a valuable check on results of their own studies.

The largest companies make elaborate annual analyses of all their own group health experience. These analyses are more up to date than intercompany studies can hope to be and reflect the influence of sales, underwriting, administrative, and claims procedures on such experience.

The smaller companies do not have sufficient exposure to justify extensive morbidity studies of their own. However, most of them consider the annual intercompany results as a standard against which to measure their aggregate experience. This is done by calculating annually the expected morbidity, based on intercompany data, for each individual case. The ratio of actual to expected morbidity, for all cases combined, is then determined. This ratio, which reflects the company's own distribution of health business by plan, female percentage, and area, can be a significant index for measuring year-by-year performance.

Numerous variations of this application are available. For example, the John Hancock prepares such a comparison between our contribution to the intercompany study and the intercompany results. These comparisons, which are available back to 1953 for the principal subdivisions of health experience, have provided a meaningful check on the relative effectiveness of our underwriting and claim-cost control procedures.

2. Few of the companies contacted use the annual studies directly for rate-making purposes. Numerous reasons are given: the unavoidable time lag, the limited number of plans covered, the apparent lack of consistency in some of the statistics, and the availability of special studies from which a rate structure can be constructed.

The annual studies are used, however, to determine trends in claim experience. Trend factors so derived can then be applied to the special study data to bring them up to date.

The Committee on Experience under Group Health Insurance has attempted to improve the value of the annual studies by developing tabular claim factors for the more common group health coverages and plans. These factors permit the analysis of health experience in greater detail

than previously possible and a meaningful presentation of cost relationship by plan, year of experience, and female percentage. They also furnish a means whereby a greater variety of plans can be submitted by contributing companies and included in the annual reports. This is because tabular claim factors for new or special plans can usually be synthesized from available special studies. Once prepared, they can conveniently be used to evaluate emerging claim experience for such plans.

Tabular claim factors are based on graduated claim costs and claim frequencies derived from the Miller studies of accident and sickness (*TSA*, Vol. III), surgical expense (*TSA*, Vol. X), and the Gingery study of hospital expense (*TSA*, Vol. XII) experience. They are somewhat analogous to net premiums derived from a mortality table which relates to a given period of time. While they are used by the committee as a convenient basis for comparing secular trends in claim costs, they can also be used as a convenient reference point for any company's own morbidity studies and for rate-making purposes. Naturally, such factors require adjustment for trend and for any marketing or underwriting emphasis of the particular company. The actuary is, of course, aware that the incidence of secular trend may vary by plan and that it is not sufficient to use blindly a flat percentage adjustment for all plans.

3. Several companies have commented on the value of intercompany tabulations which show morbidity variation by industry and geographical area. Even the largest companies find that their exposure volume is insufficient to avoid fluctuation when such detailed subdivision of the claim experience is required.

4. The companies with which I have corresponded agree that the special studies have been particularly valuable to them in that they examine in detail the many parameters involved in group morbidity experience. The results have been used extensively as source material for many actuarial studies of pricing and underwriting policy. Clearly, annual studies are vital in the development and interpretation of special studies. They are in a very real sense the foundation on which additional morbidity investigations must be based.

5. Intercompany studies have also been helpful in conserving actuarial effort. Several companies comment that, if such studies were not available, they would feel obliged to conduct their own. The planning of such studies, particularly for new coverages such as major medical, involves a great deal of thought and work. The insurance industry owes a debt to men like Messrs. Miller, Gingery, Pettengill, and Burton, whose papers have pioneered in this field.

The final question in this topic relates to the updating of the periodic special studies. These studies have involved much time and expense in collecting and collating needed source material. By the time the statistics have been processed and analyzed, they are two or three years old and more or less out of date. Under these circumstances, the need for inexpensive updating is apparent.

The programming of group operations on electronic data-processing equipment offers a unique opportunity to include modern statistical requirements in the mechanized system. Some companies are already doing so, with the result that most of the statistics needed for special studies are already on magnetic tape and can readily be included in the annual study contribution of experience.

A second advantage of mechanization is that the data supplied by contributing companies can be processed very rapidly once appropriate programming instructions have been prepared by the compiling company. With such a program, it should be possible, where needed, to make special studies annually with less cost and time lag.

Several correspondents have suggested that the annual studies be expanded to permit annual updating. In my opinion this approach has considerable merit. Since much of the expense involved in special studies arises from "tooling up" to secure desired source data, an annual call for information accumulated as a routine claim administration function might be no more costly. The largest companies might wish to use a 5–10 per cent sample. Others would possibly find it no more expensive to accumulate all their claim experience in the desired categories.

In particular, some companies are interested in the board-and-room and special service components of hospital expense cost. While this further subdivision of experience in existing annual studies should be explored, it is my understanding that the annual studies are based on dividend experience data not normally subdivided other than by coverage. As suggested earlier, the need for expanded annual studies would be reduced if the more significant special studies could be prepared annually.

One possible alternative method for updating special studies appears to me to be quite feasible; that is, to arrange for group actuaries in the various companies to prepare actuarial papers based on each company's own experience since the last special study. Thus one such paper might be on the trend in hospital special service charges, another on emerging major medical costs by area, and a third on significant changes during the past year in surgical charge relationships. Such activities might well be co-ordinated by the Committee on Experience under Group Health Insurance.

MR. DANIEL W. PETTENGILL: I want to thank Mr. Weaver for his excellent summary and to urge you to feel free to send any suggestions or opinions about these studies to me.

In response to a question about plans to present data on group long-term disability insurance, I can report that we do have a subcommittee which is working on the design of such a study. This is a difficult area in which to operate not only because of the usual health insurance problems but also because of the long-term nature of claim experience under the coverage.

MR. JOHN H. TUROFF: I believe that the annual morbidity studies have been and are of considerable help. Although the central point of exposure is approximately two years prior to the time of publication, the studies provide a general idea of how the industry sample was faring at that time. A little ingenuity in applying trend patterns derived from successive studies should establish the current situation, and a little more of the same should tell us where the claim levels ought to be a year or two hence. The recent introduction of tabular standards is invaluable in this connection.

I think we can safely assert also that the annual group morbidity experience studies bear directly on rate-making problems, and, as a matter of fact, they present some challenges in regard to them. Until recently we could accommodate our intuition as to premium scales in terms of loss ratios, retentions, and the authority of competition, but tabular costs are now an additional dimension to take into consideration. Unfortunately, the annual group morbidity studies provide only a general indication of over-all trends in actual claim costs. The result is that, while tabular costs are promulgated for component elements of specific packages of benefits, actual claim costs are matched against such packages as a whole.

Understandably, the task imposed on the contributing companies to furnish details of actual claims so that each may be related to its appropriate tabular cost element would require considerable effort in connection with the annual morbidity studies. However, information along these lines was furnished for the special Gingery hospital study, and I would hope, since tabular cost standards have now been established, that subsequent periodic studies will be able to accommodate this desirable informative feature.

MR. MILTON F. CHAUNER: Speaking unofficially, yet with a feel for what two of the larger casualty companies with life affiliates are doing

about the coverages referred to in this topic, I have a few comments pertaining to all four subheadings.

Policies for large amounts of accidental death coverage are written on a twenty-four-hour basis or as travel accident. The latter pertains to business travel and is usually a blanket plan paid for by the employer. The twenty-four-hour accident plans are usually employee pay-all, and the amount of insurance is geared to salary. The usual maximum is two and a half, three, or five times annual salary, but frequently up to ten times is written. Individuals may elect the amount specified for their salary bracket, or they may take less. There is recent interest in offering fixed schedules according to salary, with the premium expressed as a percentage of salary. One aspect of this development is the minimizing of antiselection from those who travel most and invariably elect the higher amounts of insurance.

Plans with such high amounts of accident insurance are not subject to experience rating of the retrospective rate credit or refund type; all business is pooled, and general judging of experience is the basis for rate differentials of a discount nature. Experience has been considered to be good, but recent deterioration in the rate level is expected to be a cause for concern.

Underwriting of high-amount accidental death coverage need not create pressure to relax the underwriting of traditional group accidental death and dismemberment written with group life insurance. This is because separate policies are usually involved; the sale is frequently at a different time than for group life; a different agent may be involved; and, furthermore, it is possible to describe quite clearly that a special kind of insurance risk is involved in contrast to the more modest amounts of group accidental death and dismemberment which are part of a group insurance package.

Lump-sum payment for total and permanent disability often accompanies amounts up to $150,000—maybe more—of accidental death insurance. These "T.P.D." benefits started as a fringe provision in competitive quotations but have become quite usual. There have been so very few claims as yet that it has not been possible to observe what *particular* problems might develop or the seriousness of them. There is very significant "moral risk," however, in that medical evidence after one year can establish permanent disability, but recovery occurs later. The *fewest* of lump-sum disability claims will likely dampen the ardor for writing this coverage; some companies are already encouraging the installment disability provision which provides 1 per cent, ½ per cent or less of the face

amount per month during continuing disability after one year. Reinsurance rating and underwriting on T.P.D. coverage have become considerably more conservative within recent months.

MR. PAUL H. JACKSON: We at Aetna have found actually very little interest in this coverage in the sense that we usually find interest in group products, and this is reflected in employers almost universally electing to pass the full cost of it on to the employees.

Employee pay-all coverage leads to certain plan design choices, such as the free choice of amount, which are not common in the typical group coverage. The employee pay-all aspect also leads companies to add various frills, such as medical expense benefits and T.P.D. income or lump-sum benefits. These frills simply duplicate benefits under basic group plans, and it is difficult to integrate properly these extra benefits. It just does not seem right to the covered employee that he should get less benefit from the employer's group program simply because he has elected to pay the full cost of the optional plan which the employer has sponsored.

MR. RICHARD S. MILLER: As a reinsurance company we have been approached at the American United with these proposals quite often by smaller clients. I should like to caution all of you that the experience on high amounts is much, much more in the nature of what we see in individual double indemnity reinsurance than it is like group accidental death and dismemberment insurance. Both our direct and reinsurance group accidental death and dismemberment experience is very good, but our individual double-indemnity experience on a reinsurance basis is about 60–100 per cent worse than that underwritten by our own company.

We have reason to believe this apparent pattern is characteristic of high amounts because of the insured's antiselection and lax client double-indemnity underwriting. Also, I seriously question whether or not the business I have seen quotes on is being written strictly as a loss leader by several companies. The premium dollars being developed are inadequate to pay the expenses, much less any claims.

MR. ROBERT E. SHALEN: We have not written any voluntary optional amounts for accidental death but have received requests for higher maximums on some of our regular accidental death and dismemberment contracts.

We felt that going up to $200,000 or higher for a single life was something that we should not do without making a special risk charge. Furthermore, because the pool for this class of business had so few groups

in it, we decided to reinsure amounts in excess of $50,000 or $100,000. We have had some difficulty getting this coverage.

For one thing, we have been unable to reinsure against losses from a single airplane accident involving more than $1.5 million. With a $200,000 maximum, it is easy to picture a several-million-dollar loss resulting from a single plane going down on one of the charter flights, which our policyholders may be arranging for their employees during the coming summer. We could, of course, reinsure pieces of the risk with several companies, but for the amount of premium involved this seems hardly worth doing.

MR. RICHARD B. SIEBEN: In its infantile stages dental care insurance lacks the assortment of statistical data from which valid conclusions can be drawn. In an attempt to fill that void, our sister company, Continental Casualty, will shortly publish and distribute a detailed evaluation of the first three years of experience developed by its first dental policy, written in August, 1959. My discussion includes some of the more important conclusions of that report.

As to the demand for the product, recent statistics reveal that 10 per cent of the medical care dollar is spent on dental services. This represents almost one-third of the amount spent for all hospital services and indicates that the potential market is, indeed, large enough to be given serious consideration.

The fact that dental disease attacks virtually every person in a measure which is, to a large extent, predictable by that person has been used as an argument that dental care is not truly insurable. However, there is also a high level of neglect in dental care, and it is this very neglect which introduces a measure of insurability into the field of dental health. The resulting accumulation of dental needs generally culminates in relatively serious conditions that demand costly and extensive services; and the timing of these occurrences, while not predictable for the individual, is presumably predictable for a statistically valid population.

There is a common assumption that this accumulation of dental needs presents a real cost barrier to dental insurance. However, the experience has been that, when dental insurance is introduced, the insured adult will follow his general pattern of dental care, while insured children have an initially higher utilization. The cost for children decreases by roughly 30 per cent after the first policy year.

The plan itself can help level out the cost over the early years by requiring a higher deductible in the first year in which any family member undergoes treatment than is required in subsequent years. The first-year deductible also protects against the special risks created by the constant

injection of new lives where a group is either rapidly expanding or subject to high turnover.

Continental Casualty firmly believes that the deductible and coinsurance approach for this coverage is preferable to the use of fee schedules. The great variation in the level of fees by geographical area makes it extremely difficult properly to underwrite this coverage by the use of fee schedules.

As to plan design, dental expenses are divided into four major areas: routine oral examination benefits; basic dental benefits; orthodontic benefits; and full denture-replacement benefits. Deductibles apply in the aggregate, with no deductible applicable to routine oral examinations. Coinsurance, usually 80 per cent, applies to the first two areas of expense; while a lower factor, such as 60 per cent, applies to the remaining areas. Inside maximums apply to the orthodontic benefits. There are also aggregate individual and family maximums.

A final feature has been the requirement that the dentist supply a detailed treatment plan after the initial examination. This helps define the limit of liability on termination of insurance.

Using the approach sketched above, Continental Casualty has found dental insurance to be both salable and successfully underwritable. In addition, dental insurance appears to have the gratifying effect of improving the dental health of the insureds, while the additional expense incurred for routine examinations and care is offset by the diminishing expense for serious and expensive repair work.

MR. PAUL E. SARNOFF: The Prudential feels that insurance of the expense of dental care on a group basis is an appropriate and desirable development. The risks of loss due to the occurrence of a dental defect are comparable to the risks involved in surgical or medical care expense insurance. Well-designed comprehensive dental plans include benefits for regular examinations and prophylactic care which are or should be provided for each individual covered. These benefits are desirable because it is expected that regular care will reduce the seriousness and frequency of dental defects and the claim costs resulting from them. The success of a dental insurance program depends on the support of the dental profession, and that profession is strongly of the opinion that an insurance program should place emphasis on covering the cost of preventive as well as therapeutic dentistry.

We have designed a comprehensive plan without a schedule of limits, covering basic and major dental services and supplies subject to deductible and coinsurance. A higher degree of coinsurance applies to the major

dentistry because the wide choice of elective procedures and materials makes the additional control of claim cost essential. We will provide a scheduled plan on request to groups which qualify, but, because of our desire to avoid plans which appear to impose a scale of professional fees, our sales efforts stress the favorable features of the comprehensive unscheduled plans.

MR. PHILIP M. PERLSTEIN: At the Metropolitan we feel dental care insurance can be underwritten successfully provided certain underwriting safeguards are installed in any plan issued. These safeguards encompass the following points:

1. The dental care program should be part of a complete medical program.
2. The financial experience on existing plan coverages is favorable.
3. The group should have a sufficient number of employees to provide an adequate spread of risk.
4. There should be a minimum participation required of the eligible employees, such as 75 per cent.

There has been a widespread and growing interest in dental care insurance, as is evidenced by the numerous quotes which we have made. Although we have quoted on many plans, few have been sold because the premium rates required for this coverage are quite high. We are sure, however, that the demand will increase as more of the public becomes aware of the availability of such coverages.

A Metropolitan plan of group dental care insurance follows the pattern of major medical expense insurance in that:

1. No fee schedule has been established; benefits are based on the reasonable and customary charges for the work performed.
2. There is a deductible amount, such as $25, in a benefit year which the employee must absorb before benefit payments commence.
3. Coinsurance, such as 75 per cent, is included for covered dental expenses above the deductible.
4. An aggregate total amount of benefits, such as $5,000, is payable for covered dental expenses, with a maximum such as $1,000 payable in one benefit period.
5. "Covered dental expenses" means the reasonable and customary expenses incurred for necessary dental services of the following types which are performed or prescribed by a person licensed to practice dentistry: fillings, extractions, bridgework, root-canal therapy, orthondontia, palliative treatments, X-rays, examinations, etc. We exclude from coverage: dental expenses for cosmetic purposes, expenses for cleansing of teeth, dental expenses required as a result of war or as a result of employment for wage or profit, dental expenses covered under another group plan, etc.

6. "Reasonable and customary charges" means those expenses actually incurred which in the absence of any insurance protection would be expected in view of the nature of the dental service, the training of the dentists, and the economic status of the individuals covered.
7. Eligibility under the plan includes employees only or employees and their dependents.

Our experience on this coverage is not sufficiently mature for us to determine what the financial results have been to date.

Survivor Benefits

If survivor benefits are to be provided under employee benefit programs, what are the relative advantages and disadvantages of doing this:

A. As part of a qualified pension plan?

B. As additional group life insurance?

To what extent would plan design be influenced by the method used?

MR. A. MAXWELL KUNIS: Survivor benefits have become increasingly important in recent years in the establishment of pension plans. These survivor benefits take various forms. They may be paid as a lump sum or as an annuity. They may be paid to the surviving spouse or to some other designated beneficiary. They may become payable to the survivor upon the death of an employee before retirement or upon the death of a pensioner after retirement.

The relative advantages and disadvantages of providing survivor benefits through a qualified pension plan or through additional group life insurance depend on (1) requirements and restrictions imposed by the Internal Revenue Code and Income Tax Regulations; (2) the cost of funding these benefits under these two funding media; and (3) the taxes to which the survivor becomes subject upon the receipt of the survivor benefit.

Under the Federal Income Tax Regulations, a qualified pension plan may provide for the payment of "incidental" death benefits through insurance or otherwise. A pre-retirement death benefit is considered "incidental" when the death benefit is not greater than one hundred times the monthly annuity. A post-retirement death benefit provided through the medium of an annuity option (joint and survivor or refund annuity) has generally been regarded as "incidental." However, an additional post-retirement death benefit is subject to limitation. The additional post-retirement death benefit is considered to be "incidental" provided the cost is less than 10 per cent of the cost of the pension plan determined by excluding the cost of such death benefit. Various Internal Revenue offices are now requiring a demonstration that the costs of the death benefit meet these requirements.

A survivor benefit, which develops costs substantially larger than those permitted under a qualified pension plan, may be funded separately by group life insurance. Alternately, the permissible amount of survivor benefit may be funded under the qualified pension plan, and the excess may be funded by group life insurance.

As between funding directly through a qualified pension plan and funding by group life insurance, the cost would tend to be lower under the

first method for two reasons: (1) with pension-plan funding (on either a trusteed or a segregated insured account basis), greater interest earnings would probably be credited against the costs of the benefits than would be practical with group life insurance and (2) the expense charges against the survivor benefits would probably be less if they were included as a minor part of the total pension plan benefits than they would be if they were based on the normal "retention" of the group life insurance carrier.

Group life insurance proceeds paid to a survivor are not subject to income tax but are subject to estate tax. This applies whether the proceeds are paid in one sum or in installments. If interest is included in the installments, then such interest is subject to income tax. However, where life insurance proceeds are paid to the surviving spouse in installments, the survivor is entitled to a $1,000 annual exclusion with respect to interest payments.

Under a qualified pension plan the portion of the payment to a survivor which represents life insurance paid by reason of the death of the employee is entirely exempt from income tax. The remaining payment to the survivor constitutes what is described as "employee death benefits." The employee death benefit less the employee's contributions and less a $5,000 death benefit exclusion is taxed as a long-term capital gain if paid within one taxable year. If the employee death benefit is paid in installments, then the death benefit reduced by employee contributions and the $5,000 death benefit exclusion are taxed as an annuity. The value of an annuity or other benefit paid to a survivor under a qualified pension plan is not subject to estate tax, except to the extent that the benefit arises out of employee contributions.

The $5,000 employee death benefit exclusion under a qualified pension plan does not apply to employee death benefits paid in installments with respect to which the employee, immediately prior to his death, had nonforfeitable rights.

On balance, we believe that lump-sum death payments can normally best be provided under group life insurance outside the pension trust because (1) there are no federal legal limitations on the size of the survivor benefit, (2) the proceeds are not subject to income tax, and (3) the pension trust is not exposed to unduly large drains of reserve accumulations.

A survivor benefit which provides for the payment of an annuity to the survivor can best be funded through a qualified pension plan because of the regularity of funding and flexibility of investment permitted by this medium. Furthermore, this method eliminates the "retention" cost under group life insurance. To the extent that the cost of the survivor benefit

exceeds the limitations imposed by the Internal Revenue Code, a supplementary group life insurance plan may be necessary.

It may be advantageous to fund a survivor benefit partially by group insurance and partially by a qualified pension plan. For example, a schedule of benefits based on annual earnings up to, say, $10,000 may be provided by group life insurance. The proceeds payable under the group life insurance are not subject to income tax. This would appeal to lower-paid employees. A schedule of benefits based on earnings above $10,000 may be funded through the qualified pension plan. Lump-sum amounts paid out of the pension plan as death benefits would be subject to a long-term capital gains tax but not to estate tax. This feature may appeal to the executive personnel of a company.

Since the $5,000 death benefit exclusion does not apply to amounts with respect to which the employee had nonforfeitable rights, it would be desirable to draft a survivor provision under a qualified pension plan so that the obligation to pay arises because of circumstances which occurred after the employee's death. As an alternative, the survivor benefit under such a plan may be made payable in one lump sum. Under these circumstances the death-benefit exclusion of $5,000 would be applicable in spite of substantial vesting.

MR. JOSEPH B. CRIMMINS: We would prefer to answer this question from the viewpoint of the desirable method of providing survivor benefits, assuming that we were entirely free to choose the method that seemed most appropriate to use. By looking at the problem in this light, we can see what impediments arise that make it difficult or impossible to handle survivor benefits in the most desirable way and what changes must be made because of those impediments.

We feel that group life insurance is the most obvious and natural mechanism to use in providing survivor benefits. We arrive at this conclusion from a number of reasons:

1. The risk involved is primarily a death-benefit risk, with all the risk characteristics inherent in basic group life insurance.
2. The policy provisions can be arranged to provide automatically for a life income to the beneficiary, or, if the employer feels that more flexibility is desirable, the policy provisions may offer a variety of choices to the employee or the beneficiary. The choices available can be tailor-made to the employer's desires and can be more flexible than the optional modes of settlement generally available under the basic group life insurance.
3. The survivor benefit plan can be arranged so as to utilize part of the basic group life insurance benefits to provide a portion of the life income to the beneficiary, with a reduced amount of lump-sum benefits payable at death.

Thus the employer can consider all the death benefit coverage provided for his employees as a single integrated plan rather than considering the lump-sum benefits payable under group life insurance as one plan and the income benefits payable under the pension plan as another. This integrated-plan approach is the best way to make sure that adequate coverage is provided where needed and that wasteful duplication or excessive coverage is avoided where really no need exists.

4. When the survivor benefits and basic group life insurance are provided under the same policy, the underwriting, rate structure, general administration, and experience rating can be treated as a combined coverage, with resulting savings in cost per premium dollar to the employer.
5. There is a wide range of flexibility available to the employer in planning for survivor benefits as a supplement to basic group life insurance. This flexibility is very desirable in determining eligibility requirements, level of benefits, pay-out provisions for survivor benefits, and the extent to which employees may be required to contribute to the cost.
6. The employee himself may more readily arrange to supplement the income benefits to his beneficiary through the use of the optional modes of settlement applicable to the basic group life insurance. This can be very useful to the employee in planning ahead for the protection of his dependents. He may also avail himself of the conversion privilege on termination of employment—a valuable privilege that would not be available if the survivor benefits were provided through the pension plan.

It is unfortunate, of course, that survivor benefit plans cannot always be set up in the most desirable manner. Very often we are confronted with statutory and other impediments that make it difficult or impossible to plan for survivor benefits through group life insurance and, as a consequence, make it necessary or desirable to utilize the pension plan mechanism. Some of these impediments are:

1. The state limitations on maximum amounts of group life insurance that are in effect in certain states. Assuming that the employer already has a basic schedule of group life insurance in force, there is rarely enough margin to add survivor benefits and keep within the statutory limits. This may be the case even for the employees in the lower-income brackets, and it is practically always the case for employees in the higher-income brackets. Thus, in any state where statutory limitations apply, it is almost useless to try to devise a satisfactory survivor benefit plan through group life insurance. Yet in those states no such statutory limitations will apply to survivor benefits provided for corresponding amounts through pension plans, whether insured or non-insured.
2. The incidence of taxation applicable to group life insurance as compared with pension plans may also be an inhibiting factor. The lump-sum value of the income to the beneficiary is normally includible in the employee's estate for estate-tax purposes when the income benefits are provided through group

life insurance. Where the income benefits are provided through a pension plan, there is no estate-tax problem, but the income benefits are then includible as received in the beneficiary's income for income-tax purposes. The difference in the taxation effect can be of consequence to different employees and beneficiaries, depending on their financial circumstances. One important consideration that affects employees in the higher-income brackets is that estate-tax payments must be met from the cash available in the estate and cannot be met out of future income benefits payable to a beneficiary.

3. A new impediment to the use of group life insurance for survivor benefit plans is threatened by the tax changes now before Congress if the proposal to include the employer cost of group life insurance in excess of $30,000 as taxable income to the employee becomes law. Because of the large amounts of insurance required to provide survivor benefits, this change, if enacted, can be a serious penalty operating to the disadvantage of the group life insurance method. No similar tax penalty exists or is contemplated with respect to survivor benefits provided through pension plans whether insured or noninsured.

In view of the many considerations touched on above, the Metropolitan feels it is necessary to be prepared to provide survivor benefits either through group life insurance where feasible and desired by the employer or through a group annuity contract in other situations. While the group annuity method can generally be used in those states where statutory limitations make it impossible to utilize group life insurance, it is rather inflexible because of the requirements of the Internal Revenue Code and applicable Regulations affecting the eligibility provisions and benefit levels. In particular, the benefit levels permissible are not always adequate. There are, however, some cost advantages through the generally lower state tax charges applicable to annuity considerations and through the practical elimination of federal income tax on interest earnings on the reserves for survivor benefits under qualified pension plans, so that, within the limits permissible, the group annuity method is a useful and economical mechanism for providing survivor benefits.

In conclusion, then, it may be well to restate that group life insurance ought to be the natural mechanism for providing survivor benefits, but the artificial restrictions and penalties placed upon its use have severely hindered the development of survivor benefit plans in that direction.

MR. CHARLES L. TROWBRIDGE: Employer-sponsored death benefits can be incorporated into qualified pension plans, as long as they are considered by the Internal Revenue Service as "incidental" to the pension benefit. Even more commonly, death benefits are provided under arrangements entirely independent of the pension plan, usually in the form of

group life insurance. Many employers provide certain death benefits as a part of a pension plan; other death benefits, separate and distinct from the pension plan. The over-all look at employer-sponsored death benefits should recognize both the "inside the pension plan" benefits and the "outside," as well as the substantial benefits provided by Social Security.

Whether a particular death benefit is "inside" or "outside" the pension plan will likely be determined by plan design and by tax considerations. Death benefits defined in terms of the pension or the contributions for pension are appropriately "inside" benefits. "Outside" benefits are usually those geared to job or salary classification. With several qualifications and exceptions, "outside" benefits generally have an income-tax advantage and an estate-tax disadvantage compared to "inside" death benefits. A reasonably complete discussion of these tax differences, and of the general question of "inside" versus "outside" death benefits, can be found in the "Study Notes" for the new Part 9E Examination.

I have a feeling, however, that the question proposed by the Program Committee was *not* directed at employer-sponsored death benefits in general. By "survivor" benefits they probably had in mind what has come to be called a "widow's pension," or "widow's annuity." Typically a widow's pension is a life annuity payable to a widow from the date of the employee-husband's death in an amount related to the employee's pension. A widower of an employed woman might or might not enjoy a similar benefit. The pension might or might not terminate on remarriage, as does the widow's benefit under United States Social Security, a plan with which many private plans are integrated.

The direct relationship between the benefit to the surviving widow and the employee's pension leads one to believe that this type of death benefit is most appropriately "inside." For an "inside" widow's pension several choices of vehicle are available. The benefit can be provided on an insured basis under a group reversionary annuity contract, which has been developed to especially fit the widow's pension situation. It can also be provided as an additional annuity benefit under a self-insured or deposit administration pension plan.

The different tax treatment of "outside" benefits, or a predeliction for the group life insurance vehicle, may lead some to provide the widow's benefit by group term life insurance. By careful continuous adjustment of the amount of each employee's insurance, recognizing a wife's age so that the face amount applied under settlement option will always provide the desired pension, one can use group term and, in so doing, get the outside tax treatment.

However, group term is a tortured solution at best. It just is not easy

under the laws and the practices of group term life to meet the widow's pension situation satisfactorily. Among the several difficulties are found the following:

1. State laws prohibiting group life in the necessary amounts, particularly since any other group term counts against the limit.
2. State premium tax at the insurance, not the annuity rate—with no help from the laws exempting qualified pension plans.
3. A legally required conversion privilege, which is expensive and which would not usually be offered "inside."
4. The problems of limiting the employee's right to name his own beneficiary and the beneficiary's right to take cash in lieu of pension.
5. Difficulties under group laws in limiting coverage to married employees.
6. The difficulties in accommodating to a termination of the widow's annuity on remarriage.

In summary, my analysis is that survivor benefits of the widow's pension type are naturally a *part* of a qualified plan rather than outside it. Some might feel that the tax picture favors a group term widow's benefit outside, but, when estate tax is considered, and particularly if attempts to tax group term premiums over a limit are successful, others will feel inside benefits have the tax edge.

MR. CHARLES B. H. WATSON: I would like particularly to state disagreement with the opinion expressed by the representative of the Metropolitan Life Insurance Company. He appears to believe that widow's benefits written into pension plans are primarily designed to provide lump-sum death benefits or that at least they take on this characteristic.

It has been our experience that widow's benefits written into pension plans take on the nature of providing a pension to widows or the replacement for pension in the event of the untimely death of the employee. For example, if the plan provides early retirement after age 55, then there would be a widow's benefit provided if the employee died after age 55 equal to the benefit the employee would have obtained if he had retired on the day prior to his death and had elected a joint and survivor option.

This is not the sort of benefit that we want to provide as a lump-sum benefit. It is designed to provide a replacement of income, and this is the sort of benefit that we feel should be provided to a pension plan. Granted that there is need for lump-sum death benefits, but these are more properly provided through a separate group insurance program.

I will admit that there is difficulty in tying together benefits between two plans, and we have run into places where employers do not fully integrate the fact that they have a group insurance benefit and that they

have a pension plan benefit. But we still feel that, because of the nature of the benefit and because of the fact that it is an annuity benefit where there is no immediate cash drain on the fund, and because of the fact that it can be funded in a more flexible manner usually under a pension plan, it is better to write this sort of benefit under a regularly qualified pension plan.

MR. ROBERT G. MOSS: We think this coverage should be an insured coverage for the most part. This is true even if the rest of the benefits are completely trusteed. This coverage can be handled either by purchase through the trustee or by purchase through the employer. The costs are a little higher on this basis, but a good dividend position will reduce them to costs that the consulting actuary will think about in the proper range.

We feel this way for two big reasons. First, we think this risk is not a budgetable risk. Second, we think the nature of the claims by the beneficiary if the pension plan should terminate are entirely different from the claims of the other beneficiaries, and, therefore, if the funds are segregated, so to speak, this provides a better method.

MR. DICKINSON C. DUFFIELD: If you are trying to operate a widow's benefit plan under a group deposit administration plan, there is the danger that a few large claims could wipe out the assets in the early years of the plan.

MR. WILLIAM C. PROUTY: It seems to me that there are distinct advantages in providing survivors benefits as part of a qualified pension plan instead of as additional group life insurance. I say this for the following reasons. First let me touch upon the area of cost:

1. There is no conversion cost.
2. There would either be no state premium taxes, or at least there would usually be smaller premium taxes.
3. Only employees with survivors would be covered. This would usually mean just married male employees since most survivors plans are widow's plans.
4. A remarriage provision would be possible.
5. The federal tax relief accorded pension coverages would be available.

Next the area of administration:

Since the widow's benefit is generally related in some fashion to the annuity accrued under the basic part of the pension plan, the approach seems somewhat more simple and direct, since the intermediate step of converting to insurance is not required. Also, the records that are needed in most cases can be derived as a by-product of the records being accumulated for the basic pension plan. This would seem to result in the lowest possible administrative costs for providing the benefit.

Next the area of taxes:

1. The plan is qualified as part of the basic pension plan. As far as the employer is concerned, the tax situation is completely clear and as a matter of fact is no different than if the benefits were actually a part of the basic plan.
2. Much can be argued as to the relative merits of the two approaches in the area of estate taxes and income taxes. It appears to me, however, that it is difficult to draw any generalized conclusion as to whether one method or the other has an advantage. So much depends upon the individual situation.
3. I suppose an argument can be made for considering an insured widow's pension contract as a form of insurance, thus drawing the conclusion that we might as well go the route of insurance anyway. However, it seems to me that such a contract, which is essentially a reversionary annuity contract, is definitely not a form of life insurance. Life insurance would be payable regardless of the status of the widow or survivor. This is not the case of a reversionary annuity, and it is interesting to note that a reversionary annuity is legally an annuity under the New York insurance law.

Separate Accounts

A. What problems have been encountered in obtaining approval by insurance departments of contracts providing for equity investment of pension-plan contributions by the use of separate accounts?
B. What guarantees are being attached to considerations paid into separate accounts?
C. How are capital gains and losses and unrealized appreciation and depreciation allocated to such contracts? How detailed is the information reported to the contract-holder with respect to these allocations? How are state premium taxes handled on considerations paid into separate accounts?
D. What problems are created by transfers of funds from separate account to the general accounts of the insurance company? To what extent is experience with separate account business merged with experience under regular contracts?
E. Are separate accounts limited to essentially equity funding or have they been used for fixed-dollar obligations? If the latter, what advantages are obtained as compared with undertaking such fixed obligations as part of the insurance company regular accounts?

MR. WILLIAM K. WHITE: As to the insurance department approval problems, each company has its own philosophy as to where group annuity contracts have to be filed. In the particular area of separate accounts an additional complexity is introduced by the fact that the laws in some states are somewhat obscure. This is readily understandable in view of the fact that the operation is so new that legislators and insurance department officials have not really had adequate time to gain a full comprehension of the situation.

Our company has been fortunate in that there have been no problems in this area for our half-dozen or so group annuity contracts which involve a separate account provision. The indications seem to be, however, that most insurance department officials are generally adopting a realistic approach toward approval of such provisions.

As to guarantees, the Aetna offers nothing with respect to money in a separate account—except, of course, integrity. However, because of the Securities Exchange Commission and Internal Revenue Service problems, it was decided to adopt a form of premium-rate guarantee which is very complex but applies only after money is transferred out of the separate account to the regular assets of the company.

With regard to state premium taxes, our procedure (as, I believe, is consistent with that of an increasing number of insurance companies) is to pay taxes on deposit administration funds as they are applied rather than when received. While certain state rulings may have to be complied

with to use this technique, it was found that state insurance authorities were very co-operative.

Our procedure regarding reporting to participants is to give a detailed audited statement of our holdings and unit value in the separate account as of its fiscal year. We selected July 1 as the fiscal year because there are enough other things going on around the end of the calendar year. This statement shows the cost of each security held and the market value as of the end of the fiscal year. It is to be noted that this statement applies to the separate account as a whole.

As of the anniversary of a particular contract participating in the separate account, a statement is furnished indicating its monetary value in the separate account, taking into consideration realized and unrealized capital gains and losses. The individual contract-holder's equity is determined on substantially the same basis as would be the case with a mutual fund, except that expense charges are naturally compatible with the moderate level applicable to insured group coverages.

MR. EDWARD A. GREEN: Guarantees associated with a separate deposit fund cover the allocation of investment income, valuation of the fund, and purchase rates for annuities purchased directly or indirectly from the fund. It is guaranteed that the investment income allocated to the separate deposit fund will follow the performance of the separate investment account in which it is participating and that the unused balance of the fund at any point of time will be based on the market value of the investments in such separate account.

Insofar as guarantees of purchase rates go, if there are both a deposit administration fund and a separate deposit fund, all purchases are made through the deposit administration fund which contains the usual guarantee. If purchases are made directly from the separate deposit fund, rates are guaranteed for purchases made during the first five years. These rates are based on the same interest and mortality assumptions as are used in the deposit administration rate structure for purchases in the corresponding period but with the loading reduced from 5 to 3 per cent to reflect the fact that charges for all expenses already incurred and a modest contingency charge have been made against the separate deposit fund.

The unilateral right of a contract-holder to transfer funds from his separate deposit fund to his deposit administration fund other than at the time of annuity purchase is limited in order to reduce the opportunity for antiselection at the time of expiry of a rate guarantee and to reduce potential problems of transfer of funds from the separate account to the general account. This limit for any contract year is the excess of twice

the normal costs for the year and 20 per cent of initial past-service costs over amounts paid into the deposit administration fund during the year. The problems of transfer of funds from the separate account to the general account at the time of annuity purchase are primarily those of scheduling investments, recognizing the statutory restrictions on moving assets from one account to the other.

I dwelt on the allocation of capital gains and losses and unrealized appreciation and depreciation in my paper presented at this meeting. It is our practice to give each contract-holder a quarterly report and an annual summary of the status of his separate deposit fund. The reports set forth his share of the appreciation and depreciation during the quarter as well as give a list of investments of the separate investment accounts or classes in which his separate deposit fund is participating showing their book and market values.

Finally I should like to make a comment on an area which I have been asked about but which is not covered in detail in the paper. This is the question of whether or not a company should set up separate bond and mortgage accounts as well as a separate common-stock account. I think that there are basically two reasons why a company might want to do this.

The first one is that it enables an employer to move more quickly from one proportion of assets by class to another. In other words, if he has been building up money in the general account and he feels that the account does not have the balance he wants among mortgages, bonds, and stocks, he has considerably greater flexibility in building the portfolio back of his plan into the proportions that he wants.

Second, and probably of almost equal importance is the fact that, like it or not, the federal tax law now gives a greater advantage to the fixed-income security in the separate account than it does in the general account. There are technical differences in the law. I believe that there were three of them that I mentioned briefly in the paper.

MR. OLIVER R. AINSLIE: In Canada we have three accounts: fixed income, mortgage, and common stock. In the states we are proposing to have two accounts: combined fixed income and mortgage and common stock.

Keogh Plans for Professional Associations

Have professional associations shown any interest in the use of group contracts for providing the retirement benefits permitted by Keogh legislation? Has it been found desirable to develop any products designed specifically for this class of business? If such special products have been developed, do they have broader application than to Keogh plans alone?

MR. RICHARD J. LEARSON: Keen interest in Keogh-type plans funded at least in part by a group annuity vehicle has existed from the passage of the law one year ago, but distressingly little in the way of actual accomplishment can be seen at this monent.

Three major national associations—of medical doctors, lawyers, and certified public accountants—have announced such plans, and at least one of these is in being now, although at least two important technical hurdles remain to be jumped before that plan will accept member contributions freely—to wit, approval by the Treasury under 401(a) and clearance by the Securities and Exchange Commission of the solicitation and registration aspects, since an equity fund is involved.

Many strong associations are toying with the idea, but the difficulties are so many and so real that one can confidently expect this new field for group annuities to develop very slowly.

The one plan mentioned above that is in being is to be insured by MONY under a scheme that has been five years in the drawing-board stage. It is a variant of a deposit administration contract with group deferred annuity overtones. Because it was conceived before Keogh and was intended to be used whether or not H.R. 10 became a law, it perhaps has uses for groups of individuals who do not wish Keogh-type tax relief. At least we have been asked to use it for such purposes but have not yet said "Yes" to the request.

Here is the scheme in very brief essentials:

1. The plan is split-funded fifty-fifty during active lifetime, half to an equity fund in a trust company, half to the group annuity, and no choice available to the self-employed plan member; but, if contributions from "common-law" employees are involved, 100 per cent of such money must go into the group annuity.
2. At retirement the member may, of course, cash out; but, if he continues, his equity fund moneys are transferred to the group annuity, and he thereafter enjoys a fully insured pension.
3. All contributions are paid to the trustee bank, which keeps all records and remits to the insurer its 50 per cent share in bulk, and small annual fees are charged to the plan members for this work.

4. All payments, on account of death, withdrawal, or pension, are made by the insurer, with full reliance on the records kept by the trustee bank.
5. The group annuity provides an interest guarantee on money paid into it for the first five years on a typical sliding scale DA type guarantee, 4¼ per cent for five years, 3½ per cent for five years, and 3¼ per cent thereafter. It provides annuity purchase rates that are guaranteed forever to the money put in the group annuity during the first five years and to transfers at retirement from the equity fund during the same five years. For successive five-year periods thereafter the rates quoted in the contract are not guaranteed.
6. A total and permanent disability provision permits the participant to insure a contribution equal to his average annual contribution for the preceding five years.
7. The insurer's expenses come out of a 5 per cent charge to the 50 per cent of the funds funneled into the group annuity contract and from slightly higher group annuity purchase rates for funds transferred from the equity fund at retirement. An average charge of 1 per cent for premium taxes is included at this point because the association is nation-wide in scope.

We feel that the plan has considerable merit for the participant, since it furnishes him a savings plan with a very low expense load and valuable insurance guarantees and adequate safeguards for the insurer, particularly in view of the modest interest guarantees after five years and the cash-option price adjustment in the retirement annuities. The initial response to our solicitation of a selected group of the membership has been excellent, indicating a successful final result, but it must be pointed out that the professional association being dealt with has unusual solidarity and a remarkable record of participation in its other insurance plans.

Our personal opinion is that Keogh plans that are fully insured may have too little sales appeal to build up the volume needed to cover expenses and plans too heavily oriented to equity funding will furnish the insurer too small a share in the plan to justify the risk involved in developing it. Many of the professional group brokers with whom we are acquainted share essentially the same views, and that, combined with the normal hazards of constructing qualified pension plans, probably accounts for the slow development of Keogh plans.

MR. JAMES A. ATTWOOD: I want to comment on a few problems we have encountered in designing a product for association-type Keogh plans. First of all, the association is interested in something better for their members than can be obtained by an individual on his own. Most of the companies, including the Equitable, have an individual policy available for their agents for Keogh business. Therefore, in designing a group product for an association, you run into some interesting problems.

For example, one is that the individual product has a lifetime level-premium guarantee, where typically under a group plan rate guarantees are made for only five years. For this reason alone, the individual plan could be considered to be better than the group plan.

A second problem concerns dividend illustrations. It is typical in the individual line to give dividend illustrations for individual policies. In the group line we do not usually do this. Therefore, when you are projecting potential annuity income from an illustrative set of payments, it could well be that the individual policy could provide, with the illustrated dividend, a greater benefit.

Another one of the problems exists when the association wants individual guarantees but wants either themselves or some outside administrator to keep the records. The insurance company may feel it cannot give guarantees unless it keeps the records.

These are all problems of trying to develop something on a group basis that is like an individual contract but is better than the individual contract. This also raises interesting questions as to the role of the insurance agent in this business when it is offered on a group basis. Can these plans be successful without agent solicitation? After all, we are thinking in terms of associations with small employers—perhaps one to four covered people. There are many who feel that agent solicitations are necessary. If so, does this put the operation in the group business or the individual business? If the agent solicits, what can he be paid? Individual commissions? Group annuity commissions? Should the commissions be based upon so much per group or so much per individual?

Another logical question is: If the agent is soliciting members of an association on a group basis, but he also has available an individual policy from his company, what controls need be placed upon his actions? Which should he sell, or which would he sell, or which does the company want him to sell?

Another problem alluded to by Mr. Learson is possible Securities and Exchange Commission jurisdiction, especially where equity investments are involved. Using life insurance agents to sell participation in plans which involve equity investments would be especially a problem where the employer or his employees are given options as to how much they want to go into common stocks. Maybe if it is fixed, it might not be quite as much of a problem.

The last question raised is: Do these products have broader application than to Keogh plans alone? My own opinion is that the products we are designing are probably going to be more valuable in non-Keogh-type

situations than in Keogh-type situations—that is, profit-sharing, thrift plans, tax-sheltered annuities, the plans some companies are making available to their retail distributors, etc. The techniques we are developing for Keogh-type plans actually might be ultimately more successful and meaningful to insurance companies in these areas than Keogh-type plans will be—at least the type legislation it is currently.

PANEL DISCUSSION

SECURITY OF PRIVATE PENSION EXPECTATIONS

Panel Members:

JOHN K. DYER, JR., *Moderator*
DAN M. MCGILL
RAY M. PETERSON
FRANK L. GRIFFIN, JR.
KENNETH R. MACGREGOR

JOHN K. DYER, JR.:

As you are all aware, twice during the history of the actuarial profession in North America, institutions with which actuaries have been intimately associated have developed difficulties serious enough to require public investigation and legislative remedy. The first, of course, was the life insurance institution, which went through a period of major reforms starting some fifty-seven years ago. The second involved employee welfare plans, whose widely publicized abuses are within the memory of all of us here. In neither of these instances were the actuaries held primarily at fault, but in neither case, I am afraid, did our profession end up smelling any sweeter.

Perhaps the best reason that I can offer for having suggested today's panel, and being rewarded for the suggestion by an appointment as moderator, is that I hope that the actuarial profession will never have to go through a third round of difficulties such as these. If abuses or mismanagement should develop within the private pension institution, to the extent that public investigations become necessary, I am sure that the actuaries would suffer more than any other group involved. Thus the objective of today's discussions is, in my view, essentially preventive.

Many of us realize that there are small abuses in the pension business. I do not believe there are any large ones of a widespread nature. I hope that discussions such as this, pointed toward a more vigilant attitude and a higher consciousness of professional responsibility, will enable us to detect and put out any small fires and so avoid ever suffering a major conflagration.