RECORD OF SOCIETY OF ACTUARIES
1975 VOL. 1 NO. 1

INSURANCE COMPANY REGULATION RESULTING FROM CONSUMERISM

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CHAIRMAN LOUIS GARFIN: The regulatory authorities looking out for consumers of one kind or another range from the SEC, protecting investors in insurance company stocks; to several federal agencies dealing with disclosure and confidentiality of information - Fair Credit Reporting, Truth in Lending, disclosures regarding medical information gathered by MIB; to the Employee Retirement Income Security Act with its various authorities and complex regulation of pension plans and other employee benefit plans; to all the state regulators with their very broad range of interests.

I won't try to define "Consumerism" but let me read a couple of paragraphs from the November 1974 issue of Insurance News on the theme Legislation and Regulation.

"Our nation's major social and economic problems - inflation, the Watergate mess and the consumer movement - have all played a part in establishing the climate in which insurance regulators must function. Inflation has made people more resentful of price increases and more prone to complain when they don't feel they're getting full value for their money. Watergate has made them suspicious of people in high places, whether in government or industry. The consumer movement has made them more conscious of their right to demand quality 'as advertised' in the products and services they buy.

"The result has been a rise, nationwide, in the number of complaints against insurance companies. Rates, cancellations, underwriting practices and claims handling procedures have all come in for their share of criticism. Insurance commissioners have responded by seeking new ways to make sure all complaints are heard, investigated, and acted upon."

The article goes on to say, "The continuing upsurge of interest in the commissioners' role as consumer advocate and protector of the policyholder has been the most significant trend in the insurance regulation field during the past year ..."

MR. JOHN O. MONTGOMERY: The California Department of Insurance in 1974

adopted, with only a few minor changes and some rearrangement of phrases, the NAIC model regulation defining the Life Insurance Interest Adjusted Cost Comparison Index, including disclosure requirements (Ruling Number 193, dated July 8, 1974). What has happened since then? Aside from the initial flurry of agents' inquiries and finger-pointing, there has been almost no response. The general public does not seem to be aware of this requirement.

There are a number of statutory proposals currently being considered by the California Legislature such as "Truth In Life Insurance" (A.B. 948, Papan) and "Legibility In Insurance" (A.B. 722, Hart) which propose certain requirements:

1. Rather detailed benefit and price information for the life insurance policy applicant or prospective applicant.
2. Annual statements to each life insurance policy owner showing, among other items, the interest adjusted net cost per $1000 for the immediately preceding policy year.
3. A "standard supplemental disclosure form" to be filed with the Department when a particular policy contract form is first offered to the public after the effective date of the proposed bill. This form is also to be made available to each policy applicant or prospective applicant.

These are very detailed requirements. They will cost the insurance companies a considerable amount to implement and will require a sizeable increase in the budget of the Insurance Department to provide the regulation intended by such bills.

Is such detailed disclosure and regulation really needed even if it were economically feasible? According to a rather rough but fairly reliable estimate gleaned from the records of complaints filed with the Insurance Department, only ten to twenty percent of consumer complaints involve life insurance. The other complaints concern primarily auto, fire, casualty, medical expense and disability insurance. It appears that the consumer is concerned principally with simple basic issues such as rate increases (common in health, auto, casualty, medical malpractice lines of insurance), denial or restriction on the amount of claim benefits paid (common in all lines), a reduction in dividends and, in a few cases, charges of misleading advertising. The "misleading advertising" charges frequently arise from complaints made by competing companies or their agents and possibly should not be included as "consumer complaints".

All the concern in some circles over Cost Indices, Full Disclosure and Consumers' Guides may be a case of "barking up the wrong tree". A more important issue may be to provide assurance to the consumer that the cost of insurance will be equitably determined and to provide those putting up the money to operate the insurance risk venture, either as stockholders or as mutual company policyholders, with an adequate return for their risk taking. Consideration should be given to the amount of surplus which should be retained by the company and that which should be released, either to the stockholders or to the mutual company policyholders. Is this possible under the current statutory system for the valuation of insurance reserves? This may eventually become one of the questions to be considered by the NAIC Technical Subcommittee on Valuation and Nonforfeiture Value Regulation.

Perhaps of even more immediate importance is to make the consumer more aware of the penalties that may be incurred by lapses or surrenders during the earlier policy years. This is really of more direct concern than any cost comparison index based on a ten or twenty year period. Typically such periods apply to less than half the initial applicants. To make the policyholder more aware of the penalty for early withdrawal, the interest adjusted cost index should be made known for at least each of the first ten policy years.

CHAIRMAN GARFIN: Is there any chance that the various states will eventually adopt a uniform set of disclosure requirements along the lines of an NAIC uniform regulation or are we likely to end up with fifty variations?

MR. MONTGOMERY: California will follow whatever the NAIC specifies on disclosure requirements. The intent of the NAIC is to have all states use the same form of regulation.

MR. RICHARD V. MINCK: There have been cost-comparison regulations adopted in six states to date and no two are identical. The differences are not in the method to be used in the reporting procedures and hence, although different, all six regulations are compatible. The American Life Insurance Association (ALIA) has consistently argued for uniformity of regulation and, so far, every regulator has been responsive.

MISS BARBARA J. LAUTZENHEISER: I am sure you are all aware of the women's movement. We have seen it for some time. What I would like to make you aware of is how far that movement has gone, how it threatens our entire classification system and, in essence, threatens our entire survival.

The sex discrimination issue began in the health insurance area--primarily disability income. There were questions as to whether differences in underwriting limits, issue limits, benefit period and elimination period were justifiable. Also questioned was whether the reduction of benefits if the female was not working at the time of disability was a valid reduction.

The biggest issue was pregnancy. The EEOC (Equal Employment Opportunities Commission) guidelines actually read that pregnancy should be treated as a sickness and that disability benefits should be payable as for any other sickness. Until recently, these EEOC guidelines only had policing authority if they were part of a court case. And then these guidelines were accepted only if the courts found them reasonable.

The insurance industry cannot properly provide pregnancy benefits in an individual disability income policy. It is far too antiselective and it is discriminatory against other females. The entire class of females will have to pay for the pregnancy benefits of those females who want it. This is, in itself, discriminatory.

Initially, I felt that there was not much opportunity for antiselection on pregnancy benefits in group insurance. However, the EEOC guidelines say an employer cannot deny employment to a woman because of pregnancy. This creates a selection problem in the group area as well. A woman who is 8½ months pregnant can apply for work and require the employer to give her a job. She can receive her disability benefits and never go back to work. I am sure that if someone else applied for employment and said that in two weeks he was going into the hospital for four months, he wouldn't be hired.

The courts are going both ways on the pregnancy issue. The first case was Newman vs. Delta Air Lines. The court actually stated that pregnancy was voluntary and indicated health rather than sickness. The General Electric case, however, came out the other way. G.E. helped to create their problem in that instance by providing voluntary surgery benefits for males. When G.E. tried to argue that pregnancy was a voluntary situation, they couldn't argue too well since voluntary coverage had been given to males. They lost that one. The Aiello case in the California Unemployment Compensation Disability law involved the actual costs of providing these benefits. The court expressly found that failure to cover normal pregnancy was not discriminatory under the Equal Protection Clause of the 14th Amendment. That ruling was based on two previous court cases. We have to remember that, while each court case is a precedent, each decision is based on the merits of the particular case.

what are the companies doing? Most of them are doing what I think is appropriate. They are making underwriting limits, issue limits and benefits equal. Most of them are continuing to have a rate differential, which is necessary if they are going to stay solvent and equitable. I have heard that some companies have made their rates equal. I think this is dangerous and not very wise. Many companies are making their female rates lower than their male rates at the higher ages such as 55-60. Paul Barnhart's 1971 study indicates that the claim costs do go down at higher ages for females. We are a lot safer in supporting the use of rate differences if we continue to make rates lower where studies show costs to be lower as well as to make rates higher where studies show costs to be higher. As far as pregnancy is concerned, most companies are continuing to exclude normal pregnancy but are including complications of pregnancy. Some companies are covering pregnancy with no additional premium. I do not understand how this is possible.

We had hoped that the health insurance problem was our worst and that it was over. It turned out only to be the first step in the discrimination issue. The next step was in the annuity field. Females are not content with receiving actuarially equivalent benefits but now want the same monthly benefits as males.

I indicated earlier that the only police power the EEOC had was in the courts. Recently there has been a new Memorandum of Understanding between the EEOC and the OFCC (Office of Federal Contract Compliance). The EEOC cannot require an employer to take affirmative action until a violation of the Civil Rights Act based on a specific complaint of employee discrimination is found. The OFCC, however, can require employers with federal contracts to follow certain guidelines and can require them to take affirmative action. Adoption of the guidelines by OFCC, consistent with the policies of EEOC, automatically makes them applicable to any employer with a federal contract. This affects many small employers.

Hearings were held last September to determine whether an employer with a federal contract (1) could provide either equal contributions or equal benefits, or (2) had to provide equal benefits. If equal benefits are required, it is clear that all money-purchase or profit-sharing plans either will end up extinct or, because of competition, will mandate a unisex table. The issue is still undecided. We are hoping, of course, for the "either/or" situation but we do not really know.

Just last week, an Indiana court ruled that the 1971 Group Annuity Mortality Table which results in the payment of greater monthly annuity benefits to men than to women is arbitrary, discriminatory, and in violation of the Indiana Constitution and the Equal Protection Clause of the 14th Amendment. The court ruled that, with contribution rates being equal, paying females less annual benefit is arbitrary and unjustifiable because factors other than sex also affect the length of life and are not taken into consideration. Evidently, no one has made the point that the selection process on annuities is that of the individual, not that of the insurer. The ruling actually contains statements such as, "At no time will a retired female teacher have received a total lifetime retirement benefit greater than or equal to that of a comparable male, all other factors being equal." The opinion also states that a female gets her money back only if she lives to 84 but a male gets his back if he lives to age 80. "In plain language, the fund is making money every time a female teacher retires at age 65 and dies before the age of 84. And this opportunity presents itself 70% of the time." This is because 70% of the retirees were female. I found it interesting, although perhaps not statistically valid, that 60% of the persons who were contributing were female and 70% of the retirees were female. I think this proves the point that females are living longer.

A similar court case against the City of Los Angeles Department of Water and Power is even more frightening. The court issued a preliminary injunction against the City of Los Angeles on charging higher pension premiums for equal benefits to females. The court found that the plaintiffs had a good chance of winning because of recent determinations of EEOC and because sex discrimination exists whenever general characteristics of a sex-defined class are automatically applied to an individual in a class. In other words because we can't predict when an individual will die we cannot use the tables showing that women live longer. The court quoted directly an EEOC case which said, "All the A's (the defendants) sex-segregated actuarial tables purport to predict a risk spread over a large number of people; the tables do not predict the length of any particular individual's life." Because the Department of Water and Power's practice in question here violates these considerations by applying the general actuarial characteristic of female longevity to individual female employees who in reality may or may not outlive individual male employees, the court concludes that plaintiffs have established a case of discrimination under the Equal Employment Opportunities Act.

I think it is easy to see that any classifications we have made could be faulted on this basis. I wish someone could tell me when I was going to die - I could plan better. The whole principle of insurance is based on averages, not individuals. Our real issue has become as basic as the validity of the principle of averages and our rights to classify.

This is pointed out in the actions of the Pennsylvania Insurance Department. First they questioned whether or not we could have separate rates for each sex. They said this was all right as long as the differences were genetic and not socio-economic. Pennsylvania's Catch-22 occurred when it said that it is unfair discrimination for individuals to be charged rates that deviate from the standard based on only genetic differences. This rather reminds me of Lewis Carroll's Through The Looking Glass where Humpty Dumpty says, "When I say unfair discrimination, it means just what I choose it to mean - neither more nor less." The next issue to appear in Pennsylvania was whether or not banding premiums by ages was discriminatory. They ruled that an insurance company can't band ages in large groups. Their previous objection was that the groups were too small; now they're too large. Pennsylvania is now asking the question, "What constitutes a class?" The implication is that unless we have current credible statistical data to rate a class we can't charge a substandard premium. I don't know about you, but I don't have any statistics on shark fighters and I don't want to cover them. Pennsylvania is questioning underwriting, benefits, limits, rates, and dividends. The ALIA has a task force working on this and it's still an unresolved problem.

Not all states are this bad. Washington State ruled that since most Civil Rights cases deal with individuals, not classes, and since classes are necessary in insurance, these cases can't be applied to insurance. The Washington State Attorney General issued another opinion relating to mental and physical handicaps. He said that these classes were suspect and had to be justified. He classified heart disease as a physical handicap.

As I said earlier, the issue is no longer sex but what constitutes a class or can we have classes at all because we can't predict when an individual, not a class, will suffer a risk. There are three basic arguments being brought forth:

1. While statistical data showing differences by sex may be credible, it is not socially acceptable to have different rates. We have tried to explain that while this argument may be appropriate in the public sector for social insurance, it is not appropriate in the private sector.
2. The issue of individual rights does not allow for any type of insurance classes. Thus far, this argument has only been used on the sex issue. Hope-

fully, it won't be used any further.

3. There has been a statistical overlap theory proposed by a university professor. I originally felt that no one would pay much attention to it but I see hints of it in the Indiana court case. It appears we're going to have to take it seriously to find a rebuttal.

What do we need to do as insurers? First, we must stop using the word "discrimination". None of us mind being a discriminating person but we don't want to be a person who discriminates. It's too charged a word. Next, we have to eliminate differences which are not valid - differences that are moral judgments. We must do this if we plan to make differentiations that are valid - to charge rates based on experience, to have normal pregnancy exclusions, and to be able to underwrite with judgment. We must talk about equity as opposed to equality. In equality, everyone is treated exactly the same. This is not the case in equity. It's just as inequitable to treat unequal classes equally as it is to treat equal classes unequally.

Slightly over 200 years ago, an upsurge in England's prosperity created a receptiveness to new ideas. Newly prosperous merchants, doctors and lawyers were concerned that their budding fortunes might be withered by premature death. They developed "dividing societies". Each year's dues were distributed to the beneficiaries of those members who died during the year. The amount of coverage depended on the total dues collected and the number of fellow decedents. The benefits went down as members decreased or deceased. This led to assessment insurance which meant that everyone paid a little bit more each time. Thus, when we first started, all premiums were the same regardless of age, health, occupation or sex. This concept failed because it did not take decreasing membership or selection of risks into account. Now we're being told that we can't have classes. We've come a long way, baby!

MR. ROBERT E. HUNSTAD: Another area of concern is the precise rate differential assessed based on sex differences in disability income premium rates. The New York Department of Insurance intends to establish rate differential guidelines which could not be exceeded. Perhaps this is appropriate but it's another curtailment that may not be justified in all cases. Several bills have been introduced in the Minnesota legislature which would prevent life insurance companies from discriminating against disabled persons. Actuarial data could be used to support rate differentiations.

MISS LAUTZENHEISER: One of the difficulties is that we as a Society are too silent. When you see these things happening, stand up and commit yourself. Write to people. If they get 2000 or 3000 letters from the Society, they will react. We should fight individually as well as collectively. And if we don't stay together, we're going to lose.

MR. MINCK: In one sense all regulation of insurance is consumerist in that it is intended to protect the policyholders. For example, minimum capital and surplus requirements, valuation standards, limits on eligible investments, licensing requirements, provisions for review of policy forms, and a wide variety of other activities are all aimed at protecting the consumer. However, in the last 10 to 15 years a consumerist label has been popularly applied to various people making various types of proposals for regulating business. The pace of such proposals has quickened in recent years and a measure of the impact--either already recorded or potential--on insurance companies can be estimated by simply reviewing the variety of laws and regulations adopted or considered in recent years.

The classification of risks in order to do equity to various categories of

policyholders is, of course, essential to the insurance business. One of the first limitations on insurance companies in this area was the prohibition adopted in several states in the late 1940's against charging different premiums for blacks than for whites, despite mortality statistics that apparently demonstrated a difference in risk. This was followed up by prohibition against companies keeping statistics separately by race. In this instance, public policy clearly overrode questions of individual equity. In recent years the feminists have advanced the idea that public policy should similarly prohibit discrimination by sex. The 27th Amendment to the Constitution was passed by Congress in March of 1972 and has been ratified by more than thirty states. At the same time eight states have added similar amendments to their own state constitutions. Federal legislation affecting differences by sex includes the Equal Pay Act of 1963, Title VII of Civil Rights Act of 1964 and the Equal Employment Opportunity Act of 1972. The Civil Rights Act created the Equal Employment Opportunity Commission and eight years later the EEOC was authorized to initiate legal action to enforce Title VII. In 1970 the Office of Federal Contract Compliance was created within the Labor Department and charged with preventing discrimination by federal contractors. Up to this point in time the Wage and Hour Division of the Department of Labor, the OFCC and the EEOC had each issued rules or guidelines which dealt with the differences in the provision of fringe benefits to male and female employees. These guidelines are in conflict with one another. In 1974 the Department of Health, Education, and Welfare published proposed sex discrimination guidelines for comments. Again these guidelines covered much the same area earlier covered by the different branches of the Labor Department and the EEOC. From the point of view of the insurance company, the key problem in all of these guidelines or proposed guidelines is whether or not equal treatment is afforded by an employer providing equal benefits to men and women or alternatively making equal contributions toward the cost of providing such benefits. It is likely that the matter will be cleared up during the coming year and a consistent policy will probably be adopted by all agencies of the federal government.

A number of law suits have been filed in various state and federal courts concerning differences of coverage provided men and women. There has not been a conclusive case as to whether or not insurance companies may continue to charge different premium rates to men and women. Several states have statutes prohibiting unfair discrimination. It would appear to be a violation of such statutes to charge the same premium rates to people representing different classes of risk.

Laws have been proposed in a number of states requiring that persons having one or another specified handicap be accepted on the same basis for life and health insurance as a person without that handicap. In the latter part of 1974 the Pennsylvania Insurance Department proposed a regulation prohibiting rating or rejection for any physical or mental characteristic unless the company could justify its action on the basis of statistically significant data. Objections were raised to the proposed regulation and it has not, as yet, been adopted in final form. Another question raised in Pennsylvania concerning classification was whether age groupings broader than single years of age could be considered to comply with the Pennsylvania statute prohibiting unfair discrimination. Such a question raises another side of the issue in that companies are being challenged for equal treatment rather than equitable treatment. Virtually all of the other challenges to risk classifications have contained the thrust that social policy requires equity to be ignored in favor of equality. In 1970, the Fair Credit Reporting Act was passed. As a result of that act, a company wishing to get a consumer report on an applicant must notify the consumer in writing that such a report may be made. It must also inform him that he may request information of the nature and scope

of the investigation. If he asks for such information, the company must give it to him within a reasonable period. If the company rejects the applicant or issues coverage on a substandard basis either wholly or in part because of information contained in the consumer report, it must so advise the applicant and give him the name and address of the reporting agency. If the applicant disputes the accuracy of the information in the report, the agency must reinvestigate. It must then correct the information or place a statement of the applicant's contention in the file. Future reports must contain such statement or corrected information.

Paralleling the interest in fair credit reporting, there has been similar activity with regard to the services by the Medical Information Bureau. The MIB has adopted certain procedures, including disclosure to an insurance applicant that medical findings uncovered because of his application would be sent to the MIB and might be used in connection with future applications for insurance by the same individual.

Concern about coverage provided has occurred in the field of individual health insurance policies. Some state insurance departments encountered policies offering benefits which cover only a very small portion of the total cost of any sickness or accident, or which provide benefits for only some sicknesses or which contain exclusions regarded as unduly restrictive. In such cases the departments have felt that policyholders misunderstood their coverages and may have suffered unnecessarily harsh financial losses because of this misunderstanding. In 1973, a law was enacted in New York requiring the Superintendent of Insurance to establish benefit standards for individual health insurance policies; this was subsequently accomplished by regulation. The NAIC adopted a model regulation in 1974 setting up minimum standards for individual health insurance policies. Under the model the Commissioner would have the power to approve contracts providing lesser than minimum benefits if such contracts are found to be in the public interest. A related development has been the effort by several states to require that under each type of policy issued by a company benefits paid be at least a specified percentage of premiums received.

In 1971 the NAIC studied problems arising when a group case is terminated because a policyholder fails to pay premiums. It also reviewed problems that might arise if an individual's coverage is lost because of a change of carriers. In 1972 a model regulation was adopted providing protection in the case of a change of carriers.

For more than 35 years New York has had a law guaranteeing that the insolvency of a domestic life insurance company would not result in loss of benefits to any policyholder either in New York or elsewhere. In the event of insolvency of a New York company, the other companies are assessed amounts sufficient to pay the required benefits. For much of that 35 year period, New York was the only state with such a law. However, the NAIC adopted a model solvency guarantee bill covering casualty insurance companies. Subsequently it developed a counterpart model bill covering life and health insurance companies.

Since development of the NAIC model in 1970 a similar bill has been enacted in about a dozen states. A number of the recent enactments have provided that some or all of the assessments could be offset against a company's premium tax bill in subsequent years.

An insurance commissioner's authority to supervise advertising and sales literature derives from the Unfair Trade Practices Act found in all states. In 1974 the NAIC adopted a model regulation covering individual health insurance policies which set forth a variety of requirements companies must meet in advertising such policies. A number of states have promulgated health insurance advertising regulations which specify terms or phrases deemed to be

misleading and, therefore, in violation of the Unfair Trade Practices Act.

In the field of life insurance there has been somewhat less activity - perhaps because the benefit structure of life insurance policies tends to be simpler than that of health insurance policies. However, a few states have promulgated life insurance advertising regulations. In addition, a number of states have required a 10-day free look provision in life insurance policies. A parallel provision has existed in individual health insurance for some years.

A model regulation designed to protect individuals against the replacement of existing life insurance policies with new policies, when such replacement is not in their best interest, was adopted in the 1960's by the NAIC. Such regulations have been adopted in several states and generally require that an applicant be given information concerning the old and new policy which will help him to decide whether the replacement is not in his own best interest. Moreover, the company or companies which wrote the old policy or policies must also be notified of the impending replacement.

In 1971, the NAIC amended the model Unfair Trade Practices Act to add a paragraph on claim settlement practices. The paragraph lists some 15 transactions which, if committed with enough frequency to indicate general business practices, would constitute an unfair claim settlement practice.

The same amendments also included a paragraph which required companies to maintain a complete record of all complaints received concerning the company's operations. The file of these complaints would be available for examination by insurance departments or examiners.

Paralleling this action, the NAIC has been reviewing a plan to reorganize its examination system. One of the objects of the reorganization is to have examiners spend more time on company practices than they had been able to do in the past.

The above list of areas in which consumerism has had an impact on the way companies do business is not intended to be exhaustive. However, the list is long enough to give some indication that consumerism has had an impact on virtually every part of the operations of insurance companies.

CHAIRMAN GARFIN: A bill introduced in the California legislature this year illustrates an area where we have to be alert. It would provide that no policy of disability insurance which covers any person who may become pregnant shall be issued, amended, or renewed on or after January 1, 1976, if it contains any disclaimer, waiver or other limitation of coverage relative to abnormal and involuntary complications of pregnancy. On the surface, this bill appears to be a good idea. When you read the details of the bill, though, it doesn't seem quite as good. First it restricts renewal of policies. In health insurance, policies are renewed annually. Therefore, this bill would affect all health insurance. The bill prohibits any limitation of coverage relative to abnormal or involuntary complications. Most medical expense policies contain certain limitations such as Daily Hospital Benefit, aggregate amount for one claim, and aggregate lifetime amount. It appears these limits would not be applicable to abnormal and involuntary complications. While the intent of bills like this is appropriate and desirable, the wording would produce a very unfavorable impact on the insurance industry. Actuaries need to be more alert and aware in the legislative areas. They can read these bills and make known the changes required. Fortunately, this bill was referred to John Montgomery for comment. He proposed some changes to the language which would eliminate most of the difficulties I saw in it. These are things we can do and we must be alert to them.

MR. CHARLES F. PESTAL: An insurance commissioner contacted our attorney to

say our commission system is all wrong because the average life of a permanent policy is seven years. I made some calculations based on the LIMRA long-term lapse study and determined the average life is 14½ years. He wrote back to say he wasn't convinced and enclosed a Washington Post acticle to show me I was wrong. This is an example of the wrong impressions that people have and it's up to us as actuaries to see that these impressions are corrected.