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# DIGEST OF DISCUSSION OF SUBJECTS OF SPECIAL INTEREST

## INDIVIDUAL LIFE AND HEALTH INSURANCE

*Disability Benefits under Life or Health Insurance Policies*

What is the impact of the 1965 changes in OASDI benefits on:

A. Scope of market for private insurance?
B. Underwriting considerations?
C. Policy provisions?

*San Francisco Regional Meeting*

MR. ROBERT N. POWELL: The 1965 amendment to Section 303 of the Social Security Act replaced the existing total and permanent disability program with a temporary disability program by changing the requirement that disability be of long, continued, and indefinite duration to the requirement that disability be the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months." Monthly benefits are payable after an elimination period of six months.

To help put the problems created by this change in the disability provisions of the Social Security Act in proper context, let us look at some examples of potential monthly payments. For a person with average eligible monthly earnings after 1950 of $300, the primary disability benefit is $112.40 monthly, with a maximum family payment of $240. For a person with average eligible earnings of $400 a month, the primary disability benefit is $135.90, with a maximum family benefit of $309.20. For a person with average eligible monthly earnings of $550, the primary disability benefit is $168 per month, with the maximum family payments of $360.

It will be noted that the maximum family payment is a substantial percentage of the average earnings for persons earning under $550 per month. The percentages range from 80 to 65 per cent of the gross pay and generally approximate most companies' rules for determining relationship of total benefits to gross earnings. This suggests, then, that the market for disability insurance certainly has been eliminated for persons in these income brackets who are covered under social security, and it points up the importance, for persons with larger incomes, of taking into account

the benefits available from social security in connection with participation limits, particularly in connection with long-term benefits.

The need for short-term benefits of up to six months' duration, of course, still remains except in those states which have benefit laws providing nonoccupational income-replacement coverage, such as the UCD law in California. Under this law, the current maximum payment is $80 per week if a person has wages in covered employment of at least $1,875 per quarter or $7,500 per year of high-quarter earnings (highest four out of last five completed).

One possibility is to write a benefit that reduces either at the end of the first six months or the first twelve months so as to take into account potential social security benefits. There, of course, could be occasions when benefits are approved under the social security definition of disability but disapproved under the company's definition of disability, or vice versa.

For those companies not currently using the uniform "relation of earnings to insurance" policy provision, it seems very appropriate that they should seriously consider the use of this provision, which would need to be written to include the social security disability benefit as a "valid loss of time coverage."

In our company we have, for years, taken a very liberal underwriting attitude in defining what other coverages we include when looking at the participation limit. To date, we have not included group (except for the higher benefit levels), social security, or UCD benefits. I am happy to report that our loss ratio has been very satisfactory on this business. However, with this change in social security disability benefits, we are seriously reviewing our policy because of the increased prospect of overinsurance. In this connection, it is interesting to note that LIAMA late last year surveyed a group of thirty major health insurance writers and asked specifically what changes they planned to make in their underwriting rules for disability income policies. Of the twenty-nine companies that replied at that time, twelve had either made or were making some changes in their underwriting rules, while three others planned to change their policies as well as their rules.

Six companies gave specific indications of the changes that they were making in their underwriting rules. Companies 1 and 2 will include the potential social security disability benefits when underwriting plans which have benefit periods exceeding twelve months, but social security disability benefits will be disregarded for shorter benefit periods. Company 3 arbitrarily assumes that everyone has disability coverage of $150 per month. Company 4 will assume a social security benefit of $200 per

month when the sickness benefits exceed twelve months. Company 5 assumes social security benefits of $100 per month and UCD, or state disability benefits of $150 per month, if the policy provides for sickness benefits of three years or less. For sickness benefits of five years or more, a social security benefit of $125 per month is assumed. Company 6 indicated that it was changing its participation to $1,500 per month but not more than 60 per cent of earned income. It assumed social security benefits of $150 per month for under issue age 36, $200 per month for issue ages 36–40, $250 per month for issue ages 40–45, and $300 per month for issue ages 46 and over. Alternatively, where indicated, some attempt is made to look at actual benefits to be expected from social security on the basis of average earnings for the past five years and current family composition.

I should note that an excellent review of this entire subject is available in *Medicare Bulletin No. 16-65*, dated November 24, 1965, which is a joint bulletin of the American Life Convention, Life Insurance Association of America, Health Insurance Association of America, and the Life Insurers Conference.

MR. BENJAMIN R. WHITELEY: The action of Congress in 1965 in liberalizing disability benefits provided under social security will be, in my estimation, of great significance to underwriters of disability income benefits.

The former social security benefit was a form of early-retirement benefit; it was payable only to those who were so severely disabled that ability to recover sufficiently to carry on an occupation appeared virtually impossible.

The new benefit is much more than that. It provides for temporary disability according to definitions much more like those found in insurance policies. It provides for significant amounts of benefits, too, especially for persons with incomes of $400–$500 monthly.

To the extent that the 1965 extension of social security provides persons coverage that had been provided by private insurers, I think that few would disagree with the statement that the scope of our market has been decreased. To the extent that people are made more aware of the value of protection against disability by this extension of social security, it may be argued by some that the scope of our market has expanded.

With respect to underwriting, I feel that social security must be considered in any realistic approach. The following factors seem especially important in doing this:

1. Most currently written disability income plans are guaranteed renewable or noncancelable. Underwriting limits set today should anticipate social security and other benefits likely to be in effect while currently sold policies are in force.

2. In round numbers, the amount of social security benefits for which most people will be eligible in the next few years depends on the number of dependent children: none, $150; one, $250; two, $350. These figures apply to persons with monthly earnings of $550 or more.

3. The present "6 month . . . 12 months" social security definition of disability tends to extend disabilities to twelve months. One may speculate that administration problems with this complex benefit will soon lead to its liberalization to a traditional "6 months" definition of disability.

4. It is a rare event that Congress meets without further liberalization of social security.

These factors lead me to conclude that issue limits must be reduced to offset, at least partially, social security benefits.

A practical limit, equitable for all applicants, is difficult to develop because of the variation of social security benefits by number of dependents. One possible approach is to reduce regular limits by *primary* social security benefits. This rule could lead to overinsurance for lower-earnings classes but not by serious proportions.

This approach would result in limits which are too low in the first six months of disability before the end of the social security waiting period. A plan providing higher benefits for the first six months of disability would adjust for this deficiency.

MR. EDWIN B. LANCASTER: The substantial increase in the OASDI wage base and the change in the definition of disability from total and permanent to temporary have *in theory* eliminated a substantial part of the market for private individual insurance. It seems difficult to say how much of the *actual* market has been eliminated because, in Metropolitan's case at least, very little, if any, long-term coverage was written in the "eliminated" area.

It is our thought, at this time, that the short-term (up to two years) disability policies, which make up about 75 per cent of our issues, will not require any important changes in policy provisions or underwriting rules.

In the case of long-term coverage (over two years), we are concerned about (1) the possible further extension of OASDI disability coverage and (2) benefit structure, underwriting, and related policy provisions. This covers the integration of our benefits with the OASDI benefits, including those payable with respect to wife and children, and a concern with optional retirements prior to age 65, as well as the usual concern with overinsurance.

While I have indicated an underwriting concern regarding the temporary OASDI benefits payable with respect to the wife and children, I am frank to say that I have no solution to offer that is easy for underwriters

to administer within the framework of our present long-term disability contracts.

It is our thought that there is a need to reconsider the concept of noncancelable coverage's being continued "up to age 65." The instances of early retirement or semiretirement at ages 60–64 are cause for concern and require a new type of insuring clause. The coverage might provide for expiry on the "date of retirement" if prior to age 65, and "date of retirement" might be defined as "the day immediately preceding the date the insured becomes entitled to income from any pension or annuity under a public retirement system established by the federal government."

A return to the type of benefit popular up to five years ago—involving a reduction of the benefit after the first two years of disability—may be in order. This may be a good time to reconsider offering lifetime benefits for accident disability.

The present clause providing for a prorate in the case of overinsurance, as outlined under the Uniform Provision Law, is not satisfactory, since the proration is related to total earnings. The new provision adopted by New Hampshire following a recommendation of the NAIC appears to be definitely superior, and every effort should be made to get this new provision adopted by all other states. It relates proration to a percentage of earnings established by the insurer.

MR. STORM JOHNSEN:* It has been the experience of insurance companies in Scandinavia that, whenever the government would introduce new social insurance benefits, the market in the lower-income classes would largely be eliminated. Persons in higher-income brackets, however, would soon realize that the government-sponsored benefits were not adequate and purchase the additional benefits which they needed and wanted.

MR. WILLIAM B. DANDY: Although Congress has improved social security benefits about every two years, the economy of the country has been improving at an even faster rate. As a result, there has been little, if any, loss of market for the insurance companies. If the economy were to level off for a long period of time, there would probably be a substantial loss of market, both in disability and in old age retirement benefits, because there would be less extra income to spend for additional benefits over and above those provided by the government.

* Mr. Johnsen, not a member of the Society, is associated with Farmers New World Life Insurance Co., Mercer Island, Wash.

MR. LOUIS GARFIN: In the Pacific Mutual Life Insurance Company, we also had difficulties with noncancelable income-protection benefits during the depression. I do not think that we are in the black yet. It is my opinion that, where the amount limits of the income offered were excessive, it became much more attractive during a period of depression and economic decline to be disabled than unemployed. I believe that we still have to worry about this and avoid being unduly optimistic.

It could be dangerous to expand our underwriting limits in the belief that things are going to be continually growing and improving. I do not know whether the social security laws will improve the market for health insurance or income benefits. In the Los Angeles area, the papers have carried articles stating that social security amendments and Medicare are going to be a great boon to the insurance business. Whether it will actually work out that way, I do not know. At any rate, if we say it often enough, we may begin to believe it.

MR. DANDY: We are writing mortgage disability coverage in connection with life insurance with first mortgages. We do not have a specific long-term policy geared directly toward mortgages; we use our normal disability income policies. Our regular underwriting rules apply in that we are comparing total income against total disability benefits. However, there is no point in ignoring social security disability benefits, since these represent a possible income from an outside source.

MR. ROBERT B. SHAPLAND: The Mutual of Omaha sells almost all lifetime benefits, and we feel that social security does not present any serious overinsurance problems. We do have available, however, riders to provide half-benefits and increased benefits for six months. We also issue a policy on housewives, and our experience has been satisfactory. We believe that one of the objects of the insurance industry is to cover as much of the public as possible and that undue complexity in underwriting rules which thwarts this objective should be avoided.

*Washington Regional Meeting*

MR. JOHN H. MILLER: When the early proposals to include disability benefits in the social security structure were first debated (over fifteen years ago, I believe), Mr. Albert Linton, as well as other students of the subject, predicted that proponents would urge the adoption of a relatively limited benefit provision with rather restricted conditions and that, when adopted, these benefits would be administered strictly. This would lead to the dual consequences of a demonstration of rather modest cost, on the

one hand, and, on the other, proof of the great need for expansion of the benefits and coverage as evidenced by a mounting record of complaints and hardship cases where benefits were necessarily denied.

The original plan, covering only persons of age 50 and over, was referred to as an extension of old age benefits to those workers whose superannuation had been accelerated by accident or chronic disease. This euphemistic description minimized the full implications of adding the letter "D" to the original OASI system.

Measure by measure, we have seen Mr. Linton's early predictions become actualities. The age-50 barrier was removed, dependents' coverage was added, benefits were enlarged, and now the definition of disability has been greatly liberalized, somewhat paralleling the action of life insurance companies more than forty years ago when the original total and presumably permanent definition gave way to the ninety-day presumptive clause.

The real significance of the change in definition of disability is not simply that the program has been broadened to include coverage of many temporary disabilities as well as terminal cases but that it has enormously expanded the hazard of overinsurance in respect to disability benefits issued by insurance companies.

Overinsurance arises when the combined disability benefits from social security and personal or group insurance closely approach or exceed the net take-home pay after taxes and expenses incident to employment. Overinsurance becomes significant, however, only when it can induce or encourage malingering. If a person is so completely disabled that recovery or rehabilitation is impossible or highly unlikely, overinsurance is not an underwriting hazard for, obviously, a truly terminal disability will not be extended by the conscious efforts, or lack of effort, of the individual.

For this reason the pre-1965 restricted social security disability benefits were of limited concern to underwriters. Now, however, the situation is very different, because temporary disabilities, covered under the new definition, are susceptible to considerable malingering. The temptation to lengthen a temporary disability, even to retirement age, is obviously very great when benefits are not limited to a specified duration of payment.

I suggest that we discuss Sections A, B, and C together, particularly since the scope of the market cannot be effectively analyzed without establishing certain underwriting criteria and relating the problem to at least those policy provisions stipulating the elimination period and the maximum benefit duration.

To amplify the questions a little, I would like to encourage discussion with regard to how we can avoid overinsurance under each of the fol-

lowing conditions: (1) with the issuance of policies containing no anti-duplication or average-earnings clauses; (2) with the use of the present—and, I think you will agree, definitely inadequate—relation-to-earnings clause; (3) with the overinsurance clause that has been approved by the NAIC permitting the maximum indemnity to be measured against a percentage of earnings as selected by the insurer, not less than 60 per cent; and (4) with a policy provision defining benefits as the excess of a stated monthly indemnity over other defined benefits, including social security.

With respect to the NAIC overinsurance clause, it would be interesting to learn in which states the new overinsurance clause is permissible in individual policies. With respect to the issuance of an excess indemnity benefit, I have heard of one company that has adopted a clause providing for the deduction, from the benefit otherwise payable, of social security benefits, both primary and those of dependents. In the group field, of course, many long-term disability policies are being issued on the excess basis. To what extent can this be carried over to the individual noncancelable field? What are the problems?

Now, having expanded a little on the committee's questions, I hope that some of you will volunteer to provide some answers or maybe mention some further problems.

MR. EDWIN B. LANCASTER repeated the discussion which he had presented at the San Francisco meeting.

MR. ALTON P. MORTON: I would like to ask Mr. Miller whether, in those states which have approved a policy providing benefits to be adjusted by the amount of OASDI benefits payable in the man's particular dependency circumstances, there are problems of adjusting rates because the company pays smaller benefits in certain cases than are assumed in the premium rates.

MR. MILLER: It would certainly be desirable to provide for some equitable adjustment, either in the rate or in the benefit period. For example, if benefits are payable to age 65, the policy could be issued with a fairly long elimination period which could be shortened if the amount payable is reduced by reason of OASDI benefits. If benefits are payable for five years, for example, the period of payment might be extended in similar circumstances.

MR. GEORGE A. REYNOLDS: It seems to me that the main point is to provide the benefits required by the applicant. This means that we must be careful during the underwriting process that the amount purchased does not become too high in relation to the man's income. If we

regard social security as a possible provider of $150 or $200 a month, we can determine a maximum amount that we will offer an applicant. Although the adjustment of benefits can be handled quite easily in group insurance, it does not seem administratively practical under an individual policy, even though it might be approved in some states.

MR. MILLER: The underwriting approach is subject to two severe limitations. The first is that, while a company issuing noncancelable policies might underwrite very conservatively with regard to overinsurance, it has no adequate protection against some other company's issuing additional insurance subsequently. The average-earnings clause, which makes no allowance for income tax, is not an adequate protection. The second limitation is the possibility of future increases in social security benefits. We have heard President Johnson speak about improvements to be made and cannot consider that the historical trend toward larger benefits is at an end.

Two or three years ago, the NAIC approved a new overinsurance clause. The lack of enabling legislation in the states has been disappointing. I wonder whether there is any feeling that this clause does not offer an adequate solution or at least an improvement over the average-earnings clause.

MR. W. HAROLD BITTEL: There is still a wide difference of opinion between the industry and the regulatory authorities on the form of this legislation. When it was originally adopted, there were optional provisions that were supposed to be available to the insurance departments if it were enacted in their jurisdiction. Had the industry been willing to agree to these modifications, it would have been enacted in New Jersey. Until this problem is met, I do not think that it is going to be enacted.

MR. WILLIAM H. SCHMIDT: In the Mutual Life of New York, we have tentatively reached the conclusion that we should make some kind of adjustment for social security. Although the details have not been finally settled, we have been discussing a maximum amount of coverage which is lower by $150 or $200 a month than we would currently offer on plans which provide benefits for five years or to age 65. In plans offering benefits for only one or two years, the social security hazard is not as great, and we would probably not make this adjustment.

MR. CHARLES N. WALKER: Although there is still considerable market for short-term coverage, I think that the effect of social security on the lower-income market at the older ages is such that there is little market left there.

*Changes in Individual Medical Expense Insurance in the Light of Medicare*

A. What revisions are being made in new-business portfolios with respect to:
   1. Basic hospital and medical expense coverage?
   2. Comprehensive hospital and medical expense coverage?
   3. Senior citizen coverage?
B. What adjustments are being made in existing policies with respect to:
   1. Persons who are over age 65 in 1966?
   2. Persons who will become age 65 in future years?
C. What claim problems are anticipated under continuing policies on persons eligible for Medicare?

*San Francisco Regional Meeting*

MR. ALFRED L. BUCKMAN: When the benefits of Medicare, as provided under Section XVIII of the Social Security Act as amended, become available on July 1, 1966, to persons 65 years of age and over, the character of medical care insurance as provided by insurance companies and service institutions will change considerably.

This is unlike the effect on the insurance industry of the original Social Security Act which provided, principally, retirement benefits for persons over 65 years of age. The amount of retirement benefits provided by social security was small, and there was no practical limit to the amount of additional retirement benefit an individual could or would provide for himself through insurance or other means if he had the funds to purchase such coverage.

In medical insurance, however, there is a practical limit to the amount of additional insurance an individual should have above that provided by Medicare, and that is the balance of medical expenses incurred above that paid by Medicare. Where the total amount of insurance benefits exceeds the cost of such services, the individual insured has incentive to run up medical bills, because the more bills he incurs, the more he profits. The evils of overinsurance in this field are obvious.

It is therefore incumbent upon insurance companies to make such revisions in their policies as are necessary to integrate them with the realities of Medicare.

In basic hospital and medical expense coverage and also in comprehensive hospital medical expense coverage, there are at least four areas that require consideration: (1) renewal provision, (2) conversion provision, (3) benefit provision, and (4) premium rates.

The renewal provision of noncancelable and of guaranteed renewable policies, according to the suggestion of the NAIC at its meeting in Florida last fall, should provide for termination of coverage and benefits on "the day before the date of eligibility for coverage under Title XVIII of the

Social Security Act as amended." This language does two things: It provides for cessation of coverage and benefits as soon as the insured becomes covered under Medicare and for statutory change in the age of eligibility for Medicare benefits.

The renewal provision for policies renewable at the option of the company has to be amended if duplication of coverage is not to be present after the insured becomes eligible for Medicare benefits and if the policy by its terms states that refusal to renew may occur only on a policy anniversary. This amended provision, in essence, provides for termination of benefits on "the day before the date of eligibility for coverage under Title XVIII of the Social Security Act as amended in consideration of the renewal of the policy beyond the policy anniversary next preceding the date of such automatic termination."

Our own company is adopting the recommended language with the addition of the phrase that coverage would not continue "beyond the date the Insured becomes 65 years of age." This phrase is added to apply to those few individuals who may not be eligible for Medicare benefits.

Some companies are considering the addition of a conversion provision to new policies issued at ages under 65 which would permit the insured to convert his underage coverage on the date it terminates to a plan of insurance which the company may then be issuing to senior citizens to supplement Medicare benefits.

Coming now to the actual benefits provided for persons prior to becoming eligible for Medicare, there appears to be no need to change basic benefits, although some companies may design policies that provide essentially the same benefits as those effective under Medicare for persons prior to their eligibility for Medicare so that there would be a continuity of coverage before and after the individual becomes eligible.

Some new policies provide for a reduction in benefits to the extent that benefits are paid by Medicare. These policies must have a corresponding reduction in premium. Premiums need adjustment also if policies are changed from being guaranteed renewable for life to being renewable to date of eligibility for Medicare. Also, premiums need adjustment in the last fractional period of coverage terminating on the day before the insured becomes eligible for Medicare benefits.

Benefits prior to age 65 for basic hospital and medical expense coverage, as well as benefits for comprehensive hospital and medical expense coverage, need not be changed. But benefits for senior citizen coverage need changing if not already designed to supplement or complement Medicare benefits.

There are four approaches being taken to provide benefits for senior citizens.

One approach is to fill all or some of the gaps of Medicare, that is, to provide coverage for the deductibles, the coinsurance, extended stays in the hospital or convalescent home, prescribed drugs outside the hospital, nursing care in and out of the hospital, and other possible expenses. This approach is being used by Blue Cross, some service corporations, and a few insurance companies.

Another is to provide an indemnity benefit while confined to a hospital and to a convalescent home. The cash benefit will be available to the insured to help meet expenses not covered by Medicare.

A third approach is to ignore Medicare entirely. If reports in the press are correct and up to date, there are a few companies that are planning to continue offering present types of basic and comprehensive coverage to persons over 65 years of age even after July 1, 1966. Some states, notably Connecticut and New York, prohibit this.

The fourth approach is to retire from the field entirely. Firemen's Fund, which has about $10 million of premium income on elder citizens, has announced its intention to withdraw from the field. According to the *Wall Street Journal*, an official of Firemen's Fund is quoted as saying, "We can't find any way to compute a rate to sell the supplemental coverage for oldsters at a profit. Companies that are going into it are using data from past years, but we don't think that's good enough. The Government program is going to change all past patterns of frequency of treatment."

Turning to topic B, we find that the following actions are being taken with respect to persons who are over 65 in 1966.

Some companies, like Firemen's Fund, are going out of the business entirely. Apparently, all their business is renewable at the option of the company. Metropolitan Life and a few other companies are reported to be discontinuing their policies that are renewable at the option of the company as soon after July 1, 1966, as permissible by policy provisions. Other companies, like Mutual of Omaha, are reportedly not making any effort to change existing coverages.

Most companies, however, are expected to make an effort to convert existing business on overage people either to an integrated plan or to an indemnity plan. Such attempts to convert should meet with insurance department approval, according to a recommendation of the NAIC. A few states, however, have indicated that they wish to review for approval a conversion program before it is used.

Our own company has designed a policy for overage people that provides monthly indemnity benefits of $200–$600 per month for life while hospitalized and half-benefits for a maximum of 100 days while in a convalescent home following a period of hospitalization. A few peripheral benefits are also provided.

This policy is being offered to our existing policyholders over age 65 on a conversion basis. Policies which are presently guaranteed renewable for life will be converted to the new product on the same guaranteed renewable provision; policies which are presently renewable at the option of the company will be converted to the new product on the renewable at the option of the company basis.

We have not decided what we will do with respect to policies which do not convert.

There is nothing that we can do with respect to policies which are guaranteed renewable except, perhaps, increase premiums if future experience justifies such a step. Any increase in premiums, however, must be based on the age at issue and, if this is done, it could have a detrimental effect on the persistency of existing business on persons not yet age 65.

On policies which are renewable at the option of the company, we plan to study closely the loss ratios on those that are not converted. Our future action will depend upon the degree of antiselection that may develop.

If antiselection of overage policyholders who do not convert proves to be as bad as some companies anticipate, we will, of course, refuse to renew the policies which are renewable at the option of the company. If antiselection is not too severe, we may try to get by with a suitable increase in premium rates. In addition, we may avail ourselves of the privilege of adding a rider to existing policies on persons not yet 65 years of age which will (1) offer the conversion privilege at age 65 to a form that supplements Medicare or (2) terminate the insurance on eligibility to Medicare. Still another available alternative is to amend such policies to eliminate duplication of coverage with Medicare and to have an appropriate reduction in premiums.

In conclusion, I must say that the past does not provide us with reliable information on which we can safely forecast the future of privately insured medical care for the aged, and it is most important that careful records be kept of loss experience and persistency of such business after Medicare benefits go into effect.

MR. ALEXANDER MARSHALL: We have just this week completed the filing of a new hospital expense policy with the California Insurance Department. The policy is guaranteed renewable to age 65. It replaces a commercial policies series which we have been issuing since 1956.

This policy contains language in the insuring clause which makes for nonduplication with Medicare benefits, if ever the eligibility age for Medicare is reduced below age 65. This approach has been approved by the California Insurance Department, since it is in accord with the provisions of *California Insurance Department Bulletin NS-36*, adopted and released

February 28, 1966. We are currently filing the form in other western states in which we operate.

The principal point that we would like to make in connection with this new policy—apart from certain unique features contained in it—does not relate to its co-ordination with Medicare or to the relief it grants us from duplication with Medicare benefits. The relief from duplication with Medicare benefits is only a very small piece of the much larger and much more important question of relief from duplication of benefits from all other coverages—governmental, group, and individual.

The Medicare exclusion is just the tip of the iceberg lying below the surface which can wreck the ship of medical coverages. A great deal of material has been accumulated over the years by the Health Insurance Association of America, and by others, which demonstrates the extent of duplicate coverage and the financial effect that it has on claim costs to the detriment of policyowners and of relationships existing between the insurance industry and the providers of medical services.

We engaged in several months of negotiation with the California Department—endless correspondence and many hours of discussion—in an attempt to establish the propriety of and the need for the department's allowing us to use an adequate overinsurance provision in the guaranteed renewable policy sufficient to protect our policyowners against the extra costs that arise out of duplicate coverages. The department held to a close interpretation of the Code, in spite of the great variety of evidence that we presented and in spite of an Administrative Code provision granting ". . . liberal construction for experimental coverages in the field of catastrophic coverages which the Commissioner declares to be, in his opinion, in the public interest. . . ." The policy contains features which, we submitted, fitted these criteria.

In the face of this, then (and I think that we received much individual sympathy and consideration from the staff of the department, up to a point), I would urge every one of you concerned with health insurance not to rest now and congratulate the insurance departments or yourselves that a major step has been achieved in the area of overinsurance. We submit that it is but a baby step—perhaps a valuable first step, but only a first step. Further, we urge that you vigorously press for legislation implementing the findings and the recommendations of the Seventh Status Report on Overinsurance adopted by the NAIC in December, 1963.

It appears that only by pressing for new legislation as individual companies and as an industry can we capitalize on this Medicare baby step and provide coverages which contain some real protection for policyowners against abuses of medical coverages in the area of duplication of benefits.

MR. WARREN R. ADAMS: Our basic hospital-surgical and major medical policies are being revised for future issues to terminate coverage on the premium-due date following the insured's sixty-fifth birthday. Benefits for a covered spouse also cease on the premium-due date following his or her sixty-fifth birthday. Premiums will be adjusted accordingly when the coverage ceases on either spouse. Dependent children will continue to be covered so long as husband *or* wife is insured.

The new basic hospital-surgical and major medical forms will include a provision excluding payment for expenses which are provided under any national, state, or local government program or law. It is hoped that this will operate to avoid double payment for expenses incurred during the period between a covered individual's eligibility date for Medicare, whatever that might be in the future, and the premium-due date on which coverage terminates.

We have decided not to issue any individual policy form of over-65 coverage. Medicare does a reasonably adequate job of meeting the senior citizen's medical insurance needs. We consider the deductible and coinsurance areas of Medicare as desirable in the control of utilization. Any form of private insurance which covers these items will tend to defeat their purpose. The remaining potentially insurable costs are so small, relative to the high expense of acquiring and maintaining this type of business, that the benefits-to-premium relationship is unacceptable.

The decision to offer supplemental benefits to our group customers is facilitated by the existence on each policy of a large premium base which bears most of the overhead expense. Also, in the group area our role as consultant requires us to be more responsive to the individual employer's needs and desires. For these reasons, our group approach will be very flexible, even to the point of covering the deductibles and coinsurance in those cases where the employer insists on this.

Existing policies which are renewable at the option of the company after age 65, including those guaranteed renewable to 65, that cover at least one adult family member not eligible for Medicare may be continued to age 65 for such persons with an adjustment in premium. The policy will terminate on the renewal date following the sixty-fifth birthday of the youngest adult person insured. If there is no insured adult under age 65 on July 1, 1966, the policy will be canceled on the first subsequent renewal date.

Guaranteed renewable for life policyholders will be advised that, even though their contracts can be renewed on a lifetime basis, there will be duplication of benefits since they will be entitled to Medicare coverage and the premium will, in all probability, be increased due to experience.

Consequently, it would not be to their advantage to carry on their contracts.

As a stop-gap measure, we have adopted age 59 as the limiting issue age for the current policy series. This preserves the applicability of the term "guaranteed renewable" and avoids issues for a term of less than five years.

We plan to inform all policyholders who reach age 60 in 1966 of our intentions with respect to coverage after age 65. As yet there are no firm plans for contacting the remaining policyholders in the future.

We anticipate that some of our guaranteed renewable for life policyholders will continue beyond their dates of eligibility for Medicare. In addition to the highly probable antiselection and overutilization problems expected under existing policies, the government exclusion provision of our new policy series will present difficulties during the period between the sixty-fifth birthday and the next premium-due date when this provision is effective. If the insured elects not to participate in Part B (the Voluntary Supplementary Plan), we probably will pay the benefits which otherwise would have been covered by Part B. This leads immediately to discrimination among policyholders unless a practical method can be found to adjust premiums for differences in Medicare coverage. Also, a great deal more claim information and analysis will be required to determine the eligibility of charges for coverage under our policies. It will be no small task to examine each claim item by item and to decide which and how much of each are covered by Medicare. The Part B $50 deductible will be especially difficult for, on a particular claim, none of it may be applicable since it has been satisfied earlier in the year, while on other claims from $1 to $50 may be pertinent. Hopefully, the Social Security Administration will furnish detailed reports on all claims, which will simplify our job. However, at this point, this possibility is to be viewed with some skepticism.

MR. OSCAR R. KLEIN, JR.: In your conversion program, Mr. Buckman, where you have different amounts of benefit in existing policies, will the benefit on the converted policy be the same as that in the old policy?

MR. BUCKMAN: We decided to offer a flat $300 per month on conversion, regardless of the amount of basic policy. However, in the future we will permit conversion to whatever the daily benefit was on the basic policy. This is going to be provided for in our new policy form.

MR. WILBUR M. BOLTON: Is the premium on the conversion policies less than the premium which the policyowners above age 65 have been paying for the coverage they have had? In other words, do they have an economic incentive to convert?

MR. BUCKMAN: For the most part, yes. There were some old policies in which premiums might be less than the current premium for a benefit of ten dollars a day, but, basically, there is a reduction in premium rates in most cases because surgery and miscellaneous benefits have been eliminated.

MR. JOHN F. HOOK: Did you try to draft a policy which integrates exactly with social security benefits?

MR. BUCKMAN: We gave this some thought but decided that there simply would not be enough premium that could be developed on such a policy form. I understand that Blue Cross and the Kaiser Foundation are issuing such programs, and one or two companies as well. We also felt that there would be some objection from the Insurance Commissioners to a policy integrated with social security in this way.

I am sure that you are familiar with Medicare's deductible and coinsurance features. I know that Connecticut has indicated that it is opposed to covering them. The Connecticut Insurance Department believes that this would defeat the fundamental purpose of these features and that the public should pay something with the benefits that they are getting in order to control loss ratios.

MR. HOOK: Mr. Marshall has raised a plea for a way for companies to write a policy that will control overinsurance by definition; yet, it seems to me, the insurance departments have been pretty much opposed to that.

MR. MARSHALL: I can take up the role of the insurance departments because I have to stay friends with them.

They feel that they are bound by the Code provisions. This is one area that certain people felt could not be gone beyond, and, in the California legislature last year, I think that the actual insurance provision of the Seventh Status Report which was proposed was defeated. Of course, I was not close to those hearings. I believe, however, that it was defeated in committee largely due to opposition from labor. However, we, are going to take a much more vigorous part in it when it comes up again. We will either sponsor the legislation or we will take a more aggressive part in getting it through in California.

I am also sure that other states are going to listen to us if we want to approach them with such a provision. However, we believe in it very strongly and so this, as I say, is a defense of the insurance departments.

MR. HOOK: Is there any feeling on their part that to allow this kind of clause would permit the writing of policies without reasonable benefits?

MR. MARSHALL: They did not raise that point. This would have to be considered by them, of course, since these are points contained in the Administrative Code. However, there is provision for discretion on the part of the Commissioner relating to the administration of the Administrative Code.

An important point that we made with regard to the adequacy of benefits relates to the forces of competition. If premiums are too much out of line with benefits, including prorated benefits, then business will not tend to stay on the books. Another important consideration relating to minimum-benefit requirements that we pointed out is that a most important factor is the quality of the company involved and the way it administers benefits. Minimum-benefit requirements may technically be met or exceeded, but actual claim administration can make it extremely difficult for a policyowner to actually realize even minimum benefits.

MR. LOUIS GARFIN: The first part of the question relates to revision of new-business portfolios with respect to basic hospital and medical expense coverage. At Pacific Mutual we have a hospital policy which has been guaranteed renewable for life and which we have offered to age 80 at issue.

The first and obvious step that we will take is to discontinue offering the contract beyond age 64. We will continue to offer it through this age until we have a new product to replace it, even though it is guaranteed renewable for life.

Our new policy will be a hospital policy, presumably renewable to age 65 or the earlier date that Medicare might be effective. We also propose to include a provision to the effect that there should be no duplication of benefits with those provided by Medicare. The reason is that there may be a claim which is incurred prior to the eligibility for Medicare but for which benefits would continue after Medicare benefits are available. We intend to eliminate this duplication.

We expect that the new product will also increase coverages as compared with the contract we now offer. For example, we may increase the limit for hospital services, the maximum number of days, or the maxi-

mum amount of daily hospital benefit, or some combination of these. Presumably, we will add a convalescent-home benefit.

The next subtopic relates to the comprehensive hospital and medical expense coverage. We have two such policies, one renewable to age 65 and the other renewable for life.

The contract renewable for life has not been popular because the premiums are substantially higher. We are withdrawing that policy from sale, so that we will offer only the contract renewable to age 65 until we have a revised version to offer. Again, this new product will be renewable to age 65 or the date on which Medicare benefits become effective, if that is earlier.

Assuming that we get approval of these changes (which we hope is possible, inasmuch as they are reasonably consistent with the NAIC recommendations), we will eliminate the duplication of Medicare benefits and we may increase the maximum limit of aggregate benefits. We presently have a $10,000 limit. This may go to $12,500 or $15,000, and we might increase the available deductible amounts to $750 or $1,000.

For senior citizens we propose to develop a new contract. This raises the basic question mentioned of whether it is appropriate to stay in this field. I think that there are arguments in either direction. We feel impelled to try to offer some kind of coverage for people over 65 for several reasons, one being that certain of our existing policies have a conversion privilege which permits conversion to whatever form of coverage we may be offering at age 65. We feel that it would not be quite cricket to offer no policy at that time. This is a benefit which people have been sold, so we concluded that it is desirable to consider some contract.

We considered, as one alternative, trying to fit the benefits into the Medicare benefits but decided against it for several reasons. The most basic reason, which is not very actuarial, is that this becomes a rather complicated contract which people at advanced ages would find difficult to understand and which agents at any age would find difficult to sell.

Therefore, we have decided to offer a contract which is not guaranteed renewable but collectively renewable for the entire class. We would not be in a position to cancel any contract unless we discontinued the coverage for the entire class of policies. The benefit will be a daily indemnity benefit, possibly on the order of $10 a day for the first 90 days, then going to $20 a day, or some such figure, from the ninety-first day to the end of, perhaps, a year of hospitalization. We would offer benefits during a period of convalescent-home care after a period of hospitalization, perhaps on the order of $5 a day, up to 100 days.

That is the basic intent of what we are now attempting to develop. We are not as far along, I am afraid, as some other companies from

which you have heard. We hope that we will have something to offer before July 1.

As to part B of the question—adjustments being made in existing policies with respect to persons who are over age 65 in 1966—we have not answered all of that yet. We have two categories. First, there are the optionally renewable coverages for people who are over 65; we will decline renewal on the first renewal date after July 1. There is an alternative of offering renewal to July 1, with a pro rata premium. We considered this and decided to go this route in order to have a more consistent pattern which we could apply in all situations as they develop.

In the case of the guaranteed renewable contracts, we will renew as long as the insured chooses to pay the premiums, because we have to. We will presumably offer the new conversion contract when it is available, without evidence of insurability, and we hope most people will convert.

We are not sure that conversion will always result in a premium reduction because some of these contracts have been in force for many years, as they were issued at younger ages at a presumably level premium.

There are certain contracts which would expire according to their terms before the availability of Medicare benefits in 1966. We will permit renewal to the effective date of Medicare benefits in 1966 and propose to charge a pro rata premium.

For those people who will become age 65 in future years, for the optionally renewable business we again propose to decline renewal on the first renewal date after their sixty-fifth birthdays, which thus carries them a little beyond the availability of Medicare benefits.

On the policies guaranteed renewable for life, we will again offer as replacements the new contract, which is guaranteed renewable to age 65, with increased benefits available. Presumably the premium rate would be less in nearly every case because of the limited period of years that we have been offering guaranteed renewable contracts.

Another possibility is that the contract designed to supplement Medicare after age 65 might perhaps be offered down to age 60 at issue. This would be done for the reason that a guaranteed renewable policy must, to fit that definition, be guaranteed renewable for at least five years. If it is to terminate at age 65, it cannot be issued after age 60 and still be "guaranteed renewable." Therefore, we may have to use the over-65 contract with an endorsement of some kind to provide increased benefits before the availability of Medicare.

We do not expect any claim problems at all because, after review of the language of our policies, we have concluded that it will serve no useful purpose for us to try to eliminate benefits duplicated by Medicare,

and we will expect to pay claims under the terms of the coverage as though Medicare did not exist. There may be abuses because of over-insurance, but we have some hope that the utilization review committees called for under the Medicare law may be effective in minimizing the abuses, at least to some degree.

There is one other problem about which we can only conjecture. This arises from the fact that part of the Medicare coverage is a service benefit, at least as we read it, in which the insured has to pay only for that part which is not covered by Medicare. It is conceivable that there may be some difficulty—because we propose to pay claims for reimbursement of medical expenses incurred—in getting the billings which would indicate what those charges would have been or what they were, since the individual is not going to have to pay them. However, we have concluded that, while the records of the costs of Medicare benefits to the fiscal intermediaries and the Social Security Administration are probably going to be confidential, the hospital will still be at liberty to divulge what its charges would have been so that we may not have difficulty in getting such billings.

MR. RALPH E. YOUNG:* In your thinking about the offering of benefits to age 65 to replace a lifetime benefit on your guaranteed renewable, is your inducement to policyholders going to be a reduced premium or are you considering repayment of part of the reserve that theoretically is going to be released?

MR. GARFIN: Our present thinking is that the main inducement will be more benefits for a lower premium. As we see it at this time, the reserve is not a cash value.

MR. KLEIN: Under Medicare, Part A, where it will be a service benefit, it appears possible that the insured will not receive a bill from the hospital for that portion. If no bill is presented, then, technically, no expense was incurred. Does your policy provide only for expenses incurred, or are you going to pay anyway?

MR. GARFIN: Our present thinking is that it will usually be possible to obtain a bill prepared on a factual basis, not just a fabricated bill. If we have difficulty in this area, it may be possible for us to determine what the daily room charges are for the kind of facilities used and perhaps in that way fabricate the benefits which may be payable.

* Mr. Young, not a member of the Society, is associated with Western Life Insurance Company, St. Paul, Minn.

MR. HERBERT ORENSHEIN: At Beneficial Standard Life we have already embarked on a program of converting policies on insureds who will be 65 years old or older on July 1, 1966.

We sent letters to a sample of 1,000 holders of hospital and surgical policies who would qualify for Medicare benefits and who had, in a previous solicitation sent to all policyholders, expressed an interest in information on Medicare.

The sample of 1,000 was composed of three groups: Group 1 consisted of 250 holders, each with one individual policy renewable at the option of the company; Group 2 of 250 holders, each with one individual guaranteed renewable policy; and Group 3 of 500 holders, each with more than one policy or with a family policy covering more than one life.

In each letter we explained the situation, described our conversion policy designed to supplement Medicare, and enclosed an application for a policy providing a benefit of $300 per month during periods of hospital confinement.

Of the policyholders in Group 1, 15 per cent requested conversion. Information on the other two groups is not complete, although indications are that there will be fewer conversion requests from Group 3 because the process is more complicated.

In Group 1, 23 per cent of the males requested conversion but only 11 per cent of the females; 75 per cent of the policies are on female risks. The average age of those requesting conversion was 71.4 years, compared to an average age of 73.6 years for the others. The average duration where conversion was requested was 8.4 years; it was 9.4 years for the remainder. The incidence of claim for those who did not request conversion was 35 per cent higher than for those who did. Also, 15 per cent of those who did not request conversion had filed at least one claim since January 1, 1965, as against 6 per cent of those who did.

There are several problems associated with a conversion procedure: (1) In what respect should guaranteed renewable policies be treated differently from those renewable at the option of the company? We have continued the renewal provision of the old policy. (2) If a person has more than one policy, how many should be converted? We will convert two policies, if requested. Individual consideration will be given to requests for conversion of three or more policies. (3) When should conversion become effective in cases of request for conversion of more than one policy? We will make conversions effective on the first premium-due date on or after July 1, 1966, unless some other date is specifically requested. We anticipate requests for conversions effective July 1, 1966, which will involve pro rata refunds. (4) What problems are involved

on family policies? If the conversion would result in the termination of the entire policy because children only cannot be covered on a family policy, we will explain the situation and request confirmation of the desire to convert. (5) What forms are to be eligible for conversion? For the present, we have decided to permit conversion of policies providing hospital and surgical coverage, surgical coverage only, and major medical coverage. In all cases the converted policy will provide $300 of monthly income. (6) What are the problems with insurance departments? Some states have requested our advertising literature for review and approval, while others have requested that the advertising literature be filed before approving the policy form. Most states have been prompt in dealing with these forms, but there have been greater delays in approval of forms not related to the Medicare program.

MR. MAYNARD I. KAGEN: Coverage which terminates on the date before Medicare goes into effect results in a pro rata premium charge. This could cause quite a few administrative problems, especially in connection with family policies. Has anyone faced up to these problems successfully?

MR. ORENSHEIN: Our tape system is set up with a "transfer date" for each life covered under the policy, which will be the date of first automatic change for the life. For most adult lives, this will be the date that the person becomes age 65. A separate program will be used to adjust the premium.

MR. EDWIN B. LANCASTER: On March 1, Metropolitan mailed out 165,000 letters to its policyholders aged 65 or over in connection with Medicare. Most of these policies are guaranteed renewable, and most of the guaranteed renewable ones provide what amounts to a Medicare exclusion.

We said in our letter, "Do you want us to terminate your contract on July 1, or do you want us to continue the contract with reduced benefits as indicated in this letter?" We tried, of course, to explain quite carefully the rather substantial nature of the Medicare benefits.

To date we have received some 40,000 replies, and 80 per cent of the people replying want to continue the Metropolitan policy with the reduced benefits at the rate quoted.

MR. WILLIS W. BURGESS, JR.: At Bankers Life and Casualty, we have 500,000 individual hospital-surgical policies insuring persons aged 65 and over. We did not consider converting what we call our hospital

indemnity policies (cash benefits). We are going to leave these policies in force.

We sent out our conversion offers on an original group of 150,000 policyholders. This was done in February, and we have pulled over 50 per cent in acceptance of the application to date. Therefore, we feel that we are well on our way toward getting a very satisfactory return in connection with our conversion which, in our case, involves picking up the first $40 and providing coverage after sixty days of hospitalization.

Also, may I indicate that we plan to send three follow-up letters to those who do not accept—each to be sent out at intervals of two or three weeks. We have a large group of optionally renewable contracts, and our plan at this time is that, either after the third follow-up letter or a fourth letter, we will then give them two letters in which we will indicate that after a certain date we are going to exercise our option, if they have not converted, of not renewing the contract. However, we have not interjected that comment in any of our mailings to date.

MR. WILLIAM C. BROWN: The changes required in new-business portfolios because of Medicare for basic hospital and medical, comprehensive and major medical policies are fairly obvious, and most companies seem to be doing approximately the same thing. It is quite clear that Medicare will be handling the major part of all these costs over age 65.

In order to avoid duplicate coverage over 65, age limits must be used. Most companies, therefore, if they do not already have age limits in their policies, will make provision for them. The usual limiting age is 65, or the day before qualification for Medicare, or the earlier of these two dates. These changes are being made for both guaranteed renewable and noncancelable forms. No change is needed for cancelable coverage, since the company would only need to establish a policy to cancel at the desired age. Most of us who are making these changes are doing so in the realization that duplicating benefits is fundamentally wrong and can only result in building up costs unnecessarily. I have, however, seen an announcement from one company that their policies, both old and new, will pay full benefits in addition to Medicare and any other coverage the policy may have.

In contrast with the relative unanimity of opinion with regard to what is needed for new policies at the younger ages, there are widely different opinions regarding what should be done about senior citizen policies. I hope that advocates of these differing approaches will speak later in defense of their companies' decisions.

First of all, there seems to be a group of extreme pessimists who say, in effect, "The federal government has taken over responsibility for all senior citizens' coverage or, if they have not, they will do so before long; this is an area in which we have been losing money anyway, so we will get out with good grace and not attempt to sell any coverage over the Medicare qualifying age."

Then there is a second group of companies which seems to be saying, "The government has taken a big chunk of the overage market, but we do not know how much; anyone who is ill can always use more money, so we will sell these older people a flat indemnity of so many dollars a day or week; we do not care if it is used to pay the deductibles of the Medicare plan, even though the insurance industry advises us that these were put in the plan to control claim costs."

Finally, there are a third group of companies and some of the Blue Cross plans which, after analyzing the benefits provided by both parts of Medicare, have concluded that there are substantial areas of medical costs which are not now covered by the government plans. It is, of course, true that Medicare may be extended, but there is less likelihood of that's happening if private companies successfully fill the gaps. These companies also feel that it is desirable to keep as many markets open as possible for the benefit of their sales forces. They will sell new senior citizen policies which provide specific benefits beyond those covered by Medicare. These include:

1. Part of the hospital charges from the sixty-first to the ninetieth day and an increased share of such changes after 90 days.
2. Part of the miscellaneous hospital expense after 90 days.
3. Part of the extended-care-facility costs after 20 days.
4. Private-duty-nursing costs, usually with specific dollar and/or time limits.
5. A share of the medical costs.
6. Prescription drugs within certain limits.

Companies issuing these policies generally will reserve the right to change premiums and possibly also benefit provisions, the latter being important in the event of any further extension of Medicare.

There is a serious problem for our companies in connection with persons aged 55–65. Because of the time needed to recover initial expenses, we are reluctant to issue policies in this age range with the certainty that they will terminate in ten years or less. However, there are many people in this age range who need hospital and medical coverage, and, if private industry does not fill the hole, it will be argued that government should do so. Some solution must be found—possibly a conversion provision to a senior citizen policy at Medicare age without additional

first-year commission or a lower first-year-commission scale at the higher ages.

In regard to existing policyholders where the insureds are now over age 65, the renewal provisions of the policy govern what the companies may do. When the policies are noncancelable, there is nothing that the companies can do except to hope that policyholders will be satisfied with the benefits of Medicare, may wish to reduce their expenditures, and will drop the insurance companies' policies. The companies may, of course, offer to exchange existing noncancelable policies for new ones with reduced coverage and lower premiums, but, if a policyholder wants to keep his old policy, nothing whatsoever can be done about it. If the existing coverage is on a guaranteed renewable basis, the companies are in a somewhat better position. These policyholders can be offered the new senior citizen policies at a reduced rate in lieu of a premium increase on their existing policies if the experience justifies the latter action. Since some state insurance departments are quite concerned about the effects of duplicate benefits, it may not be difficult to get approval for such a procedure. Companies will probably terminate cancelable policies on the next anniversary or at the first opportunity after July 1, 1966.

For existing policies where the insureds are now under age 65, company action is again dictated by the renewal provisions of the policy. Those policies which are noncancelable may be kept by their owners unchanged. However, such policyholders might find attractive an offer by the company to convert to a new policy with benefits limited to age 65 at an appreciably lower premium rate. Guaranteed renewable policies may be improved in the same manner, but, in addition, the company might require an additional premium for the privilege of continuing the existing policy in force. Here again, it is necessary to demonstrate to the satisfaction of the state insurance departments that the experience in the past, or to be expected, requires such an increase in premium. For cancelable policies, clearly nothing need be done until the insured reaches age 65, when the company may exercise its right not to renew.

There will, of course, always be claims problems, many of them unanticipated. However, it would seem that major problems would arise in two areas. The first area would be those policies that provide coverage intended to be secondary to Medicare, where it will become necessary to find out what benefits are being paid under Medicare. Here we ought to be able to make arrangements to get the information needed from the administrators of Medicare, so that really serious problems should not long continue. However, there will also be problems resulting in higher claim costs to the extent that our policyholders maintain insurance pol-

icies in force which duplicate Medicare benefits. It has been found that requiring an insured to share the cost of his claim is an effective method of controlling costs. When he can instead make money on a claim, there is bound to be overutilization of hospital and medical facilities and much higher claim costs.

MRS. ANNA M. RAPPAPORT: Prior to last year, at Standard Security we issued guaranteed renewable major medical and noncan hospital policies to people of all ages.

Last September, we stopped issuing these policies over age 55, and we are now issuing a noncancelable flat indemnity coverage with issue limits grading down by age. We feel that a modest amount of flat indemnity can be issued at any age, because the individual will always have additional expenses over and above the medical expenses covered by Medicare and because he is also likely to have additional expenses other than those of a strictly medical nature.

MR. STUART F. CONROD: I have a few comments on the first part of topic A. At Loyal Protective, we issue hospital and surgical riders that are attached to loss-of-time policies. We are presently revising those riders to be noncan to 65, or the day before eligibility for Medicare benefits. We are putting in a conversion privilege to permit conversion, when the noncan period is over, to individual policies of the schedule type. We will be able to issue a hospital benefit if it is a hospital rider or hospital and surgical benefits if it is hospital and surgical. It will also be constructed so that we can fit it into our new family hospital policies in order that we can also cover the spouse.

MR. E. PAUL BARNHART: I have become very concerned over what I feel has been a movement of the industry and of some of the insurance departments in the direction of an exaggerated and even disturbing concern over duplication of benefits as such. The reason that I think this is significant is that there has been less attention given to the fundamental question of why we are concerned about duplication of benefits.

This, of course, is the question of overinsurance. You might say, "Isn't it a rather academic distinction? If duplication leads to overinsurance, then what difference does it make whether we talk about duplication or whether we talk about overinsurance?" I think that this is not merely an academic distinction, and I would like to discuss what I feel are the reasons.

A modest duplication of some benefits has gone on in the business for

many years, and, for many people, this has been the means through which they maintain a reasonably adequate program of coverage. With two $15-a-day hospital policies, there is duplication of benefits, but, if the hospital is charging $30 a day, this is not overinsurance. Too often we have lost sight of this rather elementary fact in analyzing the effect of Medicare.

I think that our concern with duplication of benefits has been leading us in the direction of neglecting the matter of participation rules and limits. As an example, let us suppose that your company has decided to issue either a cash-benefit type of hospitalization plan in the senior-age market or an integrated, wrap-around type that has no duplication with Medicare but provides benefits in the areas that are excluded under the Medicare plan. Unless you maintain a concern for participation limits, you are still leaving yourself open to a quite serious danger of overinsurance, because, if one company issues $150 a week of hospital cash benefits and so does another and neither is worried too much about strict participation rules, a very evident danger of overinsurance exists. This is why overinsurance has become a problem in the past. Too many companies have been willing to observe some issue limit and issue a certain amount of coverage, but they have not often enforced participation rules.

I think that the same danger is cropping up here all over again. We are going to have mass enrolment in plans offering these integrated, wrap-around types of coverage, mass enrolment in plans providing hospital cash benefits, and group plans to some extent continuing to provide this kind of coverage. Unless the business enforces strict participation rules in this connection, we are going to have the same old problem of overinsurance. We are not going to avoid overinsurance merely by designing plans that provide benefits in a certain way.

I feel also that there has been a rather narrow and exaggerated concern over the mere fact of duplication in any form and to any degree. I think that this point of view has influenced some of our insurance departments, with harmful results to the business quite likely.

I do think that the industry is well advised to find ways of continuing to provide supplementary coverage above age 65 to delay as much as possible the continued expansion of the socialization of medical care financing. All of you know that the President promised that next year he will seek to introduce a form of Medicare financing for small children. We are never going to see the end of this. So, if we care at all about the advantages of voluntary insurance, if we think that voluntary insurance still has a place and ought to fight for its survival, then I think that

we ought to be doing something about these areas that Medicare does not cover in order to delay the spread of socialization of medical care financing.

When I see some of our insurance departments beginning to disapprove policy submissions that do tolerate a degree of duplication with Medicare but at the same time are carefully controlled by issue and participation rules that are to be strictly enforced, I think that a serious mistake is being made. These companies are following a practical and realistic method of guarding against overinsurance. As long as the strictly enforced issue and participation rules are being applied, there is no essential reason why a limited, modest degree of duplication with Medicare cannot be permitted. I think that this is a far safer approach, for instance, than issuing the cash-benefit hospitalization plan without any participation-limit rules, and this is what is happening.

Let us consider something along the line of the integrated, wrap-around type of program, such as the Blue Cross and Blue Shield plans are now beginning to offer. There are many problems presented by this type of plan, in my opinion. I believe that it is going to be somewhat complicated to describe and to understand and that the plan administration will be quite expensive. I also believe that there will be public misunderstanding if there are significant exclusions in the wrap-around plan that are also excluded by Medicare.

For instance, I saw one plan that was to pay the $40 hospital deductible, $10 a day from the sixty-first through the ninetieth day, and thereafter extended coverage for only 30 additional days. I suggest that this plan is going to lead to some dissatisfaction and misunderstanding. The person who buys it will think of it as largely filling in the gaps of Medicare, and yet, if he has an extended hospital confinement going beyond 120 days, he has nothing under either Medicare or this supplementary plan.

This kind of plan will need frequent adjustment as Medicare is revised and will be subject to very early obsolescence. Another weakness is that it provides direct coverage in fringe areas which are of questionable underwriting soundness. As Mr. Brown mentioned earlier, deductibles and coinsurance have in the past been safeguards against trivial-claims abuse. If you are specifically covering the deductibles, the uninsured part of the Medicare plan, the prescriptions, the private nurses, and the private rooms not covered by Medicare, you are providing direct coverage of those very fringe areas of expense about which we have always been dubious. I think that a safer approach would be to permit a limited degree of duplication with Medicare and provide, for instance, a regular

type of hospital coverage or modest surgical coverage with benefit levels sufficient to supplement Medicare.

The same thing can be done with major medical—tolerate some extent of duplication for the sake of clear-cut, concrete benefits, but control this through deductibles, maximum daily room amounts, and so forth so that only a modest and not excessive degree of duplication results.

I feel that the indispensable tool in the future, as in the past, will be strict enforcement of issue and participation limits and not a mere superficial avoidance of duplication.

MR. WILLIAM H. SCHMIDT: Enforcement by whom, Paul? Can the insurance departments enforce it?

MR. BARNHART: I think that they can. They can, for instance, refuse to approve overage policies unless they are assured by the company that it will maintain a participation limit.

An insurance department does not need to adopt restrictive or inflexible regulations concerning participation. The job can be done merely by (*a*) requiring that any company submitting a policy for approval declare what its participation rules will be and (*b*) requiring assurance that the company will make a realistic effort to adhere to such rules in practice. As long as the rules are within reason, I see no need for a department to attempt any rigid or precise definition of what is an acceptable participation rule.

MR. WILLIAM T. TOZER: Mr. Brown stated that a company had announced that it was going to pay in addition to Medicare on its existing policies. I do not believe that he was referring to our company, even though we have made such an announcement to our policyholders.

Our present hospital-medical policies have an exclusion that disallows payment for services received from a federal agency. Many companies feel that this exclusion or a similar exclusion permits them to deny payments for benefits received under Medicare. We found that many of our policyholders were confused by this exclusion and that we must publicly announce whether we would pay in addition to Medicare. We decided to announce that Medicare, for our purposes, would not fall under this exclusion. This decision was made for several reasons.

First, we are making decisions on what *might* happen. We do not know what will be the *real* effects of Medicare. Such factors as hospitalization utilization may curtail claims. We would rather not upset our present policyholders until we have more concrete facts.

Second, we felt that any action at this time would not only affect the elderly market but the total accident and health market. Many of the elderly policyholders do not wish to make a decision about their health insurance coverage until they have more facts and experience under Medicare. If we take an action today which might possibly hurt the elderly policyholder, society will be very critical of our industry. In addition, we have many of the children and grandchildren of these elderly policyholders insured. If you treat the elderly policyholder harshly, you are very apt to lose not only him but his children and grandchildren as well.

Third, if we enforce the exclusion and reduce the benefits, we then have a moral obligation to modify the rates. This brings up the same problem discussed in point one. What effect will Medicare have on rates? Consequently, I feel that denying payments has not solved the problem; it has simply moved it from the claim side to the premium side of the standard loss ratio.

Fourth, after Medicare is in effect and experience warrants a change, we feel that the elderly policyholder would be more receptive to changes. We have the protection that over 75 per cent of our policies may be marked for nonrenewal. However, we feel that we may have some strong arguments to the policyholder that this insurance is now unnecessary. In addition, if claims rise, we then have evidence to justify and support a rate increase. The great advantage is that we are talking about what *has* happened, not what *will* happen.

I would like to state one disadvantage of the wrap-around contracts. The ratio of administrative expenses to benefits provided by this type of contract is very high. I wonder who benefits by this type of contract—the policyholder or the employee.

The hospital indemnity contract provides a distinct service in the mar ket. The insurance industry has a tendency to talk about obvious expenses and costs when a person is entering a hospital, but there are additional expenses which also occur. Is this contract any different than a loss-of-time contract which pays only while you are hospitalized? Consequently, if a loss-of-time contract is proper, then is not a hospital indemnity contract proper as well?

Since the claimant must enter the hospital and secure the permission of the doctor and hospital to remain, a hospital indemnity contract is safer than a loss-of-time contract. Obviously it is much more difficult to malinger under a hospital indemnity contract than under a loss-of-time contract.

MR. BROWN: Mr. Tozer is correct. I was not referring to his company, but I am glad he told us the reasons behind that decision. I think that many of us feel that it has been amply demonstrated in the past that, where there is duplicate coverage and where people can make money on claims, there are going to be more claims. I also think that some of us feel that we just cannot afford the luxury of providing duplicate coverage and keep existing policyholders happy. I am sure that my company cannot afford it.

MR. CHARLES B. BAUGHMAN: One of the things that spurred the Medicare program on was the fact that too few people over 65 had adequate coverage. The insurance industry, very late, got into the field with the 65 plus plans.

The same reasons for which politicians might have wanted to give coverage to people over 65 would apply, possibly, to beneficiaries under social security who do not have a wage-earner to pay premiums on medical expense or disability policies. I am speaking, for example, of the wife of a worker who died and who no longer has coverage under a group or other plan of the employer. What about a disabled child over age 18, disabled prior to age 18, so that he would be getting benefits under social security? I am wondering if it might be possible for companies to offer policies whereby, in case of death or disability of the policyowner, premiums would be waived or coverage otherwise continued for his beneficiaries so that politicians could not say, "We're going to include this in Medicare since this is an area that the insurance industry has not provided for yet."

MR. J. STANLEY HILL: At Minnesota Mutual, we do not sell group hospital plans, but I want to assure Mr. Baughman that we buy plans for our employees, and our plan does provide coverage to the widow and dependent children of a deceased employee.

MR. SCHUYLER W. TOMPSON, JR.: I have the impression that many people feel that Medicare covers the great majority of the medical expenses which older citizens will incur. I readily admit that Medicare will cover at least 50 or 60 per cent of these expenses, but I doubt very much that Medicare will cover as much as 75 or 80 per cent.

I want to mention five areas not covered by Medicare. One is for private-room accommodations; Medicare has specifically provided for semiprivate. There is a provision in the law that states that if it is medically necessary for a person to be in a private room, then Medicare may very well pay for it. I do not know what "medically necessary" means. I will

be very interested in seeing what develops as an interpretation of "medically necessary."

Two other areas not covered are costs of drugs out of the hospital and expenses for private nursing in or out of the hospital.

The fourth area, which is quite debatable and very fuzzy and ill-defined, is the question of doctors' charges in excess of what is determined as reasonable. The law refers to medical charges which are deemed reasonable. I believe that some rules are now being formulated that will specify what charges can be termed "reasonable."

The fifth area, which is of extremely small scope although a claim may be quite large, is expenses of people traveling overseas. They are not going to be able to collect anything under Medicare, if my understanding is correct. Expenses incurred overseas for medical care will be paid for by life insurance companies, if they are on the risk.

MR. GEORGE A. REYNOLDS: Question A says, "What revisions are being made in new-business portfolios?" I had hoped to hear some comments or to get some idea of the meeting's sentiment with respect to answers to that question. I have heard a lot of theory but not too much about what is actually being done.

Our policy has been to revise our hospital, surgical, and major medical policies to accord with the pattern laid down by the NAIC. We have followed that fairly well, adjusting to correlate with the commencement of Medicare, Medicare to commence, we suspect, at a variable age in the future.

In connection with senior citizen coverage for new policies, we have decided to discontinue writing reimbursement policies because of the amount of duplication that would be present with our benefit and Medicare. We are providing a policy with a flat indemnity benefit. We feel, as others have mentioned, that there are hidden costs, and an indemnity policy has the advantage of enabling a person to cover some of those extra costs. We intend to provide lifetime renewable benefits of a fixed daily indemnity, starting at $10 a day until we see what extensions are made by Medicare and what the industry does.

I would like to emphasize again the importance to the health industry of trying to provide for the people what they need, of trying to do it in a logical way so that we can at least break even, and of trying to keep our hat in the ring so that we can prevent any further inroads by social security.

MR. RICHARD H. MORSE: About a year ago, we at Monarch Life decided that we would cease writing hospital and major medical type policies on the guaranteed renewable-for-life basis. What we did at that time was to come out with a new series of policies which terminated at 65 and which were convertible to policies that provided monthly indemnity while in the hospital after age 65.

We have been selling major medical policies since 1955 to people who have attained age 65 during the interim, so we now have several thousand of these individual major medical policies without any Medicare antiduplication clauses in force on persons who are over age 65. Before May is over, we are going to send to every policyholder in this category a statement concerning the coverage he has and an offer for him to amend his policy so that he will have a major medical policy fully co-ordinated with Medicare. With it will go a premium reduction of substantial proportions if he is covered under both parts of Medicare. We are also going to ask him to what extent he is covered under Medicare. We are going to have a recurring program that is going to go on and on, ad infinitum, unless we change our minds, so as to pick up persons with this kind of policy who in the future will reach age 65.

I mentioned earlier that our new products terminate at 65. We have prepared a new inside-limit major medical policy, that we are now circulating among the insurance departments for approval, which is a turnabout, as it is guaranteed renewable for life. However, this policy contains the so-called antiduplication Medicare clause, so we feel that we can continue to offer coverage to these people in the future on the guaranteed renewable-for-life basis.

We also offer to persons at all ages a policy that provides a certain amount of monthly indemnity while confined to the hospital.

MR. THOMAS J. KELLY: I would like to address my remarks to Mr. Barnhart's comments concerning overinsurance versus duplication of coverage.

His recommendations for preventing overinsurance would appear reasonable for health insurance programs that provide indemnity benefits or reimbursement of medical care benefits within rather well-defined scheduled limits. However, there are many plans of medical care insurance that provide service type benefits, such as semiprivate hospital accommodations and reasonable charges for surgical and/or medical procedures, where the approach Mr. Barnhart recommends would not be very satisfactory. For this type of coverage, the most effective control of overinsurance would be the application of antiduplication provisions.

*Optional Modes of Settlement*

A. Have any new settlement option arrangements been made available?
B. What are the recent trends in settlement option election rates?
C. In what way are election rates affected by economic conditions?
D. To what extent are new-money approaches being used to allocate interest to supplementary contracts?

*San Francisco Regional Meeting*

MR. JOSEPH C. NOBACK: When the Northwestern Mutual brought out its 1958 CSO policy series three years ago, we adopted two new life income option practices.

First, we made our guaranteed life income rates a function of year of settlement as well as age of beneficiary. That is to say, we adopted the generation type of annuity rates which had been suggested some years earlier in Jenkins-Lew's classical paper on mortality trends among annuitants. The particular guarantees which we used in this new series were computed on the basis of Bill McCarter's 1955 American Annuity Table. As you would expect, the guaranteed income at a particular age will decrease as time passes.

At the time we adopted these guarantees, we recognized that the rates were conservative and that they would tend to protect future generations of policyowners. On the other hand, we also recognized that if longevity became static or if interest rates were to improve, we might be able to pay more generous amounts under our life income settlements. We therefore provided in these policy contracts that the beneficiary could obtain a monthly income equal to 104 per cent of the rates applicable at the time of settlement under Northwestern's own single-premium immediate annuities. With the recent improvement in interest rates, we have, in effect, done this, although I hesitate to say that we have adopted the new-money approach in arriving at these more liberal annuity rates.

Perhaps it is of interest to note that neither the annuity income privilege nor the liberal guarantees in our older policies have generated any upsurge in the life income option settlements. This may be due to structural factors in our business—especially our pension trust business, optional-maturity-date provision, and so forth.

Somewhat the same situation exists among our interest-only funds. We have been moving up the interest that we pay on these funds from year to year, and, while the amount left with the company has increased, our total funds are now stabilized. Perhaps the only way to attract and hold

more settlement proceeds would be to adopt a new-money approach. To date, however, we have felt that since this money has been accumulated in the portfolio over a long period of time, it should be entitled only to the net portfolio rate after federal income tax. The present time is a particularly difficult one because other financial institutions are paying such very high rates.

MR. RICHARD H. TALLMAN: The answer to the first question for NWNL is "yes." We adopted new settlement options using a generation approach when we revised our policy forms to incorporate the 1958 CSO Table in 1963. From 1954 to 1963, we were using a basis for life income options that produced a monthly income of $6.07 for life with ten years certain to a male life aged 65 from $1,000 proceeds. From 1948 to 1954, we used a $6.02 factor. This was the lowest that we have ever used.

Looking back over intervening changes to the 1920's and early 1930's, we find that our policies then guaranteed $7.73. These early settlement options were about as liberal as could be found in the business in those days. They cost us some very substantial amounts of money in subsequent years, which was in large part responsible for the extent to which our company went the other direction in 1948. Our $6.02 rate at that time was one of the lowest in the country. I do not suppose that any of you ever experience comments from members of your field or agency organization along the line of "Why do we always have to be the last? Why can't we be a leader in something for a change?" We were a "leader" in 1948 with our $6.02 option, but I do not think that this was the kind of leadership our agents were looking for!

It is partly because of these problems in the past, and partly because the concept appeared logical and in our minds continues to appear so, that we adopted the generation approach. The results have been quite satisfactory. The home-office administration of the system took a little getting used to, but the familiarity gained with experience has eliminated any real problems. Acceptance by our field force was a little doubtful at first, but with good instructions and some experience our agents appear to have taken it in stride. One factor in their acceptance has been that our life income options include an option under which the income purchased by the proceeds is the income that would result from the purchase of a single-premium annuity at the company's then current single-premium annuity rates, increased by a small percentage. At our present annuity rates, this income exceeds that guaranteed in the policy.

The method we adopted for recognizing future improvement in mor-

tality was to relate the monthly income to the number of policy years elapsed between the issue date of the policy giving rise to the proceeds and the date on which the life income starts. For example, the life income with ten years certain guaranteed to a male life age 65 for each $1,000 of proceeds is $6.51 if income starts within the first five policy years, $6.38 if income starts from the sixth to the tenth policy year, $6.25 if it starts from the eleventh to the fifteenth policy year, $6.12 for sixteenth to twentieth policy year, $6.01 from the twenty-first to the twenth-fifth year, then decreases by 5¢ per $1,000 for each five-year period beyond twenty-five policy years.

While sitting at lunch with one of the members of our agency department the other day, I made my "survey" of the agency reaction. He said that our agents have only one question. They recognize that with the generation option their company is a leader, but they say, "We know that Northwestern National Life, Northwestern Mutual Life, Lutheran Brotherhood, and London Life all have the generation settlement options; but, if this idea is such a good one, why haven't a lot more companies adopted it?" Perhaps someone in the room will have an answer to this question.

We made a rather quick investigation for recent trends in settlement option election rates in our company and found an unmistakable downward trend at least as far back as 1960. By number of contracts, new supplementary contracts in 1960, involving and not involving combined, were 30 per cent of the number of policies terminated by death and maturity. In 1965, they were 20 per cent of deaths and maturities, a drop of one-third. The election of contracts involving life contingencies dropped much less than those not involving life contingencies—about 18 per cent for involving and about 40 per cent for not involving. These results were about the same when measured by amounts.

The last part of this topic asks to what extent new-money approaches are being used to allocate interest to supplementary contracts. The answer for my company is "None."

MR. ROBERT N. HOUSER: If there have recently been any new and startling settlement option arrangements, they have not come to my attention. I believe, however, that the growing use of nonpar life income rates which are in excess of minimum policy guarantees is one of the most notable developments of recent years in the settlement option area. A current survey of twenty-eight major life insurance companies showed the following results:

Ten companies have an annuity purchase option which provides for incomes running from 2 per cent to 5 per cent higher than those provided by current immediate annuities.

Seven companies have current purchase rates which are independent of immediate annuity rates. These current purchase rates are subject to change at any time but are fully guaranteed for each individual supplementary contract once income begins.

One company has both an annuity purchase option and current purchase rates.

Ten companies do not have either of these options, although some plan to pay level lifetime dividends.

Bankers Life Company is one of those companies using current purchase rates for life income options. These current purchase rates apply to all new settlements where more liberal than the policy guarantees. We have further extended this concept to noninvolving options by making our 3 per cent guaranteed interest rate applicable to all new settlements where this rate is more liberal than the policy guaranteed rate. We feel that this procedure has greatly simplified our settlement option work by minimizing the number and variety of forms required and by permitting proceeds from a variety of policies to be combined under a single supplementary contract.

Our company recently took one more step in this direction by making the "interest only" option contained in our present series of policies available retroactively to all existing supplementary contracts. Under this option there are no annual dividends. Instead, each periodic interest payment is based on the full dividend interest rate (currently 4.25 per cent).

One minor development which has come to my attention is the gradual spread of "cheaper by the dozen" philosophy to life income settlement option rates. Out of the twenty-eight companies surveyed, there were five who make some variation in life income rates based on the amount of money being placed under settlement option.

So far as I know, no company has yet seen fit to announce substandard life income rates for settlement options. However, there are still a few companies (three out of twenty-eight) who give a special rate break to nonpayee elected life income options.

We recently made a simple survey of the trend in settlement option election rates of our own company. This covered the last twenty years and was based on annual statement data. For the denominators of our ratios, we used all funds available for application under settlement option

including deaths, maturities, and surrenders. We found that our rate of life income elections has remained remarkably steady over this twenty-year period. For the last six years the election rate has been either 9 per cent or 10 per cent. This differs only slightly from the 1945 election rate of 11 per cent. On the other hand, we found that our rate of noninvolving option elections has declined quite drastically over this twenty-year period, from a high of 32 per cent in 1945 to a low of 14 per cent in 1965. This trend seems to have more or less bottomed out, ranging from 15 per cent in 1960 up to 17 per cent in 1962 and back down to 14 per cent in 1965.

I can only speculate on the reasons for this drastic drop in popularity of noninvolving settlement options. It seems obvious that the prime factor is the relatively greater attractiveness of other forms of investment. The increases we have made in dividend interest rate (from a low of 2.85 per cent in 1948 to a current rate of 4.25 per cent) have merely slowed the trend. By far the most common reason given for withdrawal of funds previously placed under a noninvolving settlement option is the opportunity for better investment elsewhere.

Insofar as the last question of this topic is concerned, I assume it refers to the allocation of interest for rate or dividend purposes rather than for annual statement purposes. So far as I know, no company in the individual policy field has adopted a full new-money approach for either settlement options or immediate annuities. However, current immediate annuity rates have been driven by competition to such a level that they at least border on a new-money approach. Without such an approach to fall back on for their justification, current immediate annuity rates would, in my opinion, be quite risky.

For those companies who use either an annuity-purchase option or current purchase rates, the same remarks made in the preceding paragraph would apply to life income settlement options. There is some room for argument as to whether settlement option money is really "new money." Without regard to theoretical considerations, I personally feel that for practical reasons the new-money approach must be used for life income settlement options to the same extent that it is used for immediate annuities. Our experience would indicate that the company is in an untenable position if its immediate annuity rates are more liberal than its life income settlement option rates. This is one of the main reasons why our company adopted a set of current purchase rates that is more liberal than our current immediate annuity rates.

MR. RICHARD H. TALLMAN: In applying our current annuity option, we do not add the adjustment for premium tax. The premium tax has been paid on the premiums for the life policy, and no further charge need be made for it after maturity.

We faced the problem of how to provide a retirement income policy after our change to generation tables. Such a policy is difficult to write because the maturity value must change with each calendar year of maturity.

Our solution was to replace it with a policy which had a maturity value of $2,000 for each $1,000 of initial insurance.

MR. DONALD B. MAIER: When we at Metropolitan Life adopted our new policies in 1965, we adopted a new basic procedure for use for settlement options. In effect, under these new options we do not guarantee a certain minimum in the policy with a provision for excess interest; rather, we specify that the amount to be paid will be the amount determined by the company on the date the proceeds become payable, subject to a guaranteed minimum.

For our interest option and instalment option, we presently base our payments on $4\frac{1}{4}$ per cent interest, beginning with the contract anniversary in 1966. When we change the interest rates in the future, the change for the interest option is, of course, simple. Under the instalment option we determine a new level of instalment payments by applying new interest rate factors to the instalment option reserve at the time of change of interest rate.

Insofar as our life income options are concerned, we have both the option where the amount will be determined on the date proceeds are payable and the annuity purchase option, under which the beneficiary may buy an annuity at a better-than-normal rate.

During the past ten years the trend in the election of optional settlements has been downward. This trend in election rates may be due to the trends in interest rates as compared to policy guarantees, but more likely it is due to the fact that the average-sized policy issued twenty-five years or so ago is quite small in the light of today's economic conditions.

MR. MELVIN C. PRYCE: In Canada the annuity purchase option is a practical necessity. Without it a company will find that settlement option proceeds will find their way into new annuities in other companies.

With regard to new developments in settlement option bases, the London Life adopted generation tables in January, 1957. The only sig-

nificant effect on our plan structure was that we found it necessary to delete the old-fashioned pension policy, because the amount of proceeds required at maturity is complex to define when generation tables are used.

MR. WALLACE R. JOYCE: I agree with Mr. Pryce that the annuity purchase option is a practical necessity in today's competitive situation. The annuity purchase option should reflect the "new money" approach.

A prominent Canadian company has recently introduced a new life income settlement option. It is on a participating basis providing, at the outset, for a level income which is intended to be maintained throughout the period of the policy. However, the policy guarantees a smaller income and is in a position to revise the original income if future conditions should require it.

The more or less general use of the current annuity option based on new-money interest rates may be responsible for the lack of development of the use of generation tables. (Only a few companies have adopted such tables.) The complex generation tables provide conservative policy guarantees which are not actually used very much and, perhaps, are not too likely to be used when policies contain the current annuity option.

MR. RAYMOND A. BIERSCHBACH: In some of Occidental Life of California's policies we include an option permitting the insured to increase his income from settlement options in order to receive a total income of $10 per $1,000 of face amount. This is accomplished by permitting the insured to add a supplementary amount to the cash value.

We originally applied these supplementary amounts at guaranteed settlement option rates adjusted for premium tax. We recently improved this feature by allowing the application of these supplementary amounts at 97 per cent of current single-premium annuity rates if more income will result.

*Washington Regional Meeting*

MR. FRANK W. KLINZMAN: In recent years the Connecticut Mutual and other companies have been improving their single-premium annuity rates due to the improving investment situation. Eventually, alternate life income options based upon the current single-premium annuity rates but reflecting the savings in commissions and premium taxes had to be offered. This was necessary to discourage policyholders and beneficiaries from taking the proceeds in cash and then purchasing a single-premium annuity.

When our new policy series based upon the 1958 CSO table came out, we provided for these alternate life income rates by a policy provision. This provision guaranteed that the policyholder or beneficiary could receive an alternate life income which would be equal to 104 per cent of the corresponding income under the single-premium annuity rates in effect on the date of settlement. This guaranteed the method of computing the alternate income rates for the future but did not guarantee the amount of income. Therefore, whenever there is a change in our single-premium annuity rates, there is automatically a change in our alternate income rates.

Just recently we had a change in our single-premium annuity rates with the introduction of a band approach in determining the income—in other words, one set of income rates where the premium is less than $25,000 and another set of income rates where the premium is $25,000 or greater. Our alternate life income rates immediately reflected the change in rates and the use of the band approach so that we now have a set of alternate life income rates where the policy proceeds are less than $25,000 and another set of income rates where the proceeds are $25,000 or greater.

In 1965 we began allowing extra income under our regular contract settlement options and our single-premium annuities which arose under qualified pension trust cases. This was done to account for the favorable income tax treatment that qualified pension plans receive. Furthermore, these improved rates assumed that once income had begun, the favorable tax treatment would continue for the life of the annuitant. This is allowed by current practice and is not a contract guaranty; it amounts to about a 2 per cent improvement in the income. Since our alternate life rates are defined as being 104 per cent of the corresponding single-premium annuity rates, then our alternate life incomes arising out of qualified plans automatically reflect this higher income.

So, about the only new arrangement made available in our settlement options has been the allowance by current practice of the improved income for qualified pension plans plus any change in our alternate rates due to a change in our single-premium annuity rates.

With regard to the trends in settlement option election rates, I have attached a table showing the results of a study we made early this year. This table shows for each of the years 1955 through 1964 a breakdown of the amount of death and maturity proceeds arising from insurance and the amounts placed under settlement options. The death claims and matured endowments that are shown are what were actually paid out for those years and before any reinsurance is deducted. The death claims also

## POLICY PROCEEDS AND AMOUNTS PLACED UNDER SETTLEMENT OPTIONS

(Insurance Only)

| | 1955 | 1956 | 1957 | 1958 | 1959 | 1960 | 1961 | 1962 | 1963 | 1964 |
|---|---|---|---|---|---|---|---|---|---|---|
| Proceeds arising from death claims: | | | | | | | | | | |
| Total death claims | $19,908,334 | $19,720,282 | $21,400,397 | $21,972,108 | $25,271,326 | $25,457,500 | $26,164,077 | $30,134,566 | $33,647,780 | $34,653,223 |
| Amount placed under options | 7,871,358 (39.5%) | 8,221,142 (41.7%) | 7,528,823 (35.2%) | 7,646,804 (34.8%) | 7,784,992 (30.8%) | 7,496,585 (29.4%) | 7,459,830 (28.5%) | 7,922,407 (26.3%) | 9,095,173 (27.0%) | 8,579,663 (24.8%) |
| Amount placed under not involving | 6,208,774 (31.2%) | 6,273,183 (31.8%) | 5,960,893 (27.9%) | 5,854,718 (26.6%) | 6,040,178 (23.9%) | 5,703,718 (22.4%) | 5,868,182 (22.4%) | 6,137,658 (20.4%) | 7,286,028 (21.7%) | 6,442,388 (18.6%) |
| Amount placed under involving | 1,662,584 (8.3%) | 1,947,959 (9.9%) | 1,567,930 (7.3%) | 1,792,086 (8.2%) | 1,744,814 (6.9%) | 1,792,867 (7.0%) | 1,591,648 (6.1%) | 1,784,749 (5.9%) | 1,809,145 (5.3%) | 2,137,275 (6.2%) |
| Proceeds arising from matured endowments: | | | | | | | | | | |
| Total matured endowments | 9,540,412 | 10,862,616 | 10,490,575 | 10,462,951 | 10,783,783 | 12,023,059 | 10,483,905 | 10,450,451 | 10,401,090 | 11,928,352 |
| Amount placed under options | 5,284,029 (55.4%) | 6,441,063 (59.3%) | 5,788,506 (55.2%) | 4,942,817 (47.2%) | 4,912,747 (45.6%) | 5,136,594 (42.7%) | 3,992,116 (38.1%) | 4,152,613 (39.7%) | 4,229,512 (40.7%) | 4,326,916 (36.3%) |
| Amount placed under not involving | 3,295,942 (34.5%) | 3,078,296 (28.3%) | 2,979,158 (28.4%) | 2,198,287 (21.0%) | 2,372,432 (22.0%) | 2,250,339 (18.7%) | 1,466,992 (14.0%) | 1,485,549 (14.2%) | 1,648,979 (15.9%) | 1,438,145 (12.1%) |
| Amount placed under involving | 1,988,087 (20.9%) | 3,362,767 (31.0%) | 2,809,348 (26.8%) | 2,744,530 (26.2%) | 2,540,315 (23.6%) | 2,886,255 (24.0%) | 2,525,124 (24.1%) | 2,667,064 (25.5%) | 2,580,533 (24.8%) | 2,888,771 (24.2%) |

included amounts arising from additional indemnity and other agreements, such as family income and decreasing term. The figures shown in parentheses are the percentages of the total proceeds that are placed under the various options.

The figures show that, where the proceeds arose from a death claim, the percentage electing a settlement option declined from 39.5 per cent in 1955 to 24.8 per cent in 1964. Of these, the percentage electing a not involving life contingency option declined from 31.2 per cent to 18.6 per cent, while the percentage electing an involving life contingency option remained about the same or possibly had a slight decline from 8.3 per cent to 6.2 per cent. Where the proceeds arose from a matured endowment, the percentage electing a settlement option declined from 55.4 per cent to 36.3 per cent. Of these, the percentage electing a not involving life contingency option declined from 34.5 per cent to 12.1 per cent, while the percentage electing an involving life contingency option remained fairly stable at around the 25 per cent level.

From these figures one could conclude that the recent trend in settlement option election rates has been a significant downward trend in the percentages electing a not involving life contingency option while the percentages electing an involving life contingency option have remained about the same.

Since over-all the period from 1955 to 1964 did reflect favorable economic conditions, one could conclude from this study that the percentages electing a not involving life contingency option are affected by economic conditions, while the percentages electing the involving life contingency option seemed to be relatively unaffected.

MR. ERNEST J. MOORHEAD: This is a good topic—not because precise information exists or is easily obtained; not because the relation between settlement option usage and economic conditions is especially useful to know, but because we tend to think too little about how well or how poorly life insurance is fulfilling its great purpose.

Whether one considers the figures for Connecticut Mutual just given us by Mr. Klinzman, or the individual company statistics given at the San Francisco regional meeting earlier this month, or a survey published by Life Insurance Agency Management Association in December, 1963, one must be impressed by the infrequency with which the life income settlement option is being used for death and endowment proceeds. The fact is that in most of our companies the bulk of life insurance proceeds is either paid in cash or is left at interest, a sort of marking time before ultimate disposition is made. Does this harmonize with our idealistic picture

of life insurance as the lifetime provider after the death of the breadwinner?

If we are dissatisfied with the present state of affairs, are there not several steps we can take?

1. We might work harder to have life insurance programmed—not just as a steppingstone to the sale of more life insurance but as a service to our too-often-neglected policyowners.

2. We might make sure that beneficiaries receive more than a perfunctory explanation of what life income settlement options can do for them.

3. We might see that our life income option really is attractive in contrast to a single-premium annuity. By this is meant two things: (*a*) our life income option should be measured not just against our own single-premium annuity but against the lowest cost annuity being offered and (*b*) our life income settlement option should be arranged to provide a level guaranteed income—and I emphasize *level* and *guaranteed.* There are various ways to accomplish this. In our company we offer on all eligible maturing policies a so-called alternate nonparticipating life income option. This grants an income that is level and is guaranteed for life. But no guarantee is made in advance of the starting date of the income. The current basis, established at the beginning of each year, is set with an eye to meeting the competition of other companies' single-premium annuity rates.

All this concerns the life income option. When we consider the options not involving life contingencies, the problem of meeting outside competition—in most cases from banks and trust companies—is another and more difficult, but I think a less serious, matter. In theory at least, our interest rate should be lower than they offer because we provide a long-term guarantee while they do not. All that I can suggest is that the differential on this account can be modest under today's conditions and outlook.

My thesis, therefore, is that (1) the economic climate has not been, and need not be, the most important influence on the usage of settlement options and (2) most of us are doing less than we could and should be doing to see that people who would benefit from the life income option are actually taking advantage of it.

I hope that several of you actuaries will express your convictions on this subject and will tell us how you are taking care of this matter—including, among other things, how you are making it genuinely worthwhile for beneficiaries to leave death and endowment benefits with you instead of placing them elsewhere.

MR. RICHARD H. TALLMAN repeated the discussion which he had presented at the San Francisco meeting.

MR. MOORHEAD: In setting our settlement option factors at the beginning of each year, we use a current interest rate but, in the strict sense, this is not a new-money rate. I believe that on single-premium immediate annuities the companies are not entirely on a new-money basis. Considering the earnings on a policy written a number of years ago, I am not at all sure that in our company the old money has not done better than the new money because we have had very substantial capital gains on the portion of our assets which is in common stocks.

Since we first started using the current settlement option idea, we have been careful to emphasize the *current* nature of those options in all sales material. We have found that the field seems to be quite content to be conservative in this respect, quoting the annuity return to the beneficiary on the basis of the guaranteed options in the policy. Perhaps the reason is that, while there is keen competition in net cost on policies, there is not such intense competition on the settlement option basis applicable to the beneficiary.

The only place in which the alternate nonparticipating settlement option basis is being used by our field force to any great extent is in the pension trust field. In that situation the employer can readily appreciate that the cost will depend on many factors before the pension-trust arrangement finally runs its complete course.

I agree that provisions in settlement options for change in purchasing power of payees are a good idea. However, from experience we have had with single-premium annuities on a participating basis, I have concluded that the individual who is taking an income for life prefers a definite statement with regard to what the income is going to be and, therefore, that a guarantee is what he usually seeks.

MR. B. FRANKLIN BLAIR: One possible way to make settlement options more popular would be to pay a small commission or service fee to the agent. That might do as much to stimulate their use as anything.

At Provident Mutual we had a current annuity option with a 104 per cent increase clause for twenty-five years, but because of administrative difficulties we dropped it from our recent series of new policies. As a substitute, we made all life income options participating during the deferred period as well as during the certain period. For our pension series of policies, we also made available nonparticipating options to be based approximately on future annuity rates but without any contractual provision with regard to the relation between the incomes under these nonparticipating options and the incomes under the annuity rates in effect at the time the income begins.

Based on our actual experience, we feel that having the formula for the current annuity option specified in the contract creates difficult administrative problems; for example, what allowance should be made for state premium tax, to what extent should the rates vary with the size of proceeds being left under the option, what special consideration should be given to qualified pension plans, and whether the regular participating option or the 104 per cent annuity option is more favorable to the payee.

MR. ELMER BILLMAN, JR.: There are two bothersome questions about the alternate settlement option plan: First, is there danger that current options may be wrongfully quoted as being available for future use? Second, when policy proceeds become available, should the applicant for a settlement option be aided in making the difficult choice between the then-current nonparticipating settlement option and the guaranteed participating option which is provided in the policy?

MR. WILLIAM H. SCHMIDT: At Mutual Life of New York we have approached the problem of helping beneficiaries to choose between guaranteed options on a participating basis and the current nonparticipating annuity option by (1) providing a level amount of excess interest over the duration of the participating option rather than letting the interest reduce on the basis of the guaranteed portion of the reserve and (2) making a computer-generated comparison for them, showing them what income they can receive on the participating guaranteed settlement option basis and what they can receive on the nonparticipating current annuity basis. Where the income available on the latter basis is much superior, we strongly urge its choice.

MR. J. STANLEY HILL: With settlement options it is somewhat a stretch of the imagination to think of policy proceeds as new money and, therefore, eligible for new-money annuity rates. However, if you do not use new-money rates, the settlement option proceeds otherwise left with your company may be placed elsewhere, under a single-premium annuity. If you can keep the proceeds, then it might be reasoned that your investment department is as well off as if you had obtained those proceeds in the form of new money.

At Minnesota Mutual we use new-money interest rates in our single-premium annuities, and we make the single-premium annuity rates available as a current life income settlement option. Without the application of the policy fee, this gives a slight break to the settlement option payee.

MR. MAURICE H. LEVITA: For one of our client companies we recently designed a life policy with benefits which increase 3 per cent per year to parallel the estimated increase in the cost of living. For this policy we have been considering a life income settlement option which provides an increase in income. Using the 1937 Standard Annuity Table set back one year, and 3 per cent interest, we found the following results:

MONTHLY INCOME PER $1,000 OF POLICY PROCEEDS—MALE AGED 65
10 YEARS CERTAIN AND LIFE OPTION

(1937 Standard Annuity Table Set Back 1 Year—3 Per Cent Interest)

| | Initial Benefit |
|---|---|
| Level income for life | $6.57 |
| Income increasing 3 per cent each year for life | 5.04 |
| Income increasing 3 per cent each year for 10 years, then level for remainder of life | 5.41* |

* Ultimate benefit is $7.27.

MR. CURTIS D. GREENE: At Columbus Mutual we have a current annuity option providing 5 per cent greater income than a new single-premium annuity. We also have a current purchase rate which replaces the guaranteed options in the policy with modern guaranteed options on a nonpar basis.

The current purchase rate is slightly more favorable than the current annuity option. This difference is intentional and avoids the more complex annuity computation. The annuity purchase option in the policy is for possible future use. Its presence in the policy is a good selling point.

Our annuity purchase option has been extended to all our old policyholders along with many other new practices. Just now we are telling all policyowners about these extensions by means of a special mailing. With the information contained in this notice, supplemented by information which agents will be prepared to give on inquiry from policyowners, we hope that our policyholders will become sufficiently informed to take advantage of this liberalization.

We are developing a kit for our agents' use in handling death claims, maturities, and surrenders, so that they will have a better explanation than we have been able to put into the rate book. It will be readily available in one place. It will tell what information the home office needs and what forms are required.

MR. CHARLES B. BAUGHMAN: A level income, as provided by most settlement options, is not level in purchasing power. It is important to note that only the insurance industry can incorporate life contingencies

in variable payments and that, because variable options are not readily available, many beneficiaries are transferring their proceeds to mutual funds and other investment media. This hurts both the insurance industry and the public.

If the face amount of the policy is fixed, conversion into a variable settlement option should be made by a dollar cost averaging approach.

MR. KLINZMAN: Connecticut Mutual's single-premium annuity rates use the new-money approach. In other words, the interest assumption is based on our current interest earnings on new investments. Since our alternate life income rates are based on the single-premium annuity rates, they too, then, to that extent reflect the new-money approach.

MR. HENRY F. SCHEIG: Aid Association for Lutherans provides an alternative to policy settlement options which do not involve life contingencies. These options reflect higher current interest rates and are essentially nonparticipating; however, we expect to pay modest amounts of excess interest during the next few years. The general long-range outlook for these options, however, is a level income.

MR. HARWOOD ROSSER: In the pension field particular care must be taken in advising the beneficiary with regard to a choice between a guaranteed option and a current annuity option. In a rather famous legal case, the court held that a beneficiary had been inadequately advised of settlement option provisions and, as a result, the employer was found liable for payment of a substantial settlement.