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DIGEST OF DISCUSSION OF SUBJECTS OF GENERAL INTEREST

AGENCY MATTERS

A. Have new or improved plans of compensation and security benefits been developed in recent years for (1) new agents, (2) experienced agents, (3) general agents and managers?
B. How can the merits of branch office and general agency systems be effectively compared?
C. What methods are used for providing service to policyholders, particularly on orphaned business?
D. What are the trends in agents' survival rates?

San Francisco Regional Meeting

CHAIRMAN HAROLD E. CRANDALL: Our panel this morning will have two members. Mr. Stuart Robertson will cover some of the recent developments with respect to the life affiliate of casualty companies. Mr. Robertson, in his capacity as consulting actuary of Milliman and Robertson, Inc., has a wide working acquaintance with the affiliate companies. Mr. Raymond Bierschbach, associate actuary of Occidental Life Insurance Company, will present some of the experience and approaches of his company.

The Occidental has a very complex agency force. It can speak for a major agency system, because it operates agencies and has at least two hundred ninety of them; it also operates with branches, having some ninety-seven of them. It likewise does a substantial brokerage business, about half of its production coming from brokers. Further, as a result of all this participating, this company is involved with all facets of agency problems and, on the ordinary side, it must cope with branch managers, assistant branch managers, brokerage managers, assistant brokerage managers, and general agents.

Now, despite the fact that we have all these agencies and so forth, I still do not believe that we have all the answers in relation to agency compensation and other related matters. I would, therefore, now like to give you Mr. Ray Bierschbach, to present you with some of these answers.

MR. RAYMOND A. BIERSCHBACH: I will try to cover the four questions in your program in order.

At Occidental Life we make great use of the bonus system in our compensation program. Each individual bonus is meant to accomplish a specific purpose. I cannot honestly say that any one of them is directed at any one of the three groups mentioned in your program. Each bonus cuts across the three groups. Let me take a few minutes to discuss each of these bonuses.

We have a production bonus for our branch managers and brokerage managers. It is a percentage bonus which is applied to first-year premium production. First-year premium production is defined by formulas but basically includes all first-year life premium and half of all accident and sickness premiums, both first-year and renewal. The branch manager receives 5 per cent of the amount by which this premium production exceeds a quota based on certain salaries within the branch, including his own. The brokerage manager receives 2½ per cent of the first-year premium produced by brokers in the branch. The branch manager's production bonus is tied to all first-year premium production in the office, both from agents and brokers.

We have also a premium-persistency bonus that is payable to general agents, branch managers, and brokerage managers. General agents and branch managers each get 5 per cent of the increase in life premiums in force for the office. The increase in premiums in force is measured over the period of a year. The brokerage manager gets 2½ per cent of the increase in life premiums in force coming from brokers. The general agent in addition gets 2½ per cent of the increase in accident and sickness premiums in his office.

Our branch manager's persistency bonus used to be based on the volume of insurance in force rather than premiums. We felt that a couple of the characteristics of our business and goals that we are trying to accomplish were in conflict with this method of paying the bonus. For example, as you no doubt know, we have a fairly large amount of decreasing term insurance on our books. This meant that the branch manager was, in a way, being penalized even if business persisted. The run-off, then, was one of our reasons for deciding to pay the bonus based on premiums rather than on insurance in force.

Second, we try to encourage the conversion of our term business. A branch office could be doing a very fine job of bringing about conversions, but this would do little or nothing to the insurance in force. However, premiums do go up at the time of conversion, so premiums seemed to be a good measure to use in the payment of the persistency bonus if we wanted to encourage conversions. We moved from the payment of the bonus on the basis of volume to the basis of premiums over a three-

year period. This is the first year that it will be payable strictly on the basis of premium, and our branch managers are quite pleased about it.

We also have a persistency bonus for subagents. In this bonus a policy is said to persist if it stays in force for two years. A selling agent can get anywhere from 1 per cent, if his business has 80 per cent persistency, to 10 per cent, if his business has 100 per cent persistency. The bonus rate is applied to the annualized premiums remaining in force.

Our general agents, branch managers, and brokerage managers can qualify for a bonus which is meant to reward them for the recruiting of new agents and brokers. A manager or general agent can get a percentage of the first-year premium produced by new agents or new brokers over a given amount of time after they have been signed up. A general agent gets 10 per cent of the first-year premium production of new agents during their first twenty quarters under contract. He also gets 5 per cent of the first-year premium produced by new brokers during their first five years. A branch manager's bonus is very similar, except that the 10 per cent bonus for new agents is payable during their first four years, and the bonus relating to new brokers is $2\frac{1}{2}$ per cent during their first three years. The brokerage manager, of course, gets no bonus for the recruiting of agents, but he gets a 5 per cent bonus for new brokers during the brokers' first four years and $2\frac{1}{2}$ per cent of the brokers' first-year premium production every year thereafter.

The last bonus that I want to discuss is called a lives bonus. For some time now, there has been concern in the insurance industry that we are writing more and more business on fewer and fewer lives. Occidental's lives bonus was meant to try to offset this trend. Our agents can get a percentage of their total first-year premium production which will vary depending on the number of lives written. A life is defined to be a policy sold to a new life within a calendar year. The agent, however, cannot load the gun on us and write five policies on one life and get five credits for the sale. The agent can get from 3 per cent for thirty lives to 10 per cent for one hundred or more lives. As I have already stated, these percentages are applied to all first-year life insurance premiums regardless of whether or not the premiums were on policies which qualified for credit as lives.

Our brokerage and branch managers can also qualify for group bonuses, but I do not want to take the time this morning to discuss them. As you can see, we have a quite complex bonus system. Naturally, there are a number of rules associated with each of these bonuses, and I have tried to keep each of their descriptions as simple as possible.

Question A asks specifically if anything is being done for new agents.

We have tried a somewhat new device for the financing of new agents. For years an agent has been able to get advances on his commissions. However, generally speaking he had to wait until the policy was paid for before he could get any compensation. This can sometimes take quite a while. We have developed a system whereby the agent can get an advance on his first-year commission at the time that the application is taken, regardless of whether it is paid for and regardless of the mode of premium payment. What this does is to speed up the rewarding of the agent for his labors. Obviously such a system requires a good deal of supervision. Our general agents and branch managers have received this approach well, and it is becoming a most popular way of financing new agents with our company.

Question B asks how one can compare the merits of branch offices and general agencies. We have two approaches to this.

We have a profit-testing program on our IBM 1620. This program accepts as input all of the parameters affecting the profit margin of a policy form and turns out the present value of future profit for this policy. When doing our profit-testing, we always test branch offices and general agencies with different sets of assumptions because of the different expense levels. We then combine the results in order to get one profit factor for each policy form. We currently assume that between 60 and 65 per cent of our business comes from general agents.

We are just now working on a project that we feel will be quite useful not only for comparing general agencies and branch offices but also for comparing offices within these groups. Basically, we are assuming that new business written by each agency office has the same characteristics in all factors affecting profit except for distribution by plan of insurance, average size, persistency, and field operating expense. We will select one plan of insurance as representative of a large block of insurance and define four of these large blocks. They are level term insurance, decreasing term, nonparticipating permanent, and participating permanent insurance. Having selected the representative policy form, we will profit-test it on nine different sets of assumptions. The sets come from assuming alternately high, low, and average persistency paired with high, low, and normal average-sized assumptions. When doing these profit tests, we will ignore field-office operating expenses. We will then look at the new business of each office and determine which of the nine profit-test results should be used for the new business of each of the four large groups of insurance written by that office. Having multiplied the average profit factor by the amount of insurance within each block, we will then have a dollar figure for the present value of future profit

for the business written by the office within the calendar year. This will, of course, then be reduced by the field-office operating expenses of that office.

There are many things that we can do with this lump sum after having derived it. For one thing, we anticipate dividing that amount by the amount of insurance written and coming up with an average profit factor for the new business of the agency. We will then rank the agencies and branch offices by the profit index. In the future, we hope to be able to refine this system so as to consider individually more of the factors which affect the profit of the business and also to include accident and sickness, group, pension, and so forth.

Question C relates to methods of providing service to policyholders. We feel that we are doing a service to our policyholders as well as to the company when we encourage the conversion of the term insurance which we have on the books. Therefore, we have developed a term conversion program. Thirty-six days prior to the policy anniversary, starting with the second policy anniversary of a convertible term plan, we send a letter to the insured. This letter is somewhat general but points out the advantages of permanent coverage. Sixty days before each anniversary we send a letter to the agent so that he can be aware of the fact that his insured is about to be contacted. Since developing this program, we have seen an increase in term conversions and we hope that this increase will continue.

As part of our policy-accounting system, which is now on tape, we have an anticipated policy-change procedure. Basically, this procedure warns the interested parties in the home office of certain events of a contractional nature which will be coming up on each of the policies in force. Many of these events should be of great interest to the insured himself. For example, we have two valuable options within our income protection policy. Also we recently included a measure of guaranteed insurability in new issues of nonpar and par whole life policies. As part of our anticipated policy-change procedure, we will send a letter to each insured if one of his options is approaching. We feel that many times the insured would tend to overlook these options unless he is reminded. We will, of course, at the same time let the agent know that we are communicating with his insured.

This question also asks about services to orphaned policyholders. I am not too sure what the definition of an orphaned policyholder is in reference to this question. If we have an insured who moves to a different geographical area and should be serviced by a different agency office, we transfer this policy to the new office for servicing. The original agent

is still protected as far as commissions are concerned. The servicing agent does not get commissions immediately. However, with the amount of term insurance that we have on the books and with the options included in some of our permanent coverages, there is great likelihood that the servicing agent will be able to bring about a conversion or the issuance of a new policy. He will *share* in the first-year commission that would result from such a conversion or new sale.

To us, an orphaned policyholder means that the original agent is no longer under contract with Occidental. We pay no commissions on this business but again assign the case to an agency office for servicing. Here again, there is a good chance that the servicing agent can bring about a conversion or new business sale, and if so the servicing agent gets all the first-year commission.

I do not have much information on trends in agents' survival rates, which is the subject of the final topic. In trying to come up with something to report, I took the ratio of the increase in number of agents to the number of new agents put under contract. In 1961 and 1962, we were doing some housecleaning, so the ratios for these two years are meaningless. I am happy to report that there has been a slight increase in this ratio in each of the last three years.

MR. STUART A. ROBERTSON: New compensation plans have been developed during the last several years to meet the needs of a new segment of the life insurance industry—the life affiliates of casualty and multiple line companies. Reference to this group of companies as new is not strictly appropriate, for there are instances in which the relationship between a multiple line company and its life affiliate extends well back into history and there are those very few instances in which casualty companies have operated a separate life department. Nevertheless, in terms of numbers and breadth of the scale of operation, the life affiliates must be regarded as a new and certainly an important development in our business.

There are two very distant subdivisions of this group of companies. One—the larger by far—is composed of the companies that contract principally with general insurance agents and brokers, generally those particular agents and brokers through whom their related fire and casualty companies are placing their business. Such an operation, of course, need not exclude contracting with career life agents, and some companies have attempted development in both directions. The other subdivision is comprised of those companies—relatively few in number —operating with controlled agency forces, agents representing exclusively the member companies of one multiple line group.

It is not surprising that the life affiliates have compensation plans that differ in some respects from those of the typical life company operating independently; nor is it surprising that each of the two subdivisions of the life affiliates has developed its compensation plans along lines that differ from those of the other subdivision. In some respects, there are differences in the objectives of these groups of companies; obstacles to be overcome in meeting their objectives differ; opportunities open to them differ; and, finally, each group is affected by different traditions.

For the larger group of affiliates—those operating through general insurance agencies—contracts generally are not exclusive; the agent is free to contract with other companies, and he does so. Territory, likewise, is not exclusive. Competition for the attention and the affection of these agents is keen and increasing. The agency contracts of specific companies in this class differ considerably one from another, just as those of independent companies do. However, we can identify some characteristics that are common to many of them:

1. First-year basic commissions are generally well above those of companies operating in New York and are equal to or perhaps a little below those of independent, non-New York companies. (Obviously, this first point does not apply to those who do operate in New York.)
2. In addition to basic first-year commissions, a bonus, which may be substantial, will be paid if the agency achieves certain standards that generally emphasize volume and sometimes relate to persistency.
3. There is some heaping of renewals in the second and third years.
4. The total period of renewal commissions is short when compared with that of independent companies.
5. Service fees, in the range of 2–3 per cent, continue after the renewal commission period ends, with payment subject to continuation of the agency contract and in some cases subject to satisfying some minimum performance standards.
6. Security benefits—group insurance, pensions, and so forth—are not usually a very significant part of the compensation plan.
7. Although they constitute a small part of the agent's total compensation, agency contests and campaigns are an important element in the marketing methods of these companies.

What follows is a summary of a typical compensation plan of the life company of a multiple line group operating through general agencies. Let me make it clear that there is no standard plan; in fact, I have not seen two that are identical or very nearly identical. The plan that I will describe is not that of any one specific company but rather a composite that displays the features found in many such compensation plans.

The first-year basic commission is 65 per cent for top commission policies. A bonus, which will be a percentage of total first-year commissions for the year, will be paid if earned. The minimum bonus rate is 10 per cent, applying where $500 of basic first-year commissions are earned. The maximum is 50 per cent, requiring $7,500 of basic first-year commissions.

Commissions of the second and third year are 10 per cent and of the fourth to sixth years, 5 per cent. All are fully vested. Service fees begin in the seventh year and are at the rate of 2 per cent, continuing for the life of the contract. These are not vested; to earn service fees, the contract must be continued in force and the agent must be writing enough new business to qualify for at least the minimum bonus—that is, $500 of first-year commissions.

Group life insurance ($10,000 graded downward after age 65), a basic hospital and medical coverage, and major medical are provided to qualifying agents. To qualify for these group coverages, the agent must have been licensed for a full twelve-month period and he must be submitting annually new written premium income of $5,000; premiums written in any member company of the multiple line group count toward qualification. The company pays the full cost of group life, and the agent contributes to the cost of medical coverages. Incidentally, I understand that my hypothetical company differs from most in this respect; I have been told that the group life coverage is common but not so with respect to the other group coverages.

The company is now conducting a sales campaign. In fact, it is almost always conducting one. Credits toward qualification are earned by placing business in any of the companies with which it is affiliated. However, there is a certain balance required. Volume of each type of insurance written is converted to credits, and to qualify the agent needs the credits shown in the following tabulation:

	Credits
Life or health insurance	300
Personal lines	300
Commercial lines	300
Unallocated	900
Total	1,800

Thus, he has some leeway, but you can see that the company is working toward one of its objectives, that of getting the agent accustomed to writing all the coverages offered by the different affiliates in its group. Prizes of considerable value will be awarded to qualifying agents. The

life company's share of the cost of the campaign is expected to be within the range of 5–10 per cent of first-year commissions on business written during the campaign period.

Next I will summarize the principal provisions of one of the compensation plans of a company operating though a controlled agency force. This is the actual plan of a very successful company of this type. I cannot tell you that it is typical. The rather meager information that I have about these companies as a whole suggests that for them there is no plan that can be called typical. I am hoping that the other panel members or volunteers from the floor will add to my incomplete knowledge of the subject.

In the case of this specific company's plan, on top commission policies first-year commission to the writing agent is 55 per cent and the second-year rate is 25 per cent. Subsequent renewals are at 5 per cent and continue through the twelfth year. Additional compensation is granted for good persistency combined with a volume quota requirement, the quota being $100,000 face amount of new business for the year. The minimum bonus is 50¢ per thousand on permanent plans, payable for just moderately good persistency. The maximum is $2 per thousand on permanent plans, paid for excellent persistency.

Renewal commissions are not vested. There is, however, an unusual provision in place of vesting, and this, incidentally, touches on the question raised in part C of our panel discussion. If an agent moves from a territory or resigns and if he has met certain qualifications, he may sell his interest to an agent appointed by the company to take his place. The transaction relates not just to his life business but to his casualty business as well. The sale price is fixed by contract and is about two or two and one-half times the total commissions earned during a six-month period. For this company, the arrangement answers the question of handling orphaned business.

Agents are covered for group life insurance, hospital, medical, and major medical.

There are two levels of supervision. Supervisors in the first level are paid on a strictly commission basis, the rates for top commission policies being 20 per cent first year, 15 per cent second year, and 2 per cent during the third to twelfth years. The second layer of supervision is charged to the life company as a relatively small percentage of first-year and renewal premiums, but the payment goes to the parent company, which compensates the men in this upper layer of supervision on a salary and bonus basis. If this feature is typical of the controlled agency company, it differs from that which I have observed in the companies operating

through general agents, where the compensation of all supervisors is principally salary supplemented by bonuses.

Let us turn to some of the other questions raised for our panel. Question B is hardly applicable to the life affiliate companies of multiple line groups.

With regard to Question C, relating to the handling of orphaned business, I have already touched on this when describing the compensation plan of one of the companies operating through controlled agencies. The general agency companies appear to have a problem in devising a satisfactory method of servicing orphaned policyholders that suits the interest of all parties. The problem arises because it is the tradition of casualty companies to make all renewals of policies the property of the agent. If actuaries of some of the companies of this type are present and have an answer to this problem, I will be interested in hearing it.

To conclude these introductory remarks, I will point out that most of the companies in this segment of the industry are experiencing very satisfactory rates of growth. I believe that much of their brilliant success can be credited to the fact that they have well-designed compensation plans. Nevertheless, these plans appear to be still in the formative stage, and changes are being made from time to time. It is my guess that, in the case of many of these companies, management recognizes that it has not quite reached the final approximation to the perfect compensation plan.

CHAIRMAN CRANDALL: The session will now be open for questions, comments, and discussions on any of the four topics. I would like to direct a question to Mr. Robertson. You mentioned a compensation pattern paying 65 per cent first-year commission with an additional fractional commission equal to one-half of the first-year commission if the agent's earnings exceeded $7,500. It seems to me that, if this company has very many agents producing a high volume, this plan could generate a very heavy commission load. I would think that the distribution of agents between those writing only a few policies and those writing a high volume of policies would then become important. Do you have any comment with regard to this distribution?

MR. ROBERTSON: Yes, I do. Part of the question included the clause "if it had very many agents producing a high volume." This is the answer, as it does not. Companies for which I have some figures have several thousand agents with life contracts. In terms of annual production of face amount, 50 per cent of the agents wrote no business; 25 per cent

wrote less than $25,000; only 1.3 per cent of the agents were writing over $200,000. This, incidentally, is why the bonus pattern fits so nicely to this type of operation. Per unit produced, the cost of supervising the agents who wrote just one policy is very high, and the company cannot afford to give them much compensation. On the other hand, per unit produced by the big producers, the supervisory costs are low, and the company can afford to pay them more. Moreover, for competitive reasons, they must be paid more.

MR. BERNARD FENSTER: How does the Occidental compensate the original agent when a policy is terminated by conversion, especially when an active agent is responsible for affecting the conversion?

MR. BIERSCHBACH: Assuming that the agents are not in the same area, each of the agents would receive 50 per cent of the first-year commission on the converted policy. This is also true of brokers.

MR. ROBERTSON: Speaking of brokers, I believe that you said that for automatic changes and conversions, you write to the brokers sixty days prior to the policy anniversary and warn them that some thirty days ahead of the anniversary you are going to write directly to the policyholders. Do the brokers mind your contacting the policyholders directly?

MR. BIERSCHBACH: They can stop us if they want to, but very, very few do. In fact, they have come to like it.

MR. CHARLES F. PESTAL: The Northwestern National has introduced a new manager's contract with a much higher salary base. The new contract calls for a $12,000 base salary, as compared to $6,000 under the old contract. In addition, there is a bonus which is composed of a percentage of the first-year commissions in excess of $37,500 and a percentage of commissions in relation to the growth in size of the branch office. The new contract with a higher base salary was designed to help reduce the unit cost of our manager's compensation plan and to give the agency department greater control over the operations of the branch offices by increasing salary and placing less emphasis on the bonus aspects of the compensation plan.

We have also been using an experimental agent's compensation plan that I believe you might be interested in. All the agents in the experimental office are compensated on a salary basis plus bonus. In effect, compensation is based upon a multiple of the first-year premium which is ap-

proximately equivalent to the first-year commission plus the present value of renewal commissions.

While we have been using this plan for only one year, it does appear that we are recruiting agents much more quickly. We advertise in the local papers, and our branch-office manager finds no trouble getting men to interview. As a result of this new procedure, we feel that the new branch has grown faster than any other new branch in our company.

Since the agent's compensation is all in the first year, our managers and those of us in the home office are going to have to watch the agent's persistency very closely. We have already had a case in which the agent's production was good but the persistency was very poor, so he was terminated.

I was interested in Mr. Bierschbach's remarks. It appears that his method of measuring effectiveness of a branch office is similar to one advocated by Mr. James S. Hekimian. Mr. Hekimian made a study of three companies for his doctorate thesis. The results of this study and his recommended method are published by Harvard Press. The book is entitled *Management Control in Life Insurance Branch Offices.* In brief, Mr. Hekimian's method requires an asset share on each policy excluding branch-office costs to give a potential profit. Each agent would be required to have a minimum profit potential on the business he wrote. The total profit potential in the branch office less costs of operating the particular branch office would determine the performance of the branch office.

I also have one point in connection with the last item. I have found it fascinating to work with standard deviations again. I tried to measure our new agents to determine if we could find any factors in the preselection that would determine potential success; I found only one of the factors had any significance and this was small. The one factor that had a small degree of prediction of success was the number of negative check points that we make on each agent. In other words, we check on whether he is well known in the community, needs financing, and so on; our policy in recruiting is that an agent should not be hired if he has more than six check points. The one factor that was highly significant was early production.

MR. ALAN RICHARDS: Life Insurance Company of California is a wholly owned subsidiary of Insurance Securities Incorporated, San Francisco, which manages a large mutual fund—Insurance Securities Trust Fund.

The degree of success of this type of operation has usually been deter-

mined by the way in which the mutual fund is distributed, either through investment brokers on a wholesale basis or directly through a controlled agency force. The latter form of distribution has been much more compatible with life insurance sales and is the method used by our company and by Investors Diversified Services, the very successful pioneer in this field.

The sales force of Insurance Securities Incorporated, numbering some 800 men entirely in the state of California, sells both participating agreements in Insurance Securities Trust Fund and life insurance products of Life Insurance Company of California. Compensation for trust fund sales is at the rate of 3½ per cent of all moneys paid in, with an additional ½ per cent each to district and division managers. Division managers (of which there are 22) are similar to general agents in the life insurance business. The principal schedule of life insurance commissions is 17 per cent each year for ten years followed by a 2 per cent service fee.

Representatives who have been with the organization for less than two years may elect to receive life insurance commissions on the basis of 65 per cent first year and 5 per cent for the second through the tenth years. Somewhat more than one-half of those who have this option elected it. At the end of two years of service, those who elected the 65 per cent and nine 5 per cent schedule are put on the level 17 per cent basis for ten years for future business.

Life insurance overwrites are at the rate of one-seventh of the representatives' compensation for district managers and another one-seventh for division managers.

No commissions are vested except upon death, retirement, or disability. On the other hand, orphaned business is always allocated to another representative who receives the full remaining commissions. In no case does the company retain commissions on orphaned business.

There is no financing plan, salary, or any compensation other than straight commission for both representatives and managers. Voluntary terminations among representatives have been very low, as little as 8 per cent in some calendar years. This stability can be, in a large part, attributed to the high caliber of representatives hired. A recent survey indicated that 31 per cent had been owners, managers, supervisors, or sales managers in their previous jobs, 28 per cent had been in sales work, 10 per cent had been insurance agents, and another 10 per cent were professional men. Of the rest, all but 5 per cent had been in banking, civil service, teaching, or farming. Some 65 per cent have attended college.

Of the insurance written, 70 per cent is term and 30 per cent is perma-

nent. However, 90 per cent of the business contains some permanent insurance, since the majority of sales are on a plan which combines both permanent and term in one policy. Total sales have been about $100,000,000 a year since the life company was started in 1963.

MR. HAROLD G. INGRAHAM: The Massachusetts Mutual introduced a deferred compensation plan, qualified under Code Sections 401(a) and 501(a), for its career agents on January 1, 1966. A brief summary of its salient points follows.

Full-time agents eligible to participate in the plan will be those who, as of a given January 1 date, have attained age 30 but have not reached their sixtieth birthdays and have completed five years of full-time service. Participation in the plan is optional for full-time agents eligible as of January 1, 1966, but mandatory for new full-time agents hired thereafter as soon as they become eligible. Each full-time agent who is not eligible to participate—and those eligible agents not opting for the plan—will have a supplemental first-year-commission schedule equal to the difference between the first-year commission on the previous schedule and that on the new schedule.

Under the plan, a new ordinary commission scale has been established for full-time agents, reducing first-year commissions by 10 per cent (e.g., a 55 per cent commission will become 49.5 per cent). An amount equal to 11.4 per cent of such reduced first-year commissions (the reduction in commissions plus an amount to compensate for the delay in payment of moneys held) will be paid by the company to a corporate trustee to be allocated among, and held for the benefit of, agents participating in the plan. Each participating agent's share of the trust will be invested and accumulated for him and distributed at death, disability, retirement, or termination.

Investment of the funds held by the trustee will be made on one of the following bases, in accordance with the wishes of the participating agent:

1. An equity fund.
2. A balanced fund (with bonds, preferred stocks, and common stocks).
3. Split 50–50 between 1 and 2.
4. Up to one-third of any payments credited to the participant will be applied to buy new life insurance to the extent permitted by the plan, with the balance of each such payment invested in accordance with 1, 2, or 3. Commissions and volume credit for such new life insurance would, of course, go to the participating agent.

For retiring participants—or when preretirement deaths occur—payments may be made in one sum, in monthly instalments over a fixed period, or as a life annuity. For disabled participants, payments may be made in one sum or in monthly instalments over a fixed period. For a participating agent terminating other than by death or disability, the amount in his account will be paid to him in instalments over a five-year period.

A number of our agencies have made effective use of an orphaned-policyholder service and sales program. In these agencies, the general agent works with his cashier or a clerk in his office to establish and maintain an orphaned-policyholder pool. The general agent then determines which of his agents should be assigned leads from the pool. Experience shows that agents with at least one but not more than five years of life insurance selling activity are more enthusiastic and active with "orphan" leads. Those agents with less than one year's experience usually are relatively ineffective in the service selling area. And, the older, established agents become increasingly involved in selling, servicing, and following up referrals to their own files of policyholders.

The key to this program is a report-back requirement which assures the general agent that the participating agent has seen the policyholder face-to-face, thereby giving him a chance to make a new sale and fortify the policyholder's confidence in the insurance company and the policy(ies) previously purchased therefrom. After the agent has received his assigned quota of orphaned policyholders, additional leads would only be assigned as reports are returned.

Orphaned policyholders represent an often neglected segment of the insurance market. An "orphaned" policyholder in our terms usually is one whose agent has subsequently terminated, for one reason or another, from the company writing his policy. However, perhaps the definition of "orphaned" policyholders should also embrace "neglected" policyholders of agents still with the writing company.

It is sobering to note that, according to a recent LIAMA survey of a sample of life insurance policyowners:

1. 44 per cent of those interviewed had not spoken with an agent in over a year.
2. 76 per cent felt that no life insurance agent had ever performed any service for them in regard to their family-security program.
3. Although 82 per cent stated that they were willing to buy in the future from the agent (or company) who had sold them their last policy, only 31 per cent reported that they had ever seen any agent from that company again.

At the Massachusetts Mutual, survival experience of agents hired under our New Agent's Financing Plan in 1963 and 1964 has been distinctly more favorable than it was for financed agents hired in 1959–62. On the other hand, this recent survival experience is still not as favorable as the rates applicable to our financed agents hired in 1956–58—apparently our "vintage" years under the plan (see Table 1). However, our recent improvement in financed agents' survival rates is, perhaps, underscored when it is noted that the average level of monthly advance now paid to new agents being hired under the plan has risen by 25 per cent during the past three years.

TABLE 1

Calendar Year Agents Hired	Per Cent Completing 3 Months	Per Cent Completing 12 Months	Per Cent Completing Plan (30 Months)
1956–58.....	79	62	33
1959–62.....	68	37	21
1963–64.....	75	51	.....

TABLE 2

Date	Average Years under Contract	Expected Survivors
12/31/z.....	0.5	75
12/31/(z+1).....	1.5	46
12/31/(z+2).....	2.5	33
12/31/(z+3).....	3.5	26
12/31/(z+4).....	4.5	22
12/31/(z+5).....	5.5	20

A recent study of our full-time agents' turnover experience on a calendar-year basis has produced the survival scale shown in Table 2 for manpower projection purposes, for each one hundred new agents hired in calendar year z.

Also, we have attempted to analyze the survival experience of our full-time agents, split according to age group hired. To my knowledge, very little information of this type has been published. We studied the experience of 5,492 full-time agents during the period January 1, 1952—December 31, 1962, exposed to December 31, 1964, and obtained survival rates on a contract-year basis. Table 3 illustrates these rates by quinquennial hiring age group. The corresponding survival rates based

on the well-known McConney-Guest table are also displayed for comparative purposes.

The analysis of this experience showed that:

1. First-year termination rates decreased steadily by increasing age group, up to the groups hired at ages 50 and over.
2. Second-year termination rates were fairly consistent for age groups 25–29, 30–34, 35–39, and 40–44. The rate was higher for the 19–24 group and significantly lower for the two oldest age groups.

TABLE 3

YEAR-BY-YEAR EXPECTED SURVIVORS (PER 100 HIRED)

End of Contract Year	Hiring Age Group								Total Company	McConney-Guest
	19–24	25–29	30–34	35–39	40–44	45–49	50–54	55 and Over		
1.....	52	55	59	63	64	68	70	70	60	57
2.....	35	39	41	45	45	50	54	55	42	36
3.....	28	31	32	36	38	40	43	43	34	26
4.....	22	26	27	30	33	37	40	39	29	20
5.....	18	23	23	27	30	33	37	31	25	16
6.....	14	21	21	25	29	30	33	29	23	14
7.....	14	19	19	23	26	28	29	25	21	12
8.....	13	18	17	20	26	26	26	21	19	10
9.....	12	16	17	20	24	25	23	20	18	9
10.....	12	15	15	18	22	23	22	15	16	8

3. The 19–24 group exhibited significantly higher termination experience for the first six contract years. The 14 per cent survivors in this group after six years seem to persist extremely well thereafter.
4. The 55 and over group shows relatively poor survival experience after about four years—undoubtedly reflecting the incidence of retirements, deaths, and changes to part-time status.
5. Even the 19–24 group shows termination experience after the first contract year that compares favorably with the McConney-Guest table.

MR. WILBUR M. BOLTON: Standard Insurance Company has maintained a continuing study of short-term survival rates of new agents placed under full-time contract since 1955. We have noticed an apparent improvement in one-year survival rates. This may be influenced by changes that we have made in methods of payment in agents' compensation. For example, the trend toward annualization of first-year commissions may have contributed to this improvement. Also, we like to think that our agency managers may be doing a better job of selection and training for new agents.

Survival rates for agents contracted in the 1956–64 period are shown in the table below:

PER CENT OF NEW FULL-TIME AGENTS SURVIVING TO END OF SPECIFIED PERIOD FROM DATE OF CONTRACT

Contract Duration	Years Contract Effective		
	1956–58	1959–61	1962–64
3 months....	63%	80%	78%
6 months....	43	64	57
9 months....	36	54	48
12 months....	29	43	41
18 months....	23	34	32*
24 months....	21	31	25*

* 1962–63 contract dates only.

MR. HARRY M. SARASON: I would like to discuss the use of stock options as a part of the agent's compensation plan. I am connected with a client who has a very successful stock-option-sales program. Their use of stock options is a part of a sales program much the same as the contests to which Mr. Robertson referred. The amount of stock the agent can purchase is based upon the amount of insurance in force. I have observed that most of the stock acquired by agents in this manner will be sold rather quickly. I believe that the use of stock options gives the agent something to be enthusiastic about, but the service that they receive from the company and the total amount of compensation are still the primary factors.

MR. HERBERT C. PETTERSEN: I would like to describe briefly a program which we initiated in 1960 to provide service to orphaned policyholders.

We survey and distribute these leads to agencies in the same geographical location. Since 1960, we have put in one refinement; it was similar to that of Massachusetts Mutual's net-response type of program. We investigate and survey the responses to find out which agencies are actually making use of the leads, and, therefore, in future distributions of the leads, we give them preferential treatment.

There is one other point. Insofar as orphaned business is concerned, when there is no logical agency to which to assign the particular policy or policies, we insert a special code in the record so that in the future,

if this particular policyholder moves or a new agency is developed in the area, we will be able to survey it immediately and make the leads available.

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CHAIRMAN DATON GILBERT: The other panel members are already well known to most of you, but I will take just a moment to remind you of their positions and backgrounds.

Milton Goldberg is assistant vice-president of the Equitable Society and has been associated with the agency department of that company for many years. He has a great deal of practical experience from the point of view of an actuary in the agency field. He collaborated with me on the preparation of some of the early study notes on agency problems for the Education Committee. Milt has been active on various committees over the years and at present is a member of the Market Research Committee of the LIAMA.

Jack Moorhead, the other panel member, is vice-president and senior actuary of the New England Life. A number of years ago he spent several years on the staff of the Life Insurance Agency Management Association and since then has continued his interest in this field, as witnessed by his discussions and papers presented before the Society. He is the present consultant to the Education and Examination Committee on agency problems. Jack is a member of the Subcommittee on Compensation of the LIAA Committee on Sales Manpower and a member of LIAMA's Research Distribution Cost Committee.

Our plan of presentation is to take in turn the questions on the program and have a full discussion of each before we pass along to the next one. One member of the panel will give a comment at some length on the topic, to be followed by a brief comment by one or more of the other panel members.

As you looked at your program this morning, some of you might have asked, "Why should actuaries concern themselves with agency matters?" I would like to suggest that there are at least three reasons for this.

First, we should base our decisions and advice as actuaries on a knowledge of total company operations, and the agency portion of those total operations is one of the most important. Second, we should be deeply involved in protecting the financial health of our companies, and agency expenditures are surely a very substantial part of total expenditures. Third, as technicians, we can be of great assistance to the agency oper-

ations of our companies in designing field compensation and security-benefit plans, attractive and salable products, and so forth.

For these reasons, may I express the hope that agency questions will continue to appear on our programs over the years ahead.

Let us turn now to Question A.

MR. MILTON J. GOLDBERG: No company should effect changes in compensation formula merely for the sake of changes per se. Any change —even a liberalization—can be disturbing to the sales force.

A company should first determine its objectives in line with its management philosophy and then "pay for what we say we want." Relatively few companies appear to know where they are heading, much less how they can expect to get there. In too many instances, companies are paying for what they do not want and are not paying for what they do want. This is hypocritical. Some companies are awarding trophies and plaques and are remunerating for performances that they cannot afford on account of excessive lapse, NTO, and expense charges incurred.

It would not be feasible to reflect every objective in the compensation formula; rather, the main, broad objectives should be the framework embracing the various factors of the compensation formula.

In 1961, the Equitable embarked upon its "New Epoch" program with the stated objective of "production growth through manpower development and career advancement with expense control"—the ultimate goal being production growth and the means being manpower development. The Equitable is determined to build the "superior sales force of the entire life insurance industry." This is no secret—in fact, we challenge the industry toward that end.

The most important factor to which the success of the program to date is attributed is the complete revision of our managerial compensation arrangements, designed to "pay for what we say we want." The program is predicated upon the success of the individual agent, recognizing that the agent who makes a decent living will not leave his company or the life insurance business.

At the annual meeting of the Life Insurance Agency Management Association in Toronto, November, 1964, Senior Agency Vice-President Coy Eklund spelled out the manpower format which he conceived as the framework on which to drape our managerial compensation arrangements, and he recommended to the industry that such a format be adopted by the industry generally so that "We'll all be talking the same language" and be able to compare performances with one another on the basis of standard terminology. Briefly, Mr. Eklund divided the

sales force into two main categories, that is, trainees and experienced sales force (ESF). Within these categories he established Trainee Classes A, B, C, and D, representing agents in their fractional year of appointment, and first, second, and third full calendar years, respectively, and ESF Segments Active and Retired. He maintains that we should do away with the use of the word "turnover"; he explains that having segregated the trainees from the ESF, it will be found that the ESF attrition rate is something like only 6 per cent or, possibly, 7 per cent, including deaths and all other terminations. I look upon the trainee classes as a sort of "factory," undergraduate school, or junior varsity team being trained to deliver experienced agents to the ESF. The various factors of our compensation formula have been designed to recognize the relative emphasis to be placed by the manager on his trainee classes as compared with his ESF and to reflect a substantial distinction in overriders on account of Honor Club Members—defined as those agents achieving a minimum average of $300 first-year commissions during the calendar year—and overriders on non-Honor Club Members, who for the most part are part-timers, at least nonperformers. As a result of this distinction in overriders, we were able to eliminate some 2,000 part-time agents at the inception of this program and at the same time have been able to experience plusses in all production results—10 per cent upon 10 per cent year after year.

The most unique development involved the creation of a quality factor remunerating for production growth *in relation to* expense control. We believe that it would be a mistake to remunerate for production growth irrespective of costs involved, and we believe that it would be a mistake to remunerate for economy irrespective of production growth. In fact, a manager can effect maximum economy and not do a building job for the Equitable, and as a result he might be relieved of his responsibilities. I would like to see all companies give consideration to the introduction of a quality factor. There is a good deal of lip service going around the country, but relatively few formulas put "teeth" into what such companies say they want to do.

Our quality factor reflects not only the usual expenses, such as rent, clerical, travel, and so forth, but also lapse, NTO, and financing charges.

Due to legal restrictions, the company does not have the same leeway in designing an agent's compensation arrangement as it does in that for its managers. Rather than attempting to spell out details that may be found in the books, I would like to offer some observations of first-hand experiences.

No matter how much we emphasize the importance of all sources of

compensation, it is the first-year commission that attracts most of the spotlight. The agent sees it as the "bird in hand" and, in too many cases, does not appreciate or understand the importance of renewal commissions, service fees, security benefits, and so forth. When I ask our agents if they would rather have high commissions or low net costs, they answer "Both!"

I am critical of a company that will cut commissions in order to produce a "special." Such practice merely gives the initiating company a time advantage, but ultimately its competitors will be forced to act accordingly and as a result it is all agents who will suffer unnecessarily.

I detect a trend toward more telescoping or heaping of renewals in the early years—which is perhaps good for the new agent who needs early stability of income at a reasonable level—and I am told that some companies are experimenting with such change in incidence of commissions even among experienced agents. However, I would caution a company to expect disappointment and misunderstanding on the part of its agents when they learn, as they must, that the arithmetical sum of the commission rates will be substantially less than it is if the commissions were spread out in the later years. You can "talk yourself blue in the face" about the interest, agent survival, and persistency factors, but the agent will still measure the package by its arithmetical sum and not by its commuted value.

As to vesting, too little vesting is not good. It is idealistic to want your agents to stay with you until retirement, but it is not realistic. We vest after fifteen years.

Much limelight is given to persistency bonuses; for example, an extra 5 per cent if the business stays in force five years. This may have some good psychological effect, but I cannot be convinced that an agent who will let his business go off the books before the end of the first policy year—and give up a 55 per cent commission, or a 15 per cent commission in the second year, or a 10 per cent commission in the third year—would go all out to keep the business on the books until the end of the fifth year for 5 per cent. What happens, I think, is that those agents who respect favorable persistency will achieve such persistency anyway, and those who do not will not improve persistency, so that the company will end up by paying additional sums and get nothing for its investment.

Just a word on the financing of new agents. The best financing plan in the world is only a tool—it can never be a substitute for good management. We in the Equitable finance all new agents, and there appears to be a definite trend in this direction in the industry. In selecting our recruits, we apply a sort of numerical rating system involving what we

call RDP's (Relative Development Potential). From a study involving thousands of our recruits over a period of years, we learned that only three factors had primary significance: age, previous occupation, and education. We have been gratified at the results achieved through the use of this simple measuring rod.

It appears that companies are beginning to recognize the importance of security benefits, commonly known as "fringe benefits." We in the Equitable, proud of our continuous liberalization of our benefit plans, believe that "fringe benefits" is a misnomer.

Companies apparently are failing to communicate to their sales forces the value of their benefit plans. They should be regarded as an integral part of a compensation formula and should certainly be taken into account in attempting any comparison of compensation arrangements.

In this area, the Equitable has recently introduced a widow's benefit plan which, in the event of the death of the agent between the earliest optional retirement age of 55 and normal retirement age of 65, pays the widow a lifetime income equal to one-third of the accrued annuity. Of course, when the agent lives to 65 and elects a joint and survivor annuity, his widow is protected; but, if he should die, say, at age 62, his widow would receive under the retirement plan just his contributions with interest; hence, our widow's benefit plan. I have reason to believe that this development will become prevalent throughout the industry.

Recently the Equitable developed a deferred compensation plan, and I sense a trend in this direction, having observed a few other companies' similar actions in recent months. In this connection, I would caution any of you who are developing such plans to be as sure as you reasonably can that they will qualify under the IRS regulations. Otherwise, much lost time and confusion can result.

Other activities, which will have to become trends, are the revisions being made generally to dovetail benefit plans with Medicare and to integrate such plans with social security.

I am concerned over the unfair competition a company operating in New York State encounters from companies not operating in New York State. I regard the other forty-nine states as the "Land of the Free" and New York as the "Home of the Brave." In some states we find our 55 per cent competing with the 75 per cent or 90 per cent of other companies—and, as pointed out before, not much weight appears to be given to anything but the first-year commission when these comparisons are made. I even ran across a fraternal, last week, paying 75 per cent first-year commission in New York City—not being subject to Section 213. To make matters worse, the situation was aggravated by the fact

that extensive proselyting is taking place with attractive offers to good agents of good companies.

I, for one, have been disturbed by the subterfuge—and I am glad to note that the New York Department evidently is vitally concerned—being created by a few companies not operating in New York State but who have established affiliates to operate in New York State—the effect being to "have your cake and eat it." To me, this is unfair competition.

Finally, I would like to echo Coy Eklund's warning that transfers of agents from one company to another will do the industry no good—that a company should recruit, train, supervise, and develop its own men and carry its share of the load, for the benefit of the agent, the company, the industry, and the insuring public generally.

MR. ERNEST J. MOORHEAD: My own company has introduced new, and we hope improved, compensation plans for both agents and general agents.

For agents we have introduced a renewal commission scale which depends on the length of service the agent has had with our company. For agents in their first and second years, the renewals are heavily telescoped; in the third and fourth contract years, renewals are moderately telescoped; on business of the fifth and later contract years, the regular almost-level scale of renewal commissions becomes effective.

For general agents we have replaced a collection-fee schedule that used to vary by policy year—1 per cent for the first ten renewal years, then 2 per cent—by a level fee of 1.3 per cent in all renewal years. It is to be expected that companies will introduce many changes in collection fees as automation changes work patterns and responsibilities between field offices and the home office.

We have also changed our expense allowances so that they depend less upon the volume of business done by the agency and more on the commission earnings of the agents.

Perhaps the day is coming when more companies will take a fresh look at the impact of agents' compensation on the attractiveness of the sales career and on the survival rates of agents. This fresh look may be the result of a stirring but controversial address made by Mr. L. J. Kalmbach at the December, 1964, meeting of the Life Insurance Association of America and by the subsequent creation of the Committee on Sales Manpower under the leadership of Mr. Roger Hull, particularly of its Subcommittee on Compensation, of which Mr. Daniel J. Lyons is chairman. This committee and this and other subcommittees are still deliberating on the very large questions involved.

Whether one agrees or disagrees with what Mr. Kalmbach said, it is

well worth studying his address in the *LIA Proceedings* and trying to decide what each of us believes is the best solution of the field problems that he described.

CHAIRMAN GILBERT: Taking a broad interpretation of the topic, we are interested not only in details of new plans but also in historical experiences that you might have had on existing plans. Also, we solicit any comments you might wish to make about the future.

MR. WILLIAM K. KRISHER: I would like to describe briefly a new retirement benefit program for Connecticut Mutual's full-time agents that became effective January 1, 1966.

Our prior retirement plan was on a money-purchase basis with contributions determined by the agent's paid-for and in-force volume for the preceding calendar year. Contributions from agents were applied immediately to purchase units of paid-up income commencing on the normal retirement date. Matching units of income were provided by the company. Preretirement death benefits consisted of a return of the agent's contributions plus up to $5,000 of company contributions. On contract termination after twenty years of participation, incomes provided by the company were fully vested if the agent left his contributions in the plan.

Under the new retirement plan, contributions from agents are based on total commission earnings with a higher rate on earnings in excess of the social security base. These contributions are deposited in an account which is credited with interest each year at the then-current rate for qualified plan reserves. At retirement, this account may be converted to life income on any option contained in our ordinary policies. At this point, the company adds $2 of income for each $1 produced by the agent's account.

Since an agent's retirement picture is quite different from that of a salaried employee, there is no specified retirement age. He may elect to convert his account to income at any time between the ages of 60 and 72 and receive the company's full matching income, provided he has been in the plan for at least ten years. Also, the plan contains an option for gradual conversion of accounts to income over a five-year period. This provides an increasing pension during a period when regular commission income is normally declining.

Vesting of company-paid pensions may begin as early as age 35 following ten years of participation and grades smoothly into the full 2 for 1 level at the point when the agent is first eligible for retirement. Preretirement death benefits from the company also grade smoothly to a

level of two times the agent's account balance, so there is no loss of benefit if death occurs shortly before the agent would have been eligible to retire.

The second part of our new retirement program is a combination deferred-compensation–profit-sharing plan. The participating agent's full-time contract is modified to pay 8 per cent less in first-year commissions. At the end of each year, a contribution is made on his behalf to the profit-sharing trust equal to 11 per cent of the first commissions actually paid. This works out to a company contribution of 26½¢ for each dollar that the agent has, in effect, deferred.

The trust provides for automatic purchase of life insurance with about one-third of the contributions. The balance is split at the agent's election between a stock fund administered by the trustee bank and a fixed-dollar fund held by the Connecticut Mutual.

Retirement may be elected at any time between the ages of 60 and 72, at which time the accumulated values may be taken in cash, an annuity certain, or a life income.

The final part of our new program stabilizes the income an agent receives from nonvested 2 per cent service fees at approximately the level earned at age 75. Subject to a minimum amount of premium-paying business on the books at age 75, the agent is thus protected against further deterioration in this source of income from policy terminations that occur beyond that point.

In making this revision, we tried to accomplish the following primary objectives:

1. Relate pension credits to actual commission earnings rather than volume.
2. Allow agents to participate directly in excess interest earnings prior to retirement.
3. Avoid discontinuities in benefits if death or contract termination occurs shortly before eligibility to retire.
4. Provide flexibility in choice of retirement date and manner of payment to recognize that agents do not, in fact, "retire" in the same sense as salaried employees do.
5. Introduce some degree of recognition of social security taxes and benefits.
6. Give our agents an opportunity to participate in a tax-sheltered program for capital accumulation similar to those they sell to their own clients.
7. Protect the agent's total retirement income from deterioration after age 75.

MR. THEODORE A. STEMMERMANN: I would like to emphasize that there is one area in connection with which life insurance companies have established a very poor record; that is in the survival rate of new agents.

I am by no means certain that a plan of compensation in itself will

cure this problem. Nevertheless, I think that the plan of compensation for new agents may be an important factor. Under almost all agents' compensation plans with which I am familiar, including agents' training-allowance plans, the new agent must produce business very quickly in order to justify the continuation of his employment beyond a period of even three to six months. I am wondering whether this might not be an entirely unreasonable requirement.

On the other hand, most companies provide some form of vested renewal commissions in connection with business produced by agents after the first few years of employment. This means that companies pay agents after they leave the service of the company. Might it not make a great deal more sense to use the money which is paid to agents who have left the company, particularly if they have even left the business, to make it easier to get new agents into production without requiring too much in the way of results during the first three or six months of employment?

In order to assist the new and younger agents to get started, perhaps the training allowance should be related to the amount of insurance produced rather than to the amount of first-year commissions which are, in turn, computed as a percentage of the first-year premium. An allowance per $1,000 of insurance will provide a much greater allowance in connection with new business written at the younger ages compared with business written at the higher ages. New young agents are more likely to have prospective clients at the younger ages than at the older ages. Furthermore, it is probably more difficult to sell a $10,000 policy at age 25 than it is to sell a $10,000 policy at age 40, because the young man at age 25 may find it more difficult to pay a $200 premium than the man aged 40 to pay a $300 premium. Another thing to keep in mind is that an agents' compensation plan should provide an incentive to produce business of a good quality rather than merely a larger volume of business.

Also, some attempt might be made to iron out, to some extent at least, the great fluctuations in income in the straight-commission basis. This does not mean that the incentive element should be eliminated. Can we not iron out great fluctuations in income from month to month and, nevertheless, still pay the million-dollar producer twice as much as the $500,000 producer?

At one time it was felt that, in the case of companies operating in the state of New York, it was essential to require that new agents produce business promptly in order to avoid exceeding the commission limits of Section 213 of the New York law. Now, it seems to me, considerable flexibility is permissible under Section 213 of he New York law in the

compensation of new agents, although companies must, of course, still comply with the limits in the aggregate. Yet, it seems to me that the life insurance industry has done a very poor job in attempting to find a solution to this very important problem.

As I have already stated, I am sure that a compensation plan alone will not solve this problem, but I feel confident that a proper compensation plan may be of material assistance in solving it. Therefore, I strongly urge all actuaries, and particularly our younger actuaries, to study this problem and to develop revised plans of compensation that may be used on at least an experimental basis.

MR. RUSSELL E. MUNRO: Both agents and managers will benefit under London Life's improved staff pension plan introduced about a year ago, which also makes provision for integration with the Canada or Quebec pension plans.

The new-man training allowance has been revised into a three-stage program so as to provide a stronger incentive to bring the new man more rapidly into early production and to assist him in establishing a favorable balance in his commission account early in his career.

A new sales-executive category—Clients' Advisory Executives—has been created. Certain experienced agents are appointed by the company and only if the appointment is merited through excellence in every phase of performance. It is not merely an award for personal performance. These agents receive an honorarium upon appointment and additional pension credits for which they are expected to undertake increased responsibilities in an advisory and leadership capacity in many areas of the company's operations.

Membership classifications in the Agents' Production or Honor Club have been increased, and these changes have been accompanied by increases in the bonuses. However, a persistency factor has been added to the qualifications. A new category of field supervisors will work along with the manager in a stepped-up program of recruiting and training of new salesmen. The salary will be shared by the company and the manager. These are successful young men who must continue to maintain a substantial volume of personal business. The appointments are temporary and will be reviewed at the end of two years with a view to possibly agency assistant or managerial responsibilities, or a return to full-time personal production.

MR. ABRAHAM HAZELCORN: In the last year some management consultants have made studies for the life insurance industry, the results of which have appeared in insurance magazines. I believe that their

conclusions can lead us to a fruitful approach in studying agency compensation and survival.

I have in mind, in particular, the conclusion of Mr. Philip H. Dutter, in his article entitled "The Marketing Multiplier" in the February, 1966, issue of *Best's Insurance News*. The main point of his article is that the quality of a company's agency manager or general agent is the greatest single factor in determining the company's marketing effectiveness. While his consequent conclusions would concern agency department officers more than actuaries, his statement can be used as a take-off point for the study of success and survival of agents.

Perhaps general agents and managers should be classified in some success rating, and homogeneous groups of agents under the general agents and managers should be grouped together to test differences in survival rates, success, and the effect of different compensation schemes on success and survival. Poor survival rates, in some cases, may indicate a very knowledgeable manager or general agent who has detected impending failure early in a new agent's development. Such action may result in lowered costs to the general agent, and the company, and it might be a considerable aid to the departing agent who did not waste time in a field for which he was not suited.

The foregoing comments can be considered to touch tangentially on Questions A and D. They can also be considered as relating to Question B, which asks for the comparison of the merits of branch office and general-agency systems. Now the general agent vis-à-vis the home office is in a similar position as the agent is to the general agent. Is the plan of compensation and security benefits paramount to the general agent or manager, or is it the agency officer who attracted him and beyond that the reflection of the company's approach and place in the life insurance business which may be more important?

The new-company development has, on the whole, employed neither the branch office nor the general-agency system as conceived by established companies. In our work at Lybrand, Ross Bros. & Montgomery, we note a tendency to call a general agent someone who is really a glorified broker. There is no question of immediate security benefits, and the compensation is new or recent in that the possibility of stock appreciation has been used to attract the broker. In the case of a general agent who acted in such a capacity with another company, in addition to the possibility of stock appreciation, it is not only a new compensation scheme which attracts him but the possibility of being of greater importance in the development of the new company that he is going to be associated with than with the one he is leaving. In addition, a real factor in his considering joining another company may be a disenchantment or misunderstanding

with the company he is leaving. However, if his new company is not fully aware of the circumstances and does not paint as accurate a picture as possible, no one will be helped by this change of association, including policyholders of the general agent and the life insurance industry as a whole.

Section 213 of the New York Insurance Law acts as an equalizer in regard to commission payments for companies authorized to do business in New York State. Other reimbursement, however, is controlled in a general way by the field-expense limits as filed in Schedule Q. The requirement of acceptable vouchers by that department keeps reimbursement from becoming additional compensation. Where this fails, illegal payments are frequently mistaken for an improved compensation plan.

CHAIRMAN GILBERT: We already have a minor conflict on the platform between general-agency and branch-office companies, and we shall see what that brings forth. I am asking Jack to lead off on the question of the relative merits of the two agency systems.

MR. MOORHEAD: The general habit has been to sidestep this question by denying that any clear-cut distinction remains, since each system through the years has borrowed ideas and characteristics from the other. My thesis this morning is that solid meaningful differences do exist; that comparison, though difficult, is possible; and that failure to attempt such comparison needlessly deprives actuaries and agency officers of great opportunities to get the best out of the system to which their companies may be committed.

Let us agree that the test of a system is its ability to distribute life insurance effectively at an acceptable cost. We must, therefore, study both how well each system operates and how much each system costs.

On the question of cost, up to this moment only one actuary that I know of has taken a positive unequivocal stand. That was the eminent Joseph B. Maclean, who has stated flatly that the branch-office system is cheaper.

On the other hand, if one looks at the net costs of ordinary life policies sold by companies domiciled in the United States—whether one uses the discredited "average surrendered net cost" method so regrettably prevalent in our industry or whether one espouses the immensely superior "one-thirtieth" method authoritatively recommended in a recent issue of the *Journal of Risk and Insurance*—he cannot help being struck by the fact that general-agency companies seem to predominate over branch-office companies in the enviable low net cost rankings.

Whether this means that the leading companies are good because they

are general agency or whether they are general agency because they are good is not for me to speculate. But we must remember that, when a general-agency company produces a block of new business, it assumes substantial liability for future deferred compensation thereon to the general agent that produced it. It follows, I think, that, when new business is increasing in quantity, a general-agency company will show over a branch-office company a cost advantage that is more apparent than is necessarily deserved.

In the history of perhaps every well-established general-agency company comes the time when desirability of changing to the branch-office system is given more than just casual thought. Recently I have attempted, for the dubious benefit of students tackling the agency-problems section of Part 101, to summarize the considerations that arise during the course of such contemplation. This morning's presentation is a distillation of the ideas of several wise and experienced life insurance people whose advice I sought. There are six points in this summary.

1. *Comparative cost.*—A model office-expense comparison between the two systems may be feasible but would require the utmost care in developing the factors to be used. The difficulty, as well as the challenge of attempting comparison, is that the two systems almost certainly produce different results in what may be described as the *basic elements of expense.* These basic elements are (1) agents' survival and production rates, (2) managerial survival experience, (3) persistency rates of business, and (4) control of field operating expenses. It would be futile and wholly misleading to go through the motions of making a model office comparison if one simply uses the same unit values of these items for both systems, because it is the difference between them that is at the heart of the distinctions that require study.

2. *Incidence of cost.*—Because the incidence of expense differs so greatly between the two systems, the choice may depend, in part at least, upon the effect of that incidence on the company's ability to meet net-cost competition, to maintain and build surplus, and to live within the margins of Section 213.

3. *Availability and cost of management manpower.*—A general-agency company may find it frustrating to pay substantial subsidies not only when a brand new agency is started but also every time a new general agent replaces one who has left or retired. The question is whether new agencies and change-overs can be engineered any more economically under the branch-office system. Another frequently encountered problem whose impact may differ between the two systems is that of persuading agency heads to part with agents and supervisors whom the company would like to appoint as heads of other agencies.

4. *Incentive for recruiting and territorial development.*—One of the most common criticisms of the general-agency system is that so many general agents cease to be hungry for growth and development—in fact, they often believe, rightly or wrongly, that they are financially better off if their agency stagnates or even liquidates. Possibly this is the principal single reason why general-agency companies have changed to the other system. And perhaps this drawback can be removed or ameliorated by incentive expense-allowance plans, by motivation and education, and by less extreme deferment of compensation than many general-agency companies still use as a heritage from the past.

5. *Philosophical or ideological contrast.*—It is fair to say that general-agency companies and branch-office companies are looking for different kinds of management manpower. Even under today's conditions, the typical general agent still has a range of responsibilities and authority that goes beyond that of a sales manager. And also it is true that a general agent who can double the size of his agency can, unlike a branch-office manager, expect approximately to double his personal compensation.

6. *Problems of making the change-over.*—Even if a general-agency company finds some features of the branch office system appealing, it may shrink from the task of changing over. It may legitimately dread the morale and organizational headaches. It may view with disfavor the long period during which it must operate both the systems, attempting to get the best out of both and attempting to maintain harmony and financial equity between a growing number of young managers and a declining number of senior general agents.

MR. GOLDBERG: We think that in branch-office operations we can operate with more uniformity, such as using one compensation formula. We can exert more control over agency managers than would be possible with general agents. Even in sales campaigns, we notice the effects as compared with the general agents who just cannot be pressured.

As to persistency, I find the general-agency companies have a better persistency rate. I know that they do on the average, and I think that it is attributable primarily to their compensation system, whereby they reward the agency heads on the basis of renewals as well as first-year commissions. But I do not think that in itself justifies the system.

I think that it requires a different type of man to be a general agent. He not only has to have capital or some capital, but he has to be a financial expert, as compared to an agency manager for whom the home office does most of the financial planning.

I think that the general-agency system has the defect of discouraging

a man from plowing back his earnings into the agency, once he becomes age 60 or 61. That is a problem we do not have in the branch-office system.

There really is not a pure general-agency system or branch-office system. They are all hybrid, with some elements of financing and expense allowances on the part of the home office.

It is difficult to maintain equity between the two systems, so, if you don't need both, don't have them. You will find each group whipsawing you from year to year, to "maintain equity" between the two groups.

MR. JOSEPH F. CROWE: This is slightly off the topic, but some of you may be interested in knowing something about our recent change from general agencies to branch offices at Aetna. I won't bother to mention all the reasons for and against a change, but we had some reasons that are probably not among the commonly listed pros and cons.

In the development of our general-agency compensation and expense-allowance system, we found that it had reached the point where a disproportionate amount of compensation was derived from group insurance. We, of course, could have rectified this, at least to some extent, without changing to a branch-office setup, but a change was called for and we felt that it could best be handled by the change in type of agency management.

We also found that, in new agencies and agencies which were embarking on growth programs, heavy investment was involved and extra home-office subsidies were required. There were so many varied expense-reimbursement arrangements that we felt it would be best to use the branch-office arrangement in order to have more uniform treatment.

Under this general-agency plan, a general agent may tend to sit back and reap rewards of past development when he nears retirement. Since his income is so heavily weighted by renewal business, he can be assured of a fairly good income if he has built up a good agency. If he does invest much money in agency growth at this point, he will have retired before the agency starts getting much benefit from the investment, and it is difficult to provide a pension plan to offset this. This is an unfortunate situation, and we felt that the use of a branch-office plan was the best way to overcome it.

Once the decision had been made to change, we made the transition gradually. Our first step was to take sixteen heavily subsidized agencies and change them over. This was little more than a clarification of an already existing condition. We also stated that any new management appointments from that time on would start under the branch-office

plan. Since then, the change has progressed fairly smoothly. Most of the remaining changes were due to financial problems in agencies, and the majority of these changes were initiated by the general agents. An example of what might cause this is a desire to invest heavily in expansion.

This program was started in 1959, and we now have less than ten agencies operating as general agencies out of a total of over one hundred agencies. We feel that, with one exception, any morale problems have been minimized by our program of change-over. This exception is a rather important one which deserves the close attention of any companies that are considering similar changes. After being independent contractors for so long, our general agents were now company employees and found that many routine decisions made on a local level were now being questioned by the home office. I am referring to such things as the ordering of supplies. When the transition was made, we did not bother to spell out just who had authority in different areas. As a result, our purchasing and supply or field lease departments might speak up when an order had been placed without their approval. Some small questions were blown up out of proportion. We feel that we have solved the problem to a large degree, but our transition would have been smoother if we had anticipated it and worked on a solution.

It seems to me that, to be able to compare and properly weigh the merits of the two systems, it is important to at least have an idea of the extent to which the different advantages and disadvantages hold true. There are some arguments often used which to a limited extent can be tested.

One point used in defense of the general-agency system is that the persistency of business is likely to be better because the general agent's income is so heavily weighted toward renewals. Dick Wright at the LIAMA has given me copies of some lapse rates that they worked up for two groups of five companies, one group consisting of all general-agency companies and the other made up of branch-office companies. The mean thirteen-month ordinary lapse rates were 9.4 per cent and 15.3 per cent in favor of the general-agency companies. Of course, there are many items other than form of agency management which affect lapse rates, but the people of LIAMA analyzed the data and were unable to explain the differences fully by differences in product-mix or market characteristics. So, although it is hard to say what the extent of the difference is, perhaps general-agency companies will experience better persistency than branch-office companies, other things being equal.

Some interesting figures show up in LIAMA's booklet *Developing New Agencies*. An argument sometimes used in favor of branch-office com-

panies is that it is easier to develop new agencies, especially spin-offs. This booklet shows that in twelve New York general-agency companies there was an average of 7.4 starts per company during the three-year period under consideration, whereas the nine New York branch-office companies average 15.4 starts over the same period. Further, the percentage of new agencies listed as "scratch" was 69 per cent in the agency companies and only 34 per cent in the branch-office companies. Quite different results were obtained for non–New York companies, but these include newer companies and are influenced very strongly by new general agents who are largely personal producers.

Since a comparison such as this is most likely to occur when a company is considering a change from a general-agency to a branch-office system, one important drawback can be measured fairly accurately. This is the extent to which expenses will be inflated for a period because of a doubling-up during the transition. Normally the compensation to general agents is heavily weighted by renewals so that company costs of general agents' compensation is spread out quite a bit. Managerial compensation, however, is usually based largely on new production plus a base salary, so it is not deferred. This leads to the doubling-up when agencies are transferred from general agencies to branch offices. This can be a very important factor in the decision.

There are, of course, many factors which cannot be measured, even to a limited degree. Where we do have measures such as these mentioned above, consideration must be given to our own company results and objectives. However, I do feel that the more we know about the extent of the influence of the relative merits of the two systems, the more effective a comparison can be.

MR. CHARLES F. B. RICHARDSON: Before you can effectively compare the merits of branch-office and general-agency systems, it is first necessary to analyze the strong and weak points of each system.

As is well known, there are enormous variations today in the compensation formulas in use under both of the systems. The general-agency system can vary all the way from the pure, old-fashioned plan under which the general agent received overriding commissions, with or without expense allowances, to the other extreme under which the company pays nearly all the operating expenses of the agency and the general agent receives compensation in the form of overriding commissions, frequently with additional incentive compensation for building new manpower. There is a great difference between these two extremes.

Let us now consider some of these variations in more detail:

1. The overriding commission scale may take a variety of forms. For example, it may concentrate substantial compensation in the early policy years, or the larger rates of overriding commissions may be deferred until after the tenth policy year. The vesting provisions may be liberal or strict.
2. Expenses may be based on a formula system, the general agent paying any excess over the formula. Alternatively, the company may pay all the expenses, or in some cases there may be an expense formula and the company may pay directly certain items of expense, such as rent. Another factor that enters into the expense picture is the trend toward home-office collection of premiums, which seems likely to become more common with the advent of computers. This is likely to result in a reduction in the profit the general agent could formerly make on renewal collections.
3. Some, but not all, general-agent-compensation plans include various forms of incentive to encourage the general agent to develop new full-time agents. However, there are still some companies that have no such factor, and these plans are, in my opinion, weak on this account. Usually the general agent is required to share in the financing losses. This has the effect of using part of the new-agent-incentive compensation.

For companies that operate in New York, the effect of Section 213 is, in my opinion, to limit severely the degree of experimentation and incentive that can be offered under a general-agent contract. This is not true under the branch-office system, and to this extent I believe that the law restricts the freedom of action of the general-agency companies.

Under the branch-office system, which may be defined as a compensation plan under which the branch manager has no vested right in any portion of the compensation, there are perhaps even wider variations in the emphasis placed on the various factors than there are under the general-agency system. Generally the formulas used start with a flat salary which sometimes depends on the size of the agency. In addition to this there are various incentive factors—sometimes one or two, sometimes several.

1. There is invariably a factor for the volume of new business, which may be based on first-year commissions, first-year premiums, or volume.
2. There is generally, but not always, a renewal factor. This may be based on a percentage of renewal premiums or commissions, or it may be x dollars per thousand in force or of the increase in force. The renewal factor is generally relatively minor in importance, and this may be said to be a weakness in the branch-office system as compared with the general-agency system because of the lack of emphasis on persistency.
3. There is generally a factor for building new agents applied most frequently during the new agent's first three years but sometimes longer. It may take the form of a percentage of first-year commissions, sometimes graded by dura-

tion of the agent, or x dollars per man-month, or x dollars per month for various types of club members. Sometimes there is a recruiting bonus for each man hired.

4. Occasionally, but not very often, the branch-manager formula includes a persistency factor. This is sometimes applied to the volume factor, giving a larger rate of compensation where there is good persistency and vice versa. Sometimes it is a direct reward or penalty based on a fixed standard or a company standard varying with the amount of business or with the rate of growth.
5. Expense factors seem to be getting more popular but still appear in only a minority of the plans. These take various forms and are generally based on a standard comparing the agency expenses with a company standard, occasionally but not very often varying with the rate of growth of the agency.
6. Some plans require the manager to share in financing losses, while some do not.
7. There are plans which include a special factor to reward the manager on a temporary basis for an assistant who is promoted to another agency.

Perhaps I have said enough to indicate the impossibility of comparing the two systems, because each of them has such extreme variations in practice. I think, however, the salient points are that the branch-office system generally provides more incentive for volume and for building new agents, while in the general-agency system there is much more emphasis on persistency and economy of operation at the expense of these other two factors.

CHAIRMAN GILBERT: I think that we should pass along to the two remaining questions, and I will first ask Jack Moorhead for his comments.

MR. MOORHEAD: The life insurance business has become heavily committed to providing service to policyholders through its sales force and to providing the sales force with service compensation which is usually about 2 per cent of the premium but tends to be paid only to the agent who produced the business and who stays with the company. Observation gives reason for doubt about the effectiveness of policyholder service provided in this manner and paid for in this way, for the following reasons in particular.

1. It results in very uneven service. Some agents are conscientious about this, while others are not. The system encourages concentration on giving service to policyholders who are believed eligible for new insurance. Also, not only is orphaned business a problem that few companies have consistently tackled but policyholders who have moved away from their agent are likely to be neglected as well.

2. It results in very uneven compensation. The usual 2 per cent service

fee may be reasonable in the aggregate, but it overcompensates the agent who accepts it and gives no service, and it undercompensates the agent who watches over his clients and attends to their needs and whims.

3. While we may comfort ourselves with the thought that a policyholder in need of service will generally request it, if his agent has lost touch with him, we must realize that this applies only to what may be called routine service—beneficiary changes, policy loans, and the like. In these fast-moving days there are increasing needs for nonroutine service, which appears to be generally haphazard. Surveys of policyholders by Life Insurance Agency Management Association and by individual companies support this conclusion. As an example, in our company we have found that too many policyholders have been paying substandard extra premiums beyond the time that they should have been required to do so because of failure on the agent's part to maintain awareness of the situation.

MR. ALBERT E. REAVILL: The Connecticut Mutual operates on the general-agency system. We have 840,000 policies in force on the lives of 588,000 policyholders. Those policies are serviced by our 1,348 full-time agents and 3,271 first-line brokers.

In addition to policyholder requests and routine servicing initiated at the agency level, several special situations which require personal contact with the policyholder are reported to the soliciting agent or to a servicing agent, in the case of orphan policyholders.

Premium payments, for instance, are collected through the agency of record. Overdue payments are followed up by the agency with a final notice to the policyholder and notification to the soliciting or servicing agent.

Service reminders—containing the date, type of coverage, name of insured, and policy number—are sent by the home office to the agency of record shortly before such occasions as (1) the expiry of the conversion period for term policies and riders, (2) the expiry of renewable term coverage, and (3) the expiry of each option period under a guaranteed insurability agreement.

Reminder letters are sent periodically on policies with out-of-date income agreements to initiate a review of their provisions and promote policyholder contact. These are always sent through an agency sufficiently near the policyholder to be of service. When a policyholder moves out of the territory covered by his agency of record, an abbreviated record card—containing such information as policy number, plan, amount, date of birth, and name and address—is sent to the agency covering the territory to which he has moved. At that time, an agent is assigned to

contact the policyholder, but, if premium collection is not transferred, future service reminders would be sent to the original agency.

Assignment of servicing agents is controlled by our general agents. One file of policy records in agency offices is organized by agent. From that file, a terminating agent's policies are immediately available for reassignment. Orphan policyholders, not reassigned at that time, would be assigned to a new agent on any of the occasions referred to above. There is no compensation involved for a servicing agent, however, except for new business generated.

These services described are provided by manual systems now in operation. Eventually, I expect that most, if not all, will be automated. We already have some specific plans in that direction. For instance, we plan to have our home-office computers automatically generate status reports for agencies in such situations as:

1. Change of address to a new agency territory.
2. Interim and final conversion dates of term coverages.
3. Expiry of renewable term coverages.
4. Option dates under guaranteed insurability agreements.
5. Age changes at selected ages.
6. Premium reductions.
7. Expiry of children's coverage.
8. Inquiries to the home office from persons other than our agents or agencies.

Wherever possible, we plan to indicate the name of the soliciting or servicing agent, to eliminate reference to agency files.

The status reports to be sent when a policyholder moves to a new territory should encourage more record transfers, but we also plan to record the new agency on home-office records. Other status reports would normally be sent to the collection agency, but we could send them to the policyholder's new agency, on approval of the original general agent.

To facilitate the co-ordination of a policyholder's complete insurance program, we plan to record a servicing agent on home-office records for referral of future status reports. This will be especially useful for orphan policyholders. Due to the volume of file maintenance which could be involved, we plan initially to limit the recording of servicing agents to those who have made a subsequent sale to the policyholder.

Although we would have the ability to prepare a list of policyholders whose soliciting or servicing agents had terminated, we do not plan to do this in the near future, since it could conflict with servicing-agent assignments made at the agency level.

Eventually we might provide general agents with the capability of recording servicing agents, even temporarily, directly on home-office

records. At that time, we could periodically prepare complete lists of orphan policyholders.

Although this project is still in the planning stage and may require further revision, we now envision it as the most useful servicing tool that we can provide at this stage of our electronic development. We expect that it will be an effective means of placing adequate and timely information in the hands of as many policyholders as possible.

MR. WILLIAM M. SNELL: At Northwestern Mutual, the basic tool for policyholder service in the field is what we call our PSC, or policy service card. This card is prepared by our computer whenever there is a transaction which changes any of the information on the card. The card is very complete, with cash and loan values, loan and dividend balances, and all other pertinent information except beneficiary and title information other than a single digit code.

This card is prepared in duplicate and sent to our agency offices. The original is filed in the agency office in place of the old card. The duplicate is for the agent. This is the heart of our service to policyholders, as we are approaching the goal of having all of these service cards assigned to some active agent, whether or not he wrote the policy in the first place.

This system puts the information needed for service into the hands of an active agent who is available to answer inquiries when they arise. In addition, and probably more important, the daily receipt of these cards is a stimulus to service in itself. The details of the transaction that caused the new card to be produced are shown on the card. While most of the cards are prepared because of a premium payment or other more routine transaction, the transactions that indicate a possible need for service are also brought to the attention of the agent as they occur.

All of this works fine as long as the policyholder is still a resident in the territory of the agency which is receiving the cards. Unfortunately, since we transfer records upon an address change only if we are requested to do so, we have a sizable number of policyholders living in a territory other than the one which is receiving these service cards. This means that these policyholders get little or no service from the field.

To help in this area, we are doing two things. First, we are trying to move to a more automatic transfer of records when policyholders move to another territory. Whether we will be able to get our field force to agree to such a change is still a question. In the meantime, we do have another procedure that helps to service these policyholders. We furnish, whenever it is requested by an agency, information on all policyowners who reside in that agency but who are being serviced by some other

agency. This information can be in the form of lists or cards, and it can be by city or county. It stimulates more transfers of records, better service to these policyowners and best of all, more sales.

All in all, we are very happy with this service card in the hands of our agents. Once we put beneficiary and complete title information on the card (and we are planning this step now), some of us feel that this will obviate the necessity of moving to a real-time system in the future.

MR. JAMES B. COPPLE: Throughout our policyholder-service work, the emphasis is on the agent and the local agency office. Although some requests for service come directly to the home office, we try to funnel all transactions through the agency office so that the agent will have an opportunity to call on the policyholder personally if he so desires. This is true even of such routine transactions as cash loans and cash dividends.

If the agent who sold the policy leaves the company, the general agent designates an active agent to provide service for the policyholder. If the policyholder moves out of the original agency's territory, the home office notifies the agency in the territory to which the policyholder has moved and supplies certain information about the policy. The agent in the policyholder's new location is usually happy to receive a lead of this kind and calls on the policyholder to offer service and to inquire whether he wishes policy records and collection of premiums transferred to the local office. Obviously, this has a double advantage of providing local service and also giving the agent who receives the lead a prospect for additional insurance in many cases.

To compensate the agent for providing policyholder service, our agency contracts are designed so that a substantial part of the agent's income is in the form of service fees. All compensation after the third policy year consists of service fees—in general, 7½ per cent in the fourth and fifth years and 3 per cent each year thereafter. The fourth- and fifth-year service fees are vested in the event of the agent's death or disability; service fees for the sixth to the tenth years are also vested if the agent dies or becomes disabled after ten years of service.

Otherwise, a service fee is paid for a given policy year only if the agent offers or renders service during the preceding policy year. About a year before the applicable anniversary month, the agent receives a list of all the policies on which he may qualify for a service fee in the anniversary month. For each policy number on the list, the agent makes a written notation of the service offered or rendered, and he reviews this record with his general agent just before the anniversary month. The general agent approves and certifies to the home office the policies on which service fees are to be paid.

In general, a service fee is paid only to the original agent. However, if the policy lapses and is reinstated by another agent more than 46 days after the premium-due date, the reinstating agent may be designated as the agent of record and qualify for commissions and service fees if the original agent is no longer under contract. If the reinstatement occurs more than one year after lapse, the reinstating agent may become the agent of record whether or not the original agent is still under contract.

MR. MUNRO: Our current method of initiating better service to policyowners is through a service memorandum prepared each year one month prior to the age change: these are distributed by the branch-office staff and the manager to the assigned agents. The orphan business resulting from the termination of an agency contract as well as the transfers of business from one district to another will usually be distributed according to the discretion of the manager to an active or new agent who is best qualified to service the policyowner. The transferring policyowner will receive a welcome letter from the manager, but no formal reporting-back procedure is in operation so far as the servicing agent is concerned.

The service memorandums are also used in connection with maturing endowments, policies becoming fully paid up, and term insurance expiries, as well as on the occasion of other privileges, such as interchanges or conversion. Some of these also involve direct notices to policyowners. Service memorandums may also be produced for the branch office at other specified times, such as possible conversions of term benefits during a sales campaign or for notification of an extension in conversion periods on family-income-type riders.

Service to existing policyowners is considered a good investment and pays off handsomely in new business. During 1965, 38 per cent of new policies and over 50 per cent of new volume came from old policyowners. The average amount of the new policies exceeded $19,000 from the old policyowners as against $11,000 for new clients. Persistency studies show much better persistency on business written on old policyowners. These apply to business written by our ordinary field staff.

The trend in agents' survival rates has not been particularly satisfactory. For each of the past eight years, the survival rate for the first contract year has varied from 59 to 65 per cent. This is to be compared with the preceding eight-year period during which the survival rates varied from 70 to 89 per cent. We are now hiring younger men in a very highly competitive market. Moreover, our production standards are higher, and we reach decisions earlier with respect to those who are not measuring up.

IMPLICATIONS OF TITLE XIX OF THE 1965 SOCIAL SECURITY AMENDMENTS FOR THE PRIVATE HEALTH INSURANCE BUSINESS

The panel will present a summary of the provisions of the Title XIX and of existing or proposed state legislative implementation of Title XIX.

There will follow a discussion of the need for private health insurers to re-examine their plan designs, contractual provisions, underwriting rules, and marketing techniques in the light of Title XIX implications.

San Francisco Regional Meeting

CHAIRMAN ROBERT N. POWELL: Title XIX is the relatively unknown title of the Medicare legislation enacted in 1965. The careful watching of the Medicare legislation was accompanied by a failure of many to see, study, and recognize the implications of what Congress was doing simultaneously in connection with Title XIX. This is the companion legislation to the well-known Medicare bill. Title XIX has very aptly been named the "Sleeping Giant."

Our plan this morning is to ask two of our members, Mr. Walter L. Reynolds and Miss Josephine W. Beers, in addition to myself, to lay the general framework of reference in relation to Title XIX. After we have made our presentations, the topic will be opened for general discussion. Walter Reynolds will lead off the discussion.

MR. WALTER L. REYNOLDS: Title XIX of the Social Security Amendments of 1965 makes possible a vast extension of government medical care for large segments of the population below age 65. It permits the states to expand, with matching federal funds, the concept of medical assistance for the aged and extends that concept to several additional classes of needy persons, including (1) the blind, (2) persons eighteen years of age or older who are permanently and totally disabled, (3) children under the age of 21, and (4) relatives with whom children under 21 are living.

There are three important concepts in Title XIX: (1) the scope of the benefits, (2) the definition of the persons eligible for the benefits, and (3) the formula for determination of the matching federal funds.

1. *Scope of the benefits.*—In order to qualify for federal matching funds, states which adopt Title XIX plans must, after July 1, 1967, provide for the inclusion in their state plan of at least the following minimum services:

a) Inpatient hospital services (other than services in an institution for mental or tuberculosis diseases).

b) Outpatient hospital services.

c) Other laboratory or X-ray services.
d) Skilled nursing-home services (other than services in an institution for mental or tuberculosis diseases) for individuals 21 years or older.
e) Physicians' services in the office, the home, a hospital, nursing home, or elsewhere.

In addition, states may provide for the inclusion of many other items of medical service, such as home care, private-duty nursing, prescriptions, dental care, eye examinations and eyeglasses, diagnostic and preventive services, and transportation costs. These additional services are optional with the states until July 1, 1975, but from that time on they must all be included. The broader the services covered and the more they cost, the greater will be the amount of federal matching funds provided.

2. *Definition by the state of persons eligible for the benefits.*—The law gives each state considerable latitude in determining how broad the definition of persons to be included in the medical assistance program will be. As a minimum, by July 1, 1967, in order to qualify for continuance of federal matching funds under Kerr-Mills, medical assistance must be made available to all individuals receiving money payments under public assistance programs, and all children under age 21 must be included who would, except for age or not attending school, be eligible for money payments under the public assistance plans. For the aged on public assistance, the state must pay the premium for Part B Medicare coverage and cover the deductible, coinsurance, and services not covered by Medicare.

In addition, if a state wishes, it can go further in including medically needy people who do not qualify for public assistance. It must include such medically needy people by July 1, 1975, but may do so sooner if it wishes. The state, not the federal government, establishes its own definition of medical indigency and may provide the benefits of the program to medically indigent people in the five classes previously referred to—the aged, the blind, the disabled, the eligible children, and the relatives with whom such a child is living.

In defining medical indigency, states are prohibited from establishing any limit on income to make any individual ineligible. It is not clear whether a limit can be set on resources. The theory is that it is possible that an individual with a very high income may have medical costs beyond his ability to pay. Therefore, income in excess of the level required for maintenance will need to be tested against the individual's medical costs to determine whether he is medically indigent. In its letter to the state agencies, the HEW Department has pointed out that, in

determining its definition of medical indigency, the state must establish money amounts, exclusive of medical costs, applicable for an individual and for families of varying sizes, as a definition of a minimum to be protected for basic maintenance. These amounts must be at least as great as the most liberal public assistance standard used in the state as long as the standard is comparable or is made comparable. HEW adds that, in its opinion, the figures now in use in many states for qualification for public assistance are too low. The more generously a state defines medical indigency, the more it will spend on medical assistance and the greater will be the amount of the federal matching funds.

3. *Formula for determination of the matching federal funds.*—The provisions for federal financial sharing in the costs of state programs are generous. For a state with per capita income at the national average, the federal government will provide 55 per cent of the funds. The formula will vary from state to state, depending upon how its per capita income compares with the national average. States with high per capita income will receive at least 50 cents of federal money on the dollar; states with lower than average per capita income will receive up to a maximum of 83 cents of federal money on the dollar.

In order to qualify for continuance of federal matching funds, there are three key dates:

a) By July, 1967, the five mandatory medical services previously described must be included in the program and eligibility for needy children may not impose an age requirement less than 21. These two requirements must be met for federal matching funds to be provided beyond July 1, 1967, under a Title XIX program.

b) The current provisions of law pertaining to public assistance matching funds will terminate upon the adoption of a Title XIX program by a state, but in no event later than December 31, 1969. In other words, if a state has not adopted a Title XIX program by December 31, 1969, the federal government will cease its current financial support of any existing public assistance program.

c) By July 1, 1975, states must have broadened their programs so that they cover substantially all persons who are medically needy in accordance with the state's standards of medical needs, and the range of services must be broadened to cover substantially all medical care and services.

The full range of medical care and services provided under the plan must be provided without deductibles, coinsurance, or other charge to the patient who qualifies for public assistance. If the state additionally extends eligibility to the medically indigent, any deductible, coinsurance, or other charge to the individual must be reasonably related to the recipient's income or resources.

It is evident that there is a financial incentive for states to establish Title XIX programs and that those states who do will have considerable flexibility and latitude in deciding exactly what sort of program they will establish. For example, a state might reimburse the provider of medical care of service directly without any *insurance* program, or it might set up a state "insurance" program that would effectively eliminate coverage by private carriers (insurance company, Blue Cross–Blue Shield, or group practice prepayment plans) of these segments of the population. Another possibility is that a state might operate its own insurance program but contract-out the administration function to one or more private carriers, as is contemplated for Medicare. Possibly the states could proceed, so as not to eliminate private insurance coverage, by subsidizing the payment of premiums for the medically indigent part of the population.

It is evident that Title XIX will encourage states to establish programs which will qualify for federal grants of matching funds and that these bills pose an important potential threat to the continuance of voluntary health insurance. Industry committees are researching these problems in an effort to reach association policy. Individual companies will have to consider the questions also and reach their own company policy.

The basic questions appear to be:

1. *Scope of services.*—It appears that Title XIX does not restrict medical care to a "subsistence level" which is any lower than the broad range of medical care available to those who can afford to pay. In other words, Title XIX would permit free choice of physician and access to any degree of medical care and services which is adjudged to be necessary, such as private rooms, private-duty nursing, expensive drugs, and so forth. Although public assistance money for food, shelter, and clothing is not geared to the luxury level, it appears that Title XIX contemplates no such distinction in the case of medical care. Are we prepared to oppose adoption of this generous set of benefits by a state as it acts to establish its Title XIX plan?

2. *Eligible classes.*—

a) Do we oppose extension by a state of eligibility for benefits beyond the classes of persons eligible for public assistance to the classes of medical indigents contemplated by Title XIX? If not, how generous a definition of medical indigency are we prepared to support?

Title XIX provides incentive for states to establish generous definitions of medical indigency that will qualify more people for the generally unlimited benefits. In turn, this may generate political pressures for the states to ex-

tend eligibility to persons who do not qualify for federal matching funds, so that the entire population can be eligible. However, if the definition of medical indigency (income less medical expenses) can be held at or near the public assistance level, there may be little adverse effect on the insurance market.

Furthermore, Title XIX is not without benefit to the insurance industry, since its minimum benefit requirements will substantially relieve the hospitals of their charity budget. Presumably, the hospitals will be fully reimbursed at going rates for the services that they perform for public assistance and medically indigent patients.

b) Do we oppose still-further extension of eligibility under a state's plan to classes that would not qualify for federal grants of matching funds? For example, to medically indigent families that do not include a dependent child under 21, or a definition of medical indigency that was based upon the family spending more than a specified percentage, but less than 100 per cent, of its excess funds on medical care? By excess funds, I mean excess over the amount of income required to be protected for basic maintenance, as defined in the HEW state letter. (The California Cal-Med plan appears to incorporate both of these extensions.)

3. *Form of state programs.*—Do we prefer that state programs for those on public assistance, or for the medically indigent, take the form of:

a) Direct provision of medical care by the government?
b) A program of government "insurance,"
(1) Administered by the government?
(2) With administration contracted out to one or more carriers?
c) Government subsidy of payment of premiums for private insurance?

4. *Availability of private insurance to all who can afford to buy it.*—

a) Should the industry be taking steps to make sure that insurance is available to all who can afford to buy it; for example, by establishing an assigned risk pool so that no applicant need be rejected?
b) Should the industry be taking steps to raise the level of private insurance benefits (group and individual) so that they are at least as generous as Medicare; at least as generous as Title XIX, in that they cover the full scope of benefits, except possibly for deductible, coinsurance, and other schedule limits?

CHAIRMAN POWELL: There is a financial incentive under Title XIX for the various states to act and to act quickly. In California, a bill—A.B. 760—was proposed in 1965. It passed the assembly but was defeated in the senate.

A.B. 2 was also passed by the assembly and defeated by the senate. The reason for defeat was that the Medicare bill, Title XVIII and Title XIX, had not been passed by Congress, and therefore ground rules under which the state program would have to operate were not known.

After Congress completed its work on Medicare, in the second special session of 1965, the California legislature proposed A.B. 5, which was passed by the assembly and the senate. It is this piece of legislation that Miss Beers will tell us about now.

MISS JOSEPHINE W. BEERS: A number of the thought-provoking questions raised by Title XIX have become academic with respect to the state of California. This state lost very little time before volunteering to serve as a guinea pig for the potentials implicit in Title XIX. By November 15, the famous Casey bill had been enacted and now, supplemented by the regulations added to the California Administrative Code, constitutes the California Medical Assistance Program effective March 1, 1966.

No one can learn what is provided by reading the Casey bill by itself. Lists of potential benefits and potential recipients of potential benefits are hedged by too many phrases such as "to the extent feasible" and "within the limits of available funds and in accordance with federal law." Also, the director is specifically empowered to prescribe and change the scope of the services to be provided and to alter the conditions for eligibility.

However, from reading that bill, I have the definite impression that the intent is for the director to exert every effort to see to it that, at all times, the program is generous enough to require "the total of state and county funds which will secure the maximum federal percentage to which the state would be entitled—plus the amount of such federal funds which the state would thereby receive." Stated more altruistically, the intent is to provide "to the extent practicable—for basic health care for persons who lack sufficient income to meet the costs of health care and whose other assets are so limited that their application toward the cost of such care would jeopardize the person's future minimum self-maintenance and security."

The recipients of such health care—both the recipients of public assistance and the newly recognized medically indigent—are to have free choice of doctors, hospitals, and so on. They are not to be forced into county hospitals or otherwise discriminated against purely because of their "economic disability."

What is to be provided, and to whom, has been developing gradually since the middle of November. The most up-to-date information that I have obtained is in Title 22 of the California Administrative Code. Two groups of eligible people are recognized: (1) public assistance recipients, including those actually receiving assistance under the pro-

grams in effect prior to March and those who might have been receiving assistance except for certain technical requirements or for not having applied, and (2) all other residents unable to pay for adequate medical care *except* single persons between the ages of 21 and 65 and couples between those ages who have no children under 21 and who are not totally disabled.

A formula will be used by the county welfare department to determine a person's inability—total or partial—to pay for his own medical care, and an I.D. card will be issued (monthly, I believe) to show that a person has been declared medically needy and what, if any, share of his medical costs should be paid by him. The medical costs to be provided are those in excess of the benefits under any governmental plan such as Medicare or any "enforceable contract" of insurance or prepaid health care (the social worker will encourage the applicant to retain and make full use of any insurance he may carry).

The benefits as of March 1, 1966, for the public assistance recipients are, with few limitations, the comprehensive benefits which Title XIX describes as the ideal package to be achieved within ten years. The same benefits will be available to the medically needy while hospitalized. Their out-of-hospital benefits will cover the full range of medical and preventive services but will be available to them only during a ninety-day period following discharge from a hospital or convalescent home or during a preoperative work-up.

Currently, the benefits are being paid by the California Physicians' Service and Blue Cross. The law specifies that "after December 31, 1966, such care shall, to the extent feasible, be provided through a system of prepaid health care or contracts with carrier." As Walt Reynolds has suggested, we should be giving serious thought to the extent that it will be feasible for the insurance companies to participate.

I understood Mr. James Brown of the Southern California Blue Cross to estimate recently that this program will have very little immediate effect on our health insurance market, for it applies to people who carry very little private health insurance. Our insureds are largely among the group not eligible at this stage. I will leave it to Mr. Powell to suggest what we should try to do for them.

CHAIRMAN POWELL: The well-publicized proposal known as Cal-Med is a product of California's Assembly Speaker Jesse Unruh and his staff. It was stimulated by the adoption of Title XIX of the Social Security Act last year and was first unveiled by the Speaker to a small group of industry and labor representatives in his office on October 5, 1965; since

then it has been given a great deal of publicity. The Assembly Rules Committee recently appropriated funds for an extensive legislative study during the balance of 1966, looking toward introduction of a bill in 1967. All comments are, of course, based on the preliminary work of Speaker Unruh and are subject to modification as this proposal evolves during the next year.

The proposal applies to the total population of California. It is designed, according to Speaker Unruh, to stimulate the purchase of private health insurance by every resident of California up to his reasonable financial ability to do so. Each individual and each family unit would be expected to devote a fixed percentage of his or its annual income to the purchase of health services. This is called "participation expense." Amounts expended upon health insurance premiums, either directly or by an employer or union on behalf of the individual or family unit, would count toward this "participation expense." The extent of health insurance that a person would be expected to purchase would increase as family or individual income increased.

At the time of medical expense and after satisfying the participation-expense requirement, the state through Cal-Med would pay a percentage of the excess medical services expenses which were not covered by private health insurance or prepayment plans. This percentage payment is called the "absorption ratio" and would vary from time to time, depending upon the availability of funds in the Cal-Med "pot." The absorption ratio varies inversely with income level, being highest for low incomes. If an individual had not purchased private health insurance, he would still be eligible for assistance from the Cal-Med program after he had met his participation expense, but the absorption ratio would be much smaller than that for the person who had purchased the adequate health insurance policy. For example, a family of five persons with an annual income of $5,500 would have a 6 per cent participation expense (or $330) and would have a Cal-Med absorption rate of 60 per cent of excess medical expenses beyond benefits received from prepayment plans. The absorption rate would only be 10 per cent in the absence of a medical prepayment plan.

Present coverage, under A.B. 5, to the welfare recipients and the medically indigent would be continued inasmuch as no participation expense would be required of such persons and the absorption ratio for them would be 100 per cent. The proposal currently requires the purchase of health insurance policies by the state for welfare recipients and the medically indigent.

As originally proposed, claims payments would be handled through banks and other financial institutions. Banks were suggested for this

purpose because it was also proposed that such institutions would be induced to make consumer loans, where feasible, to cover that portion of expenses neither reimbursed by private insurance nor covered by the absorption ratio. There was even discussion of a state guaranty fund to guarantee such loans. However, more recently the thinking of the Speaker's staff appears to be more related to the utilization of existing health insurance claims paying agencies for claim processing.

The claims paying agency would be linked with a central state computer system where the individual's Cal-Med entitlement would be stored. The entitlement information in storage would be developed from a special Cal-Med supplement to state income tax returns which all persons in the state would be required to file (even though they were not otherwise required to file an income tax return).

The only recognition in the Cal-Med proposal of an individual's or family's resources is that each $25,000 of assets is equivalent to $1,000 of additional income. This, of course, would increase the participation expense and reduce the absorption ratio. This limited recognition of resources may prove to be a troublesome point when Cal-Med is discussed with the federal authorities. It is probable that additional recognition of resources will need to be taken into consideration by Speaker Unruh and his staff.

The Speaker, in a recent speech to the Public Health League, expressed the philosophy of his proposal as follows:

> For those above the poverty line, Cal-Med provides a sliding scale of benefits based on a sliding scale of need. Most people will be expected to pay for their own normal health needs—but they will have protection against catastrophic illness and Cal-Med will not force citizens to the poverty line before they can receive this help.
>
> Secondly, Cal-Med extends the proven prepayment mechanism as the most desirable means of distributing and organizing resources for health care. Cal-Med works a fiscal conversion of existing public health care moneys into premiums for private prepayment plans. A prepaid health care plan is not only the key to free choice, it is also basic to health care self-sufficiency. Since the majority of the population must provide for their own basic care, Cal-Med will contain a strong incentive system to encourage people to buy high-quality prepaid plans.
>
> Thus Cal-Med can become the long sought "single door" for public health care in California. Cal-Med is not a categorical patchwork approach. The relationship between income and medical needs will be the only determinant of benefits.
>
> Finally, Cal-Med seeks an alternative to the welfare system of administration and proposes the use of insurance and lending institutions for handling the paper work.

This proposal has enormous implications for the private health insurance industry. Following the process of study and refinement during the balance of this year, it is almost a certainty that there will be legislation introduced in the 1967 legislative session. Its exact form cannot be predicted, but it will undoubtedly build upon the proposal as outlined above and the philosophy as expressed by the Speaker and quoted above.

Sixteen other states have implemented Title XIX either legislatively or by regulatory action. These states are:

Connecticut	New Jersey	Pennsylvania
Idaho	New York	Texas
Illinois	North Carolina	Vermont
Maine	North Dakota	Virginia
Minnesota	Ohio	
Nebraska	Oregon	

Each of you should carefully watch the development of such legislation in the rest of the country as well as in your domestic state.

Those of you who have a deep interest in Cal-Med, may obtain copies of their prepared material from the office of Speaker Unruh in Sacramento.

With this framework of reference as a background, I now invite further discussion from the floor.

MR. LAWRENCE MITCHELL: I heard the administrator of the California Health and Welfare Agency speak in Los Angeles recently. He said that under the California A.B. 5 program (Title XIX) this year they expect to cover 2 million of the approximately 19 million people in California—1 million under Group I, all recipients of social welfare, and another million under Group II, "the medically needy." He estimated the first year cost as over $600 million, compared to the $200 million cost in 1965. According to him, this will not cost the state any additional money because (1) the federal government is paying part of it and (2) the moneys were being spent in this area anyway!

There is a feature in Title XIX which requires that the state program be "progressive" and that by 1975 it must include all other costs. With A.B. 5 now providing inpatient and outpatient medical care, dental and psychiatric care, and even preventive medicine (annual physical examinations will be mandatory among the recipients), it appears as if the major progression will be in the definition of who is to be covered. Presently the medically needy are defined according to the definition of the indigent blind—a single person earning less than $133.50 per month

with less than $1,500 personal property grading to a family of seven with less than $465 per month earnings and $3,000 personal property.

Who will be considered "medically needy" next year?

CHAIRMAN POWELL: I have a publication here put out by the state which outlines the California medical assistance program and which shows the 2 million population figure. To be precise, it is 2,261,000, and this excludes persons who are potentially linked to any one of the five categorical aid programs.

Since I have dependent children, I have a potential linkage to the aid to dependent children program and, in the event of serious financial catastrophe, my understanding is that I could conceivably qualify under this program as a medically indigent individual.

There are also some very detailed cost figures in this report that would be of great interest to actuaries as they watch the development of this program.

MR. WALLACE R. JOYCE: We in Canada are very interested in this discussion even beyond the effect that it might have on our insurance operations in the United States. We have to be very seriously interested in all the social security developments in the United States because we are much too close to be unaffected by your legislation.

Our problems are closely related to those in the United States. The effect of a federal form of government is not very different in Canada from the United States, at least in some applications.

Perhaps it is a feature of the federal system that the public thinks that what the federal government provides will be paid for by somebody else and is not going to have any impact on their own pocketbooks. A provincial or state government that sees a chance of introducing legislation that will bring in income from the federal government will do its utmost to get the maximum income. This has been stated here this morning, and I have seen it operating in Canada under similar situations.

Most actuaries are concerned about the cost of social security benefits. One can become very disturbed with regard to where it is all going to end and whether we will ever reach the point at which the public begins to realize that somebody has to pay for these benefits.

I do not think that actuaries can do any greater public service than to draw attention to the cost of the program and the fact that the costs of these programs do come out of the public's pocket eventually.

MISS BEERS: Another aspect of A.B. 5 relates to the establishment of a study group for the systematic review of health insurance contracts as to benefits and grading of premiums.

In the bill, which is now law, a Health Review and Program Council is established consisting of eleven members appointed by the governor, five of whom shall be members of the health profession. The Council is directed by the Health and Welfare Agency. The director of social welfare, director of public health, director of rehabilitation and the director of mental hygiene are ex officio members. This Council performs functions such as planning for the development of a comprehensive program of medical care for all medically indigent persons by 1975; promoting the most efficient use of available health facilities, in co-operation with professional associations; comparing the medical care given under this chapter with accepted and predetermined standards of care for the purpose of reducing morbidity and mortality and improving the quality of care; reviewing the needs for systematic grading of health insurance prepayment plans; and so forth. There are all sorts of potentials involved here.

MR. ROBERT A. McCORKLE: I am the actuary for the California Physicians Service—Blue Shield. Our participation has been more administrative than actuarial. The figures quoted to you this morning by other speakers will give some idea of how much larger the program we administer is now than it was in the past. This happened on March 1, and suddenly we tripled our fifth-floor duties.

Ground rules are constantly changing, and we find that people who are comfortable doing the groundwork one minute, in the next find that they are on completely strange territory. They go to their supervisor, who has just come from a meeting where everything that he thought was clear has now become clouded, ask him questions of clarification, and find that he needs a little time in order to get himself straightened out.

I have a document dealing with "medicine in transition." It states, "Rhetoric of indignation and resentment cannot take the place of knowledge and vision." This is directed not at us, not to the federal and state bureaucrats, but to the medical profession. The points made have tremendous implications for our business and for the medical profession. Vast changes are going on in our civilization. Objectives that will, according to the report, eventually be implemented are:

1. The passing-out of existence of charity and county hospitals and the melding of all hospitals into the total of community resources.
2. An opportunity to provide high-quality medical care to all people regardless of their ability to pay.
3. Main-stream medical care—nonsegregated by reason of economic disad-

vantage. Everybody is going to be treated in the same kind of hospital by more or less the same kind of medical practitioners that everyone else has.

4. Continuity of care—regardless of source of payment.

MR. WILLIAM R. BURNS: How do we solve the problem created by those who are financially able to secure private insurance, but who fail to do so? Are there any teeth in the Cal-Med program that would require such persons to purchase their own insurance?

One would expect that a certain percentage of people in this category would fail, for whatever reasons, to avail themselves of private insurance. Should such a person suffer a catastrophic illness, then he may find himself in the position of being covered under the state program to the extent of only 10 per cent of the cost, while he would have to come up with 90 per cent of the cost from his own funds. This could produce an indigent person from a person who should be able to cover himself medically, partly through private insurance and partly through his own funds.

It seems as though these are some problems that we must solve over the course of time. There are, on the one hand, medical indigents who will be entirely taken care of and, on the other hand, there are nonindigent persons who, for whatever reasons, do not secure their own private insurance.

I am concerned with this broad spectrum of persons who are financially able to purchase their own private insurance but fail to do so. Neither program seems to cover adequately this area, at least according to my understanding. It is possible that this deficiency can be met only through the institution of a strictly compulsory and universal government medical care program. Such a program would, of itself, have many grave deficiencies.

CHAIRMAN POWELL: If I were Speaker Unruh trying to answer that question, I might say that the program is not mandatory but that it has very strong incentives built into it. Premiums toward the prepayment plans count in the participation limit and the absorption percentage or ratio grades off very steeply if a person does not have a prepayment plan.

MR. MITCHELL: There are some who wonder what will happen to the aged sick person who discovers that he is not covered under Part B. I do not think that really is a problem for us. Rather, it will be handled in a political nature just as the enrolment period for Medicare was extended. If anybody turns up who is not covered because of the limitations on benefits, or because he became sick and forgot to or could not pay his Part B premium, or because he forgot to enrol in the first place,

some regulation will be drawn to cover this unfortunate person. Remember, Medicare is not a normal health insurance scheme; it is a social insurance venture, and the normal rules do not apply.

MR. GORDON R. TRAPNELL: I notice that there is a tendency to view Title XIX exclusively as a threat to private insurance markets. However, there is another side to this that I would like for you to think about.

Among those who would like to see all medical services for all age groups provided through social security, there are those who are looking at this program in the same way in which they looked at the Kerr-Mills program. If they find that the care provided indigent people is not up to their standards, they are likely to cite this as a failure that can only be solved by the government's taking over the problem.

CHAIRMAN POWELL: In concluding the panel presentation, I would like to leave with you some questions and comments to wrestle with:

1. What can be done about nonduplication of benefits insofar as Title XIX is concerned?
2. How do you define subsistence level of medical care under Title XIX?
3. How far do you go in providing levels of medical care under Title XIX?
4. Should we oppose extension by a state of eligibility for benefits beyond the classes of persons eligible for public assistance to the classes of medical indigents contemplated by Title XIX? If not, how generous a definition of medical indigency do we support?
5. How do we provide coverage to that group of persons who are unable to obtain private health insurance? Should we consider the concept of an assigned risk pool?
6. Cal-Med is an example of what we are going to have to cope with. It is an area that we in our company have deemed sufficiently important that we have a committee of three vice presidents who are working on the subject, following the development of it, and helping to formulate company policy on it. We are also working with other companies and with health insurance industry people.

Washington Regional Meeting

CHAIRMAN RICHARD J. MELLMAN: The 1965 amendments to the Social Security Act included three sections that affect private health insurance. First there is Title XVIII, commonly known as Medicare, which provides coverage to persons aged 65 and older. Second, there are the provisions which modify the definition of disability required for social security disability benefits. Third, there is Title XIX, which some have called the "Sleeping Giant" because it was the least

noticed of the three sections but has the greatest potential impact on the insurance business.

Title XIX involves a government medical care program for the lower-income segments of the under 65 population. By providing federal matching funds, it encourages states to establish broad medical care coverages for the indigent and medically indigent. (The term medically indigent will be defined by the next speaker.) Title XIX will, within a few years, completely replace and enlarge the Kerr-Mills programs.

The Health Insurance Association of America assigned one of its subcommittees last fall the project of studying the problem of extending adequate health protection to *the uninsured* and *the underinsured,* viewed in the light of the enactment of Title XIX. The subcommittee has just completed its study and has submitted its report to the parent committee and to the HIAA board of directors, which will consider it at its May 16 meeting.

After analyzing the problem and considering possible solutions, the report concludes with a final section which consists of recommendations for insurance industry policy with respect to (1) governmental programs for the medically indigent and (2) the role of private insurance for the balance of the under 65 population. Each insurance company that writes private health insurance will also have to determine its own company policy with respect to these two questions.

Our panel this morning includes three members of that subcommittee. Mr. Joseph Crimmins will lead off by discussing the provisions of Title XIX and of existing and proposed state legislative implementation of it. Next, Mr. James Purdy will discuss the need for private health insurers to re-examine their plan designs, contractual provisions, underwriting rules, and marketing techniques in the light of Title XIX implementation. Then I will describe another facet of our subcommittee exploration. Following these three presentations, we will throw the meeting open to informal discussion and questions from the floor. At this time, may I introduce Mr. Crimmins.

MR. JOSEPH B. CRIMMINS: The method of financing health care in the United States has been revolutionized in the past two decades, as voluntary insurance for hospital and medical expenses has expanded rapidly. Twenty years ago, insurance benefits covered only a small part of health expenditures. Today they pay one-fourth of the nation's total health care expenses, insured and uninsured. Insurance pays a much higher proportion of those health bills which are difficult to provide for in the typical family budget, such as hospital charges. In 1964, insurance

benefits met 69 per cent of the consumer expenditures for hospital care.

During the same twenty-year period the proportion of personal health care expenditures financed by government funds has shown little change. Tax funds, used to care for those in the lowest-income groups, represented slightly more than one-fifth of the total spent for health care during these years.

We are now in the midst of another revolution, set off by passage of the 1965 Social Security Amendments. The thrust of this new movement is toward enlargement of the groups entitled to tax-supported medical services and far greater government financing of health care. The 1965 legislation, Public Law 89-97, created two new programs whose eventual impact on the country's system of medical care and the health insurance industry is difficult to calculate. Title XVIII—Medicare for the Aged—will provide basic hospital care, liberal coverage of physicians' services, and other benefits for 10 per cent of the population. Title XIX—Grants to States for Medical Assistance Programs—envisions a much broader program of "comprehensive care and services" for a group which it is estimated could be at least 20 per cent of the total population.

Under Title XIX, federal funds will be provided to encourage states to build up the health services presently offered the needy and to expand the definition of those eligible to receive health care at public expense. Earlier legislation made federal funds available to states for medical assistance provided to recipients of old age assistance, aid to families with dependent children, aid to the blind, aid to the permanently and totally disabled, and medical assistance for the aged. The provisions in the earlier legislation governing these public assistance programs, and the limits on federal funds available, vary by program. Under the new Title, states will establish a single medical care program for the needy to consolidate the differing programs. They will receive additional federal funds for medical care under a single matching formula, and there will be no maximum on the amount of medical expenditures subject to federal sharing.

States may start this new program any time after January 1, 1966. They are required to replace existing public assistance medical care programs with this more comprehensive program by January 1, 1970, if they wish to continue receiving federal aid for medical care.

No ceiling is placed on the scope, amount, and duration of medical care services that the states may furnish in this new program. However, after July 1, 1967, the program must include, as a minimum (1) inpatient hospital care, (2) outpatient hospital care, (3) physicians' services, (4)

skilled nursing-home care for adults, and (5) laboratory and X-ray services. Provision of other services, such as drugs, dental care, and eyeglasses, is optional with the states. States are required to pay the deductibles under Part A of the Medicare program for aged recipients of public assistance. They may also pay premiums for Part B.

Benefits of the new program must be made available to persons receiving financial assistance from the federally aided public assistance programs—the indigent aged, blind, disabled, and families with dependent children. After July 1, 1967, children in the latter category must be considered eligible for medical assistance until they reach age 21, regardless of any earlier age set by the state to determine eligibility for financial assistance.

In addition to the indigent, states may include the "medically indigent" in the program; that is, the federal government will share the cost of providing medical assistance to aged, blind and disabled persons, and members of families with dependent children who are able to meet other expenses on their own but need help in paying for medical care. States may also include all other children who could not qualify for public assistance but whose families cannot afford to pay for their medical care.

The concept of "medical indigency" is a rather elastic one. To define the indigent—those who lack sufficient income and resources to secure an objectively defined minimum standard of living—is a relatively clear-cut procedure. To determine medical indigency under Public Law 89–97, it is also necessary to take into account the costs of needed medical care, which are unpredictable. This requires establishing a level of income and resources deemed necessary to maintain a specified standard of living. Any family below this level is presumed to require assistance with medical expenses. A family whose income exceeds this level is also considered to be medically indigent if its income above the established level is less than its medical expenses. Consequently, no matter how high a family's income may be, the family may "slide into" medical indigency if its medical costs are sufficiently high. (This is a somewhat simplified statement of the methods used to determine medical indigency. In actual practice, separate levels of income and resources are set for family units of various sizes, and the resources to be taken into account may be defined in a variety of ways.)

The level of income and resources established for use in determining medical indigency is generally higher than the level used in determining eligibility for financial assistance under welfare programs. The precise level established depends upon value judgments as to the extent to which

individuals should be responsible for their own health care and the priority which health care expenditures should be given in the family budget.

Some advocate a very generous definition of medical indigency. For instance, certain groups in New York proposed to set the annual income level at $8,850 for a family of four. They held that if such a family should incur medical expenses of $200, for example, society is obligated to pay the bill, because payment of their own medical bills would cause the family to reduce their normal expenditures for other items—they would be medically indigent.

If large segments of the self-supporting population are declared to be in need of public assistance in meeting medical expenses, because medical indigency is loosely defined, the result will be that a major portion of the financing of health care will be shifted from the private to the public sector. This seems to be the goal of some who apparently do not regard Title XIX as an extension of public assistance but rather as a step toward eventual establishment of a national health service. The latter was not the intent of Congress. As the *New York Times* stated in an editorial on April 18, the program of medical aid "was not meant to be a back door to universal health care at public expense."

To continue to receive federal funds for this new program, a state must demonstrate that

> it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care.

This mandate to provide, by 1975, comprehensive medical care and rehabilitation services to all the medically indigent, regardless of whether they come under the categories for which federally aided public assistance is available, is significant. It greatly enlarges the population which is potentially eligible. "The new program could ultimately bring government aid for payment of medical care to over 35,000,000 people," according to a statement released March 31, 1966, by the Department of Health, Education, and Welfare.

At the end of the first quarter of 1966, Title XIX programs were in operation in six states—Hawaii, Illinois, Minnesota, North Dakota, Oklahoma, and Pennsylvania—and Puerto Rico. In these jurisdictions, 1.3

million persons now receive public assistance. However, the new programs will make medical care services available to an additional 7.4 million persons. In Puerto Rico nearly two-thirds of the entire population is expected to be eligible, and in Minnesota about half the population will be eligible.

All these programs will provide benefits not only to public assistance recipients but also to all persons who, except for having enough income for their daily needs (as defined by state assistance standards) could qualify for public assistance under the federally aided programs. The programs in Hawaii, Pennsylvania, and Puerto Rico also cover other adults who are medically indigent. However, no federal matching funds are available for medical assistance to this latter category.

In Illinois and North Dakota, children between 18 and 21 who would be eligible for aid to families with dependent children, except that they are over 18 and/or not attending high school or taking vocational courses, are eligible for medical assistance. In the other five jurisdictions, eligibility is extended to all children under 21 who could not qualify for public assistance but whose families cannot afford to pay for all or part of the cost of the medical care the children need.

In these programs, the amount of income and resources people have, as well as the cost of the care they need, will be taken into consideration in determining their eligibility. In the eligibility requirements of the first seven Title XIX programs, the income level established for a family of four ranges up to a maximum of $4,000. Annual income at or below the levels indicated in the accompanying tabulation is generally considered under these programs as sufficient only for maintenance and not available for medical care.

MAINTENANCE LEVELS FOR ELIGIBLE PERSONS

	Single	Family of 4
Hawaii	$1,440	$3,000
Illinois	1,800	3,600
Minnesota	1,600	2,800
North Dakota	1,600	2,800
Oklahoma*	1,728	2,448
Pennsylvania	2,000	4,000
Puerto Rico	1,500	2,600

* Maintenance levels are for eligible persons living in own home.

SOURCE.—*Title XIX Fact Sheets*, issued by United States Department of Health, Education, and Welfare.

Each of these programs will provide benefits in addition to the five basic services listed in Public Law 89-87—inpatient hospital care, outpatient hospital care, physicians' services, nursing-home services for adults, and laboratory and X-ray services. The federal share of the cost of these seven programs for the calendar year 1966 is expected to be approximately $237 million.

Plans for Title XIX medical assistance programs in New York and California are pending approval by the federal government. Legislation enacted in California provides for a broad range of services for public assistance recipients and the medically indigent. According to provisions of the law, the annual income regarded as necessary for maintenance of a family of four, exclusive of special needs, is $3,432. In addition, after January 1, 1967, individuals will be eligible for assistance in the case of catastrophic illness or accident, when the uninsured cost of required care exceeds 50 per cent of the annual adjusted gross income of the individual and his immediate family. The law requires the state, "to the extent feasible," to contract with private carriers to handle the administration of funds.

The program in New York was held up by disagreement within the legislature. The Republican-controlled senate and Democrat-controlled assembly passed conflicting bills. Two major points of difference related to administration of the program and the eligibility requirements.

The senate bill placed administration in the Department of Social Welfare and provided that the Department of Health should establish and maintain standards for hospital and related services and advise the Department of Social Welfare on standards for all noninstitutional medical care. The assembly bill made the Department of Health responsible for administration of the program, with applicants' eligibility to be determined by the Department of Social Welfare.

The senate bill provided that eligibility standards should be established administratively by the Department of Social Welfare. The latter proposed a maintenance income level of $5,700 for a family of four. Specific eligibility standards were written into the assembly bill, which gave full coverage for a family of four with income up to $6,700. In addition, the assembly bill contained a catastrophic illness provision similar to that in the California legislation.

According to the Department of Health, Education, and Welfare, it is hoped that Title XIX programs will start in 1966 in at least 19 other jurisdictions. These include such populous states as Connecticut, Kentucky, Maryland, Michigan, Massachusetts, Ohio, and Washington. Action taken by the individual states to implement Title XIX, and par-

ticularly the standards adopted for determining medical indigency, will have a major impact on the future of private voluntary health insurance.

CHAIRMAN MELLMAN: You may be interested in the degree of federal financial assistance provided by states under Title XIX. It ranges from $0.50 of federal reimbursement for each dollar spent to $0.83 of federal money for each dollar spent, depending upon the average per capita income in the state. High-income states, such as California and New York, can have their expenditures matched 50–50 by the federal government; low-income states, like Mississippi, in the ratio of $0.83 of federal money, $0.17 of state money on the dollar.

Our subcommittee report recognizes the right of all Americans to medical care. We support the principles of Title XIX *provided* that the definition of medical indigency is held at *or near* the public assistance level. HEW intends that for the indigent, Title XIX will have no deductibles, coinsurance, or schedule limits but recognizes such safeguards for the medically indigent, commensurate with their ability to pay. Even for the poor, some modest deductible such as $1 per office visit would appear to be desirable to discourage overutilization by hypochondriacs. You may have heard the story of the little lady who secured full coverage under such a program and thereafter began appearing every day in her doctor's office with some different minor complaint. Every day, when she got to the front of the waiting line, the doctor spent two or three minutes with her reassuring her and sent her on her way. One day she wasn't there, nor the next, nor the next. After two weeks she reappeared and, when her turn came, he said, "Mrs. Jones, I've missed you; why haven't you been to see me?" and she said, "Well, to tell you the truth, doctor, for the last two weeks I haven't been feeling very well."

With that, I give you our next speaker, James Purdy.

MR. JAMES L. PURDY: My comments will be directed to the second part of the discussion concerning the need for private health insurers to re-examine plan designs, contractual provisions, underwriting rules, and marketing techniques in the light of Title XIX implications.

Before you heard Joe Crimmins' comments, you might have asked why it is necessary to give so much attention to these points since we have always had numerous welfare programs which have not seemed to encroach upon the insurance market to any great extent. Clearly, however, the concepts presented in Title XIX are a substantial departure from existing public assistance for vendor medical payments which are generally tied to total income.

Within this framework then, it would seem that the insurance industry's basic goal is to prevent, where possible, medical indigence through the spread of private health insurance. Private health insurance constitutes one of the major bulwarks against medical indigency. Our most important role continues to be, therefore, the insuring of all of those persons who can be reached by private insurance and who can afford to pay for their coverage or on whose behalf someone such as the employer is willing to pay.

Who, then, are those persons that can be reached by private insurance and who might be able to pay for it themselves or have someone pay for part of it for them? Studies made by the Comprehensive Coverage Subcommittee of the Health Insurance Association of America ascertained that there are as many as 10 million individuals earning $3,000 a year or more who, presumably, have need for health insurance of some kind.

In the appendix to this discussion, I include an analysis which delineates the composition of the uninsured population in more detail. Included in this number are over 4 million persons apparently employed in clerical and service occupations. Also note that there are an estimated 142 million people under age 65 now covered by private programs. If anyone is interested in the sources underlying this data, I would be happy to meet with you after this session.

A simplified breakdown of the categories we must cover results in three primary areas:

1. Persons now covered but with inadequate benefits.
2. Persons who would like to obtain coverage but cannot due to various underwriting restrictions of both group and individual programs.
3. Persons who are not eligible for group insurance and have not bought individual insurance.

The first and largest category is perhaps the easiest to reach with conventional insurance programs. Aggressive sales activities directed toward bringing benefits up to the levels contained under Medicare will go far toward preventing medical indigency as it may be defined by various state assistance plans. As Joe Crimmins pointed out, there are already indications that a few of these plans have set limits at a point where full-time employed people could qualify for assistance.

As to the second category, insurers should consider reductions in contractual and underwriting limitations to the extent possible so as to make insurance available to more people. In particular, under group programs the following provisions should be reanalyzed:

a) Evidence of insurability requirements which may prevent certain employees and dependents, such as late entrant applicants, from obtaining group coverage.

b) Service waiting-period requirements which prevent new employees from obtaining group coverage immediately.
c) Lack of conversion or continuation provisions which deprives employees who are between jobs of coverage.
d) Limiting age provisions which exclude children below or above specified ages, even though they may be dependent upon the employee.
e) Restrictive eligible class definitions which exclude certain classes of employees from group coverage.
f) Pre-existing condition exclusion clauses.
g) Provisions for termination of coverage on surviving dependents upon the death of the employee.

In the individual insurance, too, a variety of contractual provisions and underwriting safeguards operate to limit the availability of adequate coverage. Among them are evidence of insurability requirements, use of waiver or pre-existing condition exclusion provisions, age limitations, and renewal option provisions. There are already indications that some insurers have revised their thinking in some areas as a result of Medicare.

Of course, these provisions were designed to reduce antiselection and maintain reasonable costs; however, a strong deterrent to antiselection may be found through overinsurance provisions, such as the co-ordination of benefits provision now common to most new group contracts.

Industry efforts, therefore, should be directed toward not only a broader use of the group co-ordination of benefit provision but encouragement of a more general enactment of the model overinsurance standard for use in individual policies. Extensive use of this effective barrier against overinsurance could markedly dampen the effects of liberalized underwriting safeguards, particularly as more people become aware of this provision.

I will not dwell here on some of the detailed contractual provisions that may require change for administrative reasons except to point out that some of the problems which have arisen as a result of the passage of Medicare are also present with respect to Title XIX. For example, the treatment of services under the C.O.B. provision may well need revision since there could be many situations in the future where group plans are co-ordinating with liberal Title XIX plans.

The most challenging market for the industry represents those persons who have not bought individual coverage and are not eligible for group coverage. Included here are proprietors of small business concerns, agricultural workers, household workers, and self-employed persons.

Obviously, broad, complete, first-dollar coverage at very low cost is not practical; however, efforts directed toward plans providing protection aganist substantial medical expense at rates with the low expense ratios

of group insurance would go far toward reducing the likelihood of medical indigency. To the extent that legislative restrictions dampen marketing products of this type, industry efforts should be directed toward obtaining relief.

Some of the occupational groups not now covered extensively might very well be promising if sufficient market research were undertaken and new distribution methods employed.

I have not touched on those uninsurables who cannot obtain insurance under any circumstances, as I believe that Dick Mellman will comment on that group subsequently.

Unfortunately, no one can outline a solution to all the effects on the industry as a result of Title XIX, particularly since much depends on the specifics of the programs that finally emerge from the various states. Hopefully, however, these comments will serve to generate further comments.

APPENDIX

COMPOSITION OF THE CIVILIAN POPULATION UNDER 65 YEARS OF AGE WITH RESPECT TO HOSPITAL EXPENSE INSURANCE COVERAGE, UNITED STATES

JULY 1, 1965

I. Total civilian resident population		191,900,000
Population 65 years of age and older		18,100,000
Population under 65 years of age		173,800,000
A. Total persons with private coverage	153,000,000	
Persons 65 years and older	11,000,000	
Total persons under age 65 with coverage		142,000,000
B. Persons under age 65 without private coverage		31,800,000
1. Do not need or may not want private coverage		14,430,000
a) Covered under public programs	13,135,000	
b) May not want coverage for other reasons	1,295,000	
2. With assumed need for coverage		17,370,000
a) Those in families with income of less than $3,000 and who are not included in 1, *a*	6,700,000	
b) All other persons	10,670,000	
C. Per cent of total civilian population under 65 with assumed need for coverage		10.0%

II. Categories of population under 65 who do not need or may not want coverage		
A. Public assistance recipients		5,742,000
1. General assistance	663,000	
2. Aid to the blind	95,000	
3. Aid to families with dependent children	4,429,000	
4. Aid to the permanently and totally disabled	555,000	
B. Inmates of institutions		1,375,000
1. Under 14 years of age	150,000	
2. 14–64 years of age	1,225,000	
C. Dependents of military personnel		4,000,000
D. Indians and Alaska natives		400,000
E. American merchant seamen		118,000
F. Domestic migratory workers and their dependents		300,000
G. Veterans eligible for government care		1,700,000
H. Physicians and nurses		830,000
1. Physicians	260,000	
2. Nurses	570,000	
I. Religious groups		290,000
1. Jehovah's Witnesses	230,000	
2. Mennonite bodies	60,000	
J. Persons feeling no need for coverage for reasons other than shown above		175,000
K. Total, A–J		14,930,000
L. Less duplication		500,000
M. Net total persons under 65 who do not need or may not want coverage		14,430,000
III. Categories of population under 65 with assumed need for coverage		
A. In labor force		10,700,000
1. Unemployed	1,200,000	
2. Employed	9,500,000	
a) Professional, proprietors and managers, excluding farm	1,500,000	
b) Clerical and sales workers	1,300,000	
c) Operative and service workers	2,800,000	
d) Craftsmen, foremen, and kindred workers	1,200,000	
e) Private household workers	600,000	
f) Farmers and farm managers	600,000	

g) Farm laborers	700,000	
h) Laborers other than farm and mine	800,000	
i) All other occupations	(Nil)	
B. Dependents of the uninsured labor force in need of coverage		7,500,000
C. Total of A and B		18,200,000
D. *Less* duplication between II and III		5,000,000
E. Net Total (C minus D)		13,200,000
F. Other persons		4,170,000
G. Total with need for coverage		17,370,000

CHAIRMAN MELLMAN: There is a third facet of the problem which I would like to cover briefly—the problem of whether and how we can extend private health insurance to the uninsurables. This is the most difficult part of the uninsured problem, those who, from an underwriting standpoint, are uninsurable. Some sort of an assigned-risk plan appears to be a possible solution.

To this end, a subgroup of our subcommittee has been appointed and is at the present time exploring the feasibility of this and related approaches. The subgroup has an excellent composition. It is headed by Richard Hoffman, an expert in group health insurance. It includes Edwin Bartleson, who is expert in individual health insurance; two men from casualty companies who are knowledgeable about the assigned-risk concept in automobile insurance; and Cecil White, of the Metropolitan's Canadian office in Ottawa, who is expert in the Canadian techniques, such as the Alberta Plan, for providing private health insurance to the uninsurables. In addition, the subgroup is bolstered by the assistance of Joseph Follmann of the HIAA, George Watson, and Robert Seiler, who is assistant counsel of Allstate. We are hopeful that this group will be able to develop constructive and valuable recommendations.

The problem is immense, but I believe that we can be optimistic about the future of private health insurance if we can do the job that needs to be done and do it quickly. We are living in an age of creative federalism, in which the government and private industry can work as partners, but this implies that the government may move in to do the whole job if private insurance is unable to do the job for its share of the population, namely, those who are not medically indigent.

This concludes the prepared remarks. At this time we would like to open the session for either questions from the floor to the panelists or for informal discussion.

MR. DORRANCE C. BRONSON: I have two questions:

1. With the advent, by timetable, of Medicare (Title XVIII) plus the gradual coming of "indigent"-care (Title XIX), suppose events are such that the programs fail, or falter badly, and do not do the expected job. Who is going to get the blame in the public eye? Will it be (*a*) the intermediaries; (*b*) the service organizations; (*c*) the old whipping boy, the AMA; (*d*) the federal government (HEW); or, with regard to Title XIX, possibly (*e*) the state or local government?

2. This second question concerns potential competition between Titles XVIII and XIX, or competition *within* either program per se—to wit, which claimants and/or which services (by class) would have priority if beds (for inpatients or for extended care), or doctors or nurses, or other promised care items run dry (in whole or in part)? Note that this implicitly includes the question, Would Title XVIII people score over the "medical indigent" people of Title XIX, or vice versa? (I appreciate that competition does not exist between the titles *with regard to source of funds*. Medicare costs come from the HI trust fund fed by scheduled payroll taxes plus, for Part B [SMI], $3 per month [*initial*] matched "premiums," whereas Title XIX is supported from combined state and federal allocations under matching formulas.)

CHAIRMAN MELLMAN: It would be speculation on our part to attempt to predict who would be the scapegoat. Where an insurance company is the fiscal intermediary under Medicare, there is a good chance that it could get the blame, although the administration is well spread among a great number of carriers and types of insuring organizations in the fifty states.

In answer to the second question, for those over age 65, Medicare will cover them to the extent that they are totally without funds, and, if their state Title XIX program covers them, it is possible that the Title XIX will fill in the deductible, the coinsurance, and pay the $3.

MR. CRIMMINS: I think that there is an implication in the law with regard to Title XIX that the scope and the quality of services have to be comparable all the way for the indigent and for those who are classified as medically indigent. Thus, a state could not treat the indigent less favorably than any class of medically indigent. It could go the other way, but the indigent have to be at least on a par with those who are classified as medically indigent.

MR. PURDY: I believe that one of the implications of Mr. Bronson's question was whether the people receiving government funds for their treatment would receive priority from doctors, hospitals, and so forth, at the expense of the people who are not covered under public programs.

I am under the impression that the intent of Congress was to continue to have the doctor to be the primary determiner of who gets services. I presume that this would apply to both Title XIX recipients and also to Medicare people.

MR. RAY M. PETERSON: Last month I attended a meeting of the National Council on Aging in Detroit and a representative of HEW described Title XIX. He used a couple of figures of speech that I wish to share with you. He described Title XVIII as "just the tip of the iceberg." He described Title XIX as "simply a net to catch those who fail to get benefits from other sources."

CHAIRMAN MELLMAN: When a state establishes a Title XIX program, this is pretty much the end of charity medicine. The doctors in that state will then charge the poor their reasonable and customary fees. The poor will have free choice of hospitals so that, in general, the charity city hospital will tend to integrate its patients throughout the community. The same will be true for other hospitals in the area. This is all on a reasonable and customary fee basis with free choice by the patient of doctor, hospital, and so forth.