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EMPLOYEE BENEFIT PLANS

Group Long-Term Disability Benefits

What is the impact on group long-term disability insurance of the 1965 changes in OASDI with reference to such matters as:

A. Effect on market for private insurance?
B. Underwriting considerations?
C. Policy provisions?

CHAIRMAN JOHN R. WILLIAMS: Any increase of benefits or liberalization of the definition of disability on the part of the government plan naturally decreases the amount of coverage that can be sold by private carriers. I doubt that the 1965 changes have had any profound effect on LTD business, but the constant upgrading of the social security benefit level certainly tends to erode our market. I do believe that the relatively high level of federal benefits has caused the large labor unions to ignore long-term disability benefits to some extent. The unions have negotiated disability benefits in conjunction with their pension plans, and, with this supplement to the federal benefits, they have seen little reason to negotiate separate LTD plans. This will probably continue and will leave us with the salaried employees as a market.

From an underwriting view, the increase in benefits and the higher probability of receiving benefits due to liberalized definition make it more imperative to integrate our plans with social security for the full amount of benefits.

With respect to policy provisions, the main consideration is whether or not our policies should be written to conform to social security definition. Over the years we have always been fearful of being forced to follow suit if social security approved disability claims. Up until the present time, however, they have been extremely strict in their claim approvals, so that we find ourselves approving total-disability claims that have been denied by social security. This may now change, so insurance carriers may or may not want to be consistent with the social security definition.

I have given pretty short answers to the questions, so perhaps I could take the time to outline the Lincoln's view on long-term disability. We have very few cases on the books, the reason being that our rates are substantially above the rates being used by the casualty companies and a few of the life companies. We believe that it is difficult to compete with the casualty companies on this type of coverage due to their different claim

facilities and practices. The casualty companies, especially those with large volumes of workmen's compensation business, have extensive claim and rehabilitation facilities that are almost totally lacking in the life company operation. Also, the casualty companies rarely make monthly payments over long periods of time. They will instead seek to make lump-sum settlements. Even with seemingly identical contracts, we believe that there is some justification for the lower rates being charged by the casualty companies, and we are not sure that we can match them—not, at least, unless we change our claim-payment philosophy, which we are currently unwilling to do.

MR. ABRAHAM M. NIESSEN: You made the statement that the increase in benefits, including present and possible future increases, may decrease the demand for private insurance coverage for long-term disability. It is my impression that, following an increase in social security benefits and railway retirement benefits, there is a larger demand for private insurance and pension arrangements.

CHAIRMAN WILLIAMS: I based my statement on the fact that labor unions have not negotiated for long-term-disability benefits and are therefore apparently satisfied with the level of benefits that they now have. They now have fairly adequate benefits combined with social security benefits that result in a fairly high percentage of take-home pay being covered for disability. I feel, therefore, that this market has been shut to us.

MR. RICHARD B. SIEBEN: There were two comments made at the San Francisco meeting on the same subject that made a strong impression on me. The first was that of Mr. Ken Clark, who found it rather difficult to be too concerned about the effect of the social security changes on the benefits of the 5 million people covered by the policies that we have sold when there are another 55–60 million employed people not covered. The second comment involved the effect of the increased social security benefits upon an integrated plan. These plans are often heavily contributory, sometimes employee-pay-all. Now the social security benefits are rising to a level where we need to be concerned about the equity of the contributions in relationship to the benefits that the individuals can actually collect under our insured plans.

MR. GEORGE J. VARGA: I would like to have an explanation of Mr. Williams' comment that it was not possible to approach casualty company rates without adopting some of their claim-payment philosophy.

CHAIRMAN WILLIAMS: I was referring to the practice of making a lump-sum settlement of a long-term-disability claim. I feel that these settlements are made on a basis less than the reserve which would otherwise be set up and that the company would eventually pay out less in benefits. I do not especially criticize this, as it is one way of doing business and the settlement made is agreed to by the disabled person.

Group Medical Expense Insurance

What are the implications of Medicare on group medical expense insurance with reference to such matters as:

A. Benefit structure for (*a*) new business and (*b*) existing business? Is there any evidence of increase in benefit levels for persons under 65?

B. Claims administration?

C. Group conversions?

MR. RICHARD B. SIEBEN: The questions of this topic were set several months ago, and they may not be directed to the Medicare questions foremost in your mind at this date. Perhaps a review of the impact of Medicare on at least one major group operation will properly set the stage for a discussion of the current and future implications. If I had to summarize the impact of Medicare on our operation to date in one word, I would be tempted to say "catastrophic"!

In those carefree, panicky days of last summer, Medicare was a virus, infecting only a few ivory-tower planners. We considered philosophical questions. Could we, in good conscience, insure the gaps in Medicare, thus destroying the very controls and sound insurance principles that we had so ardently supported; or, must we eagerly market a variety of supplements in order to somewhat neutralize the predictable pressures for further expansion of Medicare benefits? To fill the gaps would be hypocritical. To refuse to fill them would be suicidal.

However, the infection spread with time, and Medicare activity reached disease proportions, disabling key people in all phases of our group operation. We debated how we would insure the gaps rather than whether we would fill the gaps. Should we supplement or integrate? How would COB work? Should we enthusiastically promote supplementation or should we supplement reluctantly after all efforts to completely eliminate coverage for Medicare eligibles failed? Would we supplement for cases of all sizes? How important was uniformity, and how big a case would qualify for nonstandard treatment? Every time that we made a decision, someone would return from an industry meeting with two new questions that we had not anticipated.

Finally, the pressures to do something and do it fast became irresistible. With all the rational faculties available to a patient with a temperature of 104, we established our approach. We would first recommend elimination of all coverage for Medicare eligibles, on the theory that the sum of benefits available to them was probably in excess of the benefits available to employees under age 65. However, recognizing that this would not always be the case, we offered two types of standard supplemental plans. These

were of the "add-on" variety rather than the "carve-out" type. One is a basic plan that filled in the dollar gaps in hospitalization benefits. The other meets the benefit gaps with a major medical approach.

All but the smallest cases would be permitted to choose one or both of the plans. Rules were established concerning premium changes. Neat little lines were drawn defining cases where deviation would be permitted. We even began drafting nonstandard forms in anticipation of the maverick cases.

All decisions were made by February, and we uttered a collective sigh of relief. The patient had survived. After all, hammering out the approach was the hard part. Implementation would be sticky, but that July 1 deadline would force an end to it. We had been educating our field force, our agents, and our clients for months, and they were eagerly waiting for our expert opinion on what to do. So we told them.

A funny thing happened on the way to July 1—nothing! Some clients did arrive at decisions and sign riders; and we did expect slow returns at first, even though either a field man or an agent had called on every client. But we expected a flurry of activity to develop as July 1 approached.

It is now June 2. Of those clients permitted a decision, only a third have made one. The early returns have been dominated by cases deciding to provide no benefits for Medicare eligibles by a 9 to 1 ratio. However, it is unlikely that this will continue, since many clients are considering alternate approaches.

The disturbing thing about the no-decision cases is that I have the feeling that many of them are not going to make any decision at all. In spite of all the noise on this subject during the last year, a know-nothing philosophy seems to prevail. They are not sure how it is going to work—or if it is going to work. They are going to wait and see.

Concern over Medicare has now reached epidemic proportions. If all the cases with decisions pending act this month, we will have administrative chaos. If they do not, we will be paying claims. COB offers substantial relief, but there will still be too many cases with real overinsurance hazards. Moreover, we do not feel that COB is the final solution, and we expect to be involved in implementing Medicare riders for another year as cases renew.

The union cases may remain unresolved even longer. I am sure that you have all met the client whose hands are tied until bargaining is reopened in 1969.

There is also the southern client, who presents a special problem. The latest report that I have is that only one-third of the hospitals in the deep South have been accredited by social security. Accreditation requires a

statement of compliance with Title VI of the Civil Rights Act, which means that hospitals with segregated staffs, training facilities, or admission practices are ineligible for reimbursement for Medicare patients. Thus, many clients in the deep South want to maintain private coverage.

Thus, in spite of all our preparations, Medicare continues to have new implications every day. I have called its impact catastrophic, because of the tremendous drain on the time of key personnel over the past year. Never have so much talent and money been spent to decrease our total premiums.

One of the real effects on new business has been to hurt it, since our field force has been distracted by the revision work and our home-office personnel have been disabled in their ability to perform their normal service functions. There has been surprisingly little effect to date on active life benefit patterns. However, I feel that the Medicare pattern will soon give a boost to employee benefit formulas—particularly in the nursing-home and home-care areas.

The problems in claim administration are hypothetical so far. In any event, I am sure that the variety of contract language will be beyond our expectations, and this will complicate the task. The number of cases making no changes will increase the number of COB types of claims.

In the area of accident and health conversions, our benefit formulas were sufficiently modest to obviate the need for any supplementation. The practical problems of reapproaching individual policyholders in the event of future Medicare changes convinced us that terminating conversion policies at age 65 was the wisest course of action.

In summary, in the parlance of last night's successful Surveyor moon landing, Medicare has not made a soft landing. There has been an impact, and at times it feels as though the dent were made by an object traveling at 6,000 miles per hour.

MR. ROBERT H. DREYER: It would seem that a relatively small indemnity plan to supplement Medicare benefits could prove advantageous, particularly to a small company. Many people are looking for some form of supplemental benefits to offer without creating overinsurance and without producing any adverse effects on Medicare experience. The problem is complicated by the relatively few areas that are left uncovered by Medicare for which any substantial experience data are readily available.

One possible approach would be to provide a benefit of, say, $7 per day of hospital confinement for a maximum of 60 days, combined with a 50 per cent nursing-home benefit (following hospital confinement) for any unused portion of the 60-day maximum. Recognizing that most hospital

confinements will produce more expenses than will be reimbursed by Medicare, it seems unlikely that a nominal daily benefit will be sufficient to cause significant malingering or to give rise to substantial overinsurance. Determination of the benefit amount is largely a matter of judgment, and, if due caution is not exercised, poor experience will result. This suggests the possibility of doing some individual financial underwriting on groups containing fewer than ten lives over age 65. This approach also has the advantage in that it does not jeopardize the coinsurance feature of Medicare.

The most frequent argument against an indemnity plan is that it duplicates Medicare's hospital benefits. However, granting the existence of excess or uncovered expenses, it will be seen that the duplication is more apparent than real. Instead of producing any significant overinsurance, duplication, in this instance, provides a useful vehicle for circumventing an expense problem and allowing a small company to provide its group clients with a coverage that they have shown a desire for, at the most reasonable cost possible.

MR. J. STANLEY HILL: I would like to ask Mr. Dreyer if he could offer us his guidelines as to what represents a judicious cash indemnity that would not impair the deductible and coinsurance features of Medicare.

MR. DREYER: Although we have not made any direct studies of this point, it seems that this would vary by area, by the hospital facilities available, and in many instances by the particular group that you would be covering. It might be geared to be sufficient for a specific benefit, such as extra cost of a private room or one shift for a private nurse.

MR. DONALD M. PETERSON: I know that my company—the North American of Chicago—is looking into an approach that is very similar to that which Mr. Dreyer outlined. We do have a problem on one particular plan, which is entirely contributory, under which we are attempting to charge the same premium to both the over- and under-age-65 group, and we are providing the under-65 group with a daily hospital benefit of $22. We would have to give the over-65 group substantially more than $22 a day, which then creates serious overinsurance problems.

MR. ABRAHAM M. NIESSEN: Mr. Sieben indicated that Medicare was catastrophic to his company. I would like to ask him if these plans have been profitable to his company.

MR. SIEBEN: I represent Continental Assurance, and I believe that the question refers to the over-age-65 coverage that has been written by Continental Casualty. My reference to catastrophic was more to the point that almost all our key people have lost a lot of valuable time trying to be sure that we do not get trapped by some of the tricky problems that Medicare supplemental benefits can pose. I think of the regular business that we could have written with the same devotion of activity.

While I could not tell you what the profitability has been to Continental Casualty on their Golden 65 program, I am sure that you will be interested to learn that they have offered an alternate type of coverage and have re-enrolled something in excess of 60 per cent of their policyholders. This certainly indicates that they have preserved a fair block of that business.

MR. JAY M. JAFFE: What problems are anticipated with duplication of coverage where companies have not taken any action on Medicare and have employees over 65?

MR. SIEBEN: If the employer does not have a COB rider on his group contract, we will be paying duplicate benefits. However, although many of our cases have COB, we do not feel that this is the ideal approach, since it pays more money ultimately than a carve-out type benefit. You open up areas of coverage that you would not normally intend to pay for in your basic benefits.

MR. EDWARD J. PORTO: To what extent do you anticipate applying a governmental agency or government hospital type of exclusion to reduce payments where Medicare is applicable?

CHAIRMAN WILLIAMS: We have in all our contracts an exclusion for governmental institutions as such, but it more or less hinges on whether a bill is presented. Under Medicare, in all cases a bill will be presented so that we will have to pay duplicate coverage if the policy does not have a COB provision. It is interesting that a number of our insurance company clients do not seem to be any better than the rest of our clients with respect to this Medicare problem. There is a reluctance to take benefits away from their people on July 1 without being sure that they can get into the hospitals after that time. This is particularly true in the South. They have adopted a wait-and-see attitude.

MR. SIEBEN: There is also a third type of client, who just wants to do nothing because he is philosophically opposed to Medicare. To point up

the prevalence of this type, there recently was a front-page story here in Illinois in which a prominent doctor was accusing the insurance companies and the federal government of collusion to create a situation whereby the private individual would no longer get insurance when he was over 65.

MR. GEORGE J. VARGA: I wonder if you have looked into the implications of Title XIX on your group insurance.

MR. SIEBEN: The reference to Medicare today is limited to Title XVIII. As you know, Title XIX is another problem, and it will be discussed during tomorrow's program.

MR. RALPH H. GOEBEL: If the employer does not have coinsurance of benefits and the carrier is liable to pay duplicate claims, then cannot something be done at renewal by way of raising rates?

MR. SIEBEN: We had always assumed that there would be a few policyholders that refused to act until we had to force the issue at time of renewal negotiations. The volume is going to be much larger than we had anticipated.

MR. GOEBEL: Do you intend to be quite tough about this situation?

MR. SIEBEN: Certainly we do not intend to continue duplicating benefits without an additional premium. If someone is willing to pay what we think it will cost to provide this duplicate coverage, then we might be a little more interested in listening to them.

MR. NIESSEN: Although this is not on the subject currently being discussed, would anyone care to comment on whether insurance companies that will be acting as intermediaries anticipate any great difficulties in fulfilling their duties under this program?

MR. FREDRICK E. RATHGEBER: The Prudential is a Part B intermediary, and the answer to this question is "Yes." One of the problems that we had was to estimate what our cost would be for budgeting purposes. We also anticipate a problem on the question of fees of doctors. I guess one reason that we are intermediaries is that we are the buffer between the medical profession and the government on this question of fees. There are going to be other problems with nursing homes that we have not gotten into since this coverage is not effective for another six months. Another problem is that the claimants can demand a hearing if they do

not think that they are being treated right. We anticipate that there will be many requests for these hearings, and this might be quite an expensive thing to handle.

MR. SIEBEN: One positive thing on the nursing-home implication is that there has always been a problem in the variety of state laws and definitions of nursing homes. There is far less uniformity than there is in the area of hospitalization.

I believe that the existence of Medicare and the payment of benefits for nursing homes under Medicare will force a compliance with something closer to a model statute and will make it easier for the carriers to write the same contract in several states.

MR. EDWARD H. OWEN: If there is a hospital confinement and if the hospital is reimbursed through the Medicare procedures, do you contemplate that you may, nevertheless, get a bill for the full hospital charges?

CHAIRMAN WILLIAMS: We do not know, but we probably will. I think that many of the employers who want to continue their coverage unchanged would be satisfied without the duplicate coverage that they really do not want. They do want to be sure that their employees' bills are paid, but the problem is that it takes separate action on the part of the people above a clerical position in the home office. The whole trouble with this thing is that it gets very involved and staff-wise we are going to run into a few problems.

Separate Accounts and Variable Annuities

What are the volume and rate of growth of this business? What technical problems have arisen? What regulatory problems have arisen? What investment approaches have been taken? What is the investment experience?

CHAIRMAN JOHN R. WILLIAMS: The volume of this business has been rapidly increasing, although it tends to be concentrated in the very largest insurance companies. The Prudential estimates that it will have $150 million in separate account assets by the end of 1966. All companies combined may run as high as half a billion by the end of 1966. So far, most companies are using a fairly high volume requirement for eligibility for separate account sales. Our company uses $50,000 of annual premium now, but we started out at the $100,000 level. As these funds increase in size, we may bring this down to much smaller cases.

The technical problems have largely been caused by our lack of knowledge of the handling of unit values. This is not a difficult concept, however, but it does require precise accounting on a periodic basis.

Another problem is how "separate" the assets should be. We have used a different bank to hold our separate investment account securities, and the securities are held by a nominee so as to avoid confusion in dividend payments in cases where the same stocks are held by the Lincoln as part of our regular investment portfolio.

We are using a single account for all this type of business. We believe that this will result in a smoother operation of the plan and permit better management of the fund. We feel that if separate funds are maintained for specific employers, then the employers could feel that they have the right to dictate the investment philosophy to be followed. We feel that the employer should have the right to decide what portion of his fund should be invested in equities, but we are not so sure that the employer should select what common stocks we should purchase.

One advantage of having a separate investment account is that it is one of the first steps in writing variable annuities. Although we are not currently writing variable annuities, we felt that operating a separate investment account with all accounting done in units would provide a good background for a variable annuity operation.

The separate annual statement required for this business does cause some difficulty. We decided to use a zero gain-and-loss approach. We charge $\frac{2}{100}$ of 1 per cent of assets per month for investment expenses, or roughly $\frac{1}{4}$ per cent per year.

Regulatory problems with the SEC are almost entirely of a legal nature

and are covered very well in Arthur Blakeslee's article in Volume XIV of the *Proceedings*, Conference of Actuaries in Public Practice.

State regulation varies considerably. Some states have specific legislation, whereas other states have taken the attitude that their original laws were broad enough to permit separate accounts. We have had very few problems with states in filing our contracts with the exception of New Jersey. The attitude there seems to be that, if you have a separate investment account, you are automatically in the variable annuity business.

If a company is dealing in variable annuities, there is a problem in licensing agents as security dealers. I understand that the SEC is cooperating with the state insurance departments and has come up with a simplified examination that does not require the agent to become a securities expert. I do not know how well this is working out. Also, all promotional material has to be reviewed by the SEC, and advertising is virtually limited to the so-called Tombstone variety.

The Lincoln's single account is a 100 per cent common stock fund. As our fund was started at a time of relatively high stock prices, we have followed a fairly conservative approach and have a little over $2 million in separate account assets invested in about twenty-five stocks of "blue chip" character.

We started our fund in July of 1964 with a unit value of $1. By December 31, 1965, the unit value was $1.14. However, as of May 1, 1966, the unit value was $1.08 as a result of the declining market.

MR. MAXIMILIAN WALLACH:* I shall address myself primarily to the third item, which deals with regulatory problems. To say that there are many problems due to dual regulation and lack of uniformity in the approach to the regulation by the states is putting it mildly! Keep in mind that I am sincere and sad when I make this statement after almost ten years of experience on the state level in a jurisdiction in which two variable annuity companies are domiciled and some twenty companies are licensed to conduct separate account business. I have had the opportunity to observe the shaping—under great handicaps, I might add—of the separate account and variable annuity business, and over the last several months I have collected a wealth of material on the subject of the need for uniform laws and regulations on the state level. My research, covering thirty-one states, and my findings are incorporated in a paper delivered at the sixteenth Annual Meeting of the Conference of Actuaries in Public Practice (October, 1965, in New Orleans).

* Mr. Wallach, not a member of the Society, is actuary for the Department of Insurance of the District of Columbia.

In 1959, at the time of the Supreme Court decision of the VALIC case, there were no specific laws passed, even though variable annuities had been written in several states. By 1964, when the Supreme Court refused to hear the Prudential case, there had been thirty-four activities by the states (laws and/or regulations). By October, 1965, one or more laws and/or regulations were in operation in thirty-one states (this number now stands at thirty-six). In some states, several laws have been enacted, and some of the laws are still being amended.

The number of the activities reflects primarily quantity and, as such, a patchwork approach. Uniformity, per se, does not mean quality, but, even as of now, a sound approach to state regulation on a nation-wide basis has not as yet emerged. Dual regulation has not helped to find a common ground, except that SEC regulations have influenced the thinking of state legislatures and of state supervisory officials. It has hindered a free development. Due to this influence, a number of states have passed "half-way" instead of "full" measures—namely, separate accounts for pension funding requiring groups of twenty-five or more, fixed pay-out, prohibiting the use of employees' contributions, and so forth. Some of these states have since revised their thinking, true enough, but consider the loss of time, the demands on the legislatures, and strain on the insurance departments, as well as on the companies; last, but not least, the lack of even basic uniformity in thinking out needed model laws and regulations has still not been overcome.

MR. ROBERT D. KRINSKY: There are a number of companies offering IPG contracts where the purchase of annuities may be deferred for a long period of time (for ten years, or even indefinitely), and we are wondering whether these companies have run into any problems with the SEC or state banking departments.

CHAIRMAN WILLIAMS: I have not heard any rumblings, but we do not have any business in force of that nature where we are permitting them to go that long.

MR. SEYMOUR LAROCK:* Of the separate business so far, what proportion of it represents simply a transfer of existing business, existing DA business to separate accounts, and what proportion actually represents new cases?

* Mr. LaRock, not a member of the Society, is associated with Charles D. Spencer and Associates, Chicago, Illinois.

CHAIRMAN WILLIAMS: In our own case, I would say about half of our current assets have been transferred. Currently now, of course, it is all new money coming in, although we still have accounts that may transfer later. This may continue, of course, for some years.

I suspect that this is probably true of most of the business. The large share of it has been transferred because—well, this is just logical. So far, the bulk of this, say, roughly half a billion dollars of business, is heavily concentrated in the big eastern mutuals—Prudential, Equitable, Hancock.

MR. ERNEST R. HEYDE: We had about $25,000,000 in our separate account at the end of last year, which was our first year. About 90 per cent of this amount was received from existing contractholders, who diverted part of their current money into the separate account. There were no transfers of money into the separate account resulting from the cancellation of previously purchased annuities.

Every potential separate account situation merits intensive study. It is a new situation. The group annuity sales personnel must re-educate themselves before they can effectively participate in the solicitation of separate account business.

CHAIRMAN WILLIAMS: Incidentally, what I meant by the eligibility requirement being $50,000 is not that this amount has to be put into the separate account each year but that we will now go down to cases as small as those that contribute $50,000 per year in total to us, and we will not permit, however, more than half of the assets to be put into a separate account. So this would limit it to a $25,000 deposit.

MR. LAROCK: Most of the banks that operate collective trusts operate them on a two-fund basis, as you probably know—fixed-income fund and equity fund.

The only company that I know of that does this with their separate accounts is Union Central, and I am just wondering why the insurers have taken a position that seems to be contrary to the experience of the banks. Banks have been in the business about ten years, roughly, and most, even those that initially started out with one balanced fund, have gone to a two-fund or more setup.

CHAIRMAN WILLIAMS: First, the insurance companies have generally been able to do a little better than the banks on fixed-income securities. If you are on a new-money basis for your investment results on

group annuities, it does not make much sense to have the money put into a separate bond account.

We might get a little higher rate of interest on the trusteed fund, but, in return, we would have to tell the employer that his money is absolutely unsecured, as compared with his putting it in our regular DA account with a full guarantee of the principal and a guaranteed rate of interest.

The minute that we put it into a separate account, the state laws prohibit us from putting any guarantees on that money.

If you were an employer, then, for a relatively small differential in rate, why take the risk? So, it did not seem to us to make too much sense.

Now we may get into real estate. There are some types of investments where there may be better reasons to have a separate investment account. For example, a real estate investment account. But I would think that, as long as you are dealing in our normal types of investments, there does not seem to be a great deal of reason to have more than one separate account. That is our feeling. Does anyone else care to comment?

MR. FRANK T. YEN: I have a specific question on the very one you did, connected with the IPG and as opposed to retirement annuity only. We are aiming at transferring 50 per cent of the person's annuity at retirement to a variable annuity. Some time along the line, we have to transfer the money to a separate account. At what point would you think is the best time for the transfer?

CHAIRMAN WILLIAMS: The best time is when the stock market is low, if you take it out when the stock market is high.

MR. YEN: Now suppose that the stock market is high—for instance, now—and people are retiring right away. Then you are forced, you know, to do something right away.

CHAIRMAN WILLIAMS: Well, the point is that we are not trying to outguess the stock market in operating this separate investment fund. We would depend on long-term dollar averaging. The employer, under most of these separate account contracts, does have quite a bit of discretion about the timing of his deposits.

In our case, he can tell us, with each deposit, what percentage goes into each account, the fixed and the separate accounts. But we certainly do not urge the employer to try to again outguess the market. We want him to put in a consistent pattern of investing over the long period of years.

Also, the types of stocks that we are investing in are long-term growth stocks; they are certainly not of a speculative nature.

MR. YEN: Does this mean that you recommend on a 50-50 balance that of every contribution coming in 50 per cent would go to the separate fund right away?

CHAIRMAN WILLIAMS: That would be the best way, yes; and, regardless of the market at that time, the investment would be made immediately. I think that otherwise you would be in quite a bit of trouble with your clients.

MR. WALLACH: It has been stated that "cost of living benefits can be provided." If this refers to a benefit regardless of the cost, it can be provided under any arrangement. If, however, this refers to a benefit designed in such a way that the cost is borne by equity investment, a word of warning would seem to be appropriate.

Variable annuities, it is hoped, will offer a hedge against inflation over the long run. The emphasis is on the term "long run." There will be minor—or even major—differences between annuity payments (monthly or less frequently) based on separate accounts as compared to payments needed to match the purchasing power (cost of living). Furthermore, since hindsight is better than foresight, one should allow for the individual's conservative approach to investment. Let us keep in mind that the 50-50 approach (a variable annuity should be accompanied by a fixed annuity), as recommended by some economists and even required in some states, is really not foolproof. Also, the question arises why a combination (50-50, or whatever percentage) could not be achieved by separate accounts (more than one, of course, would be required; I call it the SUNOCO pump).

A statement that variable annuities based on an equity investment type of separate accounts would, per se, produce "cost of living" annuities should be avoided; such a presentation to the purchaser could easily be misunderstood.

May I quote Mr. William C. Greenough (*Life and Health Insurance Handbook* [2d ed.], p. 562):

> It has been said that, with "guaranteed" fixed-dollar annuities, the insurance company takes all the risks, and that with variable annuities the individual takes all the risks. Actually, with a fixed-dollar annuity, the individual takes the risk of inflation, and with a variable annuity, he takes the risks of poor performance and receives the full advantage of good performance of equity investments.

Mr. Samuel C. Cantor, second vice-president and general solicitor for Mutual of New York, in an article entitled "Group Variable Annuity Comes of Age" (*Weekly Underwriter* [January 8, 1966], p. 45), was extremely careful in pointing out that

annuity payments will vary according to the investment results of the underlying equity holdings. This conforms to the generally accepted view of what a variable annuity is. Variable annuity payments will fluctuate with the cost of living *if (and only if)* the investment returns achieved by MONY's Equity Investment Account also do so . . . and to this extent they offer the hope of protection against inflation. [Italics supplied.]

MR. RALPH H. GOEBEL: This is a question not so much with regard to the investment aspects as with regard to some of the actuarial aspects of a separate account.

I understand that, when you have a trustee pension plan, many times the consulting actuary will value the assets at cost in comparing that with the liabilities in order to determine what the annual deposit is for the coming year. On the other hand, sometimes they write up these assets to market value, or they take just the realized capital gains or something.

As insurance companies, we would operate the way trustee plans operate and value our assets at cost for certain purposes. This means that we have to keep an extra set of records, and I am just a little puzzled about that. Would you care to comment on this point?

CHAIRMAN WILLIAMS: I think that you will find that you have to keep a separate set of records. First, you will have funds operated where the valuation, at least, is being done by consulting actuaries, and they are free to make their own choice of whether they want to use cost or market or some place in between.

In our accounting, we keep track not only of the current market value of the fund, the unit value, but also the dollars as they come in and also the dividend income.

It would seem logical to carry the fund at the cost plus the dividend income each year. I think that, if you carry it at market, you are defeating one purpose of the plan. I think that the employer is thinking of a hedge against long-term inflation, and, if you carry the plan at market, then all you do is cut his current cost all the time and he has no hedge. If he can build up a difference between the cost and the market, that he can revalue at some future date, that is what he wants. So I think that it is necessary to keep two sets of books. I think that everybody is doing this.