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INSURANCE COMPANY REGULATION RESULTING FROM CONSUMERISM

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MR. GEORGE W. SHELLY: Disclosure and cost comparisons is a big topic and one that has been an area of controversy extending over the past several years. It is my observation that, in contrast to the legal profession, the actuarial profession is not generally comfortable with controversy. Those of us who have been caught up in the cost index problems seem to have responded in large part by inventing our own new indices and/or by spending our time tearing down somebody else's.

It would be nice if the problem would admit to some elegant mathematical analysis or statistical study which would objectively point us in the right direction. It has been concluded by most of those who have studied the problem that this is impossible. It is impossible for the same reason that no one has yet located the fountain of youth. The true cost index which will produce reliable cost comparisons simply does not exist. Hence, we have an infinite number of possibilities with one virtue or another and, unfortunately, an equal number of valid criticisms for each new index as it is invented.

There is no need to dwell on the complex correlation of one proposed index with another. A tremendous effort has been expended to this end. There are still two basic questions on which we should focus:

What is an index supposed to accomplish?
What do we think it will really accomplish?

As actuaries, we have a real responsibility to deal with this subject. It is, after all, an actuarial matter. If we cannot or do not contribute here, who will? Solutions developed by those who are not knowledgeable in both theory and practice usually fall short, with the result being something like the seat belt interlock system required for 1974 automobiles.

For more years than anyone knows, insurance has been sold on the basis of traditional net cost. This index answers the policyholder's natural question: How much do I put in and how much do I have in cash value at the end of, say, 20 years? It is good disclosure - probably a necessary one. It should certainly not be prohibited as a disclosure item.

As a cost comparison index, it does have a serious fault. It does not take account of when money is paid and when it is available as cash value. A

dollar of first year premium has the same impact as a dollar of twentieth year cash value. The interest-adjusted net cost index has been developed to meet this fault. Basically, this index accumulates the policyholder payments at some reasonable after-tax interest rate before comparison with the cash value. This was the index proposed and endorsed by the industry committee chaired by Mr. Moorhead. It corrects for the obvious fault of the traditional method. It is useful information as a part of the total picture of the comparison of two similar life insurance policies.

The interest-adjusted net cost index has been tentatively included as part of a model regulation adopted by the National Association of Insurance Commissioners (NAIC). This model regulation is in two parts - a deceptive practices regulation and a cost comparison regulation.

Except perhaps for its name, the model deceptive practices regulation is, for the most part, not objectionable. It requires a written proposal including the agent's name and signature, the name of the company, the name of the policy, and supplemental benefits with premiums and face amount along with a description of certain provisions which can reduce the death benefits. It prohibits a number of admittedly bad practices. It also contains a prohibition of the use of any system for cost comparison which does not recognize the time value of money. It is generally agreed that it does not prohibit disclosure of traditional cost figures so long as these are not for comparison with other policies.

The model cost comparison regulations require that 10 and 20 year interest-adjusted cost figures be made available to a prospect on or before delivery of the policy. These may be required only if the prospect requests them, or, alternatively, they may be required in all cases where a sale is made. An important feature of the model regulation is that an index figure need not be given for substandard issues or supplemental benefits. There are some other exclusions. The model regulations are stated as interim measures. Final regulations are still to be developed based upon input from a large number of research projects which are now complete. These projects will be discussed at a two-day seminar in Colorado Springs next week in conjunction with the Zone Five meeting of the NAIC.

To date, eight states have adopted some type of disclosure or cost comparison regulation. They are by no means uniform.

1. Wisconsin, Arkansas, and Oregon have their forms of both the deceptive practices and the cost disclosure regulations.

2. Kansas and West Virginia have versions of the deceptive practices regulation.

3. California and Texas require disclosure of interest-adjusted cost figures.

New York adopted Regulation 74 which is unique and somewhat confusing. The regulation itself would appear to prohibit traditional net cost figures. However, a decision accompanying the regulation suggests that traditional ledger statement figures can still be used along with the interest-adjusted cost figures or with a disclaimer that the traditional figures do not represent cost since they do not take interest into account.

At the Federal level there has also been considerable activity. Senator Hart's subcommittee has heard a lot of testimony and gathered a massive databank from questionnaires circulated to 195 companies. Much of the testimony came from generalist consumer advocates. As a result, attention was drawn to our industry's major and serious problems - high lapse rates, low agent retention, lack of agent freedom, and the failure to penetrate the low income

market. There was considerable focus on agent compensation. As a general solution, the subcommittee seems intent on bringing about a kind of competition based solely on price - hence, the emphasis on cost indices.

We are now at a point where eight states have some form of regulation. Federal regulation is a possibility. Even if no direct regulation results, the Federal effort will certainly provide stimulus and produce guidelines for the states to act on their own.

The NAIC Model Regulation will survive with relatively little change. The interest-adjusted cost index has much to recommend it as compared with the alternatives. However, I have real concern over the establishment of any government-endorsed index. This kind of index is apt to be overemphasized in the comparison of policies, rather than being taken as an important, but small, part of the total comparison. There are many good and valid reasons for competitive differences between companies. The cheapest is not necessarily the best.

For example, few companies classify insured lives in the same groupings. A broad standard class, which may be socially desirable, will surely lead to a poor index ranking. The same result comes from expensive high service standards. Operating in low income areas gives high expense, low average size, poor lapse experience, and, usually, high mortality.

The prospect is, of course, entitled to all of the information he can use in making an intelligent choice. However, the expense involved in implementing any complex and burdensome disclosure regulation is ultimately borne by the consumer rather than the company. Similarly, if the legitimate selling process is subjected to interference, it could mean less distribution of life insurance to a public which even industry critics agree is underinsured.

MRS. JOANN G. SHER*: We all know that fringe benefits, like other forms of compensation, must be made available equally to members of both sexes.

Employers charged with and desirous of providing equal employment benefits to all find themselves in the unfortunate position today of being subject to the overlapping jurisdiction in the fair employment area of multiple Federal, state, and local agencies under a variety of statutes and executive orders. Although the legislation has all been employer-targeted, the resulting chaos has a serious spill-over effect on the insurance industry.

If all of these agencies were applying consistent interpretations of equality in retirement programs and life insurance, I probably wouldn't have much of a topic to discuss with you today. But the question of what constitutes equality in retirement programs and life insurance is a matter of considerable controversy. The controversy is aggravated by a lack of understanding on the part of rule makers of the more technical aspects of retirement programs and life insurance, especially in the area of risk selection and classification.

The potential result of the current confusion is to have dramatic changes imposed upon the life insurance industry's methods of operation by well-intentioned regulatory agencies who are actually charged with the responsibility for regulation of other areas of our society and who, having expertise in these other areas, have no appreciation of the consequences of their regulations when they impact on insurance. As Caspar Weinberger, the Secretary of the Department of Health, Education, and Welfare, stated in his recent memorandum to the President (which accompanied the final draft of Title IX regulations): "With little legislative history, debate, or, I am afraid, thought about different problems of application, the Congress enacted a broad prohibition against sex discrimination."

* Mrs. Sher, not a member of the Society, is Associate Counsel for the Teachers Insurance and Annuity Association of America/College Retirement Equities Fund

It may appear that the current controversy places only the money-purchase retirement programs in immediate jeopardy. In fact, any retirement or insurance program which uses mortality tables which reflect the difference in life expectancy between males and females is faced with a serious threat.

The basis for the controversy is a fact which you all know so well - women live longer than men. What is the fair way to treat this difference in male-female life expectancy in retirement plans and life insurance in the face of fair employment legislation which, in effect, forbids classifications based on sex?

There are currently four Federal administrative agencies administering Federal bans against sex discrimination in employment: the Office of Federal Contract Compliance (OFCC), the Wage-Hour Administration, the Department of Health, Education, and Welfare (HEW), and the Equal Employment Opportunity Commission (EEOC). In addition, many Federal administrative agencies which do not have primary responsibility for equal employment opportunity are also becoming increasingly active in this area.

Initially, all four Federal agencies with primary responsibility over equal employment opportunity were applying the same guideline to determine whether or not a retirement or life insurance program was in compliance. In April, 1972, the EEOC, which administers Title VII of the Civil Rights Act of 1964, issued a new set of revised guidelines regarding sex discrimination in employment. EEOC's new, revised guideline for pensions and insurance departed from the common guideline which all of the agencies had shared up to that point.

The common guideline stated that any plan either under which an employer made equal contributions for a similarly situated male and female or under which a similarly situated male and female received equal periodic benefits would be in compliance. The revised EEOC guideline stated instead that a similarly situated male and female must receive equal benefits, and EEOC has been interpreting its guideline to mean equal periodic benefits.

In December, 1973, another one of the original four agencies, the OFCC, which administers Executive Order 11246, published notice of its intention to revise its sex discrimination guidelines. For pension and insurance, two proposed alternatives were offered and comments were requested as to which of the two should finally be adopted. These were proposed Alternative A, which mirrored the new EEOC equal periodic benefits guideline, and proposed Alternative B, which mirrored OFCC's current either/or approach.

After written comments were studied, OFCC next held hearings last September on such items as (a) respective costs of Alternatives A and B in pension plans and life insurance, (b) the effects of eliminating sex from actuarial tables, and (c) the impact of Alternatives A and B on existing plan members. Despite published reports that the decision would be issued in February, 1975, it's still a guessing game as to what will happen with this guideline, and when.

In June, 1974, another one of the four agencies, the Department of Health, Education, and Welfare, muddied the waters even more by issuing proposed regulations for administering Title IX of the Education Amendments of 1972. Title IX prohibits sex discrimination in Federally-assisted education programs, including employment discrimination by educational institutions receiving Federal financial assistance. Although the major brouhaha about Title IX has been over its athletic requirements (so that, oddly enough, in order to follow the progress of Title IX, one has to be a regular reader of the sports pages), these regulations also address themselves to equality in pension programs and other insurances.

The proposed Title IX regulations state that the either/or standard is to be applied to retirement and insurance plans. However, Title IX regulations must be signed by the President and approved by Congress before they are implemented. When the proposed regulations for Title IX were originally published

in the Federal Register, the Secretary of HEW stated in his introductory remarks that he had considered three possible approaches in this area. He had considered not only the EEOC equal periodic benefits approach and the either/or approach, but also another approach that would "mandate the use of premium tables which do not differentiate on the basis of sex" - in other words, the so-called "unisex" approach.

The Title IX regulations are now being reviewed by the Domestic Counsel, preparatory to Presidential signature. The accompanying memorandum sent by the Secretary of HEW notes the inconsistency among the Federal regulations and states: "I recommend that you direct the Domestic Counsel to convene HEW and Labor, in conjunction with EEOC, to develop immediately, a single approach to this issue."

To tally up, of the four Federal agencies with primary responsibility for equal employment opportunity, three apply the either/or standard and one, the EEOC, requires equal periodic benefits. But, of the three, one is considering changing to the EEOC approach, there's still the possibility that Title IX may mandate "unisex," and there's no telling which of the three approaches will ultimately be the single approach adopted by all.

In the midst of this continuing conflict among agency interpretations of fairness in pensions and insurance plans, there have been developments in the courts.

In a class action case brought in the Indiana State Court against the Indiana State Teachers Retirement Fund Board, the Court found that the use of the 1971 Group Annuity Mortality Table which results in the payment of greater periodic payments to men than to similarly situated women is arbitrary and discriminatory and violates not only the Indiana Constitution, but also the Equal Protection Clause of the Fourteenth Amendment.

The Court's reasoning contains several erroneous statements, such as: "At no time will a retired female teacher have received a total lifetime retirement benefit greater than or equal to that of a comparable male, all other factors being equal." The Court said that the act of paying lower periodic benefits to retired females than to similarly situated males is arbitrary and unjustifiable discrimination, reasoning that, since other factors which affect life expectancy are not considered, sex shouldn't be either.

In another case, in Federal Court this time, brought against the City of Los Angeles Department of Water and Power, the Court issued a preliminary injunction in essence forbidding the City of Los Angeles from charging higher premiums for females than for males. Female employees had been required to make larger monthly contributions than their male counterparts in order to receive equal periodic benefits. The plaintiffs alleged that this practice violates Title VII of the Civil Rights Act of 1964.

In order to issue the injunction, the Court had to make the following determinations:

(1) That plaintiffs would be likely to prevail on the merits;

(2) That plaintiffs would suffer irreparable harm without preliminary relief;

(3) That defendants will not be unduly injured by the injunction;

(4) That an injunction promotes the public interest.

In determining that the plaintiffs have reasonable likelihood of success on the merits, the Court cited the following sections of the EEOC Sex Discrimination Guidelines: "It shall be an unlawful employment practice for an employer to have a pension or retirement plan . . . which differentiates in

benefits on the basis of sex," and "It shall not be a defense to a Title VII charge of sex discrimination in benefits that the cost of such benefits is greater with respect to one sex than the other." The Court then relied heavily on the reasoning in EEOC decision #74-118 which said in part:

> "All that . . . sex-segregated actuarial tables purport to predict is risk spread over a large number of people; the tables do not predict the length of any particular individual's life.
>
> "In our view, any use of sex-segregated actuarial tables that result in the payment of different periodic pension benefits to males and females is highly suspect. Because actuarial tables do not predict the length of any individual's life, any claim that such tables may be used to assure equal pension payments over a lifetime between males and females must fail."

The Court concluded:

> "Because the Department of Water and Power's practice in question here violates these considerations by applying general actuarial characteristics of female longevity to individual female employees who in reality may or may not outlive individual male employees, the Court concludes that plaintiffs have established a case of discrimination under Title VII."

Applying this reasoning, it's easy to see that all classifications may be faulted. Since the whole principle of insurance is based on averages - not on individuals - it would appear that at least Title VII (and possibly other legislation if it falls into line with Title VII) is on a collision course with the insurance industry's risk classification system. The ultimate logical extension of this reasoning is that no classification is permissible, since it can't be predicted when an individual, rather than the class, will suffer the risk. It seems quite clear that the issue has gone beyond the threshold question of sex discrimination and even beyond the question of proper risk classification. Current activity and rhetoric appears to be aimed at the concept that there should be no classification at all.

Two basic arguments against classification seem to be in vogue these days. The first says that, even though the data is valid and it's agreed that there is a demonstrable difference, it's no longer socially acceptable to charge for and recognize the difference. The proponents of this theory are not persuaded by the explanation that objectives which are appropriate for government-sponsored social programs are not appropriate in private systems.

The second argument has equally intransigent proponents who say that guaranteeing individual rights doesn't allow classification for any purpose, including insurance. I view this as the more dangerous of the two arguments because, as I've already indicated, it seems to be working! Consequently, we are now seeing this assertion translated into interesting proposed legislation. For example, in life insurance, risks should not be classified on the basis of physical or mental handicaps. The Pennsylvania Insurance Department recently said it is an unfair discrimination and an unfair insurance practice for individuals to be charged rates which deviate from the standard on the basis of genetic or other physical or mental characteristics unless statistically significant data can be shown which will raise a "rebuttable presumption that such discrimination is justified and proper."

A year or so ago, it was expected and even hoped that the proper application of the various sex discrimination guidelines in the area of pensions and insurance would be determined by the courts, and that the judges in these courts would somehow instantly, magically understand the actuarial science and understand that even in today's climate, all discrimination isn't bad!

Unfortunately, these first two cases have had disappointing results - not merely because of adverse determination, but because the substantial confusion

and inadequate understanding which have attended this highly emotionally charged issue all along are not being dispelled.

While the interagency guideline conflict continues to create costly problems and litigation for employers, the EEOC has become a superagency with a budget in excess of $44 million and Congress has awakened to the possibility that something has gone haywire in the Federal efforts to end discrimination in employment practices. But, although late last summer committees and subcommittees began holding ongoing hearings on how Congressional intent is being carried out, to my knowledge there has been no resolution of any of the conflicts.

It seems that every month another article appears in a law review or insurance periodical condemning sex-based classification, and another state has put together another task force to look into the "unlawfully discriminatory practices of the insurance industry." As I was recently told by the female legislative assistant to a Congressman when I asked if any action was expected on his proposed legislation concerning sex discrimination in insurance: "Last year we took care of the problems women have been having getting credit, and this year the focus will be on problems women are having with insurance."

There is a suit currently pending in the Federal courts alleging that the use of the separate actuarial table differentiating by sex for the determination of benefits in a retirement plan violates Title VII of the Civil Rights Act of 1964, the Equal Pay Act of 1963, and the Fourteenth Amendment to the United States Constitution. In the guise of sex discrimination litigation, the challenge to risk classification is here.

Under scrutiny will be the validity as well as the propriety of the classification system. While the classification system is an essential element of the insurance industry, it is the actuaries who will have the burden of showing that their distinctions truly affect risk rather than moral judgments. In an era characterized by a pervasive philosophy of entitlement, I fear that carrying this burden will not be easy.

I appreciate having had the opportunity to bring these developments to your attention, for the momentum of public opinion against the risk classification system is reaching such proportions that the battle may be lost in the life insurance industry before it has really begun. As evidence one need only look at the changes already being made in the casualty and automobile insurance field. You may want to take a closer look at the articles that are being published and the kind of reasoning that is being applied by the courts and legislators. You may want to start using whatever means are at your disposal to enlighten the public by explaining what risk classification is all about, to describe the need for equity rather than equality in life insurance, and to explain that basically, by spreading risk equitably, all insurance is meeting important social objectives.

There is a positive value in maintaining private insurance as an integral part of the nation's economic system. Subjecting it to well-intentioned mandates which artificially force private insurance to meet every social goal of the moment threatens its continued healthy existence.

MR. WILLIAM A. WHITE: One of the more interesting problems of regulatory work is explaining developments involving actuarial concepts to reporters. Interest-adjusted cost disclosure methods have presented an unusually difficult challenge. It used to be almost a monthly occurrence that some newsworthy consumerist would issue a statement demanding the immediate implementation of one or another of the interest-adjusted cost methods. A sharp-eyed State House reporter, reading the wire service's account of this statement, would then call or visit the Department of Insurance to obtain an explanation. The usual actuarial explanations about level premiums for in-

creasing risks, the build-up of cash values, and the time value of money invariably produced blank stares. After a while, we achieved some measure of success by inventing a wily Greek, Mr. Aristotle Apocrypha--one of the first citizens of my home town of Cherry Hill, New Jersey.

Mr. Apocrypha became famous and prosperous almost overnight by revolutionizing the automobile retailing business. For those of you not familiar with Cherry Hill, the Apocryphal Automobile Agency is on the site of the old Chevrolet showroom, right next door to what used to be the Cherry Hill National Bank. I mention the bank for two reasons. First, the bank features 5-year certificates of deposit, minimum amount $1,000, paying guaranteed 6% annual simple interest. Second, the bank is now the Aprocryphal National Bank. Mr. Apocrypha became so successful that he was able to buy it out several months ago.

Mr. A's major contribution to automobile retailing was the introduction of the Moneyback SPX--the "car you can't afford not to buy." At first the public was turned off by the $13,000 price tag of the Moneyback SPX, but this was before it appreciated the outstanding quality implied by Mr. A's ironclad guarantee: After five years, bring me back your Moneyback SPX, or even just a hub-cap, and I will refund to you every cent you paid for it. Skeptics claimed that the Moneyback SPX looked exactly like the Chevys you used to be able to buy at the showroom for $3,000, but, needless to say, people flocked into the Aprocryphal Automobile Agency in droves, attracted by ads for "free automobiles" and the slogan "you may never have to buy another car." Fortunately, the story about the Aprocryphal Automobile Agency never moved a reporter sufficiently to appear in print, as the concept of a "grafted on" savings program designed to mislead the public could easily produce unflattering and incorrect conclusions as to the nature of permanent life insurance. Nevertheless, the story seemed to be effective as an educational tool for both reporters and people within the Department who could never understand the fallacy of the "traditional surrender net cost" method or the necessity for taking interest into account.

Most people, confronted with Mr. Apocrypha's novel selling method, are able to figure out by themselves that $3,000 is going into the automobile and $10,000 goes into a certificate of deposit which returns $13,000 after five years. The moral to our story is that an interest-adjusted cost analysis of the Moneyback SPX should reveal a true cost, assuming 6% simple interest, of $3,000.

For purposes of our discussion this morning, there are two conclusions to be drawn from the foregoing narrative. First, there is no way that the public is going to grasp the importance of the "time value of money," or foregone interest, unless the concept can be expressed in terms with which the public is generally familiar. Second, the more important, the Moneyback SPX proposition is easy to see through because the average person has a solid base of reference in that most of us have a pretty fair idea of how much automobile should be received for $3,000 or $13,000. A comparable base of reference is totally lacking in any evaluation of life insurance costs. It is primarily for this reason that I am very pessimistic about the probability that any "simple" cost disclosure method for life insurance can ever be an effective tool for use by consumers.

Let me offer three general personal observations concerning the whole field of disclosure in the area of life insurance sales. The first observation is that "product disclosure" is much more important than "cost disclosure." This implies an educational responsibility, for both the agent and his company, far beyond what is provided today. The average purchaser of life insurance is never going to be able to make a value judgment as to the cost or adequacy of his life insurance purchase until he has a fairly clear understanding of the life insurance product and its major variations. The consumer's choice of

agent or company is going to have to be made on the basis of intangible, largely emotional, factors such as reputation, personality, and "glamour" image. This is the same sort of determination that is made by the consumer in almost every other purchase decision in our economy, and it is a totally unwarranted intrusion of the government or regulatory agency if we assume the responsibility of making that value judgment for the consumer. However, the consumer, having selected his agent and company, should have available all the accurate and objective information he can digest in order to make his own personal decision as to the kind and amount of life insurance which is best suited to his personal needs and financial abilities. This, obviously, is much more easily said than done. There are companies, agents, and governmental agencies making sincere efforts to educate the public as to the nature of the life insurance product. It is still an unfortunate fact that most purchasers of life insurance do not understand what they have bought, what it will cost them, and what alternatives might have been available. The basic life insurance decisions are still being made by agents, and all too often these decisions are more in the best interests of the agent than of the buyer. Utopia will have been attained when an agent can say: "Well, Mr. Prospect, we've identified your insurance needs and your financial abilities. Here's everything my company has to offer. What kind of life insurance, and how much, do _you_ want to buy?"

My second observation deals with the dangers inherent in oversimplified cost disclosures. I feel the insurance departments and consumerists are doing the public a major disservice by striving for a single cost index that will be meaningful to the consumer. Any cost index, no matter how precisely calculated and all-inclusive of cost components, is going to mislead the insurance buyer if it concludes with an expression of average costs over an extended period of time. The fact is that the incidence of costs of life insurance differs greatly from policy year to policy year. Any system of cost presentations, especially for permanent life insurance, that conceals or plays down the disastrous cost consequences of early termination works to the disadvantage of both the public and the insurers. That is not intended to be critical of either permanent insurance or of the industry's traditional cost patterns. However, permanent life insurance must be sold as permanent, and the most effective way to accomplish this is to dramatize to the prospective purchaser, as emphatically as possible, the financial consequences of early voluntary termination of his insurance. You're probably sick of hearing me say this, but the single most glaring embarrassment for the life insurance industry is its poor early-duration persistency on permanent insurance. I have to place the bulk of the blame for this on company marketing methods. By this I do not mean individual agents. This problem is so acute that I could almost justify a requirement that each sale of permanent life insurance be preceded by a caution, in bold red letters, saying in effect: Warning: The Insurer General Has Determined That This Policy Is Going To Cost You A Hell Of A Lot Of Money If You Don't Intend To Keep It In Force For More Than A Year Or Two.

My final observation deals with dividend illustrations. Most of us who have worked for large mutual insurance companies have witnessed the emphasis, real or imagined, on contriving dividend scales so as to optimize the company's competitive position in cost comparisons. With the inevitable increased importance attached to cost disclosures and cost comparisons, this situation of the "tail wagging the dog" can only get worse, and the people most likely to suffer are those old policyholders in closed blocks of business whose dividends are no longer illustrated.

I suspect the time has come for a critical reevaluation of the traditional regulatory position (and company disclaimer) that dividends are not estimates or predictions of amounts the company will actually pay. What is wrong with a company's "predicting" what its future dividends will be? The usual concern

is that freeing dividend illustrations from the reality of dividends currently paid will lead to uncontrolled competition among optimists or liars. I see no theoretical reason why "predicted dividends" could not be soundly implemented, or even required for cost comparison purposes, given an enlightened and effective system of governmental regulations to back up the predictions. As a first step, interest, mortality, and expense assumptions would have to be either standardized or justified as consistent with logical projections of current conditions. More important, companies would be held accountable by regulators for a reconciliation of actual dividends to projected dividends, with the understanding that dividend predictions would not be permitted for any company that was unable to satisfy the reconciliation.

This is a new and potentially very controversial suggestion. It is likely to be opposed by companies as an intrusion on rate making and profit determination decisions, and by regulators as an invitation to chaotic cost illustration practices. I hope that the suggestion might have enough merit to justify study by our Society and by the NAIC. Possibly someone in this audience is enough intrigued by the idea to volunteer to write a paper on "Pros and Cons" for publication in our Transactions.

MR. SHELLY: Suppose a company decides it must improve its cost indices. The June issue of "Buyer's Guide" shows it down in the middle of the pack, and the chief executive officer has indicated a change is needed. Two possible suggestions come to mind:

Adopt an effective expense control program which would improve efficiency and cut unit expenses without reducing service or results.

Adopt a program to improve lapses without changing existing economic markets.

These could have some long-term effects but probably not until after the chief executive officer retires.

More likely, their thinking will go about as follows: Our real competition is with well-run companies with relatively low service standards. These companies also underwrite for a narrow, select,standard mortality class. They have a high average size policy with low lapse rates, presumably from operating only in the upper income classes. If we are going to get our cost indices down to their level, we are going to have to emulate them.

From a portfolio standpoint, we will come out with a complete new series built around the index rules. Shall we have pro rata refund of premiums paid beyond date of death? No way, since that costs money and does not show up in the index. How about age last birthday? No again. That gives a disadvantage. Competitive premiums for supplemental benefits? Not worth it. They do not help. Liberal conversion privileges in term policies and benefits? They increase basic costs and do not show up in the index. Same answer for settlement options and high early values.

You can go on and on with this list. I do not expect all these things to happen, no matter what kind of regulation emerges. But pure price competition just has to set the stage and create the forces for companies to move in these directions.

I am not for a minute being critical of companies whose operating policy is to have the lowest cost of insurance. I have envied them from time to time. I do object to the concept that all companies should be forced into this mold. There are different ways to cut the pie. We cannot all aim at a $40,000 average size policy and sell only to people who are so healthy they do not really need the insurance. I hope there is room in the marketing environment, and a

need, too, for companies that have different goals than the lowest price. There are millions of satisfied policyholders in such companies.

From the standpoint of administration, the model regulation is not really burdensome as it stands. However, there are proposals being considered that could be a nightmare. For example, a proposed California bill would require, among many other horrible things, that each year's dividend notice compare the actual dividend with the illustrated dividend when the policy was sold. For what purpose? Dividend illustrations are based on the dividend scale in effect at issue of a policy. If mortality, interest, or expense experience requires a reduction in dividend scale, the dividend must be reduced. What is the policyholder to do with this information? Replace his policy in another company? That could cause him a real financial loss. Write to his company and complain? That won't improve experience. Chances are that most companies are taking similar action in response to the same changes in experience.

The only real effect of such a regulation might be to deter a company from reducing its dividend scale when circumstances require that action. This is certainly not in the policyholder's best long-term interests.

There is much that companies have done over the years to respond positively to the consumer interest which receives little publicity in the current controversy. I must rely on some of the practices of my own company, The Equitable Life Assurance Society, but I know other companies have their own impressive list:

1. For reviewing and settling policyholder complaints, we have an officer committee empowered to refund all premiums and collect back commissions on any policy which the committee finds has been misrepresented in any way. I have served on this committee. It is sympathetic to the policyholder's needs. Incidentally, we sold 258,000 policies in 1974 and only about 600 resulted in complaints. That is less than 1/4% and even some of these complaints were found to be unwarranted. About 80% of the complaints were resolved in the policyholder's favor. This committee is not new. It has been around for more than 35 years.

2. We started publishing interest-adjusted net costs for all our policies in 1971 and instructed our agents how to use them for comparison.

3. We now have a ten-day free look in our policies. This guarantee grew out of long-standing practice. Our Complaint Committee has always automatically cancelled policies on which there was a quick change of mind.

4. We have a toll-free 800 number so policyholders can register complaints and ask for service from all over the country. I might add that we badly overestimated the volume of these calls and have been pleasantly surprised by the low level of activity on this line.

5. There will be no more orphaned policies. All are being assigned to quality agents for service.

6. We have inaugurated a shopping program with ten reinsurers to try to get the best underwriting rating for highly rated and declined policies.

7. Our new agent's contract eliminates our prior rights agreement, so that our agents can now place business in other companies when it is in the client's interest to do so.

These are not exactly sharp business practices and some are very expensive. However, these measures are designed to solve the consumer's problems and not to create any new ones. They have gone a long way for us in building a viable relationship with our policyholders. I feel, with some pride, that our experience belies the sensational claims of many of our critics. Further, our experience is not unique, but rather it is characteristic of an industry which is doing a pretty good job for its consumers.

MR. WHITE: There is undoubtedly a great deal of confusion and inadequate understanding surrounding consumerist developments. This is true of both the life insurance industry and its regulators. In each case, the underlying cause is parochial thinking. By this I mean the failure to convey and to comprehend an alien viewpoint. I will begin with the regulators.

Most regulators (and, in fact, most popular consumerists) are lawyers who have had fairly thorough exposure to property and casualty insurance systems, social insurance, and quasi-social insurance schemes. Their knowledge of voluntary life and health operations is at least as limited as the typical life actuary's awareness of property and casualty insurance operations.

"Consumerist regulation," to date, has been predominantly shaped by socially-oriented responses to problems which have arisen in the non-life (that is, the property, casualty, and health) insurance areas. Regulators, as human beings, tend to bring to life insurance the same prejudices and to apply the same remedies as have been encountered in non-life insurance problems. Life insurance does present legitimate consumerist challenges to regulators, but these challenges are largely unknown or ignored. If the life insurance industry is to avoid irresponsible consumer-directed regulation, it must first educate the regulators as to the unique nature of the life insurance product and as to the dissimilarities between life insurance and the insurance products with which regulators are familiar.

I know of one commissioner who seemed genuinely surprised, if not enlightened, when I suggested that the purchase of life insurance is one of the most unselfish decisions a person can make. Property, casualty, and health insurance purchases are normally made in an atmosphere of coercion: either the "mandatory" atmosphere of compulsory automobile, fire, and workmen's compensation insurance, for example, or the selfishly-defensive atmosphere of health insurance. It is absolutely necessary that the life insurance industry stress to regulators the voluntary nature of life insurance, and that a life insurance company represents a cooperative assembly of prudent people who are under no obligation to purchase.

A major fault of regulators is failure to distinguish between "discrimination" and "unfair discrimination." By the same token, the parochialism of life insurance actuaries and executives results largely from an insistence on "individual equity" in instances where these considerations must be tempered, if not ignored. The actuarial profession has paid far too little heed to the necessary justifications for community rating principles for social, mandatory, and quasi-mandatory insurance systems, where the availability of insurance at "reasonable" cost is a necessary part of everyday activities and where "ability to pay" -- the deliberate subsidy of the less fortunate by the more fortunate -- is a legitimate actuarial rate-making concern. This approach is, of course, embraced by life companies in group insurance areas. It has always been a part of social insurance schemes and has worked successfully in other non-life lines such as Blue Cross and Blue Shield. It is presently invading the automobile and fire insurance fields. I trust you have all read and re-

acted to the excellent article in the December 1974 Academy Newsletter on "The Residual Market," which digests the property and casualty problem of "availability" very nicely and indicates contemporary directions of regulatory thinking. This article, by Matthew Rodermund, F.C.A.S., describes the movement toward "full insurance availability" in the automobile insurance market and the resulting breakdown of the traditional classification system.

MR. E. J. MOORHEAD: The year 1975 promises to be significant in the area of policy cost comparison and disclosure. Maybe some actuaries are growing weary of this subject, but, weary or not, it seems in our profession's best interests to speak with a voice that is authoritative and that is sufficiently clear so that people will know that the actuaries have spoken.

Germane to this subject are three questions that surely must be faced if we are to emerge from all this with distinction. I used to think I knew the answers to them, but, for me, the confidence of yesterday has become the puzzlement of today.

First, do life insurance people consider that their ethical responsibilities to the public in the sales process are identical with those who sell supermarket products, clothing, or automobiles? Repeatedly, I am told that we should limit ourselves to so-and-so because such-and-such is what the buyer gets when purchasing a can of peas, a new suit, or a motorcar. I thought that we pictured our fiduciary relationship as different from those others; perhaps because of the complexity and long-term character of life insurance; perhaps because of the damage that wrong decisions can cause; perhaps simply because we see our own interest identified with a relationship of unusually deep trust and confidence. Now I am not so sure.

Second, is it generally believed, in home office and field, that an agent's task in the home of a prospect is amply discharged if he invariably and exclusively offers the products of the company that houses and maintains him, regardless of the prospect's best interests? Some home office people sound adamant about the economic necessity for withholding from the agent the freedom to sell the products of another company when, in his opinion, the circumstances call for it. Meanwhile, the agents seem to be going right ahead brokering business under such circumstances, creating surely an unnecessarily unhealthy relationship with their own company in doing so. The home office seems to wink at the practice while loudly deploring it.

Third, do actuaries really believe what the Institute of Life Insurance booklet, The Nature of the Whole Life Contract, says of us in its section, "As the Actuary Sees It"? Three actuaries are quoted. One is pictured as viewing a premium split between protection and savings elements as an intriguing arithmetical exercise, while the other two are said to regard such a split as either artificial or at variance with the true unitary nature of a life insurance policy. My current notion is that perhaps actuaries widely agree that splitting the premium into components is artificial, but that splitting the face amount into components is far from artificial. In fact, it is useful to the policyholder in making decisions about the disposition or continuance of his policies and is essential to the actuary for dividend computation by the customary three-factor formula.

It appears that Senator Hart will soon unveil a piece of proposed Federal legislation to get, as he has put it, "public reaction and discussion." At the state level, the NAIC Task Force on Life Insurance Cost Comparisons will conduct a two-day seminar in Colorado next Sunday and Monday, leading presumably to their recommendations.

In preparation for that seminar, two papers have been prepared. One of these sets forth what the regulators regard as their own responsibilities in this matter. The other gives highlights of the reports on the twelve research projects that were commissioned by the Task Force almost two years ago. The

hoped-for result of this array of research projects is to throw light on major questions that were being debated when the NAIC first considered regulations covering cost comparison and disclosure in 1972. The Society of Actuaries has been deeply and, I think, usefully involved, in that its Munson Committee produced two reports dealing with three of the projects, an individual actuary produced two of the other reports, and numerous Society members in company associations and companies have had major parts in the research and the writing for most of the rest.

An observer of today's business scene has said (Harvard Business Review, Mar.-Apr. 1975) that, whenever business has adopted an adversary posture toward government and has failed to help shape legislation constructively, it has usually lost both the legislative battle and the esteem of the people. This year, 1975, is a poor time for the facades, smoke-screens, and special pleading that have far too often been evident in the discussions of these questions during a period that now has extended over more than a decade.